QUALITY AND SAFETY IN HEALTHCARE: DOES LEADERSHIP BEHAVIOUR OF COMMISSIONERS AFFECT OUTCOMES?

PETER JOSEPH JOHN BOHAN

A thesis submitted in partial fulfilment of the requirements of Liverpool John Moores University for the degree of Master of Philosophy

September 2015

Abstract

Clinical Commissioning Groups (CCG's) now control two-thirds of the NHS budget for England, influencing healthcare provider priorities and playing a key role in implementing the NHS plan. However significant failures in healthcare has highlighted a dissonance between expressed values of leaders and everyday routine practices. This research aims to explore the leadership behaviour of Commissioners and the role it plays in determining Quality & Safety (Q&S) in healthcare. The research took a pragmatic mixed method approach using two phases: phase 1 used focused video ethnography to observe Commissioners (n=9) verbal and non-verbal communication in an open forum setting. The research method further develops the process to observe real time group dynamics and may aid decision making processes for leaders in healthcare. Phase 2 employed a quantitative questionnaire (n=48) to determine the leadership behaviours that subordinates would expect their Commissioners to adopt.

The findings of this research identified that the leadership style most prevalent within the Commissioners was transactional in nature. The Commissioners felt joint ownership of the risks to patients from providers of healthcare services, with empathy and understanding of the pressure their colleagues were under. The most prevalent behaviour within the group determined outcomes of risk analysis. The questionnaire to subordinates of Commissioners identified that transformational leadership had the best outcome on staff performance if this was linked to positive leadership style.

In addition Commissioners appeared to lack consistency when analysing risks effectively and therefore holding providers to account, citing issues such as "professional drift" and concerns over further scrutiny, as validation for this approach. This confusion of leadership behaviours, allied with poor analysis of risk leaves Commissioners prone to repeating previous healthcare failures.

Acknowledgements

This work is marked by the contribution of a number of people who I would like to thank for their support. Firstly, Graeme Mitchell, my Director of Study, who has encouraged me to explore new methods of working and kept me focused on the aims and objectives of the thesis. Dr Lorna Portello my second supervisor who has assisted in developing a more structured approach to my work; Dr Ivan Gee who supported the work on statistical analysis (SPSS) and finally my third supervisor Michelle Laing who without her support during my first Masters I would not be undertaking this work.

Secondly, Commissioners who took the time to attend the open forum and allowed themselves to be videoed contributing significantly to the findings of the research; the staff from commissioning groups who completed the questionnaire and the technical team at Liverpool John Moores University who undertook the filming, which provided the evidence to support the findings of this thesis.

Finally, my family who have supported me to undertake studies whilst working full time and dealt with the day to day pressures this has involved with good humour and encouragement.

Table of Contents

Publications and presentation in relation to this study are found after the list of tables.

Chapter 1: Introduction & background

1.1 Introduction..……...……....1
1.2 Background to study……..……...……1
1.3 The research questions……..……8
1.4 The research aims and objectives……...…….....8
1.5 Research process..…….…….....9
1.6 Significance of study……...12
1.7 Original contribution to knowledge.…….....14
1.8 Outline of thesis……..15

Chapter 2: Literature Review

2.1 Introduction……..…….……18
2.2 Climate within the NHS……..19
2.3 Q&S in healthcare……..…….....23
2.4 Culture…….....25
2.5 Leadership behaviour…..……...……..32
2.6 Group behaviour…..……...…….....42
2.7 Leadership questionnaire..……...……...46
2.8 Post Francis review……47
2.9 Summary……55

Chapter 3: Methodology of study

3.1 Introduction……. …….…….56
3.2 Mixed methods…….……..56
3.3 Ethnography……..……60
3.4 Coding of non verbal communication……..…….…….68
3.5 Research design……..…….....70

3.6 Research process……...75
3.7 Participants and sampling……..…….76
3.8 Phase 1: Procedure for video ethnography…..……...…….78
3.8.1 Phase 1: Data collection and analysis……...84
3.8.2 Phase 1: Non verbal communication……88
3.9 Evaluation of verbal and non verbal communication…..……...……..92
3.10 Phase 2: Questionnaire……..94
3.10.1 Rationale for selected methodology……...…95
3.10.2 Phase 2: Data collection and analysis…….96
3.11 Limitations of study……..97
3.12 Ethics of research……..99
3.13 Summary……...99

Chapter 4: Findings

4.1 Introduction……...…101
4.2 Results: Phase 1……101
4.3 Non verbal communications…… ……..……...104
4.4 Discussion Phase 1……116
4.4.1 Summary……119
4.5 Results Phase 2...……..……...……..120
4.6 Discussion Phase 2……138
4.7 Summary……..…….140

Chapter 5: Risk Analysis

5.1 Introduction…… ……..……141
5.2 Overview of risk management……..……141
5.3 Results of risk analysis……..143
5.3.1 Finance……...144
5.3.2 Misdiagnosis…….……145
5.3.3 Culture……...148
5.3.4 Complaints…….....151
5.3.5Targets……153

5.4 Discussion on findings……154
5.5 Summary……...162

Chapter 6: Discussion on findings

6.1 Introduction……163
6.2 Context of healthcare..……..163
6.3 Commissioners leadership behaviour……...165
6.4 Group decision making……166
6.5 Non verbal communication……...171
6.6 Leadership and culture……..173
6.7 Summary……...177

Chapter 7: Conclusion and recommendations……..……178

Post research position……184

References……...……...185

Appendix 1: Questionnaire & evaluation for SPSS...…….……207

Appendix 2: Open forum meeting with annotations of body language……..……211

Appendix 3: Evidence of coded actions verbal information.....……..227

Appendix 4: Commissioner 1 non verbal communication (example)..…….....230

Appendix 5: Invitation letter…..……...…….....237

Appendix 6: Participant information sheet.……..……...238

Appendix 7: Consent form…..……..……...,.240

Appendix 8: Scenarios provided to the group and model answers……..……..….241

List of acronyms

A&E Accident and Emergency

BCT Behavioural Complexity Theory

CBI Confederation of British Industry

CCG Clinical Commissioning Groups

CEO Chief Executive Officer

CIPD Chartered Institute of Personnel and Development

CMO Chief Medical Officer

CSB Chemical Safety Board

CSU Commissioning Support Units

CQC Care Quality Commission

DoH Department of Health

ED Emergency Department

GP General Practitioner

HASWA Health & Safety at Work etc Act 1974

HEE Health Education England

HCC Healthcare Commission

HCA Healthcare Assistant

H&S Health & Safety

HSE Health and Safety Executive

IRAS Integrated Research Approval System

LJMU Liverpool John Moores University

LA Local Authority

LQF Leadership Qualities Framework

MRSA Methicillin-resistant staphylococcus aureus

MLQ Multifactor leadership questionnaire

NASA National Aeronautics and Space Association

NHSLA National Health Service Litigation Authority

NHS National Health Service

NHS FT Foundation Trust

NHSLA NHS Litigation Authority

NICE National Institute for Health and Care Excellence

NMC Nursing and Midwifery Council

NPSA National Patient Safety Agency

OBM Organisational Behavioural Management

PCT Primary Care Trust

PHE Public Health England

RCN Royal College of Nursing

RM Risk Management

SHA Strategic Health Authority

SPSS Statistical Package for the Social Sciences

STEIS Strategic Executive Information System

RCT Randomised Controlled Trials

TPB Theory of Planned Behaviour

Q&S Quality & Safety

QC Queens Counsel

WHO World Health Organisation

WUTH Wirral University Teaching Hospital

List of figures

Figure (1) Overview of Commissioners structure ……..……4
Figure (2) Structure of research ……..……..12
Figure (3) Safety culture maturity model ….……..…..28
Figure (4) NHS Leadership model…….……..36
Figure (5) Theory of planned behaviour……..…….……42
Figure (6) Methods for research……..…….…….72
Figure (7) Process for research study……76
Figure (8) Behaves well as a leader ……..…….124
Figure (9) Transformational leadership style…..…….……...……126
Figure (10) Target and decision making……...……..……127
Figure (11) Behaves well as a leader and is supportive…..……..129
Figure (12) Team are positive about leader……..……..130
Figure (13) Clear vision from leader……...…….…….……...……..132
Figure (14) Leader is supportive of the team...…….……..…….……...133
Figure (15) Deals with performance and conflict……..…….135
Figure (16) Treats individuals well…..……..……....……136
Figure (17) The effects of leaders on followers performance …….138

List of tables

Table (1) Mixed method concurrent triangulated design ….……...…..73
Table (2) Stages of integration determining the mixed model method approach.…..……..74
Table (3) Conventional and focused ethnography……..……..75
Table (4) Sampling scheme used for research……..……77
Table (5) Scenario on Mid Staffs inquiry…..…….……...…….82
Table (6) Evaluation of behaviours……..……..……87
Table (7) Evaluation of non verbal communication……...…….…...……89
Table (8) Grouping of verbal and non verbal behaviours…… ..……..93
Table (9) Behaviour types observed…… ..……...…102
Table (10) The level of transactional or transformative leadership behaviour observed….102
Table (11) Commissioner actions by behaviour type……..……103
Table (12) Results of Commissioners non-verbal communication…..……..…….104

Table (13) Grouping of verbal and non-verbal coding..…… …….113
Table (14) Age range of participants……...…….....121
Table (15) Position within organisation…….....……...121
Table (16) Position of line manager……..……..121
Table (17) Time in post……...…….....121
Table (18) Frequency manager discussed values and beliefs……..121
Table (19) Frequency discussed vision…….……...…...122
Table (20) Number of times leader supports staff……...…….122
Table (21) Number of times leaders available to discuss problems issues……122
Table (22) Targets and decision making……..……..…….125
Table (23) Behaves well as leader……..…….……...126
Table (24) Team beliefs expressed ……..……..……..……..128
Table (25) Supports of staff…...…….……..…..129
Table (26) Team are positive about the leaders……...…131
Table (27) Leader shows vision…….……132
Table (28) Leader is supportive of staff…….……133
Table (29) Leader manages conflict and performance……..……..135
Table (30) Individual performance ……...…..137
Table (31) Finance scenario……..……...……...144
Table (32) Misdiagnosis scenario ……..……..……..146
Table (33) Culture scenario…….……...……148
Table (34) Complaints scenario……..……151
Table (35) Targets scenario……...……...……...153

Outline of Researcher

The researcher is employed as Head of Organisational Health and Effectiveness at Wirral University Teaching Hospital NHS Foundation Trust. The role provides visible professional leadership to the board for a full range of services including health and safety (H&S), occupational health, welfare effectiveness, budget control, maximising workforce engagement and developing strategies to maximise attendance and wellbeing. The role has a number of elements which include taking a proactive approach to the embedding of services and workforce design, staff engagement through listening in action (LiA) events and the provision of support through education and training for clinical and non clinical staff.

The researcher has a Masters Degree in Health and Social Care Management, a BSc Honours degree in Health, Safety and Environmental Management and is a Chartered Member of the Institute of Occupational H&S (CMIOSH). The researcher has successfully published papers on leadership behaviour in the British Journal of Healthcare Management (2012 and 2015) and the American Journal of Public Health (2014). The researcher has contributed a chapter on Management Culture within the NHS in the book *Patient Safety Culture, Theory Methods & Practice* (2014). In addition the researcher regularly peer reviews papers for the British Medical Journal. The researcher has both presented and chaired at International Patient Quality & Safety (Q&S) Conferences in the UK, Saudi Arabia and Abu Dhabi (2013) and IOSH conferences (2014 and 2015). The researcher has recently presented the findings of this research 'Examining Commissioners Leadership Behaviour' at the European Union of the Society of Preventative Research (Slovenia October 2015) and will be presenting on the subject of leadership behaviour in H&S at the IOSH Middle East conference in Oman April 2016.

The researcher has over 25 years experience in the public sector, which has included employment within three local authorities and four NHS providers. For the past 10 years the majority of the researcher's work experience has been within the NHS and has been centred on a Risk Manager role, with responsibility for providing pro-active leadership and support to the Board and Directors in the effective implementation and development of innovative and highly effective integrated Governance processes which include risk evaluation, management and control. As part of the researcher's current role he develops strategies and policies for the NHS around H&S and Governance, as well as delivering relevant training to staff. This role also involves representing the Trust on matters concerning the Health and Safety Executive (HSE), Merseyside Internal Audit Agency and the Care Quality Commission (CQC) thus ensuring legislative compliance is maintained through external and internal audits/inspections. The researcher manages external contracts, which include the effective development of service level agreements and the monitoring of performance.

The researcher's interest in the Q&S agenda has developed over the past ten years and was further developed whilst working at Warrington and Halton NHS Foundation Trust Hospital as Head of Safety and Risk from 2010-2013. As part of his Master's Degree in Health and Social Care Management, his dissertation focused on the leadership behaviour of executives and how it influenced Q&S. The previous research saw the development of a Trust wide cultural survey tool, which identified how Q&S was viewed by staff within the Trust This resulted in two major outcomes; firstly, a strategy for Q&S within the Trust that ran parallel to the Workforce, People and Leadership Strategy. The Q&S strategy provided a strong narrative and a 'line of sight' between the job role and the organisations vision. Secondly, an executive leadership programme was developed which ensured all projects were directly linked to the organisations vision and values. It was clear from this original research that further work on the wider leadership issues within the NHS, particularly from a Commissioners perspective, was required.

Publications and presentations supporting this study.

Presenting at the 6th International Conference and members meeting at European Society for Preventative Research

Dear Applicant,

The SPAN project is pleased to notify you that your application to attend the SPAN pre-conference workshops and EUSPR conference in prevention science has been approved.

The SPAN project is funded through the Erasmus Lifelong Learning scheme operated by the European Commission. As per our funding guidelines, all costs associated with the SPAN project are reimbursed on an ***actual costs incurred*** basis. This means that all costs associated with attending the pre-conference workshop/conference must be paid for *by the participant* and will then subsequently be reimbursed by the project.

Matej Košir

European Project Manager - SPAN

Science for Prevention Academic Network

Published article based on this thesis in British Journal of Healthcare Management August 17th 2015.

Article for Publication.pdf

The researcher also peer reviews papers for the British Medical Journal and British Journal of Healthcare Management on issues relating to Q&S in healthcare.

Published September 2014 Chapter 16: Leadership Behaviour and Safety Culture in the UK NHS: A Managers Perspective Peter Bohan

The researcher published a paper in the American Journal of Public Health
"Can leadership behaviour affect Quality & Safety (Q & S) in complex healthcare environments?"
Vol. 2, (2) pp. 56-61 DOI: 10.12691/ajphr -2-2-4
Available from www.pubs.sciepub.com/ajphr/2/2/4

Presented at International Conference (Institute of Occupational Health & Safety IOSH) London 17th June 2014'culture change in the NHS'.

Safety and Health Practitioner posted 1st May 2014 Safety Management IOSH Conference on leadership: five seminars not to miss. The theme of this year's IOSH conference is ' inspiring leadership', with speakers such as HSE chair Judith Hackitt CBE and Lawrence Waterman, Head of H&S at the Battersea Power Station Development Company (and formerly Head of H&S for the London 2012 Olympics project) delivering keynotes on effective ways to engage with a workforce. The theme runs through seminars and panel sessions throughout the conference, so we have picked the sessions you really shouldn't miss.

Peter Bohan, Head of Organisational Health and Effectiveness, **Wirral University Teaching Hospital NHS Foundation Trust Emma Jones**, Lawyer, **Leigh Day**
The Mid-Staffordshire NHS Foundation Trust scandal and its subsequent investigation will have a wider impact on the NHS in the years to come. Emma Jones, a lawyer for Leigh day, worked on the case and will share her experiences to explore the repercussions of a failure in leadership. Peter Bohan, head of organisational health and effectiveness at the Wirral University Teaching Hospital NHS Foundation Trust will add some positivity to this session, however explaining how to change the organisational culture to improve performance for patients and staff in a complex healthcare environment.

This year's conference will feature over 80 high-level speakers and four themed tracks including a track of sessions dedicated exclusively to leadership: using effective leadership to build a safety culture across your workforce, developing leadership behaviours in complex or large organisations and the psychology of leadership

Presented findings at Healthcare Strategy Forum Marriott Hotel, Worlsey Park, Country Club, Manchester, 1st October 2013.

10:40 - 11:00 **Solution Provider Case Study**

11:00 - 11:20 **Improving Quality and Safety in a Complex Healthcare Environment? What Can Us Leaders do?**

Peter Bohan
Head of Safety & Risk, Warrington and Halton Hospitals

Leadership plays a critical role in ensuring high quality and safety standards are met within the NHS. Peter Bohan has spent the last five years researching leadership styles, the effects of different styles of leadership on quality and safety as well as developing a successful organisational effectiveness strategy. He will share his research and insights into:

Topics covered

- Addressing cultural aspects of Q&S from the outset
- Looking at different leadership styles and how to develop the most optimal style
- What can we learn from previous errors and how can we successfully put together a consistent, efficient and practical quality, safety and organisational effectiveness strategy?

Warrington and Halton Hospitals NHS
NHS Foundation Trust

11:20 - 11:40 **Solution Provider Case Study -**

Presented at IOSH Conference June 3rd 2015 Effective leadership throughout the organisation.

Sustainable OSH behavioural cultures

Manchester and North West Districts Branch, Merseyside Branch and North Wales Branch

03 June 2015

Select Security Halton Stadium, Lowerhouse Lane, Widnes, Cheshire, WA8 7DZ

Introduction to the study

Chapter 1

1.1 Introduction

The aim of this chapter is to provide an introduction to the study, giving a brief overview of the context of the research, identifying the background and nature of the research problem. The chapter explores the objectives and describes the research questions, demonstrating the significance of the study. The introduction also provides detail of the methodology used and the structure of the thesis which is divided into seven chapters.

1.2 Background to the study

The public inquiry (Francis 2013) into the failings of the Mid Staffordshire (Mid Staffs) Hospital in 2013, identified that a combination of poor leadership and a culture that paid scant regard to Quality and Safety (Q&S) led to as many as 400-1,200 additional patient deaths at the hospital within a three year period from 2005-2008. These deaths were as a result of a culture within the hospital that was blind to the suffering of patients. In addition it was found that the Commissioning Board was out of touch with realities on the wards, which left vulnerable patients deprived of water and lying in their own excrement.

The inquiry led by Robert Francis Queens Counsel (QC) (2013) describes a particularly poor culture within the nursing and the medical profession with lessons not being learned and corporate memory

being lost as a result of repeated multi-level reorganisation. In an interview with The Telegraph in (May 2014), Robert Francis QC said

> 'The public had been given a falsely positive impression about the quality of care being provided in many of the country's hospitals. The NHS is so unsafe that if it were an airline planes would fall out of the sky all the time,'

Q&S in healthcare is not a new concept or the sole responsibility of any one organisation or individual but a collective endeavour requiring the efforts and collaboration at every level of the NHS management system. 'First do no harm' is the basis for universal care; it is not just a slogan for health care, it is the central aim (Advancing Quality Alliance 2013). Placing the patient at the heart of the health service requires a workplace culture of effectiveness that ensures that safety is at the forefront of all those involved in the process.

For many years the NHS benefited from crown immunity, meaning that there was no legal accountability on Doctors or other members of the NHS profession to be held to account in a criminal prosecution. Since the introduction of the NHS Community and Care Act 1990 there has been a change within the NHS as crown immunity has been revoked. In addition a number of high profile cases, such as the Bristol heart scandal (Kennedy 2001) and the Mid Staffs inquiry, have brought issues of leadership behaviour and the safety culture within the NHS under greater public scrutiny. In 2003, the Chief Medical Officer (CMO) Liam Donaldson found that even with the revision of the negligence system, redress for patients suffering the result of an adverse event in healthcare was unfair, overly complex, slow to achieve outcomes and costly in terms of legal fees. He believed that it encouraged concealment and the practice of defensive medicine, thereby acting as an obstacle to

improvements in hospital safety and quality of care (Graham 2012).

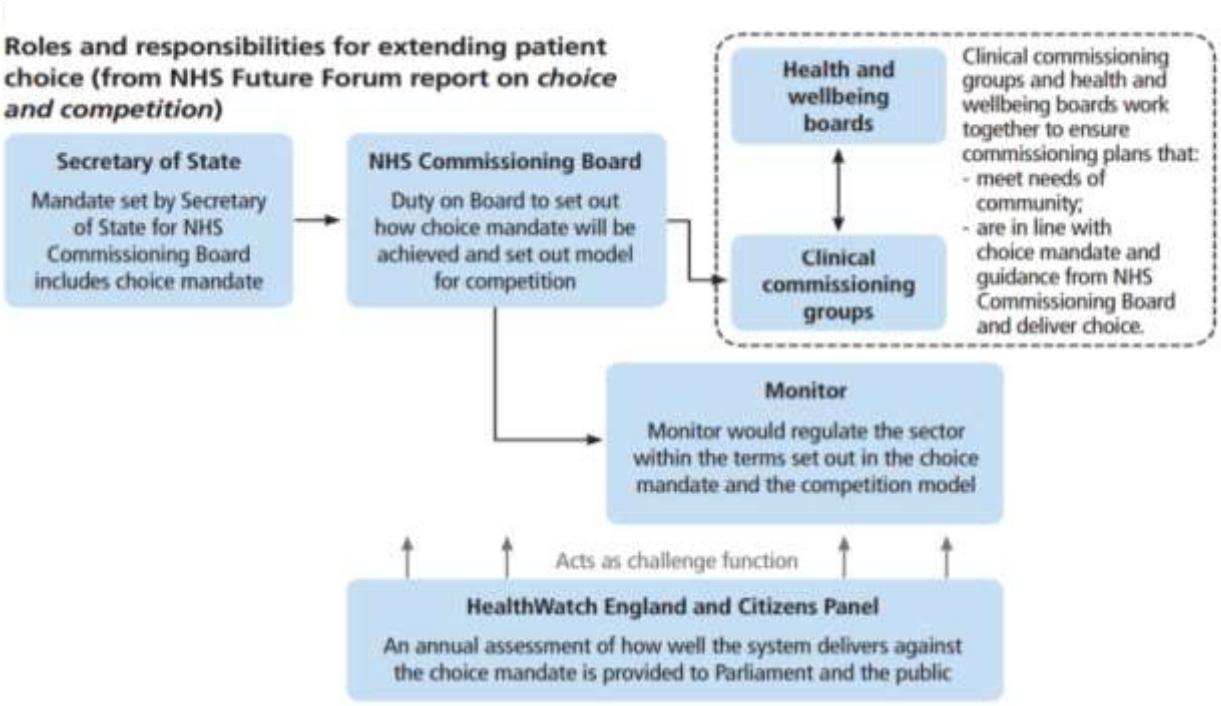
Commissioners can play a pivotal role in the development of the culture in healthcare as they have a key role in the management and control of providers who deliver care in hospitals, community health services and social care. With their power to withdraw services from providers, Commissioners have huge power and influence over the direction of where the provider organisation concentrates effort to influence policy, which could also provide tension with the Q&S strategy. Finance and 'doing more for less' are constant themes (Audit Commission 2009) with the competition to keep Q&S on the agenda against financial pressures being imposed.

The need to focus on finances cannot excuse lapses in Q&S of the kind reported over the last ten years; it must however be recognised that Commissioners and specifically leadership is still adapting to new structures and organisations following the implementation of the Health and Social Care Act 2012. Clearly, monitoring the quality of services delivered to the public is more important than ever (Quality Watch 2014).

In 2011 it was recognised that the system for commissioning healthcare provided by Primary Care Trust's (PCTs) did not have enough clinical input and control. The development of the NHS Health and Social Act 2012 gave rise to the development of Clinical Commissioning Groups (CCG's) with General Practitioner (GP) leading consortiums across England (DoH 2011). This resulted in the transfer of responsibility for commissioning to the NHS Commissioning Board (2012) and control of the CCG's (see figure 1). Whilst the NHS Commission Board has replaced the Strategic Health Authority (SHA), it now regulates commissioning supported by patient and public involvement through the Health Watch Groups. The CCGs replaced PCTs as the commissioners of most services funded by the NHS in England. They now control around £75 billion, which equates to two-thirds of

the overall NHS budget. The intention of this shift is to encourage clinicians to play a greater role in deciding how funds are spent in order to shape services in their local area (Naylor et al 2013).

Figure 1: Overview of commissioning structure.



(NHS England 2012)

The roles of the regulators have been made clearer with several statutory organisations being tasked with responsibility for Q&S within healthcare. The regulators now include the Care Quality Commission (CQC) who ensure healthcare services meet government standards and rules and have the power to remove operating licences and prosecute NHS providers for non compliance with standards.

In 2012, Monitor took over as the economic regulator of the NHS (National Audit Office 2014). This has increased financial accountability of Trusts as the efficiency drive on finance continues. One of

Monitor's key roles is to licence providers of NHS funded care and to enforce the rules for pricing. Monitor have a range of powers at their disposal, with direct responsibility for tackling anti-competitive behaviour which may in turn affect the interests of patients. They can also take action against Commissioners who do not comply with procurement, patient choice and competition rules or recourse where provider contravenes the terms of their licence (Commissioning Assembly 2014). Monitor set prices for NHS-funded care in partnership with integrated care and support Commissioners to protect essential health care services for patients, if a provider gets into financial difficulties (Monitor 2015).

Monitor works closely with the NHS Trust Development Authority, NHS England and the CCGs, all of whom require collaboration to access intelligence and information prior to inspections. The Commissioners require access to different information and different tools as levers for intervention and as such are now an integral part of the quality summits which follow CQC inspections. Health Watch act as the statutory committee of the CQC and advise the CQC of poor patient experience; this information is provided by quality groups established to raise patients concerns. The complexity of these arrangements has been established to minimise risks to patients from poor performing providers (NHS Commissioning Assembly 2014). However this complexity also creates gaps in the system if all parties do not effectively communicate with each other, posing a risk to the Q&S of care within provider services.

More recently one of the recommendations of the Francis report has included the CQC taking over enforcement powers from the Health & Safety Executive (HSE). The CQC will deliver key elements of the Health and Safety at Work etc, Act 1974 (HASWA) when clinical safety is compromised, and

take enforcement action if necessary. There is recognition that the HSE's expertise is not clinically based and the CQC is best placed to enforce the legislation where clinical risks arise (HSE 2014). The scrutiny of the NHS has increased through the inspectorate role of the CQC and public expectation on the NHS to deliver appropriate healthcare and robust governance systems. The Commissioning Boards behaviour could have significant implications on Q&S patient outcomes, staff safety and consequent future policy development (Bohan & Laing 2012). The first inquiry (Francis 2013) supported this notion that Commissioners and other bodies, with a responsibility to monitor performance at Mid Staffs, failed to do so and concluded that:

> 'There is a need for an independent examination of the operation of each commissioning, supervising and regulatory body, with respect to their monitoring function and capacity to identify hospitals failing to provide safe care: in particular: what the commissioners, supervisory and regulatory bodies did or did not do at Stafford; the methods of monitoring used, including the efficacy of the benchmarks used, the auditing of the information relied on, and whether there is a requirement for a greater emphasis on actual inspection rather than self-reporting' (Francis 2013, p10)

The Francis inquiry (2010) also stated that the failure at Mid Staffa was attributable to the provider Trust Board's inability to listen sufficiently to patients or staff when issues had been raised. The Trust also failed to tackle a negative culture that tolerated poor standards, evidenced by the disengagement from managerial and leadership responsibilities of staff involved. This failure was in part the consequence of allowing a focus on reaching national access targets such as the four hour wait at A&E, achieving financial balance and seeking Foundation Trust status. This was to the detriment of delivering acceptable standards of care. A system which ought to have picked up and dealt with a

deficiency of this scale failed in its primary duty to protect patients and maintain confidence in the healthcare system.

The Bristol heart scandal provided another clear example of poor leadership practices with a culture that created a failure to recognise and manage patient care; this resulted in 35 babies dying unnecessarily between 1990-1995, many being left with brain damage due to poor surgical practices (Kennedy 2001). It was estimated that in addition to the official figures, as many as 170 children may have died over a ten year period (The Telegraph 2010). The inquiry headed by Ian Kennedy (2001) described flaws that lay at the heart of the organisation culture and the wider NHS community at the time.

The inquiry (Kennedy 2001) described poor behaviours of leaders within the Trust who should have behaved differently, to firstly identify failures and then act appropriately once these flaws had been highlighted. The Royal College of Nursing (RCN) response to Bristol described nurses needing to challenge systems that do not allow a relationship of partnership with patients to exist. Key to success is development of a culture in which the patient is at the heart of the service, with one that nurtures and values different groups of staff with different status, this referring to the power of surgeons, who do not wish to be questioned on poor practices by subordinates. The RCN recommended the development of a more formal system of participation that reflected patient-centred values where all stakeholders are engaged equally (RCN 2001).

The evidence suggests that there is a conflict between what organisations and policy makers expect from the NHS and what happens in reality in some hospitals that results in catastrophic outcomes for patients. The incidents of poor culture within the NHS has not suddenly developed but has

incrementally increased over a number of years. Commissioners have financial control over providers therefore they can influence behaviours and outcomes. Greater understanding of the tension between finance, leadership behaviour and Q&S in healthcare is required from a Commissioners perspective.

1.3 The research questions

The research question in relation to this study is: Q&S in healthcare: Does leadership behaviour of Commissioners affect outcomes?

The specific questions that guided this study were:

1. What patterns of leadership behaviour are evidenced in groups of Commissioners?
2. How do leaders in groups emerge and take control?
3. How do groups make decisions on risks in healthcare?
4. How do subordinates of Commissioners view their behaviour as leaders?
5. Why is the behaviour of leaders regarding Q&S in healthcare important?

1.4. The research aim & objectives

The aim of the study was to analyse the complex relationships between patterns of behaviour of leaders within Commissioners who influence Q&S of providers of healthcare. The aim comprises of the following objectives:

The objectives include:-

1. To critically evaluate if there are benefits to analysing behaviours of leaders.

2. To determine if leadership behaviours can influence better outcomes for Q&S in healthcare.
3. To critically analyse group dynamics that influence decision making in healthcare.
4. To identify individual perceptions of leadership behaviour that influences Q&S in healthcare from a subordinate's perspective.
5. To define the drivers for Q&S and reasons why appropriate leadership behaviours are important in healthcare.

1.5 Research process

The research comprised of a mixed methodology using a concurrent triangulated design with two distinct phases; Phase 1 used focused video ethnography to examine the leadership behaviour of Commissioners in a group setting when presented with a number of different scenarios. The second phase used a quantitative questionnaire to obtain the subordinates views of Commissioners. The target group was senior staff of Commissioning organisations to identify their perception of Q&S. The process used a risk evaluation scenario to identify what leadership behaviour is adopted and how this influences change from a Commissioning perspective. The study provides a framework of how leadership behaviour can be analysed to enable the culture of organisations to meet targets and keep the focus on delivering safe healthcare through effective staff engagement.

Part of the evaluation of Commissioners behaviour used the Mid Staffs enquiry scenarios developed by the researcher to identify Commissioners appetite to manage risk and how they dealt with complex situations. The solutions identified a range of controls that evolved during the video recording. This has formed a significant part of the study not previously envisaged as it was anticipated that the risks

used as part of the open forum would not lead to significant outcomes, but would be used as a backdrop to the leadership behaviour being observed.

Measuring leader's behaviour in Commissioning that directly influences Q&S outcomes in healthcare is complex. CCGs were designed to encourage clinicians to play a greater role in deciding how funds are spent in order to shape services to meet local needs. The Secretary of State has responded to this challenge with a commitment to reduce avoidable harm in the NHS by 50% within 3 years. To make this happen, he believes there has to be a transformational change in approach to the Commissioning and delivery of care, specifically how Commissioners lead, train and support staff and requiring Trusts to actively engage with patients. There is a gap between what currently happens regarding patient safety and what needs to happen to fix it (NHS England 2013).

The benefits of this study are to develop a better understanding of leadership and specifically experiences of Senior Commissioners providing insight into the Q&S agenda through change and dealing with complex issues including motivation, behaviour, leadership and culture. The behaviour of Commissioners will be of paramount importance to understand how the new team dynamics deal with conflicts created by the new Commissioning Strategies (Edmondson 1999). The pressure to conform in groups is reviewed as an important issue as subjective norms are assumed to have two components, which work in interaction. Firstly beliefs about how other people, who may be in some way important to the person, would like them to behave (normative beliefs) and secondly perceived behavioural control is the extent to which a person feels able to enact the behaviour that is required (Francis et al 2004).

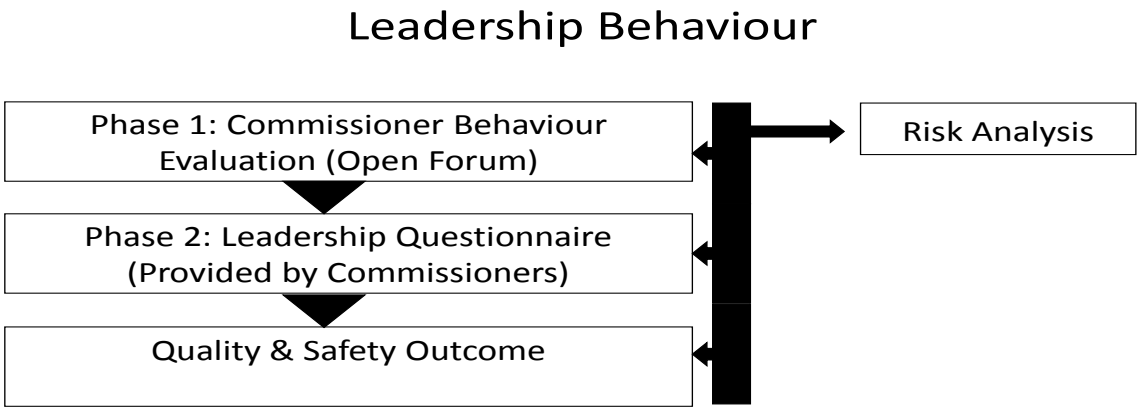
The process of identifying and informing patterns of behaviour is required to evaluate Commissioner effectiveness and to analyse new ways of working that are appropriate for changing structures and

circumstances (Storey et al 2013). The video coding scheme which emerged from the ethnography process is largely based on the actions and behaviours that relate to leadership styles, whereas the survey of this study cross referenced observed behaviours and theory to determine behavioural traits that influence Q&S improvements.

The Commissioner relationship with provider services entails reciprocity and a mutual reliance on each other for loyalty and support with the ultimate aim of providing the best patient care possible. It is anticipated that mutual trust, respect and accountability evolve during the process of commissioning services (Graen and Uhl-Bien 1995). The risks of overestimating or underestimating risk during periods of change require further evaluation (Mullainathan and Thaler 2000) as this poses a danger to organisations who either over react or under react if the process is not accurately assessed.

The study therefore evaluates the patterns of behaviour that can lead to success or failure in healthcare, focusing on the role of Commissioners managing risks and safety effectively. The important issue is specifically how leaders emerge from groups and make decisions. The study uses a pragmatic mixed method approach with the qualitative study evaluating the behaviour of a range of Commissioners from Clinical Commissioning Groups (CCGs), Public Health and Social Care providers. An open forum was established to determine how these "Commissioners" would deal with scenarios that may be presented to them by providers. The process was video-taped and then focused ethnography (Le Baron 2006) was used to analyse verbal and non verbal activity. In phase two, a quantitative questionnaire was used to evaluate the perspective of subordinates within Commissioning organisations to determine their perceptions of leadership behaviour. The results of these two phases are discussed separately and then cross referenced with each other, before overall conclusions are drawn (see figure 2 below).

Figure 2 Structure of research.



The cultural aspect of organisations is also examined as part of this study as boards frequently have had a misalignment of goals with the behaviours of leaders. This has manifested in numerous cases within the NHS that has led to boards losing their moral compass, with a tendency to deny and defend rather than improve (DoH 2015).

1.6 Significance of the study

A previous study of leadership behaviour, undertaken by Bohan and Laing (2012) in Warrington and Halton NHS Foundation Trust in 2012, identified that leadership in healthcare the behaviours of the organisations executives are considered to be of prime importance with strategy, structure and process being key elements of team and organisational effectiveness (Yammarino et al, 2008). The previous research identified that executives were clear on the type of leadership behaviour expected of them; seeing themselves as transformational, setting clear goals and expecting the best from their teams. The study also identified that elements of autocratic and transactional leadership were required frequently in the achievement of targets. There was acute recognition of the tensions between Q&S

and the target-driven approach required by Commissioners within the current financial climate and this required further research to understand the type of behaviours presented to provider organisations. To build on this work requires examination of Commissioners leadership and specific behaviour traits within the new organisations that will fund manage and promote Q&S to determine the most appropriate style that influences outcomes. The study will provide further knowledge of how groups work and leaders emerge to make decisions on issues relating to outcomes in healthcare.

Effective leadership and learning lessons from others is a key component of this research. With the new structures within the NHS it is important for leaders to pay close attention to setting the tone, communicating clear objectives and attending closely to culture and behaviour. Leaders must seek and encourage far more than compliance seeking behaviours and less box-ticking. Levels of effective engagement have highlighted a significant decrease in mortality rates, sickness absence and overall organisation performance when these issues are clearly addressed (Storey et al 2013).

Broadbent (2004) describes many behavioural based systems as being grounded in transactional management theory. The underlying principle of this theory is that the interaction between the leader and the team member is a transaction, the team members being motivated by reward or punishment. The process involves an individual joining the team, accepting the authority of the leader and being clear on goals, rewards and expected punishment handed out (Gupta et al 2009). Examining safety outcomes using this style has recognised that the results are often poor and create reduced innovation amongst staff (Broadbent 2004). Reliance on policies and procedures is likely to fail if staff are not clear on structure and behaviour that is supportive of Q&S. The approach required by organisations to meet maximum efficiency, control systems, people and process in conjunction with the current patient safety strategy is ever changing and will need to be adaptive to the change required.

The perceptions of not only executives but Commissioners needs understanding, with complex relationships being developed across provider services; focusing on Q&S outcomes and finance is critical to service delivery. In 2010 a survey of Healthcare Executives (Goetz 2010) identified the top issue confronting hospital leaders was financial challenges with nurses and supportive personnel posing the greatest percentage of the workforce of any hospital and greatest cost. The Nuffield Trust (2014) identified that 80% of NHS Foundation Trusts posted a far bigger deficit than expected in the first quarter of the financial year 2015 (April-June). The target to see 95% of patients within the four hour waiting time has only been achieved 76% of the time. In early 2015 large numbers of hospitals declared emergency status, due to an inability to deal with the demands from winter pressures.

1.7 Original contribution to knowledge

There has been limited evaluation of Commissioner's behaviour in healthcare and how this affects Q&S. This study uses a specific method not used before to evaluate both verbal and non verbal actions within a group of Commissioners. The use of ethnography (Pink, 2001) holds potential for combining quantitative trends with the qualitative words of participants. Cresswell and Garrett (2008) believe the openness to experiment with research methodologies and ways of thinking about research will encourage change to occur in the future. This experimental research approach using focused ethnography and a quantitative evaluation of subordinate's view of the Commissioners will support greater knowledge in the field of mixed methods. The methods used bring together a pragmatic approach to learning about group decision making in healthcare and a unique perspective on leadership behaviour in real time. The knowledge gained can be used to understand how leadership can be further evaluated in healthcare.

The research provides an original contribution to knowledge due to the unique position of the new Commissioning board who are developing skills and organisational standards with greater emphasis on compliance of provider organisations. The level of maturity of organisations has a direct impact on decision making and behaviour that adds to the notion that positive engaging behaviour can influence Q&S outcomes; behavioural organisational norms can improve the quality of outcomes to patients, staff and the wider NHS community (Ferlie and Shortell 2001).

1.8. Outline of thesis

This thesis is organised into eight chapters. The information below describes the chapters in brief:

Chapter 1: Introduction:

This chapter describes the purpose of the research, the research question and why this is an important issue to explore. It provides background information, defining the types of high profile failures in leadership resulting in poor patient safety outcomes. The study provides a framework for the research priorities, aims and objectives describing the methodology used in this study and how it explores the issue of leadership behaviour.

Chapter 2: Literature review:

This chapter provides a literature review of the current best practice and theories that relate to leadership behaviour in healthcare. Furthermore it elaborates on previous work undertaken by scholars and links with the aims and objectives of the research being undertaken. Over the past two decades there has been considerable interest in leadership behaviour within healthcare with particular

reference to a number of high profile cases that have resulted in determining poor patient safety outcomes. This review focuses specifically on how Commissioners behaviour can directly affect culture within provider organisations.

Chapter 3: Methodology of study:

This chapter defines the research methodology, methods, sampling technique using previous research to inform the research design process. It also provides the rationale for using focused ethnography in an open forum and a quantitative questionnaire targeting subordinates of Commissioners to understand the most effective leadership style. The chapter describes the phases of the research and why choosing a mixed methods approach is appropriate for this type of research.

Chapter 4: Findings of research:

This chapter provides details of the outcomes of the research which include the video observed method of evaluation and subsequent themes from the verbal and non-verbal data available and results from the quantitative questionnaire distributed to subordinates of Commissioners. It also provides evidence of how observing Commissioners most common behaviours identifies transactional, transformational and passive behaviour and discusses the most common behaviours observed through a structured analysis process.

Chapter 5: Risk analysis:

This chapter describes the process of reviewing the data and risk analysis capacity of the Commissioners to understand their role in identifying risks and dealing with governance issues that relate to policy framework and provider outcomes. It also explains how risks were evaluated and

described by Commissioners explaining why this is an important part of the research not previously envisaged. It also provides evidence of how best to deal with emerging cultural and organisational issues that relate to the management of risks.

Chapter 6: Discussion:

This chapter presents the information from all the research criteria used and shows how leadership within Commissioning services has a direct impact on outcomes within healthcare. The findings provide an opportunity to discuss the conflict between leadership, finances and quality which appear to be at a safety critical point within the system. The discussion focuses on Commissioners leadership behaviour through the range of information identified within this study, providing an insight into the performance improvements needed to deliver world class healthcare.

Chapter 7: Conclusion and Recommendations:

This chapter describes the key findings of the research through the findings, discussion and risk analysis process and provides an overview of leadership behaviours of Commissioners in healthcare. It also describes the limitations of the study and the policy implications of the work undertaken.

The recommendations identified from the research define how the Commissioner boards should review the work undertaken by this study and develop general techniques to determine risk tolerance flow charts for action to be taken when risks are identified. It also describes areas for future research in this area.

Literature review

Chapter 2

2.1. Introduction

The purpose of this chapter is to provide a literature review of the current best practice and theories that relate to a number of key topics focusing on leadership behaviour in healthcare. Furthermore it elaborates on previous work undertaken by scholars and links with the aims and objectives of the research being undertaken. There has been considerable interest in leadership behaviour within healthcare over the past two decades, with particular reference to a number of high profile cases that have resulted in determining poor patient safety outcomes. The literature review provides justification for conducting the study on this topic area and consists of a review of papers in relation to key elements of the research objectives. The systematic process used specific databases such as Google Scholar, online library resources at LJMU Open Athens, Healthcare Alerts via Wirral University Teaching Hospital, Kings Fund reviews, Health Foundation e-mails research scans and PUbMed. The screening of papers for relevance to the study informed the method of research undertaken described in chapter 3.

2.2. Climate within the NHS

The forward plans for the NHS over the next 5 years, described by NHS England (2014), states it will be feasible to close the funding gap of £30 billion by 2020/21. Decisions on how this will be achieved will be for the Conservative Government and the NHS to deliver. A fully viable NHS is possible if the government and NHS work together both locally and nationally to make the changes required to transform and integrate services; thus enabling patients to have seamless care which will include both physical as well as mental health needs being addressed external to hospitals avoiding duplication of effort. A more globally focused approach will look at how organisations in healthcare learn, introducing the best care models, producing the best experience for patients and the best value for money for the NHS (NHS England 2014).

The sector as a whole is now in deficit for the first time ever and even Foundation Trusts, generally thought to be the higher-performing hospitals, are expected to meet their financial and access targets, even during times of austerity (The Kings Fund 2015). The problems of implementing the findings of the Francis enquiry have placed Trusts in an increasingly difficult position to meet safety standards, particularly with the added pressure on admissions and greater reliance on agency staff to cover shortfalls in staffing. Managing large organisations such as the NHS involves orchestrating a vast number of indicators and the knowledge of the relationships between the indicators is crucial to addressing long term performance goals and a critical element of patient care (Patel et al 2008). The data retrieval systems in place often appear very complex and wide ranging, requiring cross referencing to enable themes to emerge; not just the achievement of individual targets for each quality indicator within each Department or Division but across the Trusts. Many organisations find this process difficult to adapt to. Understanding ambiguous and changing situations within the current

Structures and gathering data to inform decision making is often complex and may take considerable time to decipher (Weick 2009).

Given the complexity and continual change in systems of NHS organisation and accountability there are strong arguments that making sense of what is required of organisations and teams will become increasingly important (Storey et al 2013). The need to recognise the importance of collaboration and effective working across organisational boundaries is significant, yet to implement a myriad of policy documents concerning the desirability of improving integration between primary, acute health services, health and social care (National Association for Primary Care, NHS Confederation) and NHS will need clarity. There is a requirement for NHS England to explore the wider environment, for example policy frameworks, systems of accountability and evidence on effectiveness of the new health care system as it evolves.

Currently there is a profound challenge to maintain the quality of services at a time when budgets for health and social care are more constrained than ever. A recent review of NHS finances concluded that the financial strength of NHS Trusts is weak and declining with 66 NHS Trusts (out of a total of 249) now in deficit. The net overall deficit for 2013/14 is just over £100 million compared with an overall surplus of £383 million in 2012/13 (Lafond et al 2014). Local Authority (LA) spending on adult social care has reduced by 12% in real terms since 2010 (ADASS, 2014).

With pressure from the CQC (CQC 2012) and Department of Health (DH) to provide higher quality for less, it is increasingly difficult for providers to achieve the quality of care required with costs in the NHS rising at a much higher rate than inflation due to factors such as an ageing population, diabetes, lifestyle factors, obesity, cost of new drugs and treatment. The expectation is that the NHS

must achieve savings of twenty billion pounds by the end of 2015-2016; this will require a 4% increase in productivity for the NHS (BBC 2015).

The patient experience and quality of care currently being provided is set against a backdrop of increasing pressure on the NHS system, with emergency admissions up by 62% since the introduction of the marginal rate for emergency admissions in 2012. The reduction in real terms on resources has resulted in Commissioners having little to invest in alternative primary or community care services. The CCGs with the largest deficits are those with the widest gap between their target funding allocation and the income they receive. Forty-nine CCGs performed less well than originally planned. Eighteen of the twenty CCG's with the largest surpluses had received more than their target funding allocation (by 8.8% on average). Trusts with the best performance in achieving the 4-hour target to admit, transfer or discharge patients from A&E departments are likely to have a higher surplus than others. However, clinical performance does not generally explain financial performance (Monitor 2013).

When examining culture and patient safety 63% of employees felt the quality of care had worsened in the last 18 months (Murphy 2014). Evidence from the NHS staff survey suggests that just 5% of respondents believed that quality of patient care had improved, relative to 34% in the 2013 survey. The Health and Social Care Act still continues to be contentious with 61% of respondents disagreeing that the reforms had resulted in better care. This opinion was persistent across nurses 56%, GPs 63%, and practice managers 62%. A key part of the Act was the formation of CCG's of which all GP practices must be members. They were given a poor rating when respondents were asked if their CCG's decisions reflected their views. However views varied across professional groups, with practice managers being more positive about the CCGs than GPs and nurses.

The NHS staff survey also indicated low support for a variety of government policies designed to increase quality of care such as the setting up of new regulator the CQC. The 2012 Health and Social Care Act granted the CQC the power to place providers with significant problems and who put patients at risk under 'special care'. However, healthcare professionals in the survey indicated that they had little confidence in the scheme's ability to improve the quality of care. The CQC inspection model has recently been overhauled to deal with the same cultural issues identified in this chapter, with recognition for the need for change in healthcare. The new inspection regime makes 'well led' a key area of which organisations will be inspected and regulated on, ensuring the appropriate staff have the right values and skills to develop an effective safety culture and can demonstrate:-

> 'safety and compassion as the friend of productivity, understanding that poor care is bad for patients, demoralising for staff and bad for the bottom line' DoH (2015 p.15)

The CQC has moved from a generalist light touch and tick box model to one of a thorough approach informed by experts, patients and staff. The reforms intend to develop the most transparent and open system in the world for key aspects of patient safety and experience (DoH 2015). Berwick's (2013) recommendations following the Francis report on Mid Staffs describes leadership as requiring mobilisation of staff in the pursuit of continual reduction of patient harm through clarity and constancy of purpose among all leaders.

2.3. Q&S in healthcare

Q&S within healthcare is not clearly defined often meaning different things to different people. Norton et al (2012) identified a variety of views on its meaning which included quality defined by the World Health Organisation (WHO 2006) as:-

> 'effective, delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need; efficient, delivering health care in a manner which maximizes resource use and avoids waste; accessible, delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need; delivering health care that is adherent to an evidence base' (p.9).

The Royal College of Physicians identifies seven domains of quality including safety; patient experience; effectiveness; equity; efficiency; timeliness and sustainability (Royal College of Physicians, 2011). The Royal College of Nursing (RCN) recognises that quality of care should be centred on the person and their individual health care needs. This should also be based on the best evidence, supporting care that is safe and effective regardless of who provides the care. Staff require suitable clarity on their role and the clinical skill set necessary for the development and sustainability of an effective workplace. Organisational commitment to quality is seen through systems that sustain person-centred approaches, safety and effectiveness (Royal College of Nursing 2010). Quality is seen by the public as trust in those who deliver care and the appropriate use of resources. Patient perceptions of quality in healthcare influence the public expectations and confidence placed in the NHS system.

Safety in healthcare is generally viewed as patient safety which describes the avoidance of harm and includes deviation from accidents/errors and avoidance of preventable harm. Safety is the overall approach the organisation takes to patient care which Vincent (2006) describes as:

> 'Safety is rather an important subset of quality' (p.242)

The definition to describe quality in healthcare for the rest of this document is the WHO (2006) description above.

It is clear that a more customer focused NHS is required to ensure quality is driven through the systems; An advocate of this is Heskett et al (1994) and John (1992) who state the service-profit chain framework is how healthcare could seek improvement to show relationships between profitability, customer loyalty, employee satisfaction and productivity. The proposition is that in a service industry, profit and growth derive from customer loyalty. This is a direct result of customer satisfaction and satisfaction is largely influenced by the value of services provided to customers by employees. Hence, value is created by satisfied, loyal and productive employees. Employee satisfaction stems primarily from high-quality support services and policies that enable employees to deliver results to customers, in the NHS case the patients being the customer.

The policy implications of the recent research by the Commissioning Board (The Kings Fund 2012) identified that absolute commitment to targets and finance increase the risk of organisational failure regarding Q&S. The target driven approach is important but may produce the style of management that may sideline the Q&S agenda if not handled appropriately. The potential for the aggressive pursuit of data may result in a culture that reverts back to under reporting of incidents due to the negative response created by Commissioners. It is already clear that behaviour is key to culture and

organisational norms, this can be directly influenced by Executives, senior staff and Commissioners.

Q&S has been a key issue in recent reports by Francis (2015) and Berwick (2013) viewing the professionalism of staff from quite different perspectives. Francis arguably focuses on the individual, calling for a stronger emphasis on compassion in nurse training by an assessment of applicant's values, attitudes and behaviours in relation to patients and the implementation of the duty of candour in which all staff must report safety failures. Berwick appears less inclined to single out the attitudes and behaviours of individuals within the workforce, as contributory factors in matters of compassion and patient safety, rather advocating a more organisational wide learning culture. Berwick proposes that an individualistic (arguably punitive) approach may be counterproductive. Staff attitudes, awareness and feedback are important resources to gain insights into staff concerns. Supervisory and regulatory systems should be simple and clear and avoid diffusion of responsibility. They should also be respectful of the goodwill and sound intention of the vast majority of staff within the NHS (McMahon 2014).

2.4. Culture

Culture within healthcare has a profound affect on how safety is managed and influences organisational effectiveness at all levels, the term 'culture or climate' has variable meanings and a recent review by the Health Foundation (2013) defined climate and culture as follows:-

> 'Climate emerges through a social process, where staff attach meaning to the policy and practice they experience and behaviours they observe. Culture concerns values, beliefs and assumptions that staff infer through story, myth and socialisation, and the behaviours they observe that promote success' (p.3)

The definition of culture is important and is unique to a number of professions and industries; a literature review by the Health & Safety (H&S) Laboratory in 2005 described culture in terms of H&S as being a concept that has a set of shared corporate values, which influences the attitudes, and behaviours of its members. Safety culture forms part of the overall organisations behaviour and will directly influence members in terms of H&S performance. Safety climate is a distinct yet related concept, which can be seen as the current surface features of a safety culture, which are discerned, from the employee's attitudes and perceptions. Colins and Gadd (2002) identified that management was the key influence on an organisation's safety culture. A review of the safety climate literature revealed that employee's perceptions of management's attitudes and behaviours towards safety, production and issues such as planning and discipline was the most useful measurement of an organisation's safety climate (Health and Safety Executive 2005).

Although safety culture and climate definitions tend to be similar, the term safety culture is generally seen as more embracing than that of safety climate. Glendon and Litherland (2001) suggest that the implication of culture existing within an organisation as a stable and constant value, while climate has more passive connotations of being influenced by the external environment. A simpler definition of culture is "the way we do things around here" or 'the ideas and beliefs that all members of the organisation share about risk, accidents and ill health' (Confederation of British Industry 1990).

Climate is usually regarded as being more superficial than culture in that it involves the current position of a company being more transient (Glendon and Stanton 2000). Thus safety climate can be seen as the indicator of the organisation's safety culture as perceived by employees at a point in time (Flin et al 2000). Further work undertaken by Fleming (2001) reviewed safety culture in the offshore

industry and identified ten key elements that defined the safety climate including management commitment and visibility, effective communication, productivity versus safety, with the organisation learning lessons. Productive organisations will provide adequate safety resources including training, with the participation of staff who share the same perceptions about safety as their superiors. This leads to the development of trust, effective industrial relations and improved job satisfaction.

The culture of any organisation whether healthcare or the oil industry, is directly influenced by safety behaviour which ultimately determines safety outcomes. On 20th April 2010, a sudden explosion and fire occurred on a BP owned deepwater oil installation. The accident resulted in the deaths of 11 workers and caused a massive, ongoing oil spill into the Gulf of Mexico.

The Chemical Safety Board (CSB 2014) presented its findings and stated that the incident resulted from a complex combination of deficiencies particularly around process safety and inadequate management systems. Human and organisational factors created an environment ripe for error; organisational culture focused more on personal safety and behavioural observations than on major accident prevention with a regulatory regime unable to deliver the necessary oversight for the high-risk activities involved in deepwater exploration, drilling and production activities. A survey of the Transocean crew regarding "safety management and safety culture" found that 46% of crew members feared reprisals for reporting unsafe situations and 15% felt that there were not always enough people available to carry out work safely (CSB 2014). This has similar connotations to current issues identified within healthcare organisations, with staff raising concerns about staffing ratios affecting patient care.

Cultural or behavioural approaches to safety improvement are at their most effective when the technical systems aspects of safety are performing adequately and the majority of accidents appear to be due to behavioural or cultural factors (The Keil Centre 1999). The safety culture maturity model (see figure 3) is therefore only relevant to organisations that fulfil a number of specific criteria, including adequate safety management system with technical failures not causing the majority of accidents. The company must also be compliant with health and safety law and not solely driven by the avoidance of prosecution but by the desire to prevent accidents.

The recommendations of the research by Fleming (2001) suggest if an organisation does not meet these criteria within the model then it would be more appropriate for them to focus their resources on the technical systems aspects of safety as opposed to the behavioural and cultural aspects. The culture maturity model requires building over key stages described in figure 3.

Figure 3: Safety culture maturity model.

(The Keil Centre 1999)

Culture within healthcare has received little attention however, recent work by the Kings Fund survey undertaken in 2014 focused on leadership, culture and compassionate care within the NHS. Of the 2,000 respondents the evidence suggested that the views of executive directors were much more positive about the culture within their organisations than doctors and nurses. The responses on the culture of care identified that 39% of staff felt their organisation to be open and honest and 43% of respondents felt swift action was not taken to address poor behaviours and performance. Only 28% of staff felt pride and optimism about the organisation, however the survey also revealed that staff believed the quality of leadership had improved since the 2013 survey (The Kings Fund 2014).

This literature review has not provided specific evidence of how behaviours in healthcare can improve performance or specifically how decisions can be evaluated within Commissioners. However examples of poor cultural norms, beliefs and attitudes by management and leadership are prevalent in the NHS. The NHS staff survey (Murphy 2014) highlighted a cultural problem in the NHS, with 35% of respondents reporting having received verbal or written abuse by a NHS colleague. Together, these findings suggest there is a long-term problem with the work culture within the NHS. This is a significant issue and equally it is recognised that bullying and the organisational culture is likely to increase sickness absence.

The General Medical Council (GMC 2014) reported that bullying of trainee medical staff within the NHS is prevalent with 8.0% of respondents reporting experiencing bullying (n=49,994) and 13.6% reporting witnessing bullying (n=49,883). Evidence suggests there is a reluctance to speak out about the subject due to the risk of reprisals and lack of management action. Bullying and undermining has a serious impact on the quality of patient safety. Figures obtained by the BBC (2015) revealed 41,112 NHS staff were absent in 2014 with anxiety, stress and depression, an increase from 20,207 in 2010.

The RCN has described the figures as a reflection of the "relentless pressure" staff have been under and mirror the annual NHS staff survey results. The figures suggest sickness absence relating to mental health problems is on the rise among hospital staff (The Health Foundation 2015).

Casting a shadow across the NHS that is wide and deep is the behaviour of leaders, can be very negative and can result in cynicism about change. More prominent cultures are often seen within certain professions and medical subgroups, examples being surgery, midwifery, nursing and the therapeutic professions. Each of these subgroups has dominant cultures and values infused during education and training often maintained by influence from outside the employing organisation (for example, by professional bodies such as the Royal Colleges). Coherent cultures may also be seen within specific teams where they can be a powerful influence on work patterns (Davies 2002).

A recent report on whistle blowing in the NHS called ‘Freedom to Speak Up’ (Francis 2015) has reviewed the way staff who raise concerns are treated. Many staff felt unable to speak up or when they did, were not listened to. The 2013 NHS staff survey re-affirmed that only 28% of staff felt safe to raise concerns. The report by Francis describes a number of issues in the process of raising concerns which include poor handling of concerns issues and vindictive treatment of the staff that did so. The outcome for individuals can be devastating in terms of career and personal problems encountered.

The independent research in Berwick’s report (2013) described two distinct cultures within organisations in relation to raising concerns. A number of organisations take a strict procedural approach when concerns are raised, others take a more open minded, less rigid approach which focus on resolving the issue, learning and communicating information to avoid harm rather than following procedure. Berwick concluded that the latter were still at a formative stage and that even where there

was a willingness to be more flexible; organisations were not entirely sure how to achieve it. Berwick identified five key themes to address the issue of whistle blowing including culture change, improved handling of cases, measures to support good practice, particular measures for vulnerable groups and extending the legal protection for staff.

Berwick et al (2013) recognises that neither quality assurance nor continual improvement can be achieved through regulation based purely on technically specific standards, particularly where a blunt assertion is made that any breach in them is unacceptable. In the end, culture will trump rules, standards and control strategies every single time and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime. Safety is a key theme throughout and recognises that some risk will be prevalent where boundaries are blurred. Often in seeking the benefits of modern medicine, patients may reasonably choose treatments that involve risk or cause side effects, but where unnecessary risk occurs this is unacceptable (Berwick et al 2013).

The Government's final response to the Mid Staffs enquiry came in January 2014 with the title 'Hard truths the journey to putting patients first' (DoH 2014). The key elements of the report describe how they intend to ensure hospitals are safe through a new duty of candour requiring all staff to raise concerns about safety and develop a culture of openness, fairness and no blame. They have also appointed a new Chief Inspector to provide clear evidence to the public of the NHS performance, good and bad, without political interference in the process. This is a response to the public concern over safety in hospitals and has been established to provide assurance that the poor safety culture and performance seen within Mid Staffs can never be repeated in other Trusts.

2.5. Leadership behaviour

Despite a recent interest in leadership behaviour, few empirical studies have systematically examined behaviour of leaders and particularly the behaviours of Commissioners within healthcare (Amabile et al 2004). Most studies primarily rely on quantitative survey measures when exploring leadership behaviour (Hoogeboom 2011). Various scholars have already argued that perceptual leader data does not correspond to actual leadership behaviour; it takes a view on the leader's style not the actual behaviour which occurs in the workplace. Such representations of leadership style are potentially confounded with follower's subjective views of leadership which are difficult to assess using a quantitative approach alone (Bono and Judge 2004).

Leadership requires presence and visibility with clear first-hand knowledge of the reality of the system at the front line with leaders having the ability to learn directly from and remain connected with those for whom they are responsible. Culture change and continual improvement come from what leaders do, not what they say and require continual commitment, encouragement, compassion and modelling of appropriate behaviours. Berwick (2013) states that every person working in NHS has a duty to identify and help reduce risks to the safety of patients, acquiring the skills necessary to do so in relation to their own job, team and adjacent teams. All NHS leaders and managers should actively address poor teamwork and practices of individuals, using approaches founded on learning, support, listening and continual improvement, as well as effective appraisals, retraining and, where appropriate, revalidation.

Bass and Avolio (1997) research into leadership traits describe four main styles of leadership including transformational, transactional, leadership by exception (passive) and laissez fair with sub categories within each element. Transformational leaders display four distinct characteristics such as

the leader being a role model for the team, encouraging the team to share a common vision and goal by providing a strong sense of purpose. Secondly inspirational motivation where the leader tries to express the importance of desired goals in simple ways communicating high level of expectations and providing followers with work that is meaningful and challenging. Thirdly intellectual stimulation refers to a leader who challenges followers' ideas and values and finally individualised consideration refers to leaders who spend more time teaching and coaching followers by treating them as individuals.

Transactional leadership is mainly based on contingent reinforcement and is dominated by reward between leaders and followers in which effort is rewarded by providing payment for good performance and failure to achieve results in threats or disciplinary procedures for poor performance. Leaders who rely on management by exception (passive) will only intervene in the group when procedures or standards of work are not accomplished or met. In contrast, management by exception (active) leaders are characterised as monitors who detect mistakes early as they are deeply involved in the process of work being undertaken.

The final leadership behaviour is laissez-faire or non-leadership that exhibits when leaders avoid clarifying expectations, addressing conflicts, and making decisions; this is similar to transactional management as both are seen as negative in supporting a productive team.

Mosadeghrad and Ferdosi (2013) argues that no universal leadership style is required but a variety of styles are needed to direct employees including autocratic, bureaucratic, charismatic, democratic and participative and that managers should know when to take which approach. This may be difficult if the leader does not recognise how their own approach affects others or there is a lack of awareness of their individual behaviour traits. A recent report by the Chartered Institute of Personnel and

Development (CIPD 2014) looked at the leadership behaviour of 350,000 employees across the UK workforce and identified that often line managers are far more positive about their own behaviours than the employee is about their own managers; the more time spent with the line manager has demonstrated a positive effect on motivation of employees. It is also recognised that even if the organisation had a blame culture and poor environment, when an employee had a good line manager this would improve productivity.

Over the years there has been considerable scholarly dialogue surrounding the differences between management and leadership with management seen as supervision, monitoring and coaching. The majority of leaders have a number of styles with most scholars concluding that the two are indeed distinct concepts that should be examined separately (Bass and Bass 2008). This perspective submits that given the behavioural complexity associated with supervising employees, the role would include both managerial functions (e.g. performance management behaviours) as well as leadership functions (e.g., transformational, transactional leadership behaviours). Other scholars have advocated a "thinking grey" approach, suggesting that the lines separating management and leadership should be blurred.

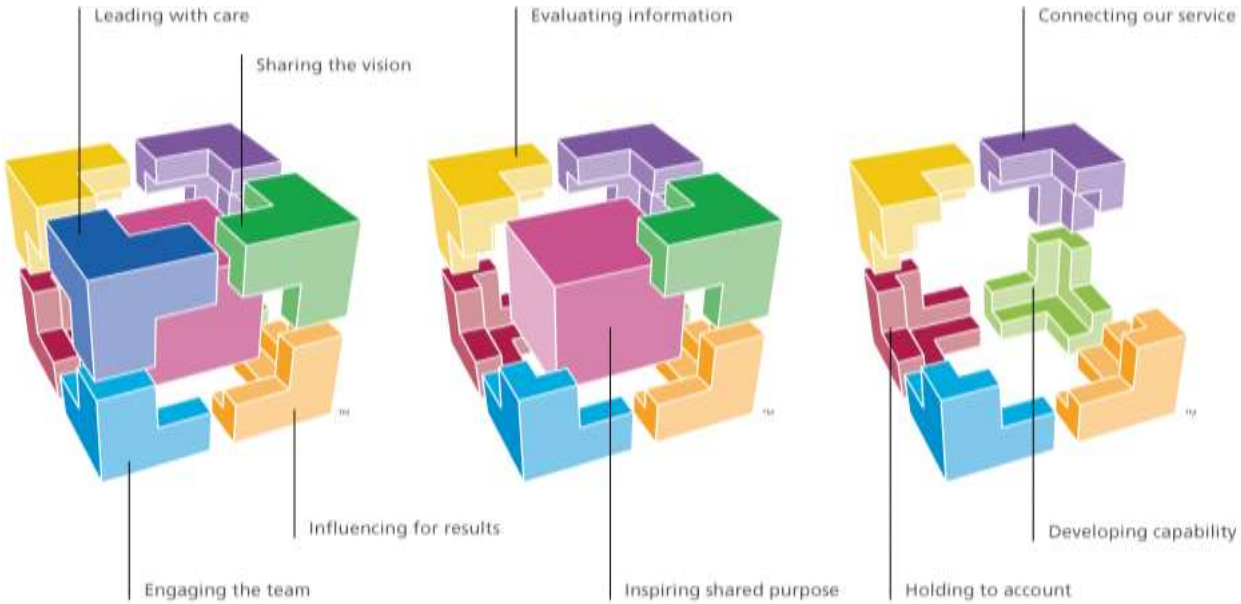
According to Hooijberg and Quinn's (1995) behavioural complexity theory (BCT) effective leaders must utilise whatever behaviours are required to meet the demands of the situation. Indeed, it has been suggested (Lawrence, Lenk, and Quinn, 2009) that effective leaders must lead and manage simultaneously. However, our ability to answer questions pertaining to clarity or execution is severely limited by the absence of a reliable, valid measure of the performance management construct. From a theoretical perspective, without such a measure there is no empirical evidence to support the distinctiveness of performance management from other forms of management or leadership. Furthermore, the ability to compare performance management to other forms of

leadership or management and assess its relative impact on work outcomes is inhibited.

The role of the external leader to the group requires skills such as coaching, facilitating and educating to be most effective. The influence that Commissioners have on internal teams is not evidenced in the literature as this is dependent on the team development stage and access to the influence from Commissioner. This is particularly important given recent concerns by researchers (Luthens and Avolio 2007) that existing leadership models are too narrow to account for enough variance in outcomes. In recent years a command and control culture with a different set of mechanisms and styles has been seen to be prevalent within healthcare. This has run alongside the Leadership Qualities Framework (LQF) which extol a more collaborative or participative approach by Senior Managers. This tells us that there can be dissonance between expressed values, hardwired regulatory mechanisms and everyday routine practices of healthcare staff to the realities on the wards. Ideally, an effective leadership model would address both kinds of priorities.

The healthcare leadership model produced by the Leadership Academy (2013) is made up of nine leadership dimensions, including inspiring shared purpose which values a service ethos to behave in a way that reflects the values of the NHS. Leading with care requires all staff to understand how the services align to the vision of the organisation, enabling the service to deliver safe outcomes that continuously improve patient care. Figure 4 describes the key elements of the framework and how they can combine to build an effective leader.

Figure 4 NHS Leadership model.



(Leadership Academy 2013)

The leadership model for the NHS also describes elements of poor leadership such as autocratic leadership, building plans without consulting staff, setting unclear targets and goals, confirming the view that poor managers are reluctant to change and emphasis using values to push a personal or a tribal agenda (Leadership Academy 2013). A study by Johnson et al (2012) drawing from identity-based theories of leadership, examined relationships of leaders identity with leader behaviour and perceived effectiveness. They observed a significant correlation between abusive behaviours being evidenced by leaders frequently when a strong individual identity was paired with a weak collective identity of the team. Frequency of transformational behaviours accounted for the largest proportion of variance in perceived leader effectiveness. Transformational consideration and abusive leader behaviours in turn predicted leader effectiveness as rated by subordinates and peers, transformational being the most effective.

The current desired shift in emphasis from leaders in the NHS towards a more autonomous approach with a clearer emphasis on individual responsibility and accountability has along with the requirement to have timely, effective clinical interventions in practice, resulted in a contemporary modification in the desired leadership model for the NHS. These emerging high priorities need to be reflected in a leadership model that is balanced with an appropriate health behavioural theory (Glanz et al 2008).

Baker et al (2011) presents a view that the measurement of leadership behaviour prevalent over the past two decades generally focuses on the benefits of transformational leadership which results in positive outcomes for organisations. Baker et al believes that leaders can be substituted by effective followers or subordinates if the group or team is well trained, experienced and are cohesive; in effect the strong minded individuals within the group could act as leaders with the role being interchangeable. However if maturity of the group is not in place and there are no sub leaders available the group may fail without strong leadership or clear direction.

There is a significant amount of research that has focused on how best to implement change in healthcare, with a number of breakthroughs from other industries being evident. According to Valdez et al (2010) the complexity of the healthcare system does not lend itself to the implementation of transformational change. The transformational change as a performance model requires impetus to change that involves senior management commitment to the quality of the service, with effective engagement of staff working across specialities. The staff require a clear alignment of the vision and culture of the organisation to achieve goals (Lukas et al 2007). Often within healthcare change is imposed externally and middle managers may be resistant to change as this may lose them power and

influence. Chaleff (2009) described the need for middle managers to be 'courageous followers' who have the ability to implement significant change within organisations.

Chaleff (2009) also states the types of desired behaviours include assuming responsibility, being prepared to take tough decisions, raising concerns with leaders, being able to participate in transformation and not holding a paternalistic image of the leader. The individual who has these traits is likely to initiate action to improve the organisation and take ownership of common purposes. The work by Schell & Kuntz (2013) takes this view. A study of middle managers within healthcare discovered that when nurses acted consistently with the behaviours described above they benefited the organisation and particularly when change was being implemented. They also highlight that complete focus on the top leadership may result in failures to implement change if middle managers are not taken along with the process. The research identified that 'courageous follower' type of behaviour if nurtured had greater influence on transformation within organisations and was more likely to occur.

Leaders and followers are interdependent on each other and great leaders have great teams. The authoritative role in hierarchical organisations will result in limited interface between follower and leader but good teams are found to have follower and leader traits within the group, which results in exchanging roles on a regular basis (Hughes et al 1999). The traditional stereotypes of leaders and followers who act independently and do not influence each other is of interest as within groups of senior staff the behaviour, verbal and non verbal, influence the outcomes on performance; actively listening to followers will influence performance within teams.

Cooper et al (2005) identified that organisational behaviour is rooted in the actions of healthcare staff and poor behaviour drives human error and unsatisfactory outcomes for some patients. One area

Cooper describes needing to improve performance is through organisational behavioural management (OBM) which has proved to have positive safety outcomes in other industries such as the oil and gas sector. The purpose is to direct people's attention and actions to perform desired behaviours on a daily basis. The research by Cooper (2005) achieved positive outcomes by carefully targeting critical behaviours of staff, focusing on a small proportion of behaviours that result in poor outcomes, in this case for patients contracting Methicillin Resistant Staphylococcus Aureus (MRSA). The research intervention process identified observable behaviours that were likely to result in transfer of infection, staff are then asked to identify improvement goals to enhance ownership of the process.

The observational method used identifying good behaviours, which were placed on a checklist. Trained staff then observed this behaviour during the work activity. The process used a sufficient sample of behaviours and the number of corrective behaviours divided by the total number of behaviours observed. Cooper (2005) demonstrated less frequent incidences of MRSA in two intensive care units with positive behaviour observed in both wards including increased recording of information, improved documentation and significant increase in hand washing. If the process can be adapted to consider how decisions are made within commissioning this may increase the likelihood of good decision making taking place within healthcare. However behaviour in groups does not currently have a format that is likely to improve decision making processes with the complexities of decisions difficult to observe in practice (Weenink 2012). Moreover, Scrull and Wyer (1979) emphasised that behavioural recall ratings of leaders used in measuring their own performance cannot be regarded as a valid means to assess actual behaviour in meetings.

Van Eek et al (2011) developed the theory of observational behaviour further by describing the process in detail identifying specifically five key behaviours in groups. Firstly the capability and

adaptability of individuals to change and reflect on conditions currently in place and how they could influence such change. Secondly to support others through effective back up behaviour, by taking over a colleague's task. Thirdly to manage conflict with the ability to build trust in colleagues who work within the team. Fourthly sharing information to support, co-ordinate and effectively communicate information and finally team learning which included activities carried out by team members through which the team obtain, collect and process data that allows the team to adapt and improve in the future. The evidence suggests the higher their team's performance, specifically when they felt psychologically safe to discuss errors, the more likely improvements are made and the better they performed (Van Eek et al 2011).

When looking at safety outcomes a number of poor work practices continue to prevail in many organisations resulting in work related injuries, occupational diseases, and fatalities (Hofsted 1983). Mullen and Kalloway (2009) have recently identified safety leadership as a key contributing factor to the prevalence of accidents and injuries in the workplace. They describe transformational leadership being positively associated with employee perceptions of workplace safety climate when the leadership behaviour focused specifically on safety. Similarly, Kelloway, Mullen and Francis (2006) examined the effects of a passive form of safety leadership and found that employee perceptions of safety climate were adversely affected when leaders did not actively promote safe work behaviour and practices. Furthermore, perceptions of safety climate mediated the relationship between leadership and safety-related events, which in turn predicted occupational injuries (Mullen & Kelloway 2009).

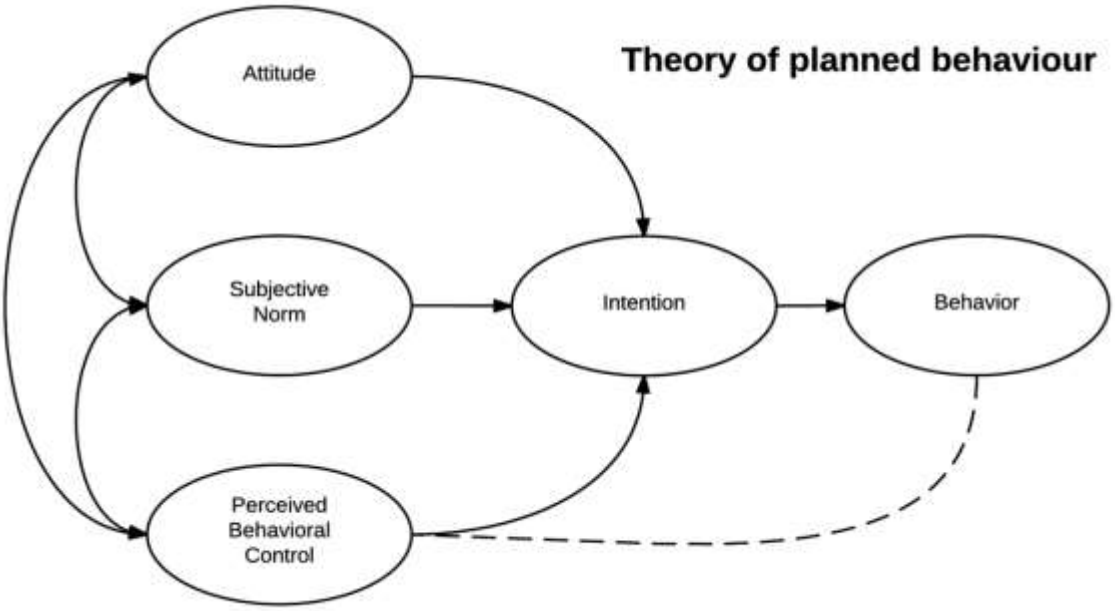
The mode of leadership that results in poor safety outcomes has had little investigation; organisations can become more effective through engagement of staff and the importance placed on each employee directly influences patient outcome (Storey et al 2013). Greaves et al (2013) and Storey (2013) both

describe how environmental behaviours affects specific beliefs and employee intentions to engage in positive behaviours within organisations. Interpreting how individuals view the wider environment, for example policy frameworks, systems of accountability, evidence on effective health care and how they interact in the system is important in making sense of what is required in organisations to build a positive emotional tone or climate.

Previous research in this area has focused on using the theory of planned behaviour (TPB) to explore environmental behavioural intentions in the workplace setting and not within the context of Commissioner and providers in healthcare. The TPB has previously been used to predict an individual's intention to engage in behaviour at a specific time and place. The key elements include the person's ability to control the behaviour. This approach has been used to predict an individual's behavioural intent; for example a tendency to excessively drink alcohol and take up smoking, identifying the subjective evaluation of the risks and benefits to the individual.

The person's control over the behaviour relates to the individuals attitude and the behavioural intentions which motivate them. Subjective norms relates to most people in the group who would approve of the behaviour or disapprove of the action. This directly links to the social norms of that particular group or sub set of the overall system they operate in. The power the individual has within the group will contribute to the control they may have over the action being taken (Van Lange et al 2012) see figure 5.

Figure 5 Theory of planned behaviour



(Azjen 2011)

2.6 Group Behaviour

Leadership is often complex with group behaviour and norms difficult to understand. It is important to consider how groups behave as this can influence Q&S outcomes. The evidence from external organisations of how groups make poor decisions is important to understand as the processes of group decision making is prevalent at all levels and in every organisational situation. Irvine Janis (1972) a psychologist working in the early 1970's identified patterns of behaviour in groups that can lead to poor decision making. Janis (1972) described this term as 'groupthink'

> ‘a mode of thinking that people engage in when they are deeply involved in a cohesive in-group, when the members’ strivings for unanimity override their motivation to realistically appraise alternative courses of action’ (p8)

According to Janis’s theory, groupthink occurs only when cohesiveness is high. Groupthink requires that members share a strong feeling of solidarity and desire to maintain relationships within the group at all costs. When colleagues operate in a groupthink mode they automatically apply the ‘preserve group harmony’ test to every decision they face. Janis claimed the "superglue" of solidarity that bonds people together often causes their mental process to get stuck.

The Challenger disaster (The Presidential Commission 1986) is often cited through retrospective analysis as an example of ‘groupthink’ a process when a group can make choices that result in poor decision being made. The National Aeronautics and Space Association (NASA) managers involved formed a cohesive in-group when they approved the Challenger launch, which ultimately ended in disaster. The Challenger broke apart 73 seconds into its flight, leading to the deaths of its seven crew members. The Challenger disintegrated after an o-ring in its right rocket booster failed at takeoff. NASA managers had known since 1977 that contractor Morton Thiokol’s design of the O-ring had a catastrophic flaw, but failed to address it properly. They also disregarded warnings from engineers about the dangers of launching posed by the low temperatures that morning, and failed to adequately report these technical concerns to their superiors.

The engineers at Morton Thiokol, mindful of losing a lucrative contract with NASA, had expressed a view about the launch being "an act away from goodness" which was not clear. The pressure on the NASA team to launch was significant with a number of previous flights delayed due to poor weather and the Reagan administration wanting to see the first teacher in space. However because cohesion of the group is favoured over individuality, a poor decision making process arose and disaster ensued (The Presidential Commission 1986).

A combination of attitude and behaviours from a group was identified in Kirkup's 2015 report of the Morecambe Bay Investigation which identified that 11 babies and a mother died unnecessarily at the hospital over a period of eight years. A picture of denial existed, with a strong group mentality amongst midwives characterised as 'the musketeers' who became hostile if criticised. The report identified distortion of the truth in responses to the investigation and disappearance of clinical records. When there was a fatality a circulation of what they described as 'model answers' for Coroner court inquests was distributed. Concealing the truth about what happened was deemed inexcusable as well as unprofessional. Kirkup (2015) further described:

> 'A stark catalogue of failures at almost every level from the maternity unit to those responsible for regulating and monitoring the Trust. The nature of these problems is serious and shocking, and it is important for the lessons of these events to be learnt and acted upon, not only to improve the safety of maternity services, but also to reduce risk elsewhere in NHS systems' (p.7)

In addition to the issue of 'groupthink' it is easy to see how strong leader preferences can lead to flawed decision-making as well. As a team member, voicing objections or concerns to a superior can

be intimidating, particularly if they have a strong opinion; this may be a cultural issue within healthcare which has a hierarchical management structure, with consultants being above managers in the decision making process.

To understand why groups or leaders may make poor decisions a recent study by Abrams et al (2013) identified that where groups face competition, leaders may find themselves gradually propelled toward disreputable, transgressive, and possibly illegal actions in support of their groups (Ashforth and Anand, 2003). Leaders may engage in transgressive acts because of their desire to benefit the group, but the research identified that if the group were complicit, it is feasible the group become comfortable with their own leaders transgressions, as long as the act is perceived as being enacted for the benefit of the group. Often these groups do not feel empathy with external organisations particularly governments, political groups or rival teams. These external agencies or observers seem likely to visit significant sanctions on transgressive leaders.

The paper by Ashforth and Anand (2003) goes on to describe the risks associated with double standards; firstly creating the potential for the group to feel the behaviour was normal; secondly working outside the rules leaves the group vulnerable to criticism from those external to the group who can view the corruption more clearly. This could cause conflict between groups and create tribes as described by the Bristol Inquiry where the tribe protected themselves, not the patients involved. With the surgeons acting outside the normal rules, causing numerous patient harm incidents (Kennedy 2001).

2.7. Leadership questionnaire

Leadership behaviour tends to be measured via questionnaires, with many previous studies using the 'multifactor leadership questionnaire' (MLQ). One of the studies undertaken by Darvish and Shirazi Pour (2013) reviewed the MLQ to assess employee's job satisfaction as an outcome of leadership styles being either transformational or transactional. The results identified a positive correlation between job satisfaction and leadership style with a 31% indication of transactional management impact on job satisfaction and 49% in those displaying transformational leadership qualities.

Muenjohn and Armstrong (2008) undertook another method used to measure leadership via questionnaire; this identified that the results of a confirmatory factor analysis revealed that the structural validity of Carless (1998) research model (x5) does not measure separate transformational leadership behaviours, instead it appears to assess a single hierarchical construct of transformational leadership.

Tummers and Knies (2014) described five dimensions of public leadership including accountability leadership, lawfulness, ethical leadership, political loyal leadership and network governance leadership and looked at the important public sector values related to this concept. Tummers and Knies believe that governance leadership is defined as encouraging employees to actively connect with stakeholders (outside their Departments) to gain resource.

A revised self-leadership questionnaire was also evaluated by Hourghton et al (2012) who examined the term self-leadership which looked at the process of influencing yourself to perform more effectively. The process involves a specific set of strategies and normative prescriptions designed to

enhance individual performance. Behaviour focused strategies provide specific approaches for identifying ineffective behaviours and replacing them with more effective ones through a process of self-observation, self-goal setting, self-reward, self-correction feedback and self-cueing. The factors analysed included behavioural awareness and volition, task motivation and constructive cognition, Houghton (2012) believed these factors encapsulated the classic leadership strategy dimension. When undertaking a questionnaire, this may influence individual perceptions, as the individual view of themselves will directly influence the view of the leader. Personality traits of those completing the questionnaire may influence perceptions of how they are being led and if individuals are reluctant to take instruction from management this may influence outcomes.

2.8. Post Francis Review

Francis (2013) identified that the underlying causes of failure at Mid Staffs directly related to leadership, culture and behaviour. Francis noted there was a consistent denial to deal with difficult situations with regulatory, commissioning and other agencies, who served different but overlapping functions, not communicating effectively, thus creating the environment that resulted in Q&S failings. Although the study by Dixon-Woods et al (2013) identified that the desire to provide good patient care was prevalent amongst staff, this was not reflected in clear objectives for staff that were measurable and challenging. Boards and senior staff were often looking for 'comfort seeking behaviours' defined as being externally focused and constantly seeking assurance that all was well with the service. Dixon-Woods described the NHS board as being:

> 'pre-occupied with demonstrating compliance with external expectations, failed to listen to negative signals from staff or lacked knowledge of the real issues at the frontline. Comfort seeking tended to demonstrate pre-occupation with positive news from staff, with bad news

leading to concerns and critical comments being dismissed as whining or disruptive behaviour' (p.110)

The paper goes on to describe culture and leadership behaviour as important for setting the direction and tone of the organisation, but which was required to be innovative and caring for it to be effective. The board's role in addressing and dealing with system problems was important to support cultural change within the organisation that would in turn have delivered benefits for patients. This paper then goes on to detail how the conflict between NHS leaders and staff existed - with the 'comfort seeking' behaviours expressed by senior leaders leading them to see the behaviour of frontline staff as the main cause of problems in relation to Q&S. Due to this issue, it is difficult to see how organisations can deal effectively with Q&S. The findings of Cater and Jarman (2013) re-affirm the belief that comfort seeking behaviours were prevalent in Mid Staffs with the inquiry stating that the Trust and wider NHS were simply unaware of the issues identified on the wards, as they were not escalated to the board. The reality was that the desire of Mid Staffs to achieve Foundation Trust status made them turn a blind eye to disgruntled staff and customer complaints and dismissive of the evidence of high mortality rates; the latter was seen as a coding issue, despite mounting evidence that mortality rates in Mid Staffs were higher than most other Trusts. Further investigations into the root cause of the Trust's failings were evidenced as early as 2004, when the Trust was given a no star rating by the Healthcare Commission. In 2006 the NHS specialist services Commissioning Group identified the care of critically ill and critically injured children as an:

'immediate risk to clinical safety or clinical outcomes' (Carter and Jarman 2013 p.1)

In 2007 the hospital standard mortality ratio (HSMR) for Mid Staffs was 127 compared to an average value of 100 for mortality in other Trusts. Despite having one of the highest HSMRs in the country, Mid Staffs gained Foundation Trust status. As a response to this, a group was established at Mid Staffs which focused solely on the coding of mortality rates not outcomes, avoiding using complaints or incidents to cross reference data. The coding of data fitted with the leadership behaviour that Dixon-Woods et al (2013) highlighted of 'comfort seeking behaviours' and were prevalent within the Trust. The rating for morbidity was later adjusted to 101 for the period May to August 2007; this did not relate to any data available at the time. It is still unknown how this figure was obtained and the subsequent inquiry later evidenced the actual figure was 108.7.

The focus of Mid Staffs leadership was to massage the mortality figures, discounting patients with palliative care needs, to reduce the mortality rate to avoid accusations of poor care for those patients who were admitted to die. Hawkes (2013) suggests that the coding changes made at Mid Staffs masked true figures and ignored clinical and patient messages of poor care. It is not known whether the coding changes were introduced innocently or with deliberate intent to make the mortality figures look better. This directly affected the payment by results process funded by Commissioners, limiting the financial difficulties the Trust was facing.

The evidence of poor mortality rates was available but did not stop the Trust achieving Foundation Trust status in February 2008. The Healthcare Commission launched a formal investigation into the hospitals mortality rates soon after. In early 2009, the inquiry provided politicians with the evidence of appalling care provided at the Trust, with the Healthcare Commission clearing the Strategic Health Authority of any knowledge of problems at the Trust before April 2007. Keogh's (2013) optimistic view, expressed post inquiry, that with systems now in place, (which include the 'friends and family test' and greater scrutiny by the CQC) similar failings would be prevented in the future, can sadly be

challenged. The evidence from the Morecambe Bay inquiry that a variety of Departmental norms and organisational cultures overcame robust systems, places Keoghs beliefs in doubt. If as a result of pressure from politicians, Commissioners and the CQC to continue to seek 'comfort seeking behaviours' the default position of many acute trusts will be to look for compliance, ensuring that senior staff do not have to tell the board bad news which ultimately will result in further failures in patient care.

The new NHS aims to empower patients and clearly identify failing hospitals and this is obviously the type of NHS we all desire. However, it is clear that within complex multi faceted organisations such as the NHS, which contain a large number of regulators and disciplines, this may be difficult to achieve. Wood (2013) believes the evidence from David Nicholson, the then Chief Executive of NHS England, that Mid Staff was a one off event is simply not sustainable; as investigations into hospital failures continue so does the evidence of poor care leadership. Woods believes that management and leaders within the NHS do not understand the complexities of patient care and lose sight of patients needs. Wood (2013) identified that those organisations with higher levels of staff engagement and wellbeing clearly demonstrated lower mortality levels for patients, especially when compared with organisations who showed higher incident rates and intentions to quit rates for staff.

The command and control regime within the NHS reduces the ability of staff to care for patients. The view of an OH Physician published anonymously in the British Medical Journal (2015), found that there was a callous disregard for staff wellbeing and claimed that NHS staff were 70% more likely to have developed work related stress, depression and anxiety than the general workforce. This is compounded by the relative (compared to the private sector) lack of OH resources in the NHS. This provides a contradiction: resources are diverted away from OH in order to provide for patient care, yet how can patient care be effective if the staff required to deliver it are unfit for work? In

conjunction, the alleged brutalisation of some NHS staff creates a cycle of care that results in some staff no longer treating patients with compassion as they are not treated reasonably themselves.

The movement of leaders within the NHS is also a significant issue, with staff at Executive level moving on average every 2-3 years, thus avoiding being in post and being caught out when implementation of their plans becomes reality.

There appears to be an inability to learn from the lessons of the past – this may be due to the relatively fluid movement of staff at executive level (who seldom stay in post for more than 3 years). This generally results in the person raising the risk often being seen as the problem and not the risk itself. Cleary and Doyle (2015) define this lack of acknowledgement around the raising of legitimate concerns as the 'deaf effect phenomenon' which occurs when a person who can effect action (decision makers) do not hear or report bad news; which therefore results in inaction to address the fundamental flaws in the process. This process of inaction by management therefore forces the individual to go down the whistle blowing route. Whistle blowers are often ostracised, being viewed as disloyal or disaffected members of staff who expose damaging information about the Trust they work for. Often the whistleblower is victimised and their message lost in attacks on their personal credibility. Staff perceive the raising of concerns as a fruitless exercise, as they believe nothing is likely to happen as a result of the concern being raised and that lessons will not be learned from their experiences.

The NHS staff survey in 2014 identified that 94% of staff knew how to raise concerns but only 57% were confident that their views would be addressed. This lack of confidence is a fundamental concern for the NHS, should it wish to engage in 'problem sensing' described by Dixon-Woods et al (2013) whereby organisations should be looking for softer intelligence, seeking out information from

patients reviews and senior leaders making unannounced visits to wards. This approach would avoid the need for whistle blowing as the information to inform the board would be readily available. However the prevalence of blaming individuals when things go wrong is the fundamental failure in the system. A review of Francis and Berwick reports by Kapur (2014) identified that staff require a 'support commission' that looks at whistle blowing, staff wellbeing, mediation and redeployment. Often, whistleblowers are seen as troublesome and are dismissed for bringing their employers name into disrepute, which is an inevitable consequence of going public with concerns.

Kieran (2014) described two key issues associated with the outcomes of the Berwick and Francis reports: firstly the wellbeing of patients and secondly the treatment of staff. Kieran states that when staff are not listened to when raising concerns, this directly influences patient care. Kieran believes the leadership at the top of the NHS is the major problem and created the culture that led to the failures highlighted in these reports. The leaders within the NHS did not accept responsibility for the outcomes at Mid Staffs yet continued to describe a more open NHS being required with an urgent need for change. Kieran believes this is not reflected in the actions and behaviours evidenced. Kieran states that the outgoing Chief Executive Sir David Nicholson possessed limited emotional intelligence and therefore has been a poor role model for the leadership of the NHS. More positively, Kieran believes the new generation of leaders have been suitably trained, have more emotional intelligence and are less accepting of the leadership culture that has been prevalent in the NHS one which previously resulted in poor performing leaders been promoted or paid off. The increase in graduate trainees working with the leadership academy is bringing management and leadership in the NHS together for the first time. Kieran believes the new regime with Simon Stevens as the new Chief Executive provides some hope of a more measured approach using research evidence as a base for change.

The NHS Confederation (2015) recognised that the number of high profile scandals in the NHS had damaged public confidence in the care given. The view of Berwick (2013) that professionals within the NHS need to avoid the compliance seeking cultures that focus on targets as a priority often leads to lack of patient care. The evidence from the oil and other industries is that the top down command and control system often creates the worst type of culture for Q&S outcomes. Berwick described the NHS as needing to become more a system of continual learning and improvement. A more open and honest NHS is what is called for but often this is stifled by senior leaders. Support for change post Francis requiring to be led from the top and filter throughout the system.

The financial challenge facing the NHS requires a much more open discussion with cost pressures growing at 4% per annum and efficiencies required at 4% per annum the funding for health and social care does not match demand. The leaders within the NHS require a transformational approach with consistent leadership which gives staff confidence and trust in them, to effectively implement the changes required in the system. This consistency of approach is difficult to achieve when NHS Chief Executives in acute Trusts are in post for only two years on average, leaving little time to implement effective leadership and culture change. New models of care require a more generalist and holistic approach to care in the community. This will require a cultural shift to enable a mix of skill sets which allow multi-disciplinary working in which staff from the acute sector can work with Community based staff to support the care of individuals. The new setting of the healthcare sector will require a breakdown of cultural barriers and an agreement to shared goals in a co-ordinated manner. This adds more complexity to the diversity of cultures within the NHS and consistent leadership will be required to make the change sustainable and provide the best outcomes for patients.

Boland (2013) describes a cultural change being needed in the NHS, not a structural change. This is unclear to evidence from leaders, when the Health Secretary announced an increase in funding of

£40m to the CQC after the revelation that the CQC had tried to cover up the failure to monitor poor performance at Morecambe Bay. The intention of the increased funding is to create an Office for Standards in Education (Ofsted) type inspections regime that gives assurance to the public and patients of sound governance systems. The CQC will often see staff behaving appropriately and providing adequate care, as staffing ratios are boosted during inspections and all documentation is in order. The regulator requires to be more open and to develop a positive engaging culture to avoid creating more fear within senior management and to gain the trust of staff. Boland believes the approach to inspection overlooks the importance of engaging clinicians, who identify most cases of abuse and neglect, as clinicians are the people who uphold Q&S on a daily basis.

A recent evaluation by the National Clinical assessment service, of 300 doctors with performance problems, identified that self awareness and emotional intelligence has a significant role in patient care. Individuals who show understanding and recognise their own emotions are more likely to perform better at work. Doctors need to understand behaviours that have positive or detrimental effects on other staff members and patient care. Reflective practice through coaching will enable improvements to be evidenced from Doctors in practice (Brown et al 2014).

Burnes and Pope (2007) identified that the NHS appears to have more prevalent levels of negative behaviour than private sector organisations, with higher levels of incivility between staff members, which would not be classed as bullying but has a negative effect on the well being of staff. Bullying cases are infrequent in healthcare as the majority of staff is reluctant to take bullying and harassment cases as they are likely to fail. The frequency of the bullying behaviour often doesn't result in formal cases being taken. The classification of lower frequency events can also be detrimental on organisational effectiveness which may not be classed as full-on bullying. The study identified that 50% of staff had witnessed negative behaviour in the NHS. This may be as a result of low job

mobility with the bureaucratic impersonal nature of the public sector, which has historically given low priority to management skills, with a competitive work environment, tight deadlines and aggressive behaviour as a management tactic to reach targets at all costs.

2.9. Summary

The literature review identified the underlying courses of failure at Mid Staffs related directly to leadership, culture and behaviour. Francis (2013) noted there was consistently denial to deal with difficult situations, with regulatory, Commissioning and other agencies who served different but overlapping functions not communicating effectively. Although the study by Dixon-Woods et al (2013) identified that the desire to provide good patient care was prevalent amongst staff, this was not reflected in clear objectives for staff that were measurable and challenging. This created a culture within the organisation that directly resulted in Q&S failings. The literature review provided limited evidence that followers such as providers in healthcare have commented on Commissioner's leadership behaviour or how potential outcomes to Q&S are affected. The majority of leadership studies offer insight into effective leadership style via follower-survey methods rather than via field-observed and systematically coded behaviour (Shondrick and Lord 2010). A mixed methodology approach is the most appropriate method to assess behaviours (Hoogeboom et al 2011) with a view to determine a true base for improvement.

Methodology of Study

Chapter 3

3.1. Introduction

This chapter describes the research methodology using a pragmatic mixed method approach, avoiding bias by using contrasting data sources (Denscombe 2008). Secondly, it details the concurrent triangulated design using two distinct methods: Phase 1, focused video ethnography identifying both verbal and non-verbal communication, and Phase 2, a quantitative questionnaire. Thirdly, it identifies different data collection and analysis processes to test the theoretically derived hypotheses (Short & Hughes 2009). This includes a unique behavioural coding system based on Gupta & Wilderon (2009), Perkins (2009) and Weenink et al (2012) identifying transactional, transformational and passive management styles. Finally, the research design process is described, focusing on the specific methodology for this research and ethical approach taken, along with limitations of the study.

3.2. Mixed methods

The field of mixed methods research has developed significantly over the last 20 years, involving many educators and engaging the attention of scholars worldwide. The process is often limited to the single context of combining qualitative methods and randomised controlled trials (RCT) in healthcare due to the focus on clinical trials. O'Cathian et al (2007) believes health researchers could further contribute to the development of the mixed methods approach in the contexts of instrument development, survey and fieldwork. O'Cathian et al (2007) states that non-randomised evaluations can be best used to evaluate social, physiological and cultural issues, which are not possible to be

measured by purely quantitative methods alone. Freshwater (2007) is critical of the approach taken in healthcare, as mixed methods are often cited with an expectation that the research fits into this preferred perspective rather than the most appropriate method. She goes on to say that often healthcare funding of research pushes for both qualitative and quantitative methods, as it must be deemed better if two methods are used. Onwuegbuzie and Johnson (2006) believe the pragmatic mixed method approach is more beneficial, as the researcher does not start with one philosophical assumption but is driven by the research question using a practical approach, which uses the best method available to gain insight into the hypothesis.

Cresswell (2003) is supportive of mixed methods research, stating 'combination both quantitative and qualitative data yields a more complete analysis which complement each other'. The definition of a mixed methods study is:

> "A mixed methods study involves the collection or analysis of both quantitative and/or qualitative data in a single study in which the data is collected concurrently or sequentially, given a priority, and involve the integration of the data at one or more stages in the process of research." (Cresswell 2003 p165).

Recent research by Luck, Jackson and Usher (2006) illustrates a number of case studies in which both qualitative and quantitative data are gathered; the qualitative data flowing into an otherwise quantitative intervention clinical trial before the treatment, while the treatment is being conducted or after the treatment giving a different perspective on the outcomes (Sandelowski 1996).

According to Bowers et al (2013) a fundamental component of mixed methods research is for the research to have a team to develop the process. Although some researchers (Hall and Howard 2008) suggest that a single researcher can conduct mixed methods research, most recognise that it is unlikely for a single researcher to possess sufficient methodological expertise to carry out a rigorous mixed methods study. Bowers (2013) goes on to state that there is limited practical guidance and protocols on how to undertake such studies and even less on the process of data collection and analysis. Greene (2007) describes mixed methods as a way of thinking in terms of methodologies (how knowledge is obtained) and epistemologies (how the enquirer is related to the research). The literature makes it clear that the process is often complex and challenging for the single researcher, as undertaken by this study. To be bracketed and removed from the research as described in the positivist approach is not possible; recognition of the researchers own perspective and individual role directly influences results and this is recognised and constantly evaluated through the research process.

Considering mixed methodologies as an overall approach to research and defining how the competing paradigms exist is important. The positivist paradigm closely related to quantitative enquiry (Polit and Hungler 1999) determines that reality exists independently of the research and there is a real world driven by positivist ontological positions which defines 'the nature of reality'. The epistemology position of the enquirer for the positivist paradigm 'how the research is related to the researcher' is also of importance, the positivist approach determining that the research is not influenced by the researcher.

The positivist view is that individuals may be bracketed and not involved in the process of research. The naturalistic paradigm closer related to qualitative enquiry defines that research interacts with those being researched and the findings are the result of the interaction. Cohen et al (2015) states that reliance on the perspective of the researcher is problematic, as many researchers do not understand the importance of post research impact and assessment on policy and process. A key feature of mixed methods research is its methodological pluralism or eclecticism, which frequently results in superior research compared to monomethod research, a single technique.

Cooper and Macleod (2010) explain pluralism as being in contrast to the 'monism' or positivist view which describes that every question has a single and definitive answer. Pluralists hold the view that there may be a number of 'right' answers to questions posed, which are not reducible to any one single truth. Central to this view is the belief that there is no single perspective from which the 'truth' can be known or claim to have a better vantage point on 'reality'. Eclecticism is a conceptual approach that does not hold rigidly to a single paradigm or set of assumptions, but instead draws upon multiple theories, styles, or ideas to gain complementary insights into a subject applying different theories in any particular cases. The process is often criticised for lacking in simplicity and consistency, compared with the single paradigm view (Cooper and Macleod 2010).

Mixed methods research is viewed as the third methodological movement and a separate paradigm. The approach has much to offer health and social science research. Its emergence was in response to the limitations of the sole use of qualitative and quantitative methods alone and is now considered by many a legitimate alternative to these two traditions (Cresswell et al 2004). In particular, healthcare research can benefit from using a dynamic approach to address the complex and multi-faceted research problems often encountered in the health care sector (Burke Johnson and Onwuegbuzie

2004). Group interaction is a key element of this study used to identify the essence of how groups behave (Walcott 2002), with the process of research pulling apart the data and putting it back together with more meaningful analysis and synthesis providing direct interpretation of behaviour of Commissioners (Stake 1995).

Cresswell et al (2003) describes six major mixed method designs. Firstly, sequential explanatory design, characterised by the collection and analysis of quantitative data and qualitative data. Secondly, sequential exploratory design, which features evaluation of the first phase qualitative data, followed by analysis of the second phase quantitative data with the priority given to the first phase. Thirdly, sequential transformation design, having two data collection phases one following the other with priority given to either method. Fourthly, concurrent triangulation design which is used to cross-validate findings within a single study; the qualitative and quantitative data are concurrent happening in one phase of the research study and the integration of results is generally in the research phase. Fifthly, concurrent nested design can be identified by one collection phase; a method may be nested or form part of the overall method used. Finally, concurrent formative design is a combination of nested design and triangulated methods described above.

3.3. Ethnography

The definition of ethnography is the science of defining a group or culture; identifying predictable patterns in lived experience, set in a naturalistic environment, were the observer can also be a participant (Seal 2008). Spradley (1980) goes on to define ethnography as ‘work of describing a culture’ with the central aim to get an insider’s view from observation. Often, ethnography is described as being more concerned with actions, interactions and social situations, with the focus of

the visual orientation of the participants as a spotlight to show specific features, with a context that can adequately describe the organisation of their action.

A study undertaken by Cooper et al (2004) identified that non-participation and participation studies have had little evaluation on the outcomes of research. However, the findings suggest that participatory studies can have an impact on the data collection method, which in turn may influence the outcomes. The non-observational approach used in some ethnographic research gains a more realistic view of what happens in a normal activity. This is in contrast to the bracketing approach taken by the positivist view described above, which determines that individuals can be separate to the research process being used; this is further explored throughout this section. The interpretation of data will be subjective dependant on the individual carrying out the research and this is recognised as potentially problematic for the single researcher to undertake as there is limited critical appraisal of the findings.

In order to determine how individuals emerge as leaders and groups make decisions, video ethnography has broad and wide ranging advantages to other forms of research. Used originally for social science research, it was first used in the field of anthropology where moving pictures provided pioneers in the field, such as Bateson and Mead (1942) with valuable documentation for research purposes. Following in this tradition. Collier and Collier (1986) wrote a practical guide for using photography as a research method. Their case for using photography and video for research is important as they describe visual images capturing the context as well as the action of an event; they can be interpreted by multiple viewers and the eye of the camera often freezes moments the human eye ignores. The Colliers (1986) base many of their convictions about the efficacy of video on those studies where human behaviour expresses communication and emotion principally through

nonverbal cues and actions. Collier and Collier (1986) specifically points out that moving records make it easier to define the nature and significance of social behaviour with responsible detail because;

> "the language of motion defines love, hate, anger, delight and other qualities of behaviour" (p.129).

The advantages of video as an observational technique prove to be obvious (Heath et al 2010) compared to observations made by the naked human eye; video recordings appear more detailed, more complete and more accurate. In a technical sense, they are more reliable since they allow data analysis independent of the person who collected the data. However, despite the fact that video is widely used today in the social sciences, there have been few attempts to discuss the methodology of working with this medium as an instrument of data collection and analysis (Knoblauch et al 2012). The technique allows the researcher to view the interaction of the group, identify individual and group dynamics and provides an excellent media to view this interaction, which includes non-verbal cues that can influence actions of people within the environment (Rosenstein 2002).

However, video ethnography has its doubters as a legitimate form of research; Collier and Collier (1986) suggest the correlation with other research using field notes and interviews had identified similar findings to ethnographic data. The Colliers (1986) were so convinced by their own findings that they departed from their traditional adherence to still photography to state unequivocally that

> "only film or video can record the realism of time and motion or the psychological reality or varieties of interpersonal relations" (p.144).

Short and Hughes (2009) offer a different view on the validity of ethnography; they define that regardless of the target of the research, when coding and statistical modelling take place, the more influence and distortion occurs and the more science demands generality, defining how much, how often and under what circumstances. To answer these questions involves the delicate interplay of qualitative and quantitative data analysis, generated with different methodologies. However, ethnography enables translation of quantitative data of everyday life of groups and individuals and from macro to individual level of explanation.

According to Pink (2001), video ethnography holds potential for combining quantitative trends with the qualitative words of participants. As an emerging approach to inquiry, mixed methods has yet to reach consensus on the validity of video ethnography as a legitimate form of research. However, increased interest in the approach worldwide is likely to continue as clarity on the method is improved. Cresswell and Garrett (2008) believe that the openness to experiment with research methodologies and ways of thinking about research will encourage manipulation of the structure of the approach taken.

Video-observation methods as a way of evaluating behaviour have been used to capture meetings in the field settings, reviewing naturalistic leadership behaviour. Erickson (1992) stated that taking field notes alone was found to be more obtrusive than videoing staff, causing abnormal behaviours in those observed. The use of video observation to assess measurement of actual leadership behaviour has been highlighted by Davis and Luthans (1979) Heath, Hindmarsh and Luff (2010), who defined that hardly anyone so far has published on such an approach. Video-taped meetings, in which the behaviours of the leaders were filmed, has identified that the leaders displayed the kind of behaviours

that had been shown in similar previous meetings (Hoogeboom et al 2011) indicating the behaviour is consistent.

Le Baron (2006) describes a move forward in the process of ethnography towards micro-ethnography which can be used to analyse small moments in human activity, analysing repeatedly, and vigorously looking at the individuals words and their embodied behaviours which includes relative location, orientation and movement of people and things. Le Baron suggests there are three distinct processes in micro ethnography which include firstly, conversation analysis to collect data on re-occurring phenomenon; secondly, a rich description of social interaction and how decisions are made and finally 'context analysis' that focuses on how visible (body language) creates interaction between participants in a group. This third element 'context analysis' has been pioneered by a number of scholars such as Van Dyjk (2008) describing contexts which are generally considered to examine social relativity and sequential unfolding of visible forms of interaction. Van Dyjk (2008) poses a view that contexts are assumed to be related to discourse and communication, with the notion of context and its possible components in linguistics, sociolinguistics and cognitive psychology, all of which are interlinked.

The view or beliefs of an individual described by Wodak and Meyer (2009) show discourse in the way individuals view a set of values and beliefs which constitute a way of looking at the world. Harrison (2000) describes discourse as 'regimes of truth which powerfully influence the meaning we attach to contemporary developments'. Their power depends on how far they are able to naturalise, to bestow a taken for granted status on understanding which are historically and culturally located within the context they operate.

The Commissioners' contexts and views are not an objective condition or direct cause of behaviour but rather (inter) subjective constructs developed and ongoing, regularly updated with interaction by participants as members of groups and communities. If contexts were objective social conditions or constraints, all people in the same social situation would speak in the same way but this does not occur. Van Dyjk (2008) believes the participant constructs also accounts for the uniqueness of each text or talk (or its fragments), as well as for the common ground and shared social representations of participants as they are being applied in their definition of the situation we call context.

In comparing observation by participant behaviour through micro-analysis Erickson's (1992) research attempted to understand events whose structure is too complex to be comprehended all at once, given the limits on human information processing (Erickson 1992). Combining ethnography using audio and visual techniques, Rosenstein research (2002) suggests the close study of interaction through ethnographically oriented analysis of audio-visual records as a useful component of an ethnographic study. Videotape microanalysis is one of several tools in the researcher's repertoire; this repertoire contains both quantitative and qualitative methodology. The video can be used to collect quantitative and qualitative data by providing documents from which researchers can categorise information.

Using similar theoretical principles, Heath (2010) applied ethnography to yet another field that of medicine. He used videotaped medical consultations between doctors and patients to establish "how participants maintain a state of mutual involvement and sustain their integration within social interaction". The main thrust of Heath's study was used to examine non-verbal behaviour of the participants as each one tried to involve the other through body movements. Ram et al (1999) concluded that the assessments to measure the effectiveness of communication between patients and General Practitioners (GPs) indicated that video assessments provided a reliable and valid method to

measure performance and were more valid than observational methods alone. Despite the findings, there is limited evidence of video ethnography being used to assess interaction between patient and GP or any other sector of healthcare management. Video ethnography has also been used to evaluate functional performance and coding of behaviours in schizophrenic patients. Bromley (2012) noted that for clients the novelty of the video taping of activities wore off after a short period of time. He used a team based iterative process to develop quantitative codes for the filmed behaviour, to identify relevant behaviours.

Historically, there has been conflict in isolating verbal and non verbal data using ethnography as they have normally been evaluated separately, with quantitative scholars being more aligned to evaluate multiple incidents in their data, implying that the behaviours observed are not specific to the surroundings or interactions. Meanwhile, qualitative researchers are more likely to analyse the specific set of interactions, usually avoiding questions about how frequently or commonplace the phenomenon may be. Jones and Lebaron (2002) suggest that qualitative and quantitative methods can be used together, so that when the occurrence of certain behaviours is quantified (non verbal), the verbal can be qualitatively evaluated; the importance is to observe interactions being displayed using the most appropriate method.

The method most aligned to this research is based on Le Baron (2006) micro-ethnography and Knoblauch (2005) focused ethnography which examines ‘small’ communicative behaviours studying audible and visible details of human interaction and activity occurring naturally within specific contexts. Micro analysis may be coupled with ethnographic methods such as non participant observations. Knoblauch (2005) defines this more specific category as focused ethnography, defining small elements of society or culture traits within the workplace, therefore capturing the detailed

descriptions of an individual's specialised and fragmented activities within the group. The characteristic of this approach is short-term field visits (i.e. settings that are "part-time" rather than permanent). The short duration of field visits is typically compensated for by the intensive use of audiovisual data collection and data-analysis. The lack of intensity of the field work is compensated for by the large amount of data and the intensity and scrutiny of the data analysis process. However, focused ethnography is not all-encompassing and may not be able to address specific aspects of groups in highly differentiated organisations; it presupposes the investigator has intimate knowledge of the fields to be studied and the group.

Sangasubana (2011) states there are three issues that need to be considered when undertaking ethnographic study which include: reactivity, reliability and validity. Reactivity is described as the influence the presence of the researcher has on the behaviours of those involved and may result in them acting differently (Neuman 2003). This study avoided such behaviour by filming alongside a technical staff member from the LJMU who had not been involved with the group previously. Secondly, reliability: is the data consistent with what would normally occur in that given situation in the same context? This is difficult to assess, since access to real Commissioners in a boardroom was not possible for this study. Validity in field research is the confidence placed in the ability to collect and analyse data accurately to represent the culture and behaviour being studied. If the study is accepted by or credible to others inside and outside the field site, it is valid in terms of outcomes. Recognition of this study is evidenced via the published paper on the findings by the researcher in the British Journal of Healthcare Management evidencing transferability relevance beyond the study itself (Angrosino 2007).

3.4. Coding of non verbal communication

The study and theory of body language has become popular in recent years as a result of psychologists being able to understand how we can interpret what individuals 'say' through body gestures and facial expressions. It provides useful information to evaluate body language which can reveal underlying feelings and attitudes. Body language is also referred to as non-verbal communication which tends to be used in a wider sense. Highlen and Hill (1984) describe a variety of non-verbal cues used in research, which can include paralinguistics, kinesics, facial expressions, visual behaviour, proximics and touch. Paralinguistics deals with vocal cues, such as pitch, tone, intonation and modulation that accompany speech, indicating levels of tension which is important to understand when dealing with situations based on high risk decisions. These may also include sounds from the throat, such as humming or filling silence with sounds like 'um' or 'aaa.' Kinesics or kinesthetics (both occur in published literature) deals with postures, gestures, head-nods and leg movements and facial expression, and is described as a dynamic canvas on which people communicate their emotional states and infer the emotional states of others (Highlen and Hill 1984).

Non verbal communication is crucial when we meet someone for the first time as it is likely we will form opinions of them in a few seconds. This initial instinctual assessment is based far more on what we see and feel about the other person than on the words they speak. It is believed observers can quickly ''read'' the faces of strangers to make evaluations of their state (emotions, intentions) and trait characteristics. Often however, facial expressions are more difficult to interpret. Modern humans are highly skilled deceivers; observers tend to perform at or slightly above chance in judging whether another person is lying (Porter and Brinke 2008). Proximics is the theory of man's use of space on interpersonal communication in evaluating not only the way people interact with others in

daily life, but also the organisation of space in their workplace.

Ekman and Wallace (1969) have further sub-categorised gestures into four types namely emblems, illustrators, regulators, and adapters. Emblems are direct translation of culture specific signs like nods of head for ‘yes’ or a V sign to indicate victory or peace (Hanno et al 1973). Illustrators emphasise actions such as banging the table, cutting the air sharply, or sketching in the air a circle to emphasize a round geometric shape and may be used to kill the conversation. Adapters are unconscious actions of the body like snapping knuckles, shaking a leg rhythmically, touching oneself, stroking hair or chin while in deep contemplation, and shifting the orientation of one’s body to get relief from imagined

pressure or discomfort (Krausse et al 1996). Regulators are used to control the flow of conversation such as nodding the head up and down to indicate agreement and as though signalling the other to continue the conversation. Roughly, 45% of the population has primary preference during cognation in terms of feelings (kinaesthetic) compared to 35% in terms of visual image and 20% in auditory form. The subtleties of the cognitive processes in usability testing or any user data elicitation technique can be interpreted through the analysis patterns of accompanying kinaesthetic cues in addition to the verbal data.

Yammiyavar et al (2008) stated that the readiness and enthusiasm of individuals at meetings can be clearly identified when they sit forward in their seat, which indicates anxiety to get going. The participants also have bright wide eyes, with their body actions being alive and animated. Yammiyavar identified if the leader does not use this period at the start of meetings to gain attention, the individuals within the group may become restive or defensive. This may then lead to individuals

showing gestures of frustration which may include hand wringing, running fingers through their hair, clenching hands on jaw or touching and stroking themselves. Individuals may use rhythmic actions to reduce the frustration. Often individuals who are asked about their discomfort would likely deny this. Nervous behaviour includes the voice cracking or the facial muscles twitching. Arms crossed are often used to protect one's self or show fear of participating in the group. A sloppy posture is likely to show disinterest. Open hands and agreeing head nods would be a receptive participative approach to the group.

The coding of behaviour requires evaluation using a simple tool that Sandy (2009) identified. Higher level successful teams share five defining characteristics; firstly, everyone on the team talks and listens in roughly equal measure, keeping contributions short and to the point. Secondly, members face one another and their conversations and gestures are energetic. Thirdly, members connect directly with one another not just with the team leader. Fourthly, members carry on back-channel or side conversations within the team. Finally, members periodically break, go exploring outside the team and bring information back. The evidence suggested by Sandy (2009) is that individual reasoning and talent contribute far less to team success than expected. The best way to build a great team is not to select individuals for their accomplishments but to learn how they communicate and to shape and guide the team so that it follows successful communication patterns.

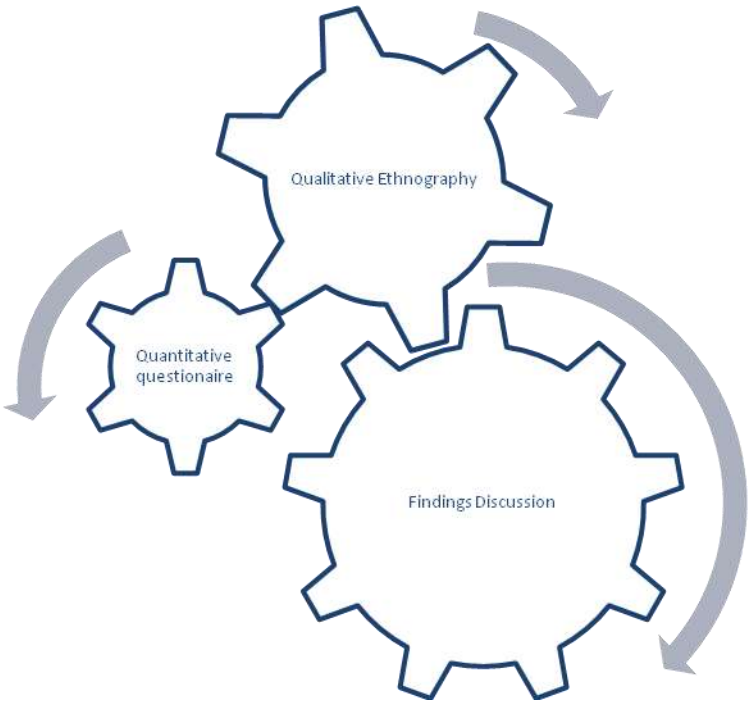
3.5. Research Design

This study has adopted a pragmatic mixed method principle, motivated by the perceived deficit of quantitative methods alone to address the complexity of research in health care, avoiding bias by using contrasting data methods (Denscombe 2008). The justification for using the mixed methods

approach is that it can be used to break down barriers and identify human interaction in a way that is unique and further develops the basic theories described within this chapter. The process involves looking at the minute detail of social interaction and getting to the truth of the research question which is specific to leadership within Commissioning of healthcare services. The process undertaken was closely aligned to the subject of interest and provided better understanding of issues of culture, leadership and behaviour being examined (Cresswell 2004). Scammon et al (2013) go on to say that the study of transformation in healthcare, which is dynamic in nature, requires a mixed methods approach because neither quantitative nor qualitative approaches alone are sufficient to understand complex phenomena within the healthcare sector.

Several mixed methods approaches were considered, particularly sequential explanatory design since it was initially thought that the qualitative evaluation may have greater impact on the research outcome. However, a concurrent triangulated design was deemed most appropriate because each area was subsequently given equal priority and the sequence was not relevant to the outcome; they were two discrete studies. The concurrent triangulation study used two phases with three distinct pieces of evidence being collected. Phase 1 included verbal and non verbal communication data and phase 2 the quantitative questionnaire, thus identifying different data-sources to test the theoretically derived hypotheses (Short & Hughes 2009). The data is then triangulated to provide an overall view of the findings of the research. The Figure 6 below describes the design of the research undertaken:

Figure 6: Methods for research



The data analysed during the integration phase is discussed in detail within this study in chapter 6. The qualitative evaluation was given as much weight as the quantitative second phase of the research. It was evaluated to cross-validate the behaviours seen in the open forum and used to corroborate that the behaviour exhibited in the forum translated to the workplace.

The process of research was divided into the initial gathering of qualitative data process and the separate quantitative questionnaire distributed after the event. As each process did not influence the other, the data analysis was concurrently being collected, interpreted and the results compared to provide an overview of the behaviour. To ensure the design was appropriate for the research a review using Cresswell's (2003) decision matrix was undertaken to evaluate the most effective way to answer the objectives of the research. The research method is described in Table 1.

Table 1 Mixed method, concurrent triangulated design process.

Concurrent triangulated design	QUAL data collection	QUAL data analysis	QUAN data analysis	QUAN data analysis	Data results compared

Consideration of how the data was collected involved the author evaluating how best to minimise the impact of his influence on the research outcome in phase 1. According to Cresswell (2004) individuals involved in the process of research will bring a personal stance to the research as they have a personal history, experience, culture, gender and class perspective. The position of the author of this study is Head of Organisational Health and Effectiveness, working in a provider acute trust. Therefore, the author is not affiliated to the Commissioners and was not familiar with them before the study; this provides a distance but may also create a pre-determined view of Commissioners behaviour from the work perspective of the author. During the open forum using video ethnography and the avoidance by the researcher of all contact with the participants, including the individual Commissioners leading the behaviour was deemed to provide a more realistic setting for the research. However it was recognised that the videoing of the group may initially have had an impact on outcomes and behaviour displayed but is likely to have been short term with individual and group norms being consistent within a short space of time (Bromley 2012).

The investigation in this case recognises the process of single individual study can lead to bias, thus adopting a bracketing or reflective approach has been required to avoid this occurring. The process of data collection and as significance on the overall outcome of the research is based on Cresswells (2003) process mapping defined in Table 2.

Table 2 Stages of integration determining the mixed method approach.

Methodology	*Data Collection method*	*Data Analysis*	*Interpretation/integration*	*Results*
1st Qualitative	Audio visual (focused ethnography) participants determined process.	NVIVO 10 themes categorised.	Personal interpretation of themes emerging from participants behaviours.	Discussion & findings.
2nd Quantitative	Questionnaire score oriented closed end process.	SPSS evaluation under taken inferential statistics.	Generalisation of themes.	Discussion & findings.

The method used to capture data is focused ethnography in its purist form. The process collects qualitative and quantitative data and both are analysed during the study (Le Compte and Schensul 1999). Ethnography is non-experimental research, a method that is "designed for discovery." This is particularly suited to gaining insight into questions embedded in social and cultural communities and is a scientific investigative process using the primary tool of data collection techniques that avoids bias and ensures accuracy. The rigor represented in codified ethnographic research methods produces scientifically valid and reliable data. Although the data collection process used was short, it demands a large amount of work in analysing the data collected in the field.

The distinction between contemporary and focused ethnography is described in Table 3 (Knoblauch 2005) providing a clear indication of what is meant by focused ethnography. The features are designated by categories which are designed in such a way as to provide clear analytical distinctions. The process of focused ethnography has been used in "requirement engineering"(Jirotka and Goguen 1994), architecture, museum research (Heath, Vom Lehn and Knoblauch 2001) and within market research. It has also been found to be beneficial in consumer behaviour studies. The majority of the focused ethnography studies do not describe a common methodological reference.

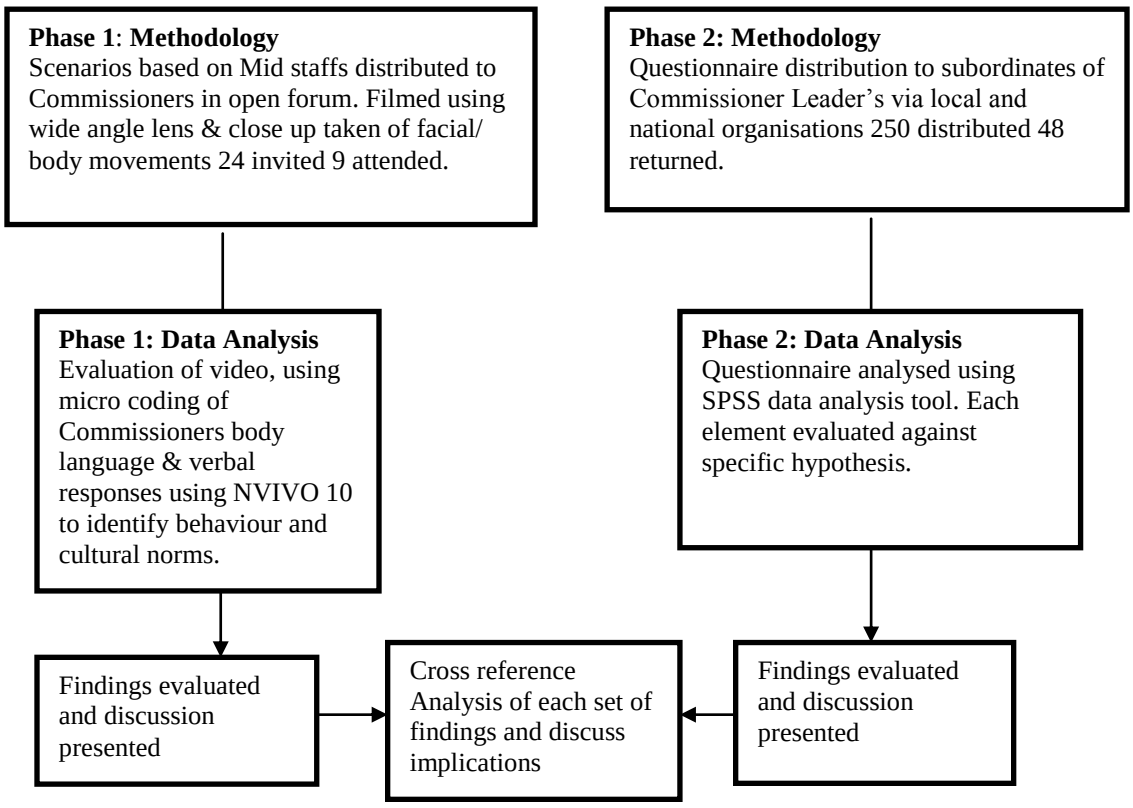
Table 3: Conventional & focused ethnography features.

Conventional ethnography	Focused ethnography
long-term field visits	short-term field visits
experientially intensive	data/analysis intensity
time extensity	time intensity
writing	recording
solitary data collection and analysis	data session groups
open	focused
social fields	communicative activities
participant role	field- observer role
insider knowledge	background knowledge
subjective understanding	conservation
notes	notes and transcripts
coding	coding and sequential analysis

3.6. Research process

The research comprises of two distinct phases. The first phase uses video ethnography of scenarios to examine the leadership behaviour of Commissioners in a group setting. The second phase uses a quantitative questionnaire to obtain the subordinates' views of Commissioners behaviour; 250 questionnaires were distributed (see figure 7). The target group for this study was Chief Executives, Chairs, Managers and Non-Executive Directors of Commissioning organisations to identify their perception of Q&S through the risk evaluation process and what leadership style is adopted. The purpose of this process is to identify what kind of behaviour is appropriate to influence change from a commissioning perspective. The study provides a framework of how leadership behaviour can be analysed to enable the culture of organisations to meet targets and keep the focus on delivering safe healthcare through effective staff engagement. Figure 7 describes the phases of the study and how this is presented within the chapters of this thesis.

Figure 7: Process for research study



3.7. Participants and sampling

The sampling of participants is an important step in the research process because it helps to inform the quality of data and likelihood that the sample chosen can provide a realistic framework to inform the outcomes. The individuals were specifically targeted via the Communication leads within a variety of organisations including Public Health, CCGs, Commissioner Support Units (CSUs) and NHS England to provide a broad spectrum of opinion and views. When considering the sample size for both quantitative and qualitative areas of this research the sample size and validity of the numbers is important to ensure generalisability of the data collected. According to Onwuegbuzie & Collins (2007) small samples in research are justified and this informed the sample scheme and size considered with 12 per group for the open forum being invited and 250 questionnaires distributed to Commissioner subordinates.

A combination of sampling techniques has been shown in Table 4, such as purposeful sampling (Cresswell and Clark 2007), which targeted 24 Chief Executives, Chairs of the Board and Commissioner organisations across the Merseyside & Cheshire footprint. However this was found to be too narrow a focus so this was extended across the North of England.

Table 4: Sampling scheme used for research

Sampling Scheme	**Description of participants**
Purposive	Choosing settings, groups, and/or individuals based on specific characteristic(s) because their inclusion provides the researcher with compelling insight about a phenomenon of interest.
Snowball/Chain	Participating Commissioners were asked to recruit individuals who were their subordinate to join the study by completing a questionnaire using likert scale. Additional questionnaires were distributed via linkedin to subordinates of Commissioners.
Method Phase 1 Micro-focused ethnography	1 cultural group (Creswell, 2007)
Method Phase 2 Questionnaire	Recommended sample size 64 participants for one-tailed hypotheses; 82 participants for two-tailed hypotheses (Onwuegbuzie et al 2006).

Participants were invited via e-mail through their Commissioning organisations, provided with participation information sheets and consent forms (Appendix 6 and 7). All participants were given an outline of the study prior to the open forum process. A total of 47 participants were invited to attend, however many had prior commitments and did not attend on the day. A total of 9 participants attended the open forum including 3 from the CCGs, 3 from the CSU and 3 individuals from Public Health, Strategic Critical Network and Head of Clinical Partnerships; this included 2 men and 7 women. Written transcripts of the video-taped forum were available to participants when requested. Questionnaires were distributed to 250 members of the CCGs with a total of 49 responses received. All participants involved in the forum were asked to complete a consent form (Appendix 6) (King et al 2010). This was not necessary for the questionnaire as completing the questionnaire is deemed as

implied consent. None of the participants are in a vulnerable group and all participated of their own volition.

3.8. Phase 1: Procedure for video ethnography

When considering the observation process for the video session a meeting with the technical department at LJMU discussed how the observation would take place. It reflected the views of Collier (1986), that the activity observed must be representative of other activities or principles within the frame of reference of the observation. Therefore the meeting room was set up with a large table in an arch with no head of the table being identified; this was to represent a board or senior management meeting. Two cameras were placed in the room, one with a wide angle lens which captured all activity on the table, and a second camera used to zoom in to focus on the individuals talking, filming was undertaken by the technical staff at LJMU.

The participants arrived at LJMU and were directed to the Lecture theatre at 9.00 a.m. for coffee and a brief introduction to the day. They all signed in and were given a name badge, only stipulating their first name, to avoid any one determining the others status or role. The initial briefing session in the lecture theatre comprised of the outline for the day, which included times for breaks and lunch, with the information re-iterated on the participation information sheet. The participants were then taken to the designated boardroom where they were asked to locate a chair at the table in the room. The table was set up in a horseshoe shape, so all faces were visible for video recording purposes. The Commissioners were asked to evaluate risks from the five scenarios described (see Table 5), all based on the Mid Staffs inquiry (Francis 2013) and each described on a separate piece of paper. They were advised to spend ten minutes per scenario and that they had to complete the task within 50 minutes. The information provided to Commissioners was that they had been informed that the provider

organisations they managed had been identified as having issues relating to finance, misdiagnosis, culture, complaints and targets. Their task was firstly to identify the hazards (anything with the potential to cause harm) and secondly they were asked to define what controls they would put in place to mitigate the risks identified.

As no leader had been allocated, it was left to the participants to decide who if anyone would take control and manage the task. The Commissioners were informed that all the scenarios were different and that they should work as a group to identify risks and controls based on the scenarios. They were also asked to document their findings. The 5 scenarios were placed in an envelope in the middle of the table along with pens and paper for them to use. The researcher left the room and told the group he would return in 50 minutes. They were informed that the technical member of staff from LJMU would remain in the room to video record the process. The technical team were informed that the group were Commissioners, and they should not speak if asked questions by the Commissioners.

The researcher advised the technical members of the LJMU staff that he would require a wide angled view of all participants and there was a requirement for close-up video of the person speaking. The technicians had undertaken video ethnography work before and had worked in the Centre for Public Health for a number of years so understood the type of information required.

After the event, a feedback session was provided for the Commissioners and although this did not form part of the research, it gave the participants time to reflect on their findings. The feedback session was based on the risk management training that the researcher has provided to a number of NHS Trusts as part of his work programme and the session described model answers, based on the Mid Staffs inquiry, to ensure all risks associated with the scenarios could be evaluated. Although this feedback session was recorded, it was clear that the information obtained in the feedback session did

not add to the research process other than to verify the evidence provided. Initial coding was started on the feedback session but it was decided at an early stage after a discussion with the DOS that it added limited value.

The sampling process began with an initial discussion with the Director of Strategy and Partnership who was the lead support within Wirral University Teaching Hospital NHS Foundation Trust. This determined how the researcher would engage with the contacts in the new CCG's to achieve the aims and objectives of the thesis. The Director had a good insight into a number of CCG's, Public Health and Local Authorities. The Director had available, a large number of e-mail addresses of the senior staff who were likely to influence Q&S outcomes in healthcare. This was supplemented by the researcher contacting the Communication Lead in each of the CCG's and asking for the names of Executives and Senior Managers who commissioned healthcare work. The initial contact was made directly with the individuals who were asked to attend the open forum on May 15th 2014. The participants received an information sheet along with the invitation that provided details of the location and explanation of the format of the day. A free lunch was also provided for the participants and they were advised that a feedback session would take place at the end of the event.

The participants were specifically targeted, via a purposive sampling process, as specific characteristics were required so as to provide the researcher with compelling insight about a phenomenon of interest. The individuals were identified to deal with the specific aims and objectives of the thesis. This included assessing the current Commissioning approach, comparing individuals from a variety of sectors analysing the group to identify norms. The focus being on regional services provided including children's head of commissioning services via the Communication leads within a variety of organisations including Public Health, CCGs, Commissioner Support Units (CSUs) and NHS England to provide a broad spectrum of opinion and views. When considering the sample size

for both quantitative and qualitative areas of this research the sample size and validity of the numbers is important to ensure generalisability of the data collected. According to Onwuegbuzie & Collins (2007) small samples in research are justified and this informed the sample scheme and size considered, with 12 per group being invited for the open forum and 250 questionnaires distributed to Commissioner subordinates. A combination of sampling techniques has been used included in Table 4, such as purposeful sampling (Cresswell and Clark 2007), which targeted 24 Chief Executives, Chairs of the Board and Commissioner organisations across the Merseyside & Cheshire footprint. However, this was found to be too narrow a focus so was extended across the North of England.

When considering the observation process for the video, the session provided a real time life situation for those working in a CCG with a similar physical nature. The discussion with the technical department at LJMU discussed how the observation would take place. It reflected the views of Collier (1986) that the activity observed must be representative of other activities or principles within the frame of reference of the observation. Filming was undertaken by the technical staff at LJMU. The data was transferred from video recording equipment to CD disc and a private You Tube setting as a back-up; it was then reviewed as required by the researcher.

The risk scenarios were devised by the researcher as a means to evaluate risks and used in Corporate Manslaughter and risk management training provided to executives and senior staff. The author is responsible for Health & Safety (H&S) and risk management within two acute trusts (Warrington and Halton NHS Foundation Trust and Wirral University Teaching Hospital NHS Foundation Trust). The process helps senior staff understand the risk tolerance and leads to better evaluation of risks and control measures in a safe environment. However, the way the group analysed and identified risks

provided further focus for the research on how risk analysis is viewed and evaluated by such groups.

This is further discussed in Chapter 6.

The 5 Mid Staffs scenarios are described below:

Table 5 Scenarios on Mid Staffs enquiry.

1. The board has had to implement stringent financial controls with a deficit of £10M this year. As a Board member, you have been asked to implement a workforce cut, based on costs, the most inefficient Departments needing the deepest cuts of £2m.
2. There have been a number of cases of misdiagnosis, including a failure to diagnose a serious injury in a young man who later died as a result. The manner of diagnosis given to patients has left a lot to be desired with patients raising concerns about insensitivity, failure to listen and lack of compassion.
3. It has been recognised that there has been a lack of compassion by a number of staff when dealing with vulnerable patients on Ward X. The poor attitude has been in place for a number of years and bullying has been raised as a concern by the Union. There appears to be a lack of structure and rules are not followed. Examples of good management behaviour are difficult to find. It appears that there is a lack of respect from all concerned.
4. There have been numerous complaints about the attitude of staff and poor hygiene standards, when staff attended to patients. One member of staff was observed using the same razor on different patients, using the same water in a bowl and not washing and brushing patient's hair.
5. Targets particularly in A&E waiting times have become an absolute priority. This has resulted in discharging patients early and there have been a number of misdiagnosis of patients. There is a rumour that staff have serious concerns but are not prepared to raise the issue as they may face the sack or it may affect their chances of promotion.

Observations of the group provided the evidence to understand the interactions between individuals

and how they assessed risks as a group. It is recognised that video-coding behaviour is a reliable systematic data collection process as defined and conceptualised by Bakeman & Gottman (1987), representing fine-grained behavioural patterns. The behavioural measure of leader and follower allows for interaction processes between leaders and measures all behaviour. The current behaviourally anchored coding scheme was adapted to view interactions. Several measures related to behavioural variables and group effectiveness indicators were used throughout the evaluation (Hoogeboom 2011). Specific behaviours provided a solid base for theory generation of leader effectiveness, contributing to better understanding of leader behaviour.

In a Board or staff meeting most Commissioners will know the role and position of the others and will directly influence behaviour. Subordinates may agree more with a superior and therefore the study undertaken is a subjective view based on a group with similar roles within Commissioning organisations. The group studied did not have any previous relationships with one another and minimal information was provided, to avoid any hierarchical assumptions being made about each other. Previous studies indicate that groups behave differently when individuals are placed together unknowing who has authority or status, as in this case as a group of Commissioners. To avoid assumptions the group were all provided with badges showing their first names with no evidence of rank or status (Perkins 2009).

The process to identify transactional or transformational management using behavioural coding developed specifically for this research is based on Gupta and Wilderon (2009), Perkins (2009) and Weenink et al (2012). When reviewing groups for studies Short et al (2009) describe the pursuit of improving validity as problematic, because the more modelling we do to extract data, triangulate it and complicate the methodology, the more influence we have on the outcome. The purpose of this

study was to view subjects in a natural setting; however it would not have been possible to undertake this work in one Commissioners premises. To undertake the current research it was deemed necessary to review current practice in a board like setting.

3.8.1 Data collection and analysis phase 1

The data was analysed by visual coding of the occurrences and verbal and non verbal communication. The unit of analysis was the user's non-verbal communication behaviour. All body movements were evaluated such as hands, arms, open palms and head movement gestures, each being observed and logged every time they occurred. The purpose was to break down the video into manageable and meaningful units of analysis (to be reassembled after the analysis), ensuring the observation provides the possibility for reliability and validity checking. The video observed method of interaction of leaders within Commissioners was placed in NVIVO10 to observe details of all Commissioners movements and transcribe verbal communication. When considering methods observation the process provides first hand evidence of how people behave in a naturalistic setting.

The coding of information to identify behaviours included verbal and non verbal communication; the data was then cross referenced and evaluated (Yammiyavar et al 2008). As part of the evaluation it is recognised that social systems exist with partial or microscopic systems of the whole system (as part of human interaction). Therefore the evidence process involved generalised ideas from smaller scale social system i.e. the open forum identifying a type of behaviour in a sub group of Commissioners. This may not mirror the larger scale social system within the CCGs or be escalated to assume the behaviours on a larger scale (Bales 1950). The video recording was placed on a private you tube account and also placed on a back up disc. The coding was analysed using NVIVO 10 to micro analyse the behaviour and observe all activity during the open forum (Noldus et al 2000). This

software allows very precise coding to identify individual behaviours that occur by taking sections of the video and freezing each frame for analysis.

It has been accepted that the non-verbal communication identified in Table 7 is based on white British culture. All the panel members who attended the forum were white British so there was no requirement for any further revalidation of cultural differences within the research. However, it has been recognised that researchers have reported observations of different non-verbal communication when individuals belong to different cultures and have different ethnicity. Within the Indian culture for example, cultural factors such as hierarchy, authority and age (elders) will play a more significant factor in outcomes (Yammiyar et al 2008). Ribbens and Thompson (2000) believe that people from India and China exhibit more non-verbal cues than people from Western Europe. However the adapters (unconscious actions such as touching oneself, stroking hair or chin) are not culturally sensitive with 'regulators' controlling the flow of conversation such as nodding in agreement used in similar ways across all cultures.

To evaluate how leaders emerge in new groups, it was necessary to define a unique coding system to ensure the behaviour could be clearly captured. This unique coding system devised by the researcher (described below) identified the type of language used and cross referenced with behaviour types. Van Der Weide's (2007) technique to objectively analyse video-observed behaviour applied a behavioural coding scheme, which Hoogeboom et al (2011) and Weenink et al (2012) developed further with twelve mutually exclusive behaviours that are found to be relevant for coding the behavioural pattern of leaders, focusing on transformational and transactional behaviours from behavioural observation schemes (Bales, 1950 and Borgotta 1964).

The coding system developed for this research is based on Weenink (2012) who divided the coding

system into three distinct areas for start up meetings to evaluate team behaviour. The three distinct areas used by Weenink (2012) for observations of leaders included 'self-defending' actions where individuals may show disinterest, defending one's own position and providing negative feedback, this was closely related to transactional management. Secondly Weenink used key themes including 'steering' of which actions include directing, verifying, informing, visioning agreeing and disagreeing. Agreeing and directing/delegating were used from this section as it was important to identify the transformational behaviours of Commissioners. Finally 'supporting', which included intellectual stimulation, individualised consideration and positive rewarding, the 'being friendly' element was described as open within this study.

Gupta et al (2009) reviewed the work of Weenink and focused his work on Chief Executives of organisations; he defined the subgroups of self-defending as being uninterested, defending one's own position and providing negative feedback. Steering included directing, verifying, leading and informing and finally supporting which included professionally challenging, providing positive feedback and listening.

The specific coding for this study required a unique process to be developed to determine the emerging leaders within a group (see table 6). Weenink's (2012) coding was used to define meetings where teams had been established for some time with clear hierarchy, looking at behavioural dynamics of effective teams focusing on team leaders' behaviour at weekly meetings. There is limited research in this area. Weenink's work was closely aligned to the criteria required in this study, however she did not look at specific behaviours in a Board or senior management meeting and this required a different focus on how leaders determined risk and made critical decisions on provider services within healthcare. The study looked for specific traits of Commissioners and expanded Weeninks work to include being passive (non-active), agreeing and being open and aligned these

behaviours to the three leadership traits of transactional, transformational and passive behaviour. This provides a new coding system trialled for this study and further develops the video observation technique used by Weenink.

Table 6: describes examples of verbal behaviour in eight defined categories to ensure the coding was specific to this task and included:-

Table 6: Evaluation of behaviours

	Behaviour	Definition	Examples
1.	Assertive is closely aligned to transactional management theory.	Clear on what is required, takes control of the situation. Self-defending and defending own position.	a. 'Start at the top' b. 'Go for it' c. 'It's about giving people a structure within the governance structure' d. 'exactly'
2.	Delegating transformational leadership style.	Giving others support/direction in a friendly open manner.	a. 'I know what you are saying but we don't want to jump to controls' b. 'who's going to time us then' c. 'your point about what does it mean about specialist staff'
3.	Agreeing in a transformational style.	Supporting others/sees others as adding value	a. 'Absolutely' b. 'yeh absolutely Board behaviours' c. 'that's one of your controls isn't it' d. 'exactly one doesn't negate the other' e. 'Again it's about what you said doing a proper impact assessment'
4.	Passive management by exception.	No clear direction provided to others or self	a. 'Gathering that evidence' b. 'Just thinking about reasons why'
5.	Negative aligned with transactional management.	Doesn't clearly listen to others, corrects others is not open to others views, talks over others, disagrees with others. Providing negative feedback.	a. 'No, no, it's not clear' b. 'how do you know they are being discharged' c. 'I don't get the link between what you said and the union'

6.	Aggressive style aligned with transactional leadership.	Disagrees strongly with others, shows negative behaviour towards others in the group, defends own view aggressively	a. 'That's the point I want to make' b. 'read that again' c. 'So we don't know ask the question'
7.	Open aligned with transformational management.	Willing to change view/seeks further information from others/clarifying, questioning, asking the group for approval	a. 'Is it about understanding how wide scale this is' b. 'So one of the risks is not having the information to make the right decision'
8.	Positive vision for transformational leadership.	Shows a vision for the future seeks change/rewards others in group by providing positive feedback.	a. 'Do you want me to read it out' 'start with finance that's favourite' b. 'Yes the safe decision' c. 'Yes that's right'

3.8.2. Phase 1: Non-verbal communication

To evaluate the non-verbal communication within the context of research required a variety of resources including Rosenstein (2002) gesture classification and Lausberg and Sloetjes (2009) analysis of gestural behaviour. The coding of behaviour is through functional movement categories being differentially associated with specific cognitive emotional and interactive actions. In order to assess if there was any correlation, the non-verbal communication (see table 7) was cross referenced with verbal actions for each Commissioner (Hartland and Tosh 2001). The development of the table was based on a number of scholars work including Hartland and Tosh (2001), Ekman et al (1969), Boyes (2005), Kuhnke (2007) and James (2008). To determine coding, the process involves the signal (body movement), part of body used, meaning and detailed explanation of the movement being undertaken. The process is to be called non-verbal communication throughout this study.

Table 7: Evaluation of non verbal communication.

Signal	Part of body	Meaning(s)	Detailed explanation of body movement
1. Head nodding	Head	Agreement	Head nodding can occur when invited for a response, or voluntarily while listening. Head nodding when talking face-to-face one-to-one is easy to see, it was important to identify tiny head nods when addressing or observing the group.
2. Slow head nodding	Head	Attentive listening	This can be a faked signal, as with all body language signals, it is important to view clusters of signals rather than relying on one alone. The eyes can provide evidence of the validity of slow head nodding.
3. Head held up	Head	Neutrality, alertness passive	High head position signifies attentive listening, usually with an open or undecided mind, or lack of bias.
4. Head held high	Head	Superiority, fearlessness, arrogance	Especially if exhibited with jutting chin.
5. Head tilted to one side	Head	Non-threatening, submissive, thoughtfulness	A signal of interest, and/or vulnerability, which in turn suggests a level of trust. Head tilting is likely to relate to 'sizing up' something, since tilting the head changes the perspective offered by the eyes, with a different view is seen of the other person or subject. Exposing the neck is also a sign of trust.
6. Head forward, upright	Head / body	Interest, positive reaction	Head forward in the direction of a person or other subject indicates interest. The rule also applies to a forward leaning upper body, sitting.
7. Head tilted downward	Head	Criticism, admonishment	Head tilted downwards towards a person is commonly a signal of criticism or reprimand or disapproval, usually from a position of authority.
8. Head shaking	Head	Disagreement	Sideways shaking of the head generally indicates disagreement, but can also signal feelings of disbelief, frustration or exasperation.
9. Head down response to speaker proposition)	Head	Negative, disinterested	Head down is generally a signal of rejection (of someone's ideas etc), unless the head is down for a purpose like reading supporting notes. Head down when responding to criticism is a signal of failure, vulnerability (hence seeking protection), or feeling ashamed.
10. Chin up	Head	Pride, defiance, confidence	Very similar to the 'head held high' signal. Holding the chin up naturally alters the angle of the head backwards, exposing the neck, which is a signal of strength, resilience, pride, and resistance. A pronounced raised chin does tend to lift the sternum (breast-bone), which draws in air, puffing out the chest, and it widens the shoulders. These combined effects make the person stand bigger. An exposed neck is also a sign of confidence. 'Chin up' is for these reasons a long-standing expression used to encourage someone to be brave.
11. Active listening	Head / face	Attention, interest, attraction	Actively listening and responsive shows in their facial expression and their head movements. The head and face are seen to respond fittingly and appropriately to what is being said by the speaker. Smiles and other expressions are relevant too. The head may tilt sideways. Mirroring of expressions may occur. Silences are used to absorb meaning. The eyes remain sharply focused on the eyes of the speaker, although at times might lower to look at the mouth, especially in male-female engagements.

12. Crossed arms (folded arms)	Arms	Defensiveness, reluctance	Crossed arms represent a protective or separating barrier. This can be due to various causes, ranging from severe animosity or concern to mild boredom or being too tired to be interested and attentive. Crossed arms is a commonly exhibited signal by subordinates feeling threatened by leaders and figures of authority. People also cross arms when they are feeling cold.
13. One arm across body clasping other arm by side.	Arms	Nervousness	Women use this gesture. Men tend not to. It's a 'barrier' protective signal, and also self-hugging.
14. Moves papers on table	Hands	Confidence, authority	Indicating control of processes being undertaken who controls who speaks controls the meeting.
15. Holding papers across chest	Arms	Nervousness	Another 'barrier' protective signal, especially when arm is across chest.
16. Palm(s) up or open palms in circular motion in air or on desk	Hands	Submissive, truthful, honesty, appealing	A common gesture with various meanings around a main theme of openness. Can also mean "I don't have the answer," or an appeal. In some situations this can indicate confidence (such as to enable openness), or trust. An easily faked gesture to convey innocence.
17. Palm(s) up, inviting grasping air	Hands	Open hand gestures in circular motion	Relaxed hands are more likely to be defensive as if offered up in protection; inviting people in to conversation.
18. Palm(s) down	Hands	Authority, strength, dominance	Where the lower arm moves across the body with palms down this is generally defiance or firm disagreement.
19. Palm up and moving up and down as if weighing	Hands	Striving for or seeking an answer	The hand is empty, but figuratively holds a problem or idea as if weighing it. The signal is one of 'weighing' possibilities.
20. Hand(s) on heart (left side of chest)	Hands	Seeking to be believed	Although easy to fake, the underlying meaning is one of wanting to be believed, whether being truthful or not. Hand on heart can be proactive, as when a salesman tries to convince a buyer, or reactive, as when claiming innocence or shock. Whatever, the sender of this signal typically feels the need to emphasise their position as if mortally threatened, which is rarely the case.
21. Finger pointing (at a person)	Hands	Aggression, threat, emphasis	Pointing at a person is very confrontational and dictatorial. Commonly adults do this to young people. Adult to adult it is generally unacceptable and tends to indicate a lack of social awareness or self-control aside from arrogance on the part of the finger pointer. The finger is thought to represent a gun, or pointed weapon. Strongly associated with anger, directed at another person.
22. Finger pointing (in the air) or at table	Hands	Emphasis	Pointing in the air is generally used to add emphasis, by a person feeling in authority or power.
23. Hand chop	Hands	Emphasis - especially the last word on a matter	The hand is used like a guillotine, as if to kill the discussion.

24. Clenched fist(s)	Hands	Resistance, aggression, determination	One or two clenched fists can indicate different feelings including defensive, offensive, positive or negative, depending on context and other signals. Logically a clenched fist prepares the hand (and mind and body) for battle of one sort or another, but in isolation the signal is impossible to interpret more precisely than a basic feeling of resolve.
25. Interwoven clenched fingers	Hands	Frustration, negativity, anxiousness	Usually hands would be on a table or held across stomach or on lap.
26. Thumb(s) up	Hands	Positive approval, agreement, all well	In the Western world this signal is so commonly used and recognised as a language term in its own right: 'thumbs up' means approved. It's a very positive signal. Two hands is a bigger statement of the same meaning.
27. Hand(s) placed over mouth	Hands / mouth	Suppression, avoiding speaking	Often an unconscious gesture of self-regulation stopping speech for reasons of shock, embarrassment, or for more tactical reasons. The gesture is reminiscent of the 'speak no evil' wise monkey. The action can be observed very clearly in young children when they witness something 'unspeakably' naughty or shocking. Extreme versions of the same effect would involve both hands.
28. Scratching nose, eye, ears, pushing glasses back whilst listening	Hands / nose	Nervous apprehensive	In many cases this is an unconscious signalling of holding back or delaying a response or opinion. Rather like the more obvious hand-clamp over the mouth, people displaying this gesture probably have something to say but are choosing not to say it yet.
29. Hands clamped on ears	Hands / ears	Rejection of or resistance to something	Not surprisingly gestures involving hands covering the ears signify a reluctance to listen and/or to agree with what is being said or to the situation as a whole. The gesture is occasionally seen by a person doing the talking, in which case it tends to indicate that other views and opinions are not wanted or will be ignored.
30. Hand stroking chin	Hands / chin	Thoughtfulness	The stroking of a beard is a similar signal, considering the situation or next actions to be undertaken.
31. Hand supporting chin or side of face	Hands / chin, face	Evaluation, tiredness or boredom	Usually the forearm is vertical from the supporting elbow on a table. People who display this signal are commonly assessing or evaluating next actions, options, or reactions to something or someone. If the resting is heavier and more prolonged, and the gaze is unfocused or averted, then tiredness or boredom is a more likely cause. A lighter resting contact is more likely to be evaluation, as is lightly resting the chin on the knuckles.
32. Neck scratching	Hands / neck	Doubt, disbelief	Perhaps evolved from a feeling of distrust and instinct to protect the vulnerable neck area. Generally due to doubting or distrusting what is being said.
33. Hand clasping wrist	Hands / wrist	Frustration	Clasping a wrist, which may be behind the back or in open view, can be a signal of frustration, as if holding one's self back.
34. Running hands through hair	Hair / hair	Flirting, or vexation, exasperation	Running hands through the hair is commonly associated with flirting, and sometimes it is, although given different supporting signals, running hands through the hair can indicate exasperation or upset.
35. Removing spectacles	Hands/ glasses	Alerting wish to speak	For people who wear reading only spectacles, this is an example of an announcement or alerting gesture, where a person readies them-selves to speak and attracts attention to the fact.

3.9. Evaluation of verbal and non-verbal communication

To evaluate the verbal and non-verbal communication from Phase 1 required the most frequent activities undertaken by the group (both verbal and non verbal) to be cross referenced, i.e. if agreeing was verbally evident this would be linked with nodding in agreement. The process involved breaking down the individual body movement for each of the 9 participants focusing on them individually in turn. The descriptions, used for all 35 non verbal actions were aligned with the verbal communication descriptors this was then cross referenced to determine the coding system. The 8 verbal results were cross referenced with the 12 most frequent non-verbal communication; not all non-verbal actions were common so were dismissed as the research focused on most frequent actions and words (see table 8) based on the description defined in Table 6 and 7. The non-verbal communication was aligned to the leadership style. For example, transformational leadership was aligned to open palms where as transactional leadership would be more aligned with palms down and chopping the air being assertive. The passive leadership style was evidenced by actions such as hand on chin or hand covering the mouth.

Table 8: Grouping of verbal and non- verbal communication.

Numbers of verbal responses evidenced.	**Non verbal communication.**
Assertive clear on what is required takes control. Transactional leadership.	Example 6. Authoritative palms down on table.
Delegating giving others support Direction. Transformational Leadership.	Example 7. Moved paper on table.
Agreeing (3) supporting others/sees others as adding value. Positive (8) shows a vision for the future seeks change/rewards others in group. Transformational Leadership.	Example 1. Head nodding agreeing.
Passive no clear direction provided to others or self. Passive Leadership.	Example 3 Hand supporting chin. Example 10 runs hands through hair Example 2 Hand placed on mouth
Negative doesn't clearly listen to others, corrects others is not open to others views, talks over others, disagrees with others. Transactional Leadership.	Example 11 Crossing arms. Example 9 Scratching nose ears pushing glasses b
Aggressive disagrees strongly with others, shows negative behaviour towards others in the group, defends own view aggressively. Transactional Leadership.	Example 4 Hand chopping the air

Open willing to change view, seeks further information from others/clarifying, questioning, asking the group for approval. Transformational Leadership.	Example 8 Open palms

The process described in table 8 gives clarity on who emerged as leaders and how their verbal information correlated with their non verbal communication, helping to identify the most common traits of the leaders in the group.

3.10. Phase 2: Questionnaire

The purpose

The second phase required the construction of a questionnaire to evaluate if the Commissioners' type of leadership behaviour was translated to the workplace focusing on transformational, transactional and passive leadership behaviours. The process of developing the questionnaire was based on a number of studies described in chapter 2 and included taking information from a number of sources including the self leadership questionnaire approach taken by Hourghton et al (2012), Tummers & Knies (2014) and Darvish and Shirazi Pour (2013). They advocated reviewing the employee's job satisfaction as an outcome of leadership styles being either transformational or transactional. Muenjohn & Armstrong (2008) and Carless (1998) questionnaires were used to evaluate leader's behaviour and how this may influence negative performance, which results in decreased job performance, absenteeism and turnover of staff.

The sample of 250 staff was used to identify the behaviour of their leader within the Commissioning organisations with the expectation that 25% would be returned (Onwuegbuzie et al 2006). It was important to understand how the new organisations identified the vision for the future and how leaders were perceived by followers (Gupta & Wilderon 2009) The questionnaire was used to verify findings using a C5-point Likert scale, ranging from 'disagreeing' to 'agreeing' this being used to report on the expected behavioural norms of commissioning leaders. The purpose of the questionnaire was to determine how leader's attitudes, subjective norms and perceived behavioural traits are seen from a subordinate's perspective, identifying how they see their leaders achieving organisational goals as the CCGs move forward delivering new health and social care plans for the NHS (Francis et al 2004).

3.10.1. Rationale for selected methodology

The questions are based on a variety of leadership styles including idealised influence (Kinicki et al 2013) which include behaviour, consideration, stimulation, motivation, transformational, transactional leadership contingent reward and management by exception passive (see appendix 1). Performance management is assessed via the dimensions of goal setting, communication, and providing feedback, coaching, providing consequences, establishing and monitoring performance and understanding individual expectations.

The questionnaire not only evidenced a particular management style but reviewed other factors that influence Q&S outcomes. The study defined the barriers that make it easy or difficult to undertake positive behaviours. A pilot study assessed reliability of the questionnaire and was conducted on n=10 staff within the researchers own NHS Department; clarity was required on a number of questions as they were misinterpreted initially by staff. The revised questionnaire was then distributed to provide a systematic way to identify behaviour. This required that the behaviour

be defined carefully in terms of its Target, Action, Context and Time (TACT), or doing what to whom, in what context and at what time. The behaviours selected for this implementation modelling were specifiable in terms of the TACT principle. For example, identifying the behaviour of their leader the target is the employee of Commissioners, the action is finding out what they know about their leader and how they perceive them, the context is the work environment and the time is within a 4 week sample period (Foy et al 2007). Francis et al (2004) describes deconstructing questionnaires based on the theory of planned behaviour. Although there is not a perfect relationship between behavioural intention and actual behaviour, intention can be used as a proximal measure through the questionnaire process used.

3.10.2. Data Collection & analysis: Phase 2

The initial process provided 10 questionnaires to each Commissioner via the participants of the open forum (total *n*=90) to distribute in their respective organisation but this had limited responses *n*=27. A targeted approach was undertaken firstly inviting participants to connect via Linkedin identifying those who worked within Commissioning organisations based on their role and position; once they had connected they were asked directly via e-mail, if they would like to be involved in a research project via a questionnaire. A further 160 questionnaires were distributed. Respondents all had appropriate backgrounds and reported to a leader within a Commissioning organisation, the total increased to *n*=48 and was deemed to be an appropriate number for a valid survey.

The questions were not asked sequentially to avoid any bias which may have affected the respondents decision making processes; the established themes within the questions included the key themes (see Appendix 1, Questionnaire formulation). The data was then coded by the researcher in SPSS21 tool and analysed. Spearman rank correlation was the test used to measure

the degree of association between two variables; it does make assumptions about the distribution of the data and is the appropriate correlation analysis when the variables are measured on a scale that is at least ordinal. Spearman rank correlation is required when you want to see whether the two variables correlate with another related variant, as one variable increases, the other variable tends to decrease (McDonald 2014). The scale used was 0.1 to 0.4 low levels of confidence 0.4 to 0.7 medium confidence and 0.7.to 0.99 strong confidence in data evidenced. The test used was Spearman rank correlation and normal distribution.

The hypothesis test in this case was how leadership behaviour was evaluated, using each specific question to test the variable, i.e. the team think positively about the leader and being associated with him/her makes the individuals feel proud, (a) this links with a transactional style of management (b) this does not link to transactional style of management. The test therefore reveals the correlation either positively or negatively with the hypothesis.

The information is used to provide the basis of evidence of the behaviours and common traits of leaders within commissioning organisations. There was no specific relationship with Commissioning bodies who participated in this study prior to the event avoiding any conflict of interest and bias in the research being undertaken. The data collection purpose was to determine if the traits exhibited in the open forum were the type of management style evident to subordinates, this is discussed further in the results and discussion chapters of this study.

3.11. Limitations of Study

The limitations of this study are that the research undertaken is a single focused ethnographic study and is not led by a team therefore the subjective view of the author may influence outcomes despite the best efforts to avoid bias. Although the open forum was based on a scenario that has

occurred in an acute hospital setting, the range of tools and backup support in the workplace may have made Commissioners evaluate risks differently in another setting. It is feasible that people behaved differently as they did not know each other and the unique coding system has not been used or tested elsewhere and therefore requires further testing for reliability. The focus of the videotaping session may be limited to the particular scenarios provided and therefore not indicate a sense of the overall response of Commissioners to dealing with risk and how leaders emerge from groups. It may not add to the breadth of knowledge on leadership behaviour or directly identify a new theory or process. Although existing theories have been developed the sample may not be large enough to indicate whole NHS learning. The coding is experimental and the body language systems may not be transferable to other Commissioning organisations without further testing. There was a relatively small sample of Commissioners subordinates who undertook the questionnaire, with the Commissioners distributing the questionnaires to individuals, who they may have selected to provide model answers. The small percentage of managers who completed the questionnaire may be reluctant to be negative about their leaders, with CCGs being relatively new organisations. The small number may not provide an overall picture of the current issues being faced by Commissioners subordinates.

A limitation of the study is that the coding of non verbal communication is based on white British culture. Whilst this was not an issue within this particular piece of research, should this tool be utilised by other researchers in the future, they would need to be aware of this and adapt the coding system accordingly in order to take into account any cultural and ethnic variations of their participants.

3.12. Ethics of research

The research did not require NHS ethical approval from the Integrated Research Application System (IRAS) because it did not have any patient involvement or clinical interventions. Ethics approval was sort from LJMU and the research department of Wirral University Teaching Hospital (WUTH) NHS Foundation Trust and provided prior to the study commencement. Anonymity was established by removal of the contact details of the researcher and names associated with the organisation. If Q&S of staff patients or any volunteer who participated in the study was compromised during the research or the process or was detrimental to a Department, organisation or individual, this will be reported through the appropriate safeguarding routes and Governance channels of Commissioning Board WUTH and LJMU structure. To maintain anonymity all identifiable data was password protected and Commissioners, during video analysis, were given a number. All names of organisations were removed adhering to the Data Protection Act. The questionnaires were stored in a locked filing cabinet at WUTH headquarters. Written consent was obtained from each participant and each asked if they wanted to withdraw during the video recording process. The questionnaires were deemed as receiving implied consent by completion of the questionnaire.

3.13. Summary

The methods identified in this chapter extend the knowledge of micro/focused ethnography to include a specific body language element that relates to behaviour in groups. The coding of individuals verbal and non-verbal cues can provide an insight into leadership behaviour within groups identifying what actions are taken at key points and who makes decisions. The quantitative questionnaire provides an insight into the perceived behaviour of leaders in Commissioning, highlighting the behaviour in the workplace towards staff. The combination of data provides a

fuller picture of overall behaviour including directly observed and subordinates self reported evidence. The common themes of data analysis that determine outcomes to Q&S in healthcare can be evaluated by the coding of behaviours in this way and the findings are discussed further in Chapter 4.

Findings of research

Chapter 4

4.1 Introduction

The purpose of this chapter is to provide details of the outcomes of the research; this includes the video observational method of verbal and non verbal communication and subsequent themes identified from the quantitative questionnaire responses. The chapter provides evidence of how observing Commissioners behaviours and actions can provide insight into how groups and leaders make decisions, focusing specifically on which leadership style is most commonly observed through the structured analysis described within the methodology chapter.

4.2. Results Phase 1

The three most common types of verbal behaviour observed accounted for 82.17% of all the actions within the open forum (see Table 9). The most common behaviour type was being ‘assertive’ which is closely aligned with transactional management and accounted for nearly half of all the actions (44.44%). The second ‘being open’ accounted for 24.29% and is aligned with transformational management and the third most common behaviour type observed was passive (neither transactional nor transformational) and accounted for 13.44% of the Commissioners’ actions. When considering the total number of actions the Commissioners demonstrated significantly more transactional actions (53.49%) than transformational actions (33.07%). The table also describes frequency of actions undertaken (see table 10).

Table 9: Behaviour types observed as a result of the video analysis.

Behaviour types	**Total actions**	**% of Total**	**Order of frequency**
1. Assertive (clear on what is required takes control/transactional)	172	44.44%	1
2. Delegating (giving others support/direction/transformational)	13	3.36%	7
3. Agreeing (supporting others/sees others as adding value/transformational)	19	4.91%	4=
4. Passive (no clear direction provided to others or self/non management)	52*	13.44%	3
5. Negative (doesn't clearly listen to others, corrects others, is not open to others views, talks over others, disagrees with others/transactional)	19	4.91%	4=
6. Aggressive (disagrees strongly with others, shows negative behaviour towards others in the group, defends own view aggressive/transactional)	16	4.13%	6
7. Open (willing to change view, seeks further information from others/clarifying, questioning, asking the group for approval/transformational)	94	24.29%	2
8. Positive (shows a vision for the future seeks change/rewards others in the group/transformational)	2	0.52%	8
Total number of actions	387	100%	8

The frequency of transactional and transformational behaviour observed in the open forum indicated by the total number of verbal communication described in table 10

Table 10: Level of transactional or transformational leadership behaviour

Types of behaviour	Transactional	Transformational
Behaviour types associated with leadership style	1, 5, 6	2, 3, 7, 8
Number of total actions associated with leadership style	207	128
% of total actions associated with leadership style	53.49%	33.07%

*52 actions (13.44%) were passive – neither transactional or transformational

Table 11 indicates the frequency of behaviour type exhibited by the Commissioners. From the table the most common type of behaviour exhibited across all the Commissioners is type 1 (Assertive). Three Commissioners (numbers 6, 8 and 9) are responsible for 50.60% of this total. In addition the same three Commissioners have the highest number of transformational behaviour types recorded (Commissioner 6 n=35, Commissioner 8 n=35, Commissioner 9 n=36). Commissioner 8 exhibits the highest value (n=30) for behaviour type 7 (Open), which is linked to transformational leadership. Of all the behaviour types recorded Commissioners 6 and 8 are the highest with 74 behaviour types recorded and Commissioner 9 is third with 54 behaviour types recorded. The least frequently observed behaviour was being positive showing a vision for the future and rewarding others in the group.

Table 11: Commissioner actions by behaviour type

	Commissioner								
Behaviour type	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
1	18	18	5	15	21	30	8	31	26
2	4	1	0	3	0	4	1	0	0
3	10	1	0	3	0	4	1	0	0
4	5	7	1	6	4	11	2	9	7
5	3	1	0	1	4	3	0	0	7
6	4	0	0	1	1	2	1	4	3
7	11	7	3	5	5	19	3	30	11
8	1	0	0	0	0	1	0	0	0
Total	56	35	9	34	35	74	16	74	54
Transactional actions	25	19	5	17	26	35	9	35	36
% of action	44.64	54.29	55.56	50.00	74.29	47.30	56.25	47.30	66.67
Transformational actions	26	9	3	11	5	28	5	30	11
% of action	46.43	25.71	33.33	32.35	14.29	37.84	31.25	40.54	20.37
Passive actions	5	7	1	6	4	11	2	9	7
% of action	8.93	20.00	11.11	17.65	11.43	14.86	12.50	12.16	12.96
Total	56	35	9	34	35	74	16	74	54
% of action	100	100	100	100	100	100	100	100	100

4.3 Non-verbal communication results

The evaluation of non-verbal communication was used to identify themes and how the evidence of individuals behaviour via the open forum demonstrated assertiveness, delegating, agreement, passive, negative, aggressive, open and positive and how these actions correlated with individuals non verbal communication. This is described in detail in table 12.

Table 12: Results of non-verbal communication coding-Commissioner 1 equates to n=1 Commissioner 2 equates to n=2 etc. Results indicate numbers of times observed actions from individual Commissioners.

Signal	Part of body	Meaning(s)	Detailed explanation
1. Head nodding	Head	Agreement	Head nodding can occur when invited for a response, or voluntarily while listening. Head nodding when talking face-to-face one-to-one is easy to see, it was important to identify tiny head nods when addressing or observing the group. *n*1=1 *n*2=7 *n*3=2 *n*4=7 *n*5=12 *n*6=12 *n*7=15 *n*8=20 *n*9=20 Total *n* =84.
2. Slow head nodding	Head	Attentive listening	This can be a faked signal, as with all body language signals, it is important to view clusters of signals rather than relying on one alone. The eyes can provide evidence of the validity of slow head nodding. *n*9=3 *n*7=1 Total *n*= 4.
3. Head held up	Head	Neutrality, alertness passive	High head position signifies attentive listening, usually with an open or undecided mind, or lack of bias. *n*2=1 *n*4=2 *n*5=3 *n*6=1 *n*7=1 *n*8=1 *n*9=2 Total *n* =11.
4. Head held high	Head	Superiority, fearlessness, arrogance	Especially if exhibited with jutting chin *n*3=1 *n*4=1 *n*5=1 *n*6=1 Total *n* =4.
5. Head tilted to one side	Head	Non-threatening, submissive, thoughtfulness	A signal of interest, and/or vulnerability, which in turn suggests a level of trust. Head tilting is likely to relate to 'sizing up' something, since tilting the head changes the perspective offered by the eyes, with a different view is seen of the other person or subject. Exposing the neck is also a sign of trust *n*2=1 *n*4=1 *n*5=5 *n*6=9 *n*8=2 *n*9=2 Total *n* =20.
6. Head forward, upright	Head / body	Interest, positive reaction	Head forward in the direction of a person or other subject indicates interest. The rule also applies to a forward leaning upper body, sitting *n*1=1 *n*2=1 *n*6=1 *n*8=2 Total *n*=5.
7. Head tilted downward	Head	Criticism, admonishment	Head tilted downwards towards a person is commonly a signal of criticism or reprimand or disapproval, usually from a position of authority *n*1=2 *n*2=1 *n*3=3 *n*6=2 *n*7=3 *n*8=2 *n*9=1 Total *n*=14.

8. Head shaking	Head	Disagreement	Sideways shaking of the head generally indicates disagreement, but can also signal feelings of disbelief, frustration or exasperation *n*4=1 *n*9=1 Total *n* =2.
9. Head down response to speaker proposition)	Head	Negative, disinterested	Head down is generally a signal of rejection (of someone's ideas etc), unless the head is down for a purpose like reading supporting notes. Head down when responding to criticism is a signal of failure, vulnerability (hence seeking protection), or feeling ashamed *n*5=1 Total *n* =1.
10. Chin up	Head	Pride, defiance, confidence	Very similar to the 'head held high' signal. Holding the chin up naturally alters the angle of the head backwards, exposing the neck, which is a signal of strength, resilience, pride, and resistance. A pronounced raised chin does tend to lift the sternum (breast-bone), which draws in air, puffing out the chest, and it widens the shoulders. These combined effects make the person stand bigger. An exposed neck is also a sign of confidence. 'Chin up' is for these reasons a long-standing expression used to encourage someone to be brave *n*4=1 *n*6=1 Total *n* =2.
11. Active listening	Head / face	Attention, interest, attraction	Actively listening and responsive shows in their facial expression and their head movements. The head and face are seen to respond fittingly and appropriately to what is being said by the speaker. Smiles and other expressions are relevant too. The head may tilt sideways. Mirroring of expressions may occur. Silences are used to absorb meaning. The eyes remain sharply focused on the eyes of the speaker, although at times might lower to look at the mouth, especially in male-female engagements *n*1=1 *n*2=1 Total *n* =2.
12. Crossed arms (folded arms)	Arms	Defensiveness, reluctance	Crossed arms represent a protective or separating barrier. This can be due to various causes, ranging from severe animosity or concern to mild boredom or being too tired to be interested and attentive. Crossed arms is a commonly exhibited signal by subordinates feeling threatened by leaders and figures of authority. People also cross arms when they are feeling cold *n*2=2 *n*3=5 *n*4=2 *n*7=8 *n*8=1 *n*9=3 Total *n* =21.
13. One arm across body clasping other arm by side.	Arms	Nervousness	Women use this gesture. Men tend not to. It's a 'barrier' protective signal, and also self-hugging *n*1=1 *n*2=1 *n*3=1 *n*4=2 *n*7=8 *n*8=1 *n*9=3 Total *n* =17.
14. Moves papers on table	Hands	Confidence, authority	Indicating control of processes being undertaken who controls who speaks controls the meeting 1=4 2=3 4=2 5=2 8=14 9=8 Total *n*=33.
15. Holding papers across chest	Arms	Nervousness	Another 'barrier' protective signal, especially when arm is across chest *n* 9=1 Total *n* =1.
16. Palm(s) up or open palms in circular	Hands	Submissive, truthful, honesty, appealing	A common gesture with various meanings around a main theme of openness. Can also mean "I don't have the answer," or an appeal. In some situations this can indicate confidence (such as to enable openness), or

motion in air or on desk			trust. An easily faked gesture to convey innocence *n*2=3 *n*4=4 *n*5=4 *n*6=4 *n*8=14 *n*9=2 Total *n* =31.
17. Palm(s) up, inviting grasping air	Hands	Open hand gestures in circular motion	Relaxed hands are more likely to be defensive as if offered up in protection; inviting people in to conversation *n*1=2 *n*2=1 *n*3=1 *n*4=1 *n*5=1 *n*6=9 *n*7=1 *n*8=13 *n*9=6 Total *n*=44.
18. Palm(s) down	Hands	Authority, strength, dominance	Where the lower arm moves across the body with palms down this is generally defiance or firm disagreement *n*1=1 *n*2=11 *n*4=4 *n*5=1 *n*6=2 *n*8=4 *n*9=10 Total *n*= 33.
19. Palm up and moving up and down as if weighing	Hands	Striving for or seeking an answer	The hand is empty, but figuratively holds a problem or idea as if weighing it. The signal is one of 'weighing' possibilities *n*1=1 *n*8=13 Total *n* =14.
20. Hand(s) on heart (left side of chest)	Hands	Seeking to be believed	Although easy to fake, the underlying meaning is one of wanting to be believed, whether being truthful or not. Hand on heart can be proactive, as when a salesman tries to convince a buyer, or reactive, as when claiming innocence or shock. Whatever, the sender of this signal typically feels the need to emphasise their position as if mortally threatened, which is rarely the case *n*6=1 Total *n* =1.
21. Finger pointing (at a person)	Hands	Aggression, threat, emphasis	Pointing at a person is very confrontational and dictatorial. Commonly adults do this to young people. Adult to adult it is generally unacceptable and tends to indicate a lack of social awareness or self-control aside from arrogance on the part of the finger pointer. The finger is thought to represent a gun, or pointed weapon. Strongly associated with anger, directed at another person *n*1=2 *n*6=3 *n*8=2 *n*9=4 Total *n* =11.
22. Finger pointing (in the air) or at table	Hands	Emphasis	Pointing in the air is generally used to add emphasis, by a person feeling in authority or power *n*6=2 *n*8=3 *n*9=9 Total *n* =14.
23. Hand chop	Hands	Emphasis - especially the last word on a matter	The hand is used like a guillotine, as if to kill the discussion *n*1=5 *n*2=9 *n*3=1 *n*4=5 *n*6=14 *n*7=1 *n*8=7 *n*9=8 Total *n*=50.
24. Clenched fist(s)	Hands	Resistance, aggression, determination	One or two clenched fists can indicate different feelings including defensive, offensive, positive or negative, depending on context and other signals. Logically a clenched fist prepares the hand (and mind and body) for battle of one sort or another, but in isolation the signal is impossible to interpret more precisely than a basic feeling of resolve *n*1=1 Total *n* =1.
25. Interwoven clenched fingers	Hands	Frustration, negativity, anxiousness	Usually hands would be on a table or held across stomach or on lap *n*1=1 *n*2=1 *n*3=1 *n*4=1 *n*6=1 Total *n* =5.

26. Thumb(s) up	Hands	Positive approval, agreement, all well	In the Western world this signal is so commonly used and recognised as a language term in its own right: 'thumbs up' means approved. It's a very positive signal. Two hands is a bigger statement of the same meaning *n*6=1 Total *n* =1.
27. Hand(s) placed over mouth	Hands / mouth	Suppression, avoiding speaking	Often an unconscious gesture of self-regulation stopping speech for reasons of shock, embarrassment, or for more tactical reasons. The gesture is reminiscent of the 'speak no evil' wise monkey. The action can be observed very clearly in young children when they witness something 'unspeakably' naughty or shocking. Extreme versions of the same effect would involve both hands *n*1=1 *n*2=3 *n*3=4 *n*4=14 *n*5=8 *n*6=1 *n*7=5 *n*8=21 *n*9=12 Total *n* =71.
28. Scratching nose, eye, ears, pushing glasses back whilst listening	Hands / nose	Nervous apprehensive	In many cases this is an unconscious signalling of holding back or delaying a response or opinion. Rather like the more obvious hand-clamp over the mouth, people displaying this gesture probably have something to say but are choosing not to say it yet *n*2=6 *n*3=3 *n*4=1 *n*5=1 *n*7=1 *n*8=5 *n*9=8 Total *n* =25.
29. Hands clamped on ears	Hands / ears	Rejection of or resistance to something	Not surprisingly gestures involving hands covering the ears signify a reluctance to listen and/or to agree with what is being said or to the situation as a whole. The gesture is occasionally seen by a person doing the talking, in which case it tends to indicate that other views and opinions are not wanted or will be ignored *n*6=1 Total *n* =1.
30. Hand stroking chin	Hands / chin	Thoughtfulness	The stroking of a beard is a similar signal, considering the situation or next actions to be undertaken *n*8=2 Total *n* =2.
31. Hand supporting chin or side of face	Hands / chin, face	Evaluation, tiredness or boredom	Usually the forearm is vertical from the supporting elbow on a table. People who display this signal are commonly assessing or evaluating next actions, options, or reactions to something or someone. If the resting is heavier and more prolonged, and the gaze is unfocused or averted, then tiredness or boredom is a more likely cause. A lighter resting contact is more likely to be evaluation, as is lightly resting the chin on the knuckles *n*1=1 *n*2=5 *n*3=7 *n*4=8 *n*5=7 *n*6=4 *n*7=7 *n*8=6 *n*9=15 Total *n* =60.
32. Neck scratching	Hands / neck	Doubt, disbelief	Perhaps evolved from a feeling of distrust and instinct to protect the vulnerable neck area. Generally due to doubting or distrusting what is being said? *n*2=1 *n*5=1 *n*6=2 *n*8=3 *n*9=1 Total *n* =8.
33. Hand clasping wrist	Hands / wrist	Frustration	Clasping a wrist, which may be behind the back or in open view, can be a signal of frustration, as if holding one's self back *n*2=1 Total *n* =1.
34. Running hands through hair	Hair / hair	Flirting, or vexation, exasperation	Running hands through the hair is commonly associated with flirting, and sometimes it is, although given different supporting signals, running hands through the

			hair can indicate exasperation or upset *n*1=2 *n*2=3 *n*3=2 *n*4=1 *n*5=1 *n*6=1 *n*7=4 *n*8=5 *n*9=3 Total *n* =22.
35. Removing spectacles	Hands/ glasses	Alerting wish to speak	For people who wear reading only spectacles, this is an example of an announcement or alerting gesture, where a person readies themselves to speak and attracts attention to the fact *n*2=2 *n*5=2 Total *n* =4.

The forum included two men and seven women with the most active individuals showing non verbal communication being Commissioner 8 with *n*=137 body movements, Commissioner 9 *n*=118 and Commissioner 6 *n*=71. The body movement most frequently evidenced was agreeing via nodding whilst listening to the group. The second most common gesture was passive management, placing the hand over the mouth indicating often unconsciously by this gesture self-regulation and control, thirdly the hand supporting the chin or side of face which signals evaluation of their next actions or options. The fourth strongest behaviour was hand chopping the air used like a guillotine to kill the discussion. The fifth example was palms up which is an open gesture to the group. Finally palms down showing authority, strength, general defiance or firm disagreement.

The frequency of non verbal communication cues are decribed below:

Agreeing via nodding was the most common non verbal communication amongst the group with the process involving analysing head nods in the group. Although Commissioner 6 agreed 24 times (verbally) the most non verbal cues were from Commissioner 8 and Commissioner 9 equally with 20 each, they showed more agreement with the majority of nodding occurring whilst listening to the group. Commissioner 7 agreed *n*=15 times but did not contribute significantly to the discussion verbally and often sat with arms crossed looking disinterested in the discussion the majority of the time. Overall results *n*1=1 *n*2=7 *n*3=2 *n*4=7 *n*5=12 *n*6=12 *n*7=15 *n*8=20 *n*9=20 Total *n*=84.

The second most common non verbal communication amongst the group was placing the hand over the mouth indicating often unconsciously self-regulation and control; clamping the mouth is evidence of stopping speech for reasons of shock, embarrassment or may be considered for more tactical reasons. Commissioner 8 was the most frequently observed with this action 21 times, followed by Commissioner 9 with 12 times, relating closely with being passive. Overall results *n*1=1 *n*2=3 *n*3=4 *n*4=14 *n*5=8 *n*6=1 *n*7=5 *n*8=21 *n*9=12 Total *n*=71.

The third most common non verbal communication was the hand supporting the chin or side of face usually the forearm is vertical from the supporting elbow on the table. People who display this signal commonly assess or evaluate their next actions, options, or reactions to something or someone. If the resting is heavier and more prolonged, and the gaze is unfocused or averted, then tiredness or boredom is the more likely cause of this body movement. A lighter resting contact is more likely to be evaluation. Commissioner 9 did this more frequently out of the group in total 15 times. Overall results *n*1=1 *n*2=5 *n*3=7 *n*4=8 *n*5=7 *n*6=4 *n*7=7 *n*8=6 *n*9=15 Total *n*=60

The fourth most common non verbal communication was hand chopping with the hands used like a guillotine killing the discussion and emphasising, this is the last word on the matter. This would be seen as being assertive the most assertive person in the group was verbally assertive and transactional in nature. Commissioner 6 *n*=31 Commissioner 8 *n*=30 and Commissioner 9 *n*=26 were the three most dominant Commissioners using this technique. Overall results *n*1=5 *n*2=9 *n*3=1 *n*4=5 *n*6=14 *n*7=1 *n*8=7 *n*9=8 Total *n*=50

The fifth most common non verbal communication was palms up inviting grasping air with open hand gestures inviting people in to the conversation. Once again Commissioner 8 being the most animated with *n*=13 followed by Commissioner 6 *n*=9 times and Commissioner 9 *n*=6 times.

Overall results *n*1=2 *n*2=1 *n*3=1 *n*4=1 *n*5=1 *n*6=9 *n*7=1 *n*8=13 *n*9=6 Total *n*= 44

The sixth most common non verbal communication identified was palms down showing authority, strength and dominance. Where the lower arm moves across the body with palm down this is generally defiance or firm disagreement. The most notable person doing this action was Commissioner 2 *n*=11 times followed by Commissioner 9 *n*=10 times; they appeared to have very set views and strong opinion when presenting their information to the group. Overall results *n*1=1 *n*2=11 *n*4=4 *n*5=1 *n*6=2 *n*8=4 *n*9=10 Total *n*=33

The seventh most common non verbal communication identified individuals who moved paper on table showed confidence and authority indicating control of processes being undertaken. Commissioner 8 distributed the paperwork *n*=14 times the most frequently followed by Commissioner 9 *n*=8 times. It can therefore be suggested that the Commissioner who controlled the papers controlled the meeting. Overall results *n*1=4 *n*2=3 *n*4=2 *n*5=2 *n*8=14 *n*9=8 Total *n*=33

The eighth most common non verbal communication was palms up, often in a circular motion in the air or on the desk indicating being submissive, truthful, and honest or appealing to others. Open palms appears to evolve from when open upward palms showed no weapon was held. A common gesture with various meanings around a main theme of openness this can also mean "I don't have the answer," or an appeal. In some situations this can indicate confidence. The Commissioner who used this most was Commissioner 8 *n*=14 times. This can be an easily faked gesture to convey innocence with outward open forearms or whole arms being more extreme versions of this signal. Overall results *n*2=3 *n*4=4 *n*5=4 *n*6=4 *n*8=14 *n*9=2 Total *n*=31

The ninth most common non verbal communication was scratching the nose, eyes, ears, pushing glasses back whilst listening, indicating nervous apprehension. In many cases this was an

unconscious signalling of holding back or delaying a response or opinion. People displaying this gesture probably have something to say but are choosing not to say it yet. Commissioner 9 indicated this action most frequently on *n*=8 occasions, it may be that although the strong views of Commissioner 9 indicated from palms down non verbal communication. The individual may have felt apprehensive in the group and this may have been displayed in an aggressive manner to self protect their position. Overall results *n*2=6 *n*3=3 *n*4=1 *n*5=1 *n*7=1 *n*8=5 *n*9=8 Total *n*=25

The tenth most common non verbal communication was running hands through the hair which may indicate vexation, exasperation, commonly associated with flirting and can also indicate being upset. Commissioner 8 was the most animated with this action doing it *n*=5 times. Overall results *n*1=2 *n*2=3 *n*3=2 *n*4=1 *n*5=1 *n*6=1 *n*7=4 *n*8=5 *n*9=3 Total *n*=22

The eleventh most common non verbal communication was crossing the arms indicating a defensiveness stance, reluctance, protection or can be used as a separating barrier. This can be due to various causes, ranging from severe animosity or concern to mild boredom or being too tired to be interested and attentive. Crossed arms is a commonly exhibited signal by subordinates feeling threatened by bosses and figures of authority. The person most frequently displaying this action was Commissioner 7 *n*=8 times she also contributed least to the discussion. Overall results *n*2=2 *n*3=5 *n*4=2 *n*7=8 *n*8=1 *n*9=3 Total *n*=21

The final most common non verbal communication was tilting the head to one side Commissioner 6 did this more frequently than any others a total of *n*=9 times compared to Commissioner 5 who did this *n*=5 times. This is evidenced as a signal of interest and vulnerability, which in turn suggests a level of trust. Head tilting is thought by some to relate to 'sizing up' something, since tilting the head changes the perspective offered by the eyes, and a different view is seen of the other person or subject. Overall results *n*2=1 *n*4=1 *n*5=5 *n*6=9 *n*8=2 *n*9=2 Total *n*=20

To group the information together it was necessary to review the data from the verbal communication and match to the non verbal communication (see Table 13). The verbal responses are numbered 1-8 and the non verbal communication shows the examples of the 12 most frequently used body movements. It was necessary to link ‘positive’ and ‘agreeing’ verbal response with non verbal communication ‘nodding’ in agreement, the n1 refers to the number given to the Commissioner placed on the table and indicates in bold the most active member of the group in each defined category.

Table 13: Grouping of verbal and non- verbal communication.

Numbers of verbal responses evidenced.	**Non verbal communication.**
Assertive clear on what is required takes control. *n*1=18 *n*2=18 *n3*=5 *n4*=15 *n5*=21 *n6*=30 *n*7=*8* ***n8*=31** n9=26 Total *n*=172	Example 6. Authoritative palms down on table. *n*1=1 ***n*2=11** *n*3=0 *n*4=4 *n*5=1 *n*6=2 *n*8=4 *n*9=10 Total *n*=33
Delegating giving others support/direction *n*1=4 *n*2=1 *n3*=0 *n4*=3 *n5*=0 ***n6*=4** *n*7=1 *n8*=0 n9= 0 Total *n*=13	Example 7. Moved paper on table. *n*1=4 *n*2=3 *n*3=*0* *n*4=2 *n*5=2 *n*6=0 *n*7=0 ***n*8=14** *n*9=8 Total *n*=33.
Agreeing (3) supporting others/sees others as adding value.***n*1=10** *n*2=1 *n3*=0 *n4*=3 n5=0 n6=4 n7=1 *n8*=0 n9=0 Total *n*=19. Positive (8) shows a vision for the future seeks change/rewards others in group *n*1=1 *n*2=0 *n3*=0 n4=0 n5=0 ***n*6=1** n7=0 *n8*=0 n9=0 Total *n*=2.	Example 1. Head nodding agreeing. *n*1=1 *n*2=7 *n*3=2 *n*4=7 *n*5=12 *n*6=12 *n*7=15 ***n*8=20 *n*9=20** Total *n*=84.
Passive no clear direction provided to others or self *n*1=5 *n*2=7 *n3*=1 *n4*=6 *n5*=4 ***n6*=11** *n*7=2 *n8*=9 n9= 7 Total *n*=51	Example 3 Hand supporting chin. *n*1=1 *n*2=5 *n*3=7 *n*4=8 *n*5=7 *n*6=4 *n*7=7 *n*8=6 ***n*9=15** Total *n*=60 Example 10 runs hands through hair *n*1=2 *n*2=3 *n*3=2 *n*4=1 *n*5=1 *n*6=1 *n*7=4 ***n*8=5** *n*9=3 Total *n*=22. Example 2 Hand placed on mouth *n*1=1 *n*2=3 *n*3=4 *n*4=14 *n*5=8 *n*6=1 *n*7=5 ***n*8=21** *n*9=12 Total *n*=71.
Negative doesn't clearly listen to others, corrects others is not open to others views, talks over others, disagrees with others.*n*1=3 *n*2=1 *n3*=0 *n4*=1 *n5*=4 *n6*=3 *n7*=0 *n8*=0 **n9=7** Total *n*=19	Example 11 Crossing arms. *n1=0* *n*2=2 *n*3=5 *n*4=2 *n*5=0 *n6*=0 ***n*7=8** *n*8=1 *n*9=3 Total *n*=21. Example 9 Scratching nose ears pushing glasses back. *n*1=0 *n*2=6 *n*3=3 *n*4=1 *n*5=1 *n*7=1 *n*8=5 ***n*9=8** Total *n*=25.
Aggressive disagrees strongly with others, shows negative behaviour towards others in the group, defends own view aggressively ***n*1=4** *n*2=0 *n3*=0 *n4*=1 *n5*=1 *n6*=2 *n*7=1 ***n8*=4** n9=3 Total *n*=16.	Example 4 Hand chopping the air *n*1=5 *n*2=9 *n*3=1 *n*4=5 *n*5=0 ***n*6=14** *n*7=1 *n*8=7 *n*9=8 Total *n*=50.
Open willing to change view, seeks further information from others/clarifying, questioning, asking the group for approval *n*1=11 *n*2=7 *n3*=3 n4=5 n5=5 n6=19 n7=3 ***n8*=30** n9=11 Total *n*=94.	Example 8 Open palms *n1=0* *n*2=3 *n*3=0 *n*4=4 *n*5=4 *n*6=4 *n*7=0 ***n*8=14** *n*9=2 Total *n*=31.

By combining the verbal and non-verbal behaviours of the Commissioners it is possible to create a "pen picture" of each of the Commissioners in relation to the open forum. The pen picture provides a summary of the individual traits and personalities observed in the forum.

Commissioner 1: Showed that he was verbally assertive but was not authoritative in his body language, he delegated the most frequently verbally out of the entire group agreeing verbally the most but did not nod in agreement except once throughout the whole discussion. He was passive and showed little evidence of non verbal cues of this action. He did not show negativity by crossing arms or not listening to others, he was not aggressive and was willing to change views as he was open.

Commissioner 2: This individual evidenced authority through body language with palms down the most out of the group and spoke assertively on eighteen occasions. She did not delegate frequently or control the paper on the table. She agreed once verbally and was positive only once verbally, she agreed with head nodding less frequently than most of the participants. At times she was passive similarly to others in the group and negative infrequently verbally but was the individual who showed negative body language by having palms down. She was not verbally aggressive but chopped the air frequently showing evidence of wanting to stop the conversation.

Commissioner 3: Evidenced limited authority, never delegating, being verbally positive or agreeing by nodding only twice in the whole session. She showed negative behaviour the most by crossing arms and had limited input to the session. She appeared to be disengaged from the process throughout.

Commissioner 4: Evidenced average assertiveness, gave some support to others in the group, agreed similar to others and showed little positive verbal interaction. She was neither negative aggressive or open within the group and often withdrew from the conversation.

Commissioner 5: The evidence shows he was assertive verbally but did not show this with his body language and did not delegate to others frequently. He was neither verbally agreeing nor positive but agreed non verbally by nodding above the average for the group; he was not passive but verbally negative second most in the group but did not indicate this in non verbal cues. He was neither aggressive nor open to the rest of the group.

Commissioner 6: Evidenced being the most assertive in the group verbally and delegated verbally the most but this was not supported by non verbal cues. She agreed with others and nodded more than others; she was only positive once verbally and passive verbally, she was non verbally the most aggressive by chopping the air. She was open the second most out of the group willing to change views and seek further information.

Commissioner 7: Was not assertive, showed little evidence of delegating or showing any verbal positive behaviour but agreed frequently by nodding. She showed little negativity verbally but had arms crossed the most frequently out of the group and had little input.

Commissioner 8: This individual was the most animated in the group being verbally assertive the most but not non-verbally. She did not delegate verbally but most frequently moved the paper on the table. She did not agree verbally with others but nodded the most frequently. She was passive frequently and evidenced this by verbal and non verbal cues. She was not verbally negative and only crossed her arms once. She was more verbally aggressive than others but only third in the

hand chopping movement. She showed being open the most verbally and non verbally and was a leader within the group.

Commissioner 9: Showed she was assertive frequently verbally and more often non verbally; she did not verbally delegate but was second highest for moving the paper on the table. She showed no agreement with people in the group or was positive verbally; however she nodded in agreement the most along with Commissioner 8. She was passive the most with her hand on her chin or over her mouth and negative the most frequently verbally. She showed signs of aggression but was the most open with palms up on the table.

4.4. Discussion Phase 1

Three Commissioners (numbers 6, 8 and 9) emerged as the most dominant and assertive; they also developed allies quickly, by being the most open and agreed with individuals more frequently. Indeed these 3 Commissioners, who were the most active, also displayed the highest number of transactional actions during the scenario. From this is it clear that a transactional behaviour type predominates within the boardroom, with the majority of the Commissioners actions in line with this. In addition two thirds of the actions observed were attributable to just 3 Commissioners (numbers 6, 8 and 9) thus suggesting that CCG meetings could be dominated by a few individuals, who may look to impose their own views on the agenda.

The significance of the body language of the Commissioners when discussing the scenario cannot be understated. Body language experts (Litlejohn and Foss 2009) generally agree that hands send more signals than any part of the body except for the face and many of the Commissioners used their hands to emphasise key points, whether it was an expression such as chopping the air or open

palms. The hands can also be used as a signal of contemplation or to avoiding speaking. Hands are used to emphasize a point and are used as a starting and end point, showing the distance people had to go or by using the fingers to emphasise a number of actions required. It was noted that a number of Commissioners had their arms crossed, particularly Commissioner 3 (*n*=5) and Commissioner 7 (*n*=8). This can act as a defensive barrier when across the body and both Commissioner 3 and Commissioner 7 made little contribution to the group and may have felt intimidated by those involved.

It was clear that individuals gave a variety of clues as to how they want to be perceived by others through gestures, posture, sound and intonation, giving real or false messages is a skill developed by many leaders (Tok and Temel 2014). Body language as an active intervention was seen as a communication tool used to manipulate others in the group drawing people in with open hand gestures or nodding in agreement. Ensuring agreement from others developed allies and reliance on those members to respond positively and more frequently to the leader.

This was also evidenced by mirroring of body language within the group, creating a mutual feeling of empathy, understanding and trust. When two people or more are using similar words and body language it is likely to encourage feelings of trust and rapport because it generates unconscious feelings of affirmation. The converse effect applies when two people's body language signals are different and therefore not synchronised. They feel less like each other and the engagement is less comfortable. The individuals involved sense a conflict arising from the mismatching of signals the two people are not affirming each other; instead the mismatched signals translate into unconscious feelings of discord, discomfort or even rejection. (Wachsmuth et al 2008).

The majority of people want to be comfortable and are co-operative so will naturally match each other's non-verbal communication to feel part of the group. The person who did not appear to be

synchronised in the group was Commissioner 9 who was also the most negative, both verbally and non-verbally. Being agitated or aggressive is normally not acceptable within most group settings and this made Commissioner 9 appear less favourable to the group, however her views were taken on and had a major influence on decisions. Perhaps therefore the competition within the group (especially by Commissioners 6, 8 and 9) may have resulted in limited contribution by the less vocal members of the group. The behaviours these members displayed may have been as a result of frustration and disengagement by these individuals. A failure to draw individuals into the group, to give them a voice, may result in a less focused group decision or less desirable outcome being achieved.

It must be accepted that non- verbal communication and the spoken words themselves are not the only mechanism to obtain an insight into an individual's behaviour. Audible signals (apart from the words themselves) are also valid and Hartland & Tosh (2001) identify how words themselves convey their own meaning. However an analysis of pace, volume and pitch of the words spoken did not form a significant part of this study. Similarly emotional expressions serve as an important social function to communicate information about beliefs, desires and intentions. Porter and Brinke's (2008) research into facial expressions identified that certain emotions are more difficult to fabricate and can be revealed by micro expressions. According to research by Celso et al (2014) facial displays of joy, sadness, anger and regret impact on people's expectations of co-operation. Joy after mutual cooperation is likely to increase expectations of future co-operation within groups. This research utilised wide and close angle lens but was unable to see all expressions of the Commissioners faces, so general movements have been captured in the evaluation process.

4.4.1 Summary

The non-verbal cues often did not match discussions but the combination of being animated and verbally assertive gave power to the strongest three leaders in the group. The Commissioner most verbally assertive and transactional in nature did not show this clearly with their body language. Commissioner 8 controlled the paper on the table and distributed this to individuals, however did not verbally delegate tasks to individuals. The most dominant in the group agreed by nodding frequently, but did not verbalise this. The three dominant people showed passive movements including hands over mouth, hands running through their hair and hand supporting chin. Commissioner 9 was the most negative verbally and non-verbally. Being aggressive verbally was not common but hands chopping the air were used frequently to stop the conversation. The most dominant, Commissioner 8, was the verbally most open and non-verbally by having open palms during the conversation. Whilst this evidence may indicate the type of leadership behaviour in a group of Commissioners, it may not mirror a much larger social system (Bales 1950) and as such, translate to all CCG's behaviour on the larger scale.

There were two objectives of the research that were specifically associated with this phase and the key findings for this phase are related to them below:

To determine if leadership behaviours can influence better outcomes for Q&S in healthcare.

The most dominant behaviour demonstrated by the Commissioners was transactional in nature. The evidence provided gives an indication that this type of behaviour may be replicated within the boardroom, with the majority of Commissioners acting in line with this approach. This type of behaviour goes to the core of the decision making process and as a result may in a service that is detrimental to patient care.

To critically analyse group dynamics that influence decision making in healthcare.

The findings suggest that the group dynamics within CCG's are likely to be dominated by a few individuals, who may steer the group along particular pathways. The implications of this mentality are evidenced in the Morecambe Bay inquiry, which found that group dynamics led the group to maintain control over ineffective policies and systems, whilst staff who voiced legitimate concerns were not heard (Kirkup, 2015).

4.5. Results Phase 2.

The questionnaire generated a total of 48 responses (female *n*=39, male *n*=9).The results from the questionnaire distributed to the subordinates of leaders identified that the age range of the participants (see table 14) was between 18 and 55 years old, with the majority of respondents (58.3% *n*=28) being in the age range 45-55 (n=28).

Table 15 identified that 29.2% *n*=14 of responses were from Managers and with Commissioner's and CSU's providing 16.7% *n*=8 of responses each. The majority of staff surveyed reported to either a Manager (45.8% *n*=22) or Executive Director (27.1% *n*=13) (see table 16). Table 17 revealed that the majority of respondents had spent a limited time in the post with 62.5% *n*=30 of staff being in post for less than 2 years.

The results indicated that the values and beliefs were discussed 34% *n*=16 fairly often and 29.8% *n*=14 once in a while (see table 18); the vision of the organisation was discussed 41.7% *n*=20 which was predominantly fairly often and frequently in the Likert scale (see table 19). Staff also felt they were supported to succeed fairly often, 20 out of 47 responses and frequently 7 times (see table 20), and that they could also discuss problems on a regular basis 17 times and fairly often 9

times (see table 21).

Table 14: Age range of participants

Age range of individuals		Frequency	Percent
Valid	18-30	4	8.3
	30-45	16	33.3
	45-55	28	58.3
	Total	48	100.0

Table 15: Position within the organisation

		Frequency	Percent
Valid	Admin/support	5	10.4
	GP	1	2.1
	Manager	14	29.2
	GP/Commissioner	8	16.7
	CSU	8	16.7
	Public Health	1	2.1
	Local Authority	7	14.6
	Other	2	4.2
	CEO/Director	2	4.2
	Total	48	100.0

Table 16: Position of line manager

Valid	Manager	22	45.8
	Deputy-Director	6	12.5
	Executive-Director	13	27.1
	Chief-Exec	7	14.6
	Total	48	100.0

Table17: Time in post

Valid	0-2 years	30	62.5
	2-5 years	7	14.6
	5-10 years	7	14.6
	More than 10 years	4	8.3
	Total	48	100.0

Table18: Frequency manager discussed values and beliefs

		Frequency	Percent	Valid Percent
Valid	not at all	2	4.2	4.3
	once in a while	14	29.2	29.8
	sometimes	6	12.5	12.8
	fairly often	16	33.3	34.0
	frequently	9	18.8	19.1
	Total	47	97.9	100.0
Missing	System	1	2.1	
Total		48	100.0	

Table 19: Frequency discussed vision

		Frequency	Percent	Valid Percent
Valid	not at all	6	12.5	12.5
	once in a while	6	12.5	12.5
	sometimes	16	33.3	33.3
	fairly often	15	31.3	31.3
	frequently	5	10.4	10.4
	Total	48	100.0	100.0

Table20: Number of times leaders support staff to succeed

		Leader-position									
		Admin/support	GP	Manager	GP/Commissioner	CSU	Public Health	Local Authority	Other	CEO/Director	Total
Succeed	not at all	1	1	0	1	1	0	1	0	0	5
	once in a while	1	0	3	2	1	0	2	1	0	10
	sometimes	1	0	2	0	0	1	1	0	0	5
	fairly often	0	0	8	4	5	0	2	0	1	20
	frequently	1	0	1	1	1	0	1	1	1	7
Total		4	1	14	8	8	1	7	2	2	47

Table 21: Number of times leaders available to discuss problems issues

		Leader-position									
		Admin/support	GP	Manager	GP/Commissioner	CSU	Public Health	Local Authority	Other	CEO/Director	Total
Problems issues	not at all	0	0	1	0	0	0	0	0	0	1
	once in a while	2	1	1	3	1	0	2	0	0	10
	sometimes	1	0	4	1	1	1	2	1	0	11
	fairly often	1	0	2	3	1	0	2	0	0	9
	frequently	1	0	6	1	5	0	1	1	2	17
Total		5	1	14	8	8	1	7	2	2	48

The scores from the 48 questionnaires returned provided limited evidence of being statistically significant and individual perceived differences were not evident. However the grouping of the 31 questions into ten distinct themes including leaders, vision, individual perception, conflict management, supportive behaviour, performance management, behaves well as leader, team think positively about the leader, team beliefs, focuses the teams efforts, finally target and decision making helped to group themes of leadership behaviour. This provided a more effective analysis of the study variables, the aim being to test the hypothesis described in each of the tests below. The data used the Likert scale 1 (not at all) to 5 (frequently) and was evaluated via SPSS 21 the scale used was 0.1 to 0.4 low levels of confidence 0.4 to 0.7 medium confidence and 0.7.to 0.99 strong confidence in data evidenced. The test used was Spearman's rank correlation and normal

distribution. The results indicate that transactional management style which focuses on targets is scored low with perception by staff that this is not a good type of behaviour. Positive responses are identified through leadership styles more aligned to transformational management style, which includes behaving well as a leader, being supportive, good team beliefs, individual positive behaviour and positive about the leader.

Table 22: Target & decision making/behaves well as a leader.

Hypothesis 1: There is correlation between behaviour and outcomes for transactional management, (a) Positive: improved performance by leaders who behave appropriately (b) Negative: does not improve performance.

The hypothesis identified a perceived statistical relationship between behaviour and outcomes for transactional management, positive performance by leaders who behaves appropriately is seen as improving outcomes. The focus on targets and finance are seen as negative. The information supports the hypothesis (a) the reliability that (a) = -.531 correlation is significant at the 0.01 level (2-tailed) behaves well as a leader provides a medium correlation with individuals responses. There was therefore strength in the statistical analysis that the better the behaviour the more likely the people will be less transactional in nature. The leader may be perceived as showing a number of transactional leadership traits, which may include a more target driven approach. The leader may also avoid getting involved when important issues arise, thus showing a lack of commitment and interest. The leader is more aligned to be focused on targets & finance and therefore may not be clear on the overall vision for the organisation and Q&S issues. Lack of decision making leaves the followers with limited direction often described as non leadership. This shows the leader is a firm believer in ‘if it isn’t broke don’t fix it’ and describes a lack of ambition to change a situation or work activity.

The leader who only focuses on dealing with mistakes, complaints and failures of staff is likely to create a blame culture and lack of trust. The better the leader is at behaving appropriately the more likely they are to be aligned with transformational leadership styles. The leader would also evidence integrity and making ethical decisions, meaning staff will feel positive towards them. Also the leader is likely to display a sense of power and confidence and give assurance to the team that he/she is not self focused but works for the benefit of the whole team.

Figure 8: Behaves well as a leader

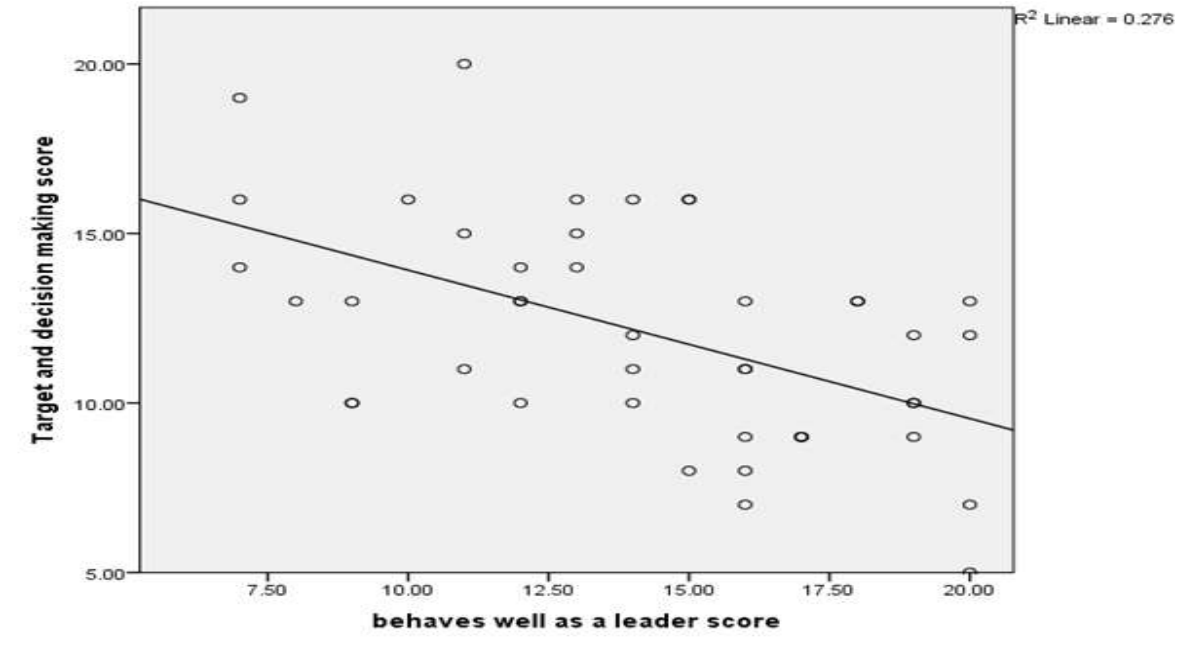


Table 22: Target & decision making

Correlations

			Target and decision making score	Behaves well as a leader score
Spearman's rho	Target and decision making score	Correlation Coefficient	1.000	-.531**
		Sig. (2-tailed)	.	.000
		N	44	44
	Behaves well as a leader score	Correlation Coefficient	-.531**	1.000
		Sig. (2-tailed)	.000	.
		N	44	48

**. Correlation is significant at the 0.01 level (2-tailed).

Table 23: Transformational style and behaves well as a leader.

Hypothesis 2: Leaders who focus the team's efforts in a transformational style (a) will also show good behavioural traits to the staff who work for them (b) will not show good traits to staff. The hypothesis test identified a perceived significantly strong correlation between strong transformational style and showing good behaviour to staff hypothesis (a) = .924 correlation is strongly significant at the 0.01 level (2-tailed) is therefore supported.

This information therefore suggests that statistically significant is the leader who focuses the team's efforts in a transformational style, which leads the group to be productive and is likely to provide effective outcomes. It is also likely to heighten the teams desire to succeed and feel part of the team who are committed to the work activity. The behaviour of the leader is positive towards staff and he/she is likely to value them as individuals.

Figure 9: Transformational leadership style

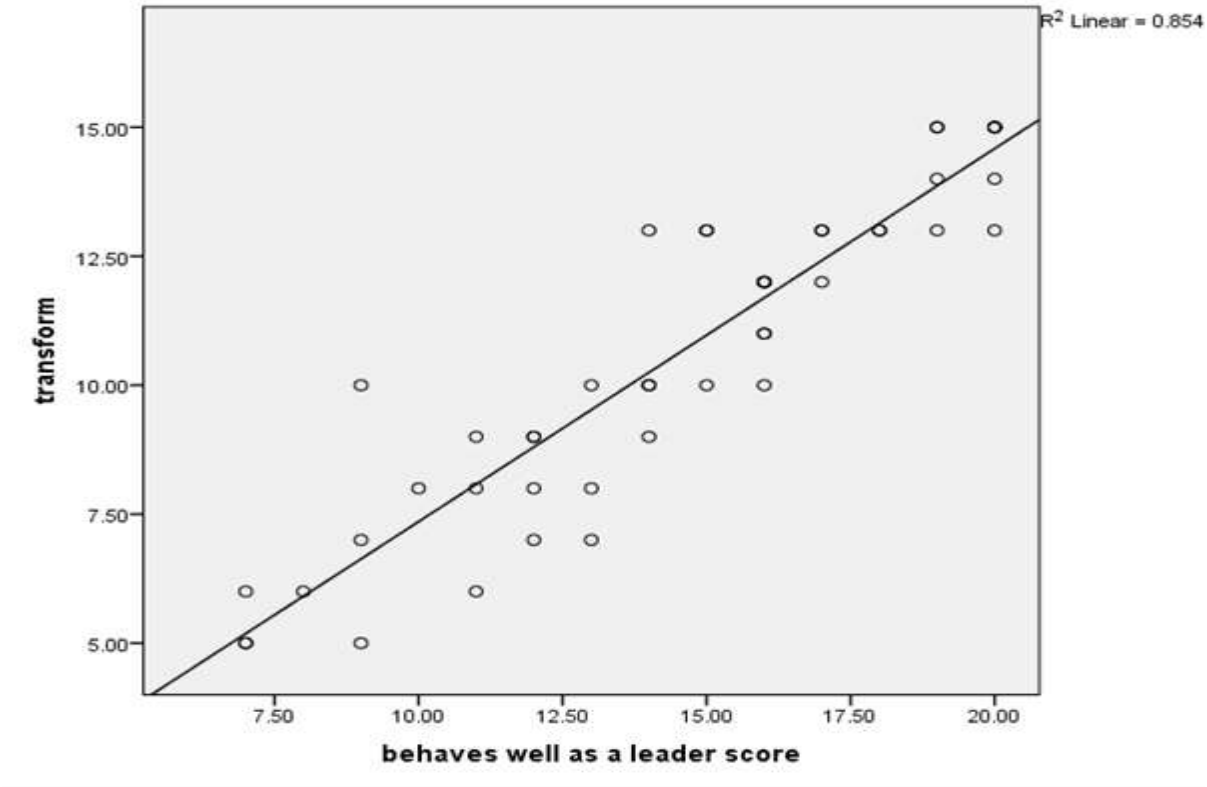


Table 23: Behaves well as leader.

Correlations				
			behaves well as a leader score	transform
Spearman's rho	Behaves well as a leader score	Correlation Coefficient	1.000	.924**
		Sig. (2-tailed)	.	.000
		N	48	47
	Transform	Correlation Coefficient	.924**	1.000
		Sig. (2-tailed)	.000	.
		N	47	47
****. Correlation is significant at the 0.01 level (2-tailed).**				

Table 24: Team beliefs/targets & decision making.

Hypothesis 3: The team beliefs on how to succeed are as a direct result of transactional leadership traits shown by the leader (a) this has positive outcomes on results (b) this has a negative outcome on followers.

The hypothesis test identified a perceived significance from participants with medium correlation between team beliefs and showing good behaviour to staff hypothesis (a) = -.466 correlation is significant at the 0.01 level (2-tailed) is therefore supported. The team are focused on the same key goals and values which makes it clear on what they need to do to succeed. The team see themselves as a high performing group and feel good about each other and their position within it. The leaders who may show transactional leadership traits may also avoid getting involved when important issues arise, thus showing a lack of commitment and interest. The leader is more aligned to be focused on targets & finance and therefore may not be clear on the overall vision for the organisation and Q&S issues. Lack of decision making (passive leadership) leaves the followers with limited direction often described as non leadership. This shows that the leader is a firm believer in 'if it isn't broke don't fix it' and describes a lack of ambition to change a situation or work activity.

Figure10: Target and decision making score.

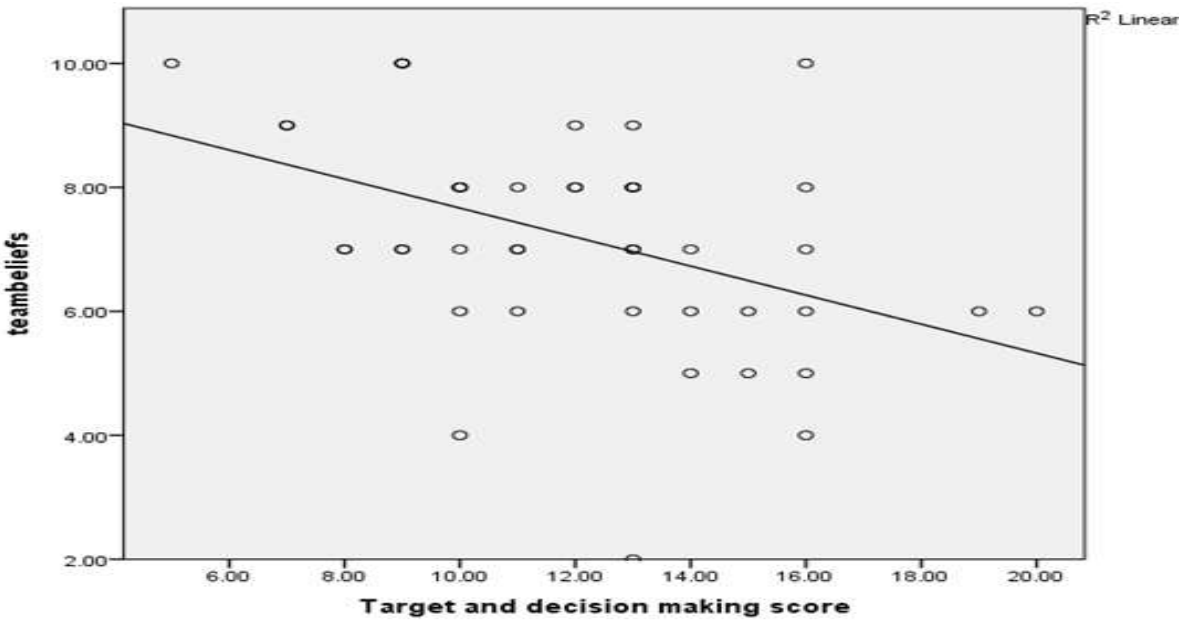


Table 24: Team belief expressed

Correlations				
			Target and decision making score	team beliefs
Spearman's rho	Target and decision making score	Correlation Coefficient	1.000	-.466**
		Sig. (2-tailed)	.	.001
		N	44	44
	Team beliefs	Correlation Coefficient	-.466**	1.000
		Sig. (2-tailed)	.001	.
		N	44	48
**. Correlation is significant at the 0.01 level (2-tailed).				

Table 25: **Supportive behaviour and behaves well as a leader**

Hypothesis 4: The leader supports their staff and spends time coaching the team members to develop their skills effectively; (a) shows good behavioural traits and correlate with transformational leadership style (b) show's negative behaviour traits.

The hypothesis test (a) is supported as there is a strong correlation between the supportive behaviour of the leader and transformational leadership style =.917 strong correlation and is therefore significant at the 0.01 level (2-tailed) is therefore supported. The leader supports their staff and spends time coaching the team members to develop their skills effectively. The leader presents feedback in a helpful and positive manner. The leader is focused on the bigger picture, is approachable & will take on new ideas from their staff members.

The leader shows good behavioural traits and correlate with transformational leadership style evidence that the leader displays good behaviour with integrity and makes ethical decisions about tasks. The behaviour of the leader is positive towards staff and values them as individuals, also displays a sense of power and confidence and gives assurance to the team that is not self focused but works for the benefit of the team.

Figure 11: Behaves well as a leader and is supportive.

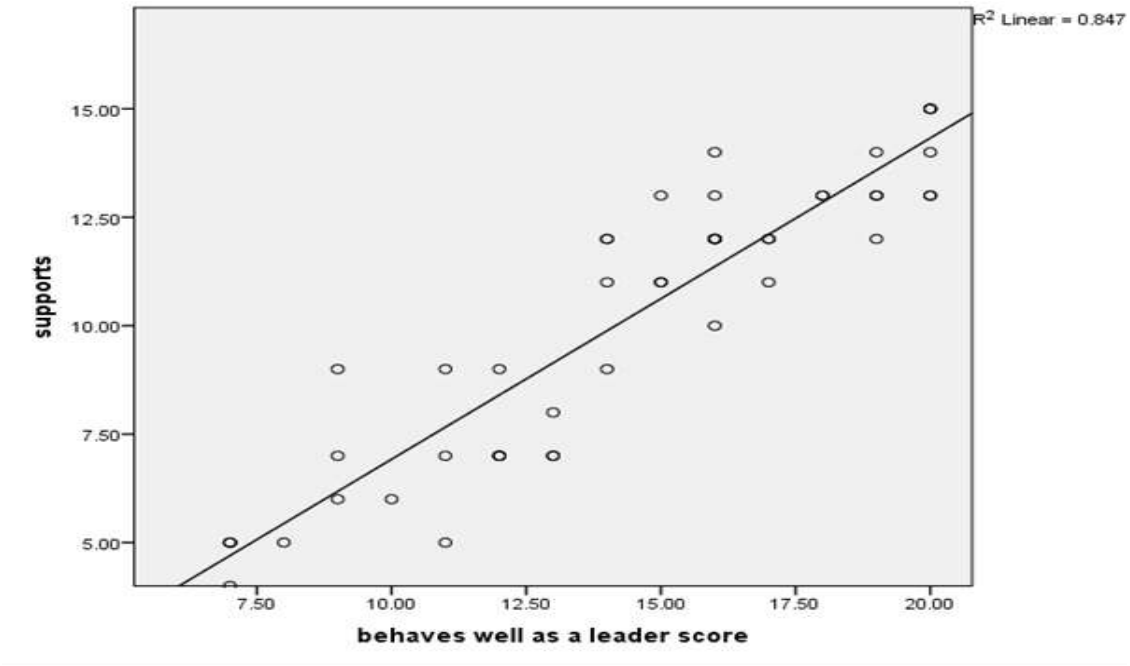


Table 25: Supports staff

Correlations

			supports	behaves well as a leader score
Spearman's rho	Supports	Correlation Coefficient	1.000	.917**
		Sig. (2-tailed)	.	.000
		N	48	48
	Behaves well as a leader score	Correlation Coefficient	.917**	1.000
		Sig. (2-tailed)	.000	.
		N	48	48

**. Correlation is significant at the 0.01 level (2-tailed).

Table 26: Team feel positive about their leader/looks at targets and decision making.

Hypothesis 5: The team think positively about the leader and being associated with him/her makes the individual feel proud (a) this links with a transactional style of management (b) this does not link to transactional style of management.

The test identified a perceived medium significant correlation between the team feeling positive about their leader, they are less likely to feel positive about a transactional style therefore (b) is supported = -.607 Correlation is significant at the 0.01 level (2-tailed). The subordinates feel positively about the leader and being associated with him/her makes them as individuals feel proud to work with him/her them as they look up to him/her and admire him/her. If the leader displays transactional leadership style this is less likely to improve staff performance.

Figure 12: Team are positive about the leader.

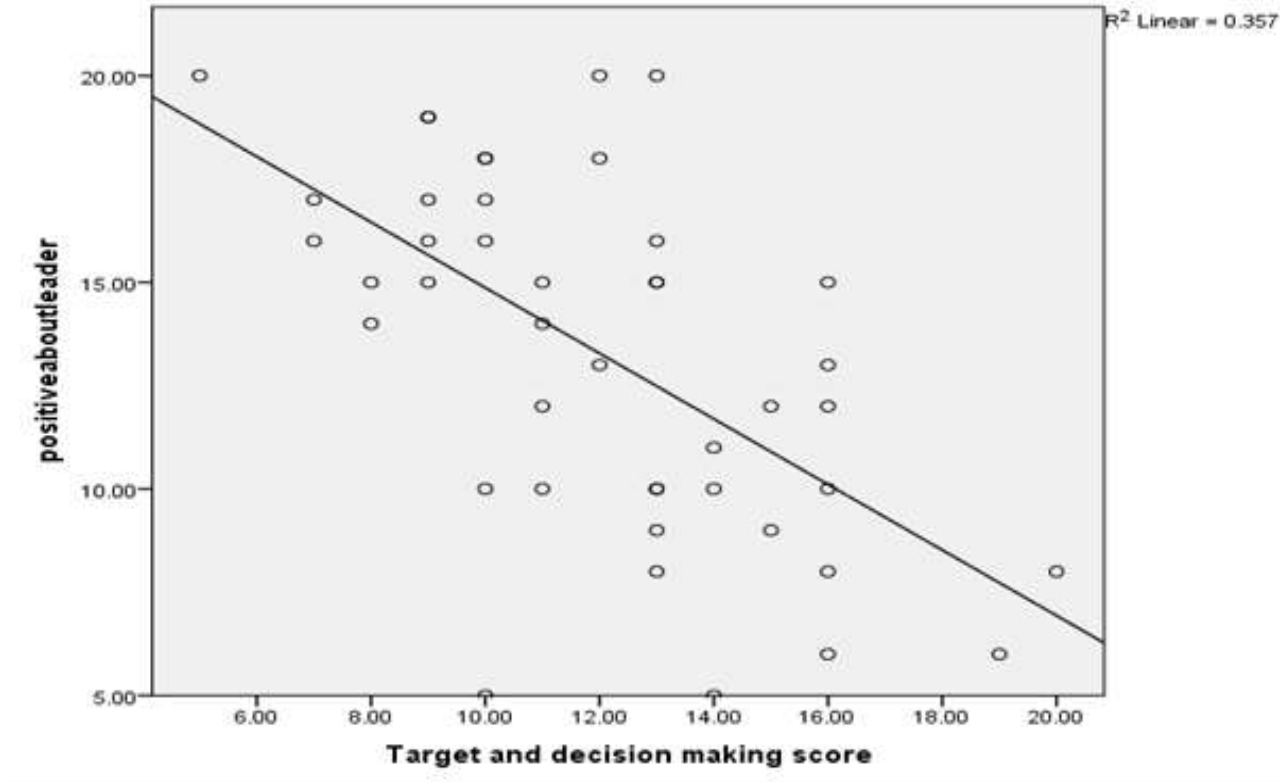


Table 26: Team are positive about the leader.

Correlations

			Positive about leader	Target and decision making score
Spearman's rho	Positive about leader	Correlation Coefficient	1.000	-.607**
		Sig. (2-tailed)	.	.000
		N	48	44
	Target and decision making score	Correlation Coefficient	-.607**	1.000
		Sig. (2-tailed)	.000	.
		N	44	44

**. Correlation is significant at the 0.01 level (2-tailed).

Table 27: Clear on vision/staff are positive about their leader.

Hypothesis 6: The vision of the leader shows a clear line of sight between the individual and job role this correlates with (a) thinking positively about the leader (b) thinking negatively about the leader. The hypothesis test identified a perceived significantly strong correlation between the clear vision of the organisation hypothesis (a) = .836 strong correlation and therefore is significant at the 0.01 level (2-tailed) is supported. The vision of the leader shows a clear line of sight between how individuals undertake daily tasks and how this contributes to the organisational goals. The leader also provides a compelling vision of the future and is inspirational about how the future will be determined. The team perceive positively about the leader and being associated with him/her makes the individuals feel proud as they look up to him/her and admire them. The leader will act in a way that builds the respect of individuals and considers the moral & ethical consequences of decisions, uses methods of leadership that are satisfying to the team and supports individuals.

Figure 13: Clear vision from leader.

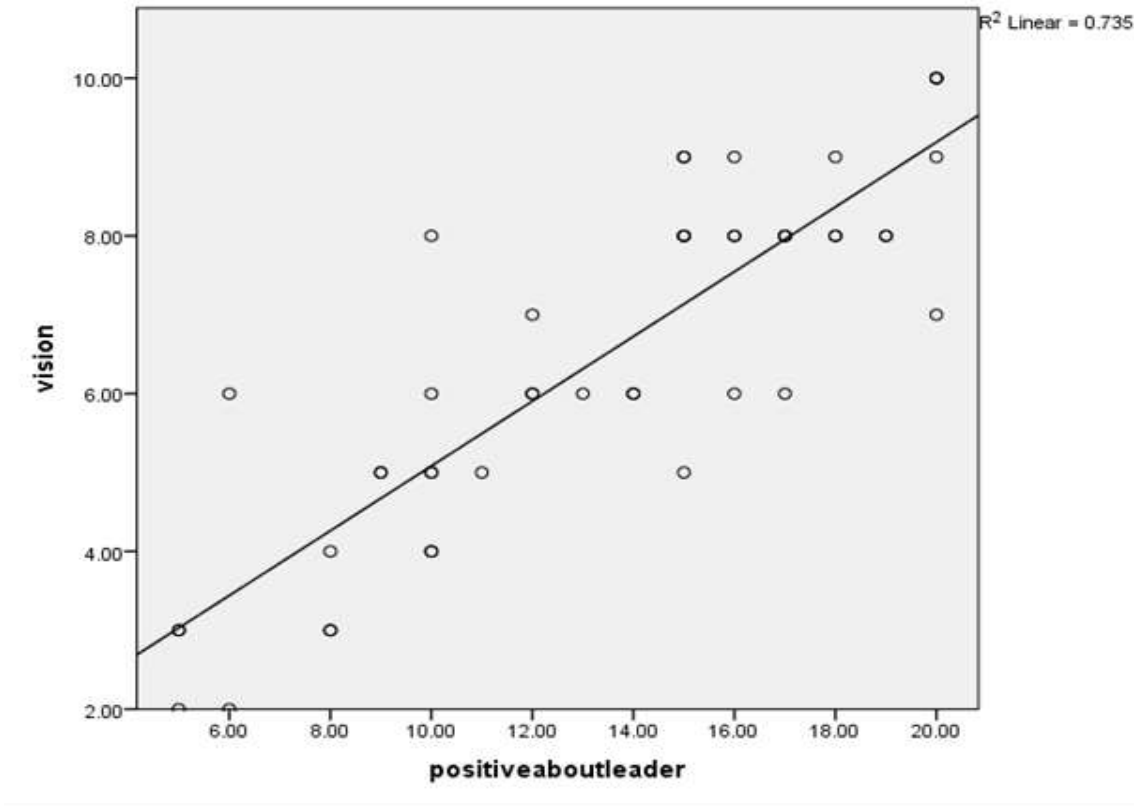


Table 27: Leader shows vision.

Correlations

			vision	Positive about leader
Spearman's rho	Vision	Correlation Coefficient	1.000	.836**
		Sig. (2-tailed)	.	.000
		N	47	47
	Positive about leader	Correlation Coefficient	.836**	1.000
		Sig. (2-tailed)	.000	.
		N	47	48

**. Correlation is significant at the 0.01 level (2-tailed).

Table 28: Team Leader is supportive and target and decision making

Hypothesis 7: The leader supports their staff and spends time coaching the team members to develop their skills effectively, (a) supporting staff relates to transactional management style (b) does not relate to transactional management style. The hypothesis test identified a perceived medium significant correlation between (b) supporting staff does not relate to the style of management described as transactional= -.539 correlation was medium significant at the 0.01 level

(2-tailed) is therefore supported. The results indicate that the leader who supports their staff and spends time coaching the team members to develop their skills effectively the more positive the team feel about him/her. The leader presents feedback in a helpful and positive manner. The leader is focused on the bigger picture, is approachable and will take on new ideas from their staff members.

Figure 14: Leaders is supportive of the team.

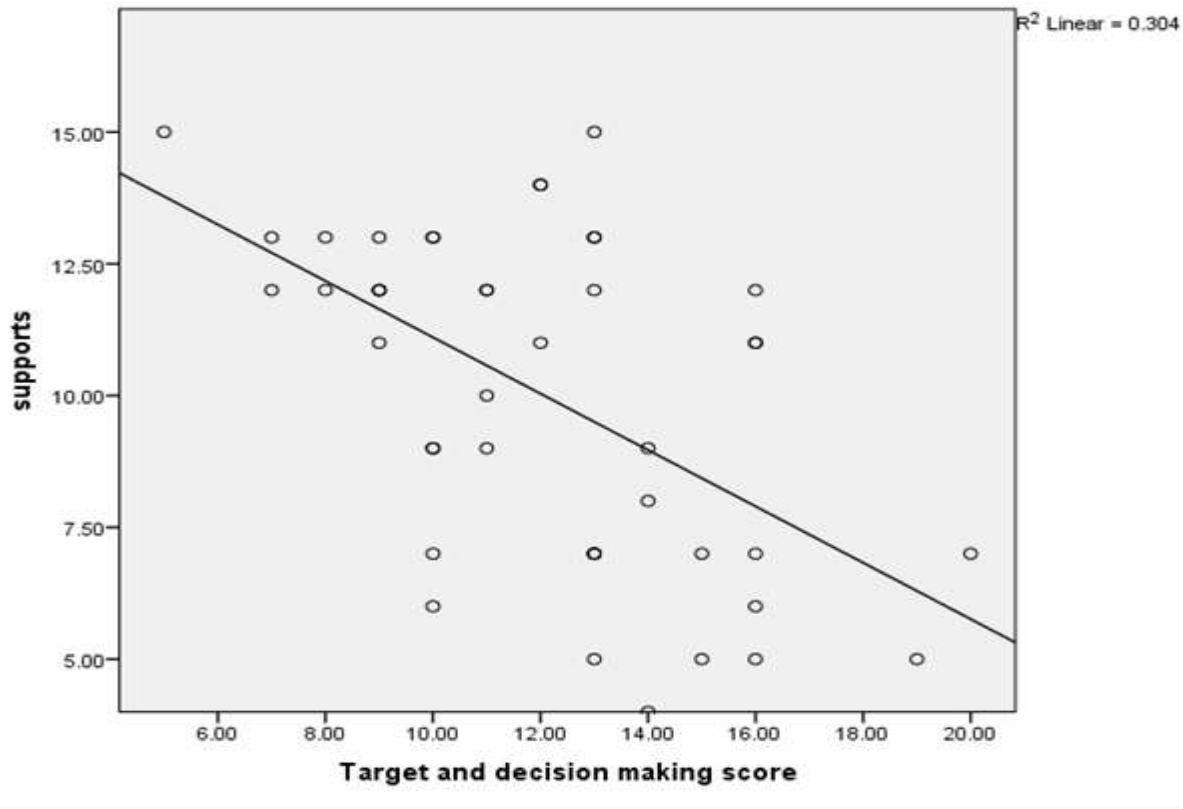


Table 28: Leader is supportive of staff.

Correlations				
			supports	Target and decision making score
Spearman's rho	Supports	Correlation Coefficient	1.000	-.539**
		Sig. (2-tailed)	.	.000
		N	48	44
	Target and decision making score	Correlation Coefficient	-.539**	1.000
		Sig. (2-tailed)	.000	.
		N	44	44
**. Correlation is significant at the 0.01 level (2-tailed).				

Table 29: Performance and dealing with conflict management

Hypothesis 8: The performance of the team is paramount and staff are encouraged to work with other team members, this relates to conflict (a) positively (b) negatively. The hypothesis test identified a perceived medium significant correlation between (a) performance and how the leader deal with conflict = .685 medium correlation and therefore significant at the 0.01 level (2-tailed) is therefore supportive of the leader. This type of leader sees the performance of the team having paramount importance; encouraged staff to work with other team members or partners and has a broad view of the department and its needs. There are good project management systems that check the team's progress on plans & targets that have been set. With good communications and clear recognition of good performance or extra effort made by the team, staff are seen to go the extra mile.

There may be conflict in the team which may be caused by destructive behaviour from the leader. It is important for staff to feel safe to discuss conflicts openly with the leader and colleagues; for this to occur the organisation will require developing trust with staff. The leader would manage conflict well, by dealing with disputes in a timely manner and therefore reducing the likelihood of it occurring. The leader who seeks differing perspectives on an issue to solve a problem requires listening to staff rather than ignoring suggestions. The better the performance the more likely the leader deals well with conflict.

Figure 15: Deals with performance and conflict.

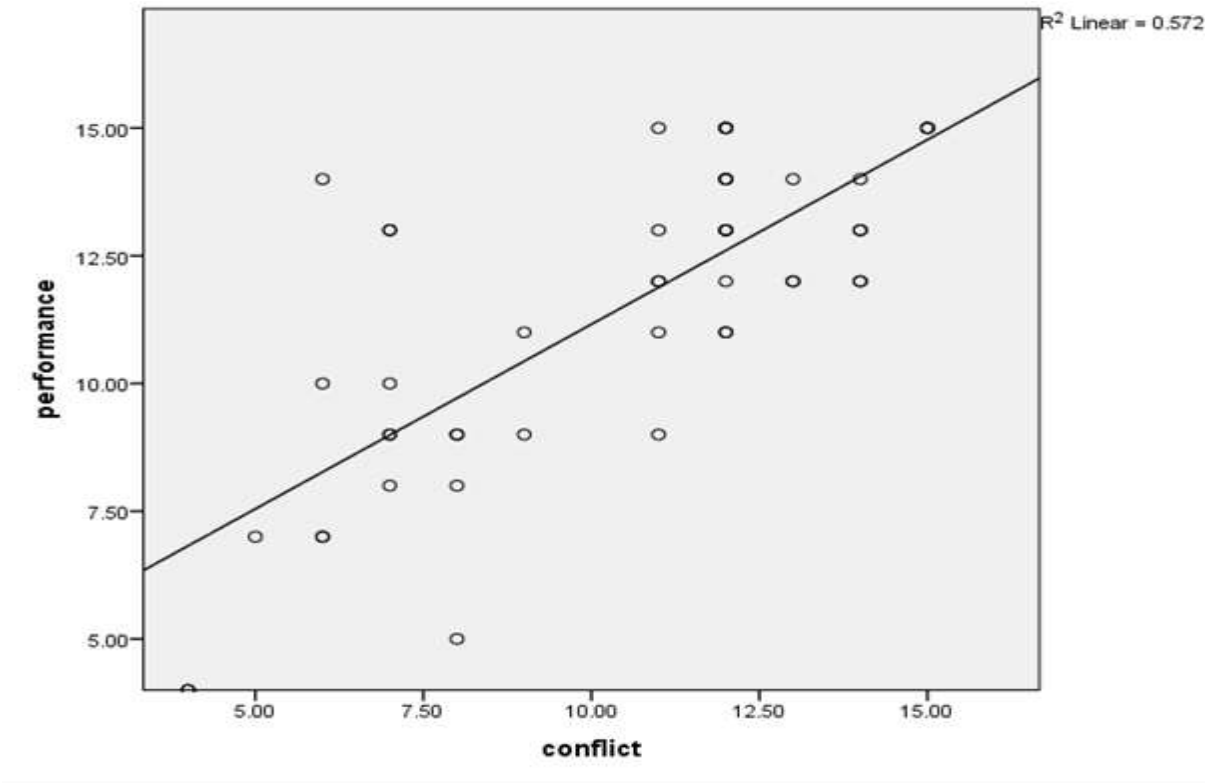


Table 29: Leader manages conflict & performance.

Correlations				
			performance	conflict
Spearman's rho	Performance	Correlation Coefficient	1.000	.685**
		Sig. (2-tailed)	.	.000
		N	48	48
	Conflict	Correlation Coefficient	.685**	1.000
		Sig. (2-tailed)	.000	.
		N	48	48
**. Correlation is significant at the 0.01 level (2-tailed).				

Table 30: Individual perception and performance

Hypothesis 9: Individual perceptions of their work activity having autonomy to carry out work with adequate control over workplace is directly linked to (a) good team performance (b) poor team performance. The hypothesis test identified a perceived medium significant correlation between (a) good team performance and individual perceptions of staff who feel they are supported in decision making = .642 correlation is significant at the 0.01 level (2-tailed) is therefore supported. Individual perceptions of their work activity having autonomy to carry out work with adequate control over workplace. Individuals within teams are included in decisions that directly affect work and how work outcomes are achieved.

The performance of the team is paramount and staff are encouraged to work with other team members or partners and have a broad overview of the department and its needs. There are good project management systems that check the team's progress on plans & targets that have been set. There is also good communication and clear recognition of good performance or extra effort made by the team with staff seen to go the extra mile.

Figure 16: Treats individuals well.

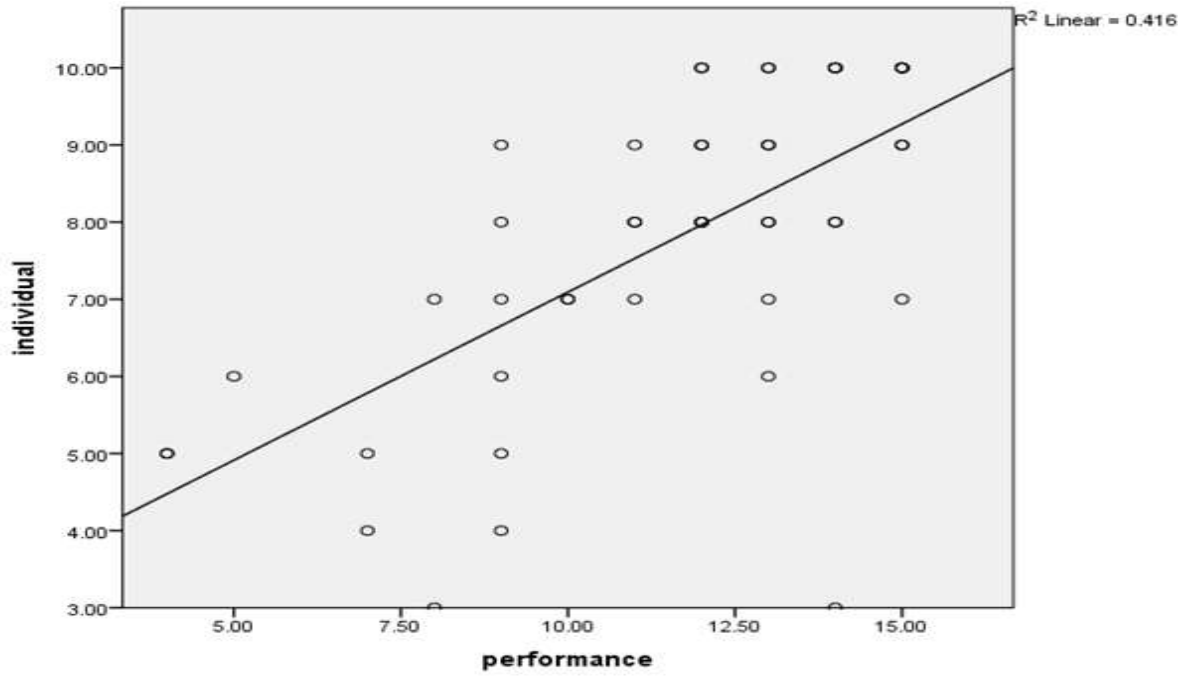
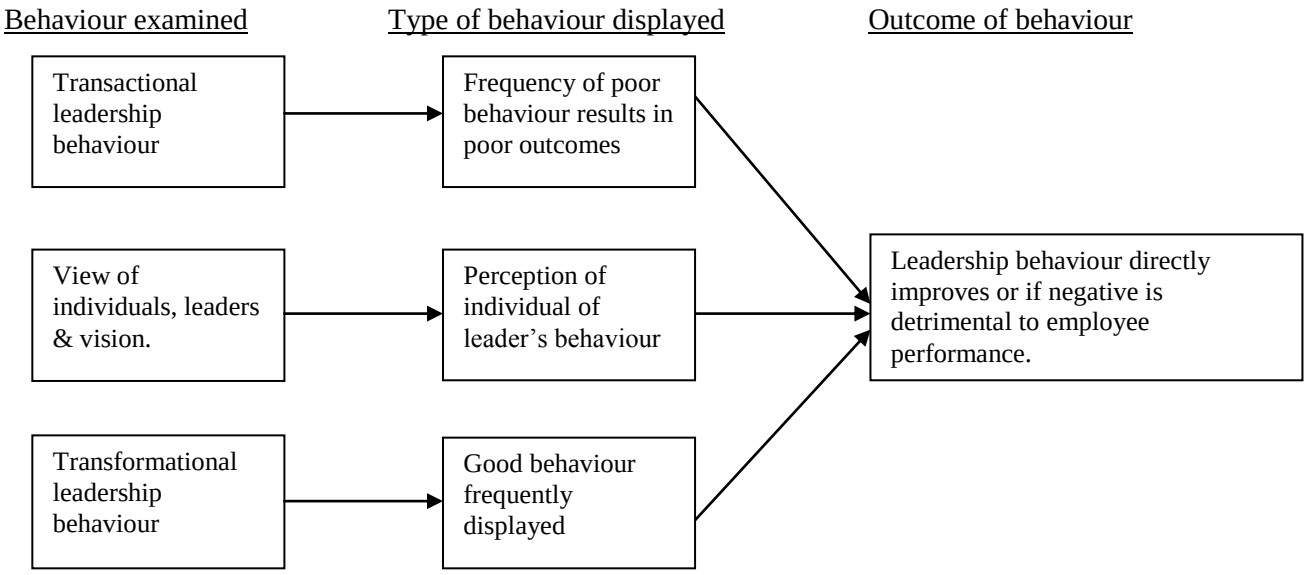


Table 30: Individual performance

Correlations				
			individual	performance
Spearman's rho	Individual	Correlation Coefficient	1.000	.642**
		Sig. (2-tailed)	.	.000
		N	47	47
	Performance	Correlation Coefficient	.642**	1.000
		Sig. (2-tailed)	.000	.
		N	47	48
**. Correlation is significant at the 0.01 level (2-tailed).				

The results suggest that the strongest evidence of good behaviours related to three clear areas identified; firstly a strong correlation between a clear vision of the organisation and staff feel positive about their leader = 0.836. Secondly a strong correlation between the supportive behaviour of the leader and transformational leadership style =.917 and finally that transformational behaviours of leaders also evidence good behaviour towards staff = .924. Transformational leaders were more highly positively correlated with their subordinates' satisfaction, extra effort, and effectiveness when compared with transactional and passive leaders and thus described by different authors to have a contemporary high relationship with leadership success. This notion is supported by (Kirkbride 2006) who describe transactional management, which is based on reward for work and a more punitive approach to employees, as detrimental to organisational outcomes. Figure 15 describes the process of leadership behaviour on follower's performance:-

Figure17: Effects of leadership behaviour on follower's performance



4.6 Discussion Phase 2.

The data obtained from the subordinate questionnaires shows that there is a clear support for leaders who adopt transformational leadership behaviour. The leader who focuses the team's efforts in a transformational style is perceived to lead the group to be more productive and heighten the teams desire to succeed. They are also more likely to demonstrate traits such as good behaviour and showing integrity making ethical decisions provides assurance to the team that the leader is not self-focused. The leaders, who coach staff, develop their skills and provide a clear vision and line of sight between how individuals undertake daily tasks and how this contributes to the organisational goals, are more likely to be perceived positively. Being associated with such a leader makes the subordinates feel proud as they look up to them and admire them. The positive nature of transformational leadership behaviour cannot be underestimated, the resulting cohesion and openness can only be beneficial to organisations.

The purpose of the questionnaire was to examine a number of leadership traits which focused on a range of leadership behaviours. Key issues included leaders who supported staff, were clear on the vision and the followers understood their role in achieving the vision. The leader who showed integrity exhibited a key trait of transformational leadership. This was compared with negative poor behaviour which correlated with poor performance.

The strongest indication of leader performance was in the correlation between behaves well as a leader showing that the leader who values their staff and has a positive outlook and works for the benefit of the team gave a strongly significant correlation value of 0.924. This type of leader also shows transformational traits and is happy to discuss problems or issues having an open door policy, showing the employee they are a valued member of the team. The second highest correlation (value = 0.917) was for leaders who support their staff, spend time coaching their staff and behave well as a leader with the leader being approachable and taking time to be with the staff they manage. They will also be focused on what is best for the group. The third highest correlation value was 0.836 when the leader provides a clear vision, showing a clear line of sight between the vision for the organisation and the job role, and staff feel positive about their leader. Individuals who perceive they have autonomy over their work activity including decision making processes are more engaged with their work and are likely to perform better for their leader.

The more negative responses indicated that targets and decision making if not aligned to team beliefs had a detrimental effect on team performance with a correlation value of 0.466. If poor conflict management was evidenced with a more transactional approach being in place, the team were less likely to be engaged. The supportive manager who behaves well as a leader is likely to get the best from their staff and this is supported in the data collected.

4.7 Summary

The leadership behaviour identified in the open forum was more transactional in nature, however the subordinates of Commissioners identified that leaders who focused the team's efforts in a transformational style were more likely to be productive and heighten the teams desire to succeed. Good behaviour with integrity and making ethical decisions provides assurance to the team that the leader is not self-focused. The passive leadership behaviour (non leadership) had limited evidence of being in place within the findings of the research, indicating that being passive was not common amongst Commissioners.

There was an objective of the research that was specifically associated with this phase and the key findings related to this below:

To identify individual perceptions of leadership behaviour that influences Q&S in healthcare from a subordinate's perspective.

The subordinates communicated a desire to have their leaders show a more transformational style, which in turn would heighten their desire to succeed. The subordinates also identified several desirable aspects for those leaders; those who coach staff, show integrity, are honest and show value to the team members, giving a clear line of sight between job role and the organisation's vision for the organisation. The data supports the notion that the supportive manager who behaves well as a leader is likely to get the best from their staff. Understanding how leaders influence Q&S from a subordinate's perspective provides organisations with clear evidence that the supportive manager or leader creates positive worker behaviour which results in better outcomes for patients. The positive nature of transformational leadership behaviour cannot be underestimated and the resulting cohesion and openness can only be beneficial to organisations.

Risk analysis findings

Chapter 5

5.1 Introduction

This chapter describes the evaluation of the risk analysis process undertaken by Commissioners with the results showing discourse between the anticipated role of Governance within Commissioners, policy framework and actual outcomes expected. At the start of the research process, two clear research phases were identified. For Phase 1, Commissioners were provided with scenarios based on the Mid Staffs enquiry (Francis 2015) and asked to discuss the risks and control measures they would implement. Phase 2 involved the quantitative questionnaire for Commissioners subordinates. It became apparent during phase 1 that the issue of risk analysis was a significant part of the participants' discussions and required further exploration. This chapter presents information on how risks were evaluated and controls defined by Commissioners within the open forum.

5.2 Overview of risk management

Risk as a concept has developed significantly in the 20th century with the classical process being based on the 'management science approach' developed by Knight (1921) which provided a link between risk and uncertainty. The three basic principles included firstly defining the problem itself, secondly understanding the range of possible outcomes concerning the problem and finally objectively assessing the likelihood of each outcome occurring. This basic concept of risk has been defined in simple terms by Myatt (2002) as:

> 'the probability or likelihood that harm may occur, coupled with the consequences of that harm' (p.10)

Moore (2013) describes risk management ‘as the effect of uncertainty on objectives therefore organisations require to be focused on recognising what drives the creation of value and what destroys it’, the value being what sustains the business. Chapman (2011) goes on to define risk as a concept of being able to understand what could stop an organisation achieving its stated goals and expressed in those terms within risk registers a process of documenting the risk evaluation, controls, with residual risks which are ranked in order of priority. The process then informs the board of objectives not being met. The reputational risk exposure is expressed through the board assurance framework which is linked to the strategic objectives of the organisation; for example delivering safe patient care as a priority which may be compromised if training is inadequate, thus resulting in incompetent staff or lack of clinical governance systems to escalate and manage such risks (National Patient Safety Agency NPSA 2007).

To reduce the harmful impact of risk or maximise opportunity to deliver safe care, this can be achieved through implementation of suitable control measures. These could include adequate training programmes and peer review of staff carrying out clinical tasks, along with effective clinical audit systems to monitor performance. Within the NPSA safety model the relationship between risk and control is shown as the dividing line to indicate the assumed positive impact of control on the risk, resulting in better outcomes, therefore reducing patient harm. This principle of funding risk or implementing control measures is the basic principle of clinical governance, which is defined as the way the NHS works to improve the quality of care patients receive and to maintain that high quality of care; ensuring patients get the right care at the right time from the right person and that it happens right first time (NPSA 2003).

5.3 Results of risk analysis

The risk analysis data was collected from the video scenarios and transcribed to review themes that emerged from the discussion. Commissioners involved in the forum described their relationships with providers as often being complex; they felt that as Commissioners they had little control over risks as providers frequently blocked information and avoided passing to them data relating to risks. Although most Commissioners felt they had a close working relationship with the providers, others had a more autocratic and punitive approach. This apparent inability or unwillingness to deal with risk effectively is highlighted in Tables 31 to 35. Of particular concern is the Commissioners acceptance of 'professional drift' (see Table 33) and their reluctance to challenge providers. Whilst Commissioners have the power to put in place contract sanctions, when providers did not 'tow the line' they felt pressured to not overreact when issues had been identified. There was a perception that they could be severely criticised and face additional scrutiny if they raised concerns too early, which were not later substantiated (see Table 35).

The issue of 'professional drift' may have wider implications, as the closeness between the Commissioners and nursing staff may to some extent excuse poor behaviour. Many Commissioners had previously been in the nursing profession and had empathy with the role and challenges staff faced on the wards. This is closely aligned with Berwick's (2013) view that individuals may be part of a system that encourages failure as it is unsupportive or see the issue as normal behaviour. This may be linked to the overall approach taken by Commissioning organisations which may lead to 'strategic drift' which has been described by Johnson et al (2008) as the tendency for strategies to develop incrementally on the basis of historical and cultural influences but fail to keep pace with a changing environment. If the environment is accepting of 'professional drift' this may in turn create organisational strategic drift within Commissioning.

To undertake the risk analysis process the group of Commissioners were provided with an envelope placed on the table, containing the risk scenarios with each described on a separate piece of paper. The group reviewed the documents and defined the order they would evaluate the risks and controls they would implement in the situation described. The sequence they decided on was firstly the finance scenario, secondly misdiagnosis, thirdly culture, fourthly complaints and finally targets.

5.3.1 Finance

Scenario 1: The Board has had to implement stringent financial controls with a deficit of £10M this year. You as a Board member have been asked to implement a workforce cut based on costs, the most expensive Departments needing the deepest cuts of £2m initially. The key issues identified by Commissioners included the following:

Table 31: Finance scenario.

Commissioner 8: The background to the rationale for this decision, the risk to staff workforce have we only considered finance and no other variable, is it just this year or is it re-occurring or current what's the impact on safety impact assessments done, will it impact on clinical effectiveness safeguarding are there any actual hidden cost so if we make savings this year will we actually with costs going forward.
Commissioner 1: Trying to mitigate I suppose it's, it's creating a risk register isn't it on keeping on top of that'
Commissioner 9: Has the appropriate quality impact assessment been done and does it affect patient safety did you have safeguarding individual's processes, safeguarding patients and safeguarding the organisation? I think we are not clear on the information. Although they are controls what are the risks they aren't clear.
Commissioner 4: Some of the controls have to be around the governance and the process cost reduction because a result in a lack of confidence in the organisation, spending all your time dealing with communications' complaints and PR rather than dealing with the cost.

The Commissioners felt there was joint ownership of risks and felt they and the provider had responsibilities for outcomes regarding finance. It was made clear by Commissioners that they also had a board that was held accountable for the actions of providers and the project lead (lead commissioner) had to have an oversight of provider governance procedures in place and how effective they were. When the Commissioners considered the relationship between quality of care and the cost, with finance now driving the NHS agenda, they felt the need to consider a quality impact assessment when a cost reduction is implemented, because it is possible that care could be compromised during this period. With the cost of care increasing and demand going up, this places risks on all services. The Commissioners recognised this would not just affect front line nursing staff but also infrastructure and support services.

The Commissioners view on finance was often based on short term gains however there was recognition that removing or reducing cost in one area was likely to have long term effects in another. The Commissioners recognised that organisations reputation may be affected which may result in increased claims due to poor clinical control and potential for additional complaints against the Trust.

5.3.2 Misdiagnosis

Scenario 2: There have been a number of cases of misdiagnosis, including a failure to diagnose a serious injury in a young man who later died as a result. The manner in which diagnosis is given to patients has left a lot to be desired with patients raising concerns about insensitivity, failure to listen and a lack of compassion being in place. The commissioners responded to this scenario with the following:-

Table 32: Misdiagnosis Scenario.

Commissioner 6: I don't know any clinicians that would set out to cause harm to patients, so if we look at that process, we have systems that are not compliant with minimal clinical standards there's not been compliance with those or else there has not been an audit review, case management supervision of those clinical decisions.
Commissioner 9: Staffing ratios because you could go onto a ward that had twice the number of staff, even if the ward wasn't of high acuity and say it had an excessive number of staff you could say you would still see all of this so it's not just about staffing levels it's about have they got the right staff to deliver high quality care is the measure.
Commissioner 4: I think this is an extreme case where we are talking about people dying but isn't there research that generally errors are made in complex situations and people generally understanding and forgive the errors are made in situations but what they cannot forgive the manner they are treated. If the misdiagnosis isn't acceptable nonetheless the situations worsened by the way the organisation treats them.
Commissioner 6: It's interesting this I think an interesting way to approach this is I mean I don't know any clinicians that would set out to cause harm to patients, so if we look at that process it means we have systems that are not compliant with minimal clinical standards there's not been compliance with those or else there has not been audit review case management er supervision that of those clinical decisions
Commissioner 9: This comes from duty of candour back to Mid Staffs and the patient who didn't have their insulin that medical director had been to the family to say we didn't know your relative was a diabetic they didn't have their insulin they would of done it once and made sure their processes and would let that happen again so it's part of the standard NHS contract, need to absolutely ensuring that the duty of candour is implemented because it can't be comfortable to have those conversations with the family. They're really powerful to make sure the processes are really robust.

Commissioner 8: So we are a CCG and we want assurances from the Trust, we want assurances of we think these are the risks and we think this is the possible control.
Commissioner 1: You know is it one or two people or is it 500

The Commissioners described being pleased if the provider they worked with was interested in identifying concerns early, generated a plan and discussed this with them, describing how they would mitigate the risks. This would be seen as beneficial and preferable to finding out through the press, CQC or other regulators. In addition the Commissioners would feel more comfortable if the provider had a grip on the governance process.

The discussion also included the situation that occurred at Mid Staffs where a patient had died and the Trust was subsequently prosecuted by the HSE for failure to provide adequate supervision. A concern raised within the discussion was that there was acceptance that errors were more likely to occur in complex situations but the patient's families would be more willing to accept this if they were treated with dignity and respect, with lessons being learned. Commissioners believed the way information was passed on to families was a cultural issue. There was also concern raised regarding interim doctors and that not having proper processes in place for inductions, before a staff member started at the Trust, may result in misdiagnosis of patients.

Commissioners also felt it was important to know the scale of the numbers of people misdiagnosed and who had died 'is it 1or 2 or 500' they appeared to have scepticism about the data and wanted a lot more validity to make informed decisions. The theme of wanting more validity to the data is as a result of not wanting to raise concerns early as this may result in being criticised. Commissioners also believed the discussion that a clinician would have with the patient's family regarding a fatality due to misdiagnosis would be extremely difficult, but would make sure that systems were robust and lessons were learned in the future.

5.3.3 Culture

Scenario 3: It has been recognised that there has been a lack of compassion by a number of staff when dealing with vulnerable patients on Ward X. The poor attitude has been in place for a number of years and bullying has been raised as a concern by the Union. There appears to be a lack of structure and rules are not followed. Examples of good management behaviour are difficult to find. It appears that there is a lack of respect from all concerned. The Commissioners described the following:

Table 33: Culture Scenario.

Commissioner 9: The first thing I would want to know is the staff survey results drill down in each division and you wouldn't just to depend on that I suppose it's the test and intelligence you have got and you as Commissioners would want to take clinical colleague with you for your own judgement and you would do that as an unannounced visit then you would want to triangulate what intelligence with other regulators what CQC what monitor have got what Healthwatch have got what complaints your SI (Serious Incidents) say you have got to understand this there is a massive amount of intelligence.
Commissioner 4: Then there is a risk of having to recruit staff to that particular ward would be difficult because of the reputation.
Commissioner 9: If people feel bullied then in theory there isn't appropriate escalation you know you would presume the nursing staff didn't have a voice so your whistle blowing mechanisms your escalation procedure the bullying is a symptom of the overall problem.
Commissioner 5: I think that is exactly right it's about some foundation trusts can close down on you if try to go in too hard and what you really want is a culture of trust and openness between Commissioner and provider where actually they are able to give you the heads up on the concerns they have got or comfortable that you are not going to put that in an extra contractual deal and you can start to develop that relationship. I've worked for provider and I am now in Commissioning

and I think most of us have its really understanding it's not easy out there as a provider but at the same time as a Commissioner you need to be mindful of the early warning signs. Like Mid Staffs and be really stringent on that and ensure controls are being put in place.
Commissioner 4: It's really difficult to change the culture where the workforce is depleted to below really significant safe levels because people can't hear the messages and take on the change'
Commissioner 8: We really need to focus on is that peer to peer challenge most professionals don't veer from you know everyone wants to start off as the best nurse and the best doctor that's why they go into it and you know they drift and that's what happened in Mid Staffs they drift and one thing that didn't happen there was why have you done that.
Commissioner 5: Some Foundation Trusts can close down on you if try to go in too hard and what you really want is a culture of trust and openness between Commissioner and provider where actually they are able to give you the heads up on the concerns they have got comfortable that you are not going to put that in an extra contractual deal and you can start to develop that relationship. I've worked for provider and I am now a Commissioner and I think most of us have its really understanding it's not easy out there as a provider but at the same time as a commissioner you need to be mindful of the early warning signs.
Commissioner 2: That is definitely a control I think one of the risks is the understanding that if the information was to get out might be referral patterns I was thinking what happened at Bristol Royal Infirmary for example.
Commissioner 9: It shouldn't be punitive as nurses and clinicians don't set off to be rubbish in that they do they get 'professional drift' that's because nobody's challenging them or their modelling or poor practice of others

The Commissioners recognised that behaviour and culture are intertwined developing over a number of years and that consistency of behaviour and recruitment of good staff was the key to developing good organisational culture, as they believed good managers tend to be drawn to places

where they can flourish. Equally it was recognised that a bullying and poor organisational culture was likely to increase sickness absence.

The Commissioners saw the importance of gathering good evidence from other agencies including CQC, Monitor, the Unions and Healthwatch in order to triangulate the data, thus providing an overall picture of the organisation. They recognised the issue that waiting for a significant amount of information to be collected is that during the time this is happening, patients may remain at risk of harm. Many of the regulators are still working in a system that reacts too slowly to identify issues until they become safety critical. The Commissioners felt that if the nursing staff felt bullied they would be less likely to be able to enact the whistle blowing procedure where they recognised poor practice. There was recognition that controls for such behaviour required clear expectations, particularly at board level, but this may vary dependant on the board perspective at a given point in time and therefore good and bad behaviour and culture is dependent on board attitude.

There was recognition from Commissioners that many providers may ‘close down’ and not have an open culture about risks but, as lead Commissioner they needed to be mindful about the early warning signs showing poor performance. This provides Commissioners with a paradox as they do not want to react too quickly but want to know the issues to address safety concerns however, waiting for data to support an intervention takes time, this is a direct result of the prevalent blame culture within the NHS.

5.3.4 Complaints

Scenario 4: There have been numerous complaints about the attitude of staff and poor hygiene standards, when staff attended to patients. One member of staff was observed using the same razor on different patients, using the same water in a bowl and not washing and brushing patients' hair' The Commissioners described the following:

Table 34: Complaints Scenario:

Commissioner 9: Why when every member of staff should have had their mandatory training they should of been supervised, so that implies the staff haven't got the information the skills to provide basic skills to provide basic hygiene.
Commissioner 6: Yeh to me it also feels to me like a cultural thing you know this is the way we work round here rather than lack of knowledge.
Commissioner 8: I would want to know what the infection rates are looking like basic care is not there and what the contribution to that.
Commissioner 9: If you were in the infection control team and that landed on your desk the infection control team would be going in to make sure there was appropriate mechanisms you would also want the infection control team to provide evidence of investigations. We don't know how accurate it is sometimes you get complaints and sometimes I'm not saying it's not inaccurate but sometimes you get complaints which is a valid interpretation from a relative but when you investigate that perhaps didn't happen and the razor was red and everyone's razor was red on that ward I don't know but you just need to get the facts right.
Commissioner 9: A strong board leads to demonstrate the right behaviours but to monitor mentor and coach the workforce so you could do a swap round with the workforce. To provide that stronger clinical leadership in the short term to get a champion in until the behaviours change that, the chief nurse in the organisation they usual hold that role and they would be held to account and

deliver on that they would have been appointed on that. There is obviously a patient safety and dignity risk complaints and incidents as a result of that a reputational risk again to the organisation and Commissioners and a risk around the contractual obligations and in terms of controls, the workforce and leadership not just transformational leadership but aspiration leadership this is the standard and this is the best practice to follow and you are aspiring to do your best for the team mandatory training has that been completed and basic things like mentorship and prerceptorship and what are the processes in that in clinical area wanting to do real time patient experience.
Commissioner 2: Doing nothing as an organisation not a very sensible position to be in.

During the discussions, regarding the use of a razor on one patient and then another as described above, there was an expectation from Commissioners that if staff had received basic training they would not behave in a way that was detrimental to infection control or patient dignity requirements, this being a very basic assumption. The Commissioners also recognised that culture within the organisation will have a significant effect on safety outcomes and poor performance. It was also recognised that strong clinical leadership was required, in the form of a clinical champion who could hold staff to account and change inappropriate behaviour; this was likely to be the Director of Nursing. There was some scepticism about the type of complaint received and doubts about the validity 'the razor may have been red but everyone had a red razor.' Commissioners also believed Trusts who did nothing about such complaints left themselves in a very vulnerable position.

5.3.5 Targets

Scenario 5: Targets particularly in A&E waiting times have become an absolute priority. This has resulted in discharging patients early and there have been a number of misdiagnosis of patients. There is a rumour that staff have serious concerns but are not prepared to raise the issue as they may get the sack or it may affect their chances of promotion. Commissioner's described the following:

Table 35: Targets Scenario.

Commissioners 8: I would need more information.
Commissioner 6: We don't know and we do need to find that out as one of the controls how much and when and what but the discharging early is a erm does sound like a clue because what's often happening is they are spending lots of time getting them off the A&E wards and off the lists so they are parked before they can be found a bed so if they are actually saying they are discharging them then they do need that is a bigger risk.
Commissioner 9: You would want to look at mortality rates re-admissions, complaints it's the same we have said for most of these things I don't read it again but it's the issue about A&E and the rumour that staff are not prepared to raise the issues that's raising concerns, risk that isn't substantiated yet I think the bit about this has resulted in discharging early there have been a number of misdiagnosis of patients I think I read that as fact and therefore that is a patient harm patient safety risk and focus on 4 hour wait rather than quality of care.
Commissioner 8: Is there a risk around if you are a Commissioner to act too quickly without gathering the facts as A&E is such a high profile target and it's constantly in the press, if we act too quickly without the evidence that might actually waste time, this creates a fuss where none of these things have been substantiated going in guns blazing isn't always the right thing but then sometimes it might be. It's about balance.

A concern of Commissioners was ‘going in guns blazing isn’t always the right thing’ a balance is required between acting too quickly or too slowly; but if relationships are poor and the culture in the provider is one of hiding data this can be problematic. The concern raised in a large number of high profile cases is the lack of prompt action being taken by the regulators. Gathering evidence is what is required as long as this is timely and does not put patients at risk during the investigation time. The Commissioners also raised concerns about the focus on the four hour wait target times and that without scrutinising re-admission rates, mortality rates and complaints, the evidence would suggest that this was likely to compromise patient care and Q&S. Getting patients away from A&E by discharging them too early, rather than them being admitted to the hospital, was seen as a significant risk to the Trust.

5.4 Discussion of findings

Many of the concerns raised within each scenario resulted in the Commissioners discussing similar themes related to Q&S such as patient safety, lack of perceived accurate data, complaints, reputation, contractual obligations, leadership and culture. Commissioners believed these should be addressed by strong leadership from the board. The board would be required to demonstrate the right behaviours to monitor, mentor and coach the workforce who may require a champion in place until the behaviours change was embedded: they saw this responsibility lying with the Chief Nurse in the organisation, acting as the clinical lead and holding staff to account.

The Commissioners described creating a risk register as a control to mitigate financial risk. There is often a misconception within healthcare that creating a risk register will somehow reduce the risk, when in fact the risk analysis and ranking (evaluation) determines the focus it attains. There is also an issue of passing on control to someone else, this often being the governance department

who manage the risk register system. There is a perception in healthcare that the responsibility is deferred to someone else by placing an issue on the risk register. Risks are often over or underestimated, which can result in lack of or over reaction to outcomes and control measures. This is often due to the subjective nature of risk analysis defining likelihood and consequences that is frequently misunderstood within healthcare; risk ranking if based on individual opinion and power is likely to lead to failure in the risk register system if not effectively checked. Many patient risks are under estimated determined on the decisions of management, and can be downgraded at senior level if the culture is one that is risk averse and does not want to see red risks presented to the board via the risk register.

The Commissioners raised particular concern regarding the financial constraints on organisations which would have a direct effect on clinical effectiveness; this issue was identified by Lankshear et al (2005) who assessed the evidence of the relationship between the nursing workforce numbers with the cost reductions required in healthcare and patient outcomes in the acute sector. The research evidenced that higher nurse staffing ratios and richer skill mix, with more registered nurses, was directly linked to improved patient outcomes. This was supported by research by Needleman et al (2002) that identified a higher proportion of hours per day of nursing care provided by registered nurses rather than healthcare assistants (HCA) are associated with better care for hospitalised patients. This comes at a cost and HCA's are cheaper than qualified nurses and along with agency staff are therefore used more frequently in the current climate to support the shortfall in nursing numbers.

The latest guidance from the National Institute of Clinical Excellence (NICE 2014) provides advice which is designed to help ensure safe and efficient nurse staffing levels on hospital wards in response to concerns about standards of patient care in the aftermath of the Mid Staffs scandal. The Francis report (2013) explicitly stated the level of staffing directly led to the poor quality of care.

The report identified that NICE should be the lead organisation in the development of guidance for the NHS on staffing levels. However with different acuity there is no single staff number that can be safely and adequately applied across the wide range of wards in healthcare. The NICE guidance committee concluded that each registered nurse should not care for more than eight patients and at this point an evaluation of risk of harm should be undertaken by the hospital Trust.

Clearly safe staffing is more complex than setting a single ratio, with many Trusts not achieving the target on night shifts. The emphasis should not just be on the available number of staff, it should be on delivering safe patient care, making sure that hospital management and nursing staff are absolutely clear on the best practice to achieve this. It has been estimated by NICE that the initial costs of putting this is in place will be offset by the savings that can be achieved through safer care. Potentially over £1 billion can be saved by preventing pressure ulcers, while reducing the number of infections patients contract after surgery could save up to £700m a year alone. Implementing the NICE guideline is likely to have significant financial impact in many trusts, but NICE believe they may simply need to adapt their processes to work out where nursing staff should be at any given time (NICE 2014). This is a simplistic view and often not practical in reality on wards that require specialist skills to deliver safe patient care; simply moving staff around a hospital is not a realistic option.

The Commissioners believed that an effective clinical audit system would be a suitable control measure to address the issue of misdiagnosis and poor practice. This was seen as a tool for improving the quality of patient care, providing a comprehensive framework that improves processes for monitoring clinical care using good timely information and effective record keeping. The process of clinical governance which is the over-arching principle of clinical audit provides a formal approach to questioning clinicians, allowing patients views to be heard to and gives managers the opportunity to generate assurance of effective practice and where necessary provide

additional resources to change such practices if required (Myatt 2002).

The process of clinical governance and risk management was highlighted by Donaldson (1998). When reviewing patient safety in healthcare he anticipated that the two processes when merged would increase the resilience of the NHS and improve quality by preventing serious service failures. However, since the inception of clinical governance there has been a continuity of serious service failures transcending a number of government administrations, often with catastrophic consequences for patients. Some of the most notable events in the last two decades have included the conviction of Harold Shipman on 15 counts of murder (Smith 2002); the conviction of Barbara Salisbury on two counts of the attempted murder of patients in order to free-up beds on the ward and achieve performance targets (Healthcare Commission 2007); the outbreak of clostridium difficile (C-diff) infection at the Maidstone and Tunbridge Wells NHS Trust (Healthcare Commission, 2007) resulting in 150 additional patient deaths and the conviction of Victorino Chua, jailed for killing two patients and poisoning 19 more at Stepping Hill Hospital (BBC 2015).

Moore (2013) describes these events as demonstrating that clinical governance alone has been ineffectual at reducing the risk of serious failure. The key question here is whether serious service failure is a consequence of insufficient clarity on clinical governance or whether there is some other explanation, such as the capacity to respond to uncertainty within the NHS. Moore further describes the concern that even if governance is clearly understood it is unlikely on its own to prevent serious service failure. This is because simply understanding governance is not enough: A recent Harvard Business Review study (Sonnenfeld, Kusin and Walton, 2013), highlighted that boards need to understand the risk-reward envelope, refrain from rubber-stamp decision making and engage in energetic debate in the boardroom to promote understanding and adaptation of risks.

In other words, to not ignore risk or see it in personal terms with boards requiring better understanding of how to deal with uncertainty in order to protect everything of value.

The culture within healthcare is a significant issue as this directly influences all the elements discussed in the five scenarios and this was recognised by Commissioners. The NHS staff survey in 2013 described poor management that had resulted in very low morale amongst NHS staff. The survey also identified poor communication, a perception of management as not appreciating their staff and staff feeling that decision makers did not have sufficient clinical expertise to make good judgements. The survey highlighted a cultural problem in the NHS, with 35% of respondents reporting having received verbal or written abuse by a NHS colleague. These findings suggest there is a long-term problem with the work culture within the NHS (Murphy 2014). This was closely aligned with the discussion by Commissioners on complaints regarding raising concerns and whistle blowing, which is a serious and contentious issue within healthcare. It is difficult to understand why the NHS would need whistle blowing policies when the patient care should be everyone's responsibility and driver for all organisations. The Chair of the Health Select Committee, Dr Sarah Wollaston MP, said that:

> 'Whistle blowing is an outcome of 'the standards of leadership in the NHS' which needs to be addressed' (15th January 2015)

The Health Select Committee goes on to note that the NHS needs to be 'moving to a culture which welcomes complaints as a way of improving NHS services.' We are seeing the language of 'complaint' and 'grievance' as the norm in healthcare. If the culture and people aspects of an organisation are right then there should be the opportunity for the voice of any member of staff who has concerns to be listened to by any level of management and leadership, meaning that matters can be dealt with before they reach the stage of 'complaint' or 'grievance.' Andrew (2015) further describes the issue of the distance between the senior leaders of organisations and their

employees, giving a sense of disengagement and lack of trust, with managers and leaders who have developed the 'hard' skills of management, strategy, structure, process and less around the 'soft skills' of culture and people management.

The Commissioners discussed the impact of targets on Q&S in healthcare with the four hour wait target time becoming a major theme to regulate the individual and collective timescales of healthcare work. The process of developing the target has resulted in the compartmentalisation of emergency departments, clinicians and their workspace. It has speeded up clinical performance and patient throughput, however Vezyridis and Timmons (2014) identified that the imposition of a wait-time target has led to the development of new and sophisticated ways of working which consist of a complex arrangement of people, process, technology and space, none of which was intended by those who originally framed the four hour wait target for A&E. There is wide agreement among clinicians that this target has raised the profile of the Emergency Department (ED) in hospital and concentrated efforts to address patients' dissatisfaction with waiting times. It forced clinicians to self-examine their practices and rethink the way they manage information and patient flows. At the same time, it has placed added pressure on them, which is likely to affect their interpersonal relationships with patients and colleagues.

During the winter of 2015 the rapid increase in medical admissions to ED departments resulted in many declaring a major incident, a largely unexplained phenomenon which has been attributed to all manner of factors. These include issues such as the ageing population, breakdown of the nuclear family resulting in the elderly living alone, more conservative GP behaviour which in turn increases hospital admission thresholds, medical technology, increasing expectations by the public and the failure to integrate health and social care. It has recently been highlighted that emergency medical admissions do not grow as a continuous trend, as would be expected but tends to grow in distinct spurts which coincides with points at which deaths show an unexplained large increase

(Jones 2015). This increase in death rate has never been adequately explained and peaks in death and in the absence of a clear explanation have largely been ignored. Due to the fact that emergency admissions tend to cluster in the last months of life there is well documented relationships between occupied bed days and deaths. It is important to note that the increase in deaths is just the tip of the iceberg in terms of medical admissions.

In (Graham) 2012, 200 deaths corresponded to increases in admissions, the rate equating to 20% of additional admissions to A&E. Mortality rates tend to decline back to baseline while the impact on admissions tends to be ongoing. All the evidence is points towards a recurring series of infectious outbreaks which dominate the trends in deaths, admissions and the trends in age-standardised mortality. It is therefore not surprising that financial and activity models are proving to be inadequate to measure this outcome of the target driven approach.

The NHS system has often relied on reactive data sets such as mortality rates to evaluate performance and is often based on harm caused by not managing emerging risks. The NHS is considerably behind other industries when reviewing risk, with inadequate safety systems in place and a poor culture. Vincent et al (2015) identified that often quick wins are the norm in healthcare when a more substantial system redesign is required, recognising that the latter will take time and persistence to deliver. Commissioners, regulators, policy makers and politicians recognise that process management and reliability in health care requires long-term mainstream investment and attention, rather than expecting sufficient progress to be made through individual short-term initiatives alone. Commissioners require understanding that risk and reliability are significant and complex challenges for health care. Providers should be supported to develop and share their insights into the nature of the hazards and risks in their systems, rather than assuming that it is possible to set sufficient meaningful performance metrics externally by Commissioners who directly influence performance outcomes (Vincent et al 2015).

The overall approach to risk taken by Commissioners is not effective and waiting for information on mortality rates, CQC inspections and other sources to determine risk evaluation processes is problematic. Myatt (2002) believes waiting to rank risks in such a precise manner becomes an end as opposed to a means to an end. Risk is a process of planning, organising a direction or programme that will identify, assess and ultimately control risks. If the blame culture reduces Commissioner's capacity to make decisions this leaves patients vulnerable. The risk management process offers a framework in which to operate the business of healthcare in a safe manner if used appropriately. The complexity of issues raised within the scenarios often mean that behaviour forms the basis of risk outcomes and actions, with leaders having the final say on direction of travel and potential outcomes for patients.

The Health Foundation (2014) recently identified that a more collaborative leadership approach is needed with proportionate risk based regulation. The CCG's will need to develop payment methods that pump prime investment, working on a system wide collaboration with providers and Commissioners to achieve change. They also describe a significant risk of quality of care being compromised by the current financial position of Trusts. Indicators such as targets for A&E waiting times are the main focus, yet other important indicators with less political visibility may be missed due to a failure to focus on all significant risks.

5.5 Summary

The results of this section of the research show that outcomes of risk evaluation made by a group dominated by a small number of Commissioners, who accept ‘professional drift’ results in risks not being accurately assessed. The domination of groups by a small number of individuals results in limited discussion and can compromise the view of the controls required, as some members of the group who do not have a voice have little contribution to outcomes. Commissioners discussed the importance of triangulating different sources of data including staff and patient surveys, friends and family test, CQC, Monitor and Healthwatch as well as complaints handling procedures, to provide evidence to inform the risk registers. The theme common throughout the scenarios is the conflict between reacting too quickly and gathering sufficient data to avoid criticism as a Commissioner of healthcare services. This lack of risk awareness shown in the open forum leaves the potential for patient safety to be compromised if avoidable risk activities are poorly evaluated.

Discussion of findings

Chapter 6

6.1 Introduction

This chapter discusses the two phases of the research undertaken and provides an overview of key themes from phase 1. It provides an insight into how leader's behaviour both transactional and transformational is evidenced within groups and how this directly impacts on the outcomes within healthcare; the discussion focuses on the context of healthcare, providing an overview of current healthcare environments in which Commissioners work, followed by leadership behaviour, group decision making and non-verbal communication. Phase 2 provides evidence of subordinate's preference for a transformational leadership style and discusses how leaders who show integrity, make ethical decisions, positively support staff with high levels of engagement are more likely to achieve organisational goals. This sits within the culture of healthcare which cannot be viewed in isolation as the complexity of demands and relationships between Commissioners and providers reflect outcomes in Q&S.

6.2 Context of healthcare

Despite the recent wave of negative headlines and concerns over significant lapses in quality within the NHS, many areas have shown signs of continued improvements. Compared with ten years ago waiting times are much shorter. There is also evidence of improvements in safety in areas such as healthcare-associated infection and with more doctors and nurses being deployed on the front line. However this has been confounded by a significant increase in demand with indicators that the NHS gains are being eroded or even reversed due to the lack of capacity to deal with the extra demand (Quality Watch 2014).

Quality Watch's annual statement (2014) indicated that quick access to services has declined in some settings over the last two years, with mental health services demand outstripping capacity to deliver urgent care. Substantial inequalities in the provision and outcomes of care persist in healthcare with many marginalised groups not being treated within appropriate time frames. A number of areas have improved, including child health and cancer outcomes. A critical question for healthcare providers and Commissioners is at what point do the lapses in performance and quality become intolerable to patients, politicians or those running health and social care services. The NHS is at a turning point where it will be required to make difficult decisions about which services to continue delivering, with the resources currently available. Commissioners will need to make the difficult decisions based on cost risk and patient needs.

The process of decommissioning services was a real concern, with Commissioners in the open forum believing patients wanted services near where they lived, so closing even a failing service was difficult as political and local pressures to keep a service open were paramount, when in reality such services should be closed for providing substandard services and poor Q&S outcomes. It may be extremely difficult to decommission a service in this type of scenario and would take a very strong will not to bend to pressures imposed from external organisations. The dilemma facing Commissioners within the NHS is, how to address the pressure to conform when they are used to managing on a day-to-day basis the resources they control. This can be a particular problem because of the background of Commissioning managers who typically have been trained over many years to undertake operational responsibility within healthcare and now are responsible for strategy and political rather than clinical decision making (Johnson and Scholes 2008). The strong relationship many Commissioners' have with providers may adversely influence the decision making processes they need to take to address shortfalls in performance.

6.3 Commissioners leadership behaviour

From the evidence provided it appears that there is a difference between the leadership behaviours that Commissioners exhibit in the boardroom (transactional) and the leadership behaviours (transformational) that their subordinates expect and desire them to demonstrate. Bass & Avolio (1997) describe the positive leadership traits of transformational leaders, claiming they display characteristics which include being a role model for the team and providing a strong sense of purpose by the sharing of a common vision and goal. This is contrasted with their view of transactional leadership which is mainly based on contingent reinforcement which is dominated by the threat of sanctions should required performance levels not be met. Therefore Commissioners, who exhibit transactional leadership behaviours in the boardroom, may replicate this behaviour when dealing with their subordinates, thus weakening the potential performance of these teams. In addition the predominance of transactional leadership behaviours may account for a small number of Commissioners becoming dominant within the group. This in turn could lead to a lack of shared leadership, which Poksinska et al (2013) state is required to get the best performance from groups.

Mosadeghrad and Ferdosi (2013) argue that no universal leadership style is required but a variety of styles are needed to direct employees effectively. This may be difficult if the leader does not recognise how their own approach affects subordinates. A recent report by the Chartered Institute of Personnel and Development (CIPD 2014) stated that when an employee had a good line manager this would improve productivity, however organisational culture and the environment they work in can counteract the good work of line managers if not clearly aligned. The better the leader the more likely they are to be perceived as showing good behavioural traits by followers.

According to Hoogeboom and Wilderom (2012) behavioural complexity theory, effective leaders utilise whatever behaviours are required to meet the demands of the situation. It has been

suggested by Lawrence, Lenk and Quinn (2009) that effective leaders must lead and manage simultaneously. The role Commissioners play as external leader Commissioners play to providers requires skills such as coaching, facilitating and educating to be most effective. Poksinska et al (2013) states that self-managed teams require shared leadership, which focus on various roles within the team and include effective internal dynamics and good relationships between team members to get the best performance. The influence that Commissioners have on internal teams of providers is not evidenced in the literature as this is dependent on the team development stage and access to the influence from Commissioners which may be infrequent and transient.

The ultimate norms of Commissioners may need additional analysis, with some individuals being given more authority and status dependant on the importance placed on them by the most animated or verbal leader within a specified group. Drawing individuals into the group to give them a voice is a positive tool required by the official or unofficial leader, providing a more focused decision making process. A review of the open forum suggested that dissenters were often seen as negative and were easily dismissed by the group. Working collaboratively with likeminded individuals was established early and often involved mirroring of non verbal communication which provides assurance of intended behaviours and actions.

6.4 Group decision making

When we consider the Commissioners as a group it is important to reflect on the recent report into Morecambe Bay (Kirkup 2015) which identified a picture of denial existing, with a strong group mentality amongst midwives who became hostile if criticised. As a team member, voicing objections or concerns to a superior in an environment with hierarchical management structure and strong group norms in place may be intimidating. The report further identified a distortion of

the truth in responses to the investigation and disappearance of clinical records which had evidence of poor clinical practice. This type of behaviour would make evaluation of risks by Commissioners extremely difficult and would be a particular concern given the description they made of providers 'closing down' and withdrawing information. In addition to the issue of "groupthink" (Janis 1972) expressed the view that it is easy to see how strong leader preferences can lead to flawed decision-making process particularly if a group is devious about hiding information. Lieberman et al (2004) defined group behavioural norms as:-

> 'implicit or explicit shared agreements among the group members about relevant behaviours, ways of thinking, and modes of effective expression' (p.265).

They suggested that, in general, adherence to group behavioural norms provide predictability and stable interpersonal interactions within groups. The specific behavioural norms of a group are generally considered to be the product of inter-actions between group members, which in the case of Commissioners will be clinical staff. This raises the issue of how their own set of behavioural norms from their primary reference group are established; this is important if the primary reference group show deviant behaviour (Lieberman et al. 2004).

The normalisation of inherited deviant behaviour has been a common characteristic identified in a number of enquiries. Chullen (2010) states that deviant behaviour within organisations is created by a lack of control organisationally, which in turn risks organisational reputation. The process firstly results in deviant behaviour directed at the organisation which may include theft, sabotage and voluntary absenteeism through sickness rates. Secondly this is likely to increase harassment, bullying and aggression between staff members resulting in poor treatment of patients. If individuals don't feel engaged with the organisation this type of behaviour is likely to increase. To deal with this high quality leader member exchange is required to ensure the employee perceives leaders as emotionally supportive towards them, trusts them and gives them positive feedback.

Poor communication and behaviour of leaders are reciprocated by their employees. When employees believe the organisation cares about their wellbeing they develop trust in the organisation and this improves outcomes for staff and patients. If the perception is one of poor performance and this becomes normalised this will increase violations of healthcare standards. The Commissioners in this case will be seen as external leaders who can influence outcomes by their behaviour towards providers.

The study by the researcher and Laing (2014) described Executives beliefs and norms of behaviour being cascaded from external bodies:

> ‘look up the style of the Department of Health (DoH) and its cascaded down so you set a target that sets the pace and targets have got to be delivered in very strict timelines and if there is a failure there is a kicking all the way down the line so that creates the behaviour because you are not truly autonomous even if you are a foundation trust you still have to comply with these monthly targets whether you think they are good or bad’ (p.186).

The report by Francis (2013) on Mid Staffs described the government as having a lot to learn, with the DoH being criticised for being too remote and not always putting patients first, prioritising policies over patient safety. Francis also warned that while there was not a culture within the DoH that could be properly described as bullying, there was evidence that:

> "Well-intentioned decisions and directives have either been interpreted further down the hierarchy as bullying, or resulted in them being applied locally in an oppressive manner" (p.63).

The conduit between the DoH and providers are Commissioners, however they did not feel empowered to control providers, with different relationships existing. A number of Commissioners have close relationships while others have a more autocratic punitive approach. Commissioners often did not feel in control of providers and described the power not always being with them depending on what type of relationship they had. Important themes to Commissioners included risk and leadership but this was compromised due to gaps in the system and how provider organisations may close down and withhold information. Many of the Commissioners had real empathy with the providers who they saw as having a very difficult job, so holding them to account by tackling poor performance may be problematic. Commissioner 6 described an organisation that had issues with safeguarding and had been failing for a number of years. They described the CQC going into the organisation and the results were not decisive and organisations are left middling along which left patients at risk and all stakeholders dissatisfied.

When considering this research the process identified that often leaders emerge from groups and were predominantly transactional. This makes risks difficult to assess for a new group if the behaviour influences decision making, sympathy with providers may also increase the risk of poor practice being left or ignored. It is feasible that if conditions are right control is lost quickly, particularly if there are long lag times from gathering comprehensive data sets from reactive incidents to support a decision on withdrawing a service. Doing more for less and significant pressures on targets and finance produce the same scenarios that created Mid Staffs and is therefore more likely to occur. This view is shared by Reid (2012) who believes the stark reality of the Mid Staffs enquiry is likely to be repeated as the variation occurs between environments, professions, organisations and health communities.

The risk of a repeat of Mid Staffs is compounded by risks not being escalated as staff are more concerned with job security, self-preservation and wanting to avoid being identified as being a troublesome employee, than raising patient risk they observe. The will of policy makers to make a more transparent system has been placed as a key priority, with the specific duty on all staff to raise concerns through the duty of candour, a key finding of the Francis report. However the implementation of the duty is unlikely to change outcomes if poor behaviour and group norms persist. Cooper (1998) suggests that this is because sections or departments within healthcare organisations will be subject to different customs and practices as well as differing levels of risk which will in turn increase the emphasis on compliance to safety, directly influencing the way safety is managed on a working level.

Janis (1972) observes that it is easy to see how strong leader preferences can lead to flawed decision making process in groups. For Commissioners this could be focused on the reluctance or inability of others within the group to identify or raise concerns relating to risks, a situation that Ashforth and Anand (2003) identified as being evident in Mid Staffs. Unless recognised and addressed, such transactional behaviour is likely to remain a characteristic of Commissioners, even if Commissioners are replaced. Yalom (1995) suggests that group behavioural norms are rarely discussed explicitly, but members learn these norms by observing the behaviour of the others within the group, hence the potential that transactional leadership behaviours will be "inherited" by newer members and remain a significant characteristic of the group.

McGrath's (1995) functional leadership theory advocates that leaders do whatever their direct reports need from them to be successful; the subordinates are likely to mirror the behaviour of the leader. Performance management behaviours are required by leaders to be successful in their roles. Morgeson, DeRue and Karam (2010) state teams will perform effectively at various stages of the team performance cycle as long as leaders engage in behaviours ranging from monitoring goal

attainment, high quality communication and effective coaching. It is vital that the leader lets group members know what is expected of them (Judge et al 2004). This was clearly
seen in the questionnaire responses from subordinates of Commissioners which evidenced that clearly aligning the role with the organisational vision, providing clear expectations and having a leader who showed integrity was likely to provide the best attainment of goals within teams.

6.5 Non-verbal communication

When examining Commissioners non-verbal communications it is clear that non-verbal communications directly influence the decision making within the group; Yammiyavar (2008) believes gestures may take precedence over verbal expressions. Mehrabian (2010) estimated that non-verbal communication can have up to 55% impact on outcomes between individuals. Certain behaviours can be better understood only through the interpretation of non-verbal cues with body movements being the only way to identify communication between individuals.

This study identified a number of examples of non verbal communication including, firstly readiness and enthusiasm to get the process going; evidence of this activity indicated by Commissioners who often began the discussion by sitting forward in their seats or sat in an erect position. They were also alert with wide bright eyes and often very animated. If the leader fails to take notice and initiate rapport during this enthusiasm stage, the user is likely to become either restive or defensive. The second element that may arise is frustrations which are called ‘adapters,’ because the individual unconsciously tries to adapt by lowering frustration levels through rhythmic actions such as touching or stroking themselves (Kendon 1981). Nervousness is indicated by people who cover their mouths when they speak this was viewed frequently by the Commissioner leaders in the group.

When evaluating behaviour it is important to know about and recognise gesture signs of nervousness and non-verbal cues are a rich source of information as to the state and behaviour of individuals (Pease 2011). Arms across the chest indicate that individuals are protecting themselves; this was evidenced by Commissioners indicating fear of participating or hesitancy. Open hands and arms, especially extended, indicated a receptive individual and was seen in the three main leaders.

The non-verbal cues often did not match discussions but the combination of being animated and verbally assertive gave power to the strongest leaders in the group. The most dominant in the group was the most open verbally and non-verbally, by having open palms during conversation, yet was more transactional over all. This indicates the complexity of individual and group interaction.

The Commissioners who led the group often had high levels of energy, Sandy's (2009) research identified that poor communication affects team performance. This is likely to include the level of energy and nature of exchanges among team members, being a critical component to improve performance. Normal conversations are often made up of many of these exchanges and in a team setting more than one exchange may be going on at a time.

The key dimension of communication is engagement, which reflects the distribution of energy among team members. If all members of a team have relatively equal and reasonably high energy with all other members, this helps the group perform. This was not evidenced in the Commissioners group as they had three key people who were highly active and others who were more passive. Teams that have clusters of members who engage in high-energy communication while other members do not participate don't perform as well and therefore result in failure of the group overall to make sound decisions.

6.6 Leadership and culture

The Phase 2 data obtained from the subordinate questionnaires shows that there is a clear support for leaders who adopt transformational leadership behaviour. The leader who focuses the team's efforts in a transformational style will lead the group to be more productive and heighten the teams desire to succeed. Good behaviour, showing integrity, making ethical decisions provides assurance to the team that the leader is not self-focused. Leaders who coach staff, develop their skills and provide a clear vision and line of sight between how individuals undertake daily tasks and how this contributes to the organisational goals, are more likely to be perceived positively. Being associated with him/her makes the subordinates feel proud, as they look up to and admire him/her. The positive nature of transformational leadership behaviour cannot be underestimated, the resulting cohesion and openness can only be beneficial to organisations.

This cannot be reviewed in isolation as the culture and context of healthcare directly affects behaviour. Leadership and culture are conceptually intertwined and common traits include: observed behavioural regularities, the way people interact, the language they use, the customs and traditions that evolve with embedded rituals employed in a wide variety of situations. The implicit standards and values of an organisation often evolve in working groups and ultimately result in the concept of culture as 'the way we do things round here' (Handy 2000). The complex structures and roles within the NHS may mask a culture which is unique within different departments. Leadership involves influencing a group of individuals who have a common purpose but if the common purpose is flawed by culture, failures will occur.

It is a widely held belief that an organisation's performance is reflective of its underlying culture and directly affects leader's behaviour. Where there is evidence of failure in healthcare there is often a call for a change of mind-set, leadership philosophy and culture (Waterson 2014). This reflection is where the term 'patient safety culture', first described by the National Patient Safety Agency (NPSA 2003) came to the fore.

The concept of changing behaviours in healthcare is not new as has been seen in a number of high level enquiries, identifying lessons not being learned and similar failings occurring. In 2007 an investigation into a poorly managed clostridium difficile outbreak killing 150 patients, at Maidstone and Tunbridge Wells NHS Foundation Trust (Healthcare Commission 2007), identified a lack of clear responsibilities, with considerable change over the relevant period in the structure relating to governance and the management of risk. The influence of transactional leadership may be detriment to raising concerns about safety and requires a desired shift in behaviour of Commissioners and providers if major disasters are to be averted.

Culture cannot be underestimated (Pauwells 2012) and the commitment we have to the organisations we work for directly influences the discretionary effort likely to be given to the work undertaken. The engagement of staff is also critical, leaders are the most audible, unavoidable and potentially influential communication feed to employees and thus have the ability to drive and enhance change (Sparrow 2012). When organisations have not established the cultural norms expected this may be problematic when evaluating risk and leaders behaviour.

Commissioners are crucial in the drive for change in the health system and to influence the culture of partners to help them overcome challenges, bringing reform and efficiencies. Commissioners also need leadership partners with frontline experience of health service delivery to help them identify where improvements can be made, designing services that most effectively address

patients' needs (Venerus 2014). Neither leadership nor culture can be understood by itself. Shien (1992) argues that the only thing a leader can do is to create and manage a culture, the culture of the relatively new CCG's and Commissioners is unique and evolving. The ability of the leaders to firstly establish the culture and understand how to work within existing cultures can be a complex issue to address (Van Dyke 2006). The subordinates of Commissioners clearly indicated that they had a preference for a culture that coaches and supports staff, listens to their concerns and engages them effectively. The outcome of this approach will have more positive outcomes on staff performance.

The desire of Commissioners subordinates for appropriate behaviours should be duplicated by Commissioners who oversee providers. The complexity of the commissioned services such as carrying out operations, dispensing medication, caring for patient needs involves a complex number of actions by numerous professions and systems. This requires effective coordination to result in positive outcomes. In healthcare the difficulty with the current regime is the system is often understaffed and increasing demand on services has resulted in cognitive overload for some staff, which creates the conditions likely to cause errors. Reid and Bromley et al (2012) believe that stress impaired cognition can mean individuals make decisions too slowly, too quickly or inappropriately, this is particularly important if the leader is aggressive or unapproachable and staff would be less inclined to speak up or raise concerns. When there is a consistent failure in the system to address the stress overload we are often surprised when a catastrophic event occurs.

The Commissioner's view on leadership identified that they thought it was important to challenge a colleague's behaviour, with leadership coming from a number of sources, not exclusively from senior management. They believed the culture of the organisation was influenced by all staff. Commissioners also felt that it would be much better to be challenged by a colleague or peers at an earlier stage rather than have the discussion with a relative of the patient at a later stage were a

clinical intervention may have gone badly wrong. It was felt that if all staff challenged, and had the right to do so this would likely decrease the risk of harm to patients. They also believed transformational leadership was the approach they should all be taking at all positions within the organisations they manage. However there was recognition that if an individual within the ward or department had a different view to others, there was a risk of either being absorbed into a poor culture or kicked out. This may result in those individuals who raise concerns being bullied or isolated as they do not fit into the group norm or behaviour that has been developed within the organisation.

NHS England (2014) believes a major challenge facing healthcare is culture, but change takes time and requires effective leadership. Boards must involve themselves in the process and act in ways that promote a 'just culture' as opposed to a blame culture.

> 'The primary need is to move from a culture which focuses on 'who is to blame' to one focused on 'has the safety issue been addressed?' and 'what can we learn?' Without this, senior levels of organisations will remain ignorant of important concerns, some of which give rise to serious safety risks' (p.6).

NHS England through the Leadership Academy (2013) has established a set of safety-leadership behaviours that can be used in leaders' hiring, in appraisals, in leadership development and in promotion. The shift in leadership behaviour should form the basis of a safety-leadership behaviour assessment. Boards and leadership bodies should employ structures and processes to engage regularly and fully with patients and carers, to understand their perspectives on and identify contributions to patient safety. When we look at what defines credible leader's behaviour Kouzes and Posner (2003) found that the most effective leaders are those who are believable; firstly they listen to staff and secondly they enact those words through positive action. If leaders

espouse one set of values then consistently act on another they lose all credibility. It is therefore important for messages from leaders to be framed appropriately providing shape and structure for the organisation with authentic connection with an individual's reality. In healthcare having the vision for the organisation is a positive step, however if it means different things to different people this can be problematic (Bibby et al 2009). The vision therefore requires effective measurable steps towards its outcome goal.

The Advancing Quality Alliance (2013) response to Francis enquiry described leaders needing to keep Q&S high on the agenda as finance and organisational pressures can lose their focus on true priorities. The Commissioner's behaviours and actions are at the forefront of developing positive outcomes for providers. If Commissioners are not fully assessing the impact of decisions and the leaders of providers hide or do not clearly understand the workforce demands, the impact of sanctions and non compliance of providers could be catastrophic for patient safety outcomes.

6.7 Summary

Commissioners identified risks, focusing on detail and a less punitive approach towards providers; they had a real concern about jumping in too quickly. Commissioner's looked for the provider themselves to identify shortfalls and give them information regarding risks. The culture of 'we are all in this together' has a significant influence on risk evaluation and perception. The concept of shared leadership described by Poksinska et al (2013) advocates that self-managed teams require focusing on various roles within the team; to be effective internal dynamics and good relationships between team members and external organisations are required to get the best performance. Transactional leadership behaviours may be "inherited" by newer members of the Commissioners organisations if this remains the groups most significant characteristic. This may result in poor relations and ultimately poor performing providers of health services.

Conclusion and Recommendations

Chapter 7

The evidence provided in this research indicates a difference between the leadership behaviours that Commissioners exhibit in the boardroom (transactional) and the leadership behaviours (transformational) that their subordinates expect and desire them to demonstrate. According to Hoogeboom and Wilderom's (2012) behavioural complexity theory, effective leaders utilise whatever behaviours are required to meet the demands of the situation. However the concern persists that the failure of Commissioners to exhibit transformational leadership behaviours in the boardroom will be replicated in their dealings with their subordinates, thus weakening the potential performance of these teams. The predominant transactional leadership behaviours may account for a small number of Commissioners dominating others within the team and providers may avoid raising risks and concerns with them.

Over the next five years (and beyond) the NHS will increasingly need to dissolve the traditional boundaries between services, as a central task of the NHS will be focused on the long term conditions of patients and their management; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. As a result there is now a wide consensus on the direction that the NHS will be taking (NHS England 2014).What is not clear is how boundaries and responsibilities will be effectively managed as a result of this change. The role of Commissioning services however, is a key element in the change required within the healthcare system and therefore the actions and leadership behaviours of the commissioners will become increasingly significant.

The current desired shift in emphasis towards greater autonomy, responsibility and accountability combined with a strong orientation towards patient care and compassion (which requires timely, effective clinical interventions and practice), represents a contemporary modification in the desired leadership model for the NHS. The current leadership model identifies behavioural norms required but is used infrequently through 360^0 feedback to a small number of participants. These emerging high priorities need to be reflected in a leadership model suitable for the time and balanced with an appropriate health behavioural theory. A broader leadership model that considers how to make employees feel psychologically safe to discuss errors or concerns, will provide better outcomes for Commissioners and providers.

This research has identified that Commissioners' leadership behaviour, to be effective requires them to pay close attention to setting the tone, communicating clear objectives and attending closely to culture that creates an atmosphere of trust between individuals and organisations. In addition Commissioners (as leaders) must seek and encourage far more than just compliance seeking behaviours. Empowering staff to undertake their roles and take responsibility is a positive approach that will enable changes in healthcare to succeed. If however, the prevailing strategies in healthcare rely on theories of control (including the scapegoating of staff) and standardised work which re-invent the system remain, then such changes are doomed to failure.

Whilst accepting Giessner et al's (2013) argument that the artificial environment created for research may not reflect a true picture of how a group would behave in a field setting or workplace. This research did provide evidence that leadership behaviours could be measured using a unique set of parameters to explore environmental behavioural intentions in a workplace setting - specifically within the context of Commissioners in healthcare. Further research to establish the links between verbal and non-verbal measurement should be explored to determine an effective behaviour analysis tool for observation of leadership styles.

The distance seen between the shop floor and board level strategic risk is a significant gap in healthcare; developing systems of good governance and effective risk management is still a significant challenge despite the numbers of high profile enquiries. Systematic mechanisms are required to follow up any actions to share lessons, with the enactment of the duty of candour and more effective whistle blowing systems. Overall, if leadership behaviour is not addressed the system that is intended to bring clinical risk to the attention of the board may not function effectively as boards may remain insulated from the realities and problems on the general wards. Waiting for triangulation of evidence from a variety of sources including CQC, Monitor and Healthwatch before Commissioners take action, due to them feeling they may be criticised, has the potential to put patient's lives at risk.

Commissioners should encourage a mature understanding of the nature of risk and harm through consistent messages and action, liaising with other regulators and other agencies. The cultural aspects of organisational behaviour requires further exploration at provider and Commissioner level as local goal-setting systems and integration will require consistent and stable leadership (Health Foundation 2014).

A wider view of policy and values placed on healthcare workers needs to address the discourse between the desire to deliver safe, effective, quality care and the realities of what's happening on the wards. The culture of how things have always been done, media misconceptions about the NHS and what can be done needs addressing (Bibby et al 2009). Currently the prevailing strategies in healthcare rely on theories of control and standardised work which re-invent the system. Empowering staff to undertake their role and take responsibility is a positive approach, however if scape-goating of staff occurs, blaming them when the system fails. The significant changes required within healthcare will not succeed. The work of Darzi (2008) advocated that leaders are

given the support needed to make change happen, with a long term social movement approach connecting the hearts and minds of healthcare staff. This will not only establish the vision but ensure it is enacted throughout the healthcare system.

This research had limitations; with a small number of participants undertaking the open forum, the expectation was that two sessions could be filmed simultaneously to provide a stronger correlation of data. Targeting future research on specific days when audits take place for Commissioners may be advantageous in gaining more participants. A more co-ordinated approach with the Northwest Leadership Academy to make the event more educational, with a higher profile, would be a consideration for future research of this type. The distribution of the questionnaire using Linked-In to target contacts was a novel way to connect with healthcare staff and could be further developed as a survey resource in the future. To evaluate leader's behaviour further it would be beneficial to explore Commissioner and provider meetings to examine group dynamics specifically and contentious contract issues in real time scenarios. This would give further validity to the coding system and better understanding of how Q&S issues can be better understood and managed in healthcare.

Recommendations

The following recommendations are drawn from the conclusions of this study:

The leadership behaviour of Commissioners is further scrutinised and effective measurement of leadership style is examined to ensure groups encourage critical friends to have a voice in meetings. This may be achieved by the formal role of governors who elect a number of representatives to provide a staff voice. Monitor's review of Foundation Trust governors suggested that only 10% of staff members were active members of the organisation. There is a requirement now to develop trust governors capability through the Govern Well programme (Monitor 2011).

The video observation methods, as a way of evaluating leadership behaviour, can be transferred to capture meetings in field settings thus reviewing naturalistic leadership behaviour. The CCG's should establish the expected behaviours within the group and consider using video based observations to tease out poor or good decision making.

The most recent reforms have sought to distance government ministers from interfering with the NHS, in the form of Commissioning via NHS England, providing clearer separation from purchasing, providing and regulating services. Many healthcare organisations struggle to provide the required large volumes of data to the requisite number of organisations which include Monitor, CQC and CCG's. This increases the risk of command and control behaviour that avoids early identification of significant risk and the risk to providers of spending significant time on external reporting compromises Q&S (The Kings Fund 2014). Clearly, CCG's need to understand and link risk, within this type of environment, with the underlying systems that create and maintain such risk. CCGs therefore should develop general techniques to determine risk tolerance flow charts for determining the appropriate action to be taken when risks are identified and to evaluate the effectiveness of any such controls.

High quality leadership is crucial during challenging times, with transformational management required at national and local level. CCG's should look to support all Commissioners in their critical role, by providing training and advice as to types of leadership behaviour and its impact, as well as the identification of risk and its management. To redesign services Commissioners and providers of healthcare will need to have strong partnerships to achieve large scale service change with local leaders embedding the culture change needed to engage staff in continuing improving patient care (The NHS confederation 2015).

The NHS should consider reviewing the current leadership model and evidence how the framework can be more widely used to support positive behaviours and outcomes in Q&S in healthcare. Creating a leader with all the necessary skills, behaviours and traits described within the framework is problematic as the culture in which leaders operate most influences leaders' ability to affect outcomes; the follower engagement is also critical to outcomes. To measure the success of this approach, a deeper understanding is needed of the numbers of senior staff who have been appraised under the framework and how the framework has influenced outcomes.

It is recommended that the methodology used for this study is used in real time meetings between Commissioners and providers to further develop the validity of the coding system.

The inquiry into Mid Staffs highlighted the overwhelming political pressure exerted on the NHS (Carter and Jarman 2013) with the former Chair of Monitor describing the culture of the NHS, particularly the hospital sector, as one of not wanting to embarrass ministers. Baroness Young from the CQC described a huge amount of government pressure to not be critical of hospitals, as by default it would reflect badly on the government. For the recommendations to endure, politicians require to take a step backwards and Commissioners require to understand and manage pressures in the system avoiding the comfort seeking behaviours often evidenced in healthcare.

Post Research Position

The researcher's background provided him with a clear insight into the way the NHS operates, specifically in relation to risk, leadership, culture and governance. The researcher's lens focused the attention on how the Commissioners interpreted risk. This is at the forefront of the researcher's role in the NHS and was a major theme drawn from the open forum. The researcher insight when coding verbal communication regarding how risks are evaluated is important, as the understanding of how risks should be ranked and controlled in reality directly influenced the outcome of the research. The researcher also had a clear view of the systems and processes in which the Commissioners operated. This understanding comes from knowledge of the language used, acronyms and financial constraints placed by Commissioners from a provider perspective. The recognition that the researcher could directly influence the outcome required a structured control process; a review of interpretation of coding with the Director of Study (DOS) enabled the researcher to monitor and question ingrained belief systems.

The strategies put in place attempted to limit the amount of interpretation placed on the findings by the researcher, particularly when examining non-verbal communication, as visible interpretation of the evidence provided was based on numbers of body movements; the researcher therefore defined what was valid and objective. The researcher has clearly stated his history and role within the NHS at the beginning of this thesis and recognises the influence this has on the outcome, with leadership behaviour being open to individual interpretation. The researcher bias is a significant issue in qualitative research and rather than try to control the bias via bracketing, the researcher used a reflective journal in an attempt to examine personal assumptions, belief systems and subjectivities (Ortlipp 2008). The researcher developed an effective working relationship with his DOS which enabled a two-way conversation to track interpretation and gain better understanding of the approach and influence on outcomes.

References

1. ABRAMS D. ET AL (2013) Double Standard When Group Members Behave Badly: Transgression Credit to in-group Leaders. University of Kent *Journal of Personality and Social Psychology American Psychological Association* Vol. 105 (5), pp. 799–815

2. ADVANCING QUALITY ALIANCE AQuA (2013) First Do No Harm *AQuA's response to the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013*
Available from: www.aquanw.nhs.uk/user/sign_in
[Accessed July 20th 2014].

3. AMABILE T. et al (2004) Leader behaviours and the work environment for creativity: perceived leader support'. *The Leadership Quarterly*, Vol. 15 (1), pp. 5-32

4. ANDREW I. (2015) *Whistle Blowing Leadership and Culture*, Head of Membership and Client Development, The Beech Centre for People, Performance and Organisational Development article Linked in Group Healthcare Leadership Model Discussions
Available from: www.linkedin.com/profile/view
[Accessed 17th January 2015].

5. ANGROSINA M. (2007) *Doing Ethnographic and Observational Research* Sage Publications ISBN 9780761949756.

6. ASSOCIATION OF DIRECTORS ADULT SOCIAL SERVICES ADDASS (2014) *Budget Survey Report*.
Available from: www.adass.org.uk
[Accessed 12th March 2015].

7. ASHFORD B. and ANAND, V. (2003). The normalization of corruption in organizations. *Research in organizational behaviour* Vol. 25, pp. 1–52.

8. AUDIT COMMISSION (2009) *Doing more for less*
Available from: www.audit-commission.gov.uk
[Accessed 26th September 2013]

9. BAKEMAN R. AND GOTTMAN J. (1987) *Observing interaction: an introduction to sequential analysis.* Cambridge University Press.

10. BAKER S. MATHIS C. STITES DOE (2011) An Exploratory Study Investigating Leader and Follower Characteristics at US Healthcare Organisations. *Published in The Journal of managerial Issues* Vol. 23 (3), pp. 341-363.

11. BALES R. (1950) Interaction process analysis: a method for study of small groups. *Cambridge: Addison Wesley American Sociological Review* Vol. 15 (2), pp. 257-263
Available from http://www.jstor.org/stable/2086790
[Accessed 5th July 2014.]

12. BASS M. AVOLIO J. (1997) Full range leadership development: Book-Manual for the Multifactor leadership questionnaire, *Sage Publication*.

13. BASS M. BASS R. (2008) *The Bass Handbook of Leadership: Theory, Research, and Management* . Free Press New York

Available from: www.simonandschuster.com.
[Accessed 25th August 2015].

14. BATERSON G. MEAD M. (1942) Use of Photography and Film Cultural Anthropology Published by: Wiley on behalf of the American Anthropological Association
Available from: www.jstor.org
[Accessed 12th April 2015]

15. BBC (2015) *Hinchingbrooke Hospital: Circle to withdraw from contract*
Available from: BBC news www.bbc.uk
[Accessed 15th January 2015]

16. BENNETT T. et al (2009) Culture Class distinction *Published by Rutledge London*

17. BERWICK D et al (2013) A promise to learn a commitment to act Improving the Safety of Patients in England *National Advisory Group on the Safety of Patients in England Crown copyright* ISBN 2901213 Produced by Williams Lea.
Available from: www.gov.uk
[Accessed 20th December 2014]

18. BIBBY J. BEVAN H. CARTER E. (2009) The Power of One, the Power of Many Bringing Social Movement to Health & Healthcare Improvement. *NHS Institute for Innovation and Improvement* ISBN 978-1-906535-82-7
Available from: www.institute.nhs.uk/qualityimprovement
[Accessed 14th August 2015]

19. BOHAN P. LAING M. (2012) Does Leadership Behaviour Affect Q&S in Healthcare. *Feature Article of British Journal of Healthcare Management* Vol 18 (4), pp. 155-165
Available from: www.bjhem.co.uk
[Accessed April 2nd 2012]

20. BOLAND B. (2013) *Rather than emulate Ofsted's culture of fear, the UK care regulator must engage clinicinians to improve standrads.*
British Medical Journal Vol. 347 f4611 pp. 1-2
Available from: www.bmj.com
[Accessed 28th December 2015].

21. BONO J. and JUDGE T. (2004) Personality and transformational and transactional leadership: a meta-analysis. *Journal of Applied Psychology*, Vol. 89 (5), pp. 901-910.

22. BORGATTA E. (1964) A very short test of personality: the behavioral self-rating form. *Published Psychological Reports* Vol. 14, pp. 275-284.

23. BOWERS B. et al (2013) Creating and Supporting a Mixed Methods Health Services Research DOI: 10.1111/1475-6773.12118 *Published Health Research and Educational Trust Health Services Research* Vol. 48 (6), pp. 2157–2180,

24. BOYES C. (2005) *Need to Know Body Language*, Published Harper Collins.

25. BROADBENT D. (2004) *Maximising safety performance via leadership behaviour* Presented at the world congress of psychology Beijing China August 11th -14th 2004
Available from: www.transformationalsafety.com

[Accessed 5th March 2015]

26. BROMLEY E. ET AL (2012) A video Ethnography Approach Assessing the Ecological Validity of Neurocognitive and functional Measures in severe mental illness: *Published by Oxford University Press Schizophrenia Bulletin* Vol. 38 (5) pp 981-991
Available from: journals.prmissions@oup
[Accessed 23rd November 2013].

27. BROWN N. McAVOY P. JOFFE M. (2014) *Defining insight: a challenge that matters*. Published in the Clinical Teacher. John Wiley and Sons ltd. Vol.11, pp. 170-173 contact National Clinical Assessment Service (NCAS) nicholas.brown@ncas.nhs.uk.

28. BURKE R. ONWUEGBUZIE A. (2004) Mixed Methods Research: A Research Paradigm Whose Time Has Come *Published in Education Researcher*
Available from: www.edr.sagepublication
[Accessed 13th June 2015].

29. BURNES B. POPE R. (2007) Negative behaviours in the workplace. A study of two Primary Care Trusts in the NHS. *International Journal of Public Sector Management* Vol. 20, pp. 285-303 doi:10.1108/09513550710750011. Emerald Publishing Limited
Available from: www.emeraldinsight.com/0951.3558.htm
[Accessed 28th December 2015]

30. CARE QUALITY COMMISSION CQC (2012) *Annual Report & Accounts.*
Available from www.cqc.org.uk
[Accessed 17th June 2015]

31. CARLESS S. (1998) Assessing the discriminate validity of transformational leader behaviour as measured by the MLQ. *Journal of Occupational and Organizational Psychology* Vol. 71, pp. 353-358.

32. CARTER P. JARMAN B. (2013) Who Knew what, and when, at Mid Staffs? *British Medical Journal* Vol 346:f1726 doi:10.1136/bmj Feb 2013
Available from: www.bmj.com
[Accessed 27th December 2015]

33. CELSO M. ET AL (2014) Reading people's minds from emotional expressions in independent decision making. *Published Journal of personality and social psychology* Vol. 106, pp 73-88.

34. CHAPMAN S. WARD S. (2011) How to manage project opportunities and risk. *Published by Wiley Press* ISBN 978-0470686492.

35. CHARTERED INSTITUTE OF PERSONNEL DEVELOPMENT CIPD (2014) *Labour Market outlook Winter 2014-15*
Available from: www.cipd.co.uk
[Accessed 10th January 2014]

36. CHELEFF I. (2009) The courageous follower: Standing up to and for our leaders 93rd ed. *Koehler Publishers.*

37. CHEMICAL SAFETY BOARD CSB (2014) US Chemical Safety & Hazard Investigation Board Report Overview Explosion & fire at Macondo Well, Deepwater Horizon Rig: *Published 5th June 2014 Report no: 2010-10-I-OS 6/5/2014*
Available from: www.csb.gov
[Accessed on line 5th February 2015]

38. CHULLEN C. BOSS W. (2010) Minimising deviant behaviour in healthcare organisations: The effect of supportive leadership and job design. *Journal of Healthcare Management* Vol. 55 (6), pp. 381-395.

39. CLEARLY S. DOYLE K. (2015) *Whistleblowing Need not ccur if Internal Voices are HeardFrom Deaf effect to Hearer Courage* Vol. 5(1), pp. 59-61 International Journal of Health Policy and Management doi 10.15171/Ijhpm.2015.177
Available from: www.ijhpm.com
[Accessed 27th December 2015]

40. COHEN et al (2015) Does health intervention research have real world policy and practice impacts: Testing a new impact assessment tool. *Health Research Policy and Systems*
Available from: http://www.health-policy-systems.com/content/13/1/3
[Accessed 12th March 2015].

41. COLLIER J. COLLIER M. (1986) Visual Anthropology (Photography as a research method) *Published by The University of New Mexico Press* ISBN 0030652-2456.

42. COLLINS A. GADD S. (2002) *Safety Culture: A review of the literature* Health & Safety Laboratory HSL/2002 25 Broad Lane, Sheffield, S3 7HQ Human Factors Group
Available from: www.hse.gov.uk/research
43. [Accessed on line 10th March]

44. COMMISSIONERS ASSEMBLY (2014) *Commissioning for Quality Views from Commissioners*
Available from: www.england.nhs.uk
[Accessed on line 10th December 2014]

45. CONFEDERATION OF BRITISH INDUSTRY (1990) *Developing a Safety Culture Business for Safety.* CBI Report.

46. COOPER D. (1998). Improving safety culture *Book Chichester: Wiley Press.*

47. COOPER ET AL(2005) Changing personnel behaviour to promote quality care practices in an intensive care unit *Published in Therapeutics and Clinical Risk Management* Vol. 1(4), pp. 321-332 Dove Medical Press

48. COOPER J. LEWIS R. URGHUHURT C. (2004) Using participant or non participant observation to explain information behaviour. *Information Research* Vol. 9(4), p 184
Available from: http://R.net/ir/9-4/paper184.html
[Accessed on line 5th June 2015]

49. COOPER M. McLEOD J. (2010) Pluralism: towards a new paradigm for therapy. *Published Therapy today* Vol. 21 (9)
Available from:
www.therapytoday.net/article/show/2142/pluralism-towards-a-new-paradigm-for-therapy
[Accessed 13th June 2015]

50. CRESSWELL J. ET AL (2003) Advanced mixed method research design. *Handbook of mixed methods in social and behavioural research* pp. 209-240 Sage Books.

51. CRESSWELL J. CLARK V. (2007) Designing and conducting mixed method research. *Sage Publications.*

52. CRESSWELL J. FETTERS M. IVANKOVA N. (2004) Designing A Mixed Methods Study In Primary Care. *Published Annals of Family Medicine* Vol. 2 (1)
Available from: www.annfammed.org
[Accessed 15th March 2015]

53. CRESSWELL J. GARRETT A. (2008) The movement of mixed methods research and the role of educators. *Published in the South African Journal of Education* Vol. 2 (8), pp. 321-333
Available from: jcreswell1@unl.edu
[Accessed on line 14th March 2015]

54. DARVISH H. SHIRAZI POUR M. (2013) Measuring Employees Job Satisfaction as Outcome of Multifactor Leadership Questionnaire (MLQ) Leadership styles: An Empirical Study
Reef Resource Assessment and Management Technical Paper Vol. 382013 (5)
Available from: www.behaviour/sciences.com
[Accessed 20th October 2014]

55. DARZI LORD (2008) *High Quality Care For All NHS Next Stage Review Final Report* Presented to Parliament by the Secretary of State for Health June 2008.
Available from: www.gov.uk
[Accessed on line 20th September 2015]

56. DAVIES H. (2002) *Understanding organizational culture in reforming the National Health Service* Published March 2002 Journal of Royal Society of Medicine Vol. 95 (3), pp. 140-142
Available from: www.ncbi.nlm.nih.gov/pmc/articles/PMC1279486
[Accessed 8th March 2015]

57. DAVIS T. and LUTHENS F. (1979) A Social Learning Approach to Organisational Behaviour. *The Academy of Management Review* Vol. 5 (2), pp. 281-290

58. DENSCOMBE M. (2008) Communities of practice: a research paradigm for the mixed method approach. *Journal of Mixed Method Research* Vol. 2(3), pp. 270-283.

59. DEPARTMENT OF HEALTH (2015) *Culture Change in the NHS Applying the lessons of Francis Inquiry* February 2015
Available from: www.gov.uk/governemnt/publications
[Accessed on line 3rd February 2015].

60. DEPARTMENT OF HEALTH (2014) *Hard Truths. The Journey to putting Patients First* Vol. 1 of the Government Response to the Mid Staffordshire NHS Foundation trust Public Enquiry ISBN: 9780101877725
Available from: www.gov.uk/government/organisations/department-of-health
[Accessed on the 15th December 2014]

61. DEPARTMENT OF HEALTH (2011) Developing Clinical Commissioning Groups Towards Authorisation

Available from: www.gov.uk
[Accessed 12th November 2014]

62. DIXON -WOODS M. ET AL (2013) *Culture and Behaviour in the English National Health Service* : *overview of lessons from a large mulit-method study*, British Medical Journal Quality & Safety Vol. 23, pp. 106-115 doi:10.1136/bmjqs-2013-001947

63. DONALDSON L. (1998) Clinical Governance and the drive for quality improvement in the new NHSW in England. *British Medical Journal* Vol. 317
Available from: www.bmj.co.uk
[Accessed 12th July 2014].

64. EDMONDSON A. (1999) Psychological *safety and learning behaviour in work teams* Published in Admin and Science Vol. 44 p 350
Available from: www.iacmr.org
[Accessed 13th June 2015]

65. EKMAN P. WALLACE V. (1969) Detecting deception from the body or face. *Journal of Personality and Social Psychology*, Vol. 29 (3) pp 288-298.
Available from: http://dx.doi.org/10.1037/h0036006
[Accessed 29th November]

66. ERICKSON F. (1992) Why clinical trials doesn't work as a metaphor for education research. *American Education Research Journal* Vol. 21 (5) pp 9-11.
Available from: www.jstor.org
[Accessed 26th November 2015].

67. FERLIE E. SHORTELL S. (2001) Improving the Quality of Health Care in the United Kingdom and the United States: A Framework for Change *Milbank Quarterly* Vol. 79 (2), pp. 281–315.

68. FLEMING M. (2001) *Safety culture maturity model* Prepared by the Keil Centre for the Health and Safety Executive: Offshore Technology Report 2000/049 HMS *Stationery Office, St Clements House, 2-16 Colegate, Norwich NR3 1BQ First published 2001* ISBN 0 7176 1919 2
Available from: www.hse.gov.uk/reserch/otopdf/2000
[Accessed 10th March 2015]

69. FLIN R. ET AL (2000) *Measuring safety climate: identifying the common features* Department of Psychology, University of Aberdeen, King's College, Aberdeen, Scotland AB24 2UB, UK Published in Safety Science Vol. 34, pp. 177-192
Available from: www.elsevier.com
[Accessed on line 1st May 2015].

70. FOY R. et al (2007) *The development of a theory-based intervention to promote appropriate disclosure of a diagnosis of dementia.* Bio Medical Central Health Service Research. Vol:7 p207.
Available from: www.ncbi.nlm.nih.gov/pmcarticle
[Accessed 13th September 2015].

71. FRANCIS J. ET AL (2004) *Constructing questionnaires based on the theory of planned behaviour: A manual for health services researchers.* Newcastle upon Tyne: Centre for Health Services Research, University of Newcastle upon Tyne
Available from:
http://openaccess.city.ac.uk/1735/1/TPB%20Manual%20FINAL%20May2004.pdf
[Accessed 9th August 2014]

72. FRANCIS R. (2015) *Freedom to Speak Up An independent review into creating an open and honest reporting culture in the NHS*
Report by Sir Robert Francis QC 11th Feb 2015
Available from:
www.gov.uk/government/groups/whistleblowing-in-the-nhs-independent-review
[Accessed 22nd February 2015]

73. FRANCIS R. (2010) The Mid Staffordshire NHS Foundation Trust Public Inquiry ISBN 97801029643942010
Available from: www.tsoshop.co.uk
[Accessed 15th October 2014]

74. FRANCIS R. (2013) The Mid Staffordshire NHS Foundation Trust Public Inquiry (Final Report)
Available from: www.tsoshop.co.uk
[Accessed on line 10th October 2014]

75. FRESHWATER D. (2007) Reading Mixed Method Research Context for Criticism Published in Journal of Mixed Methods Research Vol. 1 (2) *Sage Publication*
Available from: http://online.sagepub.com
[Accessed 15th March 2015]

76. GENERAL MEDICAL COUNCIL (2014) *National training survey 2014 bullying and undermining* Published Nov 2014 Code: GMC/NTSRBU/1114
Available from: publications@gmc-uk.org
[Accessed 27th January 2015]

77. GIESSNER S. ET AL (2013) Team Orientated leadership: The interactive effect of leader group proto typicality, accountability, and team identification *Published Journal of Applied Psychology* Vol. 98 (4) pp. 658-667.

78. GLANZ ET AL (2008) Health Behavour and Health Education Theory Research and Practice 4th ed. *Published by Jossey Bass Wiley Print*.

79. GLENDON A. LITHERLAND G. (2001) *Safety climate factors group differences and safety behaviour* Published in safety science Vol. 39, pp. 157-188
Available from: www.elsevier.com
[Accessed 27th July 2015].

80. GLENDON A. STANTON N. (2000) Perspectives on safety culture Published in Safety Science Vol. 34 pp. 193-213
Available from: www.elsevier.com
[Accessed 28th July 2015].

81. GOETZ J. ET AL (2010) Compassion: An evolutionary analysis and empirical review. *Published in the Psychological bulletin* Vol. 136(3), pp. 351-374
Available from: www.greatergood.berkely.edu
[Accessed 14th June 2015].

82. GRAEN G. UHL-BIEN M. (1995) Relationship-based approach to leadership: development of leader-member exchange (LMX) theory of leadership over 25 Years: applying a multi-level multi-domain perspective. *Management Department Faculty Publications. Paper 57.*
Available from:
http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1059&context=managementfacpub

[Accessed 9th August 2013].

83. GRAHAM N. (2012) *Making amends for adverse events arising during hospital care* Clinical Risk Vol. 18: pp. 2–5
Available from:
http://eds.b.ebscohost.com/eds/pdfviewer/pdfviewer?vid=3&sid=abec1d70-f1ae-4cd3-85ae-9ae643aefc1d%40sessionmgr115&hid=117
[Accessed 13th January 2015].

84. GREAVES. M. ZIBARRAS L. AND STRIDE C. (2013) Using the theory of planned behaviour to explore environmental behavioural intentions in the workplace. *Journal of Environmental Psychology*, Vol. 34, pp.109 -120.

85. GREENE J. (2007) Mixed method in social enquiry. *Published by Wiley and Sons inc* ISBN 978-0-7879-032-6in

86. GUPTA A. WILDEROM C. HILLEGERSBERG J.(2009) *Exploring the behaviour of highly effective CIO's using video analysis* Proceedings of the Fifteenth Americas Conference on Information Systems, San Francisco, California August 6th–9th 2009
Available from: k.gupta@student.utwente.nl
[Accessed 10th October 2014]

87. HALL B. HOWARD (2008) A synergistic approach conducting mixed methods research with typological and systematic design considerations. *Journal of mixed methods research* Vol. 2 (3) pp. 248-269.

88. HANDY C. (2000) Gods of Management: *The changing work of organisations 4th ed. Published by Arrowe Books* ISBN 0099548410

89. HANNO M. JONES, L. (1973) Effects of a change in reference person on the multidimensional structure and evaluations of trait adjectives. *Journal of Personality and Social Psychology*. Vol. 28(3), pp. 368-375.
Available from: http://dx.doi.org/10.1037/h0035108
[Accessed 29th November 2014]

90. HARTLAND D AND C TOSH(2001) *Guide to Body Language* Published by Caxton
Available from:
http://www.businessballs.com/body-language.htm#six-universal-facial-expressions
[Accessed 15th May 2015].

91. HARRISON R. (2000) Learner Managed Learning: Managing to learn or learning to manage? *International Journal of Lifelong Education*: Vol. 19 (4) pp. 312-321.

92. HAWKES N. (2013) *How the message from mortality figures was missed at Mid Staffs*. 2013 346:f562 doi: 10.1136/bmj.f562
Available from: www.bmj.com
[Accessed 27th December 2015].

93. HEALTH AND SAFETY EXECUTIVE (2014a) *Memorandum of understanding between the CQC, HSE and Local Authorities*
Available from: www.hse.gov.uk
[Accessed 28th July 2015].

94. HEALTH AND SAFETY EXECUTIVE (2005a) *A review of safety culture and climate literature for the development of the safety culture inspection tool kit*. Research Report 367 ISBN 071766144X
Available from: www.hse.gov.uk
[Accessed on line 12th July 2015].

95. HEALTH AND SOCIAL CARE ACT (2012) Health and Social Care Bill. *Published by Stationery Office*
Available from: http://services.parliament.uk/bills/2010-12/healthandsocialcare/documents.html
[Accessed 9th Aug, 2013]

96. HEALTHCARE COMMISSION (2007) *Investigation into outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS Trust* [Accessed on line 12th December 2014 www.healthcarecommission.org.uk].

97. HEALTH FOUNDATION (2014a) *Closing the Gap through Changing Relationships: An independent evaluation of the programme.*
Available from: www.opm.co.uk
[Accessed 20th January 2015]

98. HEALTH & SAFETY EXECUTIVE (HSE 2014) *Regulatory changes in health and social care: implications for HSE*
Available from: www.hse.gov.uk
[Accessed 21st December 2014].

99. HEATH, C., HINDMARSH, J. AND LUFF, P. (2010) *Video in qualitative research*. Sage Publication.

100. HEATH, C. VOM LEHN, D. AND KNOBLAUCH, H. (2001). *Configuring Exhibits.* The Interactional Production of Experience in Museums and Galleries. Published in: Knoblauch, H. and Kotthoff, H. (eds.) Verbal Art Across Cultures: The aesthetics and proto-aesthetics of communication, Gunter Narr Verlag Tubingen. pp. 281-297.

101. HESKETT J. ET AL (1994) Putting the service profit chain to work. *Published in Harvard Business Review*, Vol. 72 (2), pp. 164-170

102. HIGHLEN P. HILL C. (1984). Factors affecting client change in individual counselling: Current status and theoretical speculation. *Handbook of Counselling Psychology* pp. 334-396 Published by Wiley Press.

103. HOFSTEAD G. (1983) Cultural relativity of organisation practice and theories. *Journal of International Business* Vol. 14 (2), pp.75-89
Available from www.jstor.org
[Accessed 12th June 2015].

104. HOOGEBOOM, A. (2011) *Leader values, style and behavior in meetings: triangulated evidence of effective leadership*. MSc. Thesis, University of Twente
Available from
http://www.utwente.nl/mb/en/education/Programmes/master/ba/MasterThesis/Excellent%20Master%20Thesis/MHoogeboom.pdf
[Accessed 9th August 2013]

105. HOOGEBOOM, A. WILDEROM, C. (2012) Behavioral Dynamics (in Staff Meetings): What Patterns Lead To Success? *Proceedings of Measuring Behavior, 8th International Conference on Methods and Techniques in Behavioral Research, pp.* 314-318
Available from
http://www.measuringbehavior.org/sites/default/files/nat/Proceedings%20MB2012.pdf
[Accessed 9th August 2013]

106. HOOIJBERG R. QUINN R. (1995) Paradox and Performance: Toward a Theory of Behavioural Complexity in Managerial Leadership Published Online: Organisational Science October 1, 1995 pp. 524 – 540.
Available from www.pubsonline.informs.org
[Accessed 12th March 2015].

107. HOURGHTON J. DAWLEY D. DILLIETTO T. (2012) The Abbreviated self leadership questionnaire (ASLQ): A more concise measure of self leadership. *Published in the International Journal of Leadership studies* Vol. 7 (2).

108. HUGHES R. GINNETT R. CURPHY G. (1999) Leadership: Enhancing the lessons of experience 3rd ed. *Published by Irwan McGraw Hill*.

109. JAMES J. (2008) The Body Language Bible, *Published by Random House*

110. JANIS, I. (1972). Victims of groupthink. *Published by Hougton Miffilin.*

111. JIROTKA, M & GOGUEN, J (1994). Requirements Engineering. Social and Technical Issues. *Published by London: Academic Press*.

112. JOHN J. (1992) *Patient satisfaction the impact of past experience* JHCM Vol. 12(3) pp. 56-64
Available from www.search.proquest.com
[Accessed on line 30th June 2015].

113. JOHNSON G. SCHOLES K. WITTINGTON R. (2008) Exploring Corporate Strategy *Publisher Pearson Education Limited* .p.11
Available from www.pearsoned.co.uk
[Accessed on line 20th December 2014].

114. JOHNSON R. ET AL (2012) Leader Identity as an Antecedent of the Frequency and Consistency of Transformational, Consideration, and Abusive Leadership Behaviours *Journal of Applied Psychology American Psychological Association*
Vol. 97 (6), pp. 1262–1272 DOI: 10.1037/a0029043
Available from johnsonr@bus.msu.edu.
[Accessed 25th July 2015]

115. JONES R (2015) *Unexplained infectious events leading to deaths and medical admissions.* British Journal of Healthcare Management Vol. 21 (1), pp. 46-47.
Available from www.bjhcm.com
[Accessed 18th January 2015].

116. JONES S. LEBARON C. (2002) Research on the Relationship Between Verbal and Nonverbal Communication: *Article Published in Journal of Communication* pp. 499-520
Available from www.researchgate.net
[Accessed 14th September].

117. JUDGE A. PICOLLOR R. (2004) Transformational and Transactional Leadership: A Meta-Analytic Test of Their Relative Validity. *Published in the Journal of Applied Psychology* Vol. 89.

118. KAPUR N. (2014) *The NHS needs a staff support Commission Comment on protecting whistle blowers*. Vol 22 Health Service Journal 27th June 2014
Available from www.hsj.co.uk/comment
[Accessed 28th December 2015].

119. KEIRAN W. (2014) *Drawing the poison from NHS ledership*.
Vol 22 Health Service Journal 27th June 2014
Available from www.hsj.co.uk/comment
[Accessed 28th December 2015].

120. KELLOWAY E. MULLEN J. FRANCI L. (2006) Divergent effects of transformational passive leadership on employee safety. *Journal of Occupational Health Psychology* Vol. 1, pp.76-86.

121. KENDON A (1981) Non-verbal communication interaction and gestures; Approaches to semiotics. *Published by Krips Repro Meppel* ISBN 90-2793489-9.

122. KENNEDY I. (2001) The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary1984–1995 Learning from Bristol.
Available from www.webarchives.nationalarchives.gov.uk/20090
[Accessed on line 12th March 2015].

123. KEOGH K. (2013) *All NHS staff to be handed a role in dealing with patient complaints* Nursing Standard November 6th Vol. 28 (10)
Available from http://eds.a.ebscohost.com
[Accessed 17th January 2015]

124. KING K HULT M (2010) Educational Linguistics in Practice. *Published by the British Library* ISBN 978-1 847693532.

125. KINICKI ET AL (2013) Development and Validation of the Performance Management Behaviour Questionnaire. *Published online Wiley Periodicals, Inc.* Vol. 66 (1) pp. 1-45
Available from www.onlinelibrary.wiley.com
[Accessed 29th September 2014].

126. KIRKBRIDE P. (2006) "Developing transformational leaders: the full range leadership model in action", *Published in Industrial and Commercial Training* Vol. 38 (1), pp.23–32
Available from www.emeraldinsight.com
[Accessed on line 26th May 2015].

127. KIRKUP B. (2015) The Report of the Morecambe Bay Investigation An independent investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust from January 2004 to June 2013 Dr Bill Kirkup *Published by The Stationery Office*
Available from https://www.gov.uk/government/publications
[Accessed 3rd March 2015]

128. KNIGHT T.H. (1921) Risk, Uncertainty and profit. *Published by Houghton Mifflin Company, New York USA.*

129. KNOBLAUCH H. (2005) Focused Ethnography: *Published Qualitative Social Research* Vol. 6 (3)
Available from: http://www.qualitative-research.net
[Accessed 7th March 2015]

130. KOUZES J. POSNER B. (2003) The Leadership Challenge *Publisher Josey-Bass A Wiley Imprint* 3rd ed. p.37 ISBN 0-7879-5678-3
Available from: www.joseybass.com
[Accessed 12th June 2015]

131. KRAUSSE R. CHEN Y. CHAWLA P (1996) Non verbal behaviour and non verbal Communication what do hand gestures tell us? Columbia University appeared in M. Zanna (Ed.), Advances in experimental social psychology pp. 389-450 *Published by San Diego, CA: Academic Press.*
Available from: http://www.sciencedirect.com/science/article/pii/S0065260108602415
[Accessed 18th may 2015]

132. KUHNKE E. (2007) Body Language for Dummies, *Published by Wiley Press*.

133. LAFOND S. (2014) Into the red? The state of the NHS' finances Research Report. *Published by The Nuffield Trust*
Available from: www.nuffieldtrust.org.uk
[Accessed 23rd July 2015].

134. LAING W. (2014) *Strategic commissioning of long term care for older people: Can we get more for less?* A Laing Buisson White Paper September 2014
Available from: www.laingbuisson.co.uk
[Accessed 20th January 2015].

135. LANKSHEAR A, SHELDON T, MAYNARD A. (2005) *Nurse Staffing and Healthcare Outcomes: A Systematic Review of the International Research Evidence.* Advances in Nursing Science: April/June 2005 Vol. 28 (2) pp 163–174
Available from:
http://journals.lww.com/advancesinnursingscience/Abstract/2005/04000/NurseStaffingandHealthcareOutcomesA.8.aspx
[Accessed 2nd January 2015]

136. LAUSBERG H. SLOETJES M. (2009) *Coding gestural behaviour with the NEUROGES–ELAN system* Published Behavior Research Methods Vol. 41 (3) pp 841-849
Available from: www.download.springer.com
[Accessed 17th June 2015].

137. LAWRENCE K. LENK P. QUINN R. (2009) Behavioural complexity in leadership: the psychometric properties of new investment to measure behaviour repertoire. *Published by The Leadership Quarterly* Vol. 20 (2), pp. 87-102.

138. LEADERSHIP ACADEMY (2013) *The Healthcare Leadership Model The nine dimensions of leadership* Version 1 Leeds NHS leadership academy
Available from: www.leadershipacademy.nhs.uk
[Accessed 8th March 2015].

139. LE BARON C. (2006) Micro-ethnography *Published Dictionary of Social Research* ISBN: 9780857020116
Available from: www.srmo.sagepub.com
[Accessed 17th March 2015].

140. LE COMPTE M. SHENSUL J. (1999) Ethnography ToolKit: Designing and conducting ethnographic research, an introduction. *Published by Altamira Press*. 2nd ed ISBN 970-07591-1869-0
Available from: www.altamirapress.com
[Accessed on line 14th September 2015]

141. LIEBERMAN ET AL (2004) *Therapeutic norms and patient benefits: Cancer patient in professionally directed support groups* Group Dynamics: Theory, Research, and Practice, Vol. 8 (4), pp. 265-276.

142. LITTLEJOHN S. FOSS K. (2009) Encyclopaedia of Communication Theory. *Sage publication* ISBN 9781412959377.

143. LUCK L. JACKSON D. USHER K. (2006) Case Study: A bridge across paradigms. *Published in Nursing Inquiry* Vol. 13 (2), pp. 103-109
Available from: www.onlinelibrary-wiley.com
[Accessed 13th July 2015].

144. LUKAS C ET AL (2007) Transformational change in health care systems: An organizational Model *Published in Health Care Management Review*. Vol. 32, pp. 309-320

145. LUTHANS F AVOLIO B ET AL (2007) *Positive Psychological Capital: Measurement Relationship with performance & satisfaction.* Article first published Personnel Psychology , pp. 541–572.
Available from: www.onlinelibrary.wiley.com
[Accessed on line 1st September 2014]

146. MCDONALD J. (2014) Handbook of biological statistics. *Sparky House Publishing*
Available from: http://www.biostathandbook.com/permissions.html
[Accessed 5th June 2015].

147. MCGRATH J. ARROWE H. (1995) Membership dynamics in groups at work a theoretical framework. *Published in Research into Organisations Behaviour* Vol. 17, pp. 373-411 ISBN 155938-743-2.

148. MCMAHON A. (2014) Editorial 2014, Journal of Research in Nursing Vol. 19(1) pp. 3–7 10.1177/1744987113518130
Available from: jrn.sagepub.com
[Accessed 14th March 2015]

149. MEHRABIAN A. (2010). "Silent Messages" A Wealth of Information About Nonverbal Communication (Body Language)". *Los Angeles, CA: Self-published.*

150. MONITOR (2015) *Monitor home page*.
Available from: www. monitor.gov.uk
[Accessed 5th March 2015]

151. MONITOR (2013) Monitor and NHS England Review of Marginal Rate Rule
Available from www.monitor.gov.uk
[Accessed 15th June 2015].

152. MONITOR (2011) Current Practice in NHS Foundation Trust Member Recruitment and Engagement.
Available from: www.monitor-nhsft.gov.uk]www.monito
[Accessed 29th December 2015]

153. MOORE P. (2013) *Countering the biggest risk of all: attempting to govern uncertainty in healthcare management.* The Good Governance Institute ISBN 978-1-907610-19-6
Available from: www.good-governance.org.uk
[Accessed 20th September 2014]

154. MORGESON F. ET AL (2010) Leadership in Teams: A Functional Approach to Understanding Leadership Structures and Processes *Published by Michigan State University Journal of Management*, Vol. 36 (1), pp. 5-39 DOI: 10.1177/0149206309347376

155. MOSADEGHRAD A. FERDOSI M. (2013) Leadership, Job Satisfaction and Organisational Commitment in Healthcare Sector: Proposing and testing a model. *Published Mater Sociomed* Vol. 25 (2), pp. 121-126.

156. MUENJOHN N. ARMSTRONG (2008) Evaluating the structural validity of the multifactor Leadership Questionnaire, Capturing the leadership factors of Transformational-Transactional leadership. *Published by the School of Management RMIT University published Contemporary Management Research* Vol. 4 pp. 3-15.

157. MULLAINATHAN, S. AND THALER, R. (2000) Behavioural economics. *Published by National Bureau of Economic Research Working Paper 7948:*
Available from: http://www.aiinfinance.com/Mullainathan.pdf
[Accessed 9th August 2013].

158. MULLEN J. KELLOWAY K. (2009) Safety leadership: A longitudinal study of effects of transformational leadership on safety outcomes. *Published by the Journal of Occupational and Organizational Psychology The British Psychological Society.*
Available from: www.bpsjournals.co.uk
[Accessed 28th December 2014]

159. MURPHY E. (2014) Primary Concerns. Published by The Commissioning Review Issue 08 Autumn 2014
Available from: www.thecommissioningreview.com
[Accessed 17th January 2015]

160. MYATT V. (2002) Managing Risk in Healthcare *Book Published by Butterworth's Tolley LexisNexis* ISBN 0-406-947031 www.butterworths.com pp.126-129

161. NATIONAL AUDIT OFFICE (2014) *The financial sustainability of NHS bodies* Report by the Comptroller and Auditor General Department of Health HC 722 Session 2014-15 7 November 2014
Available from: www.nationalauditoffice.gov.uk
[Accessed on line 20th December 2014]

162. NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE NICE (2014) *Safe staffing plans for nursing care in wards* published 15th July 2014
Available from:
http://www.nice.org.uk/news/article/nice-unveils-safe-staffing-plans-for-nursing-care-in-wards
[Accessed 12th January 2014]

163. NATIONAL PATIENT SAFETY AGENCY (2007). *Healthcare risk assessment made easy*
Available from: www.npsa.nhs.uk
[Accessed 10th September 2015]

164. NATIONAL PATIENT SAFETY AGENCY NPSA (2003) *Seven steps to patient safety* Published by NPSA.

165. NAYLOR, C. ET AL (2013) *Clinical commissioning groups supporting improvement in general practice?* London: The King's Fund Nuffield Trust
Available from:
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/clinical-commissioning-groups-report-ings-fund-nuffield-jul13.pdf
[Accessed 9th Aug, 2013].

166. NEEDLEMAN, J. ET AL (2002) Nurse-Staffing Levels and the Quality of Care in Hospitals *Published New England Journal of Medicine* pp. 346
Available from: www.nejm.org
[Accessed on line 2nd January 2015]

167. NEUMAN W. (2003) Social Research Methods: Qualitative and Quantitative Approaches. *Book Published by Allyn and Bacon* ISBN 0205353118.

168. NHS COMMISSIONING ASSEMBLY(2014) *Commissioning for Quality Views from Commissioners*
Available from: www.england.nhs.uk
[Accessed 29th November 2014]

169. NHS COMMISSIONING BOARD (2012) *A Special Health Authority.*
Available from: www.commissioning/board.nhs.com
[Accessed 26 March 2012]

170. NHS CONFEDERATION (2015) *The 2015 Challenge Declaration*
Available from: www.nhsconfed.org/publications
[Accessed 28th December 2015]

171. NHS ENGLAND (2013) *The NHS Standard Contract: A guide for Clinical Commissioners*
Available from: www.england.nhs.uk
[Accessed 20th December 2014].

172. NHS ENGLAND (2013) *First Do No Harm: closing the gap in patient safety A proposal to improve the safety of patients and the effectiveness of healthcare using Human Factors methods* NQB Human Factors Concordat.
Available from:
http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-hum-fact-concord.pdf
[Accessed 20th October 2014]

173. NHS ENGLAND (2014) Five Year Forward View *Published by Monitor, Trust Development Authority, NHS England, Care Quality Commission, Public Health England, Health Education England.*
Available from: www.england.nhs.uk
[Accessed 29th December 2014]

174. NHS ENGLAND (2012) *Developing the NHS Commissioning Board NHS England*
Available from: www.england.nhs.uk
[Accessed 4th March 2015]

175. NOLDUS J. ET AL (2000) The Observer video-pro: new software for the collection, management and presentation of time-structured data from videotapes and digital media files. *Published by Behaviour Research Methods, Instruments & Computers***, Vol.** 32 (1), pp. 197-206.

176. NORTON K. LONGLEY M. PONTON M. (2012) The best configuration of services for Wales: A review of evidence. *Published by the Welsh Institute for Health and Social Care University of Glamorgan*
Available from: www.wales.nhs.uk
[Accessed 19th March 2015].

177. NUFFIELD TRUST (2014) *Nuffield Trust responds to new figures on NHS and Foundation Trust deficits.*
Available from: info@nuffieldtrust.org.uk].
[Accessed 25th October 2014]

178. O'BRIEN D. OAKLEY K (2015) Cultural Value and Inequality: A critical literature review *Published by the arts and humanities research council*
Available from www.ahrc.ac.uk
[Accessed 22nd January 2016]

179. O'CATHAIN A. MURPHY E. NICHOLL J. (2007) Why, and how, mixed methods research is undertaken in health services research in England: a mixed methods study *BioMed Central Health Services Research Article Published:* doi:10.1186/1472-6963-7-85
Available from: http://www.biomedcentral.com/1472-6963/7/85
[Accessed 12th March 2015]

180. OH PHYSICIAN PERSONAL VIEW (2013) After Mid Staffs: the NHS must do more to care for the health of its staff *Published anonymously in BMJ 2013;346:f1503*
Available from:
http://www.ajustnhs.com/wp-content/uploads/2012/06/Occup-Med-BMJ-2013.pdf
[Accessed 24th December 2015]

181. ONWUEGBUZIE A. COLLINS K. (2007) A Typology of Mixed Methods Sampling Designs in Social Science Research. *Published by The Qualitative Report* Vol. 12 (2), pp. 281-316
Available from: http://www.nova.edu/ssss/QR/QR12-2/onwuegbuzie2.pdf
[Accessed 20th March 2015]

182. ONWUEGBUZIE A. JOHNSON R. (2006) The validity issue in mixed methods research: research in schools *Published in Mid south Research Association* Vol. 13 (1) pp. 48-63.
Available from:
http://videolectures.net/site/normal_dl/tag=48066/MixedMethodsaandValidity.RITS.pdf
[Accessed 12th December 2015].

183. ORTLIPP M. (2008) *Keeping and Using Reflective Journals in the Qualitative Research Process*. The Qualitative report Vol.13 (4), pp. 695-705
Available from: www.nova.edu/ssss/QR/QR13-4/ortlipp
[Accessed 20th May 2015]

184. PATEL V. ET AL (2008) Translational cognition for decision support in critical care environments: A review. *Published in Biomedical Informatics* Vol. 41 (3), pp. 413-431
Available from: www.biomed-inform.com
[Accessed 15th May 2015].

185. PAUWELLS L. (2012) A multi model Framework for analysing websites as cultural expressions. *Published in the Journal of Computer Mediated Communication* Vol. 17 (3) pp 247-265

186. PEASE A. PEASE B. (2011) Body Language in the Workplace. *Published by Orion Books* ISBN 97814091 36835. www.orionbooks.co.uk

187. PERKINS R. (2009) How Executives coaching can change leader behaviour and improve meeting effectiveness: An exploratory study. *Consulting Psychology Journal Practice and Research American Psychological Association* 1065-929309 Vol. 61 pp. 298-318.

188. PINK S. (2001) Doing Ethnography: Images, Media and Representation in Research *Sage Publication* ISBN 0-7619-6154 Forum: Qualitative Social Research Vol. 3 (1)
Available from: www.qualitative-research.net/fqs
[Accessed 12th May 2015].

189. POKSINSKA B. SWARTLING D. DROTZ E. (2013) The daily work of lean leaders lessons from manufacturing and healthcare. *Published in Total Quality Management* Vol. 24 (8), pp. 886-898
Available from: http://dx.doi.org/10.1080/14783363.2013.791098
[Accessed 18th June 2015].

190. POLIT D. HUNGLER B. (1999) Nursing Research Principles and Methods 6th ed. *Published by Lippincott Williams & Wilkins* ISBN 0-7817-1562-8 pp11-12.

191. PORTER S. BRINKE L. (2008) Reading between the lies identifying concealed and falsified emotions in universal facial expressions. *Association for Psychological Science* Vol. 19 (5), pp. 508-512.

192. QUALITY WATCH (2014) Cause for Concern Quality Watch Annual Statement. *Published by Nuffield Trust and Health Foundation Research Programme.*
Available from: www.qualitywatch.org.uk/annual-statement
[Accessed 21st July 2014]

193. RAM P. ET AL (1999) Assessment of general practitioners by video observation of communication and medical performance in daily practice issues of validity, reliability and feasibility *Blackwell Science Ltd Medical Education.*

pp. 447-454

194. RCN ROYAL COLLEGE OF NURSING (2001) Learning the lessons: The RCN Response to the Bristol Royal Infirmary Inquiry. *Published by the Royal College of Nursing.*
Available from: www.rcn.org.uk
[Accessed 23rd December 2014].

195. RCN ROYAL COLLEGE OF NURSING (2010) Mid Staffordshire NHS Foundation Trust: Public Inquiry Report response from the Royal College of Nursing. *Publication by RCN code 004479.*
Available from: www.rcn.org.uk
[Accessed 29th July 2015].

196. REID J. (2012) Respect, compassion and dignity. *Published by The Association for Perioperative Practice* Clinical Feature Vol. 20
Available from: www.afpp.org.uk
[Accessed 22nd February 2015]

197. REID J. BROMILEY M (2012) Clinical human factors: the need to speak up to improve patient safety. *Nursing Standard RCN Publishing Arts & Science* Vol. 26 (35) pp.35-40
Available from: www.nursing-standard.co.uk
[Accessed 22nd February 2015]

198. RIBBENS G. THOMPSON R. (2000) Body language in a week. *Book Published by Hodder & Stoughton*

199. ROSENSTEIN B. (2002) Video Use in Social Science Research and Program Evaluation *Published International Journal of Qualitative Methods*, Vol. 1(3).
Available from: http://creativecommons.org/licenses/by/2.0
[Accessed 20th January 2015].

200. ROYAL COLLEGE OF PHYSICIANS (2011) Royal College of Physicians' closing statement to the Francis Inquiry.
Available from: www.rcplondon.ac.uk
[Accessed 12th August 2015].

201. SANDELOWSKI M. (1996) Using qualitative methods in intervention studies. *Published in Research in Nursing Health* Vol. 19 (4), pp. 359-364.

202. SANDY A. (2009) The New Science of Building Great Teams The chemistry of high-performing groups is no longer a mystery. *Published Harvard Business Review* pp. 61-70.
Available from: permissions@harvardbusiness.org.
[Accessed 26th December 2015]

203. SANGASUBANA N. (2011) How to conduct ethnographic research. *Published in the Qualitative Report.* Vol. 16 (2), pp. 567-573.
Available from: http://www.nova.edu/ssss/QR/QR16-2/sangasubanat.pdf
[Accessed 21st December 2014]

204. SCAMMON D. ET AL (2013) Connecting the Dots and Merging Meaning: Using Mixed Methods to Study Primary Care Delivery Transformation *Published by Health Research and Educational Trust* Vol. 48 (6), pp. 2181-2207.

205. SCHELL W. KUNTZ S. (2013) Driving change from the middle: an exploration of the complementary roles and leadership behaviours of clinical nurse leaders and engineers in healthcare process improvement. *Published in Engineering Management Journal* Vol. 25 (4) pp. 33-43.

206. SEAL C. (2008) Researching Society and Culture*:* Doing Ethnography Chapter 14 p. 248. *Book Sage Publication London* ISBN: 978-1-84920-798-0.

207. SHIEN E. (1992) Organisational Culture and Leadership 2nd ed. *Publisher Jossey Bass Inc.*
208. SHORT J. HUGHES L. (2009) Urban ethnography and research integrity. *Sage Publication* Available from: http://www.sagepublications.com [Accessed 15th March]

209. SHONDRICK, S. AND LORD R. (2010) Implicit leadership and followership theories: Dynamic structures for leadership perceptions, Memory, Leader-Follower Processes. *Published in Book International Review of Industrial and Organizational Psychology* Vol. 25. pp.1 - 33

210. SMITH, J. (2002) The Shipman Inquiry First Report: a death disguised. *London. Stationary Office*

211. SONNENFELD J. KUSIN M. WALTON E (2013) What do CEO's really think of their boards. *Published in Harvard Business Review April* Available from: www.HBR.ORG [Accessed 23rd June 2014]

212. SPARROW J. (2012) The Culture Builders: Leadership Strategies for Employee Performance *Gower Publishing Limited.* ISBN 9781409437246 (p64). Available from: www.gowerpublishing.com [Accessed 12th May 2015].

213. SPRADLEY J.P. (1980) Participant Observation *Published New York Holt Rinehart & Winston*

214. SRULL T. AND WYER R. (1979). The role of category accessibility in the interpretation of information about persons: Some determinants and implications. *Journal of Personality and Social Psychology*, Vol. 37, pp. 1660-1672

215. STAKE R (1995) The art of case study Research *Published Thousand Oaks Sage Publication* ISBN 0803957661

216. STOREY,J. AND HOLTI, R. (2013) Towards a New Model of Leadership for the NHS. *Published by NHS Leadership Academy*. Available from: http://www.leadershipacademy.nhs.uk/wp-content/uploads/2013/05/Towards-a-New-Model-of-Leadership-2013. [Accessed 9th August 2013]

217. THE HEALTH FOUNDATION (2013) Safety Culture: What is it and how do we monitor and measure it? *Published by the Health Foundation Event Report* Available from: www.health.org.uk [Accessed 19th March 2015]

218. THE HEALTH FOUNDATION (2014) Can the NHS maintain quality without additional resources? Key theme from a workshop of Providers 5th August 2014. *Published by the Health Foundation Event Report.*
Available from: www.health.org.uk
[Accessed 20th December 2014].

219. THE HEALTH FOUNDATION (2015) *Information dashboard on NHS performance.*
Available from: info@qualitywatch.org.uk.
[Accessed 14th August 2015]

220. THE KEIL CENTRE LANDREN R. (1999) *Towards a mature safety culture.*
Available from: www.keilcentre.co.uk
[Accessed 1st April 2015].

221. THE KINGS FUND APPLEBY J. THOMPSON J. JABBAL J. (2015) *Quarterly Monitoring Report.*
Available from: www.kingsfund.org.uk
[Accessed 20th August 2015]

222. THE KINGS FUND SURVEY (2014) Culture and Leadership in the NHS The Kings Fund Survey May 2014.
Available from: www.kingsfund.org.uk
[Accessed on line 29th December 2014].

223. THE KINGS FUND (2014a) Improving NHS Care by Engaging Staff and devolving Decision Making Report of the review of staff engagement and empowerment in the NHS
Available from: www.kingsfund.org.uk
[Accessed 29th December 2015].

224. THE KINGS FUND (2012) What will the Health and Social Care Bill mean for the NHS in England? Published in BMJ Vol. 344:e2159.
Available from: www.kingsfund.org.uk
[Accessed on line 27th June 2015].

225. THE PRESIDENTIAL COMMISSION (1986) *A report on the space shuttle challenger accident*.
Available from www.nasa.gov
[Accessed 26th March 2015].

226. THE TELEGRAPH (2010) *The Bristol Heart Scandal*
Available from: www.telegraph.co.uk
[Accessed 23rd December 2014]

227. THE TELEGRAPH (2014) *Francis Interview* By Laura Donnelly, Health Editor.
Available from: www.telegraph.co.uk
[Accessed 20th January 2015]

228. TOK M. TEMEL H. (2014) Body Language Scale: Validity and reliability study. *Published Journal of Theory and Practice in Education* Vol. 10 (1), pp. 103-122 e-mail hasantemel@comu.edu.tr.

229. TUMMERS L. KNIES E. (2014) The Public Leadership Questionnaire: the development and validation of five dimensions of public leadership behaviours. Paper for the IRSPM Conference Ottowa, Canada 9-11 April 2014

Available from: Tummers@fsw.eur.nl
[Accessed 20th October 2014].

230. VALDEZ S. RAMILY E. BRENNAN P. (2010) Industrial and systems engineering and healthcare: critical areas of research final report. Publication Agency for Healthcare Research and Quality.
Available from:
https://healthit.ahrq.gov/sites/default/files/docs/citation/IndustrialAndSystemsEngineeringAndHealthCare.pdf
[Accessed 4th July 2015]

231. VAN DER WEIDE, J. (2007). An explorative video-study to the behavior of effective middle leaders. Unpublished doctoral dissertation. *Published by University of Tilburg The Netherlands.*
Available from: www.essay.utwente.nl/65409/1/Kwekkeboom_BA_MB.pdf.
[Accessed 23rd June 2015].

232. VAN DIJK T. (2008) Discourse and Context A Socio cognitive Approach *Book Published Hardback* ISBN: 9780521895590 pp. 6-7.

233. VAN DYKE D. (2006) Management Commitment: Cornerstone of Aviation Safety Culture Royal Aeronautical Society (Montreal Branch).
Available from: http://www.skybrary.aero/bookshelf/books/945.pdf
[Accessed 23rd June 2015]

234. VAN EEK ET AL (2011) Behaviors in Highly Productive Continuous Improvement Teams: How to Change a Winning Team. *Published by The Netherlands Advisors University of Twente*
Available from www.essay.utwent.nl
[Accessed on line 19th October 2014].

235. VAN LANGE P. ET AL (2012) The Handbook of Theories of Social Psychology. Chapter 21 The Theory of Planned Behaviour p. 439. *Sage Publication* ISBN 978-0-857029607.

236. VENERUS K. (2014) Visionary leadership. *Published in The Commissioning Review Issue 08 Autumn 2014*
Accessed from www.thecommissioningreview.com
[Accessed 17th January 2015].

237. VEZYRIDIS P. TIMMONS S (2014) National targets, process transformation and local consequences in an NHS emergency department: A qualitative study. Published by BMC Emergency Medicine Vol. 14 (12) doi:10.1186/1471-227X-14-12
Available from: http://www.biomedcentral.com/info/authors
[Accessed 15th January 2015].

238. VINCENT C, CARTHEY J, BURNETT S. (2015) *Safer Clinical Systems: Evaluation Findings The Health Foundation.*
Available from www.health.org.uk/areas-of-work/topics/patient-safety
[Accessed 10th February 2015].

239. WALCOTT H. (2002) Writing Up Qualitative Research. *Sage Publications*.

240. WATERSON P. (2014) Patient safety Culture Theory Methods and Application MacDonald & Waring Creating a Safety Culture: Learning from Theory and Practice. *Published by Ashgate* ISBN 9781409448143. Chapter 6 pp119-121
241. Available from: www.ashgate.com
[Accessed 12th May 2015]

242. WEENINK, L.A.M. (2012) *Behaviors of highly effective continuous improvement teams: two types of video-analysis of three prototypical work situations.* MSc thesis, University of Twente, Available from; http://essay.utwente.nl/62884/
[Accessed 9th August, 2013].

243. WEICK K. (2009) Making sense of orgnisations. The impermanent organisation. *Published by John Wiley and Sons* ISBN 978-0470-74-220-4

244. WODAK R. MEYER M. (2009) Methods of critical discourse analysis 2nd ed *Sage Publication* ISBN 978-1-84787-4542.

245. WOOD H. (2013) *Mid Staffs shows whats wrong with NHS Management*
British Medical Journal Vol 346 p 25.
Accessed from: www.bmj.com
[Accessed 26th December 2015]

246. WORLD HEALTH ORGANISATION (2006) Quality of Care: A process for making strategic choices in healthcare.
Available from: www.whoint/management/quality
[Accessed 17th May 2015].

247. YALOM I. (1995) The theory & practice of group psychotherapy. 4th ed. *Published by Basic Books New York* 10022-5299.

248. YAMMARINO, F. ET AL (2008) Authentic leadership and positive organizational behaviour: a meso multi-level perspective. *Published in Leadership quarterly*. Vol. 19 (6), pp. 693–707

249. YAMMIYAVAR, T. CLEMMENSEN J. KUMAR P. (2008) Analysing non verbal cues in usability evaluation testing. *Published in the International Journal of Design* Vol. 2 (2).
Available from: www.ijdesign.org
[Accessed 10th November 2014].

Appendix 1 *Questionnaire*

☐ *I have read the information sheet provided and I am happy to participate. I understand that by completing and returning this questionnaire I am consenting to be part of the research study and for my data to be used as described.*

We are conducting a study of CCG's in the Northwest we are interested in leadership behaviour and affect on outcomes. Please complete as best as you can there are no right and wrong answers all information will be anonymised and no information will be passed to your line manager. (Tick one box only)

1. Your current role is one of the following categories-
Administrator/Support Staff ☐ GP ☐ Manager ☐ Dept Director ☐ Executive/Director ☐ Chief Executive ☐ GP/Commissioner ☐ CSU ☐ NHS England ☐ Public Health ☐ Local Authority ☐

2. Date (today's date) ☐

3. Leader's Position or Rank you report to-
GP ☐ Manager ☐ Deputy Director ☐ Executive/Director ☐ Chief Executive ☐

4. How long have you been in this role?

0-2 Years ☐ 2-5 Years ☐ 5-10 ☐ more than 10 years ☐

5. Do you work as part of a Team Yes☐ No ☐

6. Are you Male ☐ or Female? ☐

7. What age range are you 18-30 ☐ 30-45 ☐ 45-65 ☐ 65+ ☐

Use the following rating scale:

Not at all 0 Once in a while 1 Sometimes 2 Fairly often 3 Frequently 4

1. Does the leader talk about their values & beliefs	0☐ 1☐ 2☐ 3☐ 4☐
2. Do you feel safe to discuss conflicts openly with colleagues?	0☐ 1☐ 2☐ 3☐ 4☐
3. Do you feel colleagues have the same beliefs as you?	0☐ 1☐ 2☐ 3☐ 4☐
4. Does the leader avoid getting involved when important issues arise?	0☐ 1☐ 2☐ 3☐ 4☐
5. Does the leader heighten my desire to succeed	0☐ 1☐ 2☐ 3☐ 4☐
6. Does he/she seek differing perspectives when solving problems	0☐ 1☐ 2☐ 3☐ 4☐

Please Turn Over

7. Being associated with him/her makes you feel proud	0☐ 1☐ 2☐ 3☐ 4☐
8. Spends time teaching & coaching	0☐ 1☐ 2☐ 3☐ 4☐
9. Shows that he/she is a firm believer in 'if it ain't broke don't fix it'	0 ☐ 1☐ 2☐ 3☐ 4☐
10. Goes beyond self-interest for the good of the group	0☐ 1☐ 2☐ 3☐ 4☐

11. Acts in ways that build my respect 0☐ 1☐ 2☐ 3☐ 4☐

12. Only focus on dealing with mistakes complaints & failures 0☐ 1☐ 2☐ 3☐ 4☐

13. Describes & presents a compelling vision of the future 0☐ 1☐ 2☐ 3☐ 4☐

14. Avoids making decisions 0☐ 1☐ 2☐ 3☐ 4☐

14. Uses methods of leadership that are satisfying 0☐ 1☐ 2☐ 3☐ 4☐

15. Do you feel the team is a high performing group? 0☐ 1☐ 2☐ 3☐ 4☐

16. Is he/she available to discuss problems or particular issues? 0☐ 1☐ 2☐ 3☐ 4☐

17. Do you have autonomy over your work activity? 0☐ 1☐ 2☐ 3☐ 4☐

18. Does your leader considers the moral & ethical consequences of decisions 0☐ 1☐ 2☐ 3☐ 4☐

19. Encourages us to work with other team members or partners 0☐ 1☐ 2☐ 3☐ 4 ☐

20. Checks teams progress on plans & targets that have been set 0☐ 1☐ 2☐ 3☐ 4☐

21. Recognise good performance or extra effort made by the team 0☐ 1☐ 2☐ 3☐ 4☐

22. Presents feedback in a helpful manner 0☐ 1☐ 2☐ 3☐ 4☐

23. Displays a sense of power & confidence 0☐ 1☐ 2☐ 3☐ 4☐

24. Leads a group that is effective 0☐ 1☐ 2☐ 3☐ 4☐

25. Does your leader manage conflict well 0☐ 1☐ 2☐ 3☐ 4☐

26. Is the behaviour of the leader positive to you 0☐ 1☐ 2☐ 3☐ 4☐

27. Is the leader approachable & will take on new ideas 0☐ 1☐ 2☐ 3☐ 4☐

28. Is the leader focused on targets & finance 0☐ 1☐ 2☐ 3☐ 4☐

29. Does the leader display good behaviour 0☐ 1☐ 2☐ 3☐ 4☐

30. Do you feel included in decisions that affect your work 0☐ 1☐ 2☐ 3☐ 4☐

1a. Evaluation of questionnaire themes for SPSS

Leaders vision (clear to staff)
Q1. Does the leader talk about their values & beliefs?
Equates to the leader's values and beliefs being implemented at local level.
Q13. Describes & presents a compelling vision of the future:
Equates to vision for the future and is inspirational about how the future will be determined.
Individual perceptions (self-reward)
Q18. Do you have autonomy over your work activity?
Equates to control over workplace and activities.
Q31. Do you feel included in decisions that affect your work?
Equates to decision making to influence how work outcomes are achieved.
Conflict management (constructive or destructive behaviour)
Q2. Do you feel safe to discuss conflicts openly with colleagues?
Equates to the trust within the Organisation or Department for how the leader deals with conflict.
Q26. Does your leader manage conflict well?
Equates to how issues are dealt with does he/she create conflict or reduce the likelihood.
Q.6 Does he/she seek differing perspectives when solving problems?
Equates to does the leader listens to staff or certain groups or specific individuals.
Supportive behaviour
Q8. Spends time teaching & coaching?
Equates to supporting and developing staff in their job role.
Q23. Presents feedback in a helpful manner?
Equates to providing information in a positive manner.
Q28. Is the leader approachable & will take on new ideas?
Equates to being focused on the bigger picture.
Performance management
Q20. Encourages us to work with other team members or partners?
Equates to having a broad view of the department and its needs.
Q21. Checks team's progress on plans & targets that have been set?
Equates to good project management and communications.
Q22. Recognise good performance or extra effort made by the team?
Equates to staff going the extra mile.
Behaves well as leader (emotional state)
Q30. Does the leader display good behaviour?
Equates to ethical shows integrity to others.
Q27. Is the behaviour of the leader positive to you?
Equates to values staff and individuals
Q24. Displays a sense of power & confidence?
Equates to positive in his/her outlook and provides staff with assurance.
Q10. Goes beyond self-interest for the good of the group?
Equates to works with the best interest of the team.

Team think positively about the leader
Q7. Being associated with him/her makes you feel proud?
Equates to a person the individual looks up to and admires.
Q11. Acts in ways that build my respect?
Equates to being a supportive individual.
Q19. Does your leader consider the moral & ethical consequences of decisions?
Equates to works ethically and morally when making decisions.
Q15. Uses methods of leadership that are satisfying?
Equates to being in a team that supports the individual
Team beliefs (vision)
Q3. Do you feel colleagues have the same beliefs as you?
Equates to one goal within the team.
Q16. Do you feel the team is a high performing group?
Equates to the team feel good about each other and their position within it.
Targets & decision making (transactional)
Q4. Does the leader avoid getting involved when important issues arise?
Equates to lack of commitment and interest.
Q29. Is the leader focused on targets & finance?
Equates to lacking overall vision and may not focus on Q&S.
Q14. Avoids making decisions?
Equates to laissez fair and provides little support described as non leadership.
Q9. Shows that he/she is a firm believer in 'if it isn't broke don't fix it'?
Equates to lack of ambition to change a situation or work activity.
Q12. Only focus on dealing with mistakes complaints & failures?
Equates to a blame culture and focus on negative side on staff performance.
Focuses the teams efforts (transformational)
Q25. Leads a group that is effective?
Equates to positive group behaviour and outcomes.
Q17. Is he/she available to discuss problems or particular issues?
Equates to open door policy.
Q5. Does the leader heighten my desire to succeed?
Equates to feels part of the team and commitment to work activity.

Appendix 2 Open forum meeting with annotations of body language

	Comm	**Content**
1	Comm 9:	5 different ones Finance, clinical effectiveness, culture, complaints and targets
2	Comm 2:	I guess we have ten minutes
3	Comm 8:	Start at the top laughs gathers papers and removes tension
4	Comm 2:	start with finance that's favourite
5	Comm 8:	Do you want me to read it out sits up straight and looks directly at Comm 2
6	Comm 2:	Go for it
7	Comm 6:	Who's going to time us then (Thumbs up to number 4)
8	Comm 8:	Scenario the board has had to implement stringent financial controls with a deficit of £10M this year. As a Board member, you have been asked to implement a workforce cut, based on costs, the most Departments needing the deepest cuts of £2m initially describe the risks associated with this scenario and controls. hand to chin leans over to get pen and papers
9	Comm 6:	well where do we start ha-ha looks at Comm 8 said in high pitched comic voice
10	Comm 8:	well there's a start middle and end.. erm so rapid hand gestures shuffles in chair fingers crossed
11	Comm 6:	so it would be interesting to know, the decision as all it says is that it is based on costs, but what's informed that, presumably they have done some work behind that made on an assessment what was that based on presumably on processes, they cost too much so we shave off 2Million off hand on table indication of chopping on table gets scenario from table
12	Comm 8:	So have asked us to consider the risks and controls in this scenario painting pictures with hands pinching the air
13	Comm 6:	Yes
14	Comm 8:	so are you saying the risk are have they done that background work open hand gestures to group looks specifically at Comm 6
15	Comm 6:	Definitely
16	Comm 1:	yeh has it been done purely on finance
17	Comm 8:	yeh definitely open hands to all the group
18	Comm 2:	Surely one of the main risk is on service provision and er moral and on staff, you know on the organisation they would be key. Sharp movements of hands from Comm2 nods from 8 & 9 in agreement, 8 gets pen and paper from centre of the table
19	Comm 9:	I think what someone raised earlier, I think we do need to know more, as well don't know if the 10m is it recurrent, historic, may have been 40M we don't know the deficit before or the timeline for recovery. Gathers pen paper begins writing when Comm 2
20	Comm 2:	Yes
21	Comm 9:	So one of the risks is not having all the information to make the right decision.
22	Comm 6:	yes the safe decision.
23	Comm 9:	and it's what you said (pointing number 1) has the appropriate quality impact assessment been

		done erm and does it affect patient safety. Did you have safeguarding individual's processes safeguarding patients and safeguarding the erm organisation? I think we are not clear on the information. Although they are controls what are the risks they aren't clear. Quiet voice and hand movements towards 1 in agreement
24	Comm 1:	yeh for me its about will the savings had an impacts on other savings on other services areas are you avoiding other costs. If you remove this service you may save that 2m but in a couple of years time we are going to have er more critical people with not much more money we had a mini bus service for our day centres and the savings was instantaneous but after 2 years it had gone up as people where using taxis, people having to get bus passes so although the savings were there in the beginning it actually led to er bigger costs. Again it's about what you said doing a proper impact assessment on this. Left hand cupped and points to each finger indication of numbers of issues points to No 9
25	Comm 2:	So one of the issues is to making decisions on a short term basis which can actually have er longer term implications for service provision, would you like a pen. Palm on table pen handed to Comm 8
26	Comm 6:	Just thinking about the reasons why as well so as a concurrent cost whether it's a deficit or but less than it was or has there been a sudden boost to the population or something like so that and when we say identify the risks, perhaps we have to be clearer about what that means. So poor quality either as you said Comm 1 with later costs further down the line or is it actually unsafe so that does it mean staff cuts is that up front facing or is that back office. What are we talking about it's important to find that? mirrors Chopping action on table one over another points at No 1 eye contact with all round table
27	Comm 2	getting rid of staff is actually quite expensive as well erm you sort of got to have er obviously got contractual obligations and you might be dealing with staff who have been in place for a long period of time. So there are cost implications erm not just. Hands below desk uses head to nod at all round table as speaks
28	Comm 6	mmmm
29	Comm 2:	erm not just trimming down the salary budget erm there are significant implications.
30	Comm 8:	is there something there about as it says they targeted the most expensive departments and we are just looking at workforce so points at scenario and looks at 6 for assurance shrugs shoulders
31	Comm 2	Yes
32	Comm 5:	yeh absolutely
33	Comm 8:	so that could be very specialised healthcare professionals
34	Comm 2	Yes yeh
35	Comm 8:	so we don't know the quality and safety issues hands open palms up to all table but focuses on 1, 9 and 6
36	Comm 6:	Yes
37	Comm 8:	So we don't know ask the question why the most expensive department hands open
38	Comm 1:	so if we are going to do that what controls what do we mean by controls are they looking at all the things we have discussed trying to mitigate I suppose its its creating a risk register isn't it an keeping on top of that. all 3 on same side of table hands to mouth 7 8 9
39	Comm 6	How long have we got left.
40	Comm 4:	5 minutes
41	Comm 8:	ok just we just look at the risks we have identified the background and we probably need to identify

		the top 5 erm and the background to the rationale for this decision the risk to staff and workforce have we only considered finance and no other variable is it just this year or is it re-occurring or current what's the impact on safety impact assessments done, will it impact on clinical effectiveness safeguarding are there any actual hidden cost so if we erm we make savings this year will we actually with costs going forward erm and linked to that someone mentioned there are costs to reducing staff whether its redundancy redeployment their contractual employment legislation, someone mentioned about erm is there a timeframe around been done around this this short term impact versus the long term and population projections have we considered that. Did I miss anything…..lots of rapid hand movements as if moving process along 3 and 4 move back both touch hair and mouth looks directly at individuals and points to others in group.
42	Comm 5	no that's good
43	Comm 6	your point about what does it mean about specialist staff puts hands in air two fingers on each hand quotes " " to emphasis point then holds hands to side of face
44	Comm 8:	what the most expensive department
45	Comm 2:	and if its erm we don't have the information but if it's erm a speciality that other specialities rely on you know If I you suddenly get rid of it are you going then to affect service delivery elsewhere Comm 2 uses sweeping hand movements on the table 8 moves hands pointing in air to agree point with 2 mirrors actions of 2
46	Comm 8;	yes
47	Comm	2 exactly erm
48	Comm 9:	so if you where to take out the phlebotomy service in a GP Practice then your
49	Comm 2:	yeh
50	Comm 9:	you would have to pay for that all through the acute trusts which would probably cost as much the other thing is as you where talking what was going through my mind was what is 10M as a percentage if this is a massive 500M yeh no hand near mouth
51	Comm 8:	yeh percentage of the budget overall
52	Comm 9:	it might not be it might not be massive equally though hand gesture to 6
53	Comm 6:	if it's a small provider could be a big contract smiling at 9 small laugh
54	Comm 1	could put them out of business
55	Comm 2:	if I was a board member I'd want to look at the various options you know for making these cuts and then looking at what the consequences you know would be to organisation overall and then to that bit etc etc then you would make an informed decision as to what to do. Head nods frequently and chops on table 8 & 2 arms folded leans on table
56	Comm 6:	I was wondering what you three where thinking (pointing to Comm 3 4 & 5) hand waving to invite the 3 people in who have not contributed
57	Comm 5	I was thinking it's all great I am just taking it all in, one of the things I would like to understand is the deficit in the first instance as well erm as in some ways you might think you are fixing a problem with 2m savings and in fact you have a recurring problem you haven't addressed the root cause I suppose so its understanding the cause of it is. Open hands to group
58	Comm 4:	Some of the controls have to be around the governance and the process cost reduction because a result in a lack of confidence in the organisation. Spending all your time dealing with Comms complaints and PR rather than dealing with the cost reduction programme. Hands have very small movement closed or on table much bigger movements from leaders
59	Comm 1	Did you say to nominate one person to take the lead through all that?

60	Comm 4:	could do really yeh
61	Comm 1:	as a control hand from 4 directed at 1
62	Comm 9:	I don't think I heard you say it that way I thought you said there had to be processes hand gesture waving away the issue and tells 4 what she was trying to say
63	Comm 6	yes
64	Comm 9:	you know you might have a nominated lead but there wasn't just one person running with this and holding the risk and accountability but we need to make sure accountability and the escalation for this is clear. hands on table in crab like fashion
65	Comm 4:	it's about giving people a structure to work within the governance processes they won't waste their time going down blind alleys without controls and some possible options as they take a staged approach were a checklist is to ensure the impact has been assessed hands on table in crab like fashion on right hand
66	Comm 8:	so in terms of control I've been scribbling a couple of notes down when you have been talking, it's about impact assessments have option appraisals been done, governance around the process, there's something about public engagement political engagement the wider stakeholders MPs where mentioned accountability what's the escalation plan and probably de-escalation plan if things changed now uses hands with ok symbol left hand then hands in prayer like hold on table 4 mirrors nine chopping the air.
67	Comm 4:	erm
68	Comm 8:	I'll let you come in a minute, (points to Comm 4) So we are a CCG and we want assurances from the trust aren't we were saying to them we will do this but want assurances of we think these are the risks and we think this is the possible control
69	Comm 9:	It doesn't say this is a provider you know it could be our own it could be CCG money then leans agross Comm 8 and picks up paper breaks the conversation
70	Comm 2:	didn't he say you are a in a Commissioning role and this information has come to you about a provider.
71	Comm 8:	yes you missed the presentation so you wouldn't of been aware..
72	Comm 9:	I missed that uses hands to hold up and admits got it wrong waving hands
73	Comm 8:	do we agree that's what he said. 8 takes paper back from 9
74	Comm 2	yes that's right
75	Comm 8:	so we need 5 clear risk and 5 clear controls
76	Comm 4:	should we move onto the next one
77	Comm 1:	we can fill that in
78	Comm 6:	just fill it in
79	Comm 8:	so the first risk is two of them are linked together
80	Comm 9:	thank you
81	Comm 8:	which is the reason and the background to this are you happy with that
82	Comm 6:	so the reason is ere r definitely failure in quality and safety and the other stuff about ineffectiveness with customers

83	Comm 8:	we want to know the impact on safety and clinical effectiveness
84	Comm 6:	so yes the risk to safety and clinical effectiveness you put long term costs (nodding to Comm 3:)
85	Comm 9:	this is really interesting how we look at what quality means which I have the three things patient experience clinical effectiveness and erm patient safety you can't just look at one as they interchange that tries to draw the group back and reconnect hands crossed
86	Comm 6:	yeh
87	Comm 8:	risk to clinical effectiveness and hidden longer term costs Comm 2 two hands in air shaking them
88	Comm 9:	you've not got down patient experience points at scenario looks annoyed
89	Comm 6:	so we are looking at something about outcomes
90	Comm 8:	because they are all linked together
91	Comm 9:	yes thank you
92	Comm 8:	is this current or just this year
93	Comm 3:	it's about reputation to the organisation, if you strip 2M out it affects your targets, contractual obligations is it a specialised service, or is it specialised the risks to commissioning holds fingers as makes point
94	Comm 8:	yeh do we want to know so the wider implications reputation and the overall performance of the organisation. Hands shake in air together
95	Comm 6:	the whole system
96	Comm 8:	so is timeframe are we saying that's a risk or a control hand waves again towards comm 6
97	Comm 6:	it's a control
98	Comm 8:	so in terms of the 5th risk
99	Comm 6:	well it could be a risk if you have to do it in 6 months
100	Comm 1	what time are we on sorry
101	Comm 4:	yeh yes keep keep going
102	Comm 6:	someone has to do that job
103	Comm 8:	timeframe is it clear controls are a bit we have actually those boxed off quite well, Governance process, impact analysis, impact assessment,
104	Comm 6:	Comms yeh
105	Comm 8	engagement with comms accountability, escalation de-escalation plan waving hands up and down to indicate the scenario points to 7
106	Comm 6:	yeh but also one thing we picked up as a risk is a baseline and then all the way through that what's the patient experience has this affected them so an involvement work stream is erm erm a control sorry. Chops on table then uses two hands palm down to draw a widening picture on the table
107	Comm 8:	Comms and involvement
108	Comm 6:	yeh
109	Comm8:	could we do it like that

110	Comm 6:	yeh
111	Comm 8:	because we've got the impact assessment appraisal, public engagement comms and involvement, accountability and escalation, we would want to know is this working is it or not what are your plans. Hands move rapidly and body backwards and forwards
112	Comm 6:	yes
113	Comm 4:	that took 16 minutes
114	Comm 8:	it was our first one
115	Comm 1	ok Clinical effectiveness I will pass it round but the scenario is I will just write it straight on there the scenario is
116		**Scenario 2** There have been a number of cases of misdiagnosis, including a failure to diagnose a serious injury in a young man who later died as a result. The manner of diagnosis given to patients has left a lot to be desired with patients raising concerns about insensitivity, failure to listen and lack of compassion. 8 has hand over mouth
117	Comm 1	should I pass that round and people can have a read.
118	Comm 6	: mean this just sound so serious in terms of a death neglect of duty the way you do it is part of your job.
119	Comm 7:	there are obviously training issues if you are not diagnosing appropriately
120	Comm 2:	mmm one of the key risks will be a clinical negligence claim
121	Comm 2	yeh yeh
122	Comm 6:	Death of patient did they say they had died
123	Comm 4:	yeh
124	Comm 5:	yeh
125	Comm 9:	It's interesting this I think an interesting way to approach this is I mean I don't know any clinicians that would set out to cause harm to patients, so if we look at that process it means we have systems that are not compliant with minimal clinical standards there's not been compliance with those or else there has not been audit review case management er supervision that of those clinical decisions hands on table palms down left hand draws back supporting the clinicians
126	Comm 4:	it's really interesting that it describes a misdiagnosis that intimates direct clinical error but what the relatives are reflecting is the way they where communicating with and how which is not the outcome per say
127	Comm 6:	I think it they refer to patients in the pleural its more than one case and that people experience that people talk about diagnosis that might just be a spelling thing so is there a bit of a culture that' were people are finding that's not sensible all hand movements are similar to previous chopping the air etc
128	Comm 2:	there's reputational issues in terms of risk both from the provider as well as the individuals that were involved. Hands on table left hand sweeps table
129	Comm 4:	I think this is an extreme case where we are talking about people dying but isn't there research that generally errors are made in complex situations and people generally understanding and forgive the errors are made in situations
130	Comm 6:	death in care
131	Comm 4:	but what they can forgive for the error but they can't in the manner they are treated

132	Comm 5:	absolutely
133	Comm 4:	if the misdiagnosis isn't acceptable none the less the situations worsened by the way the organisation treats them. Hands on table
134	Comm 9:	How do we know there was an error under some conditions they are notoriously hard to diagnose? hand on chin and very much defending clinical position
135	Comm 3	is it the nature of the complexity hands on table
136	Comm 6:	but they described it they have identified it as that
137	Comm 9:	misdiagnosis
138	Comm 6:	oh I thought it was
139	Comm 5:	I think there are 2 things there's the misdiagnosis which could be an incident in its self but then it's a misdiagnosis then there's the way in which the message was delivered to the people concerned and that's a cultural (nods at 9) issue the way it's taken forward
140	Comm 9:	I know you are saying that but we don't want to jump straight to controls but you know you would really want an external review and would want internal investigations but you would want to be sure
141	Comm 5:	yeh it would need to be investigated
142	Comm 6:	the other thing which springs to mind is often is the use of interim doctors and err not having proper processes and things that like and not having proper processes for inductions into this is what we do before you step over the door with agencies supplies especially in relation to children's safeguarding there's a lot. chopping air when explaining situation hand back to mouth
143	Comm 2	: so one of the controls is really one of competence of staff arms crossed
144	Comm 1:	yeh
145	Comm 2:	training staff
146	Comm 5:	yeh but equally we can't, it doesn't mention agency staff er so we can't jump to the conclusion that we need to do the investigation and find out what are we the root cause try and establish particularly if there been a theme of misdiagnosis and try and put the controls in place hands rolls
147	Comm 6:	I think I was just suggesting it is often an issue
148	Comm 5:	yes it was one of the possibilities staffing is an issue
149	Comm 8:	as a CCG looking at this its understanding the the dynamics and the context there's a number of cases of misdiagnosis so we don't understand the complexity of the environment so we want to know more about that and leave the way it's been handled by the organisation but I think there's a risk to the CCG's reputation as well as the Trust. We have a responsibility we commission is service so it's not just about the risk to the trust but the risk to this is highly emotive to gets in the press now Comm 8 well established in the group speaks slower and delicate hand movements less animated
150	Comm 1:	I think for me there are 2 separate issues here the misdiagnosis one but the young man has died so we don't know how he was treated in terms of compassion and insensitivity but what we do know for definite is that patients have er er said there is in sensitivity and lack of compassion. What I would be trying to get to which patients have said that and digging more into right hand held pen
151	Comm 6:	gathering that evidence 4 holds 3 fingers up indicating 3 minutes
152	Comm 1:	yeh yeh when they say patients is it 2 out of 500 or is it what is the scale of that so for me the risk is

		not knowing what the actual evidence is saying and where it's from 4 holds hands over eyes
153	Comm 6:	Bit like the finance one yes he he (pointing to Comm 4:) left hand roles round on table to emphasise second point. Looks at comm 4 smiling laughing
154	Comm 9:	so there's 2 investigations going on there one about the culture and the care and stuff like that and then there's the other one around the clinical diagnosis left hand roles round in circle on table
155	Comm 1	yeh
156	Comm 9:	or erm I would say in terms of control I would be quite pleased if the provider I would be interested in had gone through and we got this situation ye know we really concerned about t we will let you know as a provider this is what we want to do this is our plan what's your view on that rather than us finding out through the press the CQC the regulator, you know then you would be more comfortable that your provider had a grip on this really. hands are chopping the air holding them together and occasionally pointing
157	Comm 1:	yeh you're absolutely right someone has reported this back they've not focused on the fact that someone has died they have clearly looked at the bigger picture as well
158	Comm 6:	but exept we don't know if it's coming from the provider trust left hand in ok position to explain point
159	Comm 1	No
160	Comm 6:	it may be coming via a complaint
161	Comm 1	No no its not clear
162	Comm 4:	so how many risks leans forward and not responded to.
163	Comm 2	so we all feel there is a risk of a clinical negligence claim and if there is
164	Comm 9:	is there definitely a risk around patient care isn't it secondary to patient care 8 holds hand to chin
165	Comm 5:	absolutely the risk of re-occurrence at the moment we don't know why the misdiagnosis was made
166	Comm 2:	I think also there might be an erm investigation in relation to negligence er you know which may involve the police for example so those are some of the consequences of erm
167	Comm 1:	what time are we at
168	Comm 4:	about a minute and a half opens mouths wide but doesn't speak
169	Comm 9:	are they positive controls
170	Comm 6:	I think you are right in that in as much it's from the evidence we have got there is a risk of clinical negligence case it might be negligible but it's there for either organisation or the Trust. Nods head towards 2 and dismisses 9
171	Comm 1:	by the way nowhere does it say we have to have 5 risks so we've got 2 so should we move on to someone to do number 3. 6 laughs aloud
172	Comm 1:	we have got the risk clinical negligence claim reputation additional risks from bad publicity there's the risk of recurrence
173	Comm 5:	patient safety one
174	Comm 1:	yeh
175	Comm 6:	sorry I have to take an important call
176	Comm 5:	so reputational

177	Comm 1:	got that
178	Comm 6	sorry about that
179	Comm 1	one of the controls would be looking where the research information has come from external review er staff training competency training
180	Comm 8:	I would want to show that the trust is putting something in place now until the review starts with a timeline pointing at the table two hands together very clear tone in voice
181	Comm 9:	yeh
182	Comm 8:	because there is numerous cases what are you doing now to move forward?
183	Comm 2:	regardless about the root causes to avoid them happening again
184	Comm 5:	yes that's one of the controls the investigation
185	Comm 1:	let's close this one ha-ha slaps paper on table
186	Comm 8:	Good
187	Comm 5:	Ok erm scenario
188		**Scenario 3** It has been recognised that there has been a lack of compassion by a number of staff when dealing with vulnerable patients on Ward X.
189	Comm 6:	this is culture points at scenario
190	Comm 5:	The poor attitude has been in place for a number of years and bullying has been raised as a concern by the Union. There appears to be a lack of structure and rules are not followed. Examples of good management behaviour are difficult to find. It appears that there is a lack of respect from all concerned.
191	Comm 8 & 6	mmmm
192	Comm 8:	my first risk is it mentions the management of vulnerable patients hands on chin and emphasises point with two hand when says vulnerable patients hands under chin often first to respond
193	Comm 6:	yeh
194	Comm 8:	so I think to me that crucial that this is is about vulnerable patients
195	Comm 5:	yeh So there's a safeguarding issue
196	Comm 6:	So the staff are bullying
197	Comm 1:	Do you think can I read it hands outstretched reaching for paper
198	Comm 5:	yeh it's harder when you
199	Comm 1;	yeh yeh
200	Comm 4	we need to find out exactly what the issues are the training ratio may not be quite right hands chop air
201	Comm 6:	it sounds as if the union have got a good case its more than one complaint so they raised it as an issue organisationally it's not just one individual so it sounds as if something is going on culturally
202	Comm 5:	but there certainly is a picture of safeguarding even if there is a staffing issue, so should we put that as the first one.

203	Comm 4:	then there is a risk of having to recruit staff to that particular ward would be difficult because of the reputation
204	Comm 7:	yeh because we don't know if it is just that one ward or the whole of the hospital or a culture in just this one where there is an isolated case. Arms crossed
205	Comm 2:	it is just in one ward as you say but it might be across
206	Comm 5:	it's been there a number of years is what it's saying bullying has been raised as a concern by the union.
207	Comm 4:	that recruitment is would equally apply to the management team which may be lacking that would equally apply wouldn't it. Good managers tend to be drawn to places where they can flourish an hand open points
208	Comm 6:	so the reputation effects erm effective recruitment
209	Comm 1:	does it say on there that they will struggle with recruitment it would impact but does it say it
210	Comm 7:	no
211	Comm 4	no but it would be a risk
212	Comm 1;	yeh yeh
213	Comm 5:	but there is a staffing risk because staff are more likely to go off sick with stress etc and erm.
214	Comm 9:	and I think you will find with the numbers you won't be able to deliver safe care and we also know there would be a lack of care and the causes of this are hands used to point to scenario and circle in air
215	Comm 2:	multi layered
216	Comm 9:	and one of the first thing I would want to know is the staff survey results drill down in each division and you wouldn't just to depend on that I suppose it's the test and intelligence you have got and you as commissioners would want to take clinical colleague with you for your own judgement and you would do that as an unannounced visit points to table
217	Comm 6:	exactly
218	Comm 9:	then you would want to triangulate what intelligence with other regulators what CQC what monitor have got what health watch have got what complaints your SI say you have got to understand this there is a massive amount of intelligence as each point is made it is re-affirmed with right hand movement in same rhythm as words hands on fingers 1-2-3
219	Comm 1:	you would definitely want to speak to the union because there there going to be getting the hands clasped together
220	Comm 6:	they've got an evidence bank really
221	Comm 1:	yeh yeh
222	Comm 9:	It shouldn't be punitive as nurses and clinicians don't set off to be rubbish in what they do they get professional drift that's because nobodies challenging them or their modelling or poor practice of others points then brings hands together as if praying together chopping the table with answers
223	Comm 6:	I don't get the link between what you said and the union have and stories and evidence bank of individuals being bullied and how that's nobody intends to set out intends to what do you mean sorry I missed the point frowns at start moves hands rapidly 9 leans forward 8 leans across 9 to pick scenario off the table says I missed the point loud

224	Comm 9:	if people feel bullied then in theory there isn't appropriate escalation you know you would presume the nursing staff didn't have a voice so your whistle blowing mechanisms your escalation procedure finger right hand held out then 2 fingers describe whistle blowing 3 then mechanisms
225	Comm 6:	yeh I left hand moves then to re-invite 9 back in the group
226	Comm 9:	the bullying is a symptom
227	Comm 5:	the issue concerns risks
228	Comm 6:	exactly one doesn't negate the other two hands open in flashing action towards comm 9
229	Comm 4:	we've got 2 minutes
230	Comm 5:	yes
231	Comm 4:	so one of the controls are staffing rotas, staffing levels described it's how the rotas are measured and monitored managed if the staffing is consistently hands on table crab like smoothly moved across the table
232	Comm 5:	yeh yeh
233	Comm 4:	if you address staffing consistency you can then tackle culture you cant tackle culture until you address staffing
234	Comm 8:	I would want to know if the staffing levels are affecting the vulnerable patients and getting the right level of care if they are less vulnerable they need less care. If staffing levels are right then is it a training and development issue in that department in that hospital. Moves away from 9 hands rapidly and head movement towards 4
235	Comm 1:	yeh
236	Comm 4:	In that hospital is there a nurse that can support vulnerable patients and come into a ward like that and support them.
237	Comm 5:	then there is the training and competency issue those people haven't been trained in dementia care
238	Comm 8:	yeh
239	Comm 4:	and another control could be either the involvement engagement of the governors of the organisation slightly independent
240	Comm 8:	yes health watch
241	Comm 4:	to look at overall trends
242	Comm 6:	that's the point I want to make so the staff survey is really important as a first stage they may then encourage them to have interviews but also board investigation what information do they receive have what's their attitude how do they deliver it the execs and non execs and board actually how do they deal with this sweeping hand movements on table chopping action
243	Comm 2:	I think one of the things in controls ought to be as the organisation setting out what is its accepted and expected behaviour hand sweeps on table palm down
244	Comm 5:	yeh absolutely board behaviours
245	Comm 2:	throughout the whole organisation
246	Comm 6:	so before then need to find out what is it at the moment at board level?
247	Comm 2:	that is definitely a control I think one of the risks is the understanding that if the information was to get out might be referral patterns I was thinking what happened at Bristol royal Infirmary for example so erm

248	Comm 4:	yeh
249	Comm 5:	so referral activity ok
250	Comm 8:	so this is one ward representing a whole culture or is it one ward I am not clear wether we know hands move to above head to show levels of staff
251	Comm 6:	I think that's why we need a high level view as well don't we hands part in air and widen
252	Comm 9:	isn't one of the controls we need to hear the voices of patients as well as staff holds fingers of one hand
253	Comm 5:	we got that patient service
254	Comm 9:	Not just the survey
255	Comm 5:	real time yeh real time
256	Comm 3:	Scenario 4 is this scenario is pushed to 4 from 8 encouraging her to lead
257		**Scenario 4** There have been numerous complaints about the attitude of staff and poor hygiene standards, when staff attended to patients. One member of staff was observed using the same razor on different patients, using the same water in a bowl and not washing and brushing patient's hair. thi
258	Comm 6:	there's been numerous reports
259	Comm 3:	numerous complaints
260	Comm 6:	yeh
261	Comm 3:	There have been numerous complaints about the attitude of staff and poor hygiene standards, when staff attended to patients.
262	Comm 9:	Why…. why when every member of staff should have had their mandatory training they should of been supervised so there shouldn't be numerous so that implies the staff haven't got the information the skills to provide basic basic skills to provide basic hygiene holds thumb when explaining about basic skills
263	Comm 6:	sorry what to interrupt what category is this one in? interrupts 9
264	Comm 2&3	complaints
265	Comm 6:	yeh to me it also feels to me like a erm cultural thing you know this is the way we work round here rather than lack of knowledge
266	Comm 5:	so
267	Comm 6:	but we do need to know if they had been trained
268	Comm 1:	did they say one person was witnessed using a razor
269	Comm 3:	Numerous 1member of staff was observed
270	Comm 8:	if there there were numerous is there a risk of hospital acquired infections there and this
271	Comm 5:	absolutely
272	Comm 8:	I would want to know what the infection rates are looking like basic care is not there and what the contribution to that hands held clasped near mouth then opens out when making a point

273	Comm 9:	if you were in the infection control team and that landed on your desk the infection control team would be going in to make sure there was appropriate mechanisms erm you would also want the infection control team to provide evidence of investigations aside we don't know if this is being investigated we don't know how accurate it is sometimes you get complaints and sometimes I'm not saying it's not inaccurate but sometimes you get complaints which is a valid interpretation from a relative but when you investigate that perhaps didn't happen and the the razor was red and everyone's razor was red on that ward I don't know but you just need to get the facts right points then lots of movement of hands chopping on table hands open when says don't know
274	Comm 1	yeh yeh
275	Comm 9:	but you know probably there would be something in this you don't if there is incidents like that you would want assurances from the provider that they had exercised the duty of candour to that patient.
276	Comm 6:	yeh
277	Comm 8:	is it about understanding how wide scale is this
278	Comm 6:	yes
279	Comm 8:	is it isolated to a particular area a particular wards or areas that's why we need to look at infection rates as well two arms role to side
280	Comm 6:	yeh
281	Comm 8:	so if infection rates are high it's about the scales rolling hand and open gestures
282	Comm 5:	there's a patient safety risk again erm and a dignity risk
283	Comm 2:	there's a real risk around being perceived about not taking this seriously and doing nothing so so actually erm demonstrating that it will be looked into and er er changes made
284	Comm 4:	one of the controls you could encourage the provider to take is true perhaps for a fixed period of time a strong board leads to demonstrate the right behaviours but to monitor mentor and coach the workforce so you could do a swap round with the workforce. To provide that stronger clinical leadership in the short term to get a champion in until the behaviours change hands move on table
285	Comm 9:	yes you want that
286	Comm 4:	because you will bring infection control in and they will tell you what the problems are and what needs to be done but who's going to lead that on a day to day basis to demonstrate that.
287	Comm 9:	Well there is but that would be the chief nurse in the organisation they usual hold that role and they would be held to account and deliver on that they would have been appointed on that hands on chin
288	Comm 6:	I suppose you where saying on the ward at the time
289	Comm 8:	I think it's about the nurses appointment its taking it seriously does not move arms below table only at last point raises right hand
290	Comm 4:	Absolutely
291	Comm 8:	oh it might be like just a few complaints about personal hygiene but actually it could be significant
292	Comm 4:	absolutely
293	Comm 8:	with wider issues
294	Comm 1:	I think whoever made the complaint you say to them we are taking this seriously but when you actually go and speak to the staff you would do the softly softly approach find out what had gone who reported it on ultimately to me it sounds like a member of staff who has reported that as someone's shaving someone on the ward where family can see but even then you would hope there

		would be curtained off if they were being shaved or is it in a more residential again who's seen this why yes yeh hands on table until says curtained off and shows curtains with hands
295	Comm 2:	with all of these it's about them understanding what's going on behind it because the risk is then that you can jump to the wrong decision and put in training on the wrong thing and something like this needs to be very carefully handled
296	Comm 7:	you need to talk to that member of staff why they have done that because that is basic care or is there something else underlying pressure and making them act in that way arms folded
297	Comm 5:	sure
298	Comm 9:	it's got to be mandatory training
299	Comm 7:	that's one of your controls isn't it ensuring all the staff have done there mandatory training that's a basic control
300	Comm 2:	is this a junior member of staff we must think about supervision you know all of those sorts of things head movement
301	Comm 7:	have they been in post about 2 weeks do they understand why they are complaining arms still folded
302	Comm 8:	locum, agency, bank how have they investigated round the trust root cause analysis and then what their action plan is with not just a ward or department what clarity around that uses hands more about clarity roles hands in open gesture
303	Comm 9:	and the other is likely to be erm financial sanctions particularly if they have not exercised the duty of candour they could get fined if this gosh uses hands on table moving around
304	Comm 8:	unable to hear
305	Comm 9:	if this is widespread you only need to have like 3 sanctions
306	Comm 7:	Ok I suppose the other control just to get back to the patient experience is and once I've got evidence that this is happening erm patient experience a survey doesn't have to be a survey but a quick thing
307	Comm 6:	yeh survey
308	Comm 7:	asking those sorts of questions what could we do better
309	Comm 9:	Ok last one
310		**Scenario 5** Targets particularly in A&E waiting times have become an absolute priority. This has resulted in discharging patients early and there have been a number of misdiagnosis of patients. There is a rumour that staff have serious concerns but are not prepared to raise the issue as they may get the sack or it may affect their chances of promotion.
311	Comm 7:	ohhh
312	Comm 8:	just read it out again
313	Comm 7:	read that again 8 takes scenario from 9
314	Comm 8:	Targets particularly in A&E waiting times have become an absolute priority. This has resulted in discharging patients early and there have been a number of misdiagnosis of patients. There is a rumour that staff have serious concerns but are not prepared to raise the issue as they may get the sack or it may affect their chances of promotion.
315	Comm 7:	well the first risk is patient safety and outcomes 8 laughs
316	Comm 9:	yeh the biggest issue is evidence I think the bit that's missing is

317	Comm 6:	ye yeh
318	Comm 9:	because you would want to look at the evidence that holds paper up to group to emphasize point
319	Comm 4:	how do you know they are being discharged?
320	Comm 1:	the key is if someone in my team said oh there's a rumour in a care home it's like what do you mean by rumour have you witnessed it have you been told it you know and again with this you'd want to know what the evidence was really
321	Comm 9:	and what does discharging patients early is that to go home or is does that mean an appropriate destination
322	Comm 8:	I would need more information
323	Comm 6:	we don't know and we do need to find that out as one of the controls how much and when and what but the discharging early is a erm does sound like a clue because what's often happening is they are spending lots of time getting them off the A&E wards and off the lists so they are parked before they can be found a bed so if they are actually saying they are discharging them then they do need that is a bigger risk. Hand on neck
324	Comm 8:	Is there a risk around if you are a commissioner to act too quickly without gathering the facts as A&E is such a high profile target and its constantly in the press that if we act too quickly without the evidence that might actually waste time this creates a fuss where none of these things have been substantiated hand motion in air
325	Comm 9:	you would want to look at mortality rates re-admissions, complaints it's the same we have said for most of these things places hands palm down on table and does a sweeping circular movement
326	Comm 8:	it's also the time people are discharged from the department if its shifted earlier then ask the questions why is that what is there some evidence supports this
327	Comm 9:	you see when you look over a 24 hour period
328	Comm 7:	yes because it is like that (draws roller coaster with finger)
329	Comm 5:	I don't to read it again but it's the issue about A&E but the rumour is that staff are not prepared to raise the issues that's raising concerns, risk that isn't substantiated yet but I think the bit about this has resulted in discharging early there have been a number of misdiagnosis of patients I think I read that as fact and therefore that is a patient harm patient safety risk and focus on 4 hour wait rather than quality of care. Waving right hand pen points on paper to emphasize what it says
330	Comm 9:	would you read it as fact or would you want to test this out absolutely
331	Comm 6:	I think both I mean
332	Comm 5:	it says targets in A&E waiting times have been an absolute priority which they are this has resulted in discharging patients early
333	Comm 6:	and there is some evidence of that
334	Comm 5:	and there have been a number of misdiagnosis of patients
335	Comm 1:	how can you say that?
336	Comm 5:	well that's the information
337	Comm 1:	well yeh sorry yeh
338	Comm 6:	well presume probably it has come back from GP's or they have come back round again somebody's got some evidence open hands

339	Comm 5:	the rumour is the other bit around the staff raise concerns and being fearful getting the sack or chances of promotion pointing with pen on table
340	Comm 4:	so 2 risks there
341	Comm 5:	Patient safety

Key

1. Assertive (Clear on what is required takes control)
2. Delegating (Giving others support/direction)
3. Agreeing (Supporting others/sees others as adding value)
4. Passive (No clear direction provided to others or self)
5. Negative (Doesn't clearly listen to others, corrects others is not open to others views, talks over others, disagrees with others)
6. Aggressive (Disagrees strongly with others, shows negative behaviour towards others in the group, defends own view aggressively)
7. Open (Willing to change view/seeks further information from others/clarifying, questioning, asking the group for approval)
8. Positive (Shows a vision for the future seeks change/rewards others in group)

Appendix 3. Evidence of coded actions-verbal information

1. 7	51. 7&3	101.	1&2
2. 7	52. 1	102.	7
3. 1	53. 1&7	103.	3&7
4. 1	54. 1	104.	1&3
5. 1&7	55. 1&7	105.	3
6. 1	56. 1&7&2	106.	5&7
7. 2	57. 3&7	107.	3
8. 1&7	58. 7&4	108.	1&3
9. 7&2	59. 7&2	109.	7
10. 1&7	60. 3&2	110.	1&3
11. 7	61. 4	111.	1&7
12. 1&7	62. 5	112.	1&3
13. 1	63. 1&3	113.	1
14. 3&7	64. 1	114.	1&4
15. 3	65. 1	115.	1
16. 1	66. 1&7	116.	2&4
17. 1	67. 4	117.	7
18. 7	68. 6&1	118.	1
19. 3&7	69. 5	119.	1&3
20. 1	70. 2&7	120.	7
21. 1&7	71. 1&6&3	121.	1
22. 1	72. 4	122.	1
23. 1&3	73. 1&7&6	123.	1&5
24. 1&7	74. 1&3	124.	4
25. 1&7	75. 1	125.	7&4
26. 1&7&3&8	76. 2	126.	4
27. 1&5	77. 1&7	127.	1
28. 3	78. 1&6	128.	1
29. 4	79. 1&7	129.	3
30. 7	80. 1	130.	1&3
31. 1&3	81. 7	131.	3
32. 1&3	82. 7&4	132.	4&7
33. 7	83. 1	133.	7
34. 1&3	84. 2&7	134.	1
35. 7	85. 4&7	135.	1
36. 1&3	86. 1&3	136.	3
37. 7	87. 4	137.	1
38. 1&7&8	88. 5&6	138.	6&1
39. 7	89. 3&4	139.	1&3
40. 1&7	90. 4&7	140.	7
41. 1	91. 1&3	141.	1
42. 3	92. 7	142.	1&3
43. 7	93. 1	143.	1
44. 4	94. 7	144.	5&1
45. 4	95. 1	145.	4
46. 1&3	96. 1&7	146.	1&3
47. 3	97. 1	147.	1&6
48. 4	98. 4	148.	5
49. 1&3	99. 4	149.	1
50. 7&1	100. 7&4	150.	3

151.	3	203.	1&3	255.	1
152.	1&3	204.	1&5	256.	3
153.	3	205.	3&7	257.	7&1
154.	1	206.	1&6	258.	1&6
155.	3	207.	1	259.	5
156.	6	208.	1&6	260.	1
157.	1&5	209.	3	261.	7
158.	4&7	210.	1	262.	4
159.	6	211.	1	263.	7
160.	4&7	212.	4	264.	1&7
161.	7	213.	1	265.	7&1&3
162.	1	214.	1&3	266.	3&4
163.	3	215.	1	267.	3
164.	4	216.	1&2	268.	1&7
165.	1	217.	3	269.	1&5
166.	1	218.	3	270.	3
167.	1	219.	1	271.	1&7
168.	3	220.	5	272.	3
169.	2&7	221.	5	273.	3
170.	7	222.	1	274.	3
171.	1	223.	1	275.	1&7
172.	1&3	224.	1&5	276.	3
173.	4	225.	1	277.	7&1
174.	1	226.	1	278.	1&7
175.	1&6&3	227.	1	279.	4
176.	4	228.	4	280.	7
177.	7	229.	3	281.	3
178.	1	230.	1	282.	3
179.	1&3	231.	1	283.	3&7&5
180.	1&7	232.	3	284.	3
181.	4	233.	4	285.	1
182.	1&3	234.	5	286.	3
183.	4	235.	3	287.	1&7
184.	1	236.	1	288.	3
185.	4	237.	3	289.	3
186.	1	238.	3	290.	1&7
187.	4	239.	1	291.	3&7
188.	4	240.	1	292.	1
189.	1	241.	1&3	293.	3
190.	1&3	242.	3	294.	1&3
191.	1	243.	7&3	295.	2&3
192.	1&3	244.	3	296.	7
193.	1	245.	3&1	297.	7
194.	1&6	246.	7&3	298.	1&7&3
195.	3	247.	4	299.	1
196.	3	248.	7&3	300.	?
197.	1	249.	1&7	301.	7
198.	4&1	250.	1&6	302.	3&1
199.	7&1	251.	1&7	303.	3
200.	4&7	252.	3	304.	1&7
201.	3&4	253.	4	305.	4
202.	1&3	254.	1&7	306.	4

307.	4	318.	1	329.	3
308.	1	319.	1&7	330.	3
309.	6&1	320.	7	331.	5
310.	4	321.	3&4	332.	1
311.	1	322.	3&4	333.	4
312.	1&3	323.	3	334.	1&7
313.	3	324.	3	335.	4
314.	1	325.	5&7	336.	1&3
315.	7	326.	7	337.	1
316.	7&1	327.	3&4		
317.	1	328.	1		

Appendix 4 : Commissioner 1. Non verbal communication (example)

1. 1 arms to side
2. 1 arms to side
3. 1 pulls chair forward arms placed on table
4. 1 no movement (NM)
5. 1(NM)
6. 1 (NM)
7. 1 clasps hands on table
8. 1 (NM) until 'as a board member' gets pen and post its from middle of table and starts to write not focusing on speaker.
9. 1 taps post it
10. 1 picks up post it
11. 1 plays with pen
12. 1 small hand movements starts to speak left hand used as a block motion right hand moves from side to side
13. 1 small hand movements with pen
14. 1 as above
15. 1 NM
16. 1 NM
17. 1 NM
18. 1 NM
19. 1 NM
20. 1 small movement with pen two hands on pen
21. 1 NM
22. 1 NM
23. 1 speaks left hand used for on table as if holding a cup right hand with pen emphasises 'other costs' two hands used to emphasise point uses right hnd to point to fingers when describing numbers of events when talks about an impact assessment right hand rotates holding pen.
24. 1 plays with pen
25. 1 writes note plays with post it and pen
26. 1 as above
27. 1 as above
28. 1 plays with pen
29. 1 NM
30. 1 head drops down and then nods
31. 1 NM
32. 1 NM
33. 1 NM
34. 1 plays with pen
35. 1 as above
36. 1 as above
37. 1 as above
38. 1 leans forward and speaks uses pen in a side to side motion when describing things we discussed uses pen to point to people how have made a previous point
39. 1 leans forward
40. 1 looks at Comm 4 time keeper
41. 1 plays with pen
42. 1 take lid off pen
43. 1 as above
44. 1 leans back
45. 1 leaves pen on table folds arms puts arms up and clasps hands
46. 1 NM

47. 1 NM
48. 1 NM
49. 1 NM
50. 1 NM
51. 1 NM
52. 1 NM
53. 1 NM
54. 1 Speaks
55. 1 NM
56. 1 NM
57. 1 moves left hand
58. 1 NM
59. 1 leans forward and speaks
60. 1 NM
61. 1 nods in agreement
62. 1 still leaning forward
63. 1NM
64. 1 Looks at 4
65. 1 as above
66. 1 NM
67. 1 looks around table
68. 1 NM
69. 1 clamps hands and brings both hands to mouth looks like a prayer
70. 1 looks to left still hands clasped to mouth
71. 1 look around with thumb in mouth
72. 1 NM
73. 1 NM
74. 1 NM
75. 1 NM
76. 1 Leans forward
77. 1 points to Comm 8 when speaks
78. 1 NM
79. 1 NM
80. 1 NM
81. 1 NM
82. 1 NM
83. 1 NM
84. 1 NM
85. 1 NM
86. 1 NM
87. 1 NM
88. 1 NM
89. 1 NM
90. 1 Leans back
91. 1 NM
92. 1 NM
93. 1 NM
94. 1 NM
95. 1 NM
96. 1 NM
97. 1 NM
98. 1 NM

99. 1 looks to left
100.1 Leans forward and asks question
101.1 NM
102.1 NM
103.1 NM
104.1 NM
105.1 NM
106.1 NM
107.1 NM
108.1 NM
109.1 NM
110.1 NM
111.1 Raises hands clasped and places on side of right face cheek
112.1 Moves hands down
113.1 Moves paper
114.1 Puts pen in hand
115.1 Pen in right hand and holds paper up (takes lead on scenario)
116.1 Hand held to face with pen passes paper round (loses lead role)
117.1 NM
118.1 Plays with pen in both hands
119.1 as above
120.1 NM
121.1 NM
122.1 Nods agrees with Comm 6
123.1 Plays with pen looks at Comm 9
124.1 NM
125.1 Picks up post it looks like he writes
126.1 Keeps writing
127.1 Picks up piece of paper from centre of table
128.1 Writes on paper the looks at Comm 4
129.1 NM
130.1 NM
131.1 NM
132.1 Writes on paper
133.1 Rubs nose with right hand
134.1 Left hand taps paper
135.1 NM
136.1 NM
137.1 NM
138.1 NM
139.1 Looks at Comm 9 then writes on paper
140.1 Looks at 6
141.1 NM
142.1 NM
143.1 Looks and writes
144.1 NM
145.1 NM
146.1 NM
147.1 NM
148.1 NM
149.1 Left hand moves to the side then both while talking uses pen in right hand to point to information about ‘patients and lack of compassion’

150.1 Puts two hands together fingers clasped together
151.1 Hands on table fingers clasped as if praying
152.1 NM
153.1 NM
154.1 Holds pen and uses it to point at Comm 9
155.1 Holds pen up themoves left hand to play with pen
156.1 Two hands together
157.1 Arms fold pen down
158.1 NM
159.1 Starts to write again
160.1 Writes
161.1 As above
162.1 Holds pen moves pen in both hands
163.1 NM
164.1 Folds arms
165.1 Writes again
166.1 Looks at Comm 4
167.1 Folds arms
168.1 as above
169.1 Writes on paper
170.1 Places paper in centre of table scenario complete
171.1 Brings paper back others not finished
172.1 Writes down further data
173.1 Writes
174.1 NM
175.1 NM
176.1 NM
177.1 NM
178.1 Writes
179.1 Writes
180.1 NM
181.1 NM
182.1 NM
183.1 Writes
184.1 Lifts paper up ‘says lets close this one’
185.1 Places paper in centre of table again
186.1 Puts lid on pen
187.1 Places pen on table
188.1 New scenario picks up another piece of paper and begins writing
189.1 Puts lid on pen and places paper in centre of table leans back right arm on table
190.1 Leans forward with right arm on table
191.1 NM
192.1 NM
193.1 Hand to side of head in fist
194.1 NM
195.1 Picks up paper and reads with Comm 2
196.1 Reads paper
197.1 Folds arms
198.1 NM
199.1 NM
200.1 Leans forward and places arms on table
201.1 NM

202.1 NM
203.1 NM
204.1 Hands move to clasped fingers on table
205.1 NM
206.1 NM
207.1 Leans forward when speaks
208.1 NM
209.1 NM
210.1 NM
211.1 NM
212.1 Looks at Comm 9
213.1 NM
214.1 Looks at Comm5/6
215.1 NM
216.1 NM
217.1 Leans forward
218.1 NM
219.1 Nods agrees with Comm 6
220.1 Hands to face itches ear hands clasped to side of right cheek
221.1 Starts to rub hands in front of face then clasps fingers
222.1 NM
223.1 Hands clasped on side of face
224.1 NM
225.1 NM
226.1 Hands on face fingers clasped
227.1 NM
228.1 NM
229.1 Hands to face fingers clasped
230.1 NM
231.1 NM
232.1 Moves back then leans back forward
233.1 Hands to mouth
234.1 NM
235.1 Right hand scratches head goes back to clasped hands
236.1 Hands in front of face
237.1 NM
238.1 NM
239.1 NM
240.1 NM
241.1 NM
242.1 NM
243.1 NM
244.1 NM
245.1 NM
246.1 Hands as if washing in front of face
247.1 Hands clasped
248.1 NM
249.1 NM
250.1 Hands move to mouth
251.1 NM
252.1 NM
253.1 NM

254.1 Hands like prayer in front of face
255.1 Hand itches back of head
256.1 Strokes back of head
257.1 NM
258.1 NM
259.1 NM
260.1 NM
261.1 NM
262.1 NM
263.1 NM
264.1 NM
265.1 NM
266.1 NM
267.1 Puts hands in front of face then both hands to for head
268.1 NM
269.1 Hands to forhead fingers clasped together
270.1 Leans back hands together on table
271.1 Looks at Comm 9 nods slightly when speaks
272.1 NM
273.1 NM
274.1 NM
275.1 NM
276.1 NM
277.1 NM
278.1 NM
279.1 NM
280.1 Thumb rubs hands on table
281.1 NM
282.1 NM
283.1 NM
284.1 NM
285.1 NM
286.1 NM
287.1 NM
288.1 NM
289.1 NM
290.1 NM
291.1 When speaks uses right hand to show steps then two hands in prayer
292.1 NM
293.1 NM
294.1 NM
295.1 NM
296.1 Nods
297.1NM
298.1 NM
299.1 Leans back one arm on table
300.1 NM
301.1 NM
302.1 NM
303.1 Itches back of head
304.1 NM
305.1 NM

306.1 picks post it off table
307.1 Reaches for another post it
308.1 NM
309.1 NM
310.1 Writes on post it
311.1 NM
312.1 NM
313.1 NM
314.1 NM
315.1 NM
316.1 NM
317.1 NM
318.1 Uses pen to emphasize point inright hand
319.1 Moves hands off the table
320.1 NM
321.1Left hand fingers to lips
322.1 NM
323.1 Right hand on table
324.1 NM
325.1 Right hand plays with post it
326.1 NM
327.1 NM
328.1 NM
329.1 Hands off table
330.1 NM
331.1 NM
332.1 Plays with pen
333.1 NM
334.1 Right hand used to emphasize point he makes
335.1 NM

Appendix 5: Invitation letter.

Name ……..
Address Director of Public Health for NHS Wirral and Wirral Council
E-mail fiona.johnstone@wirral.nhs.uk

RE: Analysing patterns of behaviour that lead to effective Quality & Safety (Q&S) in Healthcare: A Commissioning Perspective.

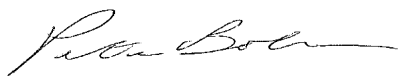
Dear Sir/Madam

As a key member of a Commissioner organisation I would like to invite you for an open forum to discuss the types of leadership behaviour that affect Q&S in Healthcare. The forum will be initially be used to describe the challenges we face in healthcare and a keynote presentation by Professor John Reid Public Health will provide a framework for the morning. Two groups will be established to discuss types of behaviour using scenarios based on the Mid Staffordshire enquiry and Francis Report to define risks and controls. The event will form part of CPD on risk management and certificates of attendance provided.

The discussion will be videoed and evaluated to understand behaviour and its effects on outcomes in Quality & Safety within Provider Services. The process will also support my Masters in Philosophy leading to a PhD. The forum and lunch will be held on the 15th May 9.30-13.00 in the Henry Cotton Building, Liverpool John Moore's. The information will be used to define the above question and assist in improving Q&S in Healthcare.

I have attached a consent form for you to complete (within two weeks of receipt of this letter) and a participation information sheet with my contact details, if you require any further information please do not hesitate to contact me.

Yours Sincerely



Peter Bohan
Head of Organisational Health & Effectiveness.
E-mail P.J.Bohan@2009.ljmu.ac.uk or bohan869@btinternet.com

Appendix 6: Participation information sheet

Study Title: To analyse patterns of behaviour that lead to effective Quality &Safety (Q&S) in Healthcare: A Commissioning Perspective.

The purpose of the study

The aim of the study is to analyse the complex relationships between patterns of behaviour that lead to effective Q&S processes and systems within Healthcare. The research is aimed at Chief Executives, Chairs and Non-Executive Directors, Senior Staff of Commissioning organisations within the North West to identify what is their perception of Q&S, what leadership style is adopted and identifies what behaviour is appropriate to influence change from a Commissioning perspective. The study will provide a framework of behaviour based systems that enable the culture of organisations to meet targets and keep the focus on delivering safe healthcare through effective staff engagement and an observational tool kit that measure behavioural outputs. Effective leadership and learning lessons will be a key component of this research. The behaviour of Commissioners will be paramount to understand how the new team dynamics, deal with conflicts created by the new Commissioning Strategies.

What will I have to do?

The process will be to give the group scenarios based on mid staffs inquiry that they then discuss how they would deal with issues relating to how behaviours affect Provider Services from a Commissioning perspective. The scenarios will be videoed please answer questions in the video interview process openly and express your own views there are no right or wrong answers to the questions being asked.

Why have I been chosen?

As a Senior member of the Commissioning organisation it is likely that you are going to influence the agenda of the organisation. It is also likely that the influence will also affect Provider Services.

Do I have to take part?

No the videoing process is voluntarily and you can withdraw at any time, even if it is during the event. After the point of withdrawal you will no longer be part of the study however it would not be possible to remove you from the scenario evidence provided as you would have already contributed to the scenario. .

How long is the interview process

The video recording will take approximately 1 hour. The video tapes will provide an accurate record of the conversation and all information will be anonymised when documented the names will be Staff Member A B C etc to ensure no individual can be identified. The video tapes will be secured and destroyed once the information is has been retrieved from them.

Confidentiality

All information will be kept confidential and secure no information of a personal nature will be kept and all information provided will be anonymised.

Who is funding the study?

The study is being funded by the researcher as part of a Masters of Philosophy Degree leading to a PhD. The

researcher has undertaken a previous study of Executives behaviour in an Acute Trust.

What indemnity arrangements are in place?

JMU is to indemnify the study and act as the sponsor. The research has been examined by JMU ethics approval, our internal Research Department for Wirral University Teaching Hospital and has been externally reviewed by IRAS.

Who reviews the study?

The study will be reviewed by the academic supervisor from John Moore's University and The Director of Strategy at Wirral University Teaching Hospital to ensure the study remains within the context of the protocol and all information is accurate and remains relevant to the protocol design and context.

How can I get further information?

Further information on the ethical review research protocol or context of questions can be gained from the Chief Investigator Peter Bohan on e-mail P.J.Bohan@2009.ljmu.ac.uk . or bohan869@btinternet.com

Permission for quotes

Quotes identified within the context of video interviews may be used as part of the published article but will not be identified to the organisation or the individual involved they may be used to provide the essence of the conversation discussed and behaviour observed.

What are the risks to the study or participants?

There is little or no risk to the study participants however if information evidenced if it is likely to cause concern of risks to the organisation or individuals this will be escalated through the normal NHS governance arrangements.

What will happen as a result of the research study?

The proposed research will provide an original contribution to knowledge due to the unique position of a new Commissioning body. The level of maturity within the organisations will be examined to understand decision making and behaviour. The information will form part of a thesis along with papers that will be submitted for publication in a recognised peer reviewed healthcare journal.

What are the benefits?

By taking part in this study we can look at how the messages about Q&S can be transferred to Providers and how behaviours influence outcomes. It is feasible that we may be able to identify different approaches to Q&S and define the most appropriate and beneficial for the CCG's.

If you require any further information please do not hesitate to contact me on e-mail P.J.Bohan@2009.ljmu.ac.uk

Appendix 7: Consent form.

Analysing patterns of behaviour that lead to effective Quality & Safety (Q&S) in Healthcare: A Commissioning Perspective.

Peter Bohan
Wirral University Teaching Hospital NHS foundation Trust
Upton Road
Arrowe Park Hospital
Wirral CH49 5PE

Dear Sir/Madam

I would like to invite you to participate in my research study about Commissioners behaviour and how it affects Q&S in Provider Services. You have been selected for participation in the study by virtue of your role and type of work you are involved in within the Clinical Commissioning Groups within Merseyside & Cheshire.

Should you be interested in participating this study and consent to this involvement it will take the form of an open forum with scenarios based on Mid Staffs enquiry and the Francis Report. The subsequent discussion will be videoed for a period of one hour. The video will analyse behaviours and wording will be transcribed, once the research project is complete all tapes and notes will be destroyed.

Thank you in advance for your time and co-operation in this project and I look forward to meeting with you.

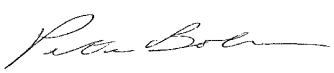
1. I confirm that I have read and understand the information provided for the above study via the participation information sheet. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect my legal rights. However the data videoed before the point of leaving will be used as part of the study. ☐
3. I understand that any personal information collected during the study will be anonymised and remain confidential ☐
4. I agree to take part in the above study ☐
5. I understand that the focus group will be audio video recorded and I am happy to proceed ☐
6. I understand that parts of our conversation may be used verbatim in future publications or presentations but that such quotes will be anonymised. ☐

Name of Participant Date Signature

Name of Researcher Date Signature

Note: When completed 1 copy for participant and 1 copy for researcher

Thank you for consenting and participating in my study. Your help has been invaluable. I am currently processing all of my data and once complete the tapes and notes of interviews will be destroyed. The anonymous findings will be available for you to see once my study is complete. If you need any further information please do not hesitate to contact me.
Yours truly, Peter Bohan



If you need any further information please do not hesitate to contact me on e-mail P.J.Bohan@2009.ljmu.ac.uk .

Appendix 8: Scenarios provided to group and answers.