The impact of Leadership on the delivery of high quality Patient Centred Care in Allied Health Professional practice

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Acknowledgements

Abstract

The Healthcare Quality Strategy for NHS Scotland, relates its overall vision of healthcare quality to six dimensions of care as: Safe, Efficient, Effective, Equitable, Timely and Patient Centred. Patient Centred Care also underpins many subsequent policies such as the management of Long Term Conditions (Scottish Government, 2008) and the Chief Medical Officers Realistic Medicine report (Barlow, et al., 2015)

Leadership styles and associated policies and procedures are often assumed to inhibit or encourage the delivery of quality Patient Centred Care and the NHS invests millions of pounds per year in Leadership training. At a clinical team and management level there are behaviours and initiatives that can arguably have positive and negative impacts on the ability of individual practitioners to provide quality Patient Centred Care. However there have been no attempts to empirically test the association between (good) Leadership and quality Patient Centred Care. Without any evidence of such a relationship, NHS investment of substantial resources may be misguided. Additionally, much of the focus of research in both Leadership and Patient Centred Care has focused on medical practitioners and nurses. There is little research that focuses on the impact of allied health professionals' (a term describing 12 differing health care professional groups representing over 130,000 clinicians throughout the United Kingdom) practice on the quality of person centred care and how this is affected by Leadership structures and styles.

This study aimed to explore whether there is a direct or indirect link between (transformational) Leadership and achieving the delivery of high quality Patient Centred Care (PCC) in allied health professional (AHP) practice.

Aim
The aim of this thesis was to explore whether it was possible to empirically demonstrate a relationship between Leadership (good or bad) and Patient Centred Care, and to do this in relation to Allied Health Professional practice.

Research questions

     I.   Is there a relationship between Transformational Leadership and Patient Centred Care in AHP practice?

     II.   How do AHP's conceptualise Leadership and its impact on their ability to deliver PCC?

     III.   Do local contexts influence the ability of leaders to support Patient Centred Care?

Study one

Study one was designed to answer research question one: exploring the relationship between transformational Leadership and Patient Centred Care using survey design. Two groups of Allied Health Professionals were selected to take part in the study: Podiatrists and Dieticians. Clinical team leaders from across 12 Podiatry teams and 12 Dietetic teams completed a survey composed of measures of transformational Leadership and self-monitoring. Clinicians from these teams were also be asked to complete questionnaires on their perception of their clinical leaders' transformational Leadership skills. This allowed comparison of self-assessed Leadership and team assessed Leadership. Clinicians were also asked to collect patient experience measures from 30 of their patients.

Study Two

Study Two was designed to answer research questions 2 and 3: how do AHPs conceptualise Leadership and how do they view the link between Leadership and their ability to deliver Patient Centred Care; and how might local context impact on professional Leadership and therefore its potential to enable or inhibit Patient Centred Care. In depth interviews were conducted with clinicians and clinical team leaders to explore the barriers and facilitators to effective Leadership, teamwork and the provision of quality care. Interviews were conducted with 21 Podiatrists and 12 Dieticians and analysed using a framework analysis approach.

Results

I. Is there a relationship between Patient Centred Care and transformational Leadership in AHP practice?

The theory that there is a link between transformational Leadership and Patient Centred Care was confirmed. A significant relationship was discovered for the dietetics group linking Transformational Leadership with patient centred quality of care measures. There was also a relationship in the podiatry group that was suggestive of a relationship.

II. How do AHP's conceptualise Leadership and its impact on their ability to deliver PCC?

AHP's in both groups had broadly similar conceptualisations of Leadership and both groups played down the role of Leadership in the delivery of Patient Centred Care. A far more salient factor in achieving the delivery of high quality Patient Centred Care for the AHP's interviewed was professional autonomy.

III. Do local contexts influence the ability of leaders to support Patient Centred Care?

A number of contextual issues related to both Patient Centred Care and Leadership were identified from the qualitative analysis. These were centred on systemic factors, relating to management and bureaucracy, and individual factors, such as relationships within teams. In Podiatry a major shift in the context of care was ongoing during the study, namely a greater emphasis on encouraging patients to self-care. This affected the relationships between patients and Podiatrists, and Podiatrists and managers, in a way that Podiatrists felt it negatively impacted on their ability to provide quality Patient Centred Care.

Conclusion

A weak relationship was observed between Transformational Leadership styles and the delivery of Patient Centred Care in two Allied Health Professional groups. Professional autonomy was identified as being more likely to facilitate delivery of person centred care. Organisational issues and intervening policy directives can impact on the delivery of Patient Centred Care, regardless of Leadership.

Recommendations

Further work exploring the link between Leadership and Patient Centred Care is required. The concept of professional autonomy should be fostered within Leadership programs to enhance delivery of Patient Centred Care. The impact of individual policies, such as moves towards more self-care, on quality criteria need to be more fully considered. Whilst such policies may make care more efficient, there may be negative consequences for other quality care criteria, such as Patient Centred Care.

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Introduction

This thesis explores the potential relationship between good Leadership in the NHS and its impact on helping healthcare professionals to deliver better Patient Centred Care (PCC). This relationship is one that has been implied and assumed in much of the policy literature relating to the NHS in the UK (and other healthcare policy worldwide) and has led to relatively large financial investment by the NHS in Leadership skills to improve quality of care, of which Patient Centred Care is a key element (Dept. of Health 2000a).

The focus of the thesis stems from research I was involved in (Duncan, Entwistle, & Liddle, 2010) which conducted a conceptual review of Patient Centred Care. Our study report suggested that that experiences and interactions which contribute to person centred care "occur within the context of organisations and systems that have the potential to either support or inhibit the likelihood of a person centred care experience". This introduced to me, the possibility that the simple linear relationship between Leadership and Patient Centred Care, as assumed in policy, may not hold true. I became interested in investigating the literature further to see whether there was empirical support for this linear relationship. I undertook a systematic review to explore 'what works' in terms of interventions to improve Patient Centred Care. During this review I noted the dearth of evidence or research that explored how Leadership interventions or training could enhance or improve Patient Centred Care. Expanding this to appraise the literature that explored the relationship between Patient Centred Care and Leadership, I noted that there was a body of work rating the Leadership of various clinical groups: however this was not explicitly linked quantitatively to improvements in the delivery of Patient Centred Care.

Working with the Nursing Midwifery and Allied Health Professions Research Unit I was introduced to a number of different research perspectives and researchers, many of whom had become researchers after working as either nurses, midwives, or allied health professionals (AHP). Whilst working in the Unit I assisted with a project that sought to validate the use of the CARE measure in AHP practice. Initially, I thought I might be able to use this large wealth of data to link Patient Centred Care and Leadership. However when exploring the utility of various measures and drawing on the conceptual work I did in previous research I quickly began to feel that the CARE measure alone was not enough to explore Patient Centred Care, as I had defined it. However, though I no longer intended to use the AHP data that had been gathered to validate the CARE measure, that project meant the Unit had strong connections and contacts with AHP groups around Scotland. I considered that these connections and contacts made exploring the relationship between Leadership and Patient Centred Care in Allied Health Professional practice a natural fit for my thesis.

The aim of this thesis was to explore whether it was possible to empirically demonstrate a relationship between Leadership (good or bad) and Patient Centred Care, and to do this in relation to Allied Health Professional practice. In doing so, there was also the awareness from the research mentioned above that the context in which practitioners work and deliver care can have a substantial mediating impact on the delivery of Patient Centred Care. This led to the development of a mixed methods study: a quantitative study of the association between Leadership (as input) and Patient Centred Care (as outcome); and a qualitative study of AHP views of Leadership and its impact on their ability to deliver Patient Centred Care and how the context in which they worked could impact on Leadership and also on their ability to deliver Patient Centred Care.

My research questions were as follows

I.   Is there a relationship between Patient Centred Care and transformational Leadership in AHP practice?

II.   How do AHP's conceptualise Leadership and its impact on their ability to deliver PCC?

III.   Do local contexts influence the ability of leaders to support Patient Centred Care?

Chapter 1 (Review of Literature) will describe the concepts of Leadership and Patient Centred Care and how they have emerged and been linked within NHS policy and practice. This chapter will also include a review of the research in the field and the evidence for an association between Leadership and Patient Centred Care, including the identification of possible mediating factors in their relationship. The findings of this chapter are then used to refine the aims and the research questions for the thesis, which include attention to a possible mediating factor: flexible responsiveness (FR).

Chapter 2 (Methods), then takes forward the concepts identified from the literature review that will be explored in this thesis and includes a review of potential measures/instruments to measure these concepts in an empirical study. Chapter 2 also describes the two studies conducted as part of this thesis: Study 1 is a quantitative study to statistically explore the potential relationship between Leadership and Patient Centred Care for AHPs and the influence of possible mediating factors (FR); study 2 is a qualitative study of AHPs views of Leadership and Patient Centred Care and what influences their ability to deliver Patient Centred Care in the context of their daily practice.

Chapter 3 presents the statistical analysis of the survey data gathered in study one, it explores the demography of the patient sample, the relationship between Leadership and Patient Centred Care within 2 AHP groups (Podiatrists and Dieticians) and compares scores between these groups. These two AHP groups were selected to reflect a contrast in their professional approaches: Dieticians are consultative and education focused in their attempts to largely change patient behaviour; whereas Podiatrists are more technical and process orientated. They therefore provide good examples of the differing types of Allied Health Professionals, and differing in their approaches to delivering patient care.

Chapter 4 presents the findings from the qualitative interviews conducted with Allied Health Professionals in study two. Following a Framework Analysis approach it identifies two major themes: 'Systemic' and 'Individual' factors affecting delivery of Patient Centred Care and a number of sub themes that identify how participants conceptualised Leadership and Patient Centred Care as well as how they considered Leadership affected its delivery.

Chapter 5 presents a discussion of these findings and includes reflection on the methods used in this research. I also reflect on my personal role as a researcher and how this may have affected the choices and decisions I made during the study. Finally, I present my conclusions and recommendations for future research and for NHS policy makers.

1 CHAPTER ONE: Review of literature

Leadership and Patient Centred Care are topics of central importance to the Scottish NHS and linked on the basis that improving Leadership is portrayed as helping to drive quality improvements in the NHS with Patient Centred Care a key component of quality improvement (Scottish Executive Health Department , 2004). However, beyond these implied links within policy and quality improvement aims, the direct relationship between these two concepts has rarely been explored. The following literature review explores the policy approach to both Leadership and Patient Centred Care in order to demonstrate their importance to the NHS, and this is followed by a discussion of the conceptual and research literature surrounding these concepts. This review provides the basis of the rationale exploring whether there is a direct (or indirect) relationship between these two concepts.

The literature review aimed to:-

1. Conduct a comprehensive review of the conceptual, policy and research literature on Leadership and Patient Centred Care.
2. Explore the identification of possible mediating factors in their relationship.

The review used a narrative synthesis approach adapted from the guidance given in Popay et al (2006) and Dixon-Woods et al (2005). The conceptual and research focused literature was drawn mainly from a search of academic journals and databases, where a general search was conducted, using search terms which can be found in the appendix E, as well as reading through key papers and their reference lists, and identifying other important sources from book chapters and from discussions with experts in the field. The policy literature was accessed directly from Government and Health Service online resources (www.gov.uk, www.gov.scot, www.gov.scot/archive). This approach allowed for the concepts and theories around Leadership, Patient Centred Care and potential mediating factors to be identified and explored. The narrative synthesis approach allows a broader discourse on the subjects of Leadership, Patient Centred Care and allows the inclusion of a wide range of perspectives in this field. This therefore allowed me to capture the breadth of research exploring these concepts, as well as relevant academic and professional commentary and policy positions.

This approach involved the development of a number of broad search strategies relating to Allied Health Professional practice, Leadership, and Patient Centred Care.

The results from these were then subjected to a process similar to the Framework Analysis described in the methods section and an abridged versions of the tables produced for this is available within appendix F.

The following sections explore theories of Leadership and Leadership styles, beginning with a discussion of the distinction between Leadership and management within the literature. This is followed by an in-depth exploration of the dominant model in healthcare settings known as Transformational Leadership, and its evidence base. Similarly, the concept of Patient Centre Care is explored via the literature to trace its origins and constructs, as well as exploring its research base. The review then focuses on these two concepts as defined and used within the NHS in the UK and their implied conceptual commonalities and relationship. Finally, the review introduces some potential mediating factors which could be explored in understanding the empirical relationship (if one exists) between transformational Leadership and Patient Centred Care in the context of delivery of improved quality of care in the UK (NHS).

For the purposes of this thesis "Leadership" is taken to mean clinical Leadership and it is the behaviours of clinical leaders in AHP practice that will be explored. Leadership is considered to be distinct from 'management' and the next section explains the rationale behind this.

1.1 Management versus Leadership

The terms Management and Leadership are often used synonymously though current thinking in the research literature indicates that the two are thought of differently by individuals and within organisations. In previous work Stanley (2006) pointed to vision as being the difference between 'management' and 'Leadership' in healthcare settings. He produced a schema (see table 1) highlighting the differences between the two concepts. From Stanley's schema we can see that positive behaviours are mostly associated with Leadership and more negative behaviours, relating to blame and control, are associated with management. It is debatable whether this table represents a true delineation between Leadership and management. Individuals may be variously or interchangeably thought of as leaders or managers dependent on situation or context and may possess traits across both Stanley's columns. Though there is some evidence to suggest that asking clinical leaders to adopt management roles or tasks can lead to conflict.

Firth (2002) addressed the balance between Leadership and management exploring ward leaders clinical and managerial roles, concluding that ward managers experience conflict between the managerial and clinical aspects of their role. This conflict between the two related, but are considered distinct and separate, roles has been explored as a central tension in a clinical leaders role. This conflict can manifest as confusion, as something that challenges the clinicians' values and beliefs, and can ultimately cause ineffective Leadership and management. This can lead to diminished clinical effectiveness and dysfunctional wards or units which in turn results in lower quality patient care (Stanley 2006a, 2006b).

Kotter (1990) has posited that Leadership and Management may not always be in opposition to one another and that to succeed an individual will have to be skilled in both of these. Kotters' view implies that a Leadership style that incorporated elements of management and Leadership would be best suited to organisational settings. Other research has also suggested individuals need to use both Leadership and Management skills to succeed within an organisation and support the organisation to succeed (Boaden, 2006). It has also been suggested that skills associated with management are required for executive positions (McCartney & Campbell, 2006)

Table 1: Differences between Leadership and management Stanley(2006) pp.33

Area or factor	Qualities associated with leaders Leadership	Qualities associated with managers or management
Goal	Change	Stability
Seeks	Vision and the expression of values	Achievement of aims or objectives
Theoretical style	Transformational or congruent	Transactional
Conflict	Uses conflict constructively	Avoids or manages conflict
Power	Personal charisma and values	Formal authority and a hierarchical position
Blame and responsibility	Takes the blame	Blames others
Energy	Passion	Control
Relationship to	Followers	Subordinates
Direction	Explores new roads	Travels on existing paths
Main focus	Leading people	Managing of work or people
Planning	Sets direction	Plans detail
Driven by appeals to	Heart and Spirit	Head and mind
Response	Proactive	Reactive
Persuasion	Sell	Tell
Motivation	Excitement for work, unification of values	Money or other tangible rewards
Relationship to rules	Breaks or explores the boundary of rules	Makes or keeps rules
Risk	Takes risks	Minimises risks
Approaches to the future	Creates new opportunities	Establish systems and processes
Who in organisation	Anyone and Everyone	Those with senior hierarchical positions
Relationship to the organisation	Essential	Necessary

1.2   Leadership and Quality Improvement

Quality improvement is a continuous proactive process focusing on improving process and systems in organisations. It is distinct and complementary to Quality Assurance which measures compliance against necessary standards. Both are required to attaining continual improvement in health care quality which is often seen as a fundamental organisational goal (Green, 1991). Whether Leadership can specifically lead to Quality Improvement is a question of central importance to healthcare organisations and policy makers.

In 2011 the Healthcare Quality Foundation published a report on Leadership and Quality Improvement to explore the links between the two. They reviewed the research literature and found it was non-specific and that there was little that could be applied to the NHS, there was a lack of conceptual clarity on the broad concept of improvement and how Quality Improvement was linked with different leadership behaviours (Hardacre, Cragg, Shapiro, Spurgeon, & Flanagan, 2011).

There is a large body of literature, in research and policy, that stresses the importance of leadership in achieving Quality Improvement. However, there are a lack of studies that provide observational evidence supporting this view and the current literature is inconsistent on how Leadership impacts on Quality Improvement (Øvretveit, 2009). There is also no research to date that shows direct causal links between Leadership and Quality Improvement. However, there is an increasing body of work exploring the indirect links that Leadership may have on Quality Improvement. Detailed work, in the private sector, has linked Leadership Style with the promotion and development of organisational cultures that can have a significant impact on organisational performance (Ogbonna & Harris, 2000). Examples of these and how they relate to different styles of Leadership can be found in the sections that follow (See: Sections 1.3.2-1.35).

1.3   Leadership Styles within healthcare.

Leadership has been extensively studied in a variety of fields including healthcare, but only recently has it become a focus for research within Nursing, Midwifery and Allied Health Professional practice. Commonly used Leadership theories including transformational Leadership and more recently, emotionally intelligent Leadership, have guided nursing Leadership research and interventions, presumably due to their emphasis on relationships as the foundation for effecting positive change or outcomes (Hibberd and Smith, 2006).

This thesis is specifically concerned with clinical Leadership, a concept which is theoretically consistent with the contemporary social psychological literature on the importance of 'local' Leadership and its ability to compensate for the potential impacts of organisational culture (Millward & Bryan, 2005). The idea of clinical Leadership as Leadership that is local or "nearby" can be found in shared governance (Edmonstone, 2000) acute hospital services and the creation of self-managed teams in community nursing services (Baileff, 2000). Nearby leaders have been found to adopt a transformational approach and those that lead form a distance have been found to be more typical of the transactional approach (Shamir, 1995) though Kotter (1990) cautions that this is slightly simplistic and in practice the styles of Leadership are likely to vary dependent upon the situation.

1.3.1 Leadership Styles

Table two below shows some of the main Leadership styles divided into those associated with positive outcomes (the white section) and those associated with negative (the black section).

Table 2: "Positive" and "Negative" Leadership styles

Leadership Style	Key Features
Transformational Leadership	• Motivates others to do more than they originally intended and often more than they thought possible (Bass and Avolio, 1994) • Transformational leaders use idealized influence, inspiration and motivation, intellectual stimulation and individualized consideration to achieve superior results (Avolio et al., 1999)
Resonant Leadership	• Inspires, coaches, develops and includes others even in the face of adversity (Boyatzis and McKee, 2005; Goleman et al., 2002) • Based on the emotional intelligence of the leaders (Boyatzis and McKee, 2005)
Congruent Leadership	• Leadership matches the values and beliefs of others (Stanley, 2006)
Authentic Leadership	• Emphasizes building the leader's legitimacy through honest relationships with followers which value their input and are built on an ethical foundation (Kernis & Goldman, 2006)
Laissez-faire	• Conceptualized as passive avoidance of issues, decision making and accountability (Avolio et al., 1999)
Passive–avoidant Leadership	• Tends to react only after problems have become serious to take corrective action, and often avoids making any decisions at all (Avolio et al., 1999).
Active Management-by-Exception	• Focuses on monitoring task execution for any problems that might arise and correcting those problems to maintain current performance levels (Avolio et al., 1999)
Instrumental Leadership	• Focuses on the strategic and task-oriented developmental functions of leaders (Antonakis and House, 2002).
Transactional Leadership	• Emphasize the transaction or exchange that takes place among leaders, colleagues and followers to accomplish the work (Bass and Avolio, 1994).
Dissonant Leadership	• Characterized by pacesetting and commanding styles that undermine the emotional foundations required to support and promote staff success (Goleman et al., 2002).

The terms used in table two are not a definitive overview of the many types of Leadership that have been identified conceptually and theoretically but it offers an overview of those most commonly used and researched in the literature. Many of the above can also be grouped into larger categories and there is a fair degree of overlap across definitions.

1.3.2 Negative Leadership styles

There are many similarities between those Leadership styles displayed in the negative part of table two. Lassiez-faire Leadership is strongly similar to Passive-avoidant Leadership and a Passive Avoidant leader could perhaps be conceptualised as a Laissez Faire leader who is forced by situational pressures to react. Much of the research into negative Leadership styles and their impact has focused on qualitative work outside of healthcare.

Laissez-Faire Leadership is described as offering little to subordinates in terms of support and general indifference to the completion of duties and productivity. Lassiez-faire Leadership describes a situation in which a leader disregards their supervisory duties (Bradford and Lippitt, 1945) and is in effect a leader in title only. In a study by Lewin, Lippitt and White (1939) adult leaders of boys' clubs were taught to lead groups as either Laissez-Faire or Democratic leaders. Lassiez-faire leaders offered little guidance or supervision and allowed the boys in their charge complete freedom. These groups worked less efficiently, were confused and disorganised and their work was of a poorer quality than the other groups led by democratic leaders. Laissez Faire Leadership characterised by non-interference in the actions of others, has been demonstrated time and again to be the least effective and most frustrating Leadership style.

Similarly active management by exception and instrumental Leadership can be thought of as examples of transactional Leadership. Including Lassiez-faire Leadership all three share a focus on task orientated Leadership behaviours and all highlight a top down conceptualisation of how Leadership operates. Bass (1990) reports that Management By Exception has its roots in contingent reinforcement theories in which subordinates are punished or rewarded for certain actions and the involvement of leaders is low until failures or disruption occurs (Bass, 1985; 1990). An active leader will enforce predetermined punishments in an attempt to address the failures and be vigilant in case any corrective action needs to be taken. Active

leaders, unlike their passive counterparts, regularly search for failures and devise systems that warn of impending failures before they occur (Hater & Bass, 1988). Passive leaders are rarely involved and tend to react only when they have been notified of failures: they do not work from a predetermined plan of action or system of punishments and rewards. Such leaders expect only the status quo from subordinates and do not encourage exceptional work (Hater & Bass, 1988). Regardless of whether a leader is active or passive if they manage by exception than the majority of their feedback to followers is negative in content and they promote a status quo that doesn't develop followers. In such situations any break from routine or change in circumstances will require leader intervention as employees have been discouraged from thinking for themselves and solving problems as they have not been given the autonomy to develop confidence or to learn from experiences (See Bass, 1985; 1990).

Transactional Leadership has been described by Blanchard and Johnson (1985) as a process of creating strong expectations with employees and by means of negotiating clearly what followers will get in return for meeting these expectations. Despite being viewed negatively by many Leadership theorist's research has linked the contingent rewards associated with transactional Leadership with positive organisational outcomes (Howell & Avolio, 1993; Lowe, Kroeck, & Sivasubramaniam, 1996). Reactive or Transactional Leadership behaviours include disclaimers, excuses, apologies and self-handicapping (Valle & Perrewe 2000). They also include tactics that exist to avoid taking definitive action such as over-conforming, playing dumb, stalling, and blame-shifting and misrepresentation (Ashforth & Lee 1990). Such behaviours and tactics lend themselves to a defensive and self-serving Leadership stance and as such can only be considered acceptable when used to protect the interests of the collective body under severe external threat (Wylie, 2005).

Arguably Active Management By Exception and Instrumental Leadership are examples of Transactional Leadership that can be seen as existing on two overlapping continuums: one of Leadership involvement and the other of follower involvement. Lassiez-faire Leadership occurs where there is little involvement from leaders or followers and transactional Leadership when there is high involvement of both leaders and followers but in a very obvious top down hierarchical structure.

1.3.3 Positive Leadership styles

In terms of positive Leadership transformational and resonant Leadership share many conceptual similarities as both highlight motivation, inspiration and the stimulation of followers. Resonant Leadership could be thought of as to be a type of transformational Leadership and arguably did not require inclusion. However as the idea of resonant Leadership chimes with the idea of matching leaders and followers preferences for Leadership or management styles it has been included as this aspect of Leadership is often neglected in attempts to determine a set of prescribed behaviours or practices that 'fit' with whatever Leadership style an organisation values.

Growing from Burn's (1978) studies in political Leadership the transformational leader is described as one who inspires and motivates followers to rally around common purposes and to achieve things over and above the status quo. There is a degree of empowerment inherent to transformational Leadership and a trust between leaders and followers that people know their own jobs and the leader inspires autonomy among their followers.

Transformational Leadership models have built on the research of a number of authors (Avolio, 1999; Avolio, Bass & Jung, 1995; Lowe, Kroeck and Sivasubramanian, 1996; Bass and Avolio, 1993; Avolio & Bass 1991; Bass, 1990; Cogner and Kanungo, 1987; Kouzes and Posner, 1988). Transformational Leadership can be viewed as an amalgam of all "positive" variants of Leadership and indeed some of the "negative" variants when they are applied consciously with the intent to develop or improve staff. According to Welford (2002, p. 9)" transformational Leadership is arguably the most favourable Leadership theory for clinical nursing in the general medical or surgical ward setting". Thyer (2003, p. 73) also feels it is a style of Leadership "ideologically suited to nurses"; Sofarelli and Brown (1998) indicate that it is a suitable Leadership approach for empowering nurses, while the NHS Confederation (1999) indicated that transformational Leadership is in their view, best suited to modern Leadership of the NHS. Given this strong academic and policy support it seems appropriate to adopt Transformational Leadership for the investigations in this thesis.

1.3.4 Outcomes of 'Good Leadership'

The transformational Leadership model, which has been dominant in recent years and appears to have been validated by much research has been clearly linked with performance outcomes (Bass and Avolio, 1995). There is also evidence that transformational Leadership has a positive effect on mediating variables in follower and leader relationships such as job satisfaction, trust and psychological wellbeing. Though these relationships will not be explored within this thesis I include them here in order to strengthen the argument that good Leadership can have positive effects. If it can have positive effects on all these various aspects of follower and leader relationships it seems reasonable that, in a healthcare context, it could be found that it has a positive impact on Patient Centred Care.

Bass (1985) makes the assertion that transformational Leadership behaviour affects the higher order needs of employees and motivates them to rise above their own self-interest in the interests of the organisation. There is a substantial body of work that links transformational Leadership to positive outcomes (Bass, Avolio, Jung, & Berson, 2003). Meta-analytic work (Judge & Piccolo, 2004; Lowe, Kroeck, & Sivasubramaniam, 1996) has shown that transformational Leadership is associated with increased employee satisfaction and organizational commitment (e.g., Bycio, Hackett, & Allen, 1995; Podsakoff et al., 1990), satisfaction with supervision (e.g., Podsakoff et al., 1990), extra effort (e.g., Seltzer & Bass, 1990), turnover intention (e.g., Bycio et al., 1995), organizational citizenship (e.g., Podsakoff, MacKenzie, Paine, & Bachrach, 2000) and overall employee performance (e.g., Yammarino, Spangler, & Bass, 1993).

Quality of Leadership has been linked to an array of outcomes within occupational health psychology (Kelloway and Barling, 2010) : positive outcomes such as psychological well-being (e.g., Arnold, Turner, Barling, Kelloway, & McKee, 2007), organizational safety climate (e.g., Zohar, 2002a) and negative outcomes, including employee stress (e.g., Offermann & Hellmann, 1996), cardiovascular disease (e.g., Kivimaki et al., 2005; Wager, Feldman, & Hussey, 2005), workplace incidents and injuries (e.g., Barling, Loughlin, & Kelloway, 2002; Kelloway, Mullen, & Francis, 2006; Mullen & Kelloway, 2009) and health-related behaviours such as alcohol use (e.g., Bamberger & Bacharach, 2006).

1.3.5 Outcomes of 'Bad Leadership'

It is notable that research into bad Leadership focuses on internal effects of Leadership behaviours as opposed to external outcomes. Studies have shown, for example, consistent adverse effects on followers, subjected to 'bad' Leadership, in terms of job satisfaction, affective commitment and psychological well-being (Benson, 2006; Benson and Campbell, 2007, Benson and Hogan, 2008). In each of these areas that bad Leadership damages organisational performance by debilitating impact on morale and motivation of followers.

Within an organisation bad Leadership has been seen to have a far more significant impact on aspects of social interaction than it has on performance outcomes (Baumeister et al., 2001). Studies have suggested that certain "dark side" traits can be potentially destructive for followers and the organisation. (Baron, 1989; Conger, 1990; Frost, 2004; Tepper, 2000). Organizational behaviour researchers exploring the dark side of Leadership have started to explore the behaviours that have consequences not just at the organisational level but at group and team level also (Griffin & O'Leary-Kelly, 2004).

The perceived behaviours of leaders by their followers can impact upon their performance and generate stress with many people citing their boss as the primary source of workplace stress (Schabracq & Cooper, 1998). Negative Leadership behaviours can be perceived as bullying and such behaviours can lead to the deterioration in a follower's health as shown in Hannan & Youngs (2004) study of litigation against employers. Leaders play a huge role in how well followers cope with stress and work related strain but are often also found to be the cause of this strain (Schaubroeck, Ganster, Sime, & Ditman, 1993). There is some literature that has started to explore the topic of abusive supervision as a first step towards developing a fuller understanding of bad or destructive Leadership. (Tepper, Duffy, & Shaw, 2001). The research by Teppler (2000) has examined situations and conditions where followers are undermined or otherwise abused by leaders (Duffy, Ganster, & Pagon, 2002). The behaviours associated with the personality trait of hostility are consistent with those seen in abusive leaders such as laying blame on others and providing destructive feedback (see Tepper, 2000). Hostility was characterised by Williams (1989) as *"a cynical mistrust of others that leads to the frequent experience of anger, which in turn is overtly expressed to those*

around him or her" (p. 70). This trait has received more attention than most in recent research due to its ability to predict cardiovascular health (Sirois & Burg, 2003; Wielgosz & Nolan, 2000). Leaders who possess a high degree of hostility are likely to become angry when disappointed (Williams, 1989); thus disappointment leads to anger and anger in turn leads to dark side Leadership as leaders are more likely to express their anger outwardly against followers. Hostility is associated with a tendency to argue with others and instigate aggressive acts (Siegman, Dembroski, & Ringel, 1987) and hostile peoples tolerance for frustration is low which tends to make people more cautious of them (Prkachin & Silverman, 2002; Richards et al., 2000) encouraging a culture of walking on eggshells to avoid repercussions.

As is noted above the literature on bad Leadership appears to be very much in its infancy and there is a distinct lack of empirical work exploring the issues raised thus far. It is however important to explore the concept of bad Leadership empirically as this could then be used to merge research on both good and bad Leadership into a more coherent picture of the phenomenon. To consider that the only Leadership is good Leadership is to risk ignoring that there may be downsides to traits widely seen as positive and that these could have subtle and pernicious influences. It is also to ignore the perils of enforcing or adopting a one size fits all approach by neglecting individual differences alongside social contexts that may render such an approach fruitless.

1.4   Transformational Leadership

Many theorists have proposed variations of what is essentially transformational Leadership including Bass (1985, 1996); Bennis and Nanus (1985), Burns (1978), Sashkin (1988), and Tichy and Devanna (1986, 1990). Some building on the ideas of Weber (1947) have refined the concept of charismatic Leadership including Conger (1989), Conger and Kanungo (1987, 1998), House (1977), and Shamir, House, and Arthur (1993). Transformational and charismatic Leadership theories differ from traditional competency based approaches by emphasising emotions and values over 'rational' processes as well as acknowledging the importance of symbolic behaviour and the role of the leader in creating meaning. Such theories have helped develop an understanding of the ways in which a leader can use influence to encourage followers to act against their own interests, commit to difficult objectives and exceed their expectations of what can be achieved. These theories go some way to providing an explanation for the exceptional influence some leaders can appear to have on their followers and make an important contribution to our understanding of Leadership (Yukl, 1999).

1.4.1   Transformational Leadership Factors

Transformational Leadership is defined by four types of behaviours. Idealized influence takes place when leaders make the effort to do what is proper and ethical and are guided by their moral commitment to their followers beyond the interests of the organization. Leaders exhibiting inspirational motivation inspire their employees to achieve more than what was once thought possible by setting high standards and articulating a vision of what can be achieved. Leaders who manifest intellectual stimulation help employees to question their own commonly held assumptions, reframe problems, and approach matters in innovative ways. Finally, individual consideration occurs when leaders pay special attention to the employees' needs for achievement and development; they provide needed empathy, compassion and guidance that employees may seek for their wellbeing (Kelloway and Barling, 2010). When followers identify and seek to emulate their leaders' aspirations and behaviours transformational Leadership has been achieved. Followers are inspired and motivated to meet challenges and to engage in shared projects, visions and goals. They are further

encouraged to generate new solutions to problems and empowered to adopt more autonomy and become less reliant on dictats from on high. (Bass, 1985).

1.4.2   Stanleys' critique of Transformational Leadership

In an important and influential review of the literature on Clinical Leadership Stanley (2006) noted there were a number of competing definitions. He noted that these definitions included a number of common or shared characteristics of clinical leaders. Stanley then built on these shared features in his own study of clinical Leadership in which the views of 833 clinical leaders were sought and 188 survey responses returned. This data was supplemented with 42 in depth interviews with nursing staff and two in depth interviews with clinical nurse leaders.

Stanley used these to inform his definition of clinical Leadership and the characteristics that effective clinical leaders display:

- Clinical competence and knowledge: knowing how to do the job and to do the job to the necessary standard.

- Effective communicator: Having listening skills and being able to communicate flexibly with different audiences.

- Decision-maker: The ability to make decisions, in clinical and other matters, was seen as a key component of clinical Leadership by participants.

- Empowerment/motivator: Clinical Leaders could motivate and inspire staff to perform.

- Openness/approachable: The participants felt it was important a clinical leaders 'door was always open'

- Role model: Clinical leaders provided an example of professional practice that their staff could follow or aspire to.

- Visible: Clinical Leaders were seen to be present in the clinical environment and not locked away in an office far from clinical practice.

Stanley argues that these key characteristics of clinical Leadership are at odds with the definition of transformational Leadership offered by others (House, 1976; Burns, 1978; Bass, 1985, 1990). Central to his argument, is the view that clinicians do not see "vision" as important in a clinical leader. Further to this Stanley argues that congruent Leadership is a more appropriate definition for clinical Leadership. However, a leader is not simply something people are perceived to be: A leader is someone who leads: uses Leadership techniques and behaviours to encourage staff to complete organizational tasks (Kotter, 1990). As such, congruent Leadership may serve as a good model for why clinical leaders are accepted by staff, however, it is not as comprehensive in identifying the Leadership behaviours that clinical leaders possess as Transformational Leadership (Bass, 1999). It's focus on 'vision' as a key component also seems at odds with the operation of clinical Leadership within the UK public sector (Alban-Metcalfe & Alimo-Metcalfe, 2000a). Given this research focuses exclusively on clinical Leadership within a UK public sector context, specifically the Scottish NHS which the next section will cover, this focus on 'vision' seems unnecessary.

1.5   Leadership in the NHS in Scotland

Health in Scotland became a devolved matter under the terms of the devolution settlement (Scotland Act 1998) which for the first time allowed distinct differences to develop between the health services of the four constituent nations of the United Kingdom – particularly in terms of organisation, structure and management (Maslin-Prothero , Masterson, & Jones , 2008) Some have suggested that divergences in policy since devolution have been driven by the drive of politicians and policy makers to develop policy that meets local needs (Greer, 2004a) and that the NHS is often a *"political football"* and never entirely free from the impact of political debate and change (Edwards, 2007)

Strategic direction for the health service in Scotland was a collaborative process and involved extensive consultation exercises with NHS staff and members of the public. It placed an emphasis on a collective ownership of the health service and a high level of involvement from both NHS employees and the general public in service development and improvement. Overall these consultations indicated that there was a strong antipathy towards 'market driven' reforms of the kind seen in England and there was a desire for people to be involved in improving the NHS (Kerr & Feeley, 2007) It has also been argued that the reformation and redesign of traditional models of healthcare management and service delivery is one that is becoming increasingly contingent on effective Leadership at all levels within NHS Scotland (Wylie, 2005). In an aim to promote and improve the effectiveness of Leadership the Scottish Leadership Foundation (SDF) was established in 2001 which aimed to *"raise the quality and effectiveness of public services in Scotland by encouraging the development of Leadership at all levels"*. In March 2002 it published its strategy to support long term Leadership development over short-term fixes by providing resources and support to local public services in the development of their own Leadership development strategies.

In 2003 the Scottish Executive Health Department (SEHD) published the "Partnership for Care" white paper which committed them to value and empower NHS staff to *"solve old problems in new ways"*. Included in this report were specific proposals to invest in the development of Leadership and develop a Leadership framework for training and clinical Leadership purposes. In response to this white paper the Scottish NHS published its

Leadership Development Framework (LDF) (2004) to affirm its commitment to developing Leadership capability and capacity. This document includes Leadership behaviour alongside more traditional strategic concerns and service components as an equally important area for development. An appendix to the framework 'leaders/managers code of personal governance' outlines the positive and negative behaviours and personal qualities that health boards should embrace in order to develop local Leadership programs. Wylie (2005) noted a major weakness which was acknowledged in the framework namely the difficulty in reviewing and evaluating the impact of Leadership development. The framework states that: *"there are certainly too many variables to consider evaluating return on investment, but on the other hand it is important to ensure that resources are being applied with the greatest impact."* (p.21)

The LDF was intended to be both focused and flexible and it aimed to:
  i.   describe the change context which informs the Leadership development agenda
  ii.   describe the qualities required of NHS Scotland leaders
  iii. identify national priorities for action in Leadership development
  iv.   Propose how NHS Scotland can work together - locally and nationally - and with partners, to develop Leadership capacity and capability at all levels.

The Framework was built around the following concepts:
  i.   To give strategic coherence, there will be a single, national approach to Leadership development in NHS Scotland. This will be focused on the needs of the service, teams and individuals.
  ii.   Within this cohesive approach there will be significant space for local systems to take forward the Leadership development agenda and for professional groups to enhance specific skills.
  iii. The goals of improving health and reforming healthcare delivery cannot be achieved by the health service alone. Wider public sector engagement is critical and this needs to be supported by joint approaches to Leadership development.
  iv.   New approaches are needed to provide opportunities for career development and give flexible support to systems where necessary.

The LDF stresses transformational styles of Leadership and makes provision for leaders to exist at all levels of the NHS. As such the LDF does not advise local health boards to take a purely top-down approach to Leadership and seeks to *"permeate each ward team, community team, functional team and support front line leaders to deliver improvements"*. The framework does concede however that the "tone" of an organisation often depends on the Leadership styles and behaviours of senior management, as they can act in a capacity as a Leadership role model for those they lead and serve. This capacity as role model was the reason given in the LDF for focusing on senior managers and clinicians and leaving more bottom-up Leadership developments to the local boards themselves. Given the stress on transformational Leadership and clinical governance this seems at odds with many of the ultimate policy aims of the LDF. The LDF further recognised that although most Leadership interventions and development plans focus on the individual leaders or managers and their attributes, teams are also important. The LDF advised that as well as developing individual leaders and managers attention should be paid to the development of teams. The Leadership qualities outlined by the LDF are given in box 2 below.

Box 2 Leadership Qualities

- Person specifications to recruit leaders
- Assessment frameworks for Leadership appointments
- Personal and team development planning and review
- Individual/team performance planning and review
- Design of Leadership development initiatives
- A potential contractual commitment to personal governance.

NHS Scotland Leadership Framework (2005)

A diagram of the Leadership Development Framework is given in figure 1 and it serves to illustrate the conceptual complexity inherent in understanding how Leadership operates within the NHS.

Figure 1: Overview of the NHS Scotland Leadership Development Framework
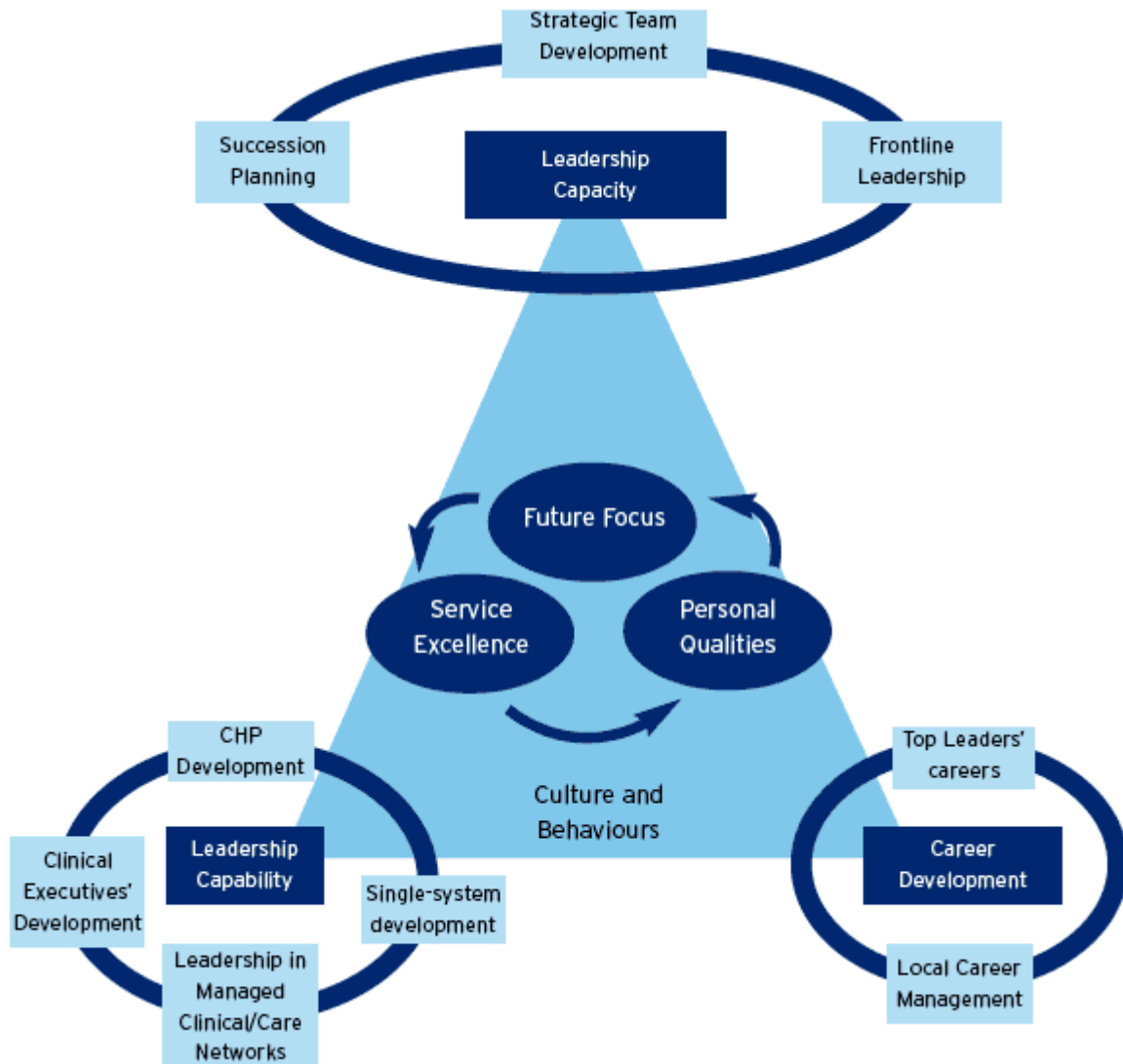
Though Hewison and Griffiths (2004) note that there is a great deal of emphasis on Leadership development without a focus on transforming health professionals work risks Leadership development being consider a transient fad. Furthermore, the implementation of Leadership in the NHS has demonstrated some of the issues clinical leaders face in practice. A number of tensions become apparent between a healthcare professionals role, the ideal of Patient Centred Care, and often constrained resources (Naughton & Nolan, 1996). The culture within the NHS can also have an impact on the effectiveness of Leadership within the health system.

1.6 1.1 Organisational culture and its impacts on Leadership in the NHS

The importance of organisational culture, and the numerous issues associated with affecting change thereof, has been an important area of research within health services. In the United States it has been recognised as a means of reducing medical errors (Institute of Medicine, 1999) and in the United Kingdom it has been considered that structural and procedural changes to the NHS organisational culture would bring with them improvements in the quality of care and staff performance.

It is also important to note that previous research has noted that 'cultural divergence' can occur between different sites within the same organisation (Mannion, Davies, & Marshall, 2005). One of the key points of cultural divergence has been found to be Leadership and Management orientation so it is important that this thesis consider the organisational context alongside measuring Leadership and Patient Centred Care.

It has been suggested in the literature that health care cultures which incorporate values centred around teamwork, group affiliation and coordination, are associated with a greater implementation of quality improvement practices (Shortnell, et al., 1995) and higher functional health in patients (Shortnell and Kaluzny, 2000). Conversely organisational cultures that emphasize a more formal and rigid structure seem to be negatively associated with quality improvement activity (Ferlie & Shortnell, 2001), though it is worth noting that studies in this area tend to suffer from methodological weaknesses and their findings should be interpreted cautiously (Scott, Mannion, Davies, & Marshall, 2003).

Scott et al (2003) conducted a systematic review of the debates surrounding organisational culture and culture change in healthcare organisations and systems. They discovered that the concept of organisational culture is imprecise and that the literature contains many competing and overlapping definitions. These can be broadly split into two streams (Smirchich, 1983) one which views organisational culture as an attribute of an organisation and another that considers organisational culture as defining the whole character and experience of organisational life. There is no doubt more than an element of truth to both of these interpretations though for the purposes of this thesis the former interpretation is more

attractive as it more strongly suggests an organisational culture is something that can be developed, changed and altered rather than something more rigid and simultaneously intangible.

Scott et al (2003) suggests that the culture present with the UKs NHS is an "orthogonal culture": a culture that tacitly accepts the dominant organisational culture whilst similarly exposing its own professional values. In essence an orthogonal culture is a culture that exists in a pluralist setting and that individuals can identify with multiple independent cultures. In the NHS this can be seen by identification with global organisational values while being independently identifying with the values of their professional group. Scott et al (2003) identify a number of barriers to organisation change including lack of ownership, complexity and resistance to change and external influence. In theory all of these could be effectively addressed were the NHS to adopt a wholesale transformational approach to clinical Leadership and management. Indeed Leadership is identified and singled out as playing a central role in any attempts to alter or change organisational culture with a transactional approach found wanting while more transformational approaches seeming to offer more chance of success (Schien, 1995).

In terms of this thesis I felt that the impact of organisational culture was important to include. Particularly given the key role that Leadership plays in changing culture and the role culture has in enabling or hindering delivery of Patient Centred Care.

1.6   The importance of Leadership to AHP practice

Leadership has also been identified as being of central importance within Allied Health Professional practice as emphasised by the Scottish NHS Allied Health Professional action plan: Allied Health Professionalss as agents of change in health and social care - The National Delivery Plan for the Allied Health Professions in Scotland, 2012 – 2015 (Scottish Government, 2012). Leadership is presented as one of the most important aspects of the National Delivery Plan with Nicola Sturgeon, MSP, the then Deputy First Minister and Cabinet Secretary for Health in Scotland stating "*The integration of services needs to be improved to deliver better health and social care services: services should be characterised by strong and committed clinical and care professional Leadership. (*Wellbeing and Cities Strategy, 12 December 2011).

The delivery plan notes that AHP leaders' influence is already high in a number of NHS boards and that AHPs have a significant Leadership role to play in the integration of health and social care service delivery. The plan also notes that AHPs are well placed to help support self-management and enablement at the point of care not simply to reduce unnecessary referrals but they could also be pivotal in creating a paradigm shift away from professional dependency towards resilience and an asset-based approach that builds personal capabilities and community resilience. This is in no small part down to an "enabling" ethos that is rooted in a person-centred approach and sits in the spectrum between a "treatment-based" approach and a "care-based" model.

AHPs already straddle local authority and health settings. They are uniquely placed to take a lead in service design and implementation and to influence the planning and delivery of health and social care services. Leadership in AHP practice is therefore an area of key interest within the NHS and potentially has far reaching consequences for service design, development and integration.

1.7   Patient Centred Care

Historically, the principles of Patient Centred Care date back to the Ancient Greek school of Cos and to this day, the concept of being patient centred is a core value of many physicians and health professionals (Stewart et al 2000). Yet there is no established consensus on an operational definition of Patient Centred Care, and the topic has been stated to lack conceptual clarity (Redman & Lynn, 2004). There are a number of definitions that share some common features but differ, sometimes subtly sometimes dramatically. The literature on Patient Centred Care illustrate the breadth of the concepts definition – although in some cases this appears to be because there is an association with anything that is "good" in healthcare being labelled as patient centred (Epstien et al 2005). This co-opting of the term person centred leads to a lack of clarity and confusion as to what the term actually signifies.

Without an adequate conceptualisation and operationalisation of Patient Centred Care, research into the extent to which it is delivered in practice, its impact on health quality; and the experience of people who are cared for in this manner is challenging. Fortunately, despite the various definitions of Patient Centred Care given in the literature, there is some common

ground. Lauver et al (2002) identified an underlying theme that Patient Centred Care is fundamentally concerned with meeting patients' needs, wants and or expectations by respecting and integrating individual differences when delivering care. This over-arching conceptualisation of Patient Centred Care as individualised can be thought of as delivering care that meets with the expectations, needs and wants of the patient and this conceptualisation of Patient Centred Care relies upon individual and contextual factors being accounted for by health care professionals.

Patient Centred Care can incorporate many distinct elements: some which stress a shared decision making approach to patients care and aim to empower them and others which focus on physician and health professionals' communication skills. However it is important to note that while interventions involving shared decision making and improving physician or patient communication can be patient centred this depends on the patient - seeking a one size fits all or mechanistic model of Patient Centred Care is contrary to its principles.

Patient Centred Care is considered and acknowledged as a good thing – with some arguing that it can have a positive and tangible impact on improving health outcomes (Stewart et al 2000, Michie et al,2002, Dieppe et al 2002). Specific benefits of person centred care include reducing patients revisiting health services unnecessarily (Channel and Frampton 2008) increasing compliance and concordance with treatment (Michie et al 2002, Ong and Hooper 2006) (although it is debatable how much a measure designed to increase compliance is truly patient centred) increasing patient satisfaction with treatment (Duggan et al 2006, (Mead and Bower, 2000, Aragon 2003). It has also been suggested that person centred care can have a positive impact on healthcare professionals (Wylie and Wagenfield-Heinz 2004) as it is in line with many clinicians motivations for becoming health practitioners and the values of the professions themselves. Others have argued that person centred care has an intrinsic value regardless of any impact or effect on health outcomes (Krupal, 2000; Epstein et al, 2005).

Regardless of whether Patient Centred Care is seen as an intrinsically or instrumentally good thing it has been recognised as being of policy importance to the Scottish Government and NHS. The Scottish Government (2009) 'A patients' Rights Bill' stated that healthcare should

be person centred: defining this as providing care that is responsive to individual patient preferences, needs and values and assuring that patient values guide all clinical decisions. The Healthcare Quality Strategy for Scotland (2010) stating that it is desirable to have *"individual care encounters which are consistently person-centred"*.

1.8   Definitions of person centred care

Despite a general agreement that Patient Centred Care is the kind of care that health professionals should aspire to there is less agreement when you try to formulate a specific definition of Patient Centred Care.   It can seem, in some cases at lEast, that person centredness has become a victim of the round-trip fallacy: in that because person centred care is considered good, any healthcare that is good becomes considered person centred. This has led to a situation arising where there are numerous definitions of person centred care, and associated synonyms and related concepts such as relationship/family /person/client centred care, to list them all in any detail would be a Sisyphean task. Rather a list of the main definitions emerging from the conceptual review that relate specifically to the concept of flexible responsiveness follows.

There are a number of definitions and models which attempt to provide an alternative to the biomedical or evidence based medicine model. For instance Mead and Bower (2000) proposed the biopsychosocial model which conceptualised person centred care as being composed of five dimensions: the patient as a person, sharing power and responsibility, the therapeutic alliance and the doctor as a person. Similarly Robinson et al (2008) treat person centred care as a recognised measure of the quality of care. They trace its roots back to holistic healthcare and see it as a shift away from the traditional biomedical *"disease orientated"* (p600) model. They define person centred care as simply patient involvement and the individualisation of care. Canada-Herbert (2005) suggest that collaborative patient-centred practice is a practice orientation that is a way of allowing health care practitioners to work together with their patients and this collaborative sentiment is echoed in Schoot et al (2006) and again in Sumison and Law (2006) and is common across the literature on the whole.

Lyness Slater (2006) defines person centred care as professional care that also respects the autonomy, dignity and privacy of the person (Ford and McCormack 2000; McCormack 2003a, Nolan et al 2001, Price 2004) in their conceptualisation of person centred care the focus of care is not the illness, disease or professional interest but the person. This definition can perhaps be taken as an example of the attitudes of some researchers and healthcare

professionals that evidence based on biomedical care and person centred care are mutually exclusive. The primary difference between these two positions, supposedly in opposition, is that person centred care focuses on the patient but biomedical care focuses on dealing with the health concern or medical problem (Robinson et al 2008). Peek (2009) addresses this argument by suggesting that better integration of the biomedical and psychological aspects of care is essential, to delivering quality care, if integrated care is geared toward enhancing usual care, and decision making, for common combinations of medical and mental health conditions. Sumison and Law (2006) believe that the definition from Sackett et al (2000) which describes evidence based medicine as *"the integration of best research evidence with clinical expertise and patient values"* (p.1) presents a vehicle for clinicians to link evidence based medicine and person centred care.

1.8.1   A lack of conceptual consistency: Too many definitions

In 1986 Donabedian noted an issue with defining quality in healthcare, what quality was used to be considered a mystery; therefore before attempting to measure or assess quality it was necessary to identify and agree on what quality was. Those trying to define person centred care face a similar task: how to operationalize and define just what person centred care is?

Patient centerdness is a term that is often used in the literature but it remains an ill-defined construct (Slater 2006) and it suffers from a lack of theoretical and conceptual clarity; many terms are used as synonyms for person centred care when they can have subtle different meanings and implications (Epstein et al 2005): For example patient centred and person centred are often used interchangeably but can be thought of as having very different meanings: the term patient is loaded with assumptions and implications relating to power in the doctor-patient/doctor-person relationship (Slater 2006). This is also an issue highlighted in Robinson et al (2008) where it is noted that the definition of person centredness can vary depending upon the setting or perspective that is being represented. What is person centred in one context, or indeed for one patient, may not be applied successfully in another.

Birks and Watt (2007) highlight how health care systems around the world are emphasising person centred care as a multidimensional concept and this acceptance of the complexity of

the construct is widely accepted. Mead and Bower (2000) note that despite of, or perhaps more likely because of, the popularity of person centred care there is little agreement surrounding what person centred care is and it has been used to refer to so many concepts that its scientific utility has been compromised. This has led to an inconsistency in the way person centredness has been defined (Michie et al, 2003) and as Sumison and Law (2006) rightly point out this inconsistency has led to misconceptions about which key elements underpin a person centred approach and how to go about implementing person centred care in practice. These misconceptions in part seem to arise because some people take different terms, with specific bespoke meanings in certain fields, to be synonyms for what they understand to be person centred care. This seems to particularly be an issue in translating concepts generated in academia from research into practice.

As Goodrich (2009) points out the language of research and policy does not necessarily translate well into the everyday language of healthcare practitioners – an issue exacerbated by the fact that health care professionals working in different fields apply different meanings to the terms and use them to refer to different practices, procedures and even moral and ethical positions. Further to this there are a number of these synonyms that are more than just the subject of debate between academics and researchers. They shape and relate to how practice in healthcare is conducted.

To take the example of the biopsychosocial model (Mead 2000) practicing clinicians can have difficulty in reconciling this model with the clinical reality they face on a day to day basis (Epstein and Borrell-Carri, 2005) partly due to confusion over what the biopsychosocial model is: Is it an aim that clinicians should intend to achieve in practice?; a philosophy of how care should be or a descriptive model of how care can be conducted?. Is it a belief system or a vision of how practice should be and a guide to achieve what is desired? These are questions that the lack of conceptual clarity within the literature has attempted to but ultimately not helped answer satisfactorily.

1.8.2   Commonalities

Sumison and Law (2006) list some of the key concepts that their analysis found are shared across definitions of person centred care; a strong emphasis on collaborative approach or partnership, respect for the patient, facilitation of choice and involving the client in determining the goals that arise from their choices. These key concepts share a number of features conceptually and are interrelated to varying degrees.

1.8.2.1   *Emphasis on collaborative approach or partnership*

One of the key concepts on which a collaborative approach or partnership is built upon is the notion that this empowers the patient and that this is a means of addressing the paternalistic or traditional modes of care that encourage less egalitarian approaches.

There is a common theme running through the literature on person centred care concerning empowerment. Sumison and Law (2006) state *that "Medical consultations [are] often more effective when the patients voice is heard"* (p.156) and empowering the patient in this way is often highlighted as important within the literature on person centredness (Michie et al ,2003; Schoot et al, 2005; Lyness Slater, 2006; Leplege et al,2007)

A report by the Pew-Feltzer task force (1997) believes that *"relationship centred care captures the importance of the interaction among people as the foundation of any therapeutic or healthy activity"* (p14). Furthermore Entwistle et al (2009) suggests that relational thinking can inform recommendations about treatment as these are more likely to be autonomy supportive if made by clinicians who seek to promote patients autonomy and not just narrow health gain. Or in other words clinicians can recognise and support patients through a collaborative relationship based approach and work together with patients in partnership to address their health concerns.

Channel and Frampton (2008) believe an effective healthcare model is used not only to treat patients but also to comfort, engage and empower them and that person centred care can be defined as a healthcare setting in which patients are encouraged to be actively involved in their own care. Robinson et al (2008) makes the case that definitions of person centredness condense into two concepts – promotion of patient involvement and care that individualises

patient treatment and both of these involve aspects of patient empowerment: involving patients' in their care goes someway to addressing the power imbalance that is inherent in doctor-patient relationships. Macleod and McPherson (2007) also make the case that treating the patient as an expert, or at least increasing the emphasis on empowering the patient as the expert on their condition is central to person centred care. However Epstien (2000) states that is a myth that person centred care means simply giving patients what they ask for.

1.8.2.2   Respect for the patient

Respect for the patient and recognition of the patient as an individual are central to most conceptions of person centred care – although what his encompasses and the extent, to which respect is of importance to conceptualisations of person centred care can, and does, vary a great deal. Hsaio and Bouet (2008) state that *"Personal aspects of care are (at least) as important as technical aspects"* (p.302) and this is a common theme running through research on person centred care – one such personal aspect is recognition of and respect for the individual patient. Suchman (2005) states that *"relationship centred care pays attention to personhood of clinician and of patient"* (p.540). However Redman and Lynn (2004) identify varying definitions and conceptual views although this does not withstand the underlying theme that they have identified: a fundamental concern with meeting patient's needs, wants and/or expectations: by respecting and integrating individual differences when delivering care (p.119). This is further underlined by Sidani et al (2006) where person centred care is seen as focusing on understanding the patient as a unique person with individual characteristics, needs, values and preferences. Other work focuses on specific elements of recognition and respect such as a focus on individual patients values (Hibbard, 2004). Duggan et al (2006) offer a broad definition: "care that is closely congruent with and responsive to patients, wants, needs and preferences" (p.271). McCormack (2002) further reinforces the idea that respect for patients is central to patient care and that the rights of the individual as a person constitute a driving force behind person centred care.

Mead and Bower (2000) state that *"patient centred medicine conceives of patient as an experiencing individual"* (p.1089) and Slater (2006) maintains that person centred care should be holistic as this improves health outcomes and has a positive impact on doctor-patient

relationships. Michie (2003) goes into more detail listing the following as components of treating the patient as an individual; communication skills, the matching of beliefs, forming a treatment alliance and formulating an agreed treatment plan which it is proposed leads to an empowered and autonomous patient.

Holstrom and Roing (2009) place the emphasis on understanding the patient and believe this can be achieved by focusing on recognising and respecting patients' perceptions and beliefs. Epstien et al (2005) similarly state that the goal of person centred communication is to *"help practice provide care that is consistent with patient's values, needs and preferences"* (p.1516). Sumison and Law (2006) believe that this recognition and respect can be achieved via a strong emphasis on collaborative approach or partnership built upon a foundation for respect of the patient (p.154-155).

1.8.2.3   *Facilitation of choice*

Facilitation of choice and involving the client in determining treatment goals are common to many conceptualisations and definitions of patient cantered care (Holstrom and Roing, 2005; Sumison and Law, 2006; Donabedian. 1988; Bosman et al, 2007) and are closely tied to the idea of patient empowerment. In McWhinney (1995) facilitation of care is central to the definition of what person centred care is: *"Considering patient's needs, wants, perspectives and individual experiences, offering patients opportunities to provide input into and participate in care"* (taken from Epstein et al 2005 p.1517). Wylie and Wagenfield-Heinz (2004) suggest that the person centred agenda found in the literature is associated with a move towards mutuality and reciprocity as key elements in an interactive process which is more and more starting to emphasize patient control.

However the seriousness of a condition can lead a patient to seek a more "paternalistic" style of care and in some cases offering a number of choices to patients can undermine trust in the doctor patient relationship: *"patients may lose trust when physicians provide information that indicates there is some ambiguity about the correct course of action"* (Ogden et al 2002 taken from Epstien et al 2005 p1518). Furthermore research has shown that when patients becomes critically ill they tend to respond better to more directive communication styles (Cassel, Leon

and Kaufmann, 2001). Yet studies on chronic disease have shown that patients trained to have a more active role in consultations were more adept at eliciting information and felt they had more control and these reports correlated with improvements in health outcomes (Williams et al 2005). The differences between chronic and critical conditions illustrate one of the tensions that exist in person centred care: namely the extent to which an approach that facilitates choice, above other considerations such as the patients situation and expectations, is truly patient centred. Practitioners need to consider how they relate to each individual patient, at any given moment, and practice a form of flexible responsiveness (Epstien, 2005) in order to meet the patients' individualised expectations in light of their needs and wants. Research has shown there is a link between involvement in care and the patients' experience of person centredness: however there are questions about the level of control patients feel comfortable in exercising.

1.9   My definition of Patient Centred Care

Drawing from the research and policy literature this study has adopted the following definition of Patient Centred Care:

- Care that is individualised,
- Care that is flexible in its responsiveness
- Care that is supportive of patient choice

Flexibility in responding to individual health patients is key to preventing the kinds of over-standardization that have been identified as problematic in providing truly individualised Patient Centred Care.

1.10 Patient Centredness and the NHS

The *Healthcare Quality Strategy for NHS Scotland* develops previous Scottish Government commitments, building upon *Better Health, Better Care* (Scottish Government, 2007), to ensure that healthcare across the NHS in Scotland is person centred (Scottish Government., 2010) There are six dimensions adapted from the Institute of Medicine report "*Closing the Quality Chasm*(2001), that are identified as important to ensuring that quality care is delivered: care should be person centred, effective, safe, timely, efficient and equitable and of these six dimensions person centredness, safety and effectiveness are considered the key drivers of the quality strategy. Of the key drivers Person centredness is of great interest to the health service and it is of paramount importance to identify areas where the quality of such care can be developed and improved.

As seen in a previous report (Duncan, Entwistle V, & Liddle, 2010) there are a number of issues that lead to a lack of conceptual clarity when trying to pin down what person centred care is which leads to inherent difficulties in determining whether it is being delivered. At an individual clinician level the report concluded that person centred care was supportive of individual autonomy, individualised and flexible in its responsiveness. The report suggested that in assessing person centred care that experiences and interactions that contribute to

person centred care "occur within the context of organisations and systems that have the potential to either support or inhibit the likelihood of a person centred care experience".

Various recent policy papers cite the importance of Patient Centred Care and provide various definitions of it and these are dealt with in greater detail in section 1.10. Giles' report for the Scottish Government "Delivering Care, Enabling Health" (Giles, 2006) simply describes Patient Centred Care as "*putting the patient and the patient's best interests first*".(pp3) The Scottish government Quality Strategy (2010) expands this slightly quoting from the Institute of Medicine report Closing the Quality Chasm (2001) : "*healthcare should be… patient centred – providing care that is responsive to individual patient preferences, needs and values and assuring that patient values guide all clinical decisions".* (p12)

A broader policy description of Patient Centred Care is given in the quality strategy and defines Patient Centred Care as "*the provision of a caring and compassionate treatment; clear communication and explanation; effective collaboration with clinician; and a clean and safe environment*". This definition is then further expanded by stating that patient -centredness can be improved by delivering care based on *"mutually empathetic relationships"* involving shared decision making and an approach that reflects the *"uniqueness"* of the individual and encourages them to manage their own health and illness (Scottish Government, 2010).

Within this context of organisations and systems there is clearly scope to explore the role of Leadership in promoting high quality person centred care as well as issues arising that could negatively impact on a healthcare teams ability to deliver such care.

1.10.1 Patient Centred Care in AHP practice

The Directorate for the Chief Nursing Officer, Patients, Public and Health Profession recently published a care governance manual as part of the NMAHP contribution to achieving the goals set out in the Quality Strategy.

This outlined how different levels of the service can work together to improve care governance. Care Governance is described as *a "vehicle to support NHS Boards deliver the NMAHP contribution to quality"* and it stresses the importance of providing assurance to patients by strengthening the connection between the quality of direct care delivery and the requirement at NHS Board level to report on the quality of service delivery. The manual sets out seven key care and caring behaviours known as the seven c's: Care, Compassion, Communication, Collaboration, Clean and Safe, Continuity and Clinical Excellence. Many of these attributes relate to how an individual empathizes with or relates to their patients and effective team working is listed as one of the important influences on the quality of care and caring delivered.

1.11 Linking Transformational Leadership and Patient Centred Care

It is perhaps not surprising that research and interventions in nursing Leadership has tended to have been guided by those styles of Leadership that emphasise relationships as a foundation for effecting positive change such as transformational Leadership (Hibbard and Smith, 2006). This focus seems appropriate in the context of Patient Centred Care as they encourage a focus on inspiring or motivating the individual as opposed to ensuring that systems, policies and procedures are rigidly adhered to.

Thus arguably they foster an environment where individual practitioners are encouraged to exercise their own clinical judgement and agency which allows them a greater degree of freedom to provide Patient Centred Care that meets the objectives of being flexible in its responsiveness, individualised and supportive of patient autonomy (Duncan et al 2010). Although there are links between theories of Leadership and Patient Centred Care in terms of shared values and similar concepts there has been little work linking the concepts in terms of NHS policy or research.

Health Facilities Scotland commissioned Patient Centred Care: A research report (Health Facilities Scotland, 2011). The report highlighted this issue and attempted to explore how Leadership could impact on the quality of Patient Centred Care patients received. They outlined the key principles as a welcoming environment, respect for patients' values and needs, patient empowerment, account taken of patients' backgrounds, the coordination and integration of care, comfort and support, shorter waiting times, convenient hours, etc., and community outreach initiatives. There is a focus on improving the environment and considering patients when designing or reorganising facilities but this is not of primary interest to this research.

The research does look at how Leadership can have an impact on the delivery of Patient Centred Care in terms of its impact on staff and organisational culture. The report notes that although widely accepted in paediatric and maternity units, management strategies at organisational and system-level are required to instil a change in the outlooks of healthcare organisations to improve person centredness in other areas. The report cites executive level

Leadership, a strategic vision, support and training for healthcare staff and appropriate monitoring of patient feedback as key Leadership or management issues to address in improving Patient Centred Care.

The report proposes a number of strategies for organisations to improve person centred care through Leadership: it suggests that Leadership development and training is essential for realising person centred care and that such development should encompass all disciplines (nursing, administration, medicine etc.) and sectors (healthcare delivery, suppliers, insurers, etc.). This training should have a quality improvement focus and steps should be taken to evaluate and measure change.

In conjunction with this they propose that a transactional system of contingent reward is used in conjunction with an overarching Leadership strategy to help retain leaders and reward them for good performance. They also advise that measurements of patient-centred-care be included in any performance reviews. They advise that these tools must be developed and made available to managers and clinical leaders and note that although there is a lack of such tools some are being developed by institutes such as the Picker Institute.

The report uses data gathered in cases studies to support t its case, of particular interest are key points one and four that state:

> **Key Point 1:** *Effective, supportive and visionary senior Leadership is a vital component of any Patient Centred Care approach.*
> **Key Point 4:** *Since staff can influence the success of a Patient Centred Care initiative, organisations must not only focus on the patients but should also ensure they take care of their staff, meet their needs and provide a satisfying work environment.*

However the evidence given in support of these key points is gathered from a motley selection of research of varying quality. The paper on the whole is overly reliant on papers produced by management consultants and has not really explored the issues of person centred care or Leadership in any great depth. The inclusion and exclusion criteria for the reports search

strategy are broad and refer mainly to what sources of information are to be trusted without giving any indication of the quality of individual papers included or referenced. The report also lacks reference to a large swathe of important and influential literature in both the fields of person centred care and Leadership.

Despite the weaknesses in the paper it is important that someone has made the first step in linking the delivery of high quality person centred care and Leadership.

This thesis intends to explore this link and to determine whether there is an impact and. if there is, how large that impact is.

1.12 Conceptual commonalities

Transformational Leadership is defined by four types of behaviours. Idealized influence takes place when leaders make the effort to do what is proper and ethical and are guided by their moral commitment to their followers beyond the interests of the organization. Leaders exhibiting inspirational motivation inspire their employees to achieve more than what was once thought possible by setting high standards and articulating a vision of what can be achieved. Leaders who manifest intellectual stimulation help employees to question their own commonly held assumptions, reframe problems, and approach matters in innovative ways. Finally, individual consideration occurs when leaders pay special attention to the employees' needs for achievement and development; they provide needed empathy, compassion and guidance that employees may seek for their wellbeing (Kelloway and Barling, 2010).

Each of the concepts which have been found to be common in definitions of Patient Centred Care (emphasis on collaborative approach, respect for the individual and flexible responsiveness) can be linked conceptually with elements of transformational Leadership. This is perhaps because the values underpinning the relational aspects of transformational Leadership and Patient Centred Care seem to be driven, in essence, by the same values.

The idea of an emphasis on collaborative approach or partnership from Patient Centred Care ties in with the concepts of intellectual stimulation and inspirational motivation. Both involve

working together within an intrinsic power dynamic be it patient-clinician or leader-follower. Both involve a relationship of respect between the two actors in any interaction or process and each other's roles within these interactions or processes is recognised.

Intellectual stimulation also ties in with the idea of a collaborative approach as it involves empowering followers to generate new and innovative solutions to problems. Echoes of the idea of respect for the patient can be found in the FRLT factor intellectual stimulation. The leader uses this as a tool to motivate his/her followers to achieve more than they perhaps thought possible. However to do this they must appeal to their intellect and to do so convincingly implies a degree of respect for the individual in question.

The central concept of Patient Centred Care, flexible responsiveness, is related to the FRLT factor individualised consideration. Flexible responsiveness refers to the need for a clinician to avoid adopting a "one size fits all" approach to their patients and adapting their consultation or approach to treatment accordingly. Individualised consideration achieves this in the leader-follower relationship. The process makes the follower or patient feel uniquely valued and important. In the case of the patient this may help built a more robust and trusting relationship with her/his clinician and in the case of the follower it motivates them to perform and realise her/his own potential.

1.13 Potential moderating variables between Leadership and PCC

In delivering Patient Centred Care the patients' context, needs, wants and expectations need to be taken into account and responded to in an individualised and flexible manner. Indeed this is what Long (1985) suggested: that clinician flexibility and responsiveness are key to the person centred approach. Donabedian builds on his by suggesting that Patient Centred Care means *"no preconceived notion of what the objectives and accomplishments of care should precisely fit any given patient"* (p.1745). Donabedian perhaps can be accused to taking an overly ideological standpoint here as Patient Centred Care occurs within a healthcare system and is provided by trained health professionals. Thus having no preconceptions of what treatment should be administered to a patient seems to ignore the issues of patient expertise

and the limitations placed upon clinicians by the policies and procedures of the systems they work within.

Practitioners need to consider how they relate to each individual patient, in any given moment, and practice a form of flexible responsiveness (Epstein 2005) in order to meet patients' individualised expectations of care in light of their needs and wants. Research has shown there is a link between involvement in their care and their experience of person centredness. However, there are questions about the level of involvement a patient wants, and has the capacity to understand, which will affect the level of control they feel comfortable in exercising. There are differences found between chronic and critical conditions that indicate one of the tensions that exists in the delivery of Patient Centred Care; namely the extent to which it is correct to involve the patient in decisions about their own care at any given point.

Also worth considering is the concept of patient-physician fit (Schwartz et al 2006) where preferences for different types of physician behaviours were measured and it was found that patients often prefer behaviours that their physicians do not. How well these preferences fit is associated with the degree of patient satisfaction with the physician-patient relationship and consultations and the authors suggest that physicians should pay heed to non-medical aspects of their patients' lives and care. Patients are typically more content with their medical care when there is an ongoing relationship with their physician but there may be no single best style of interaction for all patients. *" Behaviours that one patient values in a physician, another may eschew"* (Schwartz et al 2006 pp123) It is the contention of this thesis that if physicians could better adapt and tailor the care they offer to individuals they would provide care that was more person centred, cost effective and led to greater patient satisfaction.

1.13.1 Flexible responsiveness

The concept of flexible responsiveness is defined as individualised care that will take into account the expectations, needs and wants of a patient. This is not necessarily a simple matter of involving patients in decisions about their health or giving them more choice. It involves recognising and then adopting towards the patient an appropriate relational orientation:

recognising that for certain patients and in certain contexts a patient may desire a more formalised "traditional" approach and in others a less formal and more collaborative approach. As Holstrom and Roing (2009) put it *"Some patients do not prefer a person centred approach... nor do they wish to be empowered"* (p19) they also make the point that Patient Centred Care should be sensitive to the nature of the patient and this notion of individualisation is key to the idea of flexibly responsive care. Mead and Bower (2000) further illustrate the idea that care should be flexibly responsive by noting that patients with simple physical complaints are significantly more satisfied with directing as opposed to sharing care but that this difference disappears when patients' complaints are of a chronic physical or psychological nature.

Epstien et al (2005) provide an operational definition of flexibly responsive care*: "1. Eliciting and understanding patients' perspective, concerns, ideas, expectations, needs, feelings and functioning. 2. Understanding the patient in his or her unique psychosocial context. 3. Reaching shared understanding of the problem and its relevance to the patient that is in concordant with the patients' values. 4. Helping patients to share power and responsibility by involving them in choices to the degree they wish".* (p.1517)

It is difficult to pin down exactly what flexible responsiveness looks like as it could potentially look like anything in practice as it is designed to address specific patients' needs and expectations of care. It is a multi-faceted and multidimensional phenomenon within the doctor patient relationship and requires paying heed to the fact that the doctor-patient relationship is affected by different kinds of patients, different kinds of doctors and different kinds of health problems.

Birks and Watt (2000) suggest this involves the ability to manage and read emotions as a key skill for any flexibly responsive person centred clinician. This implies that assessing and discriminating patients emotions could have an impact on the quality of care as the authors note *"If practitioners are better able to understand patients' emotional reactions of prescribed treatments or lifestyle advice they may be able to understand why some treatments are more or less acceptable to some patients"* (p.370)

Taking the above into account I have decided to concentrate on the concept of flexible responsiveness within patient care defined as individualised care that will take into account the expectations, needs and wants of a patient. This is not necessarily a simple matter of involving patients in decision about their health or giving them more choice. It involves adopting an appropriate relational orientation (Silverstein et al 2006) towards the patient: recognising that for certain patients and in certain contexts a patient may desire a more formalised 'traditional' approach and in others a less formal or egalitarian approach.

Flexible responsiveness, in the case of patient centred individualised care, can be thought of as the clinician responding appropriately to situational and contextual information provided by the patient. Thus the clinician does not adopt an overly mechanised or systematic approach to their interactions with the patient; rather they assess each situation and each patient individually and assess how they should proceed based on this. It is recognition that a "one size fits all" approach is not appropriate to Patient Centred Care and an individualised approach is preferable. In essence it is the art of assessing what the patients' expectation and needs are 'in the moment' and then striving to meet them. Or being flexible in one's response to the individual and not just treating each patient the same.

This also does not mean that the clinician should adopt a relationship orientated interaction with every patient across all contexts and situations. A paternalistic or formal approach might, in some cases, be warranted. Where patients who expect and prefer interactions on a formal level and situations in which many patients prefer a more authoritarian approach (research suggests this could be related to the seriousness of the condition).

1.13.2 Emotional Intelligence or self-monitoring as moderator?

Emotional intelligence or self-monitoring could be key to both Patient Centred Care and transformational Leadership. Theoretically both address aspects of flexibility in an individual's response to situations and other individuals. Below both concepts will be summarised.

1.13.2.1Emotional Intelligence

In the literature emotional intelligence has been referred to as emotional literacy, the emotional quotient, personal intelligence, social intelligence and interpersonal intelligence (Dulewicz, 1999). Like many psychological constructs it has been used to describe a number of different phenomena and linked with various different theories. Emotional intelligence can be viewed as a fixed and stable personality trait which can be measured using self-report questionnaires of typical behaviour or it can be seen as a more dynamic personal quality measured using maximal performance measures which quantify actual performance.

Emotional intelligence is widely regarded in the literature as an attribute that improves the quality of work by increasing productivity and personal and organizational success (Barbuto & Burbach, 2006). A limited number of empirical investigations have been completed but these show that emotional intelligence is positively linked with academic success (Parkeret al 2004), job performance and satisfaction. (Wong C-S, Law KS 2002; Jordan et al 2002) , enhanced ability to identify emotional expressions, higher ratings of social support and satisfaction with social support, more effective mood management, (Ciarrochiet al 2000), better adaptation to stress (Ciarrochi et al 2002) and better social interaction (Lopes et al 2004).

The definition of emotional intelligence used in this piece of work is taken from Van Rooy, 2004:

> *'a set of abilities (verbal and non-verbal) that enable a person to generate, recognize, express, understand and evaluate their own and others' emotions in order to guide thinking and action and successfully cope with environmental demands and pressures.'*
> (Van Rooy, 2004)

Birks and Watt (2007) reviewed the literature on emotional intelligence in health care and explored the links between emotional intelligence and patient centred outcomes. The literature suggests that emotional intelligence is important in achieving effective practice and Patient Centred Care. (Elam, 2000; Freshwater 2004; Epstein and Hundert, 2002; Schwartz and Tumblin, 2002; Lewis et al 2004; Herbert et al 2004; Bellack 1999). However Wagner et al (2002) investigated the impact of emotional intelligence on Patient Centred Care outcomes, by administering a scale of emotional intelligence to 30 residents in a family medicine department, a medical specialty devoted to comprehensive health care for people of all ages, and found a limited relationship between patient satisfaction and emotional intelligence.

However one might expect that emotional intelligence should have a relationship with Patient Centred Care as higher emotional intelligence should make clinicians more able to relate to their patients and understand their needs and concerns. The ability to discriminate between patients emotions could well have an impact on the quality and accuracy of various aspects of clinical practice (Howie et al 1999). If clinicians could better understand patients emotional responses towards treatments and advice they might be able to better tailor care to their patients need, thereby leading to a more efficient and effective service.

Relationships between emotional intelligence and transformational Leadership have been found in the past, although in the main these have relied on self-report data and there is a dearth of studies that attempt to confirm the oft assumed relationship between the two using multiple sources of data relationships though some do exist (Barling, Slater, & Kelloway, 2000; Gardner & Stough, 2002; Sivanathan & Fekken, 2002). Efforts have been made to more explicitly link emotional intelligence and Leadership (Caruso, Mayer, & Salovey, 2002; Cooper & Sawaf, 1997; Goleman, McKee, & Boyatzis, 2002; Ryback, 1998) and some findings do seem to support the notion that emotional intelligence is a prerequisite for effective Leadership. (Higgs & Aitken, 2003; Sosik & Megerian, 1999). A number of studies are also now finding a specific and significant relationship between emotional intelligence and transformational Leadership (Barbuto & Burbach, 2006 Barling et al., 2000; Gardner & Stough, 2002). Although there has been some question over the methodology used in such studies (Lindebaum and

Cartwright 2010) specifically that there is no inter-rating of Leadership abilities which may confound the results.

It has been argued that without emotional intelligence a leader's ability to lead transformationally will be impaired (Caruso and Salovey, 2004), as leaders lacking in emotional intelligence will be unable to properly show individualised consideration, to intellectually inspire their followers and achieve idealized influence without the ability to accurately read and understand their followers emotional states (Küpers and Weibler, 2006). They would also be impaired in their ability to instill confidence in followers faced with a seemingly overwhelming task.

Given that emotional intelligence seems profoundly linked with both transformational Leadership and Patient Centred Care it could potentially be seen as a mediating factor for the relationship between Patient Centred Care and transformational Leadership. Leaders with high emotional intelligence should be better placed to understand and respond flexibly to the moods, needs and emotions of their followers, allowing them to tailor their Leadership to the individuals they lead and the different situations and contexts they encounter.

1.13.2.2 Self-monitoring

Self-monitoring is similar to emotional intelligence regarding the outcomes it achieves but views the process somewhat differently. It is concerned primarily with the phenomena of expressive controls believing that human beings differ substantially in their ability, and desire, to engage such control. Self-monitoring is defined as an ability to consciously observe and regulate one's own behaviour (Rani et al, 2011).

In this sense emotional intelligence and self-monitoring are conceptual opposites: Emotional Intelligence suggests that our ability to relate to others and be flexible in our dealings with others is an inherent trait whereas Self-Monitoring implies that this is a conscious and intentional process.

Snyder (1974, 1979) identified an individual difference characteristic called self-monitoring, which indicates an ability to monitor and control one's expressive behaviors. More specifically, self-monitoring includes three characteristics:

- a concern for social appropriateness
- a sensitivity to social cues,
- an ability to control one's behavior in response to those cues

(Briggs, Cheek, & Buss, 1980; Snyder, 1974, 1979).

According to the theory underpinning self-monitoring, self-monitoring (Snyder, 1974) reflects individual differences in the propensity to engage in certain forms of impression management (Gangestad & Snyder, 2000). Individuals high in self-monitoring use impression management to construct public images that are aligned with others' behavioral expectations to appear socially appropriate and garner favorable outcomes (Gangestad & Snyder, 2000). Individuals low in self-monitoring attempt to project images that accurately reflect their internal beliefs, emotions, and attitudes. Self-monitoring has implications for a wide range of work behaviours, such as job performance, satisfaction, and commitment (Day, Schleicher, Unckless, & Hiller, 2002).

Early research on self-monitoring focused on how readily high self-monitors adapt their behavior to social situations (see Fuglestad and Snyder 2009). More recently, however, Gangestad and Snyder (2000) called for greater understanding of the motives associated with self-monitoring and drew particular attention to status motivation. Other recent work has shown that self-monitoring may also be associated with belonging motivation (Rose and DeJesus 2007; see also Day and Schleicher 2006).

Research has shown that high self-monitors: are better able to present themselves in socially desirable ways (Lippa, 1978); are able to adapt to new situations more effectively than low self-monitors (Snyder, 1979); and are more likely than low self-monitors to speak first in interactions and to initiate more conversation sequences (Ickes & Barnes, 1977). All of these are behaviors typically associated with leaders.

Rani et al (2011) found a highly significant relationship between emotional intelligence and self-monitoring (beta = 0.924, t = 31.344). The R2 value is also sufficiently high (0.854).

Self-monitoring is being used alongside emotional intelligence in this study to provide an alternative proxy measure of flexibility. High self-monitors should be able to respond more appropriately to varying contexts and situations in a manner similar to those with high emotional intelligence.

1.13.3 My simple model of Flexible responsiveness

As explained above both emotional intelligence and self-monitoring can be used as means of explaining or as proxies for measuring an individual's 'flexibility in responsiveness'. Where emotional intelligence suggests that someone's ability to relate flexibly to others is a trait inherent within themselves and Self-monitoring suggests this is a conscious, intentional and learned behavior.

Figure 2: My simple model of Flexible responsiveness
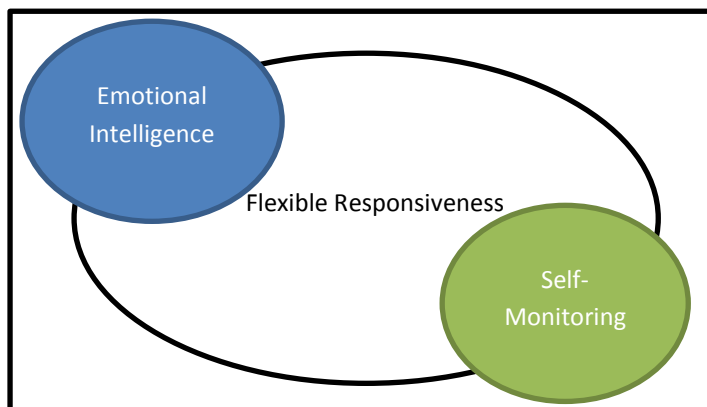
The above diagram (figure 2) details how I have conceptualised flexible responsiveness in this thesis. It is intended to show that 'flexibility in responsiveness' may be understood in terms of Emotional Intelligence and Self-monitoring, or some combination of both these concepts. Emotional Intelligence is currently well used and understood within the research literature (although there are some doubts regarding its conceptual worth and the utility of measures designed to measure Emotional Intelligence). By contrast, Self-monitoring, although no longer as widely used as it once was, offers a robust means of measuring how well someone monitors their social interactions and thus serves as a suitable proxy for flexibility in responsiveness.

1.14 Implications for thesis

Based on the review of the literature above this study aims to explore whether there is a direct or indirect link between clinical Leadership and achieving the delivery of high quality Patient Centred Care in allied health professional practice. As a secondary objective it aims to explore the (strength of the) relationship between emotional intelligence and transformational Leadership: It has been contended that the link between these two concepts may be weaker than initially thought due to confounding factors in the designs of previous studies because of common method variance (Doty & Glick, 1998; Podsakoff, MacKenzie, Lee, & Podsakoff, 2003).

As well as a link between Patient Centred Care (PCC) and transformational Leadership (TFL) this study also explores whether flexibility in responsiveness (FR) mediates both the skills of transformational leaders and the delivery of effective Patient Centred Care.

2 CHAPTER TWO: Methods

This chapter outlines the methods used within the studies in this thesis. First it outlines the study location, NHS Greater Glasgow and Clyde. The chapter then reviews the potential measures of patient satisfaction that could serve as proxy measures of Patient Centred Care and explain why the measures chosen in this study were selected. Finally this chapter outline the methods used in both studies in this mixed methods thesis.

The study takes a mixed method approach to explore the relationship between Patient Centred Care and transformational Leadership. Study one involves surveying patients, clinicians and clinical leaders and study two involves in depth interviews with a subset of clinicians and clinical leaders. This approach has been chosen as it provides a pragmatic way to explore the issue empirically while still addressing contextual issues that may affect the relationships measured.

2.1 Study Location: NHS Greater Glasgow and Clyde

The study took place in NHS Greater Glasgow and Clyde (NHS GG&C). A territorial health board in West Central Scotland. It is the largest health board in Scotland, serving 1.2 million people and employing around 38,000 staff. It was created from the amalgamation of NHS Greater Glasgow and part of NHS Argyll and Clyde on April 1, 2006.

The NHS GG&C covers the unitary council areas of the City of Glasgow, East Dunbartonshire, East Renfrewshire, Inverclyde, Renfrewshire and West Dunbartonshire and together with the towns of Chryston, Moodiesburn, Muirhead and Stepps in North Lanarkshire. It also provides some services to the East Kilbride area in South Lanarkshire (NHS Greater Glasgow and Clyde, 2015). Though the population within the Greater Glasgow and Clyde area is younger compared to the rest of Scotland there is a positive correlation found between increasing age and use of NHS services within the area (Tomlinson, 2008).

Table four below shows the number of staff employed within NHS GG&C as of March 2014 (NHS Greater Glasgow and Clyde, 2014) .

Table 3: NHS staff employed by GG&C

NHSGGC Staff in post by job family comparison to March 2013				
As at March 31st 2014				
Job Family	March 2014 headcount	March 2014 WTE	March 2013 WTE	2013/2014 Variance
Administrative and clerical – support to clinical staff	4.342	3625.8	3747.0	-121.20
Administrative and clerical – office services	1,897	1723.5	1567.0	156.50
Allied Health profession	3,187	2664.9	2610.4	54.50
Management (Non-AfC)	172	169.9	207.0	-37.10
Healthcare Sciences	1,918	1742.2	1671.0	71.20
Medical and Dental	3,833	3496.8	3378.0	118.80
Medical and Dental Support	364	300.3	289.8	10.50
Nursing and Midwifery	17,055	15146.6	14887.7	258.9
Other Therapeutic	1,327	1095.2	1044.6	50.60
Personal and Social Care	340	296.7	275.6	21.10
Support Services	4,972	3652	3608.8	43.20
Total	**39,407**	**33913.9**	**33288.9**	**627.00**

- **Note – Given the size of the NHSGGCC workforce at any given point in the recruitment cycle there can be between 400 and 700 posts being processed by the boards recruitment services team.**

2.2   AHP groups selected for study

Allied health professional staff account for around 12% of all staff employed by NHS GG&C and 20% of the total number of AHP staff employed within the Scottish NHS.

The two professional groups selected for this study were Podiatrists and Dieticians. Podiatrists were selected in part for their large throughput of patients and Dieticians were selected due to differences in how their consultations proceed when compared to Podiatrists. A Podiatry consultation is more technically orientated than a Dietetics consultation. As Podiatrists provide technical and physical care whereas Dieticians primarily provide advice and recommendations.

Podiatry or podiatric medicine is a branch of medicine devoted to the study of diagnosis, medical and surgical treatment of disorders of the foot, ankle, and lower extremity. The scope of practice of UK Podiatrists on registration after obtaining a degree in Podiatry includes the use and supply of some prescription only medicines, injection therapy and non-invasive surgery e.g. performing partial or total nail resection and removal, with chemical destruction of the tissues. (New York State Podiatric Medicine Association, 2015) Community Podiatrists treat patients who have been referred to them by other health professionals or by self-referral in a number of clinics and hospitals around the NHS Greater Glasgow and Clyde area.

A Dietician is an expert in Dietetics; that is, human nutrition and the regulation of diet. A dietitian advises people on what to eat in order to lead a healthy lifestyle or to achieve a specific health-related goal. Dietitians work in a variety of settings from clinical to community and public policy to media communications. Community dietitians work with wellness programs, public health agencies, home care agencies, and health maintenance organizations. These dietitians apply and distribute knowledge about food and nutrition to individuals and groups of specific categories, life-styles and geographic areas in order to promote health. They often focus on the needs of the elderly, children, or other individuals with special needs or limited access to healthy food. Some community dietitians conduct home visits for patients who are too physically ill to attend consultations in health facilities in order to provide care and instruction on grocery shopping and food preparation (NHS Careers, 2015).

The structure of Podiatry services in NHS Greater Glasgow and Clyde is shown in the Figure 4 below:

Figure 3: Structure of NHS GG&C Community Podiatry service
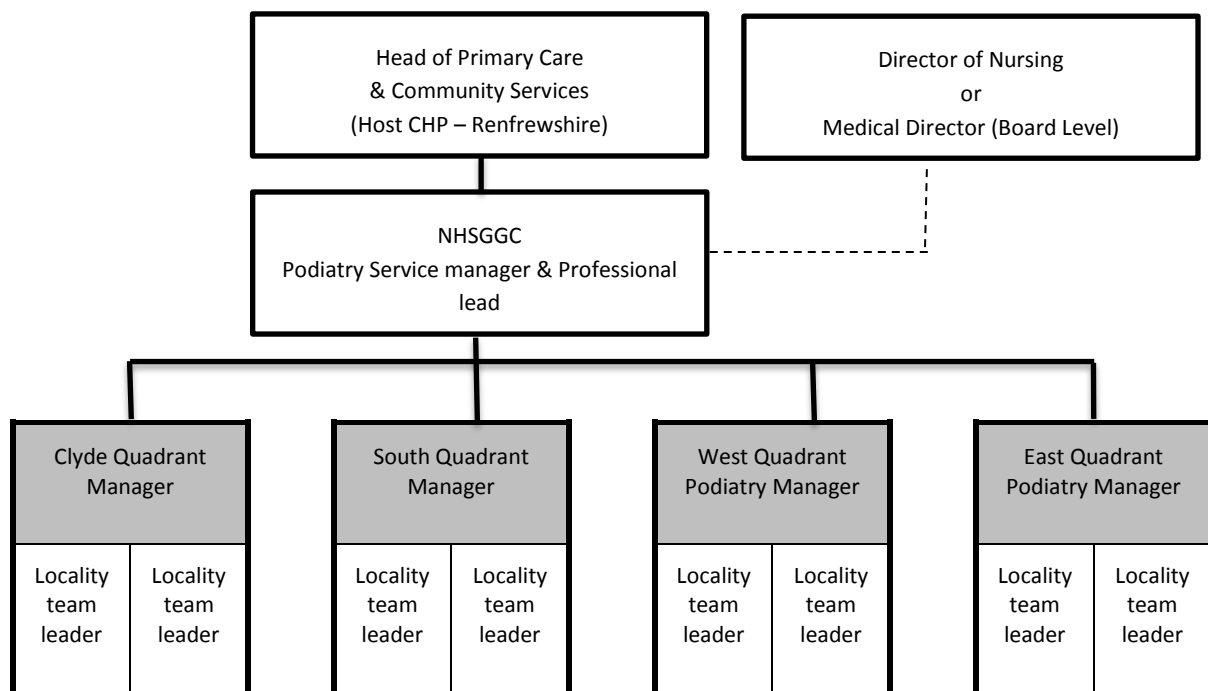
The structure of NHS GG&C Dietetics community services is shown below in figure 5. Each quadrant has a quadrant manager who oversees a number of team leaders and who reports to the head of service.

Figure 4: Structure of NHS GG&C Dietetics service
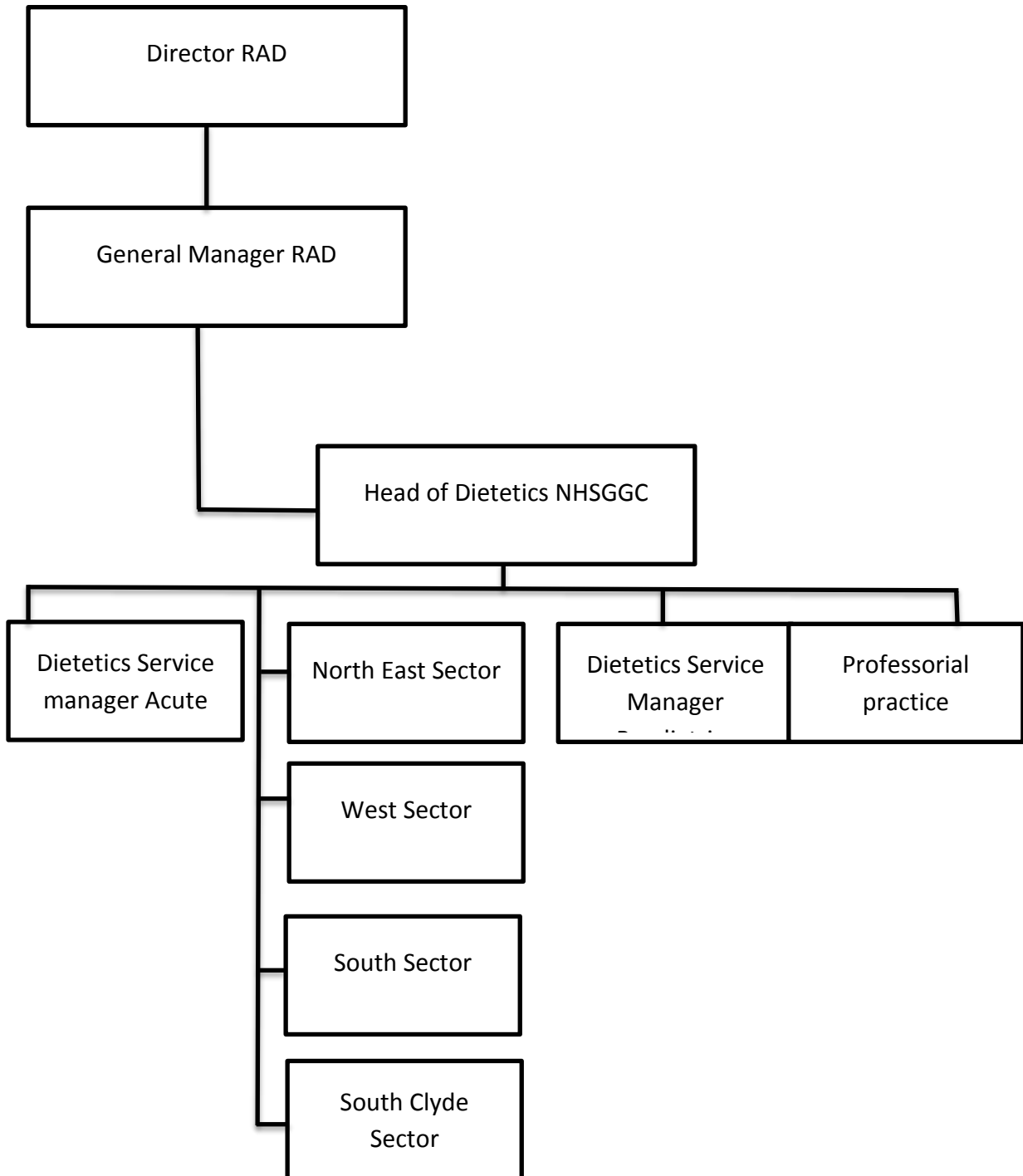
The number of Podiatrists employed by NHS Greater Glasgow and Clyde is 195 staff which is equivalent to 151.7 whole time equivalent staff. The number of Dieticians employed is 222 with 180 who are whole time equivalent (WTE). Podiatrists within NHS GG&C work across the community/acute interface, so there is not always a clear distinction. Currently 15 Podiatrists (10.84 WTE) are based solely in acute settings. The Podiatry service works within locality teams, of which there are 8. Therefore the average number of fulltime staff within a quadrant would be 24.37 headcount (18.9wte).

There are 70 Dieticians employed in community health roles across NHS GG&C. 50 (44.5 WTE) are directly managed by the Community Manager for Dietetics with the remainder (20 staff in total, 12 WTE) managed by rehabilitation teams within the health and social care partnerships the average team size is 13 WTE.

Figure 5: Map of NHS GG&C Quadrants
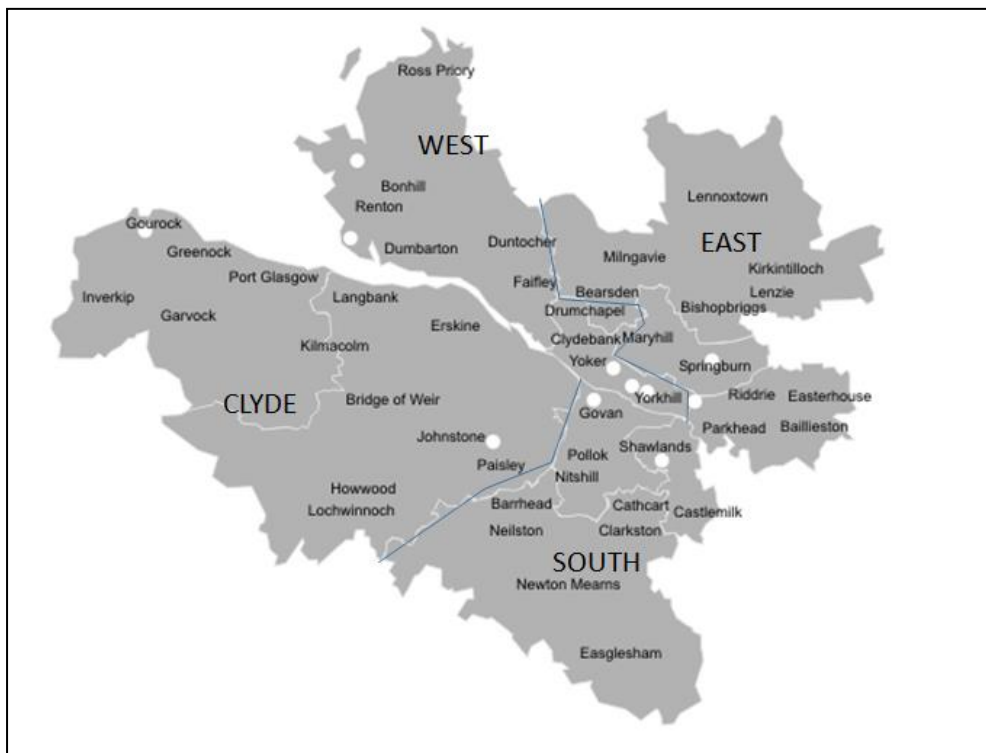
NHS Greater Glasgow and Clyde AHP services are divided into four quadrants (See Figure 3). The number of staff for both Allied Health Professional groups participating in this study is given below in table 5.

Table 4: Podiatry and Dietetics staff by quadrant

Podiatrists (by quadrant):	Dieticians (by quadrant):
East: 55 headcount (37.10WTE);	North East: 11 headcount (9.4WTE);
South Clyde: 39 headcount (31.75WTE);	Clyde: 12 headcount (9.7WTE);
South: 56 headcount (49.28WTE);	South: 15 headcount (14.3WTE);
West: 45 headcount (33.56WTE);	West: 14 headcount (11.1 WTE)

2.3 The importance of context and the mixed methods approach

Context has been described as "the surroundings associated with phenomena which help to illustrate that [sic] phenomena, typically factors of analysis associated with units of analysis above those expressly under investigation" (Cappelli and Sherer 1991:56). Cappelli and Sherer also describe how organisational characteristics provide a context for individual members. If this thesis took a purely quantitative approach to study these organisational characteristics and this context would be ignored in favour of exploring individual traits and abilities. This would ultimately impoverish understanding of how Leadership and Patient Centred Care relate to one another and neglect exploring what these concepts mean to the participants involved.

Johns (2006) asserts that researchers exploring aspects of organisational behaviour should study and report context for a number of reasons. He states that if we do not understand the situations surrounding our research than we do not understand person/situation interactions. He also further suggests that a lack of focus on context may be one reason that results of studies in organisational behaviour differ from study to study. An appreciation of context also allows researchers to produce more authentic and authoritative work which facilitates better communication with the professional audience for the research (Johns, 1993) in this case Allied Health Professional staff and NHS managers.

It is because of the importance of context detailed above that a mixed methods approach has been chosen for this thesis. Mixed methods research has become increasingly popular in both health services and social research (Johnson and Onwuegbuzie 2004; Greene 2007; Creswell et al. 2011 in part because of advancements in methodology and access to more interdisciplinary training for researchers (Brannen, 2005a). Mixed Methods research has been defined as "research in which the investigator collects and analyses data, integrates the findings, and draws inferences using both qualitative and quantitative approaches and methods in a single study or programme of enquiry"(Tashakkori & Creswell, 2007 pp.119).

This study uses mixed methods to investigate and link together clinicians' experiences of Leadership and Patient Centred Care with quantitative survey data. Greene, 2007 has considered this approach as "multiple ways of seeing and hearing, multiple ways of making

sense of the social world, and multiple standpoints on what is important and to be valued"
(p.20). It is thought that by combining the data from both qualitative and quantitative studies
in this thesis well help to provide a fuller account of how Leadership and Patient Centred Care
interact.

2.4   Theoretical perspective

Theoretically transformational Leadership could lead to improved Patient Centred Care as
both concepts share similar constructs and appear to be based on similar values (see
literature review). However, as stated above, the direct relationship (if any) between
Leadership and Patient Centred Care remains unclear. Central to both concepts is valuing and
supporting individuality (whether this involves supporting and developing staff or respecting
patients' needs, wants and values) and thus flexibility in responsiveness could prove a
conceptual bridge between Leadership and Patient Centred Care as illustrated by the diagram
below (Figure 6):

Figure 6: Venn diagram of theoretical relationships between concepts
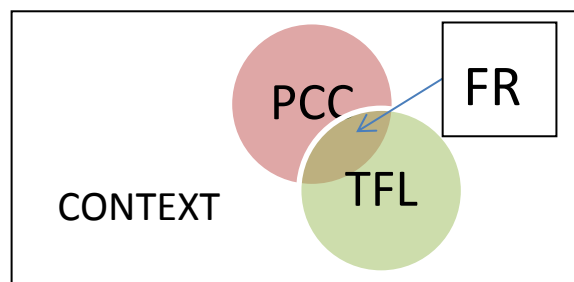
As shown previously in figure 2 in this thesis Flexibility in Responsiveness (FR) is being
measured by proxy using measures of both emotional intelligence and self-monitoring. For
clarity in the above Venn diagram the simple model of flexibility in responsiveness used in this
thesis has been truncated to simply 'FR'.

It is important to note, when reading the following descriptions of the models used in this
thesis, that the proposed relationships above do not operate in a vacuum and that the context
around the delivery of Patient Centred Care and transformational Leadership plays a key part
in how well either are achieved.

Flexibility in responsiveness could be considered the mechanism by which clinicians and
leaders respond to changing circumstances and situations and still deliver high quality care or
lead effectively.

2.5   Study design

2.6   Aim

To explore whether there is a direct or indirect link between Leadership and achieving high quality Patient Centred Care.

2.6.1   Research questions

I.   Is there a relationship between Patient Centred Care and transformational Leadership in AHP practice?

II.   How do AHP's conceptualise Leadership and its impact on their ability to deliver PCC?

III.   Do local contexts influence the ability of leaders to support Patient Centred Care?

2.7   Study one

Study one was designed to answer research question one. Further to the review of the literature a secondary question was added exploring the links between transformational Leadership, flexibility in responsiveness and Patient Centred Care using survey design.

2.8   Measures

2.8.1   Patient Centred Care

There is a broad consensus that Patient Centred Care is intrinsically a good thing but this is accompanied by a lack of clarity and agreement about what it is. This lack of conceptual clarity tends to hamper efforts to achieve and monitor it in practice resulting in a plethora of tools and scales being created to measure patient centredness. However measuring patient centredness remains an endeavor fraught with theoretical and practical concerns with compromises between the two. Many measures of patient satisfaction and experience provide a high degree of face validity in measuring patient centredness, but it is highly debatable how successful they are in truly capturing patient centredness (Epstein, 2005; Hudon, 2011; Duncan, Entwistle, & Liddle, 2010).

To select the measures used in this study the literature was first consulted and reviewed. The literature prior to the millennium was largely disappointing. While many scales had been created to measure patient centredness or patients' experiences of the quality of care received these were heavily context dependent and non-generalisable to an allied health professional context. However scales have since been developed with a more general focus on patient centredness that does not focus on specific conditions or professions and there are two main reviews of these.

In 2005 Epstein et al conducted a literature review of the available measures to assess patient centred communication. From this review 6 validated patient survey measures used to assess patient centred communication (PCC) and related constructs were identified worthy of further investigation. Epstein's paper, although useful in cataloguing the benefits and pitfalls of the most commonly used measures, was far from comprehensive and is really more of a snapshot of what was being used at the time rather than a critique of all that was available.

Hudon et al (2011) conducted a high quality systematic review of the available literature using the MEDLINE, Embase, and Cochrane databases covering 1980 through April 2009, with a specific search strategy for each database. They expanded this by including a hand search of relevant journals and incorporating expert suggestions for English Language only papers. Their criteria for inclusion were:

I.   Describing self-administered instruments measuring patient perceptions of patient-centred care;
II. Reporting quantitative or psychometric results of development or validation;
III. Being relevant to an ambulatory family medicine context.

From an extensive search of 3,045 articles 13 instruments met their inclusion criteria. Two instruments (5 articles) were dedicated to Patient Centred Care: the Patient Perception of Patient-Centredness and the Consultation Care Measure, and 11 instruments (21 articles) included relevant subscales or items. They concluded that relevant items from the 11 instruments provided partial coverage of the concept, but these instruments were not designed to provide a specific assessment of Patient Centred Care. The two instruments dedicated to Patient Centred Care addressed the key dimensions and are visit-based. While this limits their applicability for the study of care processes over time, such as chronic illness management, they were deemed suitable for the purposes of this study. The potentially suitable instruments were then examined and items and subscales were identified that tied in with the studies definition of Patient Centred Care. This is summarised in the Table 6 below:

Table 5: Patient centredness measures

Paper	Scale	Relates to this aspect of patient centredness			Total number of items
		Care that is individualised	Care that is supportive of patient choice	Care that is flexible in its responsiveness	
Little et al.(2001)	*Consultation care measure (CCM)*	14	2	3	22
Stewart et al. (2000)	*Patient-perceived patient-centredness scale (PPPCS)*	3	5	1	9
Galassi et al (1992)	Patient Reactions Assessment (PRA)	10	5	0	15
Stewart et al (1999)	Interpersonal Processes of Care (IPCS)	18	12	0	40
Mercer et al (2005)	CARE measure	6	1	2	10
Haddad et al	Patient Perception of Quality (PPQ)	5	11	0	22
Shi et al (2001)	Primary Care Assessment Tool-Adult (PCAT–A)	16	0	0	90
Lerman et al(1995)	Perceived Involvement in Care Scale (PIC5)	5	8	0	13
	Comrade	20	0	0	20

The coding of each scale, according to the patient-centred criteria used in this study, was discussed between the researcher and the supervisory team and the two measures identified as being most suited to the study, taking into account issues of practicality and utility, were the Consultation Care Measure and COMRADE. However considering the time it would take patients to complete both the CCM and the COMRADE measure it was decided to use a combination of CCM and CARE. The fact that CARE is already recognised by practitioners and widely used within the Scottish NHS also supported this decision.

The items on the CARE measure also map well on to the 7 c's laid out in the Scottish Government's care governance manual (Scottish Government, 2010) covering the topics of Care, Compassion, Communication, and Collaboration. These items are believed to be of most relevance to providing high quality Patient Centred Care. In the report's "dashboard for Care Governance" several variables can be measured using CARE. Under 'compassion' for instance "empathy" and "reassuring" are covered by the CARE items, 'communication' is covered by CARE by virtue of it being a measure of relational empathy and items under collaboration are also covered by the measure. Recent work in the Nursing Midwifery and Allied Health Professionals – Research Unit (NMAHP RU) has investigated the quality of Patient Centred Care delivered by allied health professionals (AHPs) by using the CARE Measure. The CARE Measure is a validated tool for assessing the patients' perception of the doctors' communication in primary care. Primary and secondary care patients have across a range of specialties endorsed the CARE Measure as a relevant tool. It has high face and concurrent validity, internal and structural reliability and is not subject to major influences by demographic or socio-economic factors (Mercer et al 2005).

The consultation care measure is based upon existing literature and empirical studies on the doctor-patient relationships model, and patient interviews. It takes as its theoretical basis the Stewart et al 2000 model of patient centredness which is closely related to the definition of Patient Centred Care used in this thesis. Thus it is a good fit conceptually with the research being undertaken.

2.8.2 Leadership

Numerous instruments have been designed to measure Leadership (Tichy & Devanna, 1986, Conger and Kanungo, Conger, 1989) most notably those of Bass and Avolio (Bass 1985, 1998; Bass & Avolio, 1990a, 1990b) which endeavors to measure transformational Leadership. There are currently two widely used measures of transformational Leadership: the Multifactorial Leadership questionnaire (MLQ) developed by Bass and Avolio (1990a, b) and the UK specific Transformational Leadership Questionnaire (Alimo-Metcallfe and Alban-Metcelfe, 2001).

The MLQ was built on work on charismatic Leadership from Burns (1978) and Bass (1985) work on transformational Leadership. The Multifactor Leadership Questionnaire (MLQ—also known as MLQ 5X short or the standard MLQ) measures a broad range of Leadership types from passive leaders, to leaders who give contingent rewards to followers, to leaders who transform their followers into becoming leaders themselves. The MLQ identifies the characteristics of a transformational leader and helps individuals discover how they measure up in their own eyes and in the eyes of those with whom they work.

The MLQ has received criticism from those who see it as too United States (US) centric and overly focused on charismatic Leadership (Adler, 1983, Hunt and Peterson 1998, Smith, Misumi, Tayeb, Peterson and Bond, 1989, Erez, 1990, Smith & Bond, 1993, Triandis, 1990, 1993). This is because US research on transformational Leadership has generally focused on high level managers and neglected middle and lower levels (Bryman, 1996). This focus on higher level managers, and a failure to allow those being managed to rate their leaders (Alimo-Metcalfe Alban-Metcalf, 2005), has led some to suggest that it ignores the potential damage that narcissistic, self-serving, leaders can cause (Conger, 1998; Mintzberg, 1999; Hogan et al., 1990). Research into cultural differences in Leadership between the US and United Kingdom (UK) also questions whether the MLQ is a suitable measure to assess UK leaders. Major differences have been found that include the importance of 'charisma/inspiration components of the measure and a focus on distant leaders rather than those closer to their followers. In 2005, Beverly Alimo-Metcalfe and John Alban-Metcalf undertook a study exploring these differences and found that no single dimension emerged for charisma. Of far more importance in UK Leadership is 'Genuine concern for others' well-

being and development'. To account for differences in Leadership between the UK and the US a public sector version of the MLQ was constructed the TLQ which will be used in this study. The Transformational Leadership Questionnaire (TLQ) has following dimensions:

I. Valuing Individuals (Genuine concern for others' well-being and development);

II. Networking and Achieving (Inspirational communicator, networker and achiever);

III. Enabling (Empowers, delegates, develops potential);

IV. Acting with Integrity (Integrity, consistency, honest and open);

V. Being Accessible (Accessible, approachable, in-touch);

VI. Being Decisive (Decisive, risk-taking).

Barbuto and Burback (2006) used the TLQ to assess the Leadership of 80 leaders who each had between 3 and 6 direct report staff working under them. The number of leaders in this study's sample falls far short of this, but the data gathered does represent all the quadrant managers within NHS Greater Glasgow and Clyde Dietetics and Podiatry services who were working during the data collection phase. In another study on Leadership, Barling et al. (2010) had 49 managers (60 approached) and 187 'subordinates': they suggest they needed 3 subordinate reports for manager to be included in their analysis. In these terms each manager approached who participated in this study meets the minimum suggested criteria of 3 subordinate reports.

2.8.3 *Flexibility in responsiveness*

Although my definition of Patient Centred Care includes flexibility in responsiveness, current Patient Centred Care measures currently cannot directly measure flexibility in responsiveness as they focus on individual patient experiences. One patient cannot know if the care they have received is different from the care that another patient has received. Furthermore there is currently no standard measure of the concept of flexibility in responsiveness, so for the purposes of this study emotional intelligence and self-monitoring have been selected as proxies for how well clinicians deliver individualised Patient Centred Care. The reasoning behind this decision is given below.

2.8.4 Emotional Intelligence

Measures of emotional intelligence (EI) have been used within research and within human resources and management for training development and career development planning since 2001 (Petrides & Furnham, 2001). Assessments of EI dimensions have facilitated training and development modules for customer service skills, conflict management strategies, and stress management programs (Rozell, Pettijohn, & Parker, 2004; Cherniss, 2000). Similarly, Human Resources and Development professionals have used EI measures as components in individual development plans (Cummings & Worley, 2005; Kunnanatt, 2004),

There are many varied tests available to measure Emotional Intelligence, including those developed by Lane, Quinlan, Schwartz, Walker, and Zeitlin (1990), Bar-On (1997), Boyatzis, Goleman, and Rhee (1999), Mayer, Salovey, and Caruso (2002), Jordan, Ashkanasy, Hartel, and Hooper (2002), Schutte et al. (1998), Dulewicz and Higgs (1999b),Wong and Law (2002), Petrides and Furnham (2003), Tett, Fox, and Wang (2005), as well as precursors (Ciarrochi, Chan, & Caputi, 2000) and offshoots (Brackett, Rivers, Shiffman, Lerner, & Salovey, 2005; Austin, Saklofske, Huang, & McKenney, 2004). There are also ad-hoc measures of emotional intelligence for which little or no research on psychometric properties is available. These include tests such as EIA (Emotional Intelligence Appraisal), EIP (Emotional Intelligence Profile), and the IEI (Index of Emotional Intelligence) as well as others that appear in publications and on Web sites devoted to HRD (Bradberry & Greaves, 2004; Warner, 2004; Lynn, 2004).

Each test has its own practical advantages and disadvantages and there are theoretical considerations that also require to be taken into account when selecting an appropriate measure. Two main concerns informed the choice of emotional intelligence measure: the amount of time the measure would take to complete and the construct, predictive and incremental validity of the measure used had to be high.

Over the years a large body of work has been conducted exploring the validity, or lack thereof, of many tests of emotional intelligence. However it is not easily available as it is spread across a variety of articles, book chapters, technical reports and unpublished papers which can make comparisons between tests difficult. Some researchers have also criticised the existing

research as being "piecemeal in perspective" (McEnrue and Groves, 2006 p10) with each study focusing on one or two aspects of validity.

The Mayer, Salovey and Caruso Emotional Intelligence Test (MSCEIT) version 2.0 (Mayer et al. 2002) is the most comprehensive measure of the ability model of Emotional Intelligence. It is a performance based measure based upon the number of correct answers given and assess an individual across the four domains of the four branch model of emotional intelligence (Mayer and Salovey, 1997).

The MSCEIT, and its predecessors, have been correlated with verbal intelligence, the Big Five personality traits, and self-reported empathy (Brackett, Mayer, & Warner, in press; Ciarrochi, Chan, & Caputi, 2000; Mayer et al., 1999; Salovey et al., 2001). These studies have shown that the MSCEIT correlates moderately with these constructs (rs < 0.40).

Higher Emotional Intelligence has been associated with higher levels of attending to health and appearance, positive interactions with friends and family, and owning objects that are reminders of their loved ones. Lower Emotional Intelligence has been associated with higher reported use of drugs and alcohol, more deviant behavior, and owning large numbers of self-help books (Brackett et al., in press; Formica, 1998; Mayer et al., 1999; Trinidad & Johnson, 2001). Emotional Intelligence has been linked to informant reports of positive interpersonal relations. For example, school children with higher Emotional Intelligence were rated as less aggressive by their peers and more prosocial by their teachers, and leaders of an insurance company's customer claims team with higher Emotional Intelligence were rated as more effective by their managers than those with lower EI (Rice, 1999; Rubin, 1999). Thus the MSCEIT shows reasonable predicative validity, when compared to other scales of Emotional Intelligence.

Of the Emotional Intelligence measures considered for this study the MSCEIT was most distinct among Emotional Intelligence measures (Rs <0.38). With respect to the Big Five, only Agreeableness and Openness to Experience significantly contributed to the model; for PWB, only the personal growth subscale significantly contributed to the model. findings with the

MSCEIT suggest that Emotional Intelligence as a mental ability exists as a distinct, clearly defined construct that has evidence of incremental validity McEnrue and Groves (2006)

Two main concerns informed the choice of emotional intelligence measure: the amount of time the measure would take to complete and the construct, predictive and incremental validity of the measure used had to be high. However the measure consists of a total of 141 items divided across eight tasks which rendered it too onerous for this study. For this reason a shorter measure based upon the same conceptualisation of Emotional Intelligence as the MSCEIT has been selected the Wong and Law Emotional Intelligence Scale (WLEIS, Wong & Law, 2002)

The Wong and Law Emotional Intelligence Scale (WLEIS, Wong & Law, 2002) is a popular self-report measure of Emotional Intelligence and has been widely used in the study of emotional intelligence and has also been used to assess the strength of the relationship between emotional intelligence and transformational Leadership (Lindebaum & Cartwright, 2010). The WLEIS consists of 16 items with each subscale measured with 4 items. The Self Emotion Appraisal dimension assesses individuals' ability to understand and express their own emotions The Others' Emotion Appraisal dimension measures peoples' ability to perceive and understand the emotions of others The Use of Emotion dimension denotes individuals' ability to use their emotions effectively by directing them toward constructive activities and personal performance. The Regulation of Emotion dimension refers to individuals' ability to manage their own emotions.

Previous research has found support for the underlying four-factor structure, reliability, and convergent and discriminant validity of the WLEIS scores (Law et al., 2004; Law, Wong, Huang, & Li, 2008; Shi & Wang, 2007; Wong & Law, 2002). T WLEIS scores have also shown validity for predicting life satisfaction, academic performance, job performance, and job satisfaction (Song et al., 2010; Law et al., 2008; Wong & Law, 2002).

2.8.5 Self-monitoring

Day et al (2002) conducted a meta-analytic review to determine the validity of the Self-monitoring scale. Meta-analyses were conducted (136 studies; total N= 23,191) investigating the reliability of various self-monitoring measures as well as the relationship between self-monitoring personality and work-related variables. Specifically they explored the validity of Self-monitoring in relation to its ability to predict: Job performance and advancement, Leadership and job attitudes.

In this study a total of 93 studies were identified that reported a full-scale internal consistency reliability estimate for a Self-Monitoring measure. In terms of the psychometric properties of the various scales used to assess Self-Monitoring, reliability analyses indicate that all of the scale types demonstrate respectable levels of internal consistency reliability. These findings suggest that it makes little difference empirically which particular Self-Monitoring scale or scoring type is used for predicting organizational criteria.

In terms of the other criteria assessed: Twenty-eight studies reported a relationship between Self-Monitoring and indicators of job performance and advancement. In the following section 'k' indicates the number of studies from the meta-analysis that are referenced. Most data (k =25) were collected in field settings. Outcome variables included objective (e.g., sales volume, number of promotions; (k =12) and subjective (ratings; k =16) measures. The objective–subjective distinction was examined as a potential moderator. The relationship between ability and Self-Monitoring was examined in 10 studies. The mean sample weighted correlation between Self-Monitoring and measures of job performance and advancement was .09 (k = 28). Outlier analysis was unsuccessful at rendering the effects homogeneous.

Ability measures included problem-solving performance (k =2). The mean sample-weighted correlation across 10 studies assessing the relationship between Self-Monitoring and ability measures was .06. When two outliers were removed the overall effect was rendered homogeneous (20%) but with a slightly smaller revised correlation (.05). These results suggests that the noted relationship between Self-Monitoring and work performance may be partially attributable to ability differences between high and low self-monitors.

Fifteen studies estimated a relationship between Self-Monitoring and organizational commitment. Studies included attitudinal (k =6) and behavioral (k= 9) commitment, which was examined as to explore the potential relationship between studies. In most of these studies Attitudinal commitment was assessed with one of the following measures: the Affective Commitment Scale (Meyer & Allen, 1984), Mowday, Steers, and Porter's (1979) or Hrebeniak and Alutto's (1972) commitment scale. As well as in two studies bespoke behavioral indices of commitment; including tenure or retention (k = 8) and turnover (k = 1; reverse coded). Results indicated a mean sample weighted correlation of -0.11 across 15 samples investigating organizational commitment. The effects were made homogeneous through the removal of three outliers (20%), with the average correlation becoming somewhat stronger- 0.14. These would seem to indicate that the self-monitoring scale is useful in measuring the strength of an individual's commitment to the organisation they work for.

Six studies examined the relationship between SM and job satisfaction. Several scales were used to measure satisfaction, including Hackman and Oldham's (1974) scale, the Job Descriptive Index (Smith, Kendall, & Hulin, 1969), and the Minnesota Satisfaction Questionnaire (Weiss, Dawes, England, & Lofquist, 1967). The meta-analysis reported no significant results.

A total of 23 studies were identified that assessed the relationship between Self-Monitoring and Leadership behaviors (mean sample-weighted r= .18). Outlier analysis successfully reduced effect heterogeneity by removing three outliers (13%), with a slightly larger revised estimate (r=.19). Adequate study numbers existed in each moderator category to examine the source of Leadership ratings, research setting, as well as scale type and scoring format. Results indicated that the moderator model associated with rating source fit the data somewhat well, with the correlation between Self-Monitoring and outside observers' ratings of Leadership larger than the correlations for group members' ratings and self-ratings

The above result demonstrate that the Synders Self-Monitoring scale has real world validity, when looking at Leadership, as its results mirror those found in other employment related scales. While it may not be immediately obvious that some of the outcome measures used

relate to healthcare, for example tenure-retention, it seems reasonable to assume that the Self-Monitoring Scale would correlate with outcome measures relevant to healthcare practice as well.

Day et al (2002) conclude that these results suggest that self-monitoring has relevance for understanding many organizational concerns, including job performance and Leadership emergence. They also conclude that high self-monitors tend to receive better performance ratings and more promotions than low self-monitors and are more likely to emerge as leaders. Extending these findings across organizational hierarchies suggests that high self-monitors should be overrepresented among those in upper level management positions. The results of this meta-analysis suggest that Self-Monitoring personality appears to play a pivotal role in shaping who succeeds in organizations and emerges into Leadership roles and in contributing to important work-related attitudes.

2.9   Study one method

Clinical team leaders completed a survey composed of measures of transformational Leadership (TLQ) (Alban-Metcalfe & Alimo-Metcalfe, 2000a), the Wong and Law Emotional Intelligence test (WLEIS) (Wong & Law, 2002) and the self-monitoring scale (Snyder, 1974).

Clinicians taking part in the study were asked to complete the WLES and (because of the multisource approach being taken to account for common method variance) they were asked to complete the rater versions of the TLQ (IRTLQ) on their perception of their clinical leader's transformational Leadership skills. This allowed comparison of self-assessed Leadership and team assessed Leadership and the relationship of both to clinicians and clinical leader's flexibility in responsiveness. Clinicians were also asked to give patient experience measures out to 30 consecutive patients (or as near to that number as possible as part time clinicians may not be able to achieve 30). These measures were used to rate the patients experience of Patient Centred Care delivered during the consultation.

Figure 7 below details the levels of the study and measures used by each participating group.

Figure 7: Study design
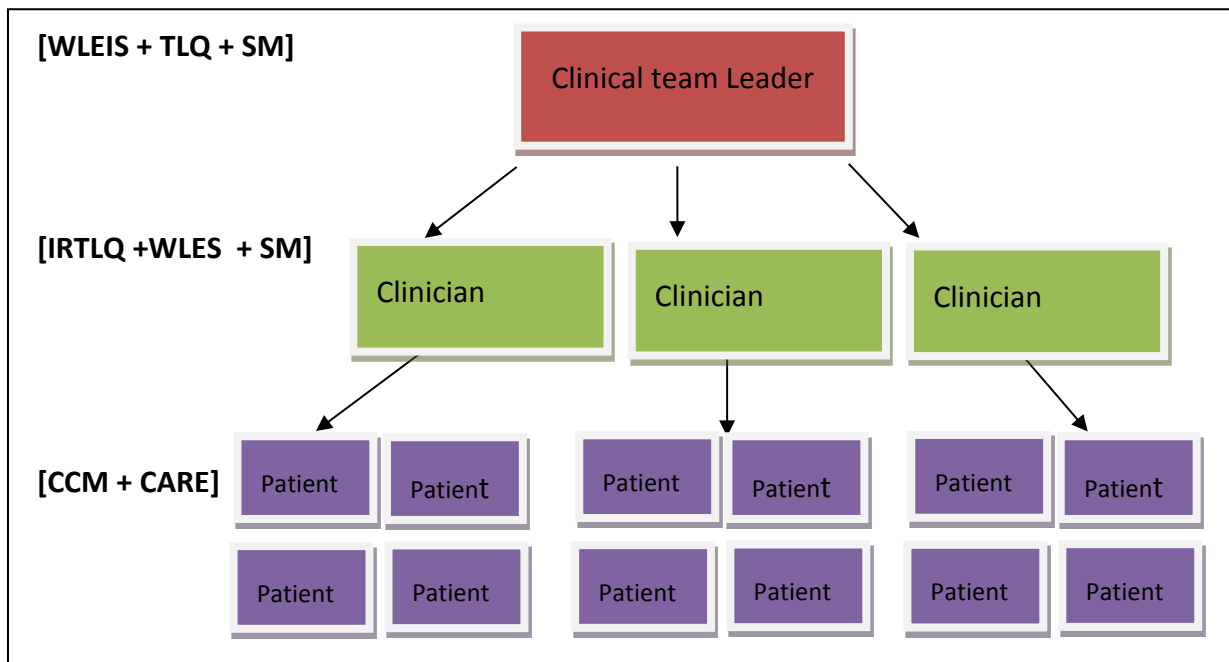
2.9.1 Sample

Allied Health Professionals from Podiatry and Dietetics, in NHS Greater Glasgow and Clyde were invited to participate in this study. NHS Greater Glasgow and Clyde serves a population of 1.2 million and employs around 38,000 staff – it is the largest NHS organisation in Scotland and one of the largest in the UK (NHS Greater Glasgow and Clyde, 2015) (See section 2.1). The Podiatry and Dietetics services within NHS Glasgow and Clyde are each split into four quadrants that cover the North, South, East and West of the Health board area. Participants were recruited across all 4 quadrants with at least two teams in each quadrant being represented.

Participants were sought at three levels: Clinical leaders, clinicians (working > 0.5 hours and in contract > 6 months) from 10 teams across the health board to ensure teams are not unduly burdened by participation and patients. The study aimed to sample all clinicians that fit this criteria, however where this proved unacceptable to the service we set out to sample at least half the members of a team in order to adequately assess transformational Leadership using the inter-rater measure.

The sample size for this phase of the study was determined based upon the size of the service approached for participation. Given the numbers of clinicians involved traditionally it would be recommended that 100% participation be sought, however this would likely constitute an unnecessary burden on the services involved. To this end the sampling criteria was refined (See Table 7):

Table 6: Inclusion Criteria

Inclusion Criteria
Outpatient setting
At least 3 staff employed > 0.5 WTE in direct patient care role
Employed for period > 6 months

In the case where all the members of a team couldn't reasonably complete the survey measures I sought to recruit at least 60% of the team, via random selection, in order to capture as accurate as possible a picture of the influence a team leader can have on Patient Centred Care.

Clinicians participating in the study in a direct patient care role were asked to distribute patient experience measures to consecutive patients in order to assess the quality of Patient Centred Care they are delivering. As a total of 30 completed patient experience measures were sought from each clinician this often necessitated distributing greater than 30 measures. Patients had to be over 18 and could be excluded for language (only native English speakers were sampled), communication or comprehension issues.

Staff were provided with 70 questionnaire packs to be handed out to sequential patients attending their appointments. For most Podiatrists involved in the study their patient completed questionnaires were then collected via drop boxes positioned within their clinics. Most of the Dieticians' patient questionnaires were returned by post in a pre-paid envelope. Clinicians were instructed to aim to collect 50 patient completed questionnaires (in line with previous studies using the CARE measure), though 30 questionnaires has been estimated as the minimum number required to run individualized statistics in other research using the CARE measure (Duncan, in Press).

2.9.2   Data Collection

Clinician participant questionnaires were delivered to participating clinicians and their clinical team leaders by post with a return paid envelope included for their return. If they had not been returned after a fortnight the participants were sent a reminder letter regarding their return, and a further reminder after a month if they had still not been returned. The clinician questionnaires should have taken no longer than one hour to complete. In practice few participants completed their questionnaires within a fortnight and multiple reminder emails were required before clinician questionnaires were returned. In some cases where email reminders were completely unsuccessful I resorted to approaching the team leaders of the staff in question to request that they gently remind staff and ask them to complete the

questionnaires. This resulted in most measures being returned. This obstacle and the reliance on gatekeepers to drive the research forward was dispiriting and raises some small concern about the validity of results obtained about leaders and management due to potential pressures exerted by the participants leaders and managers. These concerns will be more fully explored and discussed within the discussion chapter (See Chapter 5).

Clinicians were also asked to distribute the patient experience survey to consecutive patients. Clinicians were given a start date from which they would approach all consecutive consulting patients, and request that they complete the measure. Clinicians taking part in the study were asked to use their clinical judgment to decide whether or not a patient is suitable for inclusion based on issues of competence, but were explicitly instructed not to self-select suitable patients. Reasons for non-selection were instructed to be recorded (e.g. reading/ learning difficulties; severe mental distress). However no participants reported any exclusions on these terms. Again this raises some concerns regarding whether participants were engaging in some form of self-selection particularly given the low return rates as discussed in the results chapter (See chapter 3).

Participating clinicians should have handed the Patient Centred Care measure to their patient at the end of the consultation and ask them to complete it before leaving the clinic. Clinicians were advised not to be present while patients completed the questionnaires, as the patients may have felt pressured to fill it in very positively. Clinicians were recommended to ask the patient to fill the questionnaires out in the reception (where available). Designated and clearly labeled drop boxes, were available in the reception area for patients to put their completed measure into when they have finished. The measure should have taken patients no longer than 30 minutes to complete and in practice took no more than 15 minutes. Participants reported that the age of their patient cohorts affected how willing and able many participants were to complete the questionnaires. Visual problems were highlighted as one common reason for low return rates as was general disinterest from patients in consultations.

I collected the completed measures from the drop boxes on a regular basis, roughly twice a month depending on clinician availability, this involved a round trip across the NHS Greater Glasgow and Clyde health board area to the various clinics taking part. For three of these trips

I had access to private transport and this made the collection process substantially easier though it still took two full days to make it round all the study locations. For the rest of the trips public transport was used. This severely increased the amount of time it took to collect measures from all locations which amounted to 18 health centres and clinics around Greater Glasgow. This proved particularly problematic where clinicians or clinical teams served more than one base and this often meant that drop boxes were not accessible by the researcher. In these cases it was negotiated with participants that drop boxes be either kept in an accessible location or left with reception staff. Towards the end of the study many Podiatry participants volunteered to post the contents of their drop boxes to me at the University and they were provided with self-addressed envelopes for this purpose.

Podiatry patients who wanted to take more time to consider whether or not to complete the measures, also had the option of posting these back to the researcher in a pre-paid, addressed envelope. However few patients returning questionnaires took advantage of this. All Dietetics participants made use of self-addressed envelopes due to a lack of physical space available for drop boxes. While I welcomed this at the time, as it saved a lot of time and resources on travel, this does seem to have drastically impacted on return rates. This issue will be more fully discussed within the results and discussion sections.

2.9.3 Data analysis

Descriptive statistics of participant's transformational Leadership, patient centredness and flexibility in responsiveness was undertaken and reported. The data from the survey was analysed following the path diagram below (figure 8):

Figure 8: Analysis path diagram
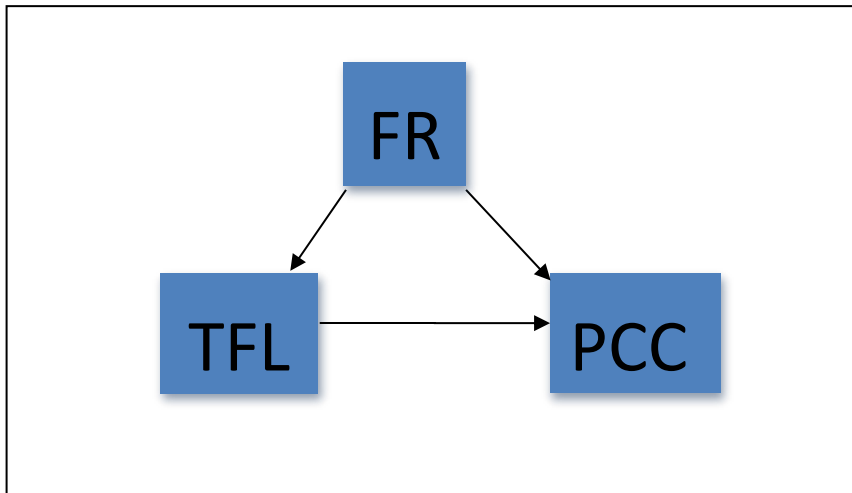
The main analysis, excluding other variables, explored the following: Transformational Leadership (TFL) as measured by the Transformational Leadership Questionnaire (TLQ) was regressed on Patient Centred Care (PCC) as measured by the Consultation and Relational Empathy measure (CARE) and the Consultation Care Measure (CCM); with emotional intelligence (EI) and self-monitoring (SM) being assessed as proxies for flexibility in responsiveness. This was to test whether flexibility in responsiveness is a moderator for the relationship between transformational Leadership and Patient Centred Care.

Descriptive statistics were used to summarise the patient groups and point towards any differences between quadrants before embarking on the rest of the analysis. The questionnaires scores and items were also summarised descriptively by quadrant to see where any potential differences between quadrants lie. For non-parametric data in the study Kruskal-Wallis H tests were used to check for statistical significance and One-way ANOVAs were used similarly for parametric data. To determine the strength and significance of relationships in the study Pearson correlations were used.

Transformational Leadership can be conceptualised as either a global construct or as a fully differentiated sum of its parts. The global construct produces the TLQ score which can then be used to correlate or compare leaders scores with themselves or other measures. The differentiated measure groups the TLQ, in the version used in this study, into 7 subscales, which allows for a deeper understanding of which components of Transformational Leadership may be important. By far the most widely used conceptualisation is to look at transformational Leadership as a global context as the internal dimensions of the scale are considered to be mutually reinforcing (Antonakis, 2003;Bass, 2003). However there are examples in the research where different behaviours have different effects on the outcomes; for example intellectual stimulation has been found to be negatively related to trust and satisfaction. (Podsakoff, 1990) and intellectual stimulation has been positively related to affective commitment and continuance commitment (Rafferty, 2004). These results demonstrate that using only a global conceptualisation of Transformational Leadership can mean more subtle relationships can be missed. As this thesis intends to explore potential mediating variables between Leadership and Patient Centred Care the analysis considers both a global and differentiated conceptualisation of transformational Leadership. This was in order to give a clearer picture of what aspects of Leadership may affect the delivery of high quality Patient Centred Care in Allied Health Professional Practice.

A breakdown of the factors in transformational Leadership is given in table 8 below. Regression analyses were conducted to determine how much each component of Transformational Leadership contributes to variation in scores of Person Centred Care for Podiatrists and Dieticians.

To determine the concordance between rater and inter-rater Transformational Leadership scores Cohens Kappa were used.

There are seven scales within the Transformational Leadership Questionnaire used in this thesis. These are described in table 8 below:

Table 7: The 7 Scales of the TLQ

Genuine concern for others	Genuine interest in me as an individual; develops my strengths
Political sensitivity and skills	Sensitive to the political pressures that elected members face; understands the political dynamics of the leading group; can work with elected member to achieve results
Decisiveness, determination, self-confidence	Decisive when required; prepared to take difficult decisions; self-confident; resilient to setback
Integrity, trustworthy, honest and open	Makes it easy for me to admit mistakes; is trustworthy, takes decisions based on moral and ethical principles
Empowers, develops potential	Trusts me to take decision/initiatives on important issues; delegates effectively; enables me to use my potential
Inspirational networker and promoter	Has a wide network of links to external environment; effectively promotes the work/achievements of the department/organization to the outside world; is able to communicate effectively the vision of the authority/department to the pubic community
Accessible, approachable	Accessible to staff at all levels; keeps in touch using face-to-face communication

From Robert J. Alban-Metcalfe and Beverly Alimo-Metcalfe The transformational Leadership questionnaire Leadership & Organization Development Journal 21/6 [2000] 280±296

2.10 Threats to validity

2.10.1 Common method variance

Both emotional intelligence and transformational Leadership are emotion loaded constructs (George, 2000) and it can be argued that both are driven by similar values (Ashkanasy and Daus, 2005; Austin et al., 2008; Küpers and Weibler, 2006). It has also been suggested that the former has been suggested to be an antecedent of the latter (Brown and Moshavi, 2005). The relationship between emotional intelligence and transformational Leadership has been well studied (Butler and Chinowsky, 2006; Duckett and Macfarlane, 2003; Leban and Zulauf, 2004) and this research would seem to confirm such a relationship. However Lindebaum and Cartwright (2010) call into question the commonly found relationship between emotional intelligence and transformational Leadership as they believe it may be particularly prone to what is known as common method variance (CMV). The above criticism should be understood in light of claims that Emotional Intelligence explains 34 per cent of the variance in a measure of TFL (Butler and Chinowsky, 2006), which is an above-average percentage in social science research (Pallant, 2005).

As emotional intelligence and transformational Leadership are conceptually similar there is a need for studies that explore this relationship while taking into consideration the issue of common method variance.

Common method variance occurs when the measurement technique introduces systematic variance into the measure (Doty and Glick, 1998). Possible causes of common method variance involve the collection of both predictor and criterion variables from the same source at the same time (Podsakoff et al., 2003). For example giving two related self-report measures to a single participant may prime them to answer both in a consistent manner thus exaggerating the relationship between the two. As noted by Schutte et al. (1998) self-report measures can be susceptible to the effects of social desirability and as a result it has been suggested that multi-rater assessment techniques be used to overcome this weakness (Roberts et al., 2001). This sentiment is echoed in Matthews et al. (2004), who emphatically argue that validation studies '"are urgently needed" (p. 184), though as of yet are not widely undertaken. The design of this study takes this view into account in the case of rating

Leadership, by having clinical team members rate the clinical leader's transformational Leadership, using the inter-rater version of the Transformational Leadership Questionnaire, as well as the clinical leader using the self-report version of the Transformational Leadership Questionnaire.

Podsakoff et al (2003) also provides further guidance on how to conduct a study to avoid the issues arising from common method variance and where possible these will be adhered to in the design of this study.

2.10.2 Cross-sectional vs. Longitudinal measurement of Leadership

The present study is constrained by demands on time and resources and thus can only explore a snapshot of Leadership within the clinical setting. Research has previously suggested that individuals' views of leaders tend to be consistent across a span of one year (Epitropaki and Martin, 2005). However other research has suggested that there is significant variability across individuals in how they are perceived as leaders over time (Tate, 2008).

However as this study is the first exploring the relationship between the concepts of Leadership, flexibility in responsiveness and Patient Centred Care discovering if there is a relationship and what it might be is best served by such a cross-sectional approach. If a relationship is discovered than it could form the basis for more longitudinal work exploring whether greater flexibility in responsiveness ameliorates concerns about shifting perceptions of Leadership and leaders.

2.11 Study two

While study one sought to find any quantifiable relationship between Leadership and the delivery of Patient Centred Care study two seeks to investigate the context in which Leadership and Patient Centred Care exist. It also seeks to discover how participants conceptualise Patient Centred Care and Leadership. This section explains the methods employed in exploring these conceptualisations and the influence of context on Leadership and the delivery of Patient Centred Care. This includes how the topic guide was constructed, which participants took part, how data collection proceeded, and how the data was analysed.

2.11.1 Study Two Method

Semi-structured interviews were conducted to explore how local context can impact on professional Leadership and therefore it's potential to enable or inhibit Patient Centred Care.

Semi-structured interviews were conducted with members of participating healthcare teams and these were based around the topic guides focus on the Leadership behaviours associated with transformational, transactional and laissez faire Leadership styles. These interviews were used to identify the elements of Leadership and teamwork that have most salience with practitioners.

Interviews also explored the issues and barriers to effective Leadership, teamwork and the provision of quality care to identify global and local issues that impact on the provision of high quality Patient Centred Care. The interviews were also be used to highlight contextual issues that may affect their patients scoring on the patient experience survey used in study one. The themes for this part of the interview were initially guided by the research literature however these were be amended and expanded in an iterative process depending on what issues are raised in the interviews.

There are three main types of research interview: Structured, semi-structured and unstructured. Each has its own advantages and disadvantages and is appropriate to address different kinds of research questions. Structured interviews are rigid in approach and involve asking the same questions in the same way to each participant. This strategy is best suited to quantitative or pseudo-quantitative research for example census interviews or polling

research. Unstructured interviews are conversational in nature and the researcher will have at most a broad list of topics to discuss. This type of interview is best suited to exploratory qualitative research where the generation of theory is important or the subject or the participant groups' perspective is relatively unknown within the research literature. Semi-structured interviews represent something of a compromise position between unstructured and structured interviews. In a semi-structured interview the interviewer has some of the freedom of unstructured techniques in that they can ask questions that explore issues raised by the participants they did not expect to arise when constructing their topic guide (Bryman, 2012). The use of a topic guide, a set of topics that will be discussed with all participants, also allows for the researcher to compare participants' views on set subjects of interest to the study. Thus semi-structured interviews allow the researcher a degree of flexibility in their research: they can be used to ensure the focus of the research is maintained and the research questions addressed but they also allow the inclusion of unexpected or novel data to arise that may better inform understanding. This study aims to explore participants' conceptualisations of Leadership and Patient Centred Care, as well as access information about their particular professional contexts. Therefore a semi-structured interview approach was selected as it allows the flexibility to address issues arising from the literature to be addressed but also participants the space to direct or redirect the direction the interviews are taking towards concerns and ideas that are more salient to them individually or as a professional group.

Interviews can be conducted individually or in a focus group situation. Each of these methods presents its own challenges and benefits. Focus groups require a greater deal of coordination than individual interviews as they require multiple participants to be available at the same time and in the same place to be conducted. There may also be issues with group dynamics within focus groups where quieter or more introverted participants might allow the direction of the conversation to be dominated by those who express themselves more forcefully or have very strong opinions. Furthermore, it is questionable when interviewing work colleagues whether a focus group setting would reveal anything more to the researcher than the existing dynamics and politics of the work setting that is being explored. On the other hand individual interviews are relatively easy to schedule or reschedule and they can also be conducted at a distance over telephone. This reduces the amount of time and money a researcher has to

spend conducting interviews and makes the data collection process more efficient. In light of these methodological and pragmatic considerations individual semi-structured interviews were selected as the most appropriate means to address the research questions in this study and increase understanding of how Patient Centred Care and Leadership interact in context.

Twelve clinicians (4 clinical leaders and 8 clinicians) from both the podiatric and dietetic study 1 groups were invited to participate. The interviews lasted, on average, between 45 minutes and an hour. Clinicians were contacted through their service leads within NHS Greater Glasgow and Clyde initially by email and telephone. Participants were also invited to attend presentations regarding the research and its aims at their regular staff meetings.

2.11.2 Study Topic Guide.

A topic guide was constructed to guide the interview process (Appendix C). The topic guide used in this study was developed through discussions of iterative drafts with my supervisors. Topic guides are a structured set of topics that reflect the purpose of the interviews and maintain the interviews focus on addressing the research questions. The topic guide was based initially on the literature reviewed for this thesis but was subject to alteration and expansion over the course of the interviews as is often considered advisable in using semi-structured techniques (King & Horrocks, 2010). This allowed unexpected insights gained from one interview to inform subsequent interviews as a means of respondent validation. The ordering of the topic guide was not prescriptive and topics and sub-topics were arranged in order to mimic the natural flow of a conversation. The topic guide was thematically based asking clinicians to discuss issues surrounding what constraints exist that can hamper Leadership. Potential interview questions included, "Are there policy concerns that restrict the extent to which a leader can enable the delivery of high quality Patient Centred Care?" "Are there specific events or challenges that clinicians feel impact on ratings of Patient Centred Care?"– For example waiting times, condition of clinics etc.

The terms Leadership and Management are both used within the topic guide but not defined by the researcher. This was in order to assess the participants own views on Leadership and Management and determine if they diverged from the literature.

2.11.3 Sample

The Podiatry interviews were conducted with clinical leaders (n=3) and clinicians (n=8), and the Dietician interviews were conducted with clinical leaders (n=4) and clinicians (n=8) to determine what impact they feel good and bad Leadership can have on Patient Centred Care in practice. Only three Podiatry leaders were available for interviews due to sick leave and absences.

The sample was a convenience sample and was spread across all four quadrants in NHS Greater Glasgow and Clyde with an average of three participants from each. Interviewees were drawn from the previous pool of participants in order that there was a link between the qualitative and quantitative data. When participants indicated they were happy to take part in study one they were asked if they would be willing to take part in a follow up interview addressing Leadership and Patient Centred Care.

By Sampling across quadrants the researcher was able to distinguish local concerns within teams and broader issues such as policy or infrastructure that impact across teams.

2.11.4 Data Collection

Interviews were conducted by telephone with participants during their working day at time suitable to them. For pragmatic reasons these interviews could not be conducted face to face but instead were conducted over the phone. The absence of visual cues via telephone may have resulted in loss of contextual and nonverbal data and possibly compromised rapport, probing, and interpretation of responses. Yet, telephones may allow respondents to feel relaxed and able to disclose sensitive information, and evidence is lacking that they produce lower quality data (Novik, 2008). However, it is possible that the interviews yielded less useful responses than face-to-face interviews and it is important to digest the findings with this in mind.

Three interviews were recorded over the phone with a digital recorder and uploaded to a secure file on the Stirling University hard drive immediately afterwards. The remaining interviews were recorded using Voice Over Internet Protocol software (SKYPE). They were then transcribed and managed using the data analysis software package QDA miner lite

(Provalis Research, 2015). QDA Miner Lite is free computer assisted qualitative data analysis software developed by Provalis Research. The program was designed to assist researchers in managing, coding and analyzing qualitative data. QDA was used to manage and code the data which was analysed manually as described below.

Most participants were happy to take part in the interviews within Podiatry and seemed more enthusiastic to take part in this study than in study one. However, recruitment remained challenging. Some Podiatrists and the majority of the interviews conducted with Dieticians only took place after management encouraged participation via a group email. This did not seem to overtly affect participants' responses within the interviews as there was a degree of commonality across transcripts. However this apparent reticence in participation is worth bearing in mind when approaching the study findings.

The recording equipment failed to record one interview conducted over a landline and a further two interviews were not recorded when VOIP (voice over internet protocol) software was used to conduct the interviews. These interviews have not been quoted in the findings chapter but the notes taken during these interviews informed the direction of the thematic analysis.

2.11.5 Data analysis

To analyse the interviews a thematic approach was employed but applied using a framework analysis approach (Richie & Spencer, 1994). This method has been chosen for its transparency in thematic analysis: giving a clear account of the analytical process is a recurrent theme in the qualitative research methods literature (Miles and Huberman 1994; Ritchie and Spencer, 2004).

Framework analysis involves a number of distinct, though interconnected, stages which logically follow on from one another. However it is not a purely mechanical process and stages can be revisited. Though systematic and disciplined it relies on the creative and conceptual ability of the analyst to determine meaning and the salience of connections found (Ritchie and Spencer, 1994). One of the strengths of framework analysis is that by following a well-

defined procedure it is possible to reconsider and rework ideas precisely because the analytical process has been documented and is therefore accessible.

There are five key stages to qualitative data analysis involved in framework analysis: Familiarisation, identifying a thematic framework, indexing, charting and mapping and interpretation (Ritchie and Spencer, 1994). Each of these is open to adaptation from a single research study context to a narrative synthesis context.

Familiarisation is the first step in the analytical process before the researcher starts to sift and sort the data in earnest as it is the process of becoming familiar with the range and diversity of the data. During the Familiarisation process the analyst takes notes and lists key ideas and recurrent themes building towards identifying a thematic framework for the research.

Indexing is the process that follows and it this is where the theoretical framework is systematically and transparently applied to the corpus of data although this is not a routine or mechanised exercise it is highly documented and a more transparent means of undertaking thematic analysis. At first the index will be largely descriptive of the data in the synthesis but it is refined as more data is explored thematically and conceptualisations that encapsulate and represent the diversity and conceptual similarities across the corpus are found.

Once the thematic coding framework had been identified, it was applied systematically to the whole (qualitative) data. I used a qualitative analysis software package, to facilitate this process.

Following indexing, the data was re-arranged according to their thematic reference and charted to the appropriate part of the thematic framework). During this process, data was summarized, abstracted and synthesized. Finally, the charts, abstracts and summaries were used to develop and refine concepts and to establish associations between themes).

I followed a pragmatic approach, developing charts for selective themes (those of particular interest to the study) and using these to guide my deeper analysis within the qualitative analysis software used. During this process it became apparent a number of themes that I had considered to be worth exploring from my reading of the literature did not apply to the data

I had gathered. After consideration and consultation with supervisors these were amended and new themes that emerged during this process were explored instead. From a general coding identifying Leadership behaviours and participants conceptualisations of Leadership and Patient Centred Care two main higher order themes became apparent: systematic and individual. Into these higher order themes I was able to sort my initial coding and then to group codes by charting into the sub-themes presented within the analysis chapter.

2.12 Data security

The University of Stirling's Code of Good Research Practice was used as a guide to protecting the data. The University of Stirling has adopted the Model Publication Scheme (MPS) for Scottish Higher Education Institutions (HEIs) which has been developed by Universities Scotland. The MPS was approved by the Scottish Information Commissioner on 25th March 2004.

The results of following this code of practice were as follows:

- Participant consent forms were stored in a locked filing cabinet within the NMAHP Research Unit, University of Stirling for the duration of the project. Thereafter, they were stored in a commercial off site data storage facility.

- Interviews were recorded via software through a VOIP system. They were transferred to a password protected computer and deleted immediately afterwards.

- The research team were allowed access to the anonymised interview transcripts. This was required in order to analyse interview data. Consent was sought for this level of access.

- Data were stored securely in the NMAHP Research Unit until completion of the project and publication of resulting report and publications.

- The data will be stored for a period of 10 years in accordance with the Code of Good Research Practice which states 'The safe and secure storage of the primary data will normally be for at least 10 years, and a safe and secure method of disposal must be used after this time, all in accordance with the requirements of the Data Protection Act.'. At the end of the 10 year period the data will be destroyed in a secure manner.

2.13 Ethics

The research study was submitted to the School of Nursing Midwifery and Health Research Committee at the University of Stirling. The investigator is of the opinion that from an NHS perspective this study was classifiable as service evaluation under the criteria set out by the National Research Ethics Service (See www.hpa.org.uk/webc/HPAwebFile/HPAweb C/1272032326180). Confirmation of this status was sought from NHS Ethics prior to study commencement, and the investigator's opinion was confirmed. NHS Research and Development approval was also obtained prior to study commencement.

The data from clinical leaders and clinicians was collected, analysed and is reported within this thesis. Participants were informed that some data might appear in a future academic publication. No identifiable data was released to a third party out with the research team and all feedback data provided to team leaders was given at an aggregate not individual level to ensure anonymity.

All data (e.g. interview recordings, transcripts, diary entries) was anonymised and kept in a secure, password protected folder on the university hard drive. Personal details of participants was stored separately from all other data.

2.14 Consent

The study was opt–in at service level, but individual clinicians and teams had the option of opting out. Informed consent was assured by providing all participants with information sheets detailing exactly what is expected of them, what data will be gathered how it will be used and who will have access to it. All participants were asked to sign a consent form that indicates they are willing to participate in the study and participants were free to withdraw from the study at any point.

Team members attended a scheduled pre-enrolment visit with the principal investigator. During this visit, the principal investigator presented an overview of the study and what it will involve. Each team member was then be given a study information sheet (see health professional study information sheet) and consent form (see health professional consent form). Potential participants were asked to complete the consent form within 5 days

indicating whether they would like to take part in the study or not. Health professionals were encouraged to contact the researcher if they felt they need more information or had questions they would like to ask prior to making their decision.

Health professionals were also reassured that their decision about whether to take part or not would be kept confidential and that no other team member (including the team lead) would made aware of any other team members' choice. This was to ensure that health professional did not feel pressured into taking part and that they were free to make their own decision independently of other team members. Patient consent was implied by the return of completed patient experience questionnaires.

2.15 Feedback

Feedback was offered, to clinicians at aggregate level at an appropriate team meeting. No clinicians took up the option of receiving feedback.

Quadrant management was provided with an overview of the factors emerging from interviews that clinicians and clinical leaders felt enabled or inhibited leaders in assisting or encouraging them to deliver high quality Patient Centred Care.

3 CHAPTER THREE: Quantitative analysis of Study 1 data.

This chapter provides summaries of the statistical results obtained from the patient experience and staff surveys disseminated in the NHS Greater Glasgow and Clyde health board area. First it reports the results of the analysis of data relating to the Podiatry participants and then it reports the Dieticians' results.

The diagram below shows the relationships being explored in this analysis (figure 9):

Figure 9: analysis path diagram
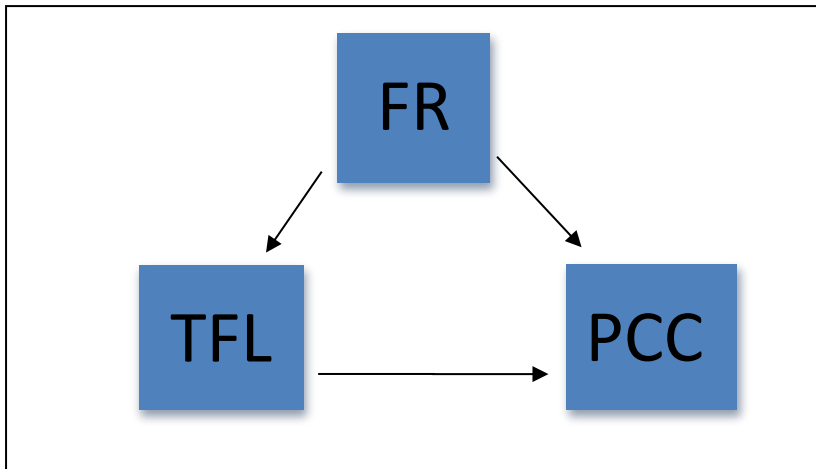
In the above diagram TFL refers to (Transformational) 'team Leadership', FR to 'flexibility in responsiveness' and PCC to 'Patient Centred Care'.

For this study, 21 Podiatrists and 12 Dieticians were recruited from the Greater Glasgow and Clyde health board. They each completed questionnaires assessing their quadrant leaders Leadership scores (TLQ), their own Emotional Intelligence (WLES) and Self-Monitoring scale (SM). Self-respondent Transformational Leadership Questionnaires (TLQ) were also completed by the 3 Podiatry team leads and 4 Dietetic team leads taking part.

Podiatrists and Dieticians also disseminated patient experience questionnaires, comprising the Consultation and Relational Empathy (CARE) measure and Consultation Care Measure (CCM) to their patients.

One Podiatry team leader also took part in the dissemination of patient questionnaires alongside staff. The aim was to obtain patient experience data for 30 consecutive patients attending consultations from a given start date.

Patient data collection was slower than anticipated and was conducted over a period of six months as opposed to the initially planned three. The following table (table 9) summarises the return rates at all levels of the study.

Table 8: Return rates

Quadrant	Podiatrists (21)					Dieticians (12)				
	TLQ	WLES	SM	CCM	CARE	TLQ	WLES	SM	CCM	CARE
East/North East	6	6	6	35	28	3	3	3	3	3
Clyde/North	3	4	4	28	23	2	2	2	21	20
West	1	2	2	102	72	3	3	3	77	70
South/South Clyde	3	3	3	115	102	1	1	1	28	23
Total	13	15	15	280	225	9	9	9	129	116

3.1 Staff Survey Responses

Participants were asked to complete a survey composed of measures of transformational Leadership (TLQ) (Alban-Metcalfe & Alimo-Metcalfe, 2000a) and measures acting as proxies for flexibility in responsiveness: the Wong and Law Emotional Intelligence test (WLES) (Wong & Law, 2002) and the self-monitoring scale (Snyder, 1974).

In total 33 questionnaires containing the Transformational Leadership Questionnaire (TLQ) , Wong and Law Emotional Intelligence Scale (WLES) and Self-Monitoring scale (SM) were sent out to Podiatry and Dietetics staff. One member of Podiatry staff dropped out before data collection began, leaving a total of 32 potential questionnaires, with an eventual return of 15 questionnaires from Podiatry staff (only 11 completed the Transformational Leadership Questionnaire (TLQ)) and 12 from Dietetics staff. The number of expected patient completed questionnaires returned for each clinician varied from 13% to 47% per quadrant.

The scores for each of these measures across all participants are summarized in Table 9 below:

Table 9: All AHP staff survey responses

	Minimum	Maximum	Mean	SD
TLQ Score	0	105	69.94	19.52
WLES Score	0	4.63	4.12	0.47
SM score	0	28.00	9.15	3.13

There is a large variation in Transformational Leadership Questionnaire (TLQ) scores across all participants, but there is little variation in scores on the measure of self-monitoring (SM) , and even less on the Wong and Law Emotional Intelligence Scale (WLES) scores. There is no significant difference in scores when individual quadrants are compared.

3.1.1 Clinician survey data: Podiatrists

3.1.1.1 Return rates

In total 21 questionnaires containing the Transformational Leadership Questionnaire (TLQ) , Wong and Law Emotional Intelligence Scale (WLES) and Self-Monitoring scale (SM) were sent out to Podiatry staff. These staff were then provided with 70 questionnaire packs to be handed out to sequential patients attending their routine Dietetics appointments.   All Podiatry participants were able to collect completed patient questionnaires in drop boxes left outside their clinics or at their services reception. Podiatrists were instructed to aim to collect 50 patient completed questionnaires (in line with previous studies using the Consultation and Relational Empathy (CARE) measure (Murphy, Mercer, & Duncan, 2013)), though 30 questionnaires was estimated as the number required to run individualized statistics.

Table 10 below summarises the return rates of the staff survey by quadrant for Podiatry staff.

Table 10: Podiatry Return rates

Quadrant	TLQ returns	WLES returns	SM returns	Patient Surveys returned
South	4	6	6	141 (47%)
East	3	4	4	42 (21%)
Clyde	1	2	2	32 (13%)
West	3	3	3	111 (37%)
Totals	11	15	15	326 (31%)

3.1.1.2 Podiatrist Staff Survey Responses

In total 15 of 21 recruited Podiatrists completed all these measures (see table 10). The scores for each of these measures across all participants are summarized in the table (table 11) below:

Table 11: Podiatry Summary scores for TLQ, WLES and SM measures

	Minimum	Maximum	Mean	SD
TLQ Score	28.00	71.00	53.73	12.63
WLES Score	3.38	4.63	4.01	0.44
SM score	4.00	13.00	9.93	2.69

There is a large variation in Transformational Leadership Questionnaire (TLQ) scores across all participants, but there is little variation in scores on the measure of self-monitoring (SM), and even less on the Wong and Law Emotional Intelligence Scale (WLES) scores. Table 12 shows how the scores above differ by quadrant:

Table 12: Podiatry Staff survey scores by quadrant

QUADRANT		TLQ Score	WLES Score	SM score
Clyde	Mean	49	3.79	12.33
	N	2	3	3
	SD	29.70	0.38	1.15
East	Mean	58	3.96	8.75
	N	3	4	4
	SD	12.12	0.41	2.22
West	Mean	47	3.83	10.33
	N	3	3	3
	SD	6.24	0.252	3.06
South	Mean	59.33	4.29	9.20
	N	3	5	5
	SD	2.52	0.53	3.11
Total	Mean	53.73	4.01	9.93
	N	11	15	15
	SD	12.63	0.44	2.69

Looking at the breakdown of the Wong and Law Emotional Intelligence Scale (WLES) scores by quadrant we can see there is little difference between the quadrants. All the Wong and Law Emotional Intelligence Scale (WLES) average scores are within 0.5 of each other. The highest score is found in the South quadrant (4.2) and the lowest in Clyde (3.7). There is also less variation between Podiatrists Wong and Law Emotional Intelligence Scale (WLES) scores within quadrants. There is more variation between quadrants in terms of the Self-Monitoring score (SM), with East being the lowest (8.7) and Clyde having the highest (12.3) and the variation within quadrants is also higher.

The average Transformational Leadership Questionnaire (TLQ) score by quadrant can be divided into two groups: Clyde and West (49 and 47 respectively) and East and South (58 and 59 respectively). This indicates that Podiatrists in the East and South rate their Leadership more highly than those in Clyde and West. Though in the cases of East and Clyde the variation in responses from Podiatrists is far greater than it is in South and West where there were relatively high levels of agreement between staff regarding their ratings of their quadrant leaders.

The Wong and Law Emotional Intelligence Scale (WLES) scores were largely uniform across all Podiatrists though there was more variation within the Self-Monitoring (SM) scores on the whole these tended towards the higher end of the scale. The most variation was found in the Transformational Leadership Questionnaire (TLQ) ratings Podiatrists gave and these can be grouped into low, middling and high.

A one way analysis of variance revealed no significant difference in Transformational Leadership Questionnaire (TLQ) scores by quadrant, F (3, 7) = 0.6067, p= 0.631. Similarly no significant difference by quadrant was found for the Wong and Law Emotional Intelligence Scale (WLES) scores F (3, 11) = 1.118, p= 0.384 or Self-Monitoring scale (SM) scores F (3, 11) =8.683, p=0.331.

As discussed in section 2.10.1, Common-method variance (CMV) is the spurious "variance that is attributable to the measurement method rather than to the constructs the measures are assumed to represent" (Podsakoff , MacKenzie, Lee, & Podsakoff, 2003) or equivalently as "systematic error variance shared among variables measured with and introduced as a function of the same method and/or source" (Richardson, Simmering, & Sturman, 2009). This variance can inflate or deflate correlations between variables from the same source. To account for common method variance Transformational Leadership Questionnaire (TLQ) scores from quadrant managers were compared with inter-rater Transformational Leadership Questionnaire(TLQ) scores from their staff. Cohen's κ was run to determine if there was agreement between leaders and team members ratings of Transformational Leadership. There was fair to good agreement (Banerjee, 1999) between the two groups ratings, κ = 0.528, p <0.0001. Therefore we can be reasonably confident that the leaders ratings and their staffs show a reasonable level of agreement and that common method variance is unlikely to be a substantial issue.

3.1.2   Clinician Survey data: Dieticians

3.1.2.1   Return rates

In total 12 questionnaires containing the Transformational Leadership Questionnaire (TLQ) , Wong and Law Emotional Intelligence Scale (WLES) and Self-Monitoring scale (SM) were sent out to Dietetics staff. These staff were then provided with 70 questionnaire packs to be handed out to sequential patients attending their routine Dietetics appointments. Only two Dieticians involved in the study could allow their patient completed questionnaires to be collected via drop boxes positioned within their clinics. All the others were provided with self-addressed envelopes to be returned by post. Dieticians were instructed to aim to collect 50 patient completed questionnaires (in line with previous studies using the Consultation and Relational Empathy (CARE) measure (Murphy, Mercer, & Duncan, 2013)), though 30 questionnaires was estimated as the number required to run individualized statistics. Table 14 summarises return rates:

Table 13: Dieticians Return rates

Quadrant	TLQ returns	WLES returns	SM returns	Patient Surveys returned
South Clyde	3	3	3	28 (18%)
North East	2	2	2	3 (2%)
South	3	3	3	22 (14%)
West	1	1	1	83 (55%)
Totals	9	9	9	136 (23%)

As the numbers above indicate returns were disappointing from the Dieticians and clearly indicate that where it was possible the drop box method of collecting returns was far superior. It is regrettable that the nature of Dietetics clinics surveyed meant that this was not an option most of the clinicians could use. Two Dieticians who initially volunteered to take part failed to return any questionnaires or practitioner surveys and were considered to have dropped out of the study.

3.1.2.2 Dietician Staff survey responses

Table 14: Dieticians survey scores

	N	Minimum	Maximum	Mean	SD
TLQ Score	9	56.00	105.00	87.22	18.11
WLES Score	9	3.38	4.56	3.97	0.42
SM score	9	6.00	14.00	9.79	2.86

There is a large variation in transformational Leadership questionnaires (TLQ) between participants, though typically scores were high. The lowest scores for Dietetics participants on the Transformational Leadership Questionnaire (TLQ) (56) are higher than the average score seen from participants in the Podiatry group (54). This could indicate there are significant differences between Leadership in Podiatry and Dietetics within NHS Greater Glasgow and Clyde.

There was very little variation in the Wong and Law Emotional Intelligence Scale (WLES) and self-monitoring (SM) scores within the Dietetics group and the average scores for the Wong and Law Emotional Intelligence Scale (WLES) (3.9) and self-monitoring (SM) (9.7) are almost the same as the respective Podiatry scores for the Wong and Law Emotional Intelligence Scale (WLES) (4.0) and self-monitoring (SM) (9.9).

When the scores for the Wong and Law Emotional Intelligence Scale (WLES), Transformational Leadership Questionnaire (TLQ) and self-monitoring (SM) are compared by quadrant we can see that they are broadly similar across the Dietetics participants. A one way analysis of variance revealed no significant difference in Transformational Leadership Questionnaire (TLQ) scores by quadrant, $F_{(3, 5)} = 0.181$, $p = 0.905$. Similarly no significant difference by quadrant was found for the Wong and Law Emotional Intelligence Scale (WLES) scores $F_{(3, 11)} = 1.375$, $p = 0.352$ or Self-Monitoring scale (SM) scores $F_{(3, 51)} = 1.123$, $p = 0.432$.

Table 15: Dieticians staff scores by quadrant

QUADRANT		TLQ Score	WLES Score	SM score
Clyde	Mean	89.00	3.75	12.50
	N	2	2	2
	SD	7.07	0.18	0.71
East	Mean	101.00	3.38	11
	N	1	1	1
	SD	.	.	.
West	Mean	85.67	4.19	8
	N	3	3	3
	SD	23.86	0.35	1.73
South	Mean	83.00	4.10	9.33
	N	3	3	3
	SD	24.27	0.51	4.04

To account for common method variance Transformational Leadership Questionnaire (TLQ) scores from quadrant managers were compared with inter-rater Transformational Leadership Questionnaire (TLQ) scores from their staff. Cohen's κ was run to determine if there was agreement between leaders and team members ratings of Transformational Leadership. There was fair to good agreement (Banerjee, 1999) between the two groups ratings, κ = 0.410, $p < 0.0001$. Therefore we can be reasonably confident that the leaders ratings and their staffs show a reasonable level of agreement and that common method variance is unlikely to be a substantial issue. Though the level of agreement was lower for the Dieticians than for the Podiatrists. This could be because there was a lower number of team members and team leaders participating from this professional group which would make their data more prone to individual differences. Though it could also indicate differences in Leadership within Dietetics when compared with Podiatry.

3.2   Patient Survey data

3.2.1   Patient Demographics

The patient sample for both Allied Health Professional Groups was made up of mostly female participants (269, 57.3%) compared to   male (184, 29.5%) and was predominantly (96%) White with, 0.6% Black, 0.6% Asian and 0.2% of Mixed Race. 3.2% or patient participants did not respond to this question. The youngest participant was 17 and the oldest was 99. The average age of patient participants was 65. In total 446 patient survey measures were returned.

Due to constraints regarding cost and time it was not possible to produce survey materials designed for any patients with visual impairment. It is possible that this negatively affected return rates as the questionnaire materials may themselves have excluded people from taking part.

A one way analysis of variance revealed no significant effect of age on return rate by quadrant, F (3, 317) = 3.876, p > 0.005. However a Tukey post-hoc test shows that the average age of patients surveyed in the South quadrant was significantly different from those in the Clyde and East quadrants. The West and East quadrants were also significantly different in terms of average age. Furthermore the higher the average age of patients each Podiatrist was treating the lower their overall return rates are.

3.2.2 Patient demographics Podiatry

The Podiatry patient sample was mostly white (315, 95.7%) and female (193, 61.1%) drawn from across the four quadrants served by NHS Greater Glasgow and Clyde. There were 2 Black/Black British participants (0.6%), two Asian/Asian British Participants (0.6%) and one participant of mixed race (0.3%) 2.7% of participants chose not to reveal their ethnicity. 123 Men returned surveys (37.4%) and 2.4% of participants did not record their gender.

Table 16: Podiatry Patient sample demographics

Age	N	Mean	SD
Clyde	32	71.59	9.83
East	41	71.98	12.2
South	135	64.30	16.3
West	113	66.39	15.42
Total	321	66.75	15.41

Ethnicity	Frequency	Percent
White	315	95.7
Black/Black British	2	0.6
Asian/ Asian British	2	0.6
Mixed	1	0.3
Total	316	96.0

Gender	Frequency	Percent
Male	123	37.4
Female	193	58.7
Total	316	96.0

3.2.3 Impact of Podiatry patient demographics

Performing regression analyses on the Podiatry patient groups demographics showed that there were no statistically significant effects of age, gender or ethnicity on Consultation Care Measure Scores (CCM) or Consultation and Relational Empathy (CARE) scores. The two following tables (table 17 and table 18) summarise the means, standard deviations, intercorrelations and alpha coefficients from these regressions.

Table 17: Regression summary for Podiatry CCM and demographics

	Mean	SD	1	2	3	4
1. CCM Score	40.66	16.42	-	-	-	-
2. Gender	-	-	0.08	-	-	-
3. Age	64.52	15.96	-0.15	-0.19*	-	-
4. Ethnicity	-	-	-0.61	0.017	-0.015	-

$*p < .05, **p < .01.$

Table 18: Regression summary for Podiatry CARE and demographics

	Mean	SD	1	2	3	4
1. CARE	34.74	7.11	-	-	-	-
2. Gender	-	-	-0.13	-	-	-
3. Age	65.85	15.28	0.80	-0.17*	-	-
4. Ethnicity	-	-	-0.42	0.15	-0.08**	-

$*p < .05, **p < .01.$

Descriptive statistics, reliability estimates and intercorrelations are displayed in the tables above. The correlations indicate that neither gender, age or ethnicity are significantly correlated with Consultation Care Measure (CCM) or Consultation and Relational Empathy (CARE) score for the Podiatry group.

3.2.4 Patient Demographics: Dietetics

Table 19: Dietetics Patient sample demographics

Age	N	Mean	SD
South Clyde	28	66.68	13.97
North/East	3	53.33	21.60
South	21	57.43	22.90
West	81	62.31	15.03
Total	133	62.26	16.52

Ethnicity	Frequency	Percent
White	132	97.1
Black/Black British	1	0.7
Asian/ Asian British	1	0.7
Mixed	134	98.5
Total	132	97.1

Gender	Frequency	Percent
Male	60	44.1
Female	74	54.4
Total	134	98.5

The average age of patients attending Dietetics clinics was 62 and the sample was mostly white (132, 98%) and female (74, 55%). There was two non-white participants one of Black/Black British (0.7%) and one of Asian/Asian British (0.7%) ethnicity 1.5% of participants did not answer this question. Sixty men completed the patient surveys (44.1%) and 1.5% of participants did not answer this question. The Dietetics patient sample is younger than the Podiatry sample so it is unlikely that poor returns in this group are due to age.

Dietetics staff do see a high volume of patients with comprehension of cognitive impairments and this might go some way to explain why the return rate is so low. However the main difference between both the groups is that the Podiatrists had clinical space in which they could put drop boxes for patients to return measures and the Dieticians could not. Patient participants seem to have been far more willing to complete the patient survey after their consultation at the clinic than they were to take the survey home and post it back using a pre-paid envelope.

3.2.5 Impact of Dietetics patient demographics

Performing regression analyses on the Dietetics patient groups demographics showed that there were no statistically significant effects of age, gender or ethnicity on Consultation Care Measure Scores(CCM) or Consultation and Relational Empathy (CARE) scores. The two following tables (table 20 and 21) summarise the means, standard deviations, intercorrelations and alpha coefficients from these regressions.

Table 20: Regression summary for Dieticians CCM and demographics

	Mean	SD	1	2	3	4
1. CCM Score	40.70	16.19	-	-	-	-
2. Gender	-	-	-0.9	-	-	-
3. Age	61.65	17.41	-0.9	-0.08	-	-
4. Ethnicity	-	-	0.08	0.12	-0.28**	-

*p < .05, **p < .01

Table 21: Regression summary for Dieticians CARE and demographics

	Mean	SD	1	2	3	4
1. CARE	35.83	5.27	-	-	-	-
2. Gender	-	-	-0.10	-	-	-
3. Age	61.76	16.47	-0.24	0.01*	-	-
4. Ethnicity	-	-	0.02	0.11	-0.28**	-

. *p < .05, **p < .01.

Descriptive statistics, reliability estimates and intercorrelations are displayed in the tables above. The correlations indicate that neither gender, age or ethnicity are significantly correlated with Consultation Care Measure (CCM) or Consultation and Relational Empathy (CARE) score for the Dietetics group.

3.2.6 Patient Survey Responses

Patients were asked to complete both the Consultation Care Measure (CCM) and the Consultation and Relational Empathy (CARE) measures of patient satisfaction. These were used as proxy measures for determining how successfully individual clinicians delivered Patient Centred Care.

Patient survey responses to the Consultation Care Measure (CCM) were scored as follows:

0 – neutral disagree, 1 – Agree, 2 – Strongly Agree, 3 – Very Strongly Agree.

The level of variation in patients' responses tends to increase towards the end of the questionnaire. Generally there is not a great deal of variation within responses to most items, with patients being positive about their experiences of care. On average the responses show that patients find that Podiatrists in Greater Glasgow and Clyde communicate well and in line with their expectations and needs.

Alongside the Consultation Care Measure (CCM) patients were also asked to complete the Consultation and Relational Empathy (CARE) measure. Their responses to this measure were scored as follows:

0 – Not Applicable, 1 – Poor, 2 – Fair, 3 – Good, 4 – Excellent.

When Compared to the Consultation Care Measure (CCM) patient responses to the Consultation and Relational Empathy (CARE) measure show less variation and on average cluster around scores of Good to excellent (3.5 and above). The last two items show the greatest levels of variation in patient's responses to CARE. These items relate to "helping you take control" and "Making a plan of action with you".

The Consultation and Relational Empathy (CARE) measure is a global construct and not divided into subscales but the Consultation Care Measure (CCM) can be differentiated into five separate scales ("Communication and partnership", "personal relationship", "health promotion", "Positive and clear approach to problem" and "interest in effect on life") how the Consultation Care Measure (CCM) scale is broken down is shown in table 22 below:

Table 22: CCM subscales

Communication and partnership	CCM1 Was interested in my worries about the problem
	CCM2 Was interested when I talked about my symptoms
	CCM3 Was interested in what I wanted to know
	CCM4 I felt encouraged to ask questions
	CCM5 Was careful to explain the plan of treatment
	CCM6 Was sympathetic
	CCM7 Was interested in what I thought the problem was
	CCM8 Discussed and agreed together what the problem was
	CCM9 Was interested in what I wanted done
	CCM10 Was interested in what treatment I wanted
	CCM11 Discussed and reached agreement with me on the plan of treatment
Personal relationship	CCM12 Knows me and understands me well
	CCM13 Understands my emotional needs
	CCM14 I'm confident that the doctor knows me and my history
Health promotion	CCM15 Talked about ways to lower the risk of future illness
	CCM16 Advised me how to prevent future health problems
Positive and clear approach to problem	CCM17 Explained clearly what the problem was
	CCM18 Was definite about what the problem was
	CCM19 Was positive about when the problem would settle
Interest in effect on life	CCM20 Was interested in the effect of the problem on my family or personal life
	CCM21 Was interested in the effect of the problem on everyday activities

By exploring how patients responded to the items in these subscales we can see some subtle differences we might have missed by only looking at the global construct.

The level of variation in patients' responses tends to increase towards the end of the survey perhaps indicating there was an element of survey fatigue in completing the measure. However there is not a great deal of variation between patients for most items with patients being positive overall about their experiences of care.

Table 23: CCM Scale Averages and Standard Deviations (All AHPs)

CCM Scale	Average Score (Scale total)	Standard Deviation
Communication and Partnership	21.18 (44)	7.74
Personal relationship	4.88 (12)	2.91
Health Promotion	3.71 (8)	1.96
Positive and Clear Approach to Problem	5.47 (12)	2.83
Interest in Effect of Life	3.23 (8)	2.10

The "Communication and Partnership" Scale contains eleven items and it is therefore not that surprising that it shows the largest level of variation of all the subscales in the Consultation Care Measure (CCM). The least variation is seen in the "Health Promotion Scale" which is interesting as it would seem to suggest a more standardised approach across both Allied Health Professional Groups than might be expected. For Podiatry, which is a more technical profession with more formal procedures and treatments, this result is not unusual.

However, for Dietetics which is a profession which is largely concerned with the promotion of good health practices and nutritional advice we might have expected some more variation to be reflected on this scale. That said the scores are biased towards the high end of the scale so this could simply reflect that patients feel they are experiencing a high basic level of health promotion activity across both professional groups.

The variation for the subscales, "Personal Relationship" and "Positive and Clear Approach to Problem" is relatively small and these are the two subscales with items most focused on the professional aspects of the consultation and the therapeutic alliance. Particularly their focus on the health professional building trust and rapport with the patient and clearly explaining the problem.

The variation for the "Interest in the effect on life" scale is proportionately similar to the variation for the "Communication and Partnership" scale though the former contains considerably less items. This variation could perhaps be explained by the different focuses of the two Allied Health Professions. Podiatrists would perhaps be more likely to ask about the impact of the problem on everyday activities whereas Dieticians might be more likely to ask about the impact on the patients family or personal life.

3.2.7 Podiatrist Patient survey responses

The level of variation in patients' responses for the Podiatry group tends to increase towards the end of the survey again perhaps indicating there was an element of survey fatigue in completing the measure. However there is not a great deal of variation between patients for most items with patients being positive overall about their experiences of care.

Table 24: CCM Scale Averages and Standard Deviations (Podiatry)

CCM Scale	Average Score (Scale total)	Standard Deviation
Communication and Partnership	21.02 (44)	7.75
Personal relationship	5.00 (12)	2.91
Health Promotion	3.62 (8)	1.98
Positive and Clear Approach to Problem	5.70 (12)	2.78
Interest in Effect of Life	3.40 (8)	1.99

Items on the Communication and Partnership scale" and items on the "Positive and clear approach to problem" are scored very similarly and show similar levels of variation in patient responses. This is unsurprising as these items on the measure relate to staffs levels of communication with patients. On average the responses show that patients find that Podiatrists in Greater Glasgow and Clyde communicate well and in line with their expectations and needs. Items twelve, thirteen and fourteen are concerned with how well the Podiatrist knew the patient, their medical history and understood their emotional needs. Scores for these questions were slightly lower than those on communication and there was a greater degree of variation.

By looking at the average scores for the items on the "Communication and Partnership Scale" and the "Positive and Clear Approach to Problem" scale it seems that there does appear to be a difference between scores depending on whether the patient knows the practitioner or not. With knowing the practitioner increasing the score slightly from agree to strongly agree on average.

A Kruskal-Wallis H test showed that there was a statistically significant difference in the scores for items in the Consultation Care Measure (CCM) s 'personal relationship' scale depending on whether the practitioner knew the patient: Taking each question individually within the scale we can see that for CCM12 $\chi2(2)$ = 62.026, p = 0.00, for CCM13 $\chi2(2)$ = 47.315, p = 0.00 and for CCM14 $\chi2(2)$ = 27.835, p = 0.00.

The above shows that patients judge how a health practitioner knows and understands them highest, followed by understanding their emotional needs and then lastly knowing their history as counting as knowing them well.

Items in the Health Promotion scale of the Consultation Care Measure (CCM) relate to future planning. Again these show slightly lower scores and greater variation though these differences overall were not statistically significant across all quadrants. The answers relating to items in the 'Interest in effect on life' scale of the Consultation Care Measure (CCM) also show a similar pattern. These questions relate specifically to the impact that the patient's health problem would have on their personal life and everyday activities. Again over all quadrants these differences were not found to be statistically significant

Alongside the Consultation Care Measure (CCM) patients were also asked to complete the Consultation and Relational Empathy (CARE) measure.

When Compared to the Consultation Care Measure (CCM) patient responses to the Consultation and Relational Empathy (CARE) measure show less variation and cluster around scores of Good to excellent (3.5 and above). The last two items show the greatest levels of variation in patients responses to Consultation and Relational Empathy (CARE) and these items relate to "helping you take control" and "Making a plan of action with you".

The summary statistics for Consultation and Relational Empathy (CARE) and Consultation Care Measure (CCM) scores (given in table 23 below) shows that there was greater variation overall in patient responses to the Consultation Care Measure (CCM) measure than the Consultation and Relational Empathy (CARE) measure. They also show that scores for both measures were generally high indicating that patients' experiences of Consultation and Relational Empathy (CARE) in Greater Glasgow NHS and Clyde were generally positive.

Table 25: Podiatry CARE and CCM Scores

	N	Minimum	Maximum	Mean	SD
Care score	280	0.00	40.00	34.64	7.13
CCM score	225	2.00	63.00	40.56	16.52

When these scores are compared by quadrant (see table 26 below) no large differences are found between the quadrants despite a large disparity in return rates. Patients generally rate their experiences as positive across all quadrants. West quadrant performed best on both measures, East performed worst on Consultation and Relational Empathy (CARE) scores and Clyde worst on Consultation Care Measure (CCM) scores. This suggests that while there are differences between the quadrants they are not substantial and in general patients are happy with the levels of Patient Centred Care they receive across the health board.

Table 26: Podiatry CARE and CCM scores by quadrant

Quadrant		Care score	CCM score
Clyde	Mean	34.82	34.47
	N	28	23
	SD	7.32	16.65
East	Mean	31.94	42.10
	N	35	28
	SD	9.97	17.08
South	Mean	34.37	39.73
	N	115	102
	SD	7.85	17.12
West	Mean	35.80	43.08
	N	102	72
	SD	4.38	15.05
Total	Mean	34.64	40.56
	N	280	225
	SD	7.13	16.52

A Kruskal-Wallis H test showed that there was no statistically significant difference in Consultation and Relational Empathy (CARE) or Consultation Care Measure (CCM) scores across the quadrants,

For the Consultation and Relational Empathy (CARE) measure $\chi 2(2) = 4.589$, p = 0.205 with a mean rank Consultation and Relational Empathy (CARE) score of 142.43 for the Clyde quadrant, 114.64 for the East quadrant, 143.91 for the South Quadrant and 146.34 for the West quadrant.

For the Consultation Care Measure (CCM) the χ2(2) = 6.788, p = 0.075 with a mean rank Consultation and Relational Empathy (CARE) score of 84.96 for the Clyde quadrant, 117.96 for the East quadrant, 110.90 for the South Quadrant and 124.60 for the West quadrant.

While differences across the four quadrants proved to be fairly small, differences between Consultation Care Measure (CCM) and Consultation and Relational Empathy (CARE) scores for individual Podiatry participants were larger. However, it seems apparent that much of the variation between individual participants' Consultation Care Measure (CCM)   and Consultation and Relational Empathy (CARE) scores could simply explained by individual return rates.

Table 27 below shows the average time (by quadrant) patients spent with Podiatrists, how satisfied they were with the amount of time they were seen for:

 (0 – not satisfied, 1 – Fairly satisfied, 2 – Very satisfied, 3 – Completely satisfied)

and how well satisfied they were with their consultation overall:

 (0 – not satisfied, 1 – Fairly satisfied, 2 – Very satisfied, 3 – Completely satisfied).

Table 27: Podiatry Satisfaction with consultation overall

Quadrant		time	Satisfied with time	Satisfied overall
Clyde	Mean	00:17	2.50	2.53
	N	24	32	32
	SD	00:06	0.72	0.56
East	Mean	00:16	2.29	2.37
	N	28	41	41
	SD	00:06	0.64	0.66
South	Mean	00:19	2.49	2.53
	N	103	133	133
	SD	00:07	0.62	0.64
West	Mean	00:21	2.55	2.54
	N	90	112	113
	SD	00:07	0.70	0.64
Total	Mean	00:19	2.49	2.51
	N	245	318	319
	SD	00:07	0.66	0.64

On average patients across all quadrants were either very satisfied or completely satisfied with the treatment they received from Podiatrists, as well as the amount of time they were seen for across the quadrants. With only the East quadrants scores dipping slightly below the levels of the other quadrants (though not significantly). Interestingly patients in the East quadrant also felt that they were seen for the least time.

A one way analysis of variance revealed no significant effect of time on how satisfied patients were with their care overall, $F(3, 315) = 0.817$, $p = 0.45=85$. However a Tukey post-hoc test on how satisfied patients were with the time they were seen shows that there was a significant difference between the West and East quadrants.

How well known a Podiatrist is to a patient may well change how well they rate their experience of care above and beyond the already noted difference in the Consultation Care Measure (CCM) relationship questions. Table 28 shows the difference in mean Consultation and Relational Empathy (CARE) and Consultation Care Measure (CCM) scores depending on whether a patient indicated they knew their practitioner well or not at all.

Table 28: Podiatry CCM/CARE means for how well known

How well known		Care score	CCM score
Don't know them at all	Mean	32.29	35.97
	N	106	92
	SD	8.61	15.86
Know them very well	Mean	36.26	44.11
	N	161	120
	SD	5.48	15.78
Total	Mean	34.69	40.58
	N	267	212
	SD	7.15	16.29

From this it does look like there is a difference between the groups with a slightly higher Consultation and Relational Empathy (CARE) score and a far higher Consultation Care Measure (CCM) score if the patient knows the practitioner well. This relationship was tested by running a Mann Whitney test on Consultation and Relational Empathy (CARE) and Consultation Care Measure (CCM) scores depending on whether the patients had said they knew the practitioners well or did not know them at all. Median care scores in groups for don't know them at all and Know them very well were 110.36 and 150.56 for the Consultation and Relational Empathy (CARE) score and for the Consultation Care Measure (CCM) score 90.6 and 119.71. The distributions in the two groups differed significantly for the Consultation and Relational Empathy (CARE) score (Mann–Whitney U = 6030, P = 0.000 two-tailed) but not for the Consultation Care Measure (CCM) scores (Mann–Whitney U = 4055, P = 0.001 two-tailed).

3.2.8 Dieticians Patient survey responses

Dietician's patients responses to most items were uniform showing little variation in Consultation Care Measure (CCM) scores. However there is some variation in responses to items on the "Personal Relationship", "Health Promotion", the "Positive and clear approach to problem" and "interest in effect on life" scales. By looking at the averages in responses to these items there does appear to be a difference between scores depending on whether the patient knows the practitioner or not. Where the patient declaring that they know the practitioner increasing the score slightly from agree to strongly agree on average.

Table 29: CCM Scale Averages and Standard Deviations (Dietetics)

CCM Scale	Average Score (Scale total)	Standard Deviation
Communication and Partnership	21.52 (44)	7.73
Personal relationship	4.61 (12)	2.89
Health Promotion	3.89 (8)	1.88
Positive and Clear Approach to Problem	4.98 (12)	2.87
Interest in Effect of Life	3.09 (8)	2.18

A Kruskal-Wallis H test showed that there was a statistically significant difference in the scores for items in the Consultation Care Measure (CCM) 'personal relationship' scale depending on whether the practitioner knew the patient: This difference can be confirmed as statistically significant for items CCM12 and CCM14 but not for CCM13. For CCM12 $\chi2(2) = 20.130$, p = 0.00, for CCM13 $\chi2(2) = 10.738$, p = 0.01 and for CCM14 $\chi2(2) = 19.026$, p = 0.00.

Table 30: Summary statistics for Dieticians CARE and CCM scores

	N	Minimum	Maximum	Mean	SD
Care score	129	14.00	40.00	35.86	5.27
CCM score	116	1.00	63.00	40.38	16.65

When Compared to the Consultation Care Measure (CCM) patient responses to the Consultation and Relational Empathy (CARE) measure show less variation and cluster around scores of Good to excellent (3.5 and above). The summary statistics for Consultation and Relational Empathy (CARE) and Consultation Care Measure (CCM) scores (given in table 31 below) shows that there was greater variation overall in patient responses to the Consultation Care Measure (CCM) measure than the Consultation and Relational Empathy (CARE) measure. They also show that scores for both measures were generally high indicating that patient's experiences of Consultation and Relational Empathy (CARE) in Greater Glasgow NHS and Clyde were generally positive.

Table 31 below shows there is a degree of uniformity in both Consultation Care Measure (CCM) and Consultation and Relational Empathy (CARE) scores when compared across quadrants (despite the marked difference in numbers of participants). This uniformity is confirmed by the lack of statistical significance when a Kruskal Wallis test is run for CARE score $\chi2$ (2) = 1.926, p = 5.88 and CCM score $\chi2$ (2) = 1.55, p = .671

Table 31: Summary statistics for Dieticians CARE and CCM scores by quadrant

quadrant		Care score	CCM score
South Clyde	Mean	36.	42.57
	N	28	23
	SD	6.77	16.99
North/East	Mean	34	40.33
	N	3	3
	SD	4.58	15.70
South	Mean	36.00	42.60
	N	21	20
	SD	5.43	17.02
West	Mean	35.84	39.03
	N	77	70
	SD	4.69	16.67
Total	Mean	35.86	40.38
	N	129	116
	SD	5.27	16.65

3.3   Comparing Scores by profession

This section compares scores from the patient and staff surveys. It starts by looking at the differences, between Podiatry and Dietetics, found between items on the Consultation Care Measure (CCM) and then looks at how the professions scores for the Wong and Law Emotional Intelligence Scale (WLES), Self-monitoring (SM), and Inter Rater Transformational Leadership Questionnaire (TLQ) compare to one another.

Items in the 'personal relationship' scale were also subject to more variation in the Podiatry sample, depending on the rating the patient gave for how well they knew a practitioner, and this was considered to be due to the items relating to the therapeutic alliance between a practitioner and patient.

The Dietician's results for items on the "personal relationship" and "health promotion" scales mostly matches those found in the Podiatry group, but the result for CCM13 in this case is found not to statistically significant. Item CCM13 asks how well the practitioner "Understands my emotional needs". This is perhaps significant in the Podiatry group because it is an indicator of the impact developing a patient and practitioner relationship over a number of consultations. However in practice Dietetics uses a far more communication focused consultation from the start and relies upon building rapport quickly. A Dietician needs to take account of the patients' emotional needs as an inherent part of the consultation as parts of their consultation will be more akin to negotiation than dispensing advice or treatments as the more technically focused consultation and practice of Podiatry is. The difference between the two is also highlighted by the responses to items in the health promotion scale which shows a greater degree of variation in the Podiatry results. Specifically item CCM15; this item asks patients whether the practitioner "talked about ways to lower the risk of future illness with them". This is central to the purpose of a Dietetics consultation given their necessary focus on self-care, so it is not surprising there is little variation there. With regards to Podiatry it is interesting to note that during the study the Podiatry service was moving towards a self-care model for some aspects of its service. Perhaps this could explain why variation in CCM15 is observed within this group? Items in the 'Positive and clear approach to problem' scale show variation within the Dietetics group also and these items are primarily concerned with the nature of the patient's health problem.

The responses to these items also vary depending on how well known the practitioner is to the patient. The averages scores for these items certainly appears to show a difference depending on how well known the practitioner is to the patient. However no significant statistical difference was found matching the results found in the Podiatry group. Variation is also shown in the Dietician's patient's responses to items in the 'Interest in effect on life, scale which contains the items "Was interested in the effect of the problem on my family or personal life" and "Was interested in the effect of the problem on everyday activities". Both these items rate whether the practitioner considered the patients situation during their consultation but there is no significant difference here depending on how well the patient knows the practitioner.

Comparing scores by professional group, Podiatry or Dietetics, the average scores for each group for the Wong and Law Emotional Intelligence Scale (WLES) and Self-Monitoring scale (SM) are very similar for both Podiatrists (Wong and Law Emotional Intelligence Scale -4.01, Self-Monitoring scale (SM) - 9.93) and Dieticians (Wong and Law Emotional Intelligence Scale (WLES) - 3.97, Self-Monitoring scale (SM) -9.78), but differ greatly for Transformational Leadership Questionnaire (TLQ) scores between the two groups (Podiatrists - 53.73, Dieticians - 87.22).

Table 32: Average scores for Podiatrists and Dieticians

	TLQ Score	WLES Score	SM Score	CARE Score	CCM Score
Podiatrists	53.72	4.01	9.93	34.6	40.6
Dieticians	87.22	3.97	9.78	35.86	40.38

When a one way analysis of variance is run there is no significant difference in self-monitoring scores by profession $F_{(2,21)}$ =0.239, p= .790.

Similarly no significant difference by profession was found for the Wong and Law Emotional Intelligence Scale scores $F_{(2, 21)}$ =1.107, p=.349. Consultation and Relational Empathy (CARE) scores and Consultation Care Measure (CCM) scores were very similar between the two professional groups (Podiatrists: Consultation and Relational Empathy (CARE) - 34.6, 5 Consultation Care Measure (CCM) - 40.6; and Dieticians: Consultation and Relational Empathy (CARE)   35.86, Consultation Care Measure (CCM) - 40.38). A one way analysis of variance confirmed that there was no significant differences by profession in Consultation and Relational Empathy (CARE) score $F_{(1,408)}$ =2.952 P=0.87 or CCM score $F_{(1,340)}$ =0.014 P=0.905.This would seem to indicate that these AHP groups were broadly similar. However a significant difference was found in scores for the Transformational Leadership Questionnaire (TLQ) by profession $F_{(2, 17)}$ =11.422, p= .001. This indicates that to assess the impact of Leadership on Patient Centred Care it may be more instructive to analyse responses from each group separately.

However a significant difference was found in scores for the Transformational Leadership Questionnaire (TLQ) by profession $F_{(2, 17)}$ =11.422, p= .001. This indicates that to assess the impact of Leadership on Patient Centred Care it may be more instructive to analyse responses from each group separately.

3.4 Testing the theoretical model

This section explores the relationships between Transformational Leadership, Flexibility in Responsiveness and Patient Centred Care via the analysis outlined in the figure below:
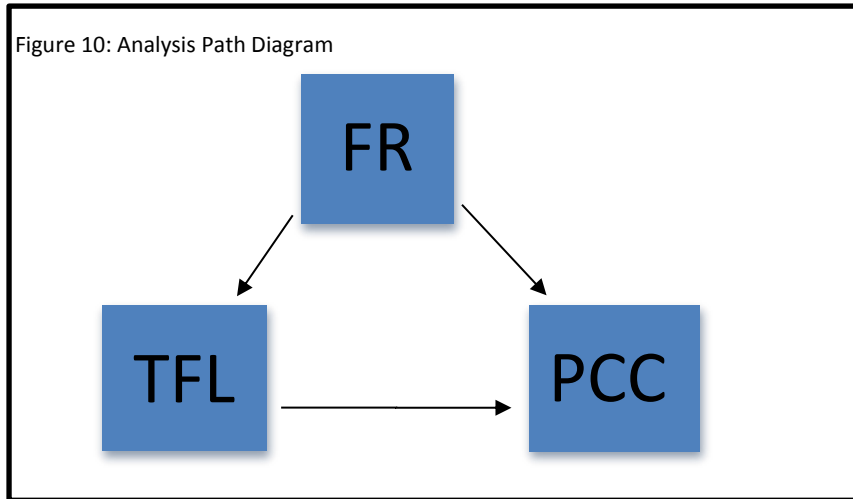
Figure 10: Analysis Path Diagram

The main relationship of interest is between Patient Centred Care (PCC) and transformational Leadership (TFL). However flexibility in responsiveness (FR) may underpin both the skills of transformational leaders and the delivery of effective Patient Centred Care. Thus the other two relationships are being explored to assess the potential role of flexibility in responsiveness as a moderator.

Given a significant difference was found between scores for the transformational Leadership Questionnaire between the Allied Health Professional groups in this study they have been analysed separately to test the theoretical model. This is to ensure that the large differences in Transformational Leadership Questionnaire (TLQ) scores do not skew or obscure the results.

The relationships between these scores will be tested using Pearson Correlations.

3.4.1 Relationships between Podiatry scores

The relationship between the Wong and Law Emotional Intelligence Scale (WLES) and Self-Monitoring scale (SM) scores with Transformational Leadership Questionnaire (TLQ) scores for Podiatrists is given in Table 33 below:

Table 33: Podiatry - relationship between FR and TLQ

		TLQ Score	WLES Score	SM score
TLQ Score	Pearson Correlation	1	0.07	0.04
	Sig. (2-tailed)		0.40	0.57
WLES Score	Pearson Correlation	0.07	1	-0.09
	Sig. (2-tailed)	0.40		0.18
SM score	Pearson Correlation	0.04	-0.09	1
	Sig. (2-tailed)	0.57	0.18	

Here we can see there is a weak negative (-0.09) correlation between the Wong and Law Emotional Intelligence Scale (WLES) and Self-Monitoring (SM) scale measures however this correlation is not significant which is perhaps surprising. The direction is not unexpected as the Wong and Law Emotional Intelligence Scale (WLES) and Self-Monitoring scale (SM) could both be thought of measuring flexibility in responsiveness, but conceptually are effectively the opposite of one another. However the lack of a significant correlation between the two measures does question whether they are measuring the same thing. We can also see from table 30 above that there is no significant correlation between the Transformational Leadership Questionnaire (TLQ) measure and either the Wong and Law Emotional Intelligence

Scale (WLES) or Self-Monitoring scale (SM) proxies for flexibility. This casts doubt on the theoretical relationships proposed.

Table 34 shows the relationships between the Person Centred Care measures Consultation and Relational Empathy (CARE) and Consultation Care Measure (CCM))and Transformational Leadership (TLQ):

Table 34: Podiatry: relationship between PCC and Leadership

		TLQ Score	CCM score	Care score
TLQ Score	Pearson Correlation	1	-.174	-.179[*]
	Sig. (2-tailed)		.054	.029
CCM score	Pearson Correlation	-.174	1	.562[**]
	Sig. (2-tailed)	.054		.000
Care score	Pearson Correlation	-.179[*]	.562[**]	1
	Sig. (2-tailed)	.029	.000	

*. Correlation is significant at the 0.05 level (2-tailed).

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

From this we can see that there is a weak to moderate significant (p=0.029) correlation between Transformational Leadership Questionnaire (TLQ) and Consultation and Relational Empathy (CARE) scores and a similarly weak to moderate correlation between Transformational Leadership Questionnaire (TLQ) and Consultation Care Measure (CCM) scores which is of borderline statistical significance (P=0.054). This helps support the theoretical relationship between Transformational Leadership and Patient Centred Care. Unsurprisingly, there is a significant relationship between the two measures used to assess Patient Centred Care and this correlation counts as a moderate correlation under Dance and Reidy's (2004) categorisation.

Similarly when tested there is also a relationship of borderline significance between the measures of flexibility in responsiveness and the patient centredness scores. For both the Wong and Law Emotional Intelligence Scale (WLES) and Self-Monitoring (SM) scale scales there is a weak correlation with Consultation and Relational Empathy (CARE) of borderline significance (P=0.51). There is also a moderate correlation between Consultation Care Measure (CCM) scores and the Wong and Law Emotional Intelligence Scale *WLES(scores that is of borderline significance (p=0.51.)

Table 35: Correlations between CARE, CCM, WLES and SM

		Care score	CCM score	WLES score	SM score
Care score	Pearson Correlation	1	0.56[**]	-0.05	0.05
	Sig. (2-tailed)		.00	0.50	0.51
CCM score	Pearson Correlation	0.56[**]	1	-0.15	-0.09
	Sig. (2-tailed)	.000		0.05	0.28
WLES score	Pearson Correlation	-.049	-.154	1	-0.09
	Sig. (2-tailed)	0.51	.051		0.18
SM score	Pearson Correlation	0.05	-.086	-0.09	1
	Sig. (2-tailed)	0.51	.279	0.18	

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

3.4.2 Relationships between Dieticians scores

The main relationship of interest is between Patient Centred Care (PCC) and transformational Leadership (TFL). However flexibility in responsiveness (FR) may underpin both the skills of transformational leaders and the delivery of effective Patient Centred Care. Thus the other two relationships (between Leadership and Emotional Intelligence and Leadership and self-monitoring) are being explored to assess the potential role of flexibility in responsiveness as a moderator.

The relationship between the Wong and Law Emotional Intelligence Scale (WLES) and Self-Monitoring scale (SM) scores with the Transformational Leadership Questionnaire (TLQ) scores is given in Table 36.

Table 36: Dieticians WLES, TLQ, SM correlations

		WLES Score	SM score	TLQ Score
WLES Score	Pearson Correlation	1	-0.82[**]	0.23[**]
	Sig. (2-tailed)		.000	.007
SM score	Pearson Correlation	-0.82[**]	1	-0.54[**]
	Sig. (2-tailed)	0.00		0.00
TLQ Score	Pearson Correlation	0.23[**]	-0.54[**]	1
	Sig. (2-tailed)	0.01	0.00	

There is no correlation between the Wong and Law Emotional Intelligence Scale (WLES) scores and Transformational Leadership Questionnaire (TLQ) scores in the Dietician participant group. There are correlations between the Wong and Law Emotional Intelligence Scale (WLES) and Self-Monitoring scale (SM), again as with the Podiatrists an inverse relationship, and between Transformational Leadership Questionnaire (TLQ) scores and Self-Monitoring scale

(SM) scores. The correlation between Transformational Leadership Questionnaire (TLQ) and Self-Monitoring scale (SM) was not found in the Podiatry group, which perhaps points to another difference between the professional groups. Table 37 below shows the relationships between the Person Centred Care measures (Consultation and Relational Empathy (CARE) and Consultation Care Measure (CCM)) and Transformational Leadership (TLQ):

Table 37: Dieticians CARE, CCM and TLQ correlations

		Care score	CCM score	TLQ Score
Care score	Pearson Correlation	1	0.65[**]	0.07
	Sig. (2-tailed)		0.00	0.47
CCM score	Pearson Correlation	0.65[**]	1	0.21[*]
	Sig. (2-tailed)	0.00		0.03
TLQ Score	Pearson Correlation	0.07	0.21[*]	1
	Sig. (2-tailed)	0.47	0.02	

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

*. Correlation is significant at the 0.05 level (2-tailed).

Again, as with the Podiatry group there is a significant correlation between both proxy measures of Patient Centred Care the Consultation and Relational Empathy (CARE) measure and the Consultation Care Measure (CCM) (P<0.001). There is also no significant correlation between the Consultation and Relational Empathy (CARE) measure and Transformational Leadership Questionnaire (TLQ) (P=0.47).

However there is a significant correlation between the Consultation Care Measure (CCM) and Transformational Leadership Questionnaire (TLQ) (P=0.03). This relationship was also found in the Podiatry where a relationship with the Consultation and Relational Empathy (CARE) measure and Transformational Leadership Questionnaire (TLQ) was also found. This perhaps points to differences in how Leadership impacts upon Patient Centred Care between the two allied health professional groups in this study.

Table 38: Dietetics Correlations WLES, SM, CCM and CARE

		WLES Score	SM score	Care score	CCM score
WLES Score	Pearson Correlation	1	-0.82[**]	0.21[*]	0.22[*]
	Sig. (2-tailed)		0.00	0.02	0.02
SM score	Pearson Correlation	-0.82[**]	1	-0.16	-0.17
	Sig. (2-tailed)	0.00		0.07	0.06
Care score	Pearson Correlation	0.21[*]	-0.16	1	0.65[**]
	Sig. (2-tailed)	0.02	0.072		0.00
CCM score	Pearson Correlation	0.22[*]	-0.17	0.65[**]	1
	Sig. (2-tailed)	0.02	0.06	0.00	

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

*. Correlation is significant at the 0.05 level (2-tailed).

From table 38 above we can see that when tested there are significant relationships between the measures of flexibility in responsiveness and the patient centredness scores. For both the Wong and Law Emotional Intelligence Scale (WLES) and Self-Monitoring scale (SM) there is a weak correlation with Consultation and Relational Empathy (CARE) that is statistically significant (P=0.02). Though, unlike the Podiatry group, no significant correlations are found between the Self-Monitoring Scale (SM) and either the Consultation Care Measure (CCM) or Consultation and Relational Empathy (CARE) measure.

3.5 Analysis of TLQ domains and their impact on Patient Centred Care

There are seven scales within the Transformational Leadership Questionnaire (TLQ) used in this thesis. These are described in table 39 below:

Table 39: The 7 Scales of the TLQ

Genuine concern for others	Genuine interest in me as an individual; develops my strengths
Political sensitivity and skills	Sensitive to the political pressures that elected members face; understands the political dynamics of the leading group; can work with elected member to achieve results
Decisiveness, determination, self-confidence	Decisive when required; prepared to take difficult decisions; self-confident; resilient to setback
Integrity, trustworthy, honest and open	Makes it easy for me to admit mistakes; is trustworthy, takes decisions based on moral and ethical principles
Empowers, develops potential	Trusts me to take decision/initiatives on important issues; delegates effectively; enables me to use my potential
Inspirational networker and promoter	Has a wide network of links to external environment; effectively promotes the work/achievements of the department/organization to the outside world; is able to communicate effectively the vision of the authority/department to the pubic community
Accessible, approachable	Accessible to staff at all levels; keeps in touch using face-to-face communication

From Robert J. Alban-Metcalfe and Beverly Alimo-Metcalfe The transformational Leadership questionnaire Leadership & Organization Development Journal 21/6 [2000] 280±296

A full break down of the subscales and items can be found in appendix B.

3.5.1 Subscale analysis of Podiatry data

The table below (table 40) presents the descriptive statistics for the Podiatrists Transformational Leadership Questionnaire subscales. From this we can see there was the least variation in the items "Political Sensitivity" and "Skills, Decisiveness, Determination and Self-Confidence", and "Integrity, trustworthy, honest and open". These are also the three subscales where Podiatrists score their leaders the lowest. Large variation was found in the results for the subscales "Empowers, develops potential", "Inspirational networker and promoter" and "Accessible, approachable" though these scales also show the highest average subscale scores.

Table 40: Transformational Leadership Subscale descriptive stats Podiatry

	Average Score (Scale total)	Standard Deviation
Genuine concern for others	34.00 (68)	9.30
Political sensitivity and skills	9.14 (24)	2.32
Decisiveness, determination, self-confidence	10.58 (32)	3.78
Integrity, trustworthy, honest and open	13.13 (36)	2.17
Empowers, develops potential	22.47 (32)	24.80
Inspirational networker and promoter	32.13 (40)	34.10
Accessible, approachable	21.53 (30)	24.82

To determine how much each of the above Transformational Leadership factors impacted on the level of Patient Centred Care delivered a number of regression analyses were conducted. The two following tables (table 41 and table 42) summarise the means, standard deviations, intercorrelations and alpha coefficients from the regressions comparing Consultation Care Measure (CCM) and Consultation and Relational Empathy (CARE) scores with Transformational Leadership Questionnaire (TLQ) subscale scores for the Podiatry group.

Table 41: Regression summary for Podiatry CARE and TLQ scales

	Mean	*SD*	1	2	3	4	5	6	7	8
1. CARE score	34.11	7.99	-	-	-	-	-	-	-	-
2. Genuine concern for others	35.77	8.01	0.03	-	-	-	-	-	-	-
3. Political sensitivity and skills	9.63	2.36	0.18**	0.12	-	-	-	-	-	-
4. Decisiveness, determination, self-confidence	10.77	3.76	0.07	-0.03	0.84**	-	-	-	-	-
5. Integrity, trustworthy, honest and open	12.59	1.23	0.05	-0.11	0.15	0.04	-	-	-	-
6. Empowers, develops potential	21.91	22.53	-0.20**	-0.13	-0.26*	-0.16	0.49**	-	-	-
7. Inspirational networker and promoter	30.54	31.24	-0.23	-0.23*	0.23**	0.41**	-0.15	-0.09	-	-
8. Accessible, approachable	15.97	10.09	0.09	-0.31*	-0.53	-0.15	-0.08	-0.00	-0.18**	-

*$p < .05$, **$p < .01$ $R^2=0.145$

Table 42: Regression summary for Podiatry CCM and TLQ scales

	Mean	*SD*	1	2	3	4	5	6	7	8
1. CCM score	40.18	16.26	-	-	-	-	-	-	-	-
2. Genuine concern for others	36.40	7.66	0.11	-	-	-	-	-	-	-
3. Political sensitivity and skills	9.70	2.33	0.25**	0.10	-	-	-	-	-	-
4. Decisiveness, determination, self-confidence	10.73	3.83	0.19*	-0.11	0.84**	-	-	-	-	-
5. Integrity, trustworthy, honest and open	12.53	1.20	0.21*	-0.12	0.14	0.04	-	-	-	-
6. Empowers, develops potential	21.08	20.94	0.06	-0.15	-0.25**	-0.14	0.47**	-	-	-
7. Inspirational networker and promoter	31.33	32.14	0.18*	-0.27**	0.23**	0.42**	-0.15*	-0.08	-	-
8. Accessible, approachable	15.48	7.87	-0.09	-0.25**	-0.0.	-0.12	-0.04	0.01	-0.21*	-

*$p < .05$, **$p < .01$ $R^2=0.23$

Descriptive statistics, reliability estimates and intercorrelations are displayed in the tables above. The correlations indicate that for the Podiatry group Consultation and Relational Empathy (CARE) scores the subscales 'political sensitivity and skills' $\beta1 = 0.18$, SE = 16.24, p < 0.01 and 'Empowers, develops potential' $\beta_1 = -0.20$, $SE = 16.24$ $p < 0.01$ were significant at the P<0.01 level. This indicates that for the Podiatry Group a leader who was able to empower staff and help them develop was associated with a weak positive increase in patient satisfaction scores measured using the Care and Relational Empathy Scale (CARE). It is also interesting that "political sensitivity and skills" was also found to be significant, albeit again at a weak level, given that the Podiatry service featured in the study was going through a service re-organisation. This possibly reflects the importance and the need of managers and clinical leaders to help manage change within the NHS.

For the Podiatry group Consultation Care Measure (CCM) scores the correlations indicate the 'Decisiveness, determination, self-confidence' $\beta1 = 0.19$, SE = 7.06, p < 0.05, 'Integrity, trustworthy, honest and open' $\beta1 = 0.21$, SE = 7.06, p < 0.05 and 'Inspirational networker and promoter' $\beta1 = 0.18$, SE = 7.06, p < 0.05 were significant at the P<0.05 level with 'political sensitivity and skills' $\beta1 = 0.25$, SE = 7.06, p < 0.01 significant at the P<0.01 level. Here the results differ slightly from the Consultation and Relational Empathy (CARE) subscale analysis results. This reinforces the decision to use both the Consultation and Relational Empathy (CARE) measure and the Consultation Care Measure (CCM) in this study as both appear to have addressed different aspects of how Transformational Leadership affects Patient Centred Care.

3.5.2 Subscale analysis of Dieticians data

The Table below (table 43) presents the descriptive statistics for the Podiatrists Transformational Leadership Questionnaire subscales. From this we can see there was very little variation in the subscale scores between Dieticians. Particularly when the results for Podiatry are considered. This could be because of the small sample size or because the nature of the Dietetics service means Leadership is more coherently and consistently experienced by Dieticians. It could also show us that the impact of the Podiatry service reorganisation seriously affected some staffs views of their clinical leaders.

Table 43: transformational Leadership Subscale descriptive stats Dietetics

	Average Score (Scale total)	Standard Deviation
Genuine concern for others	52.11	8.9
Political sensitivity and skills	16.78	3.19
Decisiveness, determination, self-confidence	18.33	6.63
Integrity, trustworthy, honest and open	12.67	1.58
Empowers, develops potential	15.88	0.99
Inspirational networker and promoter	21.43	2.30
Accessible, approachable	14.88	2.17

To determine how much each of the above Transformational Leadership factors impacted on the level of Patient Centred Care delivered a number of regression analyses were conducted. The two following tables (table 44 and table 45) summarise the means, standard deviations, intercorrelations and alpha coefficients from the regressions comparing Consultation Care Measure (CCM) and Consultation and Relational Empathy (CARE) scores with Transformational Leadership Questionnaire (TLQ) subscale scores.

Table 44: Regression summary for Dietician CARE and TLQ scales

	Mean	SD	1	2	3	4	5	6	7	8
1. CARE score	34.41	2.26	-	-	-	-	-	-	-	-
2. Genuine concern for others	47.10	10.53	-0.12	-	-	-	-	-	-	-
3. Political sensitivity and skills	18.50	9.55	-0.23	-0.52**	-	-	-	-	-	-
4. Decisiveness, determination, self-confidence	18.80	4.20	-0.30	0.66**	0.24**	-	-	-	-	-
5. Integrity, trustworthy, honest and open	13.46	2.28	-0.09	-0.81**	0.90**	-0.10	-	-	-	-
6. Empowers, develops potential	14.69	1.15	0.03	-0.02	-0.69	-0.76	-0.53	-	-	-
7. Inspirational networker and promoter	20.10	2.20	0.70	0.28	-0.48**	-0.37	-0.58**	0.82	-	-
8. Accessible, approachable	13.70	5.83	0.03	-0.33**	-0.47**	-0.92**	-0.24*	0.95**	0.70**	-

*$p < .05$, **$p < .01$

Table 45: Regression summary for Dietician CCM and TLQ scales

	Mean	SD	1	2	3	4	5	6	7	8
1. CCM score	36.17	17.48	-	-	-	-	-	-	-	-
2. Genuine concern for others	46.83	10.74	-0.06	-	-	-	-	-	-	-
3. Political sensitivity and skills	18.57	9.79	0.04	-0.52**	-	-	-	-	-	-
4. Decisiveness, determination, self-confidence	18.72	4.26	-0.07	0.66**	0.25*	-	-	-	-	-
5. Integrity, trustworthy, honest and open	13.5	2.32	0.03	-0.81**	0.90**	-0.10	-	-	-	-
6. Empowers, develops potential	14.69	1.16	0.07	-0.02	-0.69**	-0.76**	-0.53**	-	-	-
7. Inspirational networker and promoter	20.06	2.18	0.11	0.23*	-0.48**	-0.36*	-0.59**	0.81**	-	-
8. Accessible, approachable	13.72	2.28	0.09	-0.33**	-0.47**	-0.92**	-0.24*	0.95**	0.69**	-

*$p < .05$, **$p < .01$

Descriptive statistics, reliability estimates and intercorrelations are displayed in the tables above. The correlations indicate that for the Podiatry group Consultation and Relational Empathy (CARE) scores no Transformational Leadership Questionnaire (TLQ) subscales were statistically significant. For the Podiatry group Consultation Care Measure (CCM) scores the correlations indicate no Transformational Leadership Questionnaire (TLQ) subscales were statistically significant.

3.6   Summary of results

This chapter has provided summaries of the statistical results obtained from the patient experience and staff surveys that were disseminated in the NHS Greater Glasgow and Clyde Health Board Area.

It reported the statistics from the staff survey measures which were comprised of the Transformational Leadership Questionnaire (TLQ) and the measures that were acting as proxies for flexibility in responsiveness: the Wong and Law Emotional Intelligence test (WLES) and the self-monitoring scale (SM). There was wide variation in Staff scores for the Transformational Leadership Questionnaire (TLQ) but there was markedly less variation in the scores relating to 'flexibility in responsiveness' in participants. When the data was compared in terms of the geographical quadrants of NHS Greater Glasgow and Clyde no significant differences were found.

When the data was interrogated by profession and by quadrant we can see that there appeared to be a divide in Transformational Leadership Questionnaire (TLQ) scores between Clyde and West (49 and 47 respectively) and East and South (58 and 59 respectively). With the scores from Clyde and West showing a greater degree of variation between staff participants' scores. However, this divide was ultimately not found to be statistically significant. There were no substantial or statistically significant differences noted between quadrants in the Dietetics participants data. The average Dietetics staff Transformational Leadership Questionnaire (TLQ) score (56) was higher than the average score seen from participants in the Podiatry group (54). This could indicate there are significant differences between Leadership in Podiatry and Dietetics within NHS Greater Glasgow and Clyde.

The results from Cohen's κ show that both groups leaders self-ratings of Transformational Leadership and staffs inter-rater ratings showed fair to good levels of agreement. Meaning we can be reasonably confident that any major issues associated with Common Method Variance are not present in this study.

As well as looking at the Consultation Care Measure (CCM) and Transformational Leadership Questionnaire (TLQ) as global constructs this chapter also looked at the subscales within these measures to explore if any subtle differences could be discovered. When comparing Staff Transformational Leadership Questionnaire (TLQ) subscale scores and patient group demographics no statistically significant associations between age, gender or ethnicity were found for either the Podiatry or Dietetics participants. There was little variation between the Podiatry or Dietetics participants Consultation Care Measure (CCM) subscale scores. There was also no significant difference in scores on the patient experience measures that could be attributed to the amount of time that the Allied Health Professionals spent in the consultation with the patient. Though if the patient felt that the Allied Health Professional knew them then that lead to a small statistically significant improvement in scores. Highlighting perhaps the importance of continuity of care within health services.

When Podiatrists' Consultation and Relational Empathy (CARE) scores (as completed by a sample of their patients/clients) were compared with Transformational Leadership Questionnaire (TLQ) subscale scores, significant associations were found for the 'political sensitivity and skills' and 'Empowers, develops potential'. Though the strength of these associations was at quite a weak level. The Podiatrists Consultation Care Measure (CCM) scores also showed there were significant weak associations with the Transformational Leadership Questionnaire (TLQ) subscales 'Decisiveness, determination, self-confidence', 'Integrity, trustworthy, honest and open' and 'political sensitivity and skills'. That both patient experience measures showed significant associations with different aspects of the Transformational Leadership Questionnaire (TLQ) helps to justify the use of both measures as opposed to one or the other. No significant results for any of the subscales were found for the Dietetics group.

For the Podiatry group no significant relationship was found between the proxy measures for 'flexibility in responsiveness' (The Wong and Law Emotional Intelligence Scale (WLES) and Self-Monitoring (SM) scales) and Transformational Leadership. This casts doubt on the thesis's theoretical model as, using these proxy measures, no significant relationship between 'flexibility in responsiveness' and Transformational Leadership can be confirmed statistically. However, there is a significant weak to moderate relationship between Transformational Leadership Questionnaire (TLQ) and Consultation and Relational Empathy (CARE) scores and a similarly weak to moderate correlation between Transformational Leadership Questionnaire (TLQ) and Consultation Care Measure (CCM) scores which is of borderline statistical significance.

Similarly for the Dietetics groups no significant relationships were found between the 'flexibility in responsiveness' proxy measures and Transformational Leadership. Further supporting rejecting the theoretical relationship that 'flexibility in responsiveness' acts as a moderating variable between Leadership and Patient Centred Care. There is no significant relationship between Consultation and Relational Empathy (CARE) scores and the Transformational Leadership Questionnaire (TLQ) scores for Dietician participants. However, there is a significant relationship between Consultation Care Measure (CCM) scores and Transformational Leadership Questionnaire (TLQ) scores.

4 CHAPTER FOUR: Qualitative analysis of Study 2 findings.

This chapter discusses the findings from interviews conducted with staff in NHS GG&C.

Individual semi-structured interviews were conducted with members of participating healthcare teams across the four quadrants within the health board area. These interviews were used to identify the elements of Leadership and Patient Centred Care that have most salience with practitioners.

The interviews explored:

   I.   Participants' perceptions of Leadership behaviours, and how the participants defined good and bad Leadership in practice

   II. Participants' conceptualisations of Patient Centred Care, what it entailed and how it was achieved

   III. The barriers and facilitators participants perceived as impacting on effective Leadership and on their ability to provide high quality Patient Centred Care.

The findings from this study are presented according to the themes that were developed through framework analysis. These themes are then presented in relation to the two main concepts of this thesis, namely Patient Centred Care and Leadership. Both concepts were identified as being influenced on two levels: via systemic factors and via individual level factors. The sub-themes are presented in relation to both systemic and individual level factors which were identified as impacting on AHPs abilities to deliver Patient Centred Care and to impact on Leadership. Quotes have been attributed to participants in square brackets following the text of the quote. A 'P' indicates Podiatrist and 'D' - Dietician M - denotes quadrant manager, this is followed by the participant number and quadrants are labelled Q1, Q2, Q3 and Q4. So **[D3QS]** indicates the third Dietetics participant who works in the Southern quadrant of NHS GG&C. Where the interviewers question is included this is highlighted using **INT:** participants responses are indicated using **PRT:** any quote given in inverted commas is drawn directly from participants.

4.1 Leadership

This study explored whether there was a direct or indirect link between clinical Leadership and achieving the delivery of high quality Patient Centred Care in allied health professional practice. Transformational Leadership has been chosen as the model of Leadership used in this thesis. Transformational Leadership theories (REFS) differ from traditional competency based approaches (REFS) because they emphasise emotions and values over 'rational' processes as well as acknowledging the importance of symbolic behaviour and the role of the leader in creating meaning.

In the interviews I asked participants for examples of 'good' and 'bad' Leadership as well as exploring some of the values they felt were associated with Leadership. As the interviews progressed it became apparent that there were two Leadership processes at work in allied health practitioner practice within the two groups involved in this study: Leadership and management. When we look at these two broad categories we can see that they correspond well with the two narratives that emerged from the Patient Centred Care interview data, systemic and individual.

These are to an extent mirrored in the way participants understood Leadership. The participants drew a distinction between Leadership and management with Leadership operating at the level of the individual and management being concerned with systemic or corporate issues.

There was markedly more focus on the individual level and on good and bad Leadership behaviours and communication. Participants also made reference to their own autonomy within the context of working in a team and supporting one another informally and formally.

Systemic issues affecting Leadership tended to focus on negative conceptualisations of bureaucracy and how management can sometimes appear distant.

There was far greater commonality between professions in how they viewed Leadership and management so the following sections are not analysed by profession as above, but a pooled analysis of all the interviews. In understanding how Leadership and management exist in the

context of individual and systemic narratives it is important to understand the nature of the distinction participants draw between the two. Following on from that we can then understand and explore further the systemic and individual factors participants reported affecting Leadership and it's relation to Patient Centred Care.

Figure 12 shows the themes that were developed from the interviews relating to Leadership.

Figure 11: Diagram of Leadership themes in interviews
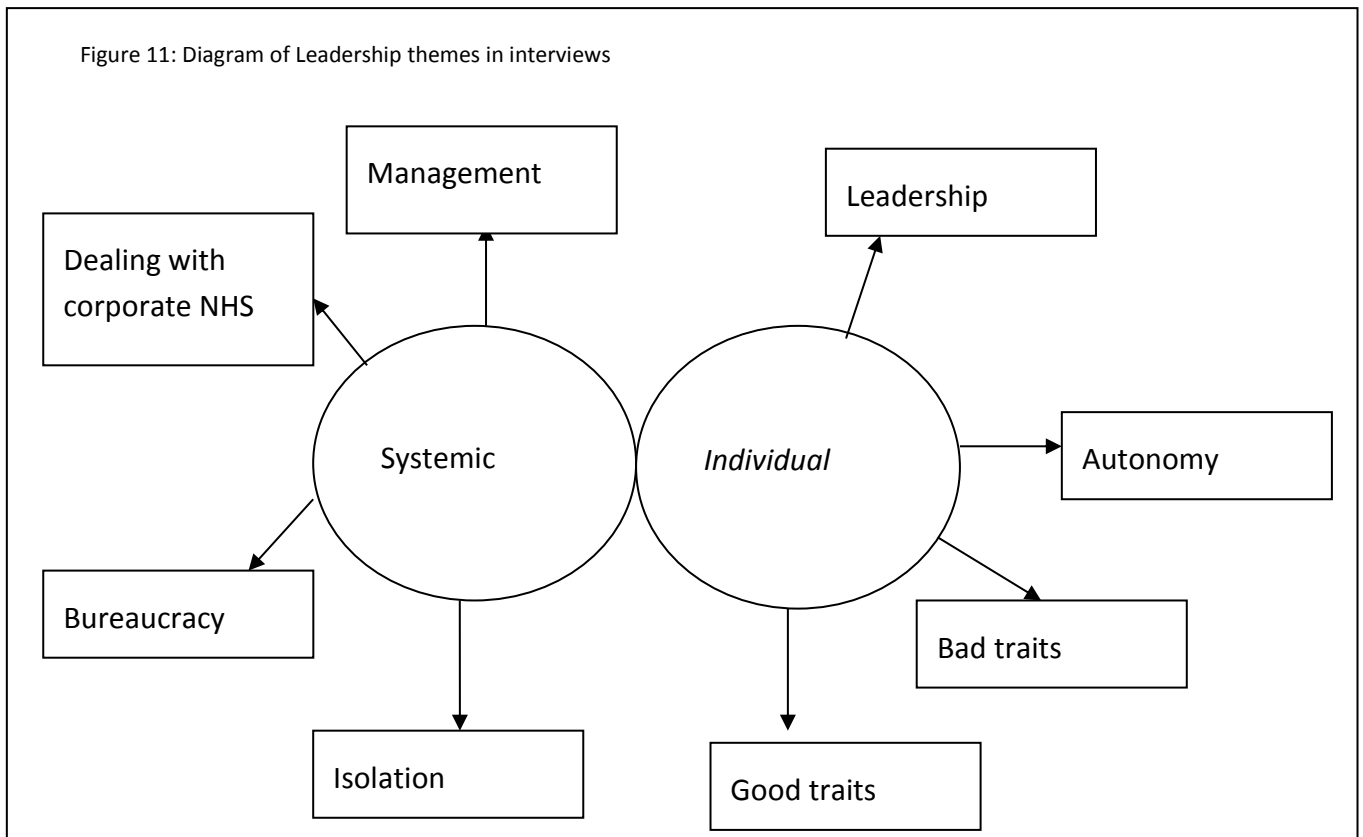
4.1.1 Distinction between Leadership and management

Systemic and individual issues became apparent when Podiatrists were asked to consider the tension between conceptualisations of Leadership and managerialism. However by focusing the participants on the idea that there could be a difference or a tension between the two they were able to identify and highlight differences between the two roles or concepts. This can be seen as an illustration of the tension between the systemic and individual pressures that can impact upon the provision of Patient Centred Care and effective Leadership: A tension between managerialism, a need to manage finite and sometimes sparse resources' effectively; and Leadership, which was viewed more idealistically and driven by the value of putting the patient first and supporting staff to do so. In this sense Leadership appeared to be the art of compromise between reaching for the ideal system and allowing staff to perform in a system that will likely never be ideal.

> **INT:** You mentioned earlier the two hats of management and Leadership and I'm coming back to it now because I'm just interested to see if you think if there's a distinction between Leadership and management?
>
> **PRT:** I think there is because you don't have to be a manager to be a leader I suppose. I think quite often we'll have different bandings within a team and for different aspects of the job or what they do, there might be the lowest banding person who's the best person for the role and they take kind of ownership and Leadership on it. So I think Leadership is not always a management job or a management role. It's a big aspect of management to be leaders and effective leaders, but I think anybody can be a Leadership role within a team or whatever within a particular piece of work. Yeah, so there is a distinction there, it's not the same, management isn't necessarily Leadership and vice versa.
>
> **[PM2]**

Here a participant frames the Leadership and management question in a way that can be framed as individual versus systemic. Behaviours that are associated with Leadership occur at the individual level and do not rely upon title or position. The type of Leadership described here fits with the definition of transformational Leadership (Judge & Piccolo, 2004) and suggests a flat hierarchy, where staff can and are trusted to be autonomous and take ownership of their practice and issues arising.

Leadership is seen as the domain of the individual and team management is seen as dealing with the systemic aspects of the corporate NHS. The following quote indicates that the Podiatrist participants associated management more with systemic concerns as well as how Leadership and management should interact:

> **INT:** So what specifically is to your mind the difference between management and Leadership?
>
> **PRT:** I think management I suppose is really just making sure that a lot of kind of... the corporate part of your job is done, the day to day running of an operation/running of a department is complete, everything's safe, all your health and safety stuff, all your HR stuff, all that is all there. I think Leadership is more akin to backing that up I suppose and ensuring that staff are on board with the philosophy of what you're trying to do, you know, there's a reason for policies and guidelines to be in place and we have to make sure that certain aspects of it   are completed and done, but I think how you do that is done by Leadership skills and by example or explaining this is why it's done, you know, this is the best practice, evidence based practice, this is why we do it and yes I think that's the kind of distinction.

[PM2]

The above quote arguably also shows that, at some level, traditional ideas of what leaders should be affect and mold participants' expectations of leaders. This is more clearly seen in the following quote where Leadership is seen as something inspirational and motivational:

INT: D'you think there's a distinction between Leadership and management?

PRT: Yeah I think there is. Leadership for me is basically selling the idea, getting people with you, to get people on the same page as you to get that whole mindset, hearts and minds, cultural buy in sort of thing. Management to me is old school 'right we need to do this so just get it done', you know, old style school management if you like where the manager was the manager and whatever he said or she said was gospel therefore it had to be done. There are still times where things have to be done anyway and that will never change, there are things that are non-negotiable in terms of targets we need to meet, but it's how we have that level of communication to meet those targets. It's not a case of 'do it or else', it's a case of 'well if you can't do it, why can't you do it, what can we do to help you achieve that, is it because of resources, is it because of clinical set up, is it because of bla, bla, bla, let's have a discussion about it and let's see how we can manage that process' rather than just saying 'too bad, get it done'. So it's more getting people to buy into the ideal, buy into the process, buy into the service, buy into your mindset and buy into the corporate system of what you're trying to sell to me is much more about Leadership rather than the 'thou shall do'.

[PM1]

Management is associated primarily with a positional or hierarchical leader - one who must be obeyed. This 'totalitarian' and authoritarian style of Leadership is viewed negatively. This "old school" style of management is most associated with higher levels of management and more corporate or systemic aspects of NHS practice. However this association did not seem to be that strong in most of the participant's interviews. The association was presented as more just the 'way things are' and the nature of the NHS as complex and hierarchical organisation than as a complaint or protest. Where management is associated with issuing orders, through policy and targets Leadership is concerned with motivation and inspiration.

Leadership is associated with getting individuals 'on board' with management decisions and supporting staff to meet common goals. This is further supported by the returning to a previous extract:

"I think there is because you don't have to be a manager to be a leader I suppose. I think quite often we'll have different bandings within a team and for different aspects of the job or what they do, there might be the lowest banding person who's the best person for the role and they take kind of ownership and Leadership on it. So I think Leadership is not always a management job or a management role. It's a big aspect of management to be leaders and effective leaders, but I think anybody can be a Leadership role within a team or whatever within a particular piece of work. Yeah, so there is a distinction there, it's not the same, management isn't necessarily Leadership and vice versa."

[PM2]

The idea that anyone can be a leader is one that ties in with notions of professional autonomy that staff participants expressed in the interviews (See Section 4.9 for further discussion of this issue).

4.1.2 Systemic factors affecting Leadership

In terms of addressing issues with current management and Leadership professionals in both groups would talk about managers and structures removed from their day to day work identifying managements role as being 'behind the scenes'.

> "Yeah, yeah it's making sure that things are, I suppose, by the book and things are running effectively up there, whereas when it's on the ground managerial, that's just making sure things are running efficiently and effectively on the ground, but with that   there's a lot of behind the scenes work that needs to be done which is probably what the higher up managerial side tend to do."
>
> **[P2QN]**

Higher levels of management were associated with official meetings and communication via email as opposed to face to face:

> "I mean, managers tend to do all the kind of finance I think and employing people and keeping the service running and sending out emails about policies and things that you follow, but I don't really have an awful lot of one to one, I mean, it's not as if... we have meetings occasionally to tell us of different changes and different things, but actually today, I mean, I didn't need the manager at all, you know, there's no communication with him because you just get on with the role as a Podiatrist."
> **[P8QN]**

They would identify problems as coming from higher up the NHS management and administration hierarchy with which they had little direct contact. However, clinicians recognised that although management seemed removed from day to day practice it played an important role in how the service was run.

> "A lot of the Leadership higher up tends to be more of the sort of paperwork side of things and the red tape side of things that they cover, so for that reason organisation is really important as well." **[P2QN]**

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Participants referred to management and Leadership having to work with-in their own set of constraints when talking about attendance of training courses and personal development. Although staff felt management were very supportive of training and development they acknowledged that pressures on the service were a bigger priority.

INT: And if you wanted to go on a training course or explore some aspect of professional development, is that a fairly easy process within the clinic?

RES: No. No it's difficult to... I think at the end of the day it comes down to the budget and things, so (1) the cost for the course and also they then back fill for you not being in attendance in your clinic as well, they both play big parts on it, so I don't think it's not through lack of them wanting us to do the course, it's other factors that prevent it.

[P1QS]

Dietician participants identified the nature of the Dietetics service in the community as the main systemic factor that affected Leadership. As the health board covers a large area many Dieticians work mainly in settings without Leadership on-site:

INT: So Leadership isn't necessarily an on-site thing?

PRT: Well it is an on-site, I mean, we share an office with... X is in an office with us, yeah, I mean, Leadership, the head of service just happens to be based in this health centre, you know, she really... you know, she covers all the health centres so it's really... most community Dieticians you'll find won't have our dietetic manager within their site but you'd probably get the team lead would be on site in one of the few health centres that we cover, it depends

[D6QNE]

One Dietician indicated that not being located in the same place as the rest of your team it could lead to issues with communication and structured meetings:

"I was in a team, but not really in the team; I was a bit out; I'd been put in a different team and...but I was very...I was doing not lone working but I was part of Glasgow but not really part of Glasgow, and so I was getting left out of...you know, again, it's poor communication. It really came down to poor communication; wasn't told about meetings; would only get...meetings were arranged at difficult times when I couldn't make them or wasn't told about meetings. I had annual leave and then they would change a meeting and it would be first thing on the day I'd get back from holiday; just poor communication or no communication."

[D2QNE]

The Dietician was left out of communications between the team that meant they missed meetings but they also lacked the social support of their teammates they had previously had. They go on to describe how this lack of communication and distance between them and the rest of their team had a negative impact on their work and stress levels.

PRT: ...if you were upset about something or you kind of really need somebody to be able to talk it through, and that just wasn't possible with that at all. Just because of the way it's quite different in the hospital setting and the Dieticians are all...they don't have their own base; they have to move around, and so you can't always get them, and again, it comes into communication. But it's very difficult to track somebody down, and if that's your leader, and there's nobody underneath that you can then talk to then that can be quite stressful.

INT: Okay, so was there an issue with physical distance between yourself and the rest of the team in that case or...?

PRT: Yeah, it was just that purely I was with one team and then there was a big redesign and I was put into a different team, We were all put into different specialties and the rest of the renal specialty was in Glasgow, but all the Dieticians rotated, so they all were all over the city. So it went from people having a base to then not having a base, and I went from working in quite a close team location-wise to then being in a Glasgow specialty team but not very good communication and couldn't really attend very many of the meetings. So, I didn't feel like I really belonged anywhere.

[D2QNE]

The Dietician lost a close team location which lead to them not feeling like they belonged to either their old service or the one they had been moved to.

Another Podiatrist experienced issues relating to not knowing what the role of team leader was for and preferred to just keep in contact with their manager as there was a pre-existing relationship there:

"Yeah we have a team leader as well. Funnily enough I tend to go to the manager before I go to the team leader, and I think that's just kind of history because we didn't used to have a team leader and this team leader is kind of an extra... not an extra, but another layer, and before we used to have just the manager and you would just, you know, email the manager or whatever, but now this team leader... I'm finding it quite difficult sometimes to direct issues to them, you know, I don't know how to get round that but I do find that sometimes that the team leader is not really... I don't know, I don't know what their role is sometimes."

[P6QNE]

Although this Podiatrist often approached their manager directly instead of their team leader most participants in either profession saw the team leader as a closer figure and a first point of contact and management as removed from that:

> "Well, I suppose, yes, I suppose, in the NHS we talk about our team leads as being our day to day managers and management as being the organisation. I suppose, that's how I would, maybe the terms are wrong but that's what we would, we're always getting told we're, the team leads are, we've to do this, we've to do that, and that's coming from higher management. So, we probably see them as being out of the control picture or I do anyway. The people that sit in offices in the business level and then the team leads as being more the ones that are on site and involved in the clinical, maybe they're not doing so much clinical themselves, only keeping their hand in clinically but they are managing the clinical people or leading the clinical teams and then the management being the business managers and directorate managers and things."

> **[P2QW]**

Here again we see that higher management is associated with a more authoritarian approach to management and again their distance from clinical practice is highlighted. Although this view was not held by all participants, as some felt that communication with management was more of a two way street.

> **INT:** Okay. Say there was a suggestion that you or a colleague wanted to make related to patient care or service design, would you feel that you could raise that quite comfortably with your team leader/with management?

> **PRT:** I suppose it would depend on what it was that you wanted to sort of bring up, I think you'd have to sort of gauge that before you spoke about it because our service underwent a big redesign sort of 18 months/two years ago and everyone at that point when we underwent that redesign, we were all able to sort of fill out sort of ideas or concerns or issues that we had anonymously and

send them to management, and then they were discussed at those meetings and also within emails as well.

INT: And how involved did you feel as a clinician within that process?

PRT: Fairly well involved I think, well I personally felt that they did listen to the issues that were raised, I mean, obviously not everything that was put forward or people had thought were good ideas were put forward and implemented in the redesign, but I think definitely it was taken into account.

[P1QS]

Participants in both dietetic and Podiatry groups felt that management was remote and although it was necessary to carry out important bureaucratic functions they felt that its effectiveness could be constrained by other factors. Participants felt that this sometimes gave rise to poor communication and could lead to feelings to not belonging within the organisation. There was also a feeling that higher management was more associated with more authoritarian styles of Leadership and that this could lead to an atmosphere of 'us and them'.

4.1.3 Individual factors affecting Leadership

Participants were able to identify characteristics or traits of negative Leadership and positive Leadership. Positive traits included:

Openness to discussion and to other people's views

> **INT:** Alright, so thinking more abstractly about Leadership or management as that might be more relevant to your situation, what sort of behaviours do you associate with good Leadership?

> **PRT:** Openness, I think communication, like, being very kind of open to discussion and open to other people's views and not be 'right this is the way we're going to do it', you know, just kind of more like 'how are you getting on?' you know, just open to a suggestion which I think our new manager has definitely been open for, you know, sometimes you feel as if you're giving him things to think about, you know, which is quite good, I mean, that's the way it should work that we're all kind of working together and giving each other ideas and not being dogmatic.

> **[P2QW]**

Being supportive, fair and having good communication skills:

> **INT:** I suppose I'm thinking of in terms of if an issue arises either with practice or with... I don't know, I suppose the example that comes to mind is with stress or with something on those lines, is there support from Leadership or management in that regard?

> **PRT:** Yeah, very much I think with my direct manager anyway, she's very sort of open to you going in to speak to her about things like that and would encourage you to actively speak up in situations like that and she would support you, whether that be a sort of reduced clinic load or someone else taking on part of your workload, definitely.

INT: So thinking in those terms and in formal terms, I mean, what sort of things d'you think contribute towards making a good leader or good Leadership?

PRT: I think probably communication and knowing sort of what's going on within your department, know our staff's sort of strengths and weaknesses and encourage them clinically and encourage them to progress and explore things in their career. I think that makes a good leader and also someone that's fair towards everyone.

[P1QS]

Having listening and negotiation skills and being able to relate professionally to staff.

INT: What sort of behaviours do you associate with good Leadership?

PRT: I think listening skills I suppose, being able to kind of listen and understand what your staff are saying, positive and negative, and being able to relate to that I think. I suppose negotiation skills, I think you need to be able to be aware that they're not always right and you need to negotiate and get support and things done that way. I think you've got to be quite assertive sometimes but the impression I think you've got to lead by example, so you have to be kind of, you know, maybe not talk a game but as near as you can be to it I think professionally.

[P4QS]

The idea that a leader has to be able not only to 'talk a good game' but has to lead by example ties in with other views expressed by the participants that leaders and managers were most effective when they had relevant clinical experience.

> **INT:** Okay, so in terms of understanding, d'you think at that level it helps to have a leader who has clinical experience or who is in the same profession?

> **PRT:** Yeah, yeah I would say it's important for them to be in the same profession. Having clinical Leadership... experience might not be necessary but, you know, even just having an interest in that sort of thing, and I think some people, their own personality sometimes, they do have that, you know,
> **[P2QW]**

In the above quote having clinical experience is considered to be even more important than having clinical Leadership experience and good Leadership was tied into how close to clinical practice the leaders were. It was generally felt that a leader who had experienced first-hand clinical practice would be better placed to lead or manage staff. To understand where intervention or support might be warranted and to know when they could comfortably take a back seat. Practitioners saw this as their leaders trusting them to be able to do their jobs and that a "hands off" approach indicated there was an implicit trust in their abilities as practitioners and health professionals. Negative traits of behaviours mentioned by the participants included:

Being only interested in power:

> Well, I suppose this sounds horrible, but being on sort of a power trip probably, you know, sometimes you find that because a person can just have a one-way destination they don't really have the same sort of care about the profession or the job that's getting done, it is just a case of making themselves look good so that they can get somewhere in life.
> **[P2QN]**

Authoritarian Leadership style and being untrustworthy

Somebody that's very bossy, that talks an awful lot and doesn't really say very much, somebody that you can't trust, that goes behind your back and talks about you or talks about other people and gives you the impression they know   something but they can't... they know stuff but they're not telling you the whole story, something like that, just poor communicator and untrustworthiness.

[D2QNE]

Someone who lacks integrity and communicates inefficiently or inappropriately with staff:

I think someone who doesn't listen, somebody who isn't aware of any issues that are going on and they think they're doing their job correctly but actually they're probably not. I think someone who's dishonest obviously, you know, if they're kind of telling half-truths or telling one person one thing and somebody else another, I think that's quite important to be consistent. Obviously just bad behaviour generally, you know, shouting and screaming all that kind of thing is just totally unacceptable, you know, it's your responsibility to treat people properly. Just being responsible I think, and integrity. I think that's the biggest thing so anybody who's not displaying these kind of things is bad Leadership. Not following through, not getting back to people, that kind of thing.

 [P4QS]

Being more concerned about statistics than patients:

"Being more concerned with waiting lists and statistics than safety of patients. Taking on an unfair caseload or taking on more patients when you don't feel you've capacity to take them on. You're going to feel stretched with every patient and not being able to give them the proper care that you need to give that patient. So, if there's pressure coming, which obviously you can get from your team lead but they might be getting it from further up, that more targets have to be met, more than caring whether that patient's getting the level or reviewed as often as you should be reviewing them. Because you can maybe get that where you've got a certain number of patients and you're reviewing them at   the time that you feel you need to review them but if you are told to take on new then do that. Then the patient that you would have been reviewing has to wait because you're taking on somebody else new so you're not then giving anybody particularly great care. Not having the time for any of the patients, the new ones or the existing patients."

[P2QN]

And a lack of support:

"The biggest thing is support. Bad Leadership, I think if the support's not there then everything else... it's like a domino effect, everything else will fall with it. Support's important, also having that sort of understanding about the job, so you know where you had said about it being someone who's part of that post or who actually has a background   of that profession, that's very important as well cause then only then will they understand what the issues are."

[P2QN]

However none of the interviewees gave the impression that they felt negative traits were reflected in their current immediate team Leadership or management. Some were able to recall instances within the health service where they had experienced poor Leadership or management:

"My experience, not just the NHS? Okay, I mean, there is that sort of…it's a very autocratic Leadership and a Leadership borne by fear, I guess, as well. Because that's a big thing both in the NHS now. I guess, well, my own experience, this is only my personal experience of maybe working with somebody, not in this role, years and years ago. I mean, it was dependent on the power. And that's interesting. And having that very autocratic manager style, and so on and that. I don't think that's good Leadership at all, I really don't, not listening to people's views or tick boxing and actually not listening to people's views and making decisions that maybe concern the team. That has happened. And then what happens is, the team are not involved in it and they think, you know, now   there's   the   whole   change   management concept, well, why would they be involved. "

[D4QSE]

While practitioners felt that good Leadership only had an indirect effect on Patient Centred Care they felt that bad Leadership could have a direct effect:

INT: So, it's in terms of the impact of a negative Leadership like that is I suppose it sounds like, it's not necessarily a major thing but there could be lots of little things that build up and then there's a, it lowers the atmosphere and the mood with everything, yes.

PRT: Yes. I just think most people have gone into the healthcare profession because they want to do a caring role so you do probably always try and do the best for that person you can but if you're getting particularly unsupported and, well, pushed to do extra things there's only so much people can take as well so you start pushing back I suppose and not, saying,

well, it can wait until I'm in the next day or whatever and then thinking, well, it's not, I mean, you would look at something that was urgent and leave it but if it was something that would have been nice if that person got the phone call back then are you going to keep yourself late to do that if you don't feel particularly rewarded or thanked for it.

[D4QSE]

Practitioners value a leader that respects their individual professional autonomy. There was far more of a focus on individual autonomy with regard to how Dieticians felt they should be treated by their leaders.

    INT: What sort of things d'you think that the manager or management can do to help you or to support you in delivering Patient Centred Care or within daily practice?

    PRT: I don't know [laugh] I mean, cause I'm quite independent, I mean, we're Podiatrists, we're quite independent, we just get on with our own work, I mean, managers tend to do all the kind of finance I think and employing people and keeping the service running and sending out emails about policies and things that you follow, but I don't really have an awful lot of one to one, I mean, it's not as if... we have meetings occasionally to tell us of different changes and different things, but actually today, I mean, I didn't need the manager at all, you know, there's no communication with him because you just get on with the role as a Podiatrist.

    [P6QNE]

This autonomy is something managers in Podiatry have encouraged:

INT: Okay. You mentioned there that one of the things you can sort of do, because there are sort of 40 clinicians at various sites that you're overseeing, the one thing that you do is try to encourage teams within their clinics to sort of spot issues and sort of help each other out...

PRT: Yes absolutely.

INT: What sort of ways can that be encouraged or developed?

PRT: Well I think just ownership of the caseload in that area, you know, each kind of member of staff have probably got specific strengths both clinically and kind of personally I suppose and it's just a case of, you know, making sure not one person does everything and spreading the load and being aware if you're colleague is struggling or extremely busy that day, give them a wee hand. Just allowing the team to actually do that as well, not feeling that they've got to directly go to the manager and ask if it's okay if I do this, is it okay if I do that, just give them a bit of kind of ownership and responsibility and knowing that... you know, most times you'll be right, you know, just do it, make a decision and be confident and do it. But teamwork, it is a big thing because they do need to help each other out, particularly in their job because it's busy and you need to have support.

   [PM2]

Dieticians also saw their practice as largely autonomous:

INT: Okay. D'you think it makes a difference having, well, a leader on site or the manager on site?

PRT: Yeah but what I would say is... it's good to have a lead on site but we are clinicians that are autonomous, we can work autonomously, you know, we don't... you know, there's lots of Dieticians that are working when their team

leader isn't on site, you know, so it's not a day to day asking what I should do with this patient or what I should do with that patient, and it's very much... what I would see myself is, we would see ourselves as equal clinically to our team   leads, but they are managerially our team lead but we're all equal clinicians, cause we're at a level of Dietetics that we work totally autonomously. I've not got... we don't have our team leader looking over our shoulder saying 'what are   you doing with Mrs. Blog/Mr. Blog?', we don't have any of that at all, so that's not what that is. It's more collaborative, definitely a flatter more collaborative approach there in my opinion.

[D8QW]

One Podiatrist felt that Leadership within the NHS was not defined simply as being a position of management:

INT: Okay. So would it be fair to say that within the NHS system Leadership isn't defined in a purely sort of hierarchical term, as in somebody has a position of leader?

PRT: Yes, no. No I would say it doesn't necessarily have to be because, you know, if you're working... it's very important to work as a team and because we do work as a team we do support each other and bounce off each other in various aspects of it, so yeah no definitely, it doesn't have to be up there in management.

[P2QN]

From the above quote we can see that Leadership is associated with teamwork on the ground and teamwork was considered important to most of the participants. This teamwork was also considered something that arose from the bottom up rather than from any top down influences:

INT: You mentioned earlier the team coming together to meet and to communicate so they could keep care consistent, is that something that happens organically or is that with the influence of the likes of a team leader or...?

PRT: No I think it happens kind of organically, anything that we kind of crop up in our day to day, if we think it should be changed then we kind of get together as a   team and then the team implement it and change it.

[P9QS]

Teams were more associated with helping with the immediate stresses of day to day work:

"I suppose if you're having a bad day, just your colleagues round about you just sort of... I don't know, having a discussion with you just so that you can I suppose vent as to why you're having a bad day or things, and I suppose if we were having a bad day what some of us do is we just step in and finish off a patient for someone and let them take time out,   take five minutes and come back in sort of thing; I think that's more of a team thing."

[P1QS]

Participants identified a number of traits corresponding to positive and negative Leadership styles.

Positive Leadership traits included: an openness to discussion of other people's views, having good communication skills - including being able to listen and negotiate, that managers were supportive of their staff and fair in their dealings and having the relevant clinical or administrative experience for their role.

Negative Leadership traits included: Being untrustworthy or authoritarian, lacking integrity in their dealings with staff, poor communication skills such as being inefficient or inappropriate in their dealings with staff, being more concerned with statistics than patients and being more concerned with their own position than with supporting staff.

In this chapter key findings from the interviews were grouped into two narratives, systemic and individual, where systemic referred to how Patient Centred Care can be facilitated or blocked within the corporate NHS and Individual referred to how a clinician, in individual practice, delivers Patient Centred Care within a clinic or consultation.

Systemic concerns regarding Patient Centred Care for Dieticians concerned the referral process at work within NHS Greater Glasgow and Clyde and the difficulties of working in multidisciplinary teams. Both Podiatrists and Dieticians were concerned with shortages of staff and the resulting pressure this put on their services. Participants also identified the Podiatry service reorganisation and the move to the Personal Footcare guidelines across the service as having an impact on the delivery of Patient Centred Care. From some of the interviews it seemed that there was a tension between management and staff regarding this move. Although Podiatrists reported that they had been consulted and their views taken on board there seems to be questions regarding whether this was an inclusive process or a top-down reorganisation where some management were less than successful in getting some staff to take ownership of the change.

Participants seemed highly committed to the delivery of high quality Patient Centred Care and their values of professionalism and autonomy were central in their approach to dealing with those systemic issues that impacted upon Patient Centred Care. Participants in both

groups reported using individual clinical communication skills, "listening to patients" and managing expectations about treatment, as the means they used to overcome this systemic issue.

Participants felt that good Leadership traits could have an indirect positive effect on patient care but that bad Leadership could have a direct adverse effect. This effect was expressed by its impact on staff morale. Participants in both groups were reluctant to identify negative traits in their current Leadership or management structures. This could be because access to study participants was negotiated through the services management structures or because the management culture within Greater Glasgow and Clyde Dietetics and Podiatry services is positive overall. Participants in both Allied Health Profession groups interviewed felt that Leadership should be supportive of professional autonomy within the service.

4.2 Patient Centred Care

Drawing from the research and policy literature this thesis has adopted the following definition of Patient Centred Care:

- Care that is individualised,
- Care that is flexible in its responsiveness
- Care that is supportive of patient choice

For a fuller explanation of this definition see the section 1.10 of the literature review.

4.2.1 Support for my definition of Patient Centred Care

Participants reported delivering care that was flexible in its responsiveness as demonstrated by the quote below:

> "Sometimes when patients come in, their having a fight with a neighbour and they're upset and so you have to tailor the oral communication and the whole clinic session to how they're feeling emotionally. Because if you're very upset, you're not going to get over a lot of information, so it's very much about listening to them and then tailoring it to what they need at that point in time."
>
> **[D2QNE]**

In the above quote the clinical participant, in this case a Dietician, reports responding to non-medical information presented during the consultation as it may impact on how the appointment proceeds. Participants also reported delivering care that was "holistic" and focused on the whole person. Showing that they felt care should be individualised as well as flexible in its responsiveness. This was also seen in terms of how the participants approached the technical aspects of care, in the example below a Podiatrist relates how they would have to tailor their practice to patients individual pain thresholds:

"we've got a lot of people who [inaudible 00:12:41] and you know what you're doing is very painful to them and they don't flinch, they just let you do it and then the next patient can be really difficult to treat because they have such a low pain threshold, you know, can be very similar treatment you're doing but it becomes very difficult because the patient can't tolerate it."

[P7QW]

Participants also felt that care should be supportive of patient choice and that they should take into account patient wishes and expectations:

"I think it's more to do with that we can pinpoint what our treatment should be to kind of into the patient's aspect of what they want to achieve, so if it's myself, like, Podiatry, that they understand the treatment I'm going to give is what they expect they're going to get, and it's all round their expectations."

[P7QE]

Throughout the interviews participants made comments that linked their conceptualisations of Patient Centred Care to themes identified in the literature that tie in with the definition adopted in this thesis. Though beyond this definition professionalism and autonomy were also seen as important in delivering Patient Centred Care. However it is debatable whether these aspects of practice should be considered part of any definition of Patient Centred Care or whether they simply serve to facilitate the delivery of Patient Centred Care.

Seven broad themes were identified from the interview data relating to Patient Centred Care and these can broadly be split into two narratives concerning systemic and individual influences on the delivery of Patient Centred Care. Figure 10 shows the themes identified within the interview data relating to Patient Centred Care.

Figure 12: Diagram of PCC themes identified in study
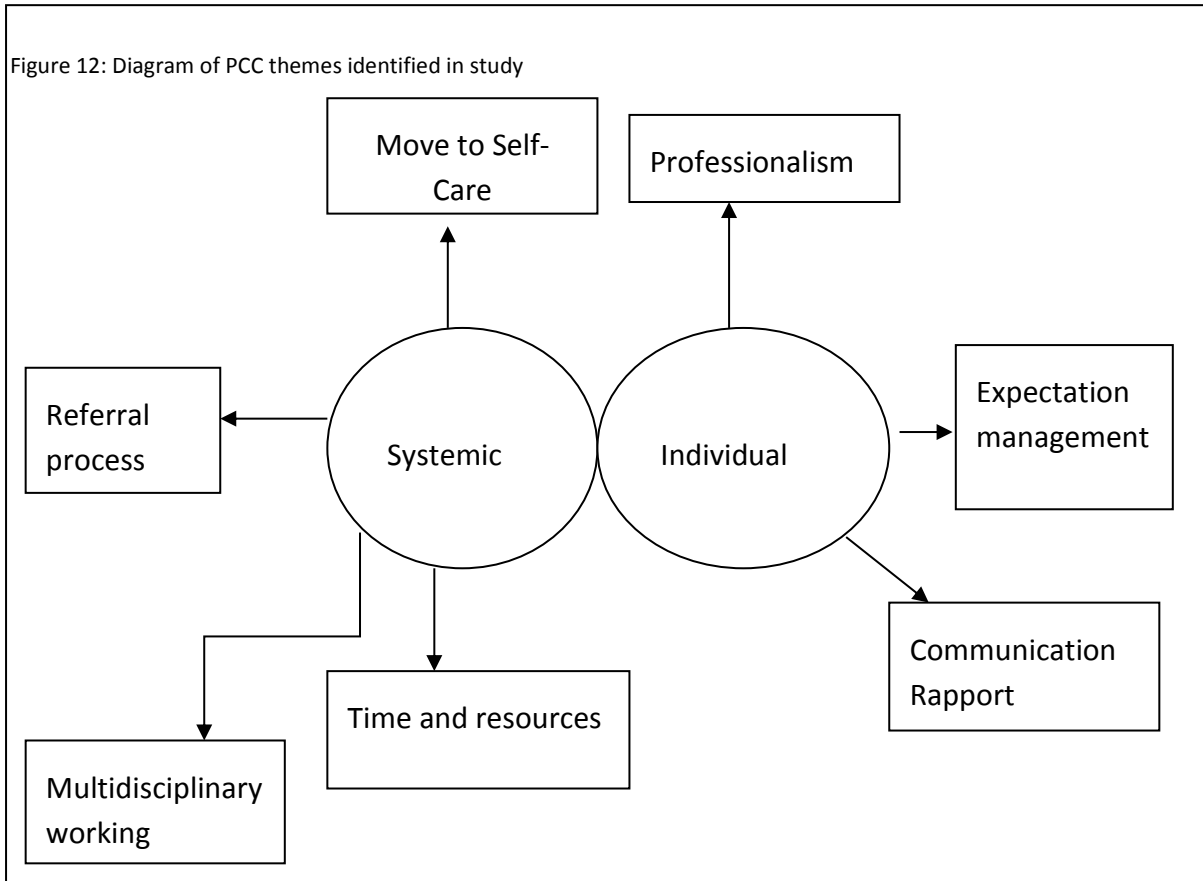
The systemic narrative contains themes that describe how Patient Centred Care can be facilitated or blocked within the corporate NHS: A shortage of time and resources was one of the main external pressures participants felt upon their delivery of Patient Centred Care. Participants also drew attention to the nature of multidisciplinary practice and referral processes as themes that impacted upon Patient Centred Care. Specific to the Podiatry group was also their move to a self-care agenda and their perspective of how patients viewed this.

The individual narrative pertains to how a clinician, in individual practice, delivers Patient Centred Care within a clinic or consultation: Communication was seen as the most important factor in delivering high quality Patient Centred Care and within that the importance of

building a rapport. Practitioners also described how they would manage the expectations of their patients regarding the care they would or could receive. Another strong theme within the individual narrative was professionalism. This theme related to the skills and knowledge of the individual allied health professional that participants felt were important in delivering high quality care.

After conducting the interviews it became clear that Patient Centred Care exists in a different context for both the professional groups who took part in this study. For the Podiatrists, care is a more formal and technical discipline and Patient Centred Care is conceptualised in a more immediate physical sense. Podiatrist participants often considered that patients would be more concerned about the outcomes of a treatment, whether it would cause them pain or discomfort, than how the individual clinician spoke to them on the day.

With Dietician participants Patient Centred Care worked differently. While it is no less 'technical' a health profession in terms of the evidence base supporting treatments, its consultations are far more individually rather than condition focused. Dieticians have to understand the context in which an individual patient presents to them in a community setting. They have to understand how much insight the patient has into their condition, pressures at home, pressures from other branches of the NHS and take all these into account when advising on a course of action or diet.

The Podiatry service in NHS GG&C was in the process of implementing the Scottish Governments personal foot care guidelines (Scottish Government, 2013) in its treatment of patients while the study was taking part. This involved patients taking a more self-care orientated approach to many treatments and services that were formerly offered by Podiatrists. The guidelines state that "*Personal Footcare includes the tasks that adults normally do for themselves such as cutting and filing toenails, smoothing and moisturising skin, looking for signs of infection or other problems which need referral to a Podiatrist".* (p.2)

Figure 11 summarises which aspects of care are considered to fall under Personal Footcare and which fall under clinical Podiatry.

Figure 13: Taken from Scottish Government Personal Footcare Guidelines
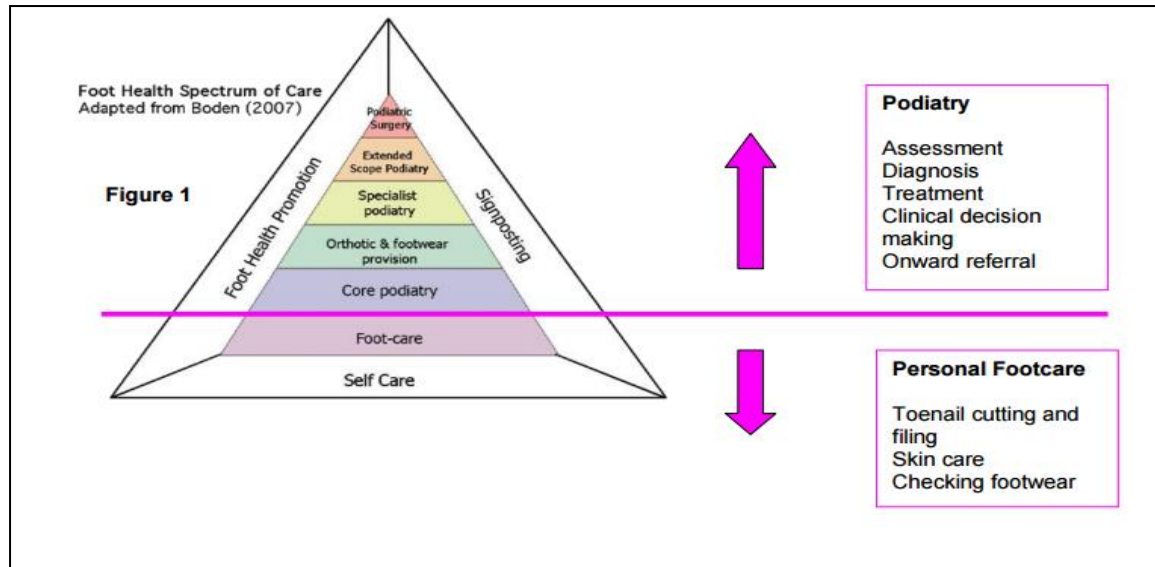
The Scottish Government considers this to be a patient centred approach to Podiatry services that promotes empowerment and enablement of patients (Scottish Government, 2013). This transition was referred to within the interviews.

The focus of the following sections is on each of the two narratives, systemic and individual, and the themes within them. Due to the professional group differences findings been presented separately for Podiatrists and Dieticians.

4.2.2 Systemic factors affecting Dieticians delivery of Patient Centred Care

Systemic in this context refers to concerns or opinions given by participants that relate to the wider structures and procedures of the NHS. In the case of Dieticians one issue that highlighted system wide concerns was the referral process - patients often attended appointments without knowing why they had been referred by another healthcare professional or in some cases what the role of the service they were attending was:

"So when they came in, I would always start by introducing myself and also explaining the reasons for the referral. Because a lot of people don't know, as soon as they come into the Dietician they call you doctor and they call you nurse, they don't know why they've been sent. Of course, somebody has told them they need to go to a Dietician, inverted commas. "

[D1QNE]

This is a fairly concrete example of how systemic issues can impact upon a patient's experience of care. Though Dieticians felt that the issue was usually resolved once the Dietician had explained their role and the reason for the patient's referral. The Dieticians have adopted a strategy of "not assuming" the patient knows what their role is, what service they provide or what the consultation involves.

"we don't go into any consultation with any expectation that the patient knows why they're there, because even although they've had a referral from their doctor or consultant and letters from us for appointments, very often they'll come and they're still a bit clueless as to why they're there believe or not"

[D3QNE]

So prevalent was this issue that most of the Dieticians interviewed used their patient's lack of knowledge as a means of building rapport with the patient. As a way of introducing the service by discussing why the patient thinks they have been referred; and in this way they can illicit explicit or implicit information from the patient about their expectations. In this sense, while

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most Dieticians viewed the referral problem as a nuisance they have adapted within the system to use it to their advantage to improve their delivery of Patient Centred Care.

"And that example I used previously. So they're referred to us from the GP with no explanation. So they come in, they're really anxious and think something, what have I got. And it takes five minutes to say, do you know, this is why you're being referred. And I can tell you loads of times I've seen this where people relax and they go, oh, right, okay. Or they might say, oh, I didn't know I had that. And I think, they should have been told this. So it's not just us, it's the whole system that's responsible for it in a sense as well, including the patient as well."

[D4QSE]

As well as reducing patient anxiety, this strategy was also thought to increase Patient Centred Care by making the patients more aware of what their conditions are so they can place the Dietician's advice in context.

"So I always do that at the very, very beginning. And that generates a bit of conversation. Because, you know, a lot of people think 'I didn't know I was being sent here'. Well, let me explain to you why, and you read out the referral. And that sets the scene. And usually, more often than not, it alleviates any sort of anxiety because, do you know, a lot of people get very nervous when they go to see the doctor and they might not always retain the additional information when they leave that room. And when they get referred to us, they walk in and say, you know, nobody's explained to me, for example, I've got diabetes. So you would sit down. We have half an hour for a new consultation, so you would sit down and Explain the reasons why, here's your blood results, here's this and this. And that is so important; that is so important to establish."

[D4QSE]

They could also use the issue with referrals as a way to gain more information from the patient than they might otherwise have received about their condition, their lifestyle and what was happening in their lives.

> **INT:** Okay. So, does that take into account of the wider context rather than just focusing on the condition or...?
>
> **PRT:** Absolutely, yeah. I'm using the holistic...you usually look to the patient's previous medical history anyway, so you're aware of the other things that are affecting...the whole conditions that are affecting the patient but sometimes when patients come in, their having a fight with a neighbour and they're upset and so you have to tailor the oral communication and the whole clinic session to how they're feeling emotionally. Because if you're very upset, you're not going to get over a lot of information, so it's very much about listening to them and then tailoring it to what they need at that point in time.

[D2QNE]

These issues were common across Dietician interviews with the assumption across most that it was an issue of miscommunication or omission from other services or general practitioners. However some interviewees felt that GPs were using the Dietetics service as a means of refusing a patient their desired prescriptions without damaging the general practitioners relationship or rapport with their patients.

> "a big thing for us is underweight patients that want nutritional supplement drinks so there's a lot more awareness that these are a prescribe-able drink and previously GPs prescribed them but there's a lot more guidance around use of these products now so the best practice is they're referred to a Dietician, they get food reassessed and food advice and then if appropriate give supplements whereas [before] they were quite willingly prescribed by GPs without much consultation."

[D6QS]

The impact of this 'passing the buck' type of referral was in the Dieticians' views to make them appear the barrier rather than the GP. This was felt to have the effect of causing patients to expect a Dietician consultation to be something of a tick box exercise. As GPs were referring patients on the grounds that the Dieticians would give them what they wanted, which is not the case. As one Dietician said:

> "So, they see us as like a barrier to getting these supplements that they want and there's an awareness that maybe sometimes the GPs haven't explained things to patients of why they're referring them. They see us as a bit of like the gatekeeper to what they want and then you're not maybe giving them what they want because you're saying, well, I'm not here just to prescribe you supplements. I would like to assist you with your diet and see what we can improve on that. It would improve your overall health and then, yes, if I do deem it's appropriate then the supplements   can certainly still be considered but it's not our first line advice but maybe like GPs don't say, they'll just say, well, to get supplements I need to refer you to a Dietician and then they refer to the Dietician so people come with a completely different expectation of what they think they're going to get."

[D4QS]

The latter referral issue presents a far more serious systemic issue with process and communication within the health service than the former. With the former, patients simply being unaware of what to expect, the Dietician was able to craft the patient's expectations at the start of the consultation and they could use this positively. In the latter case the GP has fostered an expectation in the patient that the Dietician may not meet and this could have potentially serious implications for the clinician patient relationship. Setting up and 'me versus them' dynamic and reducing the likelihood that the patient will take on board the Dietician's recommendations. This has obvious negative implications for patients' experience of Patient Centred Care, but more than that it opens up the possibility that patients' health could be detrimentally affected as they ignore the advice of the practitioner who didn't prescribe them their supplements.

INT: in that specific case do you think perhaps there's an element of GP's trying to avoid that unpleasant, well, a potentially unpleasant or potentially difficult conversation then they say that this is...

PRT I think, that, yes, that the GP's got that ongoing relationship with the patient. They're always going to be their general practitioner unless they move practice which a lot of patients would need to actively go and do something about it so they have that and the GP would, yes, fix it without maybe saying to the patient directly what the issue, they'll just say, well, I'll refer you onto the Dietician when really they're not wanting to prescribe them. So, they don't have that difficult conversation because they've got a rapport with that patient they don't want to risk as well."

[D6QS]

One Dietician sympathised with the case load and the breadth or practice GPs encounter in their daily practice and described efforts between the Dietetics service and other services to address the issue:

"And some of it, I think, is misinformation from the GP's as well. They're dealing with a lot of different areas and they feel supplements they can't just prescribe from the formula now so we need to go through a Dietician but they don't really maybe say to the patient supplements aren't necessarily going to be the answer but you could get advice for yourself to support you for your diet but it's maybe just not explained to the patient but we do, at the moment, feed all that back to our prescribing Dieticians who are working with the GP's to try and improve that as well because it is an ongoing issue for the prescribing, but there is also the inappropriate referrals and people not knowing what they're coming for but, I mean, generally, I would write back to the GP and mention the patient was referred for this, they thought they were coming for this, or try and address it that way as well."

[D3QS]

What is perhaps notable about the above quote is that the Dietician describes how they would write directly to the GP to address the issue. There is no mention in the rest of the transcript of any involvement of team leaders in this process where in other similar situations outside of a health context you might expect this to be an issue a manager or team leader would deal with. As the referrals issue was identified over many of the interviews it seems likely that this was a common systemic problem. However the Dietician views this as a collegiate issue and takes ownership of the problem and is actively involved in attempting to solve this. This ties in with other themes uncovered in the research that I will discuss later namely professionalism and clinician autonomy.

Another systemic issue encountered by Dieticians involved working within multidisciplinary teams related to differing conceptualisations of Patient Centred Care:

> "Where we're involved in multidisciplinary teams like GP practice based clinics for diabetes, then we are really at the behest then of the practices, the GP practices, because it's the practices that organise the clinics that we go to, so again in that patient centredness, then we would like to think that we're all... everybody involved in that clinic, the GP/the practice nurse/the Podiatrist and the Dietician, all have the same aims and objectives in that it's about the patient and we want to give the patient who's coming along to that clinic to see the different people either on the same day or within weeks of one another, we want to give the patient the best deal we possibly can"

> **[D3NE]**

While the Dietician acknowledges that everyone involved in the patients care has the same overall aims there were sometimes tensions arising from different professionals having differing conceptualisations of what was patient centred:

"but from a dietetic point of view because the practice then are organising that clinic and inviting the patient along, then the Dietician's not in control of that. So sometimes then that Patient Centred Care is maybe not up to our particular standard but it's what we've got then, so there are different factors that impact then on the way that we are able to provide Patient Centred Care, whether it's within our own professions, whether it's within our service specification or whether it's outwith that other forces involved in that as well."

[D3QNE]

In summary participants identified a number of systemic factors affecting Dietician's delivery of Patient Centred Care: There were concerns about the process by which patients were referred to the Dietetics service with some moderate criticism of the role of General Practitioners and Consultants in relation to this. Participants felt that this lead to patients not being aware of why they had been referred to the service but framed this as something they as individual clinicians incorporated into their consultations to assist in the delivery of Patient Centred Care. Thus they were able to identify a systemic issue within the NHS, the referral process, but also how they as individual clinicians overcame this issue.

Some concerns were also raised about the nature of multi-disciplinary teams and the role of Dieticians within them. The participants felt that there were sometimes aspects of multidisciplinary working that inhibited the delivery of Patient Centred Care but that best practice meant that individual clinicians worked together for the benefit of all patients.

Participants seemed highly committed to the delivery of high quality Patient Centred Care and their values of professionalism and autonomy were central in their approach to dealing with those systemic issues that impacted upon Patient Centred Care. Across the interviews there certainly was the impression that Dieticians took ownership and responsibility for their patients receiving high quality care regardless of the situation or context in which they are delivering it. By stating they take this approach the Dietician is emphasising their own professionalism and autonomy within a wider healthcare context. This theme we will be returned to later in the thesis (See section 44.2 Individual Factors Affecting Leadership p.191).

4.2.3 Systemic factors affecting Podiatrists delivery of Patient Centred Care

All of the Podiatrists expressed some degree of concern about the same systemic issues: time and resources. Indeed nearly all the Podiatrist participants' first responses when considering what barriers there were to delivering high quality Patient Centred Care involved pressures arising from a lack of these.

> **INT:** Thinking in terms of the wider service or the wider clinic, basically the larger scale of the NHS, what d'you think can help yourself or other clinicians to deliver Patient Centred Care?
>
> **PRT:** I think I suppose time. I suppose we're always under sort of time constraints to see more people in a day, so you have shorter appointment times, and I think if you were provided with more time then I think that would have a positive impact upon patient care cause you've got more time for treatment and sort of consultation.
>
> **INT:** Is there any other aspects, other than time, that might?
>
> **PRT:** Staffing as well, staffing levels I suppose, that impacts on it.
>
> **[P1QS]**

Time and staffing pressures have led to the current service reorganisation within the Podiatry service in NHS GG&C. There has been a move towards self-care for some treatments the service used to provide under the 'personal foot care approach'. One of the Podiatrists acknowledged these systemic pressures when describing the relationship between themselves and their management:

I mean, I know that he's obviously got lots of different big stresses and money on all this that we don't have anything to do with, but I think where patients are concerned I think, you know, it's quite equal. We were talking about kind of the care of patients, we're singing the same, you know, we're talking about the same things, but I mean, he's on a different... I think the managers have got different things to think about as well that we don't need to think about.

[P2QW]

Here a Podiatrist quadrant manager identifies a failure in transitioning to the self-care agenda as being down to poor communication and poor Leadership skills. It is worth noting that they identify poor Leadership skills in both management and in the individual clinicians:

Again, going back to I'll use the personal foot care approach, it would be discussed initially what we've found and other clinicians were doing were basically trying to pass the buck. Instead of doing it in a managed way they would say 'no we've been told we can no longer do this for you' you know, and it made it very much an almost top down driven approach by management and the Board to say 'no we no longer do this; I would do it for you however we've been told we can no longer do this', and absolutely a clear example of really poor Leadership style and Leadership communication skills, and we spent quite a bit of time of, likes, what would be deemed as good Leadership behaviour in terms of the Leadership behaviours work, the NHS Leadership framework, to demonstrate very clearly to staff what would demonstrate good Leadership behaviours and what wouldn't

[PM1]

The manager goes on to describe how this failure impacted upon the delivery of Patient Centred Care:

> and it's basically just to try and again bring that to life, rather than it being clearly if a patient sees it as it's almost a service being withdrawn 'well we can't do that anymore' therefore that becomes a problem; but if we're saying 'listen, this is what you can do for yourself' in terms of trying to sell it almost as a positive for the patient, in terms of their own ownership of their condition and their own care. It's a much easier sell than just saying 'we have been told not to do this' – that's the easy way out and because it's easier to do that as a clinician to say 'we've been told we can no longer do this', however that generates an awful lot of heat in the system because of the style that's been... it's almost been sold as a negative in terms of treatment being withdrawn because we've been told to, rather than it being 'well listen, this is something you can do for yourself, absolutely personal care's been deemed by the Scottish Government as being what people normally do for themselves...' and all that sort of interaction, so we came up against a problem with that at the start and had to make it clear to people that they were the   corporate face of the organisation at a clinical level on a face to face basis, and it's not a case of 'we must do because we've been told to' but 'listen, this is what you can do because this is going to be good for you for your best optimal clinical outcomes for your own sort of control of your own conditions and so on'. So we came up against a bit of a barrier with that and it's probably the most simplistic one I can explain to you, but it was... and changing again that style, changing that style of communication can make that conversation a bit more meaningful at every interaction rather than it being a 'we can no longer do this, we've been told no'. That created a lot of initial heat.

[PM1]

Whilst management have tried to sell the self-care agenda to both staff and patients as empowering and positive; this is not a view that is necessarily shared by everyone. Staff reported that patients feel that that a service is being withdrawn, and staff themselves reported feeling discomfort in the service being withdrawn. Staff have identified this as creating a barrier and generating a lot of complaints and "heat". This possibly shows that although the self-care agenda has been accepted by the organisation as being a means of delivering Patient Centred Care long term patients and some staff do not share management's view of it as empowering.

> if it's a new patient, they come in, that's all they know anyway so there's not going to be any issues, there's other patients who might have been there long term and then a change occurs or something happens, you know, for them it is a drastic thing, but then quite easily, you know, if it's explained to them why the change has happened, you know, again keeping them in that loop and having that understanding with them, they do, they accept things quite easily.

[P2QN]

Issue relating to this transition were only raised by two participants directly within the interviews. However, the fact that this transition was also been identified by a manager as having proved problematic is significant, as they identify problems across a number of Podiatrists within the organisation.

Another Podiatry manager touched on the issue of self-care when discussing how a normal consultation would proceed:

PRT: Well it's just having a structured assessment I think and just having questions that allow you to kind of find out exactly what's wrong with the patient and I suppose just sort of allowing you to kind of... although the patient may feel what they want is required, it may actually be discussing with them and saying to them 'well this is actually what we will be doing because the diagnosis is not quite what you think it is' and we'd have to change it slightly, you know, kind of trying to get a kind of common ground between that and try to sometimes persuade them that there won't be an actual cure, there might be just an improvement of symptoms or get them to realise that they may have to do some stretching for example on their own and need to do that before we can go further with what we do. And sometimes that's difficult because they want the kind of magic wand and come in and do a consultation and that's it finished, so sometimes you've got to explain that this may take a little time and, you know, as I say, there might not be a complete cure but there might be a reduction in pain or slight improvement in their mobility, that kind of thing. So essentially really good questioning and kind of allowing the patient to kind of say what they have to say and then just sort of conversation around that and not rushing them, making them Comfortable and allowing them to be confident to say exactly what they want to say.

INT: So there's an element of expectation management within it?

PRT: Oh yeah I think that's a big part of our job I think is the expectation. They will come in thinking they're going to... in our service a lot of it is we will be discharging patients because they're coming, say for example, nail cuts and things and that's personal care, so there's an expectation in that case that well we won't actually be providing a service and it's conversation around that why we won't and where they will go and that kind of thing.
That's the basic level and then, you know, expectation as to what we can do for them, that's a big part of our consultation issues. **[PM2]**

Here the participant identifies that patients expectations of care can exceed what the service offers in some cases and what is an appropriate treatment in others. Tied into the idea that an element of the consultation involves a negotiation with the patient is an element of persuading the patient to adopt some self-care behaviours in order to improve their condition. The participant also acknowledges that patients will now be being discharged for services and procedures that are now deemed personal care.

One further participant mentioned service reorganisation though they did not directly mention the self-care agenda or the personal foot care approach, and how it relates to management and Leadership.

> "I think... again its two kind of hats, management and Leadership. I mean, certainly a lot of it will be yes to encourage staff to provide the Patient Centred Care, we've also got to I suppose have Leadership to have a service that puts the patient at the centre and I suppose what we try to do, maybe it's difficult to do it, is involve patient groups in decisions that we make, you know, any change of service or redesign of service we try and involve patients in that discussion, it's not always easy to do and it's something I suppose that's not... because it's difficult to do we maybe don't do it as well as we should do or as often as we should do, so I think that's something that the Leadership maybe need to improve on, asking patients to attend focus groups and stuff like that."

> **[P4QS]**

Here there was a feeling that the Podiatry service wasn't involving patients in wider decisions about the care being offered as well as it could be.

Though another Podiatrist felt that their concerns were listened to during the consultation about the service design:

"our service underwent a big redesign sort of 18 months/two years ago and everyone at that point when we underwent that redesign, we were all able to sort of fill out sort of ideas or concerns or issues that we had anonymously and send them to management, and then they were discussed at those meetings and also within emails as well."

 [P5QS]

In many of the interviews there was also a general feeling that Podiatrists were being asked to do more with less due to pressures on the service. Participants felt that pressure had increased slightly on the service since the number of Podiatrists had decreased and that this had some knock-on effect on patient care though not an impact that they felt was drastic.

The participants tended to frame systematic barriers to the delivery of high quality Patient Centred Care in terms of nuisance to the patient; patients being unable to get appointments when they would have preferred them; and having to wait longer than they might have liked for referrals or follow up appointments.

"at the moment some patients are waiting four months for a treatment but we have to prioritise the patients and we do tend to see the ones obviously that have got, like, infections or whatever we see them weekly, but it's sometimes difficult to... some patients complain that they have to wait so long for treatments but it's just trying to kind of, you know, I suppose it's not good but, I mean, we do the best we can really, we do try and prioritise and see the patients that are needing to be seen, you know, more quickly, but I don't know how really to make that better with the resources we've got."

[P2QN]

They also viewed the actual time that their consultations lasted not in terms of whether they felt they had enough time to treat and care for their patients but whether they thought patients felt they had enough time within the consultations.

> "I would think some of them might feel that they would benefit from more time – not in terms of say we allocate them enough time for their Podiatry treatment to be carried out, it's not that that's sort of rushed, but just I suppose other issues to be discussed, they would maybe wish to have more time."

> **[P5QS]**

The same Podiatrist identified that having more time might have a beneficial impact upon the delivery of Patient Centred Care later in the same interview:

> "not everyone that we see gets seen at a set time, we decide sort of when they're seen, but some people... obviously we see a lot of elderly patients here, patients `that live by themselves and things and they would obviously love to have a wee bit more time just to have, I think, more of a social sort of just able to speak to someone and discuss problems."

> **[P5QS]**

The size and scale of the NHS as a corporate entity was raised as a systemic issue in the delivery of Patient Centred Care as patients could sometimes feel that they were not being listened to or that their voices were heard. One Podiatrist noted how they had to defuse issues arising from this within consultations and they did so by putting the patient at the centre of their practice.

"people just want to know that they're being heard, everyone has... no, you can't please everyone, no matter how much you try to do something, you just can't please everyone, especially when you're offering a sort of a service such as within the NHS, so it's just... and sometimes you can diffuse, you know, a lot of issues can arise if people feel they're not being listened to or they're not being heard, you know, or that their opinion doesn't matter, so it's trying to defuse that sort of situation and making patient... as well as making patient care the centre of what we do as an organisation but actually making patients the centre of it as well. So listening to the patients, you know, giving them an opportunity to voice any concerns they have, whether that's through comment boxes and things, but then showing that their concerns have been dealt with and, you know, they aren't just wasting their breath or their time."

[P2QN]

In this section we can see that Podiatry participants identified a number of systemic factors affecting Podiatrist's delivery of Patient Centred Care. Chief among these were somewhat nebulous concerns voiced about the scarcity of time and resource. Participants felt that this lead to a pressure on the service and in turn on individual Podiatrists. They felt in particular that this lead to a poorer service being delivered particularly in terms of increased waiting times for patients.

Participants also identified the Podiatry service reorganisation and the move to the Personal Footcare guidelines across the service as having an impact on the delivery of Patient Centred Care. From some of the interviews it seemed that there was a tension between management and staff regarding this move. Although Podiatrists reported that they had been consulted and their views taken on board there seems to be questions regarding whether this was an inclusive process or a top-down reorganisation where some management were less than successful in getting some staff to take ownership of the change.

Again, as with the Dietician participants, Podiatry participants reported using individual clinical communication skills, "listening to patients", and managing expectations about treatment, as the means they used to overcome this systemic issue.

As well as systemic factors Podiatrists identified a number of individual factors that could impact on the delivery of high quality Patient Centred Care. These centred mainly on the key role communication plays in the consultation.

4.2.4 Individual factors affecting Podiatrists delivery of Patient Centred Care

Individual refers to the opinions given by participants that relate more to the individual's role in Leadership or Patient Centred Care. The individual category that emerged from analysis of the interviews with Podiatry participants focused on the behaviours and characteristics of individuals in delivering high quality patient centred. Participants saw communication as key to the delivery of high quality patient care with all participants giving examples of good and bad communication as central to their experiences of delivering patient care.

> "Once you build up a rapport with a patient you know that you can then be yourself with that patient and sometimes that is the best thing in terms of getting the compliance from the patient having that rapport, building that rapport in a strong way with patients, that is what helps the best."

> **[P2QN]**

Participants were able to identify specific communication techniques and behaviours that helped facilitate Patient Centred Care.

> **INT:** And what sort of things d'you think you can do to see the patient as a whole person?

> **PRT:** Make sure you give them sort of a good environment that they feel comfortable in talking about whatever, like, it's quite quiet and you don't have many disruptions and you just look as if you're listening to them and give them time to talk about things, make sure the clinic's nice and clean and they get a good impression that you're going to look after them. This is hard at the end of the day [laugh]!

> **INT:** So it's a mixture between the environment and communication with the patient?

PRT: Yeah, yeah.

INT: Of the two of those which would you think would be the most important?

PRT: Communication.

INT: And d'you think there's any particular kind of communication or, I suppose, ways of communicating with patients that improve Patient Centred Care?

PRT: Just making them feel as if you're listening to them, you know, you're not answering their questions for... you know, they're discussing what's wrong rather than you telling them what's wrong kind of listening to them more.

[P6QNE]

Putting the patient at the centre of the consultation was a strategy that was mentioned in a number of interviews with participants emphasising listening skills as one factor that was central to building a rapport with the patient.

INT: In terms of patient care, what sort of behaviours or practices d'you think go towards making a consultation a good experience for the patient?

PRT: I think giving a patient the opportunity to discuss their problem and to let them explain that fully before sort of being cut off or being sort of intervened on by the healthcare professional, and empathy towards them also.

INT: And what sort of behaviours d'you think can develop that sort of idea of empathy with the patient?

PRT: Well showing actually concern I suppose towards their problem or what they're complaining of, eye contact, sort of body language as well – don't be sort of moving around the room doing different things or playing with the computer sort of thing, give them your full attention.

[P1QS]

In the above quote the Podiatrist shows that they put the patient at the centre of their consultation by not performing other tasks and ensuring the patient has their full attention. Another Podiatrist introduces the idea of expectation management into the consultation and describes the consultation process as holistic: taking into account the patients situation and context as well as their condition and the treatment required.

INT: Just basically to ask you what you think constitutes Patient Centred Care?

PRT: I think it's more to do with that we can pinpoint what our treatment should be to kind of into the patient's aspect of what they want to achieve, so if it's myself, like, Podiatry, that they understand the treatment I'm going to give is what they expect they're going to get, and it's all round their expectations.

INT: Okay, so there's an element of making the care individual to the patient that's...?

PRT: Yeah.

INT: Okay. And Patient Centred Care, is it mainly focused on the sort of clinical aspects of care or is there...?

PRT: I think there is a... proportion of it has got to be the clinical side but I think you've also got to take in the background of where the patients live, their family history, just kind of a whole holistic approach to them rather than just pinpoint on the area that you're working on.

INT: And how d'you achieve that sort of holistic approach?

PRT: I think it's just good communication really, just listen to the patient before you start jumping in and doing any treatments and see what do they want in their mind for the outcome of their treatment or their stay in hospital.

INT: In terms of good communication, what sort of behaviours or ways of communicating would you say...?

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PRT: I think listening first and don't interrupt the person you're talking to, if they've got any kind of hearing impairment maybe write it down or take things a wee bit slower, change the way that you're maybe asking a question, make a more kind of open question rather than a closed.

[P7QE]

While Podiatry staff identified a number of communication techniques that placed the patient at the centre of the consultation few mentioned the structured nature of the consultation though this was raised by one of the Podiatry managers:

INT: So how d'you think that Patient Centred Care is achieved within an appointment/within a consultation; what sort of techniques or practices are best practiced to your mind?

PRT: Well it's just having a structured assessment I think. [And] just having questions that allow you to kind of find out exactly (a) what's wrong with the patient and I suppose just sort of allowing you to kind of... although the patient may feel what they want is required, it may actually be discussing with them and saying to them 'well this is actually what we will be doing because the diagnosis is not quite what you think it is' and we'd have to change it slightly, you know, kind of trying to get a kind of common ground between that and try to sometimes persuade them that there won't be an actual cure, there might be just an improvement of symptoms or get them to realise that they may have to do some stretching for example on their own and need to do that before we can go further with what we do. And sometimes that's difficult because they want the kind of magic wand and come in and do a consultation and that's it finished, so sometimes you've got to explain that this may take a little time and, you know, as I say, there might not be a complete cure but there might be a reduction in pain or slight improvement in their mobility, that kind of thing. So essentially really good questioning and kind of allowing the patient to kind of say what they have to

say and then just sort of conversation around that and not rushing them, making them comfortable and allowing them to be confident to say exactly what they want to say.

[PM2]

Previously we touched on how this quote addressed expectation management within the context of introducing the Personal Foot care plan self-care agenda. We can also see here examples of where Podiatrists find the flexibility to provide Patient Centred Care within the context of structured consultation. We can also see from the above quote that the delivery of Patient Centred Care involves negotiation between the patient and the Podiatrist. Negotiating over what treatments are appropriate and what level of ownership the patient should take for their own care in a process of finding a "common ground".

INT: And in terms of finding a common ground, I mean, what sort of ways can you do that within a consultation?

PRT: Yeah, usually negotiation I think. I think just good negotiation skills and just sort of say 'well yeah, if you want this can happen we can do this, if you do that we can maybe meet you in the middle and give you a treatment regime, we can maybe give you a pair of insoles, however you might need to change your footwear and this is the sort of footwear you would be wearing to accommodate that', so it's a lot of negotiation I think and compromise on both sides, cause obviously we think we know best and you'll do this, but you've got to be careful how you kind of do that and you won't always be able to do exactly what you want to do, and you can't take it personal, you know, you've got to say 'well okay, we'll meet you in the middle and we'll try and do this'

[PM2]

From the above quotes we can see that central to Podiatrist's communication strategies is how they ask questions and what they ask questions about. However Podiatry is not just about communication it involves physically treating the patient. Some Podiatrists related how satisfied a patient would feel with their consultation to the treatment process or it's outcomes:

PRT: usually the younger type of patient is coming because of an acute, they're not coming because they can't get down to cut their toe nails, they're coming because they've got pain from something, so usually they're on a short term, you know, treatment plan where they'll be treated, cured and then discharged. Whereas, you know, wee Mrs. Smith that's 85 that's got arthritis and cataracts and diabetes and all the other things that go along with it, that can't get down to cut her nails is not happy that she's got to wait five months for her next appointment, you know, but I think a lot of it now is about promoting self-help and being a bit more understanding to the patient and also trying to explain to the patient a bit more what they can do to help themselves.

INT: You mentioned there briefly more acute conditions and patients who are there because they're experiencing pain; in your experience does perhaps the patient's perception of that pain or severity of the condition that they're presenting with, does that impact how you think they're experiencing the care?

PRT: Their level of pain?

INT: Uh huh.

PRT: I think if they're in pain and we can help them then they're always grateful.

[P8QN]

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The issue of pain highlighted how that even within the context of conducting a standard technical procedure Podiatrists are required to take account of patients individual care needs:

"we've got a lot of people who [inaudible 00:12:41] and you know what you're doing is very painful to them and they don't flinch, they just let you do it and then the next patient can be really difficult to treat because they have such a low pain threshold, you know, can be very similar treatment you're doing but it becomes very difficult because the patient can't tolerate it."

[P7QW]

One of the Podiatry managers identified the technical aspects of Podiatry care as the taught aspects of patient care and the patient centred aspects as communication skills that Podiatrists learnt through working with rather than on patients:

PRT: Well where I'm based, with the Podiatry degree students here, this is the clinical training part of it, so there's two elements, you've got to actually obviously get the patient in front of you or the student has, and it's trying to get the student to kind of get the Patient Centred Care stuff going and thinking cause they're concerned about 'oh I've got to do this right, I've got to do this process and I've got to do this assessment or whatever' but they've also got to provide the care and the patient's still got to receive the care and get better care. So it's a twofold thing of actually encouraging the student to put the patient at the centre and not them [laugh] difficult in student's cause they think they're the centre of the universe! So that's kind of quite difficult personally, you know, from where we are

INT: Is there an issue perhaps in the early stages of the career or studying to become a Podiatrist that there is that greater focus on the technical aspects of care and, you know, the structures rather than relating to the patient?

PRT: That's the trick really because obviously they're attending the Uni and they're getting all their academic stuff and then they come over here and it's very technical, you know, what they do with the scalpel or instrument or whatever they do, and it's to relate why they're doing it, you know, with this condition, you know, if it's a rheumatoid patient why is it important you do A, B and C and it's linking between the condition and to the individual, and that's the difficult, well not difficult part of it, that's what they've got to try and get by the time they've been here in their fourth year, that's what they should get, you know, cause the technical aspect isn't probably that difficult to teach, you know, the use of the scalpel and all that kind of stuff, you know, after a couple of years they're usually quite proficient at that, but it's why they're doing it and how they do it differently on different conditions and, you know, the contraindications and what they've got to be careful of and all that kind of stuff. So the whole essence for the course I suppose.

[PM2]

In this section Podiatrists reported that key to their delivery of Patient Centred Care was communication within the consultations. Listening skills and giving the patient their full attention were seen as being central to achieving this. Podiatrists also reported that although they delivered a structured assessment within their consultations that flexibility was required in order to allow patients and Podiatrists to negotiate treatment need, particularly in light of the move to the self-care agenda.

4.2.5 Individual factors affecting Dieticians delivery of Patient Centred Care

The focus in Dietetics was similarly on communication and this was seen as the single most important factor in the patient-Dietician relationship.

> "I just think communication is key to all aspects of our job. You know, its patients, staff, knowing how to speak to staff, knowing how to speak to patients. Yeah, doing our job. If we're talking about processes or change, because there's loads of change in the NHS, communication is vital."

[DM1]

That communication was central to Dietetics practice was common across the interviews. The following quote highlights how communication is a vital part of Dietetics and that the Dietician's role is perhaps better understood as one of a translator:

INT: and it's coming back to that listening and building that rapport, and so communication is really, really central to the...

PRT: It's absolutely vital and I think...I mean, the more I work in Dietetics, it's just that I feel the more I...you're more like translators...that you're translating the diseases and the diet and how diet can help, and it's getting that over in an appropriate way, so it's got to be tailored to the individual patient as well, so it's...you need a whole understanding of all the medical condition, but also obviously how the diet is going to help that, and then being able to get that across to the patient.

[DM1]

The communication behaviours that Dieticians regarded as important were broadly similar to those highlighted by the Podiatrists:

PRT: Well, I suppose it's when they come to clinic, you would...you're working to their story; you don't immediately jump in, you build up a rapport and I suppose it's using your communication skills; building up the rapport; working to their story; what they want to get out of the consultation, because it might be very different to what you want or think that should happen in the interview, and that's what it's all about. It's about them having a better understanding of their condition and what are the important points to take away. Something that they can change or they feel they can change.

INT: So, it's about not making assumptions with...okay. And what sort of communication skills do you think are important in that?

PRT: I think obviously building up a rapport; being friendly and building up a rapport with the patient straight away. And listening skills really, listening to what they're...doing less talking, so that the patient does more of the talking; you're doing more of the listening.

[D2QNE]

This quote does highlight one possibly significant difference between patient communication in Podiatry and Dietetics consultations. In Podiatry, a rapport with the patient is something that is built up over time, but in Dietetics it is something that has to happen straight away. This is unsurprising given the differences between the two allied health professions: Podiatrists typically see patients who require a specific technical treatment which contrasts with the highly communication dependent nature of the Dietetics consultation.

The Dietetics consultation was reported by one participant to be an equal and engaging process:

> There's a bit more engaging with the patient. So for example, our assessment tool, so we have a record card that we have some information about their diet, so the 24-hour recall and the food frequency questionnaire. And then that gives us a sort of idea as to a picture of what their sort of lifestyle and diet, and so on, looks like. But at no point are we telling them what to do. We advise them. And that's always how it's pitched, it's always advising, but also correlating it with…for example, if you lose five or ten per cent of your body weight, your…because one of the markers for diabetes is your haemoglobin A1c, so if that comes down, it's improving your diabetes. So that's the sort of angle we would take, rather than saying this food is bad for you and you shouldn't eat it. It's not about that. It's more about, so what can you do about this, you know, we're giving you all the information, so really it's up to you to take it forward, but let's help facilitate that.
>
> **[DM1]**

This idea of patient empowerment, similar to the self-care agenda in Podiatry, was a key feature of participants reporting of how Dietetics consultations worked as a more holistic approach:

>
> **INT:** Yeah. So it's selling the benefits of the action the patient can take rather than dictating it?
>
> **PRT:** Yeah. Do you know, it's encouraging them to say, look, you can do this. Here are the benefits, for example, you lose five or ten per cent of your body weight, but in order for you to do this, let us give you some information. ... Because it's not about diet only care, it's about - ..., and they might have been through stress or whatever, so they might take in part of what I'm saying, but maybe nutrition is only one part of it. And I would be using this particular organisation to look at the other parts of the issue as well. So we're providing that in addition to the patient care, the more holistic approach to it as well, so it's not just diet when they come and see the Dietician.
>
> **[DM1]**

There is also an element of social prescribing within Dietetics as they may refer patients to external services such as gyms or local health groups to support their dietary and health requirements.

> "So we'd maybe have things like exit strategies from my clinic. So I'll use my clinic as an example. So I would maybe look at if they need more physical exercise, you know, I direct them to some of the community-based initiatives, some of the local gyms. There's loads of little council-run walking groups and so on. So that sort of thing I would give to the patient and give them as much information. I would also give them a lot of hyperlinks to the web as well. So for example, there's a fitness app, a nutrition app, a lot of the Diabetes UK, Celiac UK websites, so it's empowering them to take ownership. They know, they've got all the knowledge away with them, it's really up to them to do a bit further action and reading. And I would be strongly suggesting that, you know, rather than telling them what to do. With all the added benefits, so explaining the benefits if you did this, this is the benefit to your action."

[DM1]

There was a greater emphasis in the Dietetics participants interviews on the importance of considering and adapting their advice to individual patients contexts. This could take the form of eliciting within the consultation concrete examples of lifestyle factors that affected the patient's treatment:

> **PRT:** And for them to understand and accept; and you do get that, there are times when it's like the patients will...there was a patient that was anaemic and wasn't taking her iron tablets properly and we had been referred her, and she was knocking back her iron tablets with teas, and of course, tea stops the absorption of iron...
>
> **INT:** All right.
>
> **PRT:** ...so again, that was...so just by that one message, hopefully her iron levels would improve. Just have your tea at a different time from your iron tablets, so...
>
> **[D7QE]**

Or it could take the form of discovering things about the patient that could indirectly impact on treatment:

> "Because we do get people that are drunk; you get people that are on drugs, so it's being conscious of that as well and taking onboard how much information people can as well; some medical conditions mean that the short term memory is quite poor. So, trying to get over a lot of information isn't going to be easy, so you then maybe give them one thing and bring them back another time."
>
> **[D2QNE]**

In the example above the Dietician details how issues of capacity can affect the outcome of a consultation and how they tailor consultations to patients who might not be able to take on board all the information given.

Dietetics is also a profession where there can be more stakeholders involved in the treatment of a patient - family members and careers. Dieticians sometimes have to manage these stakeholders' expectations as well as their patients.

"I'm dealing with [people who] are older, over maybe 60, 70, they are not so much but a lot of times it can be family that would expect, especially maybe if people cancel an appointment and then they have to reschedule that you can have a 12 week wait so they get quite then frustrated but they'll have to wait again to be seen. Things like that with people because there's a lot more awareness around waiting times"

[D4QS]

As well as being an issue with older patients there were also issues when Dieticians dealt with children. One Dietician describes how important it is to build a relationship with parents as well as the patient and to establish a continuity of care:

"a patient I had in yesterday a wee six year old boy that just wasn't eating properly, had his very, very anxious parents in, you know, I think it's really important for me to follow them up and not pass that person onto another colleague, cause you want to develop trust with them."

[D8QW]

One Dietician also stressed the importance of not making judgements about the people they were treating and accounting for their situation and context:

"Yeah, absolutely. Everybody's got a story, yeah, everybody's got a story. And that's what we're trying to teach students, don't judge, you know, do not judge and you mustn't judge. And it's really, really hard not to, but you've got to leave everything at the door type of thing, you know, and we're all human. But it's trying to create that. I think if you've got that environment, it gets easier. I have been in some departments where you hear things and you think, oh, I would not have said that, that's not correct."
[D4QSE]

Again we can see from this section that participants considered communication is all important in the achievement of high quality Patient Centred Care. Dieticians also stressed the importance of listening skills in the consultation in order to build up a rapport with the patient. However unlike Podiatrists the quantitative data suggests that this was something they had to develop within their first consultation as opposed to over a period of time like the Podiatry participants.

in summary in this section Dieticians also reported that flexibility was important within their consultations and that they had to adapt the advice they gave to individual patient's contexts and situations. They also reported having to take into account the impact their advice might have on other stakeholders such as family members or care-givers.

5   CHAPTER FIVE: Discussion

The overall aim of the studies contained within this thesis was to explore whether it was possible to empirically demonstrate a relationship between Leadership (good or bad) and Patient Centred Care, and to do this in relation to AHP practice.

The research questions that were set out to address this aim were as follows:

I.   Is there a relationship between Patient Centred Care and transformational Leadership in AHP practice?
II.   How do AHP's conceptualise Leadership and its impact on their ability to deliver PCC?
III. Are there contextual issues in practice that may influence how leaders facilitate or inhibit Leadership supporting Patient Centred Care?

This chapter discusses the results and findings of the studies that addressed these aims.

Study one was designed to answer research questions one- exploring the relationship between transformational Leadership and Patient Centred Care using survey design. In exploring this relationship, the concept of 'flexibility in responsiveness' was included as a potential mediating variable. This was explored through two proxy measures: emotional intelligence and self-monitoring. Clinical team leaders from across 12 Podiatry teams and 12 Dietetic teams completed a survey composed of measures of transformational Leadership (TLQ) (Alban-Metcalfe & Alimo-Metcalfe, 2000a), the Wong and Law Emotional Intelligence Scale (WLES) (Wong & Law, 2002) and the self-monitoring scale (Snyder, 1974). Clinicians from these teams were also asked to complete the WLES and (because of the multisource approach being taken to account for common method variance) were asked to complete the inter-rater versions of the TLQ (IRTLQ) on their perception of their clinical leader's transformational Leadership skills. This allowed comparison of self-assessed Leadership and team assessed Leadership.

Study two was designed to answer research question questions two and three. In depth interviews were conducted with therapists to explore these questions: how do Allied Health Professionals conceptualise Leadership and how do they view the link between Leadership and their ability to deliver Patient Centred Care; how might local context impact on

professional Leadership and therefore its potential to enable or inhibit Patient Centred Care?. Interviews also explored the issues and barriers to effective Leadership, teamwork and the provision of quality care. From within Podiatry services, 24 clinicians (3 clinical leaders and 20 clinicians) were invited to take part in a qualitative interview and 3 clinical leaders and 11 clinicians. From within Dietetics, 12 clinicians (4 clinical leaders and 8 clinicians) were invited to take part in interviews, 7 clinicians and 4 clinical leaders took part.

I. Is there a relationship between Patient Centred Care and transformational Leadership in AHP practice?

It is suggested from the findings of study one that the theory of a link between transformational Leadership and Patient Centred Care has merit (See Summary of Results in section 3.5). Significant relationships or relationships approaching significance were discovered for each group linking the Transformational Leadership Questionnaire (TLQ) scores with the Consultation Care Measure (CCM) and there was a significant relationship between Transformational Leadership Questionnaire (TLQ) scores and the Consultation and Relational Empathy (CARE) scores for Podiatrists. However these relationships between Leadership and patient centredness scores were weak to moderate and it is questionable whether this is strong enough evidence to justify the theoretical assumptions implied in many of the policy documents (e.g. NHS Leadership Qualities Framework, Department of Health, 2002; 'Workforce and Development' Leadership Working Group, 2000). In particular the assertion in the Health Facilities Scotland commissioned report "Patient Centred Care: A research report" (Health Facilities Scotland, 2011) that Leadership development and training is 'essential for realising person centred care' is not evidence based, and is not supported by the findings contained within this thesis. This also makes it difficult to justify the policy that Leadership development and training should encompass all disciplines (nursing, administration, medicine etc.) and sectors (healthcare delivery, suppliers, insurers, etc.) in order to enhance Patient Centred Care.

Before expanding Leadership training as a key mechanism for delivering on Patient Centred Care, it is also important to understand what might influence this relationship. Study 1 explored whether 'flexibility in responsiveness' might influence the relationship between Leadership and Patient Centred Care (hypothesizing that higher flexibility in Responsiveness (FR) traits would enhance the translation of Leadership skills into delivering Patient Centred Care. This study found no statistically significant relationship between the proxy measures for flexibility in responsiveness (Wong and Law Emotional Intelligence Scale (WLES) and Self-Monitoring scale (SM)) and either Leadership (Transformational Leadership Questionnaire) or patient centredness scores (Consultation Care Measure (CCM) and Consultation and Relational Empathy (CARE)).

However, the results indicate that exploring the issue further with a larger sample is warranted. It would also be appropriate to expand the number of professions taking part in the study to explore differences in Leadership and Patient Centred Care across Allied Health Professions.

II. How do AHP's conceptualise Leadership and its impact on their ability to deliver PCC?

Allied Health Professional's in both groups had broadly similar conceptualisations of Leadership and both groups played down the role of Leadership in the delivery of Patient Centred Care. A far more salient factor in achieving the delivery of high quality Patient Centred Care for the AHP's interviewed appears to be professional autonomy. This focus on autonomy fits within the framework of transformational Leadership discussed earlier (See section 1.3 Transformational Leadership p. 30). One of the central features of Transformational Leadership is motivating others to pursue high standards and long term goals and achieving this by shifting responsibility downwards in a more egalitarian flattened hierarchy. This blurs the lines between superior and subordinate and both can come to view each other as equals. This fosters autonomy and thus increases job satisfaction. Bass (1999). It is also possible that increased staff autonomy might lead to better Patient Centred Care as suggested in Entwistle et al (2009). Entwistle states that relational thinking can inform recommendations about treatment as those who engage in this are more likely to be supportive of patient autonomy. If staff have leaders and managers who support their autonomy they may feel more able to exercise their professional judgement in allowing patients more autonomy regarding their treatment. This would contrast with a view where staff were more concerned with demonstrating processes for example: worrying about completing a box ticking exercise because they are being micro-managed from above.

During the interviews some participants implied that there has been a cultural change within the NHS from an old school style of management which was autocratic to one which is more supportive and equal and this is a view which can be found in other research (Dunleavy & Hood, 1994). This change has perhaps been driven by an acknowledgement of individual clinicians' professionalism and autonomy. Leadership in the allied health professional groups in this study appears to operate through developing relationships of trust with staff rather than micro managing them. With the emphasis on teamwork, and every individual taking ownership for the service provided, there is a sense that everyone has responsibilities regarding Leadership.

Overall, the participants indicate a preference for transformational styles of Leadership within the NHS. This is unsurprising Transformational Leadership has been recognised by the Cabinet Office (1999) as a means of meeting "the varying needs within our diverse population" (p.56) through its' features of innovation, empowerment and change management. Wirrmann and Carlson (2005) identify that recent lists of NHS Leadership skills confirm this preference for transformational Leadership with a focus on Leadership skills and styles that are relational in practice.

Transformational Leadership describes the ability to motivate others to pursue high standards and long term goals. Increasingly the lines between superior and subordinate are blurred and leaders and followers come to view each other as colleagues in a more egalitarian flattened hierarchy. This flattening was seen in participants' reports of how close Leadership operated and participants reported that being treated as the equal of their clinical leaders helped in fostering professional autonomy. This was seen positively by many of the interviewees. However when it came to distant Leadership, or management, there remained a strong association with the old hierarchical structures and a more negative view.

Clinical participants interview responses tended to suggest that their ideas of what Leadership and Patient Centred Care are, were grounded in their conceptualisation of their profession's values. There were similarities between how practitioners felt they should treat their patients and how they felt they should be treated by their team leaders. Flexibility was one key similarity with practitioners agreeing that they should treat each patient as an individual and listen to their context and situation and expecting their leaders to respect their professional autonomy. Flexible responsiveness, a central concept in the definition of Patient Centred Care within this thesis, refers to the need for a clinician to avoid adopting a "one size fits all" approach with their patients and adapting their consultation or approach to treatment accordingly. The process makes the follower or patient feel uniquely valued and important. In the case of the patient this may help built a more robust and trusting relationship with their clinician and in the case of the follower it motivates them to perform and realise their own potential.

Leadership was not seen as highly important in facilitating the delivery of Patient Centred Care, but participants were able to report some ways in which it proved to be a facilitator or, when conceptualised as 'management', was perceived as a barrier to the delivery of Patient Centred Care. These broadly match the definitions given earlier in this thesis relating to "good" or "bad" Leadership.

Overall the interviews did not provide evidence that participants felt Leadership had a direct or obvious impact on Patient Centred Care. However participants did report how bad Leadership could have a consequential negative impact on their ability to deliver Patient Centred Care. This could be because the conceptualisation of Patient Centred Care is considered by practitioners at the individual level: It is primarily seen as something they are responsible for and something that they provide and conceptualisations of Patient Centred Care as a global or organisational responsibility seem less salient.

It is worth noting that within the qualitative interviews participants expressed views that suggested they felt Flexibility in Responsiveness was important in the delivery of Patient Centred Care. This is at odds with the results found in the qualitative research and arguably supports exploring the potential relationship of 'flexibility in responsiveness' and Patient Centred Care with a wider sample across more Allied Health Care professions.

III. Are there contextual issues in practice that might influence how leaders facilitate or inhibit Leadership supporting Patient Centred Care?

The Podiatry staff were interviewed while their service was going through a re-organisation to implement a self-care orientated model of treatment. In this case Leadership was not mentioned as having any particular impact on the change, but management was associated with negative impacts on Patient Centred Care.

Participants drew a distinction between management and Leadership where management was generally perceived negatively and associated with bureaucracy and resources shortages. This fits with research that has associated Management with Transactional forms of Leadership based on contingent reward. From the literature review we can see that this type of Leadership or management has also been shown to negatively affect followers' levels of satisfaction and performance (Hunt & Schuler, 1976; Klimoski & Hayes, 1980; Podsakoff & Schriesheim, 1985 Yammarino & Bass, 1990).

However while 'management' was seen as explicitly hindering Patient Centred Care in some instances (e.g. through the introduction of new policies and restriction of resources) Leadership was not explicitly singled out as a means by which Patient Centred Care was improved or achieved. In terms of its impact on Patient Centred Care, participants did not consider Leadership to have a strong direct relationship. Arguably Leadership was seen as facilitating the delivery of Patient Centred Care by being strongly tied in-to the themes of supporting staff in their professional development and in respecting their professional autonomy.

In general both professional groups associated Leadership as being largely a support role and that leaders were, or should be, there when the practitioner needs them to be and not omnipresent or micro managing. However Leadership in this context was not seen as being defined as a positional role and it was rather something that arose from teamwork and colleagues in a bottom-up sense rather than enforced by a top-down hierarchy. This is not to imply that leaders have no impact, but that any impact they do have is likely indirect as

opposed to direct: Relating to their role in facilitating a productive and inspirational work environment.

The key qualitative findings were grouped into two narratives, 'Systemic' and 'Individual': where 'Systemic' referred to how Patient Centred Care can be facilitated or blocked within the corporate NHS; and 'individual' referred to how a clinician, in their individual practice, delivers Patient Centred Care within a clinic or consultation.

Systemic concerns which Dieticians reported as impacting on the delivery of Patient Centred Care concerned the referral process at work within NHS Greater Glasgow and Clyde and the difficulties of working in multidisciplinary teams. Both Podiatrists and Dieticians were concerned with shortages of staff and the resulting pressure this put on their services. For Podiatrists, their service re-organisation and the move to introducing the Personal Footcare guidelines across the service were seen as having an impact on the delivery of Patient Centred Care. Some interviewees reported a tension between management and staff regarding this move. Although Podiatrists reported that they had been consulted and their views taken on board there seems to be questions regarding whether this was an inclusive process or a top-down re-organisation where some management were less than successful in getting some staff to take ownership of the change.

One issue in determining whether there are contextual issues where Leadership may facilitate or inhibit Patient Centred Care is that staff determine Leadership as behaviour that is supportive of staff and define management as 'something that typically affects them negatively'. This tends to suggest that close Leadership, on site or at a similar level to staff, is viewed positively but distant Leadership, managers and those higher up in the hierarchy, are viewed as bringing in negative, though often accepted grudgingly as necessary, changes to practice. This in itself is an issue of context: in which Allied Health professionals view their Leadership or management being defined by two separate conceptual ideas depending on whether the find the outcomes of either favourable or in line with their values. Unfortunately obfuscates whether if other more specific or subtle contextual factors may be at play.

It can certainly be demonstrated that changes to the organisation of local clinics and new policies can affect how staff view their Leadership. However, as staff typically viewed Leadership as irrelevant to their delivery of Patient Centred Care, or viewed their professionalism as a means of overcoming systemic issues, there is little to suggest contextual issues affect how Leadership and patient centredness interact.

5.1 Further reflections and discussion of results and findings

From the results of the survey study it seems that patients' experiences of care were generally very positive and patients were happy with the levels of Patient Centred Care they received. Both groups scored highly in terms of communicating with patients and patients were in turn satisfied with their treatment. In both groups, how well a patient knew their practitioner was associated with slightly higher scores and this increase was slightly more marked for the Dietetics group than the Podiatry group.

Within the Podiatry group there was little variation between patients' scores on the Consultation Care Measure (CCM) with the exception of the 'personal relationship' subscale which contained items relating to how well the Podiatrist knew the patient, their medical history and understood their emotional needs. This variation is perhaps explained by the number of patients who were assessing their patient experience on the first time they had seen an individual Podiatrist. At the start of a therapeutic alliance, or relationship with the Allied Health Professional, it is unsurprising that scores on how well the Allied Health Professional knows the patient score lower and vary more than communication. When this was statistically tested it was indeed found to be the case. However, in contrast the Dietetics group did not show the same levels of variation based on how well known the clinician was to the patients. This finding seems coherent with the differences in both professions in terms of what a consultation entails. In Podiatry a consultation revolves around a treatment which may be a one-off or one requiring repeated visits. There is perhaps more of a luxury of time in this scenario to develop a therapeutic alliance between patient and Podiatrist over several visits than there is in the Dietetics consultation. The Dietetics consultation, by its highly communication dependent and advisory nature, requires Dieticians to develop a rapport and nourish their therapeutic relationship with their patients from when they first meet.

'Communication' was the key theme that arose within both groups regarding how Patient Centred Care was delivered at an individual level. This is unsurprising as communication is central to many of the policy approaches to Patient Centred Care. Participants detailed how they use communication to overcome systemic issues and build relationships with their patients in line with the emphasis on a collaborative approach or partnership that is common across many of the different definitions of Patient Centred Care in the research. This was

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typified by the Dieticians' responses to the issue with referrals where the participants described using a number of communication techniques to overcome problems that arose because of this. Communication was also seen as important to Dieticians in seeing the patient as a "whole person" and they reported tailoring their consultations, advice and prescriptions to individual patients. Again this reflects another of the conceptual commonalities present across definitions of Patient Centred Care regarding health professionals respecting the patient and their needs and concerns. This more holistic approach to treatment of the patient was in contrast with the role of communication in Podiatry where clarity and reassurance were more prominent. This likely reflects the differences between Podiatry and Dietetics practice as Podiatry is a more technical Allied Health Profession and treatment is given within the consultation. Thus patients may be more wary of immediate physical discomfort in treatment than they are concerned about the potential long term impact of Dietetics advice.

It is interesting to note that the Dietetics approach is, by necessity and design, a self-care approach which relies on the quick formation of a rapport or therapeutic alliance with patients where in Podiatry this relationship has more scope to be developed over time. There is some evidence from the quantitative data to back this up: Where answers on the consultation care measure show statistically significant results when checked against how well the patient feels they know their practitioner. The same items are not found to be statistically significant for the Dieticians. The differences between the Dietetics and Podiatry consultations are perhaps why the quantitative results for the Consultation Care Measure (CCM) measure show a difference between the two groups on the communication items when 'how well known' the clinician is to the patient is taken into account.

Differences across the four quadrants for both the Consultation Care Measure (CCM) (Little, Everitt, & I, 2001) and Consultation and Relational Empathy (CARE) (Mercer, Watt, Maxwell, & Heaney, 2004) were fairly small. The differences between CCM and Consultation and Relational Empathy (CARE) scores for individual Podiatry participants were larger although it seems apparent that much of the variation between individual Allied Health Professionals Consultation Care Measure (CCM) and Consultation and Relational Empathy (CARE) scores could simply be explained by individual return rates. As return rates increase, the scores become closer to the overall or quadrant averages which could indicate that if participants

with few returns had returned more, their scores would be closer to the overall average. Alternatively lower return rates might be expected from participants whose patients had a worse experience of care than those with high return rates. The results obtained would seem on the whole to support the former hypothesis more than the latter however: as those with the lowest return rates appear to have higher average scores for both the Consultation Care Measure (CCM) and Consultation and Relational Empathy (CARE) measure. Scores for both the Consultation Care Measure (CCM and Consultation and Relational Empathy (CARE) measures increased, and this was found to be statistically significant, if the participant indicated they knew their Podiatrist, again reinforcing the idea that the therapeutic alliance in Podiatry is strengthened over time.

No significant differences were found between the scores on the Wong and Law emotional intelligence scale, the Transformational Leadership Questionnaire or the Self-monitoring scale when these were compared across quadrants. The lack of significant differences in Transformational Leadership Questionnaire (TLQ) scores in particular calls into question the theoretical underpinnings of this thesis. As it would seem more probable that if Leadership had an important impact on staff than there would be more obvious differences between quadrants. Alternatively this could indicate that there is a strong homogeneity within NHS Leadership and that Leadership across the NHS is off a similar standard and style, or it could also indicate that Leadership in the NHS is generally seen as a positive thing by staff. The findings from the interview study would seem to support this in the case of close Leadership, team leaders and those managers embedded within teams, but the interview data also shows that management in general was seen as distant and bureaucratic.

In the Podiatry group there was a significant correlation for both the Consultation Care Measure scores, the Consultation and Relational Empathy (CARE) scores and the Transformational Leadership Questionnaire. In the Dietetics group there was a small correlation between the Consultation Care Measure and the Transformational Leadership Questionnaire. This suggests that there may be a small effect of Leadership on the delivery of Patient Centred Care in some allied health professional professions. However given that the correlation found exists only weakly (0.207, $P<0.05$) it is insufficient on its own to validate

the underlying theory of this thesis. More detailed work exploring the issue with larger groups of allied health professionals is needed to confirm the theory.

To understand clinical participants' perceptions of Patient Centred Care it is important to understand the manner in which Dietetics and Podiatry differ in their conceptualization and delivery of Patient Centred Care: Patients can go into a Podiatry consultation with the expectation that they have a medical problem that this appointment can address. They could carry this same expectation into a consultation with a Dietician but the nature of Dietetics means that their expectation may be challenged. A Dietetics consultation cannot be understood in terms of a set 'recipe' for treatment, they are in effect far more diagnostic and advisory than that. Patients are not routinely prescribed a course of treatment by a Dietician that they can passively take regardless of differences in lifestyle and personal situation. The Dieticians have to work within the patients' context and situation in order to persuade them to make a lifestyle choice that will benefit their health or support treatments they are receiving elsewhere. A Dietetics consultation is not fundamentally about prescribing a treatment but is far more advisory in nature and carries a greater emphasis on what the patient can do for themselves regarding treatment or health improvement.

Participants across both professional groups had more to say on the issue of Patient Centred Care than they did about Leadership. This perhaps reflects participants' beliefs that Patient Centred Care is more central to their day to day practice than Leadership. It could also be an artefact of how participants were recruited to the study. Team managers in Podiatry and Dietetics services were first approached regarding recruiting staff. This was necessary in order to obtain the cooperation of the service and could not have been avoided. Despite reassurances regarding the confidentiality and anonymity of participation, it is possible that this mechanism of recruitment may have resulted in staff feeling less able to disclose as much as they might have if the management of the service was not involved. It is also possible that I, the interviewer, did not press as much on Leadership issues as on some level I may have felt grateful to management for allowing the study to progress.

Patient Centred Care was largely thought of in terms of the individual narrative, such as the communication skills that aided in the delivery of Patient Centred Care, though participants were able to identify systemic issues that impacted upon the delivery of Patient Centred Care such as issues with internal procedures, interdisciplinary working and a shortage of time and resources. Participants seemed highly committed to the delivery of high quality Patient Centred Care and their values of professionalism and autonomy were central in their approach to dealing with those systemic issues that impacted upon Patient Centred Care. Participants in both groups reported using individual clinical communication skills, "listening to patients" and managing expectations about treatment, as the means they used to overcome systemic issues of pressures limiting consultation length, appointments being unavailable or usual clinics not being available.

When Transformational Leadership Questionnaires were compared across professional groups it was found that Dieticians rated their leaders significantly more highly than Podiatrists (87.22 against 53.72) which points to a difference in how Leadership operates within the two services. However When Consultation and Relational Empathy (CARE) and Consultation Care Measure scores were compared between professional groups it was found that Dieticians' scores did not differ significantly from each other. This suggests that any impact of Leadership on Patient Centred Care could be minimal, that it is hard to measure quantitatively or that there is no direct relationship between the two. Though it is also possible that there exists a similar NHS wide Leadership culture or context that provides a strong foundation on which to provide Patient Centred Care.

Podiatry interviews were conducted while the service was undergoing a service re-organisation, which has seen them move some procedures onto a self-care programme where patients take responsibility for some aspects of their own care. Some NHS staff I was in contact with during the study intimated that they felt this was in response to policy pressure from the Scottish Government through the PFG - Personal Footcare Guidelines (Scottish Government, 2013), have taken on board the self-care agenda and perceive this as a positive direction for Patient Centred Care. A common theme that emerged in the Dietetics interviews was staff reporting that patients often went into a consultation not knowing why they were there or what was due to happen in the consultation. It was noted that this lack of information

could result in patients being more anxious about attending. If patients had better information prior to their referral to the Dietetics service, then they would likely feel less anxious and their experience of care would improve. Though staff were able to find ways of working this to their advantage in tailoring the consultation to the individual and their specific needs and circumstances, they still felt it diminished Patient Centred Care.

Podiatry staff often felt that time pressures meant that patients would experience less than ideal care. They felt that if the service was under pressure that reduced consultation times would have a negative knock on effect on patient satisfaction levels, though this was not found to be the case statistically. Further to this, they also felt that delays in patients receiving appointments due to service restrictions meant patients were less satisfied. In this sense health professionals aligned themselves with patients against service restrictions and other systemic issues. Despite a lack of evidence to suggest that delays in getting an appointment or having to wait on the day affected patient satisfaction scores professionals expressed their disquiet about this as concern for the patients. In other situations relating to service design and change professionals would align both with patients and with their own direct Leadership against the higher up management.

Overall clinical participants' conceptualisations of what Patient Centred Care is matched well with the definition given in this thesis. Participants believed that care should be individualised and tailored to individuals. Though individualised care was more prominent among Dietician participants it was also an important element in Podiatrist consultations. Dieticians' consultations were also more focused on supporting patient choice, which is unsurprising given the nature of Dietetics practice. The move to a self-care agenda in Podiatrists' consultations, however, has caused a tension between management and participants around patient choice. This is because the move to self-care is seen in different terms by management and participants. From a management perspective the move is supportive of patient choice and encourages autonomy, while some participants' perspective was in direct contrast as they felt that the move reduces patient choice as it decreases the services and procedures they can access.

As noted earlier participants across both professional groups had more to say on the issue of Patient Centred Care than they did about Leadership. This perhaps reflects the value clinicians place on their own professional autonomy within the NHS. Clinicians didn't necessarily see any fundamental differences between themselves and their team leaders professionally.

5.2 Relationship to other research

The qualitative findings mirror previous work exploring the differences and tensions between Leadership and Management. When management was discussed in the context of Patient Centred Care it was usually to identify systemic problems impacting on the service, for example: Leadership was generally seen more positively and associated with close Leadership within teams and related more with dealing with supporting staffs on the ground. The idea was expressed that Leadership was not a purely hierarchical positional role but that "anyone could be a leader" and Leadership was closely identified with peer support. These tensions can also be seen in relation to Quality Improvement where a balance must be struck with a number of tradeoffs between centralisation and decentralisation in efforts to sustain the impetus for quality improvement over time (Ferlie & Shortell, 2003). Quality Improvement often adopts a holistic approach and its attention to whole systems may impair or impact negatively on individual leaders and the relationships they have created with their staff. Particularly where there are systemic changes being implemented "from above" akin to the Self-Care strategy implementation in Podiatry.

Another tension often found between Leadership and Management in Quality Improvement concerns the tensions between managements promotion of a risk-averse culture and leaderships support and development of professional autonomy. Barry (2007) has noted that the public nature of mistakes in public services such as health and social care can lead to a culture of 'blame avoidance' where professional autonomy is constrained by individuals who are concerned with following process and avoiding errors. A risk averse culture can cause an individual to feel depersonalised and disempowered as they feel unable to exercise professional judgement because of the potential costs of being wrong. This culture also discourages the reporting of near misses or incidents where harm was ultimately avoided but by not reporting these important learning and development opportunities are missed, as well as the potential for service improvement (McLean, 2017). While this tension was not explicitly

mentioned in the interviews by participants as something they had experienced it was strongly alluded to when participants described the negative aspects of micro-managing. The participants acknowledgement that micro-managing impacts on professional autonomy could arguably be taken as a sign that a risk averse culture is recognised as counter-productive within the NHS. Though more research would be necessary to more fully explore this idea.

Participants conceptualisations of Leadership and Management broadly align with how the concepts have been defined within the research literature. With both the positive behaviours participants associated with Leadership and the Negative behaviours associated with Management matching well with Stanleys' scheme (See table 1 pp22). Although, there was some agreement that both Leadership and Management skills were necessary to support the success of the organisation (Boaden, 2006). Participants also acknowledged that tasks typically associated with management (e.g. organising staff Rota, meetings and planning clinics) were important but did not associate management skills with suitability for executive positions (McCartney & Campbell, 2006).

As discussed in the literature review the Cummings el al. (2001) meta-analysis found that relationally focused Leadership styles significantly improved job satisfaction in 23 studies and task focused Leadership significantly decreased job satisfaction in 10. This result highlights the differences in how staff view Leadership styles associated with more traditional management styles and those associated with more relational Leadership styles. Given the results of past research (Sofarelli and Brown, 1998; Thyer, 2003; Welford, 2002) it is unsurprising that participants in both groups felt that Leadership should be supportive of professional autonomy within their services.

While the majority of participants did not divulge any negative Leadership behaviours they had experienced whilst working within the NHS when asked what they thought negative leadership would be like they identified behaviours such as excuses, apologies and self-handicapping (Valle & Perrewe 2000). They also identified blame-shifting and misrepresentation (Ashforth & Lee 1990) as negative leadership behaviours they felt would impact badly on team performance. The behaviours described by participants in the interviews are largely congruent with those associated with Transactional or Reactive styles

of Leadership (Blanchard and Johnson, 1985). Interestingly the participants did not mention or focus on contingent reward or reinforcement despite it being linked in the research literature with improved organisational outcomes (Howell & Avolio, 1993; Lowe, Kroeck, & Sivasubramaniam, 1996).

Within the research literature there is some support for the idea that Leadership may have a subtle impact on nurses' wellbeing and the quality of care they deliver. As staff wellbeing and quality of care have been shown to be interdependent (Maben, Adams, Peccei, Murrells, & Robert, 2012). Leadership has the potential to indirectly impact on Patient Centred Care by affecting healthcare professionals wellbeing at work. The impacts of occupational stress, burnout, and compassion fatigue feature prominently in the research literature (Chang et al., 2007, Lee et al., 2012 and Tucker et al., 2012); as do workforce turnover and nurse shortages (Hayes et al., 2012 and Roche et al., 2014). Patient Centred Care will likely suffer when staff are fatigued and even more when staff feel burnout. Many nurses cope with the impacts of stress and fatigue by distancing themselves from patients (Mackintosh, 2007) which leads to a less patient centred form of care. One that can perhaps be thought of in the sense of 'working to rule' rather than 'going the extra mile'. Consistency of care is also negatively affected by poor staff wellbeing and this weakens the therapeutic alliance or rapport that health professionals can have with their patients. If Leadership is focused on reducing stress and encouraging staff wellbeing it has the potential to lessen the negative impact of stress on the delivery of Patient Centred Care.

In terms of positive Leadership behaviours participants mentioned being satisfied with supervision and monitoring (Podsakoff et al., 1990) and made reference to how their leaders would help them rally around against systemic pressures and barriers (Burns, 1978) In terms of positive outcomes these behaviours are linked to transformational Leadership in a large body of research literature (Bass, Avolio, Jung, & Berson, 2003). Meta Analyses (Judge & Piccolo, 2004; Lowe, Kroeck, & Sivasubramaniam, 1996) have shown that transformational Leadership is associated with increased employee satisfaction and organizational commitment (Bycio, Hackett, & Allen, 1995; Podsakoff et al., 1990), satisfaction with supervision (Podsakoff et al., 1990), extra effort (Seltzer & Bass, 1990), turnover intention (Bycio et al., 1995), organizational citizenship (Podsakoff, MacKenzie, Paine, & Bachrach,

2000) and overall employee performance (Yammarino, Spangler, & Bass, 1993). This literature shows that the negative impact that stress can have on the delivery of Patient Centred Care can be ameliorated by Transformational Leadership.

Participants responses in the qualitative interviews largely reflect Scott et al's (2003) view that the NHS has an 'orthogonal culture' as they accepted the cycle of change within the NHS and systemic pressures such as shortages of time, resources or staffing as things that could not be changed. Though while they accepted these issues and aspects of the NHS's organisational culture they also deeply valued their own professional values and autonomy. We can also see the importance of Leadership in changing organisational culture through the Podiatry participants responses to the introduction of the self-care footcare strategy. Depending on their quadrant leadership and clinical management there was different levels of comfort in adopting this new strategy from staff and this is reflected in some of the interview responses. However, this difference may be too subtle to have been picked up in the quantitative results. There was little to suggest any great deal of 'cultural divergence' within the professions across NHS Greater Glasgow and Clyde (Mannion, Davies, & Marshall, 2005) with participants attitudes to both Leadership and Management unaffected by their geographical location or specific team or department.

Communication was seen as central to the provision and delivery of Patient Centred Care by all participants. Key to this was treating the patient as an individual and respecting their autonomy, dignity and privacy (Ford and McCormack 2000; McCormack 2003a, Nolan et al 2001, Price 2004). There was an emphasis on striving to find a collaborative approach or to build a rapport or partnership with the patient to empower and involve them (Michie et al ,2003; Schoot et al, 2005; Lyness Slater, 2006; Leplege et al,2007). Dieticians in particular were concerned with the personal aspects of care (Hsaio and Bouet, 2008) and recognizing and respecting the impact their suggestions for treatment or intervention could have on the patients day to day life and family or work. Thus they valued paying attention to the personhood of the patient (Suchman, 2005) and understood them as a unique individual with their own characteristics, needs, values and preferences (Sidani et al, 2006).

To varying degrees both Podiatrists and Dieticians attempted to facilitate patient choice. Podiatrists by trying to offer suitable appointments for patients and Dieticians by tailoring the advice given within their consultations. Though for Podiatrists it is debatable how much this would qualify as *"Considering patient's needs, wants, perspectives and individual experiences, offering patients opportunities to provide input into and participate in care"* (taken from Epstein et al 2005 p.1517) it would be fair to say that Dieticians practice a form of flexible responsiveness (Epstein, 2005).

The importance of teamwork, in practice and in supporting it as a value, was associated by participants as being supportive of Patient Centred Care. This is similar to other findings in the literature where greater functional health in patients (Shortnell and Kaluzny, 2000) and greater implementation of quality improvement practices (Shortnell et al, 1995) is associated with teamwork and greater group affiliation.

There has been one major study that quantitively explores transformational Leadership in Allied Health Professionals in Scotland. Wylie's (2005) research study aimed to establish the degree to which each of the nine Leadership behaviours within the Full Range Leadership Theory was present within the six largest AHP groups across Scotland. The primary aim of this research was therefore to explore and attempt to measure the comparisons between self-reported Leadership behaviours across six Allied Health Professions, and to examine contextual factors that may influence or contribute to any significant differences. Wylie (2005) found that there were significant differences between Dieticians, Occupational Therapists and Physiotherapists, in their views of line managers as role models. Podiatrists, Radiographers and Speech & Language Therapists reported that only around 55% of their line managers were positive role models for effective Leadership. This supports some of the differences found in this thesis between the Dietician and Podiatry professional groups Transformational Leadership Questionnaire (TLQ) scores.

One area of concern for Dieticians, where potentially better Leadership could improve Patient Centred Care, was concerned with their interactions with other departments. Specifically in relation to the referral process for Dietetics where it was felt there were sometimes failures in explaining the process to patients. There is scope here for improving the consistency of

care received and an authentic leader can support their staff in dealing with the processes and procedures of the health service more effectively. Laschinger and Smith (2013) investigated the relationship between Authentic Leadership and inter-professional collaboration. Authentic Leadership is leadership that emphasises building the leader's legitimacy through honest relationships with followers which value their input and are built on an ethical foundation (Kernis & Goldman, 2006). Laschinger and Smith (2013) used a predictive nonexperimental design to test a model integrating authentic Leadership and workplace empowerment as resources that support inter-professional collaboration. They analysed the results using Multiple regression and found that 24% of the variance in perceived inter-professional collaboration was explained by unit-leader authentic Leadership scores and structural empowerment ($R2 = 0.24$, $F = 29.55$, $P = 0.001$). Authentic Leadership ($\beta = 0.294$) and structural empowerment ($\beta = 0.288$) were significant independent predictors. Their results would seem to suggest that Leadership styles can have an impact on health professional practice in terms of inter-professional collaboration.

Time pressures and the issues associated with service reorganisations were mentioned by Podiatrists as barriers to the delivery of high quality Patient Centred Care. Research exploring the convergences and divergences of diabetic patients and healthcare professionals' opinions of care (Lauvergeron, Mettler, Burnarnd, & Peytremann-Bridevaux, 2012) has shown that in a self-care situation health care professionals do relate improvements in diabetes care as secondary to physician reinforcement of care and intervention by health professionals. Which perhaps provides some support for the primacy of physician's self-image over and above the implementation of self-care programs. Patients also related sub-optimal care to professionals having a perceived lack of time to deal with patients. This again might indicate a reason why participants in this thesis seemed to side with the patients in order to preserve the integrity of their relationships and maintain levels of perceived care.

In summary, while there is limited quantitative research to directly compare this thesis with, there is a large body of qualitative work that relates to some of its findings. Where good Leadership was seen to have a positive effect it was not always seen as "Leadership" but rather as part of a more collegiate team environment. This connects with the idea in transformational Leadership that everyone is a leader and to the Allied Health Professionals

image of themselves as autonomous practitioners. Research has shown that in situations of high autonomy, transformational Leadership relates positively to proactive behaviour for individuals high (but not low) on self-efficacy (Den Hartog & Belschak, 2012).

5.3 Limitations of Study

This section presents the limitations of this study including potential sources of bias, reflections on the role of the researcher and methodological issues that may have affected the results or findings.

5.3.1 Potential sources of bias in study

Bias does not simply arise from the personality and assumptions of the researcher and can be introduced to the study in a number of ways. One such way is in sampling as this can introduce a limiting bias (Groger et al. 1999). While care was taken to maintain a logical and pragmatic sampling frame within this study it could still be questioned whether the relatively small amount of questionnaire and interview participants, limited by practical considerations of time and resources, are truly representative of the views of all Allied Health Professional groups interrogated in the study. This is a particular concern when dealing with voluntary research on professional groups as participant's reasons for taking part may be intrinsically tied to their experiences of Leadership or management. Participants who volunteered for the study may have been more positively predisposed towards their leaders and managers and thus more willing to take part in surveys or interviews than those whose experiences of Leadership or management were more negative. There is little ethical recourse available to the researcher in addressing the problem of accessing the views of people who do not want to be research participants.

For participants who took part there was also the risk that the information materials given to potential participants could affect the answers they gave during participation. The information given has to be sufficient to allow participants to make an informed decision on whether or not they wish to participate. However the information that was given to participants was also carefully selected in order to limit any potential priming effects or the introduction of bias.

Another potential source of bias arises when the means by which the participants were recruited to the study. Clinical participants had to be contacted through their department's management structures. This in effect cast the role of managers within these departments

as gatekeepers of the research population. This raises similar concerns as mentioned earlier in relation to clinician participants self-selecting patient participants in the survey study.

The quantitative element of this thesis, study one, narrowed the focus onto one form of Leadership (Transformational) and used only one measure to determine its strength. However, the qualitative interviews found 'professional autonomy' was perceived as most important to the participants in impacting their ability to deliver Patient Centred Care, and the measures used in this study only really address that tangentially in terms of how well their leaders support them to be autonomous. This doesn't really address how autonomous participants were allowed to be or felt that they could be within their work setting as it muddies the concept of autonomy by linking it specifically to the actions of the leader.

5.3.2   Role of the researcher

In order to maintain transparency within the research process and the analysis and interpretation of findings it is important that the researcher consider how their assumptions or personality can impact or influence research outcomes (Thomas & Magilvy, 2011). To attempt to address this I maintained a process of writing field notes during and after each interview, which contained reflections on what new insights had arisen within each interview as well as personal and theoretical biases that might have affected my interpretation of the data during analysis. These notes were of great use when it came to discuss the findings of the interview data and consider my position and role as a researcher in the study.

While conducting the interviews I attempted to stay neutral by avoiding steering participants towards certain answers by using leading questions. However despite these efforts to maintain objectivity it is important to note the impact that I as the researcher could potentially have had on the direction of the research and the content and quality of qualitative data obtained.

My research background in psychology and my lack of knowledge of Allied Health Professional practice and NHS processes and procedures cast me in the role of outsider (Dwyer & Buckie, 2009) in relation to the professional groups interviewed in this study. In a number of interviews participants referred to acronyms and procedures within the NHS that I was

unaware of and for which I had to seek definitions or clarification on the participants meaning. This may have served to limit the potential responses that participants gave to my questions as they may have felt that I would not understand what they meant. Alternatively this may have allowed participants to focus on the more abstract concepts of Leadership and Patient Centred Care that were of interest to me as a researcher, than of concrete examples of process and procedure.

5.3.3 Methodological issues

One of the key limitations of this research was that overall return rates for the survey study (study one) were disappointing and due to a number of factors fell short of expectations. One possible explanation may be that Podiatry patients tend to be older and study materials were not designed with visual impairment in mind. However, far lower rates of return were seen in the Dietetics cohort. Another explanation may have been the lack of on-site support to the clinicians and their patients during study data collection. The method of using drop boxes or having to rely on patients taking home and returning survey measures in self-addressed envelopes may have reduced the number of surveys that were returned. The multi-site nature of this study meant it was not possible for myself as a lone researcher to offer such on-site support. The lack of any or consistent reception staff at many sites also limited the potential to forge relationships with others who may have been able to help with this administrative process.

Very few clinical participants collected enough patient data in order for individual analysis at a clinician level of patient satisfaction to take place. However, all quadrants returned enough survey response to allow valid quadrant comparisons. It is interesting to note that in both Allied Health Professional groups it was the same geographical areas where return rates were poor. This could be due to these areas being more geographically sparse when compared to other quadrants within NHS Greater Glasgow & Clyde, or could indicate issues with deprivation or other social factors in these areas.

When considering the results of the survey study (study one) it is important to note that there is an ongoing debate in the literature regarding the use and utility of measures of patient satisfaction. The lack of definitive quantitative proof of this thesis' theory that Patient Centred

Care and transformational Leadership are related, could in part be down to the limitations and other issues with the measures used. Both the Consultation and Relational Empathy (CARE) and the Consultation Care Measure (CCM) are measures of patient satisfaction and have in this thesis been used as proxy measures for patient centredness.

Since patient satisfaction measures became a common means of eliciting patients' views, on the care they had received, difficulties have arisen because of the limited theoretical underpinning of satisfaction as a concept. (Staniszewskae & . Ahmed, 1999). Few studies have defined satisfaction or been able to place the measurement of satisfaction within a theoretical model (Pascoe, 1983) this lack has made it hard to determine a generally accepted definition of satisfaction: some broad agreement on what is being measured, how to measure it and whether it measures something truly meaningful. Patient satisfaction measures are assumed to increase patient representation and participation through their evaluation of services. Yet most instruments used to measure patient satisfaction typically produce reports of high patient satisfaction. This seeming bias towards positive evaluation raises questions about the utility of the measures and whether they are a true measure of patient experience (Williams, Coyle, & Healy, 1998).

Within the survey results it is clear that the patients nearly unanimously rated their care as satisfactory. This may be due in part to the issues touched upon above or it could have a far simpler explanation: Patients that are dissatisfied with their care may not be motivated to complete patient satisfaction measures. It is also worth considering that the use of patient satisfaction measures based on single consultations may also have biased patients towards rating aspects of care that are more related to individual clinicians than those that might be directly affected by the quality of clinical leaders. Attempts are being made to address this within research (Williams et al 1998) by incorporating the idea of dissatisfaction into measures of patient satisfaction or care. However these measures are still very early in their development and would have been too large in their current state to use in this study. Furthermore the measures of patient satisfaction used in this study are well established within research and familiar to clinicians working within the NHS. Despite all the issues covered above the patient satisfaction measures used in the survey section of this study are still the best available at present.

5.4 Recommendations

A number of recommendations arise from the research conducted in this thesis for future research, practice and policy, these are outlined in the following sections.

5.4.1 Recommendations for future research

Further work exploring the link between Leadership and Patient Centred Care is required. A number of questions arise relating to the methodology in this thesis: Would a study with better recruitment and a wider range of allied health professionals produce different findings?, Does the degree of professional autonomy impact on the quality of Patient Centred Care?, What are the antecedents to bad leadership, and can these be ameliorated? Were the measures appropriate?, Was the study biased by gatekeepers?.

5.4.1.1 Sample size

The relatively small sample size of health professionals used in this study is worth considering. In any future research in this area, it would be important to obtain larger samples. In the case of this study time and resources meant a smaller sample of Allied Health Professionals and their leaders and managers was selected. Small samples affect research findings in two ways, namely in terms of the generalizability of the findings (the representative nature of the sample) and statistical conclusion validity. Future research should seek a larger sample as smaller samples tend to provide conservative results. A larger sample might be able to reveal in more detail whether there definitively is a relationship between Patient Centred Care and Leadership.

5.4.1.2 Professional Autonomy

The impact of professional autonomy on Patient Centred Care is also an area worthy of attention. Previous research has found that increased health professional autonomy was positively correlated with better perceptions of the quality of care delivered and higher levels of job satisfaction (RaVerty, Ball, & Aiken, 2001). In another study greater nurse autonomy, at hospital level, was significantly associated with lower odds of 30-day mortality and Failure To Rescue for surgical patients even after accounting for patient risk and structural hospital characteristics. Each additional point on the nurse autonomy scale was associated with

approximately 19% lower odds of 30-day mortality (p < .001) and 17% lower odds of failure to rescue (p < .01) (Rao, Aparna, & McHugh, 4 November 2016). Any such research in this area would have to be mindful of the tensions present between health professionals and healthcare systems when encouraging individual autonomy. Some have identified that the systemization of care may be positive for health professionals autonomy (Ferreira, Pereira, Souza, Almeida, & Taleb, 2016) by assisting in raising health professionals' confidence in conducting systemized procedures and freeing them to make clinical judgements in non-systemised situations. Whereas others have identified individual autonomy as a barrier to accepting and implementing systemic changes across health services and even suggested that professional autonomy can act as a bulwark against accepting new research and evidence (Armstrong, 2001). Arguably the conceptualisation of Transformational Leadership should be supportive of professional autonomy and results from the Transformational Leadership Questionnaire (TLQ) should reflect this there may be another construct or measure that could pick up on the subtleties touched on in the qualitative findings. It is also possible that the TLQ could be further developed for a specific public health service context and focus more on Leadership behaviours that promote or support professional autonomy.

5.4.1.3 *Exploring bad leadership*

Much of the focus of Leadership research has been on uncovering or explaining what constitutes good or effective Leadership (Kellerman, 2004; Aasland et al., 2008; Benson and Hogan, 2008). In response to this rather one sided approach a number of researchers have started to explore what makes bad leaders (see Conger, 1990, 1997; Tepper, 2000; Benson and Hogan, 2008). Recognising there is a difference between good and bad Leadership as concepts, or that there are differences between the roles of bad and good leaders could be a fruitful avenue or direction for future research. Burns (2003) comments that '*If it is unethical or immoral it is not Leadership. . .*' (p. 48) and this highlights the view some feel is prevalent in Leadership research that anything that is not 'good' Leadership does not qualify as Leadership. It is this view that some think has led to bad Leadership. Bad Leadership is a concept that emerged from the work of the Centre for Creative Leadership in relation to the issue of '*leader derailment/failure*' (McCall and Lombardo, 1983). This work identified that personal flaws and performance shortfall were the main causes of Leadership failure and derailment. McCall and Lombardo further identified a range of causal factors including skill

deficiencies, 'burn out', insensitivity to others, aloofness, arrogance, betrayal of trust and being overly ambitious. They argue that these personal flaws were more important than skill deficiencies in cases of bad Leadership. Future research could also focus on determining if there is a quantitative link between levels of stress, closeness of teams and Leadership and see if those are linked to measures of Patient Centred Care.

5.4.1.4 Antecedents of bad leadership

Similarly, while bad Leadership is thought to either be the absence of Leadership or negative outcomes arising from poor Leadership behaviours, little work has explored the antecedents of bad leader behaviour. There is a strong case to explore these antecedents and investigate how their effects could be ameliorated. Hogan et al. (1994), in some of the little work in this area, adopted a personality theory based view and suggests that certain extreme personality traits can give rise to personal shortcomings and negative Leadership behaviours. For instance ambition can be a positive influence on Leadership and is linked with taking imitative to improve organisational structures and performance. However it has a 'dark side' in that in can encourage damaging competition within organisations. It has been argued that it is the leader's position of power that can give rise to the behaviours that lead to bad behaviour Kets de Vries (1993b) argued that: "Leadership is the exercise of power, and the quality of leadership – good, ineffective or destructive – depends on an individual's ability to exercise power" (p22). Kets De Vries further suggests that leaders need a sense of individual potency in order to exercise power. They determine that this sense of potency includes ambition; a need to make a mark; a longing to be conspicuous and an urge to take initiative and control. He views all of these are legitimate but that if these are pursued to excess then these are the roots of bad leadership.

In a similar vein a leader who displays high levels of agreeableness may be highly liked by their followers but can also tend to avoid conflict. Overall this can have negative effects on the functioning of a team as issues go unaddressed and individuals are not censured for failings or transgressions. Research building on the idea that certain Leadership qualities have a 'bright' and 'dark' side suggests that the dark side personality dimensions predict Leadership behaviours that have a negative effect on followers (Hogan et al., 1994; Benson and Hogan, 2008; Benson and Campbell, 2007; Benson, 2006).

One of the major issues in the debate concerning the nature and impact of bad leadership is that there is little in the way of empirical research exploring it. There is a significant failure of general leadership research to address this issue (Maccoby, 2000, 2004; Doyle and Lynch, 2008). Much of the work is at present case based or uses demographic variables as indicators of personality traits; though much of this takes a psychoanalytic approach (Zalegnik and Kets de Vries, 1975). There are also trait based approaches that have focused on the relationship between the need for achievement, tolerance of risk and organisational outcomes (Ones et al., 1993) though these have failed to provide conclusive results.

It has also been suggested that Leadership quality is socially constructed and that what is construed as 'bad Leadership' is really a mismatch between leader and follower expectations (Benson, 2006; Benson and Hogan, 2008). There is arguably a demand for more research in this area to confirm whether the subjective terms 'good' or 'bad' Leadership relate to Leadership that succeeds in the short term but fails over a longer term.

However highlighting the negative aspects of traits that are generally considered to be positive is an important consideration. Not simply because some leaders may simply give the appearance of competence or effectiveness but also because leadership is in part defined by how one is viewed by those they are leading.

5.4.1.5 Measures and Scales

Future research should also consider whether the scales used in this study were appropriate to measure the theoretical relationships proposed. There may be more appropriate measurements for Leadership and Patient Centred Care that could be used to test whether there is a relationship between the two. The same is also true for the proxy measures used for Flexibility in Responsiveness. It might be worthwhile investing in developing new measures to explore these concepts. Additionally, it might be worth conducting research which could explore in detail the 'logic model' of policy makers when investing in leadership to achieve better patient centred care. This might elucidate hypothesized pathways to impact (PCC) and what mechanisms they anticipate will be enacted via Leadership. These mechanisms might then be studied using existing or new measures in line with my comment above.

It is also worth pursing research that explores measures of patient dissatisfaction rather than patient satisfaction as work in this area could prove enlightening.

5.4.1.6 Gatekeepers

When approaching this topic researchers should be mindful of the impact that gatekeepers could potentially have on their research. Particularly if those individuals allowing access to participants are themselves responsible, on some level, for managing the participants. Ideally managers and team leaders should have little influence over who takes part in studies but in reality this is often impractical or difficult to avoid. Access to funding to allow covering staff hours lost to research could potentially help lessen the reliance on gatekeepers and avoid any issues related to the selection of participants. Enthusiastic gatekeepers may also be unable to transfer their interest and enthusiasm to other staff, especially those at the coal face, to engage in research. In these circumstances it is important for a researcher to be able to have access to all potential participants to explain the rationale for the research and what it aims to achieve.

5.4.1.7 *Perceptions of Self-care programs and their impact on PCC*

Another area worthy of further exploration is health professionals' perceptions of self-care programs: how they view their introduction; what they think patients think of them; whether they feel they promote conflict or disharmony between staff and managers, and staff and patients, and what barriers they think exist to introducing more self-care orientated treatment. Currently there is a large body of literature that focuses on patients' perceptions and experiences (of self-care) where professionals' experiences aren't fully or are poorly addressed. Given trends within the Scottish NHS towards more 'empowering self-care' initiatives this is an issue that would benefit from further detailed exploration.

5.4.2 Recommendations for practice

There are a number of recommendations arising from this research for clinical team leaders, for the specific Allied Health Professional groups in the study, and for individual Allied Health Professionals.

5.4.2.1 Recommendations for Clinical Team Leaders

Clinical team leaders should avoid setting rigid hierarchies and relying on features of Transactional Leadership such as contingent reward and punishment. Team members should be treated as the colleagues and peers of clinical team leaders rather than 'subordinates' and should be involved and consulted in decision making as much as is possible or practical. Team leaders should be available to offer advice and assist when needed but they should be careful not to micro-manage or over monitor their clinical staff as this could very easily lead to resentment and increased stress within the workplace.

5.4.2.1.1 Balance between organisational and individual needs

Team leaders also have to strike a balance between organisational and individual needs and manage any tension or disagreement between the two. It will assist organisational change if team leaders can involve their teams as early as possible in the cycle of change, as this will help insure that their views are consulted by higher management. This will help 'sell' organisational change to the front-line staff who will be implementing it as well as helping to identify any issues that may prove a barrier to the proposed changes.

5.4.2.1.2 Reducing staff stress

One potential way clinical leaders could enhance Patient Centred Care could be through the reduction of stress or by encouraging collegiate working. There will be many causes of work related stress, and not all will stem from perceptions of leadership. However, leaders can contribute to alleviating some levels of workplace stress via their supporting roles. Leadership could perhaps operate more effectively if viewed as a 'mentoring' role; there to support staff when needed but typically hands off and trusting of their professional competence and judgement. Clearly a balance would need to be struck between the autonomy of clinicians and the needs of the health service at large because there will be a risk that increasing autonomy will increase resistance to organisational and systemic changes.

5.4.2.2 Recommendations for Podiatrists Clinical Leads

5.4.2.2.1 Supervision and mentoring

Podiatrist clinical leaders should endeavor to ensure that their staffs' expectations are met regarding their supervision, mentoring and development needs. They should ensure that staff are offered and able to attend development opportunities such as training courses and manage resources effectively to allow this to happen.

5.4.2.2.2 Open Door policy

Clinical Leaders in Podiatry should continue to be available to their staff and respectful and open to their ideas and issues. This helps staff feel supported and fosters a collegiate atmosphere that allows staff to feel informed and that they are part of a team.

5.4.2.2.3 Implementation of self-care agenda

Clinical leaders might help staff in transitioning towards the introduction of self-care by patients. This could be at the level of recognizing the resistance that patients may express to staff and the impact it may have on patient satisfaction. Clinical leaders might help with additional training to support staff to encourage self-care practices among patients.

5.4.2.3 Recommendations for Dietetics Clinical leads

5.4.2.3.1 Communication

Clinical Leaders in Dietetics should cultivate and develop stronger lines of communication with referrers to ensure patients are better informed. This would be a small improvement that could make a big difference by increasing patients' knowledge of the Dieticians role and by letting them know what to expect from the consultation so patients can prepare and can maximize the opportunity to ask questions and seek appropriate advice. This will also help Dieticians optimize their time within the consultation and learn more about the patient and build a rapport to help strengthen the therapeutic alliance.

Clinical Leaders in Dietetics should also ensure that they are in contact with all members of their team so those operating away from hubs do not end up feeling isolated. This can help build collegiate team working and by keeping lines of communication open it ensures no one misses any important updates or organisational news and developments.

5.4.2.3.2 Recognition and Reward

Dietetics clinical leaders should ensure that any extra effort staff put in is acknowledged and rewarded as not doing so can build resentment and decrease organisational affiliation. This could be challenging given the dispersed nature of most dietetics teams but it is important to recognise and reward individuals going the extra mile for the service.

5.4.2.4 *Recommendations for Individual Clinicians*

Individual clinicians should continue to develop and use their 'soft skills' in communication and building rapport with patients. As this helps strengthen the therapeutic alliance and positively impacts upon the patients perception of the care they are receiving. They should also take into account their patients individual circumstances and needs during the consultation and when recommending or prescribing treatment choices.

Clinicians should continue to manage the expectations of their patients and ensure these are realistic where they relate to the success of treatments, availability of appointments and continuity of care. Clinicians should also be aware of the potential impact their treatment or advice could have on individual patients given their specific circumstances.

5.4.3   Recommendations for Policy

This study proposes a number of recommendations for policy makers to consider including shifting the focus of leadership development programs, developing evaluation strategies that reflect the intended impact of leadership development programs, consulting staff on system redesigns and exploring how changes in policy impact on quality criteria.

5.4.3.1   Leadership Development programs

Services should consider shifting the focus of their Leadership development towards the development and respect of Professional Autonomy. The concept of professional autonomy should be fostered within Leadership programs to enhance delivery of Patient Centred Care. Indeed the qualitative research in this thesis suggests that there may be a case that Leadership has an indirect impact. Leadership that is supportive of staff autonomy may support and enhance Patient Centred Care though this relationship may be subtle.

Services should consider how they currently evaluate leadership development programs and look to measure the impact these programs have on services and outcomes as well as individuals. This would be a more comprehensive exercise than the evaluations currently conducted and it will require a great deal of investment to ensure these are designed correctly so robust evaluations can occur. There should be less emphasis on evaluations that report self-efficacy and measure individual personal benefits such as growth in confidence and more focus on objective measures of performance.

In line with the recommendations for individual clinical leaders Leadership development programs should also include an emphasis on developing communication skills alongside more traditional leadership behaviours as supervision and mentoring.

5.4.3.2   System redesign and staff consultation

When system redesigns or changes are being considered there needs to be more input from frontline staff. Consultations with staff on these changes need to be seen by staff as genuinely consulting them and not simply box ticking exercises. Involving staff more fully in the decisions that affect their patients care could result in them taking more ownership of organisational change. This could also possibly help them cope when external forces, such as funding or resources, are seen by staff as threatening Patient Centred Care. As these could potentially be seen as processes they are involved in rather than being managed through.

5.4.3.3   The impact of policy changes on quality criteria

The impact of individual policies, such as self-care, on quality criteria need to be more fully considered. While such policies may make care more efficient, there may be negative consequences for other quality care criteria, such as Patient Centred Care. Healthcare policies or investment, such as investment in Leadership programs or policies aimed at delivering better Patient Centred Care, should have a 'logic' model to articulate how these policies or investments are intended to work, what mechanisms need to be in place to enact the policy/investment goals and that short, medium and longer term impact do they anticipate will be delivered by the policy/investment. Such a 'logic' model can then help define whether outcomes can be measured (what tools are available or could be developed) and also help to assess the 'evaluability' of the policy or investment.

There should be a particular focus on consulting health professionals about the introduction of self-care programs which shift responsibility for care from the professionals to their patients. It is important that NHS Scotland understands what staff think and feel about moves in this direction and how it impacts upon health professionals practice. As this affects whether staff buy in to new ways of doing things and how professionals react to these changes and inform their patients of them has the potential to greatly affect how successful such moves are.

5.5 Conclusions

From the quantitative study, significant relationships were discovered for both AHP group linking Transformational Leadership with patient centred quality of care measures, however, the correlations between Leadership scores and patient centredness scores were weak. This, on its own, is not strong enough evidence to justify the theoretical assumptions reflected in policy on improving Patient Centred Care through Leadership. Further work with a larger sample and more complex multi-level statistical analysis would help to confirm and describe any effects.

The findings of the qualitative study showed that Allied Health Professionals' in both groups had broadly similar conceptualisations of Leadership and both groups played down the role of Leadership in the delivery of Patient Centred Care. A far more salient factor in achieving the delivery of high quality Patient Centred Care for the AHP's interviewed was professional autonomy. A number of contextual issues related to both Patient Centred Care and Leadership were identified from the qualitative analysis. These were centred on systemic factors, relating to management and bureaucracy, and individual factors, such as relationships within teams. In Podiatry a major shift in the context of care was ongoing during the study in the switch to self-care. This affected the relationships between patients and Podiatrists and Podiatrists and managers in a way that Podiatrists felt was negative.

Professional autonomy was identified as being more likely to facilitate delivery of person centred care through the interviews and organisational issues and intervening policy directives were felt to impact on the delivery of Patient Centred Care, regardless of Leadership. It is arguable that in some sense professional autonomy serves as something of a proxy for flexibility in responsiveness. Originally this was considered in this thesis as the mechanism by which clinicians and leaders respond to changing circumstances. Professional autonomy could be conceived of as a reflection of the everyday operationalisation of flexible responsiveness in the sense that the professionals interviewed valued an individualised approach to Patient Centred Care. Being flexible in their responsiveness could therefore be seen as key to their day to day provision of care and a central part of their professional identities. However the statistical results strongly suggest, that if the measures chosen as

proxies were generally reflective of professionals being flexible in their responsiveness, that this isn't the case.

In conclusion, the theory that there is a link between transformational Leadership and Patient Centred Care was not strongly confirmed. Though some results reached of statistical significance they were not sufficient to demonstrate a strong link between Leadership skills and the delivery of patient centred care. There is a strong argument for further work to be conducted in this area to more conclusively test the theory though the results of the studies in this thesis also provide other potential avenues for future researchers to pursue.

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Appendix A: Study materials

The impact of Leadership on the delivery of high quality Patient Centred Care in allied health professional practice

Professional Information Sheet

Leadership and patient centredness are currently of key interest and importance within the health service. While it may seem reasonable that Leadership can have an impact on the delivery of Patient Centred Care, little has been done to try and directly measure this relationship in practice. Research has determined that the most successful Leadership style is transformational Leadership (TFL). In this study I intend to investigate this relationship using a combination of survey and interview methods to examine which aspects of Leadership enable and inhibit the delivery of care.

Why have you been asked to take part?

The practice with which you are associated has agreed to take part in this research. You have been asked to contribute as a clinician working in outpatient care.

What will we ask you to do?

In **phase 1**, we will ask you to complete a three surveys measuring your emotional intelligence and self-monitoring and your clinical team leader's transformational Leadership.

We will also ask you to distribute patient experience questionnaires to your patients.

What will we ask patients to do?

We will ask patients to self-complete a brief questionnaire at the end of their appointment. This will rate their experience of Patient Centred Care received during their appointment.

Data Security and Confidentiality.

The identities of yourself and all patients will be coded and treated as confidential. Only members of the research team will have access to the data, which will be stored securely at the University of Stirling.

At the end of the research, all recordings will be deleted. Anonymised transcripts will be kept for a period of 7 years as requested by NHS Health Scotland. No identifying information will be attached to these.

What will we do with the results?

The data will be used to complete the researchers PhD thesis. In addition, any useful findings will be reported by the research team in professional publications and meetings.

We will provide written feedback to clinical teams on the relationship between Leadership and Patient Centred Care in their service.

Study contacts.

If you have any questions about the study, please feel free to contact Keir Liddle (details below). If you have a complaint about the study or would prefer more information, then please contact his supervisor, Dr Edward Duncan.

Researcher: Keir Liddle, NMAHP-RU, University of Stirling

Supervisor: Dry Edward Duncan, Nursing, Midwifery and Allied Health Professionals Research Unit, University of Stirling, 0044 (0)1786 46 6286.

The impact of Leadership on the delivery of high quality Patient Centred Care in allied health professional practice Study

Patient Information Sheet

Leadership and patient centredness are currently of key interest and importance within the health service. While it may seem reasonable that Leadership can have an impact on the delivery of Patient Centred Care, little has been done to try and directly measure this relationship in practice. Research has determined that the most successful Leadership style is transformational Leadership (TFL). In this study I intend to investigate this relationship using a combination of survey and interview methods to examine which

Why have you been chosen to take part?

You have been asked to take part because your cliinician has volunteered to help with this study. They have been instructed to ask consecutive patients to complete the accompanying questionnaire so we can assess their delivery of Patient Centred Care.

What information will we be collecting?

From you….We are asking you to complete a **brief questionnaire** at the end of your appointment.

This will be about your experience of the care you received today.

You do not need to do anything else.

From your Clinician….

We will be asking them to collect **basic information** about you such as age and gender. We are also asking your physiotherapist to complete their own set of questionnaires.

Data security and Confidentiality.

Your questionnaire and the other collected information will be used for research purposes. The data will be **coded**, so they can be matched together, but your name and identifiers will **not** be used. Only the researcher and their supervisors will have access to the data, which will be stored securely at the University of Stirling Nursing Midwifery and Allied Health Professionals Research Unit.

The data will be kept for a period of 7 years as requested by NHS Health Scotland and then securely destroyed.

If you need to complete the questionnaire at home rather than in the clinic, you will be asked to complete a brief reminder card, which will be sent to you 1 week after the appointment. Completion of the questionnaire is always voluntary and by completing the questionnaire (or providing your contact details) you are consenting for your information to be used for research.

What will we do with the results?

The data will be used to complete the researchers PhD thesis. In addition, any useful findings will be reported by the research team in professional publications and meetings.

Study contacts

If you have any questions about the study, please feel free to contact Keir Liddle (details below).

Researcher: Keir Liddle, NMAHP-RU, University of Stirling

Supervisor: Dr Edward Duncan, Nursing, Midwifery and Allied Health Professionals

Research Unit, University of Stirling, 0044 (0)1786 46 6286.

The impact of Leadership on the delivery of high quality Patient Centred Care in allied health professional practice

Professional Consent Form

As part of this study, we are asking you to help to test the relationship between Leadership and the delivery of Patient Centred Care.

All information will be used for research purposes only, anonymised and held securely by the NMAHP-RU.

I confirm that I have read and understood the information sheet for the study and have had the opportunity to ask questions.

Yes	No

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason, without employment rights being affected.

Yes	No

I understand any data submitted to the questionnaire will be

confidential

Yes	No

I agree to take part in this phase of the study.

Yes	No

Yes	No

I agree that copies of any correspondence will be kept as part
of the study.

Name of professional   Date   Signature

Researcher   Date   Signature

Researcher: Keir Liddle, keir.liddle@stir.ac.uk

Independent advisor to project:

Dr Edward Duncan,
Nursing, Midwifery and Allied Health Professionals Research Unit,
University of Stirling,
0044 (0)1786 46 6286

Appendix B: Survey Measures

Transformational Leadership Questionnaire

This questionnaire is designed to provide information about how you/your team leader conduct management and Leadership situations. Consider each statement and click on the appropriate tick box to indicate how far each statement applies to you/your team leader.

		Never	Once in a While	Fairly Often	Frequently	Always or Almost Always
1.	I have spent time coaching people					
2.	I have assumed people know why the team's work is important					
3.	I have encouraged people to lead					
4.	I have been unable to trust people to do things right					
5.	I have talked about my vision and values					
6.	I have taken decisions on my own					
7.	I have shown my appreciation for the team's efforts					
8.	I have made people feel they are engaged in something important					
9.	I have communicated the idea that we are involved in something bigger than ourselves					
10.	I have recognized each individual's successes					
11.	I have conveyed a collective sense of mission					
12.	I have initiated change					
13.	I have failed to communicate a simple vision					
14.	I have forgotten to take everyone's views into account					
15.	I have failed to tackle poor performance					
16.	I have demonstrated that I value people					
17.	I have involved people in planning					
18.	I have focused on the process rather than getting results					
19.	I have acted ethically					
20.	I have reviewed team members' performance					

		Never	Once in a While	Fairly Often	Frequently	Always or Almost Always
21.	I have left others to say thank you for me					
22.	I have overlooked people's ideas and suggestions					
23.	I have avoided taking unpopular decisions					
24.	I have failed to energize people					
25.	I have avoided giving bad news					
26.	I have displayed drive to meet my goals					
27.	I have set unrealistic standards					
28.	I have forgotten to attend to everyone's needs and aspirations					
29.	I have spent the majority of time with the best performers					
30.	I have maintained standards of integrity					
31.	I have forgotten to give people feedback on their performance					
32.	I have committed to delivery regardless of the impact on the team					
33.	I have rewarded team successes					
34.	I have concentrated solely on the task					
35.	I have encouraged people to come up with ideas and solutions					
36.	I have failed to communicate passion					

		Never	Once in a While	Fairly Often	Frequently	Always or Almost Always
37	**I have taken the credit for others' contributions**					
38	**I have looked to others to communicate the larger mission**					
39	**I have been unable to take time out to celebrate team achievement**					
40	**I have failed to get across messages people can identify with**					
41	**I have lacked energy and drive**					
42	**I have persisted despite setbacks**					
43	**I have covered up personal mistakes**					
44	**I have built trust through being reliable and genuine**					
45	**I have been driven by fear of failure**					
46	**I have treated people as individuals**					
47	**I have assumed individuals know what is required of them**					
48	**I have assumed people feel that they are doing something worthwhile**					
49.	**I have instilled a sense of purpose in the team's work**					
50.	**I have challenged the status quo**					
51.	**I have showed people how they can make a difference**					

		Never	Once in a While	Fairly Often	Frequently	Always or Almost Always
52.	**I have overlooked personal development efforts**					
53.	**I have treated people fairly**					
54.	**I have pursued goals beyond what's required**					
55.	**I have failed to inspire people**					
56.	**I have expected people to know what I want without having to be told**					
57.	**I have offered assignments to grow people's skills**					
58.	**I have agreed on key goals with the team**					
59.	**I have instilled pride by celebrating our achievements**					
60.	**I have emphasized the importance of providing a service**					
61.	**I have checked that people understand the team's goals**					
62.	**I have told people precisely what to do**					
63.	**I have given direction to people's efforts**					
64.	**I have spent the majority of time with the best performers**					

Genuine concern for others	Genuine interest in me as an individual; develops my strengths
Political sensitivity and skills	Sensitive to the political pressures that elected members face; understands the political dynamics of the leading group; can work with elected member to achieve results
Decisiveness, determination, self-confidence	Decisive when required; prepared to take difficult decisions; self-confident; resilient to setback
Integrity, trustworthy, honest, and open	Makes it easy for me to admit mistakes; is trustworthy, takes decisions based on moral and ethical principles
Empowers, develops potential	Trusts me to take decision/initiatives on important issues; delegates effectively; enables me to use my potential
Inspirational networker and promoter	Has a wide network of links to external environment; effectively promotes the work/achievements of the department/organization to the outside world; is able to communicate effectively the vision of the authority/department to the pubic community
Accessible, approachable	Accessible to staff at all levels; keeps in touch using face-to-face communication

Factor/ Item loading	1	2	3	4	5	6	7
1	GC1						
2	GC2						
3	GC3						
4	GC4						
5	GC5						
6	GC6						
7	GC7						
8	GC8						
9	GC9						
10	GC10						
11	GC11						
12	GC12						
13	GC13						
14	GC14						
15	GC15						
16	GC16						
17	GC17						
18		PS1					
19		PS2					
20		PS3					
21		PS4					
22		PS5					
23		PS6					
24			D1				
25			D2				
26			D3				
27			D4				
28			D5				
29			D6				
30			D7				
31			D8				
32				I1			

Factor/ Item loading	1	2	3	4	5	6	7
33				I2			
34				I3			
35				I4			
36				I5			
37				I6			
38				I7			
39				I8			
40				I9			
41					EP1		
42					EP2		
43					EP3		
44					EP4		
45					EP5		
46					EP6		
47					EP7		
48					EP8		
49						N1	
50						N2	
51						N3	
52						N4	
53						N5	
54						N6	
55						N7	
56						N8	
57						N 9	
58						N10	
59							AA1
60							AA2
61							AA3
62							AA4
63							AA5
64							AA6

Wong and Law Emotional Intelligence Scale

Please respond by placing an "X" in the box to indicate how much you agree with each statement.

		Strongly disagree			Strongly agree	
		1	2	3	4	5
1	I have a good sense of why I have certain feelings most of the time.					
2	I have good understanding of my own emotions.					
3	I really understand what I feel.					
4	I always know whether or not I am happy.					
5	I always know my friends' emotions from their behaviour.					
6	I am a good observer of others' emotions.					
7	I am sensitive to the feelings and emotions of others.					
8	I have good understanding of the emotions of people around me.					
9	I always set goals for myself and then try my best to achieve them.					
10	I always tell myself I am a competent person.					
11	I am a self-motivated person.					

		Strongly disagree				Strongly agree
		1	2	3	4	5
13	I am able to control my temper and handle difficulties rationally.					
14	I am quite capable of controlling my own emotions.					
15	I can always calm down quickly when I am very angry.					
16	I have good control of my own emotions.					

Self monitoring Scale	T	F
DIRECTIONS: The statements below concern your personal reactions to a number of different situations. No two statements are exactly alike, so consider each statement carefully before answering. IF a statement is TRUE or MOSTLY TRUE as applied to you, circle the "T" next to the question. If a statement is FALSE or NOT USUALLY TRUE as applied to you, circle the "F" next to the question.		
1. I find it hard to imitate the behaviour of other people.		
2. My behaviour is usually an expression of my true inner feelings, attitudes, and beliefs.		
3. At parties and social gatherings, I do not attempt to do or say things that others will like.		
4. I can only argue for ideas which I already believe.		
5. I can make impromptu speeches even on topics about which I have almost no information.		
6. I guess I put on a show to impress or entertain people.		
7. When I am uncertain how to act in a social situation, I look to the behaviour of others for cues.		
8. I would probably make a good actor.		
9. I rarely seek the advice of my friends to choose movies, books, or music.		
10. I sometimes appear to others to be experiencing deeper emotions than I actually am.		
11. I laugh more when I watch a comedy with others than when alone.		
12. In groups of people, I am rarely the centre of attention.		
13. In different situations and with different people, I often act like very different persons.		
14. I am not particularly good at making other people like me.		
15. Even if I am not enjoying myself, I often pretend to be having a good time.		
16. I'm not always the person I appear to be.		
17. I would not change my opinions (or the way I do things) in order to please someone else or win their favour.		
18. I have considered being an entertainer.		

19. In order to get along and be liked, I tend to be what people expect me to be rather than anything else.		
20. I have never been good at games like charades or improvisational acting.		
21. I have trouble changing my behaviour to suit different people and different situations.		
22. At a party, I let others keep the jokes and stories going.		
23. I feel a bit awkward in company and do not show up quite as well as I should.		
24. I can look anyone in the eye and tell a lie with a straight face (if for a right end).		
25. I may deceive people by being friendly when I really dislike them.		

Questionnaire given to patients: Consultation Care Measure:

The patient rates their agreement with each of the statements given below:

	Very strongly agree	Strongly agree	Agree	Neutral/ disagree
Was interested in my worries about the problem				
Was interested when I talked about my symptoms				
Was interested in what I wanted to know				
I felt encouraged to ask questions				
Was careful to explain the plan of treatment				
Was sympathetic				
Was interested in what I thought the problem				
Discussed and agreed together what the problem was				
Was interested in what I wanted done				
Was interested in what treatment I wanted				
Discussed and reached agreement with me on the plan of treatment				
Knows me and understands me well				

	Very strongly agree	Strongly agree	Agree	Neutral/ disagree
Understands my emotional needs				
I'm confident that the doctor knows me and my History				
Talked about ways to lower the risk of future illness				
Advised me how to prevent future health problems				
Explained clearly what the problem				
Was definite about what the problem was				
Was positive about when the problem would settle				
Was interested in the effect of the problem on my family or personal life				
Was interested in the effect of the problem on everyday activities				

CCM subscales

Communication and partnership

Was interested in my worries about the problem

Was interested when I talked about my symptoms

Was interested in what I wanted to know

I felt encouraged to ask questions

Was careful to explain the plan of treatment

Was sympathetic

Was interested in what I thought the problem was

Discussed and agreed together what the problem was

Was interested in what I wanted done

Was interested in what treatment I wanted

Discussed and reached agreement with me on the plan of treatment

Personal relationship

Knows me and understands me well

Understands my emotional needs

I'm confident that the doctor knows me and my history

Health promotion

Talked about ways to lower the risk of future illness

Advised me how to prevent future health problems

Positive and clear approach to problem

Explained clearly what the problem was

Was definite about what the problem was

Was positive about when the problem would settle

Interest in effect on life

Was interested in the effect of the problem on my family or personal life

Was interested in the effect of the problem on everyday activities

---

CARE Patient Feedback Measure

Please rate the following statements about today's consultation. Please mark the box like this with a ball point pen. If you change your mind just cross out your old response and make your new choice. Please answer every statement.

How good was the practitioner at	Poor	Fair	Good	Very Good	Excellent	DNA
1) Making you feel at ease (introducing him/herself, explaining his/her position, being friendly and warm towards you, treating you with respect; not cold or abrupt)						
2) Letting you tell your "story" Giving you time to fully describe your condition in your own words; not interrupting, rushing or diverting you)						
3) Really listening (paying close attention to what you were saying; not looking at the notes or computer as you were talking)						
4) Being interested in you as a whole person (asking/knowing relevant details about your life, your situation; not treating you as "just a number")						
5) Fully understanding your concerns (communicating that he/she had accurately understood your concerns and anxieties; not overlooking or dismissing anything)						
6) Showing care and compassion (seeming genuinely concerned, connecting with you on ahuman level; not being indifferent or "detached")						
7) Being positive (having a positive approach and a positive attitude; being honest but not negative about your problems)						
8) Explaining things clearly (fully answering your questions; explaining clearly, giving you adequate information; not being vague)						
9) Helping you to take control (exploring with you what you can do to improve your health yourself; encouraging rather than "lecturing" you)						
10) Making a plan of action with you (discussing the options, involving you in decisions as much as you want to be involved; not ignoring your views)						

Appendix C: Topic Guide

Aims and purpose

To explore clinicians perceptions of Patient Centred Care and Leadership and how the two may or may not interact.

To explore the barriers and facilitators to providing Patient Centred Care and the role Leadership takes in this context.

Topic Guide

What do you think constitutes Patient Centred Care?

- How do you think it is achieved in practice?
- How does your clinic deliver Patient Centred Care?
- Who is responsible for the delivery of Patient Centred Care? (Is it everyone? Individual clinicians? Etc)
- What would be examples of good/bad Patient Centred Care?
- What can help the delivery of Patient Centred Care?
- What can hinder the delivery of Patient Centred Care?
- How is Leadership related to Patient Centred Care?
- To what extent do you think Leadership plays a role in delivering Patient Centred Care?
- How could a leader help staff to deliver Patient Centred Care?
- Do you feel supported by (team) leaders and NHS management in delivering Patient Centred Care

How is Patient Centred Care supported?

- How would you describe a "good" leader or "good" Leadership?
- What behaviours do you associate with good Leadership?
- What behaviours do you associate with bad Leadership?
- Is there a distinction between Leadership and management?
- How are decisions made within your clinic/team/quadrant? (patient care, service design, professional development)
- How is professional development handled in your clinic/team/quadrant?
- How are new policies or procedures communicated to frontline services? E.g. Quality strategy

Appendix D: Ethics

From: Godden, Judith [mailto:Judith.Godden@ggc.scot.nhs.uk]
Sent: 15 May 2013 12:11
To: Keir Liddle
Subject: FW: R&D and ethics Enquiry

Dear Keir

From the information you have sent to us in the e-mail below I suggest that this is a service evaluation. Service evaluations do not require to be reviewed by an NHS research ethics committee but you should ensure that the Health Board Department involved is fully aware of the project and will benefit from the findings.

Kind regards

Judith

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Appendix E: Search strategies and Framework Analysis

Search protocol

1. patient-centred

2. patient-centered

3. patient-focused

4. patient-orientated

5. person-centred

6. person-centered

7. person-focused

8. person-orientated

9. client-centred

10. client-centered

11. client-focused

12. client-orientated

13. relationship-centred

14. relationship-centered

15. relationship-focused

16. relationship-orientated

17. relationship-based

18. patient-based

19. person-based

20. client-based

21. S1 or S2 or S3 or S4 or S5 or S6 or S7 or S8 or S9 or S10 or S11 or S12 or S13 or S14 or S15 or S16 or S17 or S18 or S19 or S20

22. Leadership

23. Management

24. S21 & S22 or S23

Holstrom and Roing (2009)	Mead and bower definitions. (168) Stewart Definition (168) Can be regarded as a process (171)	"No clear definition of concept in research literature" (169)	Being realistic about patients choices (168) Understanding the patient (170)	Focusing on patientas perceptions and beliefs (171) Understanding the patient (170)	Bound by context of healthcare settings (168)		
Epstien et al 2005)	Both a state and a trait (roter et al 97) Something with intrinsic value regardless of other outcomes Krupat et al (2000 Widely endorsed as central component of quality care (1516))	Lack of theoretical and conceptual clarity (1516) Terms PC communication, Pcness and PC care are used interchangably (1516) Requirement for clear theory-based operational defintions. (1524)	Can be viewed as a means to an end or an end in itself (1523)	Goal of PC communication is to help practice provide care that is consistent with patients values, needs and preferences (1516)			Goal of PC communication is to help practice provide care that is consistent with patients values, needs and preferences (1516)