Stepping off the treadmill: a study of coaching on the RCN Clinical Leadership Programme

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Abstract

This phenomenological study is set in the context of leadership development in the National Health Service (NHS). The aim of the study was to provide an in-depth understanding of the Royal College of Nursing Clinical Leadership Development Programme (RCN CLP) participants' experience of the coaching component of the programme. In-depth interviews were undertaken with eight clinical leaders who had recently completed the RCN CLP. The overarching theme emerging from the data suggested that coaching was seen as an opportunity for 'stepping off the treadmill'. This main theme is underpinned by a further eighteen theme clusters, organised into 6 categories: out and in the comfort zone; mirror mirror; unconditional positive regard; creative conversations; ripple effect; and I'm OK, you're OK. In this paper, the implications of the findings are discussed and recommendations for further research identified.

Keywords: coaching; leadership; clinical leadership; National Health Service; phenomenology

Introduction

Despite the growing interest and investment in leadership development, there continues to be what is seen as a deficit in effective leadership (Alimo-Metcalfe and Alban-Metcalfe, 2003) and a renewed call for improved leadership throughout organisations. A recent report (Audit Scotland, 2005) provided an overview of activity and investment in leadership development across the Scottish public sector. The key findings support the view that leadership development in the public sector is highly variable with little attempt to address return on investment.

The context for this study is the Royal College of Nursing Clinical Leadership Development Programme (RCN CLP). This 12 month programme is one of the largest international clinical leadership development programmes available within the NHS and over 4000 clinical leaders have completed it. The aim of the programme is to assist healthcare practitioners, and their teams, to develop patient centred and evidence based leadership strategies within the context of their day to day practice, their organisational climate and the policy agenda (RCN, 2003). The RCN CLP is based on the understanding that employers influence care, but it is individual practitioners who have a direct effect on how patients are looked after.

The programme uses a range of interventions to support the development of clinical leaders, including monthly coaching sessions with the programme facilitator. Research evaluations have consistently demonstrated that the programme provides an effective way of building clinical leadership capability and capacity in the NHS (Cunningham and Kitson, 2000a; Cunningham and

Kitson, 2000b; Cunningham et al, 2002; Mackenzie and Cunningham, 2002; Large et al, 2005). The specific contribution of the coaching component to the participants' development, however, had not been studied.

The aim of the study was to provide an in-depth understanding of the RCN CLP participants' experience of the coaching component of the programme. The intention was to carry out in-depth taped interviews with 8 clinical leaders who had recently completed the RCN CLP and were willing to be involved in the study. Following the interviews the tapes were transcribed, mapped and themes were identified. By gaining an understanding of the experience of coaching from the perspective of the programme participants, it was hoped that the findings from the study could be used to strengthen the coaching component of the RCN CLP and fill some of the gaps in appreciating the way in which coaching may be helpful in developing effective leaders.

This article summarises the issues identified from the literature; sets out the methodological approach and the findings and identifies areas for further research which may be fruitful in building a clearer understanding of the contribution of coaching to leadership development.

Leadership in the NHS

Goodwin (2000) states that the study of leadership generally has been prolific in recent years with 3000 studies being published in 1974 rising to over 7000 in 1990. A similar trend can be seen in the number of articles relating to leadership in the NHS. What is clear in the literature is that there is a shift away from focussing on 'management' of the NHS and towards 'leadership' of the NHS. Although leadership and management are both important, Bennis and Nanus identify a profound difference between the two stating that *"managers are people who do things right and leaders are people who do the right things"* (Bennis and Nanus, 1985, p21).

The literature reviewed in relation to leadership in the NHS is also notable in the extent to which the link between high quality leadership and high quality patient care is increasing emphasised. (Donaldson, 2001; Firth-Cozens and Mowbray, 2001; Edmonstone and Western, 2002) The Scottish Executive boldly states that *"Improving the health of Scotland and reforming how healthcare is delivered depends on effective leadership at all levels of NHS Scotland"* (2005a, p1)

What is interesting from the review is that while there are a number of articles about the style of leadership required and the impact of leadership on the quality of care, there is comparatively little attention focussed on how to develop the leadership potential in the NHS. The most recent policy documents to be published in Scotland (SEHD 2005b and 2005c) set out the direction of the Health Service over the next decade and emphasise the need for leaders, at all levels, to drive service change. However the complexity of the task is somewhat obscured by the amount of detail on the 'what' of leadership and yet very little on the 'how'.

The approach to dealing with this complex agenda is addressed by *Delivery through Leadership* (SEHD, 2005a); the leadership development framework and accompanying leadership development plan for the next two years in NHSScotland. The real value of *"Delivery through Leadership"* (SEHD, 2005a) is that it goes beyond the 'what' of leadership to look in detail about the 'how' of leadership (style, qualities and behaviours) and the 'how' of leadership development (processes, approaches, methods) in order to deliver on this complex agenda. The accompanying leadership development plan, sets out the approach to developing leadership capacity and capability at all

levels of NHSScotland both in terms of national activity and how that needs to be balanced with local activity.

A review of literature on clinical leadership suggests not only is there confusion over the use of the term, there is also a very limited literature on the kind of skills required by clinical leaders or how these skills might be developed. An exception to this is the literature around the RCN CLP (Cunningham and Kitson, 2000a; Cunningham and Kitson, 2000b). The programme is underpinned by the finding from an action research project looking at the role of the ward leader / charge nurse. (RCN, 1997) which ran from November 1994 through to October 1997. It was clear from existing research that the pivotal role of the ward leader determines the quality of care delivered within a ward. (Pembry, 1980; Orton, 1981; Ogier, 1982) The project aimed to promote better practice by identifying the skills needed by ward leaders to make them more effective, then demonstrating how these skills could be transferred to nurses and patients. Research evaluations of the programme (Cunningham and Kitson, 2000a; Cunningham and Kitson, 2000b; Cunningham et al 2002; Mackenzie and Cunningham, 2002) as well as personal accounts or articles from people who had undertaken the programme (Carlowe and Cole, 1997; Hambridge, 1997; Black, 2000; Simons, 2003a; Simons 2003b; Simons, 2003c; Govier, 2004) repeatedly indicate that the interventions used on the programme support the clinical leaders to develop their skills in the areas highlighted in the framework.

In terms of the impact of coaching on leadership development, a literature search identified some good examples of personal reflections (Newell, 2002; Landale, 2005), but few robust research studies. The exceptions to this included studies by Cramm and May (1998) who used a case study approach to demonstrate the impact of executive coaching; Tach (2002) who looked at the impact of executive coaching and 360 feedback on leadership effectiveness and Vaartjes (2005) who integrated action learning practices into group executive coaching and looked at return on investment.

The limited empirical evidence in the field of coaching is explained by Ellinger and Stalinski (2004) who point out that coaching has a rich history in practice but it is only more recently, with the rise in interest in coaching, that the need to ground the practice of coaching in scholarship to enhance its credibility has come to the fore.

It would appear therefore, that in relation to leadership in the NHS, there is literature describing the leadership agenda but less about how to develop the leadership capability and capacity. In relation to clinical leadership the literature is unclear in terms of how it defines the concept and again is fairly limited in terms of identifying the relevant skills that clinical leaders need. Finally the coaching literature is rich with models and processes and techniques but less overt about how these might be applied in a leadership context. In terms of the impact of coaching on leadership development the empirical evidence is quite limited.

Methodology

For the study of participant's experience of the coaching element of the Programme a phenomenological approach was used. Phenomenology provides an ideal framework for studying life experiences, the main focus being to describe particular phenomena in terms of subjective lived experience (Wall et al, 2004). This focus sat well with the orientation of the study.

The study participants were sought from one NHS Board area in Scotland. For the purposes of my research the most important inclusion criteria were that the participants had recently completed the RCN CLP and that they were willing to be involved in the study. The RCN CLP had been running in this Board for some time and consequently there were a large number of participants who had completed the programme. In addition, there were four different coaches involved in the programme.

Data was collected by means of a tape recorded semi-structured interviews with the eight clinical leaders who had completed the RCN CLP. The interviews ranged from 30 minutes to 90 minutes and commenced with an open question: *"Tell me about your experience of coaching during the programme?"* The rationale for this question was to open up the topic and encourage the participants to start talking about their experiences. From this point I probed and asked for clarification: *"Can you tell me more about that?" "You said xxxx, what do you mean by that?"* In this way the direction of the interview and issues covered were dictated by the participant and my main role was to clarify and probe to gain an understanding of the experience from the participant's perspective.

The procedural steps for analysing data described by Colaizzi (1978) provided a helpful framework for approaching the analysis of the data. The steps were repeated independently for each interview and the process was helpful in identifying and organising the themes into theme clusters and categories, across the data. Each of the 6 categories that emerged was underpinned by 3 theme clusters which provided an essential structure of the phenomenon and a rich description of the participants' experience. The names of the 6 categories and overarching category were inspired by the analysis of the data.

The final step in the analysis was to provide a summarised narrative of the findings, highlighting the categories that had emerged. This was then sent to the participants to check that the categories, that had been identified, resonated with their experience. In particular, they were asked if they felt there were any gaps in the description. The participants reported that they were happy that the finding encapsulated their experiences.

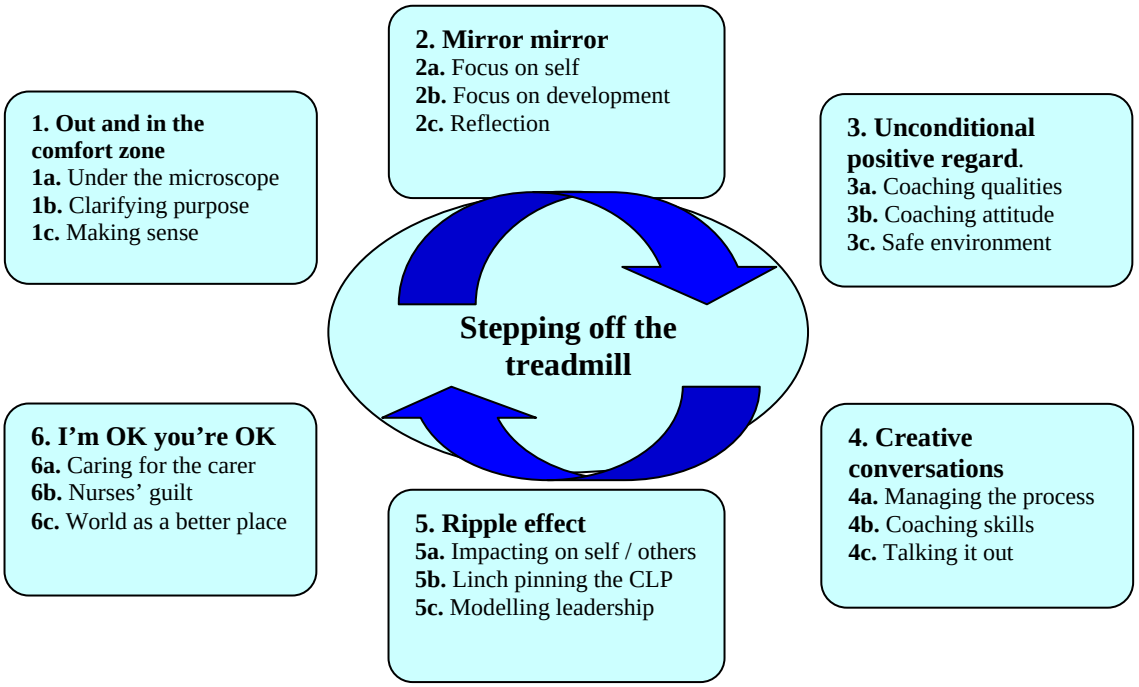
The Findings

Throughout the interviews the story of participants' working lives emerged as a treadmill driven by the clinical imperatives that they faced on a daily basis. They described their perception of their work as allowing little time to step back and reflect on what they were doing or change what they were doing; instead there was a shared sense of responding to whatever faced them in their immediate environment. This sense of urgency and immediacy impacted not only on their working lives but on their lives outside the workplace. What emerged from the data was that coaching provided the personal reflective space that they had otherwise been unable to secure for themselves. As they described their experiences of coaching, a picture emerged of coaching as a dynamic process which impacted positively on the individual participants, their teams and ultimately their patients.

This theme of 'stepping off the treadmill' was underpinned by 18 theme clusters which were organised into 6 categories. The model presented in Table 1 below, demonstrates that the categories all interrelated and each was seen as important in generating a rich description of the participants' lived experience. In order to provide a coherent account of this experience, each category is

summarised in turn using the participants' own words to bring the descriptions to life. To protect the confidentiality of participants, their names have been changed to AA, BB and so on.

Table 1: RCN CLP participants' experience of the coaching component of the programme.



Category 1: Out and in the comfort zone

The first category, *out and in the comfort zone*, emerged from the descriptions that the participants gave of their thoughts and anxieties at the start of the coaching relationship and describes their transition from having a sense of being scrutinised, *under the microscope,* to *clarifying the purpose* of coaching and *making sense* of the programme.

The participants described feeling *"daunted"* (DD) and *"uncertain"* (AA) prior to their first coaching session. The role of the coach emerged as extremely significant in *clarifying the purpose* of the coaching, supporting them to work through this transition and engage in the coaching as FF explains:

"She was very helpful, she seemed to know that I was worried … and she kept saying 'you're the gatekeeper' and that felt good."

As the participants engaged in the coaching they described *making sense* of not only the coaching but of the whole programme (RCN CLP). This finding seems important given that the coaching literature pays limited attention to what learners may 'bring' to coaching in terms of their anxieties.

Cox, however, emphasises the importance of context stating that personal relationships are shaped by the environment in which they are set and "*all partners in the relationship bring with them contextual understandings, beliefs and perceptions that influence the relationship"* (Cox, 2003, p9)

Category 2: Mirror mirror

The category of *mirror mirror* emerged as the participants spoke in detail about the focus of coaching. Coaching was described as focusing on the *self.* This was not an end in itself but a means to an end which was to *focus on development.* This 'both and' focus is captured well by DD:

"It became evident what it was about and it wasn't about talking about yourself but it was about exploring yourself and finding new ways of learning…it was constructive... knowing that I was going to come away with something new in my head or to do or to develop myself on that basis."

DD's description supports the idea discussed in the literature (O'Neill, 2000; West and Milan, 2001; Lee, 2003; Bluckert, 2005) that coaching in a leadership context requires specific interpersonal engagement that is quite different from the more 'hard edged' coaching. The importance of the coach being skilled at looking at these more personal aspects of performance is further emphasised by English and Sutton (2000) who suggest that, in order to be effective in the environment of the NHS, individuals must be willing to work with courage and manage their own fears in addition to their knowledge and skills.

The whole category of *mirror mirror* was underpinned by reflection. This related not just to the space and protected time to reflect, which was so scarce in these participants' everyday lives, but to the actual process of coaching. Reflection encouraged the participants to step back, off their treadmill, and look at themselves and look at their leadership development. In the words of EE:

"That is what I really enjoyed about it (the coaching) *because you had time to think, you were off the merry-go-round that you live on day-by-day. And you could reflect on it all and think yes 'I'll do this' and 'I don't think I like how I do that and I'm going to tackle it differently.'"*

This resonates with the work of Brockbank et al (2003) who describe reflective learning as an intentional process in which learners are active individuals, wholly present and engaging with others and open to challenge. They further suggest that when reflection is seen in this way it involves transformation as well as improvement for both the individual and their organisation.

Category 3: Unconditional positive regard

Unconditional positive regard, a term first introduced by Carl Rogers (1961) in relation to counselling, emerged from this study as a category describing the conditions for effective coaching. In the context of the study, the term refers to both the participants' perception of what the coach brought to the relationship, described as *coaching qualities***,** and to how the participants experienced the coach within the coaching relationship, described as *coaching attitude.* While there is a great deal of overlap between these two theme clusters, both are seen as important in interacting to create the third theme cluster, a *safe environment*, for the coaching to take place.

There were four different coaches involved with this group of participants and yet there was a great deal of similarity in how the participants described their coaches' qualities:

*"His manner and his attitude, he makes you feel comfortable…it is just who he is as a person really" (*CC).

*"I think it's the way she is as a person ….I think she is just a wonderful person" (*EE).

It was clear from all of the participants that they had a great deal of respect for their coaches and had perceived them very positively, however it was very difficult for them to really tease out what the specific qualities were. The integral nature of qualities, attitude and behaviours is clearly explained by Lee (2003, p142), who argues that coaching in a leadership context requires three sets of qualities or competencies:

- Psychological mindedness (self awareness and awareness of others).
- Business mindedness (organisational and business awareness).
- Relationship development.

Lee explains that relationship development is not wholly separate, but is the overarching capacity that brings these other competencies into the service of enabling change. The participants in this study were very clear about the impact of this on the nature of the coaching and specifically in creating trust and a safe environment where meaningful coaching could take place. HH highlights the confidential nature of the relationship:

"And that was the thing (the creation of a safe environment) that really made me open up and I honestly don't know how he did that… I think he just had this way of letting you see him as a human as well as a coach."

The importance of establishing trust is well documented in the coaching literature (Flaherty, 1999; Starr, 2003). What is not so apparent is this emphasis on the participants' experience of the coach (or the quality of the relationship) as being fundamental to creating trust. However, Deutch's (2003) definition of trust as an individual's confidence in the intentions and capabilities of a relationship partner and the belief that a relationship partner would behave as one hoped, makes this relationship explicit.

Category 4: Creative conversations

The category of *creative conversations* emerged from the data as the participants described, in detail, their experience of the coaching sessions. The participants described coaching as a conversation with a purpose and highlighted the coach's role in *managing the process.* What emerged form the data was the way in which the coach was able to respond to the individual's needs as described by GG:

"And it was very clear from the start that it was about me and what was important to me. I never felt that it was the coach's agenda, and that was a really great feeling."

This was underpinned by the *skills of the coach.* Key skills that emerged included listening and asking questions. The integral nature of listening and asking questions was highlighted by the participants:

"She seemed to know what I was going to say before I said it…she would just be listening and then she would ask something and it was like …. how did you know to ask that?" (BB).

The findings from this study support Whitmore's (2004) view that asking effective questions is at the very heart of the coaching relationship, helping to build awareness and responsibility. Whitmore suggests that when we ask questions as a coach, the answer is of secondary importance. Rather, in answering the question, the learner surfaces information that they can use to make sense of their situation. This complex relationship between listening, asking questions and the judgements in between is explicit in HH's account:

"it was great because he just listened and let me talk… and asked occasional questions that really challenged how I was thinking…. Even as I was speaking I began to see it more clearly…and it was huge (the issues) *but I began to see how I needed to move it forward."*

HH's experience echoes Flaherty (1999) who stresses the importance of the coach helping the client to see in new ways. In a similar way Egan (1990) suggests that the core of a helping relationship lies in transforming blind spots that inhibit progress into new perspectives.

Category 5: Ripple effect

The complexity as well as the synergy of coaching emerged from the accounts that the participants gave of their experiences. While the findings from the research are presented under separate headings it is clear that they are interrelated. In short, it is not one single element, technique or intervention that is effective in creating transformational learning and change, but the cumulative impact of the all the component parts.

The category, *ripple effect,* emerged as a way of describing this cumulative effect and the impact of the coaching. It is underpinned by three theme clusters. *Impacting on self* reflected the positive impact that the coaching had on the participants' self awareness. Many of the participants shared the view that they had moved from a position of being unclear about their strengths but clear about their weaknesses, to a position where they were clear about both. The coaching was seen as instrumental in *"getting that balance back"* (EE). Leedham (2005) points out that while sports coaching literature emphasises the importance of confidence and self-efficacy, the general coaching literature has failed to focus in any great depth on issues of confidence. Bachkirova (2004), however, posits that the way an individual sees themselves inevitably influences their attitude towards themselves and their motivation for change.

The coaching was also seen as highly significant in *lynch pinning the CLP* helping to pull the programme together. This also enabled the participants to transfer their learning back into their work environment and to sustain the learning in a holistic way. One of the factors that appeared to enable the transfer of learning was the role of the coaching in *modelling leadership.* If the participants didn't notice this during the programme then they came to realise it later, as in the case of CC:

"At the end of the programme I started to investigate leadership theory and styles and I realised that is what he (the coach) *was doing. He was enabling and encouraging and leading. I didn't realise it at the time"* (CC).

In an environment where naturally arising role models may be in short supply, the coach has a very important role in modelling leadership behaviours in a way that shows what to do; demonstrates how to do it; guides the learner as they practice; and helps the leaner to experience the consequences of doing the task correctly (Scarnati, 2002).

Category 6: I'm OK, you're OK

The final category that emerged from this study represented the context in which the participants worked and in this way it almost wrapped itself around the other categories. The category, entitled '*I'm OK, you're OK',* was inspired by the work of Berne (1967) on transactional analysis and represents the participants' perception of their professional culture as nurses and the way they saw this as impacting on their experiences. Throughout the interviews a very detailed picture emerged of the participants' day to day context. The category of *I'm OK, you're OK* also reflected the journey through the coaching and the way in which the coaching enabled the participants to reflect on their cultural context and change the way they approached their lives and their work.

The category was underpinned by 3 theme clusters. *Caring for the carer* reflected the challenges that theses nurses found in caring for themselves. An issue that is well documented in the literature (McNeely, 1995; Brotheridge and Lee, 2003; McFadzean and McFadzean, 2005; RCN, 2006)

The participants in this study described real sense of the combination of working in a very high pressure environment but never having time to effectively deal with the emotional impact of the work. The notion of 'carrying' unresolved emotions and not having time to resolve them emerged from the participants accounts:

"I know I carry a lot of stuff around. We're not good to ourselves... We are too busy looking after everyone else" (EE).

Coaching emerged as an effective way of helping the participants to care for themselves and manage the *nurses' guilt* that they experienced when they were not involved in direct patient care. The impact of this change in world view was a realisation that coaching offered a way to experience the *world as a better place.* And an appreciation that when they had time to step off their tread mill and reflect during the coaching sessions, everyone benefited:

" And the coaching makes me realise that when I have that time everyone benefits because I am more efficient and effective in my role." (BB)

Conclusion

This study set out to gain an understanding of the RCN CLP participants' experience of the coaching component of the programme. The methodology selected proved to be a highly effective way of achieving the aim of the study and eliciting a very rich picture of the participants' lived experience. In addition to gaining an in-depth understanding of the participants' experience of coaching, the data that emerged provided insight into the daily context in which these front line clinical leaders worked. The participants' descriptions suggested a treadmill driven by the clinical imperatives that they faced with little time to step back and reflect on what they were doing and specifically, what they were doing effectively.

Despite the limitation of this study, there are a number of important conclusions which can be drawn from the findings. The study has highlighted the anxiety and concerns that participants may bring to coaching and the approach of the coach that may prove fruitful in guiding participants through the transition to meaningfully engaging in coaching. The detailed insight into the skills required of the coaches provides an opportunity to strengthen the Programme both in terms of

selection and development of coaches. Finally the importance of the coaching component in *lynch pinning* the programme and enabling the transfer of learning is very encouraging and again offers and opportunity to strengthen the programme and other programmes which aim to build clinical leadership capability and capacity.

One of the rather unexpected outcomes of this study was that as the participants spoke about their experiences of coaching, a picture also emerged of the culture in nursing and the many challenges faced in their work environment. The extent to which this is specific to nurses is not known but it offers an opportunity for further research into the acceptability of coaching as a way of building clinical leadership capability and capacity in the NHS.

In relation to coaching in a leadership context the participants' account of their experiences and the categories that emerged from the data supports the literature that suggest that coaching in a leadership context requires different skills and is fundamentally different from other forms of coaching (O'Neill, 2000; West and Milan, 2001; Lee, 2003; Bluckert, 2005).

Mirror mirror, described the participants' experience of the coaching as focusing, in depth, on them and their development, underpinned by a dynamic process of reflection. This supports West and Milan's (2001) description of development coaching as providing psychological space for the participant to reflect on themselves and their leadership task. Similarly, the category of *unconditional regard* which described the qualities and attitudes of the participants' coaches, and the interaction of these elements in creating a *safe environment* to which they could bring challenging issues, reflects Lee (2003) and Bluckert's (2005) description of psychological mindedness which they suggest as the key to creating the right environment for leadership coaching to take place. The near invisibility of skilled coaching to the eye of the person being coached, which the participants in this study described, will continue to make this a very challenging area to comprehend fully. This is clearly another area where further research might be very helpful

In conclusion, the aim of this study was to gain an in-depth understanding of the RCN CLP participants' experience of the coaching component of the programme. What has emerged from the study is a very rich picture of this experience which has important implication for the RCN CLP team, clinical leadership development and coaching in a leadership context. In drawing conclusions, the limitations of the study have been emphasised but it is clear that the study opens up the opportunity to build on the findings by raising further questions and areas that are worthy of research.

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