Leadership and the everyday practice of Consultant Radiographers in the UK: Transformational ideals and the generation of self-efficacy

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Abstract

Introduction: This paper outlines findings from a broader, two-year project investigating the role of Consultant Radiographers (CRs) in the UK, focusing specifically on the leadership aspect of that role.

Methods: Using a qualitative-thematic approach, the leadership-related experiences of a purposive sample of six participating CRs are explored, alongside the systems through which they evaluated how successful they had been as leaders.

Results: It is evidenced that many of the ways in which participants describe their own leadership practice, particularly in the intra-team domain, is consistent with the precepts of the Transformational Leadership Model. For example, they highlight how they have asserted positive influence and encouraged collective action and decision-making. However, the experiential focus of the analysis reveals that in specific examples of practice, the transformational approach was not always seen as the most useful route to a productive outcome given constrictions on time and other resources within real professional environments. More 'direct' managerial approaches were

sometimes deemed necessary, and at others leadership was reduced to simply ‘solving other people’s problems’. It was also found that the manner in which participants evaluated their own success as leaders was a practical concern, based in part upon having satisfied ‘hard’ institutional goals, but also on the more personal business of having affirmatively ‘surprised’ oneself, or a general sense of feeling trusted by colleagues.

Conclusion: These findings may help support CRs in the business of real leadership, not least through better understanding how even apparently mundane outcomes can have significant impacts on professional self-efficacy.

Keywords: Consultant radiographers; thematic analysis; leadership; self-efficacy; qualitative research

Highlights

CRs report a rich variety of diverse tasks emerging from their leadership roles.

The leadership role is both inward and outward facing.

Transformational leadership strategies are often seen as ‘ideal’ practice.

Practical situations often require CRs to find non-transformational ‘workarounds’.

Personal self-efficacy is a key driver in a CR’s sense of leadership capacity.

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Introduction

The structures and functions of leadership in the modern healthcare sector have, in recent years, come to be of critical academic and professional concern.[1-3] Understanding the underpinning economies of expertise embedded therein, moreover, is widely taken to be a linchpin aspect of advancing effective transformation in practice.[4,5] As Adams[6] notes, "[L]eadership wisdom is an essential component to being successful in a fast-paced, ever-changing, and highly complex health environment." Despite this general trend, however, there remains a lack of research addressing the general matter of leadership in professional radiography, intellectual or otherwise.

This paper reports findings from a broader qualitative study of the relatively new place of the Consultant Radiographer (henceforth CR) within UK healthcare settings, an issue that has itself become of recent interest to researchers in the domain.[7-11] As a part of this consultant position, appointed senior radiographers are institutionally mandated with embracing a broad 'leadership' role within their day-to-day work, and one that is centrally designed to address the advancement of research and intellectual development in the field. However, and as noted by Hyrkäs and Dende[1], the practicalities of such roles in clinical work are often ambiguously defined. Early evaluations of the CR role in the UK mirror this concern; Nightingale and Hardy[12], for example, identify that radiographic professionals promoted into consultancy positions often lack confidence and/or clarity particularly regarding what

is expected of them as 'leaders'. It is against this backdrop that this paper aims to the explore the variegated ways in which CRs themselves interpret the expectations, practicalities and ambiguities of the leadership role with which they are charged. This approach does not profess to describe the total distribution of issues, nor the range thereof for all involved practitioners. Rather, describing in detail the divergent and convergent experiences of a small sample of involved professionals can – at the very least - help us ground future investigations in *active* clinical experience.

Literature Review

While Rees' insightful (and very positive) study of the role of consultant breast radiographers in Wales[7] does take steps towards situating leadership components within the experience of its participants, the broad focus of the work does not really permit detailed unpacking of variabilities in how those participants interpret and/or actualise what is required of them within the actual everyday business of 'leading'. Notwithstanding a valuable body of pertinent research in the field of leading radiographic/radiological education[13,14], and as noted above, literature pertaining to leadership in *clinical* radiographic settings remains scant at best. This gives us cause to consider how the issue has been addressed in other spheres of medical/healthcare research, such that the findings below may be situated within a wider investigative tradition.

As a rule, it is fair to argue that literature on healthcare leadership in recent decades has leant more towards the prescriptive than the descriptive. Practical adjustment to real-world clinical leadership, the core topic of this paper, is often rendered subordinate to theoretical discussions of how leaders themselves *could* or

should address their roles. This evidences a trend towards what David Silverman terms the 'Explanatory Orthodoxy' in social science[15]; a rush to explain/legislate real-world phenomena without first properly interrogating what they actually *are*. When analysis is more descriptively targeted, meanwhile, systemic issues around the specification of what leadership might entail for involved individuals is rarely a concern. Rather, leaders' actions are largely explored with reference to how they might 'fit' pre-ordained categories of leadership 'style'.

For a broad overview of the evolution of healthcare leadership theory and practice, one might refer to the excellent synopsis provided by Ledlow and Coppola.[16] Herein it is illustrated how a range of leadership styles have been advocated in the long-wave, including the *laissez-faire* ('fly or fall') approach and the transactional style (geared more around typically behaviourist systems of reward and punishment). The authors are clear, however, that over the last 15 years (at least) it has been the Transformational Leadership Model[17] (henceforth TLM) that has held particular sway in the broad Western healthcare domain. This approach, still drawing to some extent on Max Weber's classic sociological model of 'charismatic authority'[18], advocates the efficacy of leading by (emotionally) inspiring others, connecting individual goals to organisational aims, and developing a shared, clear vision among co-workers[19]. Although still particularly popular in nursing literature[20], the TLM has not been without its critics – many of whom are primarily concerned with how the TLM's focus upon leading through emotional appeals does not inherently promote affirmative moral values.[21] Some authors actively allude to the 'Dark Side' of the approach, citing the manner in which it can allow such individuals to wield excessive power and make changes for their own gain.[22] Such manipulative activity is noted to be particularly common in workplace scenarios

where a leader has narcissistic tendencies, and/or the followers have 'dependent' personalities that foster over-reliance on the charismatic figurehead.[21] As such, some recent work in healthcare leadership has begun to argue for 'blended' approaches that move beyond simple charismatic motivation and also foreground collective interdependency and, particularly, the 'boundary-spanning' role of the leader.[23,24]

Methodology

Originally funded by the College of Radiographers Industry Partnership Scheme (CoRIPS) in 2010, the broader study from which this paper emerges was based upon a classically qualitative-thematic approach to mapping the structural experiences of CRs, with a view to expanding the body of substantive knowledge already gleaned in the field of radiographic consultancy[7,8,10] Given this inherently inductive approach, the specific aim herein is to clarify the character of leadership in radiography as-understood by those charged with the role, without recourse to an evaluative framework of nominal 'good practice'.[25]

Participants

Participants were recruited from the College of Radiographers' Consultant Radiography Group (henceforth CGR); all members of the group at the original time of sampling (N=31) were invited to participate.[a] Of these, nine consented to be involved. Prior to the first round of interviews, two withdrew. A further participant withdrew after the first round of interviews was conducted. All withdrawals were

[a] Further historical details on the broader character of the participant group can be found in a prior paper.[8]

upshots of the time commitment required for the study, and clinical workload. However, the remaining purposive sample of six is, by the recommendations of Smith et al.[26], optimal in qualitative work of this order if the detail in the data is of sufficient quality. The data collected clearly have this quality, as evidenced below.

Procedure

Three rounds of extended, semi-structured interviews were conducted by the first author (a radiographer/academic uninvolved in the CGR) from a pre-developed guide, with minor prompts used to draw empirical examples around the emergent issues from the participants' actual practice. With each new tranche, iterative interviewing[27] was employed to clarify developing themes, ensuring that matters pertinent to the CRs themselves were made consistently relevant. All three rounds are rendered relevant in the analysis below.

Analysis

Thematic analysis, in line with the systematic approach advocated by Braun and Clarke[28], was manually utilized (i.e. without the use of qualitative data analysis software). Provisional codes were developed from the raw data by the second author (also a radiographer/academic uninvolved in the CGR); these were then reviewed by the first author, and revised by both first and second authors until a mutually satisfactory baseline analysis of the entire corpus was achieved. These codes were then grouped by both authors into a set of (often overlapping) intermediate thematic clusters, analogous to the axial coding method described by Strauss and Corbin.[29]. From these, a set of global themes, each fully descriptive of convergence and

discrepancy within an inducted thematic issue, were drawn.[28] The third author, a seasoned academic in qualitative health research without experience in clinical radiography itself, reviewed the interpretation of data from initial codification upwards. Given this input, all three authors then revised the total analysis independently and then collectively, to complete a full process of triangular consensus validation.[30] Classical data saturation[31] could not be achieved on account of a pragmatically limited participant group. Within this group, however, the findings were saturated insofar as the available data would allow. Of the finalized global themes, leadership was one; the other core themes are addressed in the three parallel papers.[8-10]

Trustworthiness

As a 'member check',[32] participants themselves were sent copies of their transcripts such that they could confirm the accuracy of the interview represented. All that responded confirmed full recognition of the veracity of representation therein. In line with the trustworthiness standards outlined by Yardley,[33] meanwhile, *transparency and coherency* are ideally evident below; at no point is any summation of qualitative findings made without reference to direct evidence. In terms of the *impact and importance* of the broader project, the peer-reviewed status of prior outputs[8-10] would ideally stand as a transparent case.

Ethics

As this research was conducted on clinical staff, full NHS REC (National Health Service Research Ethics Committee) review within the UK was not required;

nevertheless, the research followed good ethical practice guidelines as stipulated by the Research Ethics Panel at the first author's academic institution.

Results and Discussion

The overall theme of leadership within the data corpus emerged from two (often overlapping) key issues. These, outlined in detail and with reference to pertinent literature below, were as follows:

1. How do I lead as a CR?
2. How do I know I've made a difference?

1. How do I lead as a CR?

As one might expect, nuances relating to this issue increased across interview tranches 1 to 3, as the participants' own levels of experience within their roles - and thereby their capacity to critically reflect upon them - expanded. Most of the issues raised across all three tranches did reflect at least some of the more generic (and typically TLM-related) issues raised above, such as being a role-model and inspiring others. Not least among these was the business of constructively helping others on a day-to-day basis and being *seen* as someone who can help:

> *"It's…the ability to recognize, you know; when something's maybe not quite right – about what you need to do to change it and influence people to make that change"* (2:001)

> *"People will say…give that to* [participant's name], *ask* [participant's name], *she's really good at doing workflow and finding the best way to do things and*

sorting things out and…I am actually quite good at coming up with different solutions." (3:006)

However, and in contrast with the more utopian tones employed in much of the TLM-based literature reviewed, such tasks were progressively understood to be *hard work* within an already demanding role. Similarly, they did not always reflect a reciprocal relationship with colleagues based on encouragement and response[6,17]; indeed, they were sometimes couched more in terms of direct 'troubleshooting' activities. For example:

"I think a lot of the heavy everyday life is just solving other people's problems." (3:003)

Equally, like 'helping', the leading of learning was widely reported to be practical, *ad-hoc* and task-specific rather than a general exercise in the dissemination of leadership 'wisdom'[6]:

"You have to be able to…solve a clinical problem for a patient or to give advice to the multiple disciplinary team setting – or to teach" (2:003)

Indeed, on one occasion, this part of the role was framed in terms of the more banal (though hardly unimportant) activity of simply "*…demystifying a lot of the stuff"* (3:007) for others should the need to do so arise.

Most participants maintained a very upbeat tone in reporting how collective problem-solving[1,6,24] was a growing consequence of team development. For example:

"I've gone into this [problem] *with the team that we've built together"* (2:006). Rather, what is being illustrated is that real leadership in consultant radiography is a pragmatic activity governed less by 'ideal models' of good practice and more by the necessities of everyday clinical and managerial work. As such, the TLM-consistent caring, sharing stance[17] is clearly taken to evidence good leadership by participants in many contexts, even when it is not easy to sustain. There are others cases, meanwhile, where a more instrumental, swift and executive approach – more consistent with a transactional style[16] - is reported to have been the most potent option. This was true even in the earlier interviews, and particularly where the CR's own position gave them a better view of the 'big picture':

> *"It's being able to see a gap in the market and just take the opportunity and run with it."* (1:001)
>
> *"Leadership is [also] about looking at patient pathways and deciding how you can do things better – projecting into the future - how are you going to cope with an increase of 30% cancers – how you are going to adapt your processes and things like that."* (1:006)

Participants also raised some more novel matters. The importance of situational awareness had proven crucial for some, while others stressed the efficacy of a strategically-oriented disposition. All, however, cited their functioning as facilitator[20] or 'boundary-spanner'[23] *between* teams, departments and agencies as central to their identity as a leader as much as – if not more than – their intra-team role. For example:

> *"I feel I'm the link between surgery and radiology."* (1:003)

> *"I am very much involved with the senior management team within the division."* (1:005)
>
> *"I work very closely with the breast surgeons and radiologists, consultant pathologists, superintendents…radiographers…and couple of* [specialist registrars]*."* (1:006)

In this way, the ambassadorial task of *"representing your profession at different levels"* (1:007) was recognised by participants not only as 'part of the job', but was directly experienced in terms of (a) being the 'face' of a radiology department, in sometimes difficult circumstances, and (b) actually leading cross-departmental knowledge-transfer. Typically:

> *"The* [multi-disciplinary team] *is a difficult place to be, where you're providing the radiology opinion."* (1:003)
>
> *"I do an awful lot of liaison work with other departments looking at, you know, their setting up of services similar to what we have established."* (1:009)

In short, representation was keyed into activities that defended a professional position where necessary, and assisted others where productive – a broad approach being highlighted as good practice in some of the most recent academic literature.[23]

2. How do I know I've made a difference?

The importance of 'making a difference', exerting influence[19] and improving healthcare service quality as a leader was a salient concern for all participants, both within the local working domain and at higher levels:

> *"I think we need to be influencing government thinking and be more involved in that…get on these consultancy panels and…have a say about our profession."* (3:007).

More particularly, participants were concerned with making an explicit difference for patients, and were all broadly confident that they had succeeded in this respect:

> *"You're in a position where you're essentially dealing with patients, and let's face it patients are the centre of all this, and you're making decisions on a patient's management, which are extremely important"* (1:003)

> *"I love the clinical side of it and I love knowing that I'm making a difference for the patients … I feel you're really making a difference to the patient and for the organisation"* (1:004)

> *"I have managed to do a lot in the three years I have been here … We have changed the way we do the new patient clinics."* (1:006)

This focus on leading so as to effect change for all is highly consistent with various extant TLM-based studies[16,34]. Perhaps more important still, from an analytic perspective, however, were the mechanisms cited as instrumental for actually measuring success in this domain; such mechanisms, after all, reflexively highlight the leadership outcomes that the CRs themselves value most highly. In the data

collected, these related to two main issues: (a) practical innovation and (b) subjective satisfaction.

Regarding the former, all participants measured their successes to some extent in terms of a variety of concrete, objective achievements[b] – generally the revamping of existing services and "*…changing the way that service looks"* (1:004), the introduction of brand new initiatives and having direct influence on policy. For example:

> *"*[We have introduced] *out-of-hours sessions for reporting."* (1:004)
>
> *"*[We have introduced] *one-stop clinics with biopsy facilities."* (1:006)
>
> *"We established the first radiographer-led new patient clinic for endometrial cancer patients."* (1:009*)*
>
> *"We're writing the follow up protocol for the whole network, surgical and oncology, to be rolled out across the rest of Scotland and, in actual fact, along with one of the MCN managers I've actually put the protocol together."* (3:001).

Sometimes, however, what we might term 'softer' measures were proposed to be key in terms of assessing successful change. For instance, the knowledge that a department that is happier - and is *seen* to be happier - or more generally satisfied patients:

[b] Which is highly conversant with the mandates of the 2015/16 NHS Outcomes Framework[36], which specifies that all evaluation of service quality needs to be linked directly to measurable patient impact.

"They (SPRs) are now starting to see that this department is different – that it is happier – that the radiographers are happy" (1:006)

"That to me has been the thing that has kept me going because ultimately you then see…hopefully a more satisfied patient" (1:009)

Indeed, for the participants, the very notion that others were happy *with them* and the changes they were making was deemed a critical measure of their general leadership credentials. As such, alongside more informal systems of feedback, '360-degree feedback' devices were seen as instruments that could provide a major boon to self-confidence, and the motivation to continue moving forward with change:

"People did seem to agree that I was a [good] *leader where sometimes I've had a bit of doubt about that."* (2:003)

"I think with the 360…you sort of think yeah I'm not just being over-confident; people are confident in me." (3:006)

In this respect, the perceptions held by important others (particularly direct colleagues) could prospectively have as much personal impact on these CRs' sense of self-efficacy as any nominally 'objective' outcome measure. Nevertheless, the sustained focus of some participants on these matters, even over 'hard' performance outcomes in some cases, might still be a little surprising given the contemporary culture of the NHS in which objective targets (not least financial ones) have become ever more dominant in recent years. We might instead reflect, thus, upon the matter of self-efficacy[35] itself in this professional context. Structural changes in organisations are virtually always effected at the conjunction of individual effort, practical

circumstances and collective action. The capacity to inspire confidence and to make others 'happy' even during difficult interactions, however, a core feature of effective Transformational Leadership[34], is more demonstrably an output of specific interpersonal skills – and skills that some of the participants were not always confident they possessed:

> *"I find it very difficult to challenge people and to do that in a way that I feel comfortable with."* (2:009)
>
> *"I feel still that the weakness is in shall we say people managing at the sharp end of…people who are actually working in the department under me."* (3:003)

Consequently, and on a practical, everyday level, it is quite logical for professionals to draw the highest levels of confidence from achievements that they can perceive as theirs and theirs alone[35], especially in domains where they may have formerly had doubts about their abilities to succeed. However, what is noteworthy here is that the participants showed a strong and specific tendency towards interdependence with their colleagues[24] when evaluating such success.

Limitations

Although a traditionally quantitative concern, the matter of 'non-response' bias has weight with respect to this study. As noted above, the CRs that did not participate often did so as a consequence of workload. Given that the participants who *were* involved consistently cited workload as a significant issue in their experience of being leaders, this renders apparent a potential gap in the data. This is to say, the prospective participants under the most stress around day-to-day leadership may not have

contributed to the study, thereby limiting the range of pertinent issues that could be described herein. One might reflect, thus, on how a broader method for understanding of the key issues for CRs around leadership might be generated.

Conclusion

The findings reported above describe a range of key issues pertinent to the participating CRs' experiences of adapting to the 'leadership' dimension of their roles. With respect to intra-team work[c], many of the these are strongly convergent with extant literature in the domain of transformational leadership; exerting positive influence and inspiring others, developing collective action and so forth.[17,20] For the participants to work in these ways - and draw particular attention to them during an interview - is, perhaps, unsurprising given that the TLM has been the touchstone for 'good leadership practice' in the NHS for well over a decade.[16] However, and in line with current research that advocates a more 'blended' approach to leadership in complex modern healthcare systems[23,24], the experiential focus of the analysis revealed that in specific examples of practice, the transformational approach was not always seen as the most useful route to a productive outcome given constrictions on time and other resources. In these cases, more 'direct' managerial strategies were sometimes deemed apposite. In short, an 'ideal' way of leading people emerged, but was often framed *as* an ideal to be employed when circumstances permitted.

Perhaps more strikingly, it became clear that the manner in which participants evaluated their own success as leaders was as contingent upon 'soft' measures where

[c] Though, in the domain of facilitation, participants often focused more extensively upon their boundary spanning function between teams than upon that within their own.

a success was demonstrably their own (especially when it utilised a skill in which they previously had limited confidence) as upon institutionally-favoured hard performance measures for collective/structural success. Thus, how they derived self-efficacy within their leadership role was a practical concern based in part upon having satisfied institutional goals, but also on the more personal and interdependent business of having affirmatively 'surprised' oneself, or felt trusted by colleagues.[24]

In sum, the findings above are manifestly designed to augment the growing body of knowledge regarding how the role of the CR is developing in real terms. It is further hoped, however, that they might assist in developing systems to further support CRs in the everyday business of real leadership, not least through better understanding how even apparently mundane outcomes can have significant impacts on self-efficacy.

References.

1. Hyrkäs K, Dende D. Clinical nursing leadership -- perspectives on current topics. J Nurs Manage 2008;16:495-498.

2. Lafranconi A, Gomes B, Stankunas M, Babich SM, Rethmeier KA, Czabanowska K. Medical leadership--from inspiration to education. Lancet 2015;386:1531-1532.

3. Williams G, Wood EV, Ibram F. From medical doctor to medical director: Leadership style matters. Br J Hosp Med 2015;76:420-422.

4. Negandhi P, Negandhi H, Tiwari R, Sharma K, Zodpey SP, Quazi Z, Gaidhane A, Jayalakshmi N, Gijare M, Yeravdekar R. Building interdisciplinary leadership skills

among health practitioners in the twenty-first century: An innovative training model. Front Pub Health 2015;3:221-221.

5. Twedell DM. Lessons in nursing leadership: Transition from academic medical center to community practice. Nurse Leader 2015;13:43,48-44,48.

6. Adams A. Developing leadership wisdom. Int J Lead Pub Serv 2007;3:39-50.

7. Rees Z. Consultant breast radiographers: Where are we now? an evaluation of the current role of the consultant breast radiographer. Radiography 2014;20:121-125.

8. Booth L, Henwood S, Miller PK. Reflections on the role of consultant radiographers in the UK: What is a consultant radiographer? Radiography 2015;22:38-43.

9. Henwood S, Booth L. On becoming a consultant: A study exploring the journey to consultant practice. Radiography 2015;22:32-37.

10. Henwood S, Booth L, Miller PK. Reflections on the role of consultant radiographers in the UK: The perceived impact on practice and factors that support and hinder the role. Radiography 2015;22:44-49.

11. Harris R, Paterson A. Exploring the research domain of consultant practice: Perceptions and opinions of consultant radiographers. Radiography 2015;22:12-20.

12. Nightingale J, Hardy M. Facilitating the transition to non-medical consultant practice: A longitudinal evaluation: A report for the mid yorkshire hospitals NHS trust. Salford: Salford University; 2012.

13. Hendry JA. Are radiography lecturers, leaders? Radiography 2013;19:251-258.

14. Powers K. Radiologic science faculty needs assessment. Radiol.Technol. 2015;87:95.

15. Silverman D. Discourses of counselling: HIV counselling as social interaction. London: Sage; 1997.

16. Ledlow GR, Copolla MN. Leadership for health professionals: Theory, skills, and applications. , 2nd ed. Sudbury, MA, USA: Jones and Bartlett; 2014.

17. Benson D. The five fundamental tasks of a transformational leader. Physician Leadership Journal 2015;2:58-62.

18. Tucker RC. The theory of charismatic leadership. Daedalus 1968;93:731-756.

19. DuBrin AJ. Leadership: Research findings, practice and skills. , 7th ed. Boston, MA, USA: Cengage Learning; 2013.

20. Allen S. The revolution of nursing pedagogy: A transformational process. Teaching & Learning in Nursing 2010;5:33-38.

21. Stone AG, Russel RF, Patterson K. Transformational versus servant leadership: A difference in leader focus. Leader Organ Devel J 2004;25:349-361.

22. Carter E. The dark side of transformational leadership. Psychologist 2015;28:503-503.

23. Onishi M. Measuring nurse managers' boundary spanning: Development and psychometric evaluation. J.Nurs.Manag. 2016;24:560-568.

24. Malloch K. Beyond transformational leadership to greater engagement: Inspiring innovation in complex organizations. Nurse Leader 2014;12:60-63.

25. Miller PK. Depression, sense and sensitivity: On pre-diagnostic questioning about self-harm and suicidal inclination in the primary care consultation. Commun Med 2013;10:39-51.

26. Smith JA, Flowers P, Larkin M. Interpretative phenomenological analysis: Theory, method and research. London: Sage; 2009.

27. Charmaz, K., Grounded Theory, in: Smith, J.A., ed., Qualitative Psychology: A Practical Guide to Methods, Sage, London, 2008, 81-110.

28. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Research in Psychology 2006;3:77-101.

29. Strauss A, Corbin JM. Basics of qualitative research: Techniques and procedures for developing grounded theory. , 2nd ed. London: Sage; 1998.

30. Woods AL, Miller PK, Sloane C. Patient obesity and the practical experience of the plain radiography professional: On everyday ethics, patient positioning and infelicitous equipment. Radiography 2016;22:118-123.

31. Glaser BG, Strauss A. The discovery of grounded theory. Chicago: Aldine; 1967.

32. Silverman D. Interpreting qualitative data. , 4th ed. London: Sage; 2012.

33. Yardley L. Dilemmas in qualitative health research. Psychol.Health 2000;15:215.

34. Bass BM, Riggio RE. Transformational leadership. , 2nd ed. Mahwah, NJ: Lawrence Erlbaum Associates; 2006.

35. Bandura A. Self-efficacy: The exercise of control. New York: W.H. Freeman; 1997.

36. Department of Health . The NHS outcomes framework 2015/16. FN-NHSG-NHSCPS-17185. London: Williams Lea / Department of Health; 2014.