Relational Leadership in the NHS: how healthcare leaders identify with public engagement

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Candidate declaration

I hereby declare that:

1. I have not been enrolled for another award of the University, or other academic or professional organisation, whilst undertaking my research degree.

2. None of the material contained in the thesis has been used in any other submission for an academic award.

3. I am aware of and understand the University's policy on plagiarism and certify that this thesis is my own work. The use of all published or other sources of material consulted have been properly and fully acknowledged.

4. The work undertaken towards the thesis has been conducted in accordance with the SHU Principles of Integrity in Research and the SHU Research Ethics Policy.

5. The word count of this thesis is 64, 002

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Abstract

This qualitative study engaged 12 healthcare leaders, from a range of contexts, to explore how leaders identify with public engagement. The leaders reported how public engagement led to a level of collaboration and genuine relationship that has hitherto been under-reported and relational leadership is discussed as a perspective. This study contributes to knowledge about how leaders recognise the importance of public engagement.

The study investigates how relational methods are used in public engagement and help leaders to understand themselves, and others, and how this improves the wider range of leadership relationships in their given context. Data was gathered using narrative interviews combined with participant selected artefacts. The artefacts formed a conduit for representing their sense of professional identity, in relation to their leadership, and were key to getting closer to participants construction of themselves in their current roles. Data was analysed using a variation of voice-centred relational analysis (Mauthner and Doucet, 2003). A secondary analysis was undertaken using Ganz (2010) model, which enriched the findings and led to a new 'public story'. By recognising both the linguistic and non-linguistic ways of identifying with public engagement this study provides new insights for building relational practices.

The research identified what motivates leaders to be collaborative with the public, how leaders identify with public engagement and conditions needed to support collaborative practice. Findings demonstrate how leaders understand their identity is socially constructed, dynamic and changing over time; professional and personal experience being intrinsically linked. The concept of self-identity is offered as an example of reflexive bricolage; a process of re-visiting experiences through a variety of lenses to form holistic understanding of self in professional leadership and public engagement practice.

Findings hold implications for healthcare leaders interested in collaborative relationships between public and the NHS, and between patients and staff. The study aligns to healthcare policy arising from Francis (2013). The policy focus on the importance of "*fostering a culture of inclusion and belonging*" and its encouragement to "*work together differently to deliver patient care*" (NHS, 2020, p.6) chimes with findings on leaders' sense of self, their relationships, and their context. It is relevant to health and social care leaders and public engagement practitioners as well as policy makers and education providers. The research may also be relevant to the growing community of 'patient leaders' in the NHS but further research is needed to understand the public perspective about relating to leaders.

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Abbreviations and terms

Care Quality Commission	CQC
Doctorate in Professional Studies	DProf
Foundation Trust	FT
Health and social care	H&SC
National Health Service	NHS
Narrative inquiry	NI
Visual narrative inquiry	VNI
Voice-centred relational analysis	VCRA
United Kingdom	UK

Key words

leadership, relational, public engagement, collaborative, identity, reflexive bricolage

1. Chapter One
Introduction

1.1. Introduction

The relationship "*between the public and the NHS, and between patients and staff, has been neglected for too long"* (Ham et al, 2018, p.1). Despite increasing emphasis on public engagement to enhance healthcare quality, defining what is needed remains a leadership challenge (Fischer and Ereaut, 2011; Pederson et al, 2013; Beech et al, 2019). Reports on health service failure at an organisational level regularly identify poor leadership and a lack of public engagement as a contributing factor (Francis, 2013; Berwick, 2013; Keogh, 2013).

Healthcare policy in the UK has brought the changing nature of public engagement relationships to the fore by encouraging more collaborative styles of leadership than traditional leadership has achieved. The Five Year Forward View (NHS, 2014) and subsequent policies (NHS, 2019a; NHS, 2020) all point to the need for the right kind of leadership in the NHS. According to the Rose review of leadership (2015) a lack of cohesive leadership produces "*an organisation where relations between staff and patients are merely transactional, doggedly contractual, obsessed with data and lacking in innovation and inspiration*" (Rose 2015, p.47). But what is the right leadership and what does this look like? This thesis is the result of a sustained and comprehensive exploration of how healthcare leaders identify with public engagement. Relational methods were used to elicit leaders understanding of their relationships, with themselves, with others, and with their leadership context.

1.2. Main area of research interest

Although much has been written about the importance of quality healthcare relationships in the UK, very little emphasises how to make quality relationships happen between healthcare leaders and the public. Despite significant changes in

health policy in response to issues arising from Francis (2013), a lack of clarity on leadership persists. Leadership associated with public engagement is therefore not only a topic of academic interest, but it also has significant implications for understanding healthcare quality (Beech et al, 2019; NHS People Plan, 2020). The Rose NHS Leadership Review (2015) shows that these issues "*produced a critical tipping point in the NHS*" (p.45). To understand leadership relationships with the public it was important to situate the study within a policy and political context. This study responds to the challenge to understand how healthcare leaders identify with public engagement, by exploring the holistic experiences of twelve leaders across a range of professional contexts in the NHS.

1.3. The relational journey

The initial aim of this study was to better understand how healthcare leaders understand public engagement. The first iteration of the title was: *Behind the Cover Story: What influences leadership for public engagement in healthcare?* What became clear in the literature review was that the leadership associated with public engagement necessitated a level of collaboration and genuine relationship that has hitherto been under-reported from a relational perspective. The aim of the study was therefore refined to better understand how healthcare leaders identify with public engagement. A methodology was needed that would elicit how leaders engage with others, self, and their context for public engagement to answer the research questions (Chapter 3, p.51).

As this study was focused on relationships, I became drawn to a relational world view. The inclusion of a relational ontology (Chapter 3) was a basis for holistic exploration around how healthcare leaders identify with the public. The Voice-Centered Relational approach to data analysis (Mauthner and Doucet, 2003) was especially appealing as it is informed by ontological and epistemological assumptions that were congruent with a relational study.

Data was gathered over the period of one year during 2017. Narrative interviews were combined with artefacts to elicit leaders understanding of relationships with themselves, with others and with their leadership context. Participant selected artefacts formed a conduit for representing leaders' sense of self in relation to their public engagement practice. This approach opened space to engage in a relational exploration around how leaders identify with public engagement, and how holistic views as a relational issue become involved in professional and personal conceptions of self. The data was analysed using a variation of Voice-Centred Relation Analysis (Mauthner and Doucet, 2003), which involved multiple readings for story, voice, artefacts, relationships, and context. Leadership portraits were scaffolded (Chapter 4) to recognise both the linguistic and non-linguistic ways that healthcare leaders identify with public engagement, and to provide new insights on relational leadership in the NHS.

Relational leadership in the NHS came into focus, somewhat unexpectedly at a late stage of the study when re-visiting the literature during the writing up phase. This revealed a small yet emerging literature on relational leadership in healthcare, mostly originating outside of the UK. These studies, which are discussed in Chapter 2, all supported the call for greater relationship orientated leadership, enriching the review and justification of the relational research path described in this thesis.

The shift to relational leadership in the NHS brought into focus a connection between the work the researcher had undertaken with participants stories using Voice-Centred Relational Analysis (Mauthner and Doucet, 2003) and the Ganz (2010) model. Its relational orientation provided a valuable frame to add a further layer of analysis, to test the analysis, and to enrich perspectives of the findings. This enabled an alternative way of looking at data. Ganz (2010) reminds us that how we identify with public engagement is an active dynamic process between ourselves, our relationships, and our leadership context. The process provided a reflexive perspective to enrich the data analysis themes by re-framing the research findings. The relational orientation of the Ganz model (2010) was particularly helpful for a practice-based professional doctorate because of its focus on 'public story' (action).

The willingness of participants to share their experiences showed how leaders identify with public engagement as a relational endeavour, with themselves, with others and with their leadership context, thus questioning the fragmented view of leadership and public engagement. As a result of this reflexive process this study leads to a new 'public story' (Ganz, 2010) on *relational leadership in the NHS.*

This research is relevant to health and social care leaders and public engagement practitioners as well as policy makers and education providers interested in how to build collaborative relationships between the public and the NHS and between patients and staff. The research may also be relevant to the growing community of 'patient leaders' in the NHS. The specific contributions that arise from my research are discussed in Chapter 8. My contribution to knowledge is rooted by Francis (2013) who showed the risk of not having good public engagement - a seminal moment, which pointed to leadership as a critical factor. This thesis speaks to the search for reasoning behind why, despite the policy imperative of public engagement, it remains a leadership challenge almost a decade after Francis (2013). This is the reason why my motivation for the study, which can be traced back to my own experience almost three decades ago remains so resonant.

1.4. Personal rationale

There was always a personal motivation to study, which holds individual relevance to me as a healthcare leader, public engagement practitioner and practice-based doctoral researcher. Reflecting on my personal experiences of using services was formative in guiding my professional practice within the areas of 'engagement', 'leadership' and 'change'. I became interested in how the cultural and behaviour changes that are needed to effectively embed collaborative ways of working in every day practice might be achieved.

Over a period of more than a decade prior to the study I observed that despite a plethora of public engagement policy initiatives, people's experiences in practice contexts didn't necessarily feel any different. I began my doctoral journey with the

rather pessimistic view that despite increasing emphasis on public engagement in health policy, we fail to achieve this adequately. Public engagement is not necessarily being translated into everyday practice in an embedded way. The issues this study addressed are viewed as complex because of the many factors that impact on the way that leadership and public engagement are understood including political, social, cultural, and historical. Reflexivity in the research is discussed in depth (Chapter 7) to acknowledge personal influences in the study and consider the development of my own thinking and practice. The concept of the self-identity is offered as a possible example of reflexive bricolage. Reflexive bricolage is described in my study (Chapter 7, p.232) as a process of re-visiting experiences through a variety of lenses to form holistic understanding and as a way for discovering profound moments of self in professional leadership and public engagement practice.

1.5. Study aims and objectives

1.5.1. Aim of the study

The aim of this study is: *to better understand how a small group of healthcare leaders, from a range of contexts, understand public engagement.* This study therefore adopts relational methods that elicit leaders understanding of relationships with their self, with others and with their leadership context. Relational [leadership] is defined as comprising "*a strand of leadership that brings to the fore the significance of relations and relational dynamics*" (Crevani, 2019, p. 223).

1.5.2. Study objectives

The intended objectives of this study include:

- To use relational methodology and methods that elicit leaders understanding of relationships with self, with others and with their leadership context.
- To develop ways in which healthcare leaders identify with public engagement, their motivations and conditions needed for leaders to practice collaboratively.

- To make recommendations to policy makers, education providers and all leaders wishing to build collaborative practice, to show how the findings of this study can influence future leadership policy and relational leadership practice with the public.

1.5.3. Definitions, terms, and concepts

At the time of embarking on the study there was relatively written on the specific topic of 'leadership' *and* 'public engagement' as the unification of these concepts was emergent. To contextualise discussion on how healthcare leaders identify with public engagement this section begins by situating relational leadership. The core terms used in this research are defined below:

- *Relational leadership*: Relational leadership comprises a strand of leadership research that brings to the fore the significant and relational dynamics of leadership. It therefore affords a more nuanced understanding of sensemaking and leadership practice, which is important given the role of healthcare leaders who are often steeped in a single ontology of science and rational methods (Fulop and Mark, 2013, p.222). In contrast to other leadership theories and models, it offers "*a different lens over what counts as leadership that can lead to different practice"* (Crevani, 2019 in Carroll et al, 2019, p.223-247) through, which to explore how healthcare leaders identify with public engagement in the NHS.

- *Relational:* The relational perspective in this study attends to the extent to which leaders shape the relations they engage in and/or the extent relations shape the individual they connect with. "*The more we assume that leaders not only shape interactions they engage in, but are also simultaneously shaped by such social engagements, the more we move to a constructionist perspective in the range of possible approaches"* (cf. Dachler and Hosking, 1995, in Cravani, 2015, p. 226). In this sense relational leadership does not only challenge the individualistic focus of leadership, but at a more profound level questions how we see ourselves in the world as leaders of public engagement (Crevani, 2019).

How leaders identify with public engagement, therefore emerges as an active relationally dynamic process (Ganz, 2010) between ourselves, our relationships, and our leadership context.

- *Public engagement*: The term 'public engagement' is used inter-changeably with 'involvement', 'participation', 'consultation', 'collaboration' and 'patient and public voice'. The literature paints a confused and confusing picture, yet the variety of terms all point to the importance of context. This research moves beyond process (Chapter 2); here the individual conversation between leaders and the public is scaled up and viewed as just "*one 'turn' in a much bigger conversation between the patient [public] and the health service as a whole*" (Fischer and Ereaut, 2012, p.36) such as self-care, management of long-term conditions, shaping services, quality improvements including future health and social care education and research.

- *Staff engagement:* Positive staff engagement has been associated with improved patient experience as well as improved staff wellbeing (Maben et al, 2012). Research along with the Boorman Report (2009) evidences the value of investing in staff engagement in relation to improving quality in healthcare. In this study the close relationship between public engagement-experience and staff engagement-experience was an un-intended consequence of the literature review (Chapter 2, p.44) as organisations that engage both staff and patients are found to achieve better outcomes and experiences for patients they serve; and for staff themselves too (Kings Fund, 2012). NHS England recognises the links between staff engagement, and values the contribution that staff members can make, not only as employees, but also as people using services and member of the community (NHS, 2017). It is perhaps un-surprising that my participants raised staff engagement, in their stories, as fundamental to underpinning their public engagement practice (Chapter 4, 5 and 6).

- *Patient experience*: A good experience of care, treatment and support is increasingly seen as an essential part of an excellent health and social care health and social care service, alongside clinical effectiveness, and safety. A

person's experience starts from their very first contact with the health and care system, right through to their last, which may be years after their first treatment, and include end-of-life care (NHS Improvement, 2018).

- *Story*: Stories are central to human understanding. According to According to Greenghalgh (2009) stories are the smallest unity by which human beings communicate their experience and knowledge of the world. Consistent with this view, Bolton (2005) suggests; *"lives are made sense of and ordered by the stories with which they are re-counted: told and re-told daily through actions, memories, thoughts, dreams, habits, beliefs, speech and behaviour patterns"* (p.105). Essentially, stories are reflective, creative and value laden, usefully revealing something important about the human condition. Yet, so often in the social sciences research participant quotations are extracted from transcriptions to simply reference the data. The very source of data within my research is held within participant stories. Story rapidly became a central to this relational research and is fundamental to my personal understanding and appreciation of the world - and what I found in the research conversations.

- *Storytelling:* Numerous definitions of the concept of storytelling exist. All share common elements, though some scholars use the word 'narrative' as a synonym for 'story'. Haigh and Hardy (2011) conclude that storytelling can be viewed as; "*the effort to communicate events using words (prose or poetry), images and sounds often including improvision or embellishment* (p.408). We spend our lives storying and re-storying ourselves and contributing to wider social stories around us. In my research, in addition to problematising taken fore-granted assumptions about the nature of how healthcare leaders identify with public engagement (leadership identity) is leaders experiences, which "*raises questions about the possibility and limits of linguistic representations*" (Stone, 2004, p.10). As a way of organising and making sense of my research, I was reminded the children's tale *Alice in Wonderland* and *Through the Looking Glass*. "What is the use of a book", thought Alice, "without picture or conversation" (Carroll, 1865, 1954, p.1). Wise Alice knew that texts, such as this thesis, must capture hearts,

imagination, and spirit, as well as mind to communicate (Bolton 2005, p. XVII). Therefore, the research combines narrative (stories) with visual (artefacts).

- *Artefacts*: Artefacts are a valuable way for researchers to help people connect important events and memories (Clandinin and Connolly, 2004). According to Bach (2007) visual narrative adds another layer of meaning. Pattison (2007) describes the significance of numerous humble artefacts, such as photographs and objects that are found in everyday life, but often overlooked. Combining narrative interviews with artefacts in my research allowed participants to select an object, which had meaning for them, and to choose which part of their story to tell (and not tell). Consistent with Saldaña and Omasta (2018) I found that it is not what the artefacts are that matters most, but rather what they symbolize to participants. Participants can therefore attribute specific symbolic significance and meaning that may not be readily available in the object. This study embraces the challenge of combining personal artefacts with narrative interviews as it would allow participant leaders to select an artefact that had meaning for them, and to choose which part of their story to tell in the research.

My research shows that using more than one method by layering data (narrative and visual) is helpful for shedding new light on contradictory meanings that images (Berger, 2008; Rose, 2016) and words (Bruner, 1997) express (discussed in Chapter 3). The approach also encouraged researcher and participant reflexivity in the research (discussed in Chapter 7).

1.5.4. Positioning the study: how leaders identify with public engagement

In this study the issue of how healthcare leaders identify with public engagement is explored. The impetus for leadership change may be derived from leaders professional and personal experience, providing a more holistic view of leadership and public engagement. My research explores how healthcare leaders understand public engagement, and how they understand themselves in relation to their relationships, with others and with their leadership context. A dimension of how leaders identify with public engagement is understanding how they make-meaning

of policy (values espoused) and how they practice (values enacted). Relevant elements of my own story are included within the thesis to acknowledge the need for a reflexive approach to my role as researcher, leader, and engagement practitioner.

1.6. Summary

This study began with a desire to cultivate collaborative relationships in the NHS. It evolved over time to focus on leadership in the NHS to show how healthcare leaders identify with public engagement. This relational orientation developed new insights into how healthcare leaders identify with public engagement, their motivations and conditions needed to support collaborative practice as an example of relational leadership in the NHS. Having outlined the origins of the study the remaining chapters are arranged to enable readers to follow the relational journey of the research. The next section of the thesis (Chapter 2) will examine the literature to develop a specific and detailed knowledge of published research that helps public engagement to be led more effectively in healthcare, which informed the research questions.

2. Chapter Two

Literature review

2.1. Introduction

In Chapter 1 the context and scope of the research topic were introduced. The encouragement of improvement in the NHS, through changing relationships between health professionals and the public is increasingly present in health policy (NHS, 2020). However, the way that public engagement is understood by leaders remains unclear. Understanding the changing nature of relationships between leaders and the public is especially relevant within ongoing reform of the English NHS (NHS, 2020). The increasing need for leaders to engage with the public collaboratively illustrates the importance of understanding what helps public engagement to be led more effectively given that this relates to clinical and non-clinical interactions across the health system.

The specific aim of the literature review was therefore to develop a specific and detailed knowledge of what is known about research that helps public engagement to be led more effectively in English healthcare to identify research gaps and questions that will further develop the knowledge base. The review addresses three key objectives relating to the research aims and objectives discussed in Chapter 1:

1. To define public engagement with regards to leadership in the English NHS
2. To explore the concept collaborative relationships with the public and the way this translates into leadership discourse in professional practice
3. To establish the nature of the leadership in the context of public engagement in healthcare

In the context of this review leaders include all NHS staff - and patients - "*where everyone takes responsibility for the success of patient care and the healthcare service"* (Silva, 2021, p.2).

This chapter is structured to situate public engagement in relation to healthcare leadership. The nature of relationships is explored from different perspectives leading to the identification of the research gap and questions. The scarcity of studies on the relational aspects of healthcare leadership was striking. The discussion is therefore organised to show that relational leadership is not where the study began but rather discovered as an outcome of the review. The review on relational leadership justified the gap and relational path described in this research; an investigation about how healthcare leaders engage with others, self, and their context for public engagement from a relational perspective. The approach and justification for the study is summarised in table 2.10 (p.50).

2.2. Review search strategy

The search strategy was designed to access peer-reviewed, published studies for the period 2001-2015. The period was determined by the policy context for public engagement in healthcare. The Department of Health, under the government leadership of Tony Blair focused on public engagement as a statutory duty (DH, 2000; DH, 2001). Towards the end of this the search period the Francis Inquiry (2013) prompted a renewed focus on leadership and the implications for the research to build more collaborative ways for leaders to engage with the public. At the end of the initial review period the Five Year Forward View (NHS England 2014) outlined its renewed focus on leadership and need for new ways of working (Ham and Murray, 2015). Given this, and the significance of the NHS Long Term Plan (NHS England, 2019a) and NHS People Plan (NHS England, 2020) the review was extended to address policy implications for the research for the period 2001-2021.

2.2.1. Planning phase

An early examination of the literature initially inspired the selection of a critical review using narrative synthesis. This early view, which mapped key leadership theories (table 2.1) and public engagement policy landmarks (table 2.2) revealed that there was little UK based research into the kind of leadership characteristics

needed to achieve the required cultural change described post-Francis (2013). This led to a small surge of grey literature reports being published on leadership and public engagement, enriching the context for the review - see for example, Kings Fund (2011, 2012, 2013). This review addresses a new space in the literature; it attempted to bring the research literature on healthcare leadership and public engagement more closely together.

Era	Leadership styles	References
From: Heroic leadership Leader as expert	Trait theory: innate qualities	Carlyle (1841) Bernard (1926)
	Style Theory: e.g., autocratic, democratic	Blake & Moulton (1964) Lewin (1939)
	Situational leadership: e.g., a repertoire of styles	Fiedler (2002) Yukl (2006)
	Transformational leadership: e.g., 'new leadership', charismatic, visionary	Bass (1985) Bryman (1992)
	Leadership as performance	Graen & Uhi-Bein (1995) House (1996)
	Leadership as socially constructed	Grint (2000)
	Leadership as a collective and creative process	Senge (1990) West et al (2014), Raelin (2011)
Towards: Shared leadership models (relational) Leader as enabler	Leadership as engaging Leadership for patient engagement Leadership as patient-centred Leadership as collaborative Leadership as compassionate	Alimo-Metcalfe & Alban Metcalfe (2008) Coulter (2012) Berwick (2009) Van Vactor (2012) West (2014), Raelin (2011)
	Relational leadership	Dachler & Hosking (1955) Hosking (1988) Uhl-Bien (2006) Uhl-Bein & Ospina (2012) Fairhurst and Uhl-Bein (2012) Crevani (2019)

Table 2.1 Leadership theories map: towards relational leadership

The leadership theories map above (table 2.1) showed how leadership theories have emerged over time Ola and Lok (2019) consider three distinct phases: traditional, modern theories and new theories (Ola and Lok, 2019, p.11). The new leadership theories, such as collaborative and relational, began to dramatically surface in the literature in response to the Francis Inquiry (2013). This recent turn within the field of leadership studies towards constructionist (e.g., Grint, 2005; Fairhurst and Grant, 2010) and relational (e.g., Hoskin and Morley, 1988; Hosking,

2011; Uhl Bien, 2006, 2011; Cunliffe and Eriksen, 2011; Crevani, 2019) has moved the focus of leadership onto emergent processes of influencing and meaning-making where the role of the individual leader and followers are openly explored and contrasted rather than assumed (Crevani, 2015; Schedlitzki et al, 2018). When public engagement doesn't work well, it could be perceived that the patient is the absent follower in a more traditional leadership perspective. The leadership theories map (table 2.1) was enriched by conducting a secondary mapping of public engagement policy landmarks (England) (table 2.2). This additional critical lens surfaced the relationship between relational leadership theories and the shift in policy which has increasing emphasised collaborative leadership practice.

1948	1950+	1970+	1980+	1990	2000	2010	2018
NHS founded	Paternalistic, (medical model)	Towards person-centred care	Towards information giving	Patient and public involvement becomes a statutory duty	Consultation Involvement Shared decision making Towards co-production	Inclusion Partnership	NHS 70 years old Collaborative models of care and leadership
	- GREAT BRITAIN, Department of Health (1993*). Patients Charter.* London, DH. - GREAT BRITTAIN, Department of Health (2000) NHS Plan: a plan for investment, a plan for reform, London, DH. - GREAT BRITTAIN. Department of Health (2001) Section 1, Health and Social Care Act, London: DH. - GREAT BRITTAIN, Department of Health (2012) Health and Social Care Act, London: DH. - GREAT BRITTAIN, Department of Health (2014) Five Year Forward View, DH. - GREAT BRITTAIN, Department of Health (2019) Long Term Plan			- (1993) Patient and public involvement is no longer a choice issue, but rather, a responsibility, duty and right. - (2001) This placed a statutory duty on NHS organisations to involve the public in the planning and development of services and consult them on service change. - (2015) NHS Constitution - sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively - emphases shared responsibility. - (2014) Five Year Forward View - emphasises building new relationships with patients, carers and communities - (2020) NHS People Plan and Our NHS People Promise - strands flowing from (2014) - emphasises integrated care, place-based care			

Table: 2.2. Public engagement - selected policy landmarks

The relationship between leadership theories (table 2.1) and policy landmarks (table 2.2) is taken into the research literature review.

2.2.2. Search phase

Once the complexity of the review topic had been established my interest and focus on the literature shifted as discussed in the introduction. It was necessary to extend the literature from a collaborative to relational leadership perspectives to make relevant connections to public engagement. As the basis for the literature review each of the review objectives (p.18) were approached with the following questions in mind (Greenhalgh et el, 2005):

i. what were the parameters of the topic; historical, context, key concepts, and assumptions?
ii. what topics have been addressed on building collaborative relationships with the public from a leadership perspective?
iii. what were the main findings from literature?
iv. how have the traditions of collaborative leadership and public engagement evolved; the way that earlier research has influenced current research and thinking?

The search was not straightforward. Considerable discussion was required, with the supervision team as complexities of the review emerged. This served as a tool to refine the study focus, establish clarity around gaps in the literature and manage, sometimes reluctantly rejection of literature. Creating an early impression of the complex review landscape was helpful for establishing some clarity within a significant amount of literature. Having established this it became clearer, that while there is a plethora of literature on leadership in healthcare (1,760,000), collaborative leadership in healthcare (396, 000) and public engagement in healthcare (1, 390,000) there was a dearth of literature that addressed the review focus. A variation of 'SPIDER' (Cooke et al, 2012) was used to establish search categories and terms and areas of interest (table 2.3) and definitions and inclusion-exclusion criteria (table 2.4). SPIDER (Cooke et al, 2012) was tested as a potential approach to overcome the challenges described on embarking on the review to identify literature. Consistent with Methley et al (2014) this review found that the PICO tool did not easily accommodate the search terms relating to the qualitative

nature of the search. Given the significance of 'context' within the review this was added as a further search category.

Search categories	Variation of 'spider' - C	Questions asked of the literature
Leaders (health professionals and public	**S**ample	What were the parameters of the topic: historical, contextual, key concepts, assumptions? What topics have been addressed on public engagement from a leadership perspective? What were the main findings from the literature: barriers, enablers? How have the traditions of leadership evolved, in the way that earlier research has influenced current research and thinking?
Changing relationships between healthcare leaders and the public	**P**henomenon of interest	
Types of data collection and analysis: qualitative	**D**esign	
Experiences or perspectives: leaders, public, organisation, system	**E**valuation	
Types of knowledge contribution	**R**esearch type	
Context of leadership associated with public engagement, relevant to collaborative relationships in healthcare	**C**ontext	

Table 2.3: SPIDER-C search categories and headings - based on Cooke et al (2012)

The resulting criteria for inclusion and exclusion are summarised below (table 2.4).

Inclusion criteria	Exclusion criteria
Intervention: Must be relevant to understanding collaborative relationships between leaders and public in healthcare e.g., policy, conceptual frameworks, models, interventions, evaluations. **Context:** Healthcare or associated e.g., education, organisational development **Time:** 2001 – 2021 (peer reviewed) **Scope of the literature:** Research literature and selective grey literature **Language:** Published in English	**Intervention:** Not having justified relevance to collaborative relationships in healthcare. **Context:** Not relevant to collaboration in healthcare settings with the public. **Results:** Insights that do not originate from the literature. The data extracted from the literature may not present new data, just interpretations or contextualisation of the review findings. **Time:** Pre-2001 **Language:** Non-English publications

Table 2.4: Inclusion and exclusion criteria

The review focused on UK health policy but considered international literature and empirical studies that could shed light on the nature of collaborative relationships and how leaders identify with this. Although terms relating to collaboration are

widely used there is a surprising lack of clarity as definitions in the literature are often tailored to specific contexts (Patel et al, 2012). This led to the following search operators, key words, and terms (table 2.5 and 2.6).

Leadership	AND Patient Public Service user Citizen AND Health-professional Staff	AND Engagement Involvement Patient-centred Person-centred Partnership Collaboration Collaborative	AND Relationship(s) Interaction Encounter Dialogue Deliberation

Table 2.5: Key search terms for leadership for public engagement (initial review)

Collaborative Collaboration Shared Collective	AND Leadership Leader Lead Leading	AND Healthcare National Health Service Public Services	AND Relationship(s) Professional Interaction AND Public Patient

Table 2.6: Key search terms for collaborative leadership (renewed review)

Peer reviewed data bases were searched together with government databases (table 2.7). In addition, grey literature was searched for commissioned pieces from bodies that are well respected by academics and healthcare practitioners. In the absence of this the review lacked context.

Cochrane database	Kings Fund
Medline	Health Foundation
Health management information consortium	NHS Confederation
PsycINFO	Patient Experience Library
Department of Health	Picker Institute
CINAHL	

Table 2.7: Data bases and literature sources

There was a huge linguistic challenge in the review in the search for key words and Boolean searches (see 'challenges', 2.4.9., p.47). It was necessary to find a way of getting through this complexity to establish a holistic interpretation of the literature. One of the challenges was that searches on collaborative leadership primarily focussed on staff and organisational perspectives with less attention to

collaborative relationships with patients. Conversely, the literature on public engagement focussed primarily on initiatives for securing direct public engagement. It was necessary to establish how public engagement is translated by leaders in practice to bring the fragmented literature on the concepts of leadership and public engagement more closely together.

Hand searching was found to be important to include reference lists of all identified reports and papers that were explored to identify additional studies and thinking in the grey literature that addressed the review issues. The reason for the extension was recognition that earlier studies focussed often on processes for securing direct public engagement. Less attention had been given to the relational aspects of leadership for gaining a holistic understanding of leadership identity. As part of a constant search for literature the term 'relational' came up late in this study. Given its significance, this was explored further and included as an addendum to the review. As a final step in the literature search the reference lists of the included articles were compiled in a word document to identify citations that appeared in further literature and establish if there were any studies of influence that did not appear in the initial search. The contribution of the sources of literature is summarised in the route-map to the literature review and justification for the study (Table 2.11, p.50).

2.3. Data extraction and synthesis

2.3.1. Data extraction and quality assessment: Following screening of texts, categorisation was undertaken to critically review and justify literature included in this study. A data extraction form was established to summarise the research purpose, context, theoretical basis, study design, participants, nature of the findings and contribution. The context of each article and common themes in relation to the research objectives were identified, coded, and recoded over several readings. Codes were based on the notion that underlying epistemologies will influence the ways in which the phenomena of leadership and public engagement are researched (Creswell, 2013). Drawing on Mackennzie and Knipe

(2006) this review sought evidence of various conceptual frameworks within the interpretivist-constructionist paradigm.

Literature was reviewed according to quality criteria discussed below. In addition to the primary research papers carefully selected examples of grey literature were included in this review, using commissioned pieces from bodies that are well respected by academic and healthcare practitioners. National health policy documents were mapped, and exemplars included to assure quality for the purpose of context. It is acknowledged that the evidence (theories and concepts) that informs policy landmarks for public engagement is unclear. A checklist for qualitative research was used, where possible to assess the qualitative literature, categorised according to the assessment guide (CASP UK, 2018). The results of the literature and characteristics of the included literature were tabulated. Although this approach does not have a uniform quality threshold it provided clearly defined areas to check for adequate explanation prior to the synthesis phase.

2.3.2. Synthesis: Narrative synthesis was chosen because narrative approaches are valuable in qualitative studies such as this that emphasise the significance of context (Cassell and Symons, 2004). A further benefit was being able to address a wide range of issues and questions beyond effectiveness of interventions that support collaborative relationships in healthcare. This approach was also open to flexibility allowing connections across professional contexts. Principally a narrative synthesis approach was adopted as a means of synthesis that enabled a full review of all the included literature. The following questions were guided by Greenhalgh et al (2005). This formed a tool to look at data extraction and quality in multiple contexts:

i. what is the range of contexts, issues, and questions that researchers have addressed?
ii. what are the commonalities in the research and to what extent can contradictions in the research be explained, such as barriers?
iii. what are the overall findings and implications that arise from these contrasting perspectives?

iv. what is the gap in the literature and how can this inform the research, questions, methodologies, and methods?

Having critiqued the literature, several themes emerged to address the review objectives (p.18). The dimensions included: 1) leadership, public engagement, policy and politics 2) leadership, language and complexity 3) relational leadership; conceptual frame 4) changing relationships in healthcare 5) public engagement and leadership studies 6) barriers to leadership and public engagement or blind-spots? 7) implications of staff engagement 8) relational leadership in the NHS: research implications. Each theme is discussed sequentially in the following discussion (section 2.4).

The output of the review process can be conceived a 'mosaic' or 'map' (Hammersey, 2001) framing the results. It provided a way to summarise the findings of the review in a succinct and coherent way. This could be described as taking a series of slices of the evidence through included research literature, grey literature, and health policy, thereby layering the evidence to take account of multiple perspectives. Given the significance of the NHS People Plan (2020) to leadership and public engagement the literature was refreshed following its publication to ensure that the literature provided a sound foundation on which to base the research questions. As part of the study there was a constant search for relational literature. Several studies emerged during the write-up of the research. Whilst none of these affect the research undertaken the emerging literature on relational leadership further justified the research gap and the path followed in the research that spanned seven years. To address this issue an addendum on relational leadership is added to the review.

By encompassing research, together with relevant policy, and selective grey literature the review process permitted a more holistic analysis of healthcare leadership and public engagement from a relational perspective. The literature that has really pushed collaborative relationships and new leadership theories was associated with Francis (2013). Following Francis (2013) significant grey literature was pulled together from primary research sources by experts in the fields of

leadership and public engagement, such as West, Berwick, Ham, Coulter and Greenhalgh who are primary researchers but became writers of grey literature. This inter-connectivity established a range of perspectives on the issues that the review objectives set out to explore pushing relational leadership in the NHS to the fore of the study.

2.4. Discussion

2.4.1. Theme 1. Leadership, public engagement, policy, and politics

Concerns over leadership in the UK National Health Service (NHS) first came into focus in the late 1980s (Mackie, 1987, Smith et al, 2018). For almost two decades leadership and leadership development have been central to healthcare quality and improvement with leaders increasingly encouraged to share responsibility for the delivery of services, outcomes of care, and quality improvement (Alimo-Metcalfe and Alban-Metcalfe, 2008; Ham et al, 2018). This shifts attention from heroic leadership to more relational approaches (Cunliffe and Eriksen, 2011). Despite a continued emphasis on public engagement, policy reports on health service failures at an organisational level have regularly identified poor leadership as a contributory factor in criminally negligent care quality (Francis, 2013; Keogh, 2013; Berwick, 2013).

When the labour government came to power in 1997 public engagement was recognised as a critical factor in the reform agenda to modernise the NHS (Goodwin 2000). Since then, the Kings Fund (2011) has consistently called for the replacement of heroic leadership models which focus on the development of individuals in favour of an increased focus on collaborative, shared and collective leadership models extending leadership development attention to all levels for staff and more recently patient leadership (McNally et al, 2015). Ham and Harley (Kings Fund, 2013) emphasise re-discovering purpose, encouraging NHS leaders to *"help build collaborative relationships and develop genuine co-production as a way of improving services"* (2013, p. vii). This report suggests that this forms part of leadership identity, a recurring theme in the research and grey literature. The

research interest in person-centeredness is due to the richness it shows; in contrast to other approaches, it is not simply looking at process.

In the last decade a variety of collaborative leadership models have emerged, such as collective leadership (West et al, 2014a, West et al, 2014b) - inclusive leadership (West et al 2015) - compassionate leadership (West et al, 2017). Evidence brings a sense of kindness to collaborative leadership (Murray and Gill, 2018) suggesting that compassionate leadership influences innovation in healthcare (West et al, 2017).

Bolden et al (2018) set out the evidence base for 'building leadership for inclusion' suggesting that more power aware approaches are required, which *"support the creation of safe spaces, where people can engage in issues of identity (of self and others)"* (2018, p.3). This called for a critical review of assumptions underpinning current approaches given the changing nature of leadership in the NHS (Verschuere et al, 2012). The previously dominant one-dimensional perspectives on leader and follower identities, discussed by Cunliffe and Erikson (2015) have been problematised with a view to their tendency to *"ignore context complexity and multiple and shifting identities and (…) power dynamics"* (Harding, in Carroll et al 2015, p.153). The challenge of embedding public engagement practice is considered just as significant today despite a plethora of policy, empirical research, and grey literature from experts in the field. The changing picture of leadership and public engagement, discussed in the planning phase (2.2.1) resembles a shift from 'heroic' to 'relational' leadership (figure 2.1).

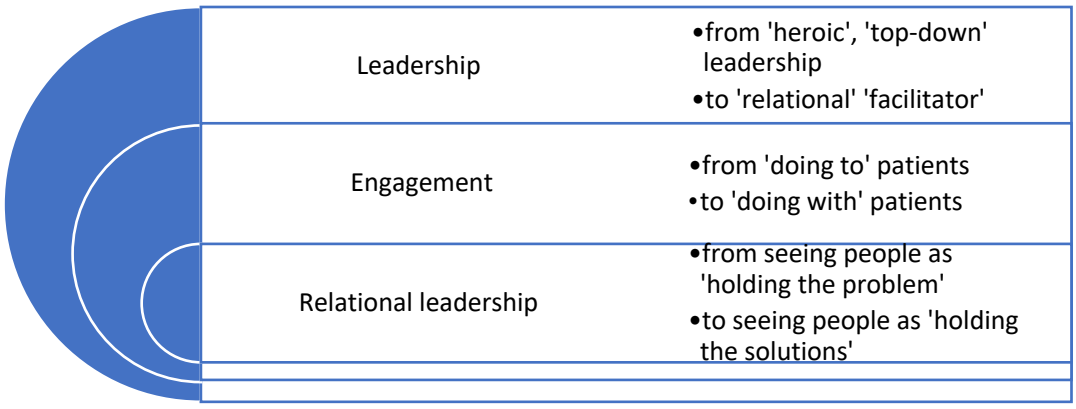


Figure 2.1: Shift from 'heroic' to 'relational' leadership

One of the reasons that collaborative relationships in healthcare are considered challenging is that many policies and structures established in response to the Health and Social Care Act (2012) are based on competence rather than the post-heroic leadership theories (Anandaciva et al, 2018). Evidence suggests that 21st century healthcare leadership requires that staff and public have a role to play creating a sense of leadership as a continuum spanning from professional leader to the emerging concept of patient leader (McNally et al, 2015).

2.4.2. Theme 2. Leadership, language, and complexity

Leadership is a multi-layered concept, and the research literature uses different terms interchangeably describing collaborative leadership associated with public engagement in multiple ways including 'shared' (Forsyth and Mason, 2017; Aube et al, 2018); 'collective' (West et al, 2014a; West et al, 2014b; Raelin, 2018) and 'collaborative' (Van Vactor, 2012; Markle-Reid et al, 2017; Okpala, 2018; Lachini et al, 2019; Orchard and Rykhoff, 2019). Researchers, such as Learmonth and Morrell (2016) raise concerns about the popularity of language of leadership within academic writing and organisation practice.

Many leadership theories (table 2.1) attempt to capture a simplified and coherent version of the world and position of the leader as a discreet individual who can change situations by applying leadership techniques, principles, or strategies. While such theories may offer a way of reflecting on practice, they do not necessarily help leaders to grapple with the complexities experienced by leaders in the field of public engagement (Cunliffe and Erikson, 2011).

The complexity of leadership terms encountered in this review indicated how researchers position themselves within the practice of leadership for public engagement (Coulter, 2012a). Many scholars advocate a particular approach to leadership associated with public engagement as if there is only one right way of doing it. These linguistic issues (Morley and Cashell, 2017) cautioned against the risk of building an incomplete picture of leadership associated with public engagement. The nature of linguistic challenge makes clarity on leadership and public engagement difficult.

Research studies subsequently show different types of collaborative leadership, which are contextual. Many examples focused on collaborative leadership to improve services for patients (Rubin, 2009; Buyan et al, 2020). Other examples address issues of balancing health service quality and costs through collaborative leadership (Okpala, 2018) or more widely a focus in advancing inter-professional practice (Smith et al, 2018) or collaborative learning for collaborative working (Pollard et al, 2004). There was a lack of research on building collaborative leadership with the public despite patient-based collaboration strategies developed in the USA (Okpala, 2018). One example of practice-based research on collaborative relationships between staff and the public is a qualitative evaluation undertaken in Australia based on the Kings Fund Collaborative Pairs Programme in the UK (Dickenson et al, 2020).

The commitment to leadership associated with public engagement associated in UK healthcare is firmly rooted in legislation bringing the issue of collaborative leadership relationships with the public to the fore. This includes the Health and Social Care Act (DH, 2012), the NHS Constitution (DH, 2013) and duty by NHS England (s13Q of the National Health Service Act 2006, amended by the Health and Social Care Act (2012). Regulations for public engagement are embedded as essential standards of quality and safety, that people who use health and care services have a right to expect together with complementary policy approaches (Chapter 1). The increasing call for leaders to build collaborative relationships with the public has created the challenge of enabling a health and care workforce with diverse professional backgrounds, knowledge, skills, and experience to work differently with the public than traditionally happened.

The understanding of the leadership discourse associated with public engagement is partial and incomplete. The review reveals a growing body of research; yet despite this there was a lack of research relating to the nature and quality of the relationship between leaders and the public in UK healthcare. The questions I encountered in the review caused me to re-think my ideas about leadership. Consistent with Cunliffe and Erikson (2015) I began to engage with practice and

noticed the emphasis on relationships and belonging. So, I examined the literature on relational leadership as a conceptual frame.

2.4.3. Theme 3. Relational leadership: conceptual frame

Relational leadership comprises a strand of leadership research that brings to the fore the significant and relational dynamics of leadership (Crevani, 2019, p.223). Leadership is considered as social process (Uhl-Bein, 2006). Relational leadership theories emerged when Hosking and Morley (1988) and Hosking (1988) first argued that need to attend to the social construction organising how leaders construct 'realities' and identities in socio-psychological processes occurring in relation to other people (Cunliffe and Erikson, 2011, p.1429). Despite its history spanning several decades, relational leadership appears as a relatively new term in the leadership literature (Cunliffe and Eriksen, 2011).

Cunliffe and Eriksen (2011) aimed to extend contemporary work on relational leadership theory by conceptualising leadership as "*embedded in everyday relationally-responsive dialogic practices of leaders*" (Cunliffe and Eriksen, 2011, p.1425). Some examples focus on relationship between nursing leadership and patient outcomes (Wong et al, 2013). Other examples address issues such as accountable care (Rundall et al, 2016) or more widely team-working. One example of research addresses the challenges of a relational leadership and the implications for efficacious decision-making in healthcare (Harden and Fulop, 2015).

In contrast, Parr et al (2020) explored the effect of relational leadership, leader exchange relationships and perceived organisational support on work engagement and patient outcomes using a cross-sectional survey design with 2552 nurses and clerical staff. Their research re-enforced the need for relational styles of leadership to achieve the common goal which are now favoured over task orientated styles (Cummings et al, 2010). Consistent with Wong et al (2013) they found that the relational leaders appear to have a positive effect on relationships in healthcare. Uhl-Beins' (2006) work on Relational Leadership Theory offers two perspectives; entity perspective (view on identifying attributes of individuals as they engage in inter-professional relationships) and relational perspectives (view on leadership as

a process of social construction through which certain understandings of leadership come about) - (table 2.8).

	Entity	**Relational**
Ontological assumptions	Realist (assumes and objective reality): Views individual in relation to separate, independent bounded entities	Relational (assumes a social reality): All social realities – all knowledge of self and of other people and things – are viewed as interdependent or co-dependant constructions existing and known only in relation
Approach to process	Cognitivist, constructivist: Individuals performing internal cognitive operations (separate from external social influences) to make sense of and understand how things really are	Constructionist: Person and context are interrelated social constructions made in ongoing local-cultural-historical processes
Approach to methodology	Views things as an individual act: These acts are reduced to one-way causal relations with feedback; therefore, the basic *unit of analysis is the individual* and studies are operationalised using individual-level variables	Assumes the primacy of relations: Focuses on communications the medium in which all social construction of leadership are continually created and changes
View of leadership	Emphasises the importance of interpersonal relationships: Focuses primarily on leadership in conditions of already "being organised"	Emphasises the importance of "relating" and relatedness: Considers leadership as a "process of organising"

Table 2.8: Comparison of entity and traditional perspectives (in Uhl-Bien, 2006, p.665).

From a theoretical perspective the literature points to the importance of relational approaches to making health professional more innovative and creative in how they deal with organisational dilemmas, such as public engagement. For example, Fulop and Mark (2013) suggests this allows leaders to engage in robust, informed, and inclusive decision-making processes. The more that we assume that individuals not only shape the relationships they engage in but are simultaneously shaped by each interaction, the more it encourages a constructionist view of leadership. Crevani (2019) offers helpful interpretation of Uhl-Bien and Ospina (2012) classification along the entity-constructionist perspective (table 2.9). It provides an overview of influential scholars, differences, and issues.

	Entity perspective		Constructionist perspective
Starting point	Individuals are stable entities that enter relationships		Meshes of relations are fundamental – both actors and reality itself exist and are known in relations
Focus	Individual properties and the quality of the relation between individuals		Relations and interaction – what goes on and what is co-constructed
Leadership is about	Leaders' interpersonal relationships with followers and heading them properly		Relating, co-creation and emergence throughout the organisation
Example of issue	How to increase innovation by attending to the relationships between leader and followers		How to reflect on the practices one is involved in order to enhance mutual learning
Example of authors	Graen, Gersten & Day, Hollander, Shamir, Seers & Chopin	Uhi-Bien, Fletcher	Hosking, Gergen, Ospina, Carroll, Simpson, Cunliffe, Barge, Fairhurst, Drath

Table 2.9: An illustration entity and constructionist perspectives (Crevani, 2019, p.228).

These scholars (table 2.8) share the firm view that relations are central to leadership work. Crevani (2019) argues that before we can discuss what leadership is we need to explore our own assumption about the social world. In this view, "relational leadership doesn't only challenge the individualistic focus of leadership research, but at a more profound level questions how we see ourselves in the world (Crevani, 2019, p.226).

In sum, relational leadership is "*not a theory or model of leadership, it draws on an intersubjective view of the world to offer a way of thinking about who leaders are in relation to others*" (patients, public) *"and how they might work with others within the complexity of experience"*. It shows that relational leadership means *recognising the entwined nature of relationships with others"* (Cunliffe and Eriksen, 2011. p.1434). The relational perspective offers practical theories for research on understanding how leaders identify with public engagement. Relational leadership affords a more nuanced understanding of sensemaking and leadership practice, which is important given the role of health professionals who are often steeped in a single ontology of science and rational methods (Fulop and Mark, p.222). In

contrast to other leadership model's relational leadership is not a different kind of leadership but offers "*a different lens over what counts as leadership that can lead to different practices"* (Crevani, 2015 in Carroll et al, 2019, p.246).

2.4.4. Theme 4. Changing relationships in healthcare

The conceptualisation of relationships illustrates the multi-dimensional nature of relationships in healthcare. All leadership theories acknowledge that leadership involves 'relationships', yet, consistent with Shein and Schein (2018) very few were found to take the trouble to analyse and explain what they mean by 'relationship'. (Shein and Schein, 2018). For Schein and Schein (2018), the concept of 'relationship' refers "*sociologically to how people connect with each other"*. This is helpful as the sociological perspective conveys a "*symmetry in relationships"* (Schein and Schein, 2018, p.22). Relationship is therefore, by this definition an interactive 'relational' concept (see Chapter 1, p.18). This sociological view of relationship resonates with relational leadership. In Schein and Schein's discussion on culturally defined levels of relationship it is evident that relationships in healthcare are built within a given culture, by what we are taught to expect of each other (healthcare leader-public) within the roles that we hold (professional-patient), hierarchy (professional ethos) and relationship (Schein and Schein 2018, p.22-39.Thus, leaders attributes have a significant effect on the extent to which people feel engaged (Cardiff et al, 2018; Barello et al, 2014).

Despite a longstanding focus on the importance of quality relationships in healthcare, little progress has been made towards a theoretical framework for understanding the contemporary relationships between leaders and the public in healthcare (Potter and McKinley, 2008, Fischer and Eurat 2011). Relationships have been categorised in a variety of ways that draw on different academic disciplines, psychological and sociological and more widely communication and business theory, medical anthropology, and economic perspectives (Pederson, 2013). Few studies analyse and explain what is meant be the concept of relationship (Phillips-Salimi et al, 2012; Harden and Fulop, 2015).

Over 36 systematic reviews on healthcare relationships were available at the time of the review; yet the search revealed these were clinically orientated around interactions of care. To date, research on healthcare relationships has tended to utilise semi-structured / in-depth interviews (e.g., Cunliffe and Erikson, 2011; Pomey et al, 2015; Dickenson et al, 2020), case studies (e.g., Coulter, 2012b; Byan et al, 2020) and increasingly mixed methods / multiple data sources (e.g., Fischer and Ereaut, 2011; Cardiff et al, 2018).

Although beyond the initial review, the constant search for relational literature found that research undertaken by Cardiff et al (2018) appeared to be the first to conduct research on nursing leadership from a relational perspective. The study explored how person-centred leadership manifested itself in clinical nursing resulting in a set of attributes, relational processes and contextual factors that influence becoming and being person-centred. Although the study doesn't focus specifically on leadership in relation to public engagement the study calls for greater relationship orientated leaders. An American paper by Koloroutis (2020) based on her earlier doctoral research suggests the importance of relational proficiency in healthcare (table 2.10).

1	Attuning	Attuning is a way of being intentionally present that conveys openness and interest. It requires listening, seeing, and noticing both verbal and nonverbal cues. Attuned leaders cultivate a culture of psychological safety.
2	Wondering	Relationally competent leaders are genuinely interested in and curious about others. They're open to what can be learned about everyone while intentionally suspending assumptions and judgements.
3	Following	Relationally competent leaders focus on what another person is teaching them about what matters most. Relationally competent leaders listen, consciously avoid interrupting and validate what they have heard, exploring areas of disagreement with curiosity and respect.
4	Holding	Relationally competent leaders skilfully care for and create emotional safety and dignity for individuals and teams. This requires them to provide support to teams.

Table 2.10: Relational proficiency taken from Koloroutis (2020).

Healthcare relationships involve shifts in perspective, which require re-defining the meaning of self from professional and personal perspectives (Berwick, 2009). However, as discussed in the previous section healthcare research on leadership and public engagement have tended to favour functionalist debates. At the time of the review, it seemed that although much has been written about the importance of quality relationships in the UK, very little was written on the nature of leaders' relationships with the public in healthcare (Potter and McKinlay, 2005; Raelin, 2016) or how to make quality relationships happen (Koloroutis, 2020) especially from a leadership perspective. This chapter now moves on to consider barriers to how leaders identify with public engagement.

2.4.5. Theme 5. Public engagement and leadership studies

Despite the call for more collaborative relationships between leaders and the public debate continues regarding the ways the public can be effectively engaged (Serio, 2018). Anandaciva et al (2018) assert that approaches are challenging, as many structures driven by the Health and Social Care Act (2012) are based on competence-based perspectives. Academic discussion on public engagement according to Barello et al (2014) has focused on clinical and economic aspects of engagement causing public engagement to be viewed as static rather than dynamic. Manafò et al (2018) echo the researcher challenge of comprehensively identifying public engagement literature on the specific topic of inquiry. They call for clarity around the terminology and language of engagement, which was found to impede progress.

Over 250 systematic reviews on public engagement were available around the inception of the review; yet the search found a dearth of literature on public engagement from a leadership perspective. The literature draws from different disciplines including leadership, education, communication studies, medicine, nursing, and psychology. Empirical studies, theoretical and thought papers hold many examples of healthcare practitioners working in ways that support greater collaboration with the public, driving change and improvement, and holding services to account. The primary research literature on public engagement

leadership was not neatly defined in the literature due to the complexity of language and diversity of contexts. Selected grey literature provided valuable insight into how public engagement is translated by leaders into everyday healthcare practice. Ocloo and Mathews (2016) believe that current models for public engagement are too narrow. Little UK based research was found on the leadership qualities required to achieve the cultural change described as public engagement in healthcare.

Understanding public engagement from a leadership perspective is partial and incomplete as the literature reviewed on public engagement was focused in the main on functionalist debates. This issue resonated with the review on leadership literature. Relationships were rarely mentioned in the literature. Devonport et al (2018) for example, were critical of the lack of focus on the inter-personal dynamics encouraging a greater focus on understanding and thinking about the relational dynamics of public engagement.

2.4.6. Theme 6. Barriers to leadership and public engagement or blind-spots?

Despite a variety of frameworks to develop, assess, select, encourage, and regulate collaborative relationships with the public there appears a lack of congruence creating a challenging context for leaders responsible for public engagement. Leaders are increasing responsible for building collaborative relationships with the public, yet healthcare staff often feel isolated, inadequately supported, and valued in the (NHSI, 2016).

A commonly cited barrier to leaders building collaborative relationships with the public is that health professionals are reported to believe that the care they provide is already collaborative in nature (Coulter, 2012a). Evidence shows however, that this is often not the case (Coulter et al, 2012a; Da Silva, 2012; Newman et al 2014). Despite a continued emphasis on public engagement, policy reports on health service failures at an organisational level have regularly identified poor leadership as a contributory factor in criminally negligent care (Francis, 2013; Keogh, 2013; Berwick, 2013).

Research indicates that staff may be more resistant to engaging in collaborative relationships than the public (Davies et al, 2008; Gronene et al, 2009). This issue is evident in several international studies (Davies et al 2008, Légaré et al 2008, Gronene et al, 2009) and evident in UK grey literature (Coulter, 2012). Historically, relational skills appear to have hardly featured in leadership development or health professionals' education. This was little reported in the literature on collaborative leadership relationships at the time of the initial review and therefore was unclear about how leaders are supported to identify with public engagement or the conditions to support leaders in establishing collaborative practice.

Research shows that patient attitudes and values are likely to interact with the attributes and behaviours of professionals and thus influence the relationship, for example in relation to shared decision-making (De Silva, 2012). In the real-world of public engagement Arnsteins' Ladder of Citizen Participation (1969) has been influential for policy makers and practitioners. Tritter and McCullam (2006) critically assess this model drawing on evidence from UK, Netherlands, Finland, Sweden, and Canada. Findings suggest that the emphasis the model places on power is problematic for the complexity of leadership, as the model ignores relevant diverse forms of knowledge and experience reflected in current health policy for public engagement.

This review found that policy, leadership theories, and academic literature are often context specific. This may be one reason why it is necessary to focus on relationships within the collaborative discourse, to understand better the leadership challenges. It suggests that these barriers impact on the knowledge translation of public engagement policy into everyday practice and therefore how collaborative relationships with the public might be viewed; beliefs, attitudes, and behaviours (Greenhalgh and Wieringa, 2011). This review acknowledges that leaders like to learn from practice, such as professional networks, not just academic literature.

2.4.7. Theme 7. Implications of staff engagement

Several studies evidence the link between engagement and performance; fewer errors, improved wellbeing, and morale (Laschiger and Leiteir 2006; Prins and Hockstra-Weebersta, 2010; Maben et al, 2012; Maben, 2015). The literature shows that organisations that engage both patients and staff will be open and accessible, emphasise collaboration, see the world through the eyes of others; feel valued and listened to (Alimo-Metcalfe and Alban-Metcalfe, 2008). The close relationship between public engagement-experience and staff engagement-experience was an un-intended consequence of the review as organisations that engage both staff and patients are found to achieve better outcomes and experiences for patients they serve; and for staff themselves too (Kings Fund, 2012).

The language of public engagement (and staff engagement) together with traditional hierarchies and assumptions appear to get in the way of creating a shared understanding of how collaborative relationships in health might be developed and supported from a leadership perspective. Within contemporary studies on leadership, it is increasingly common to look at the process-based nature of practice, clinically orientated and context specific. Less attention appears to be paid to the relational aspects of how leaders identify with public engagement. This review brings to the fore the importance of the relationship and how leaders generate relationships with others and their self. A relational leadership style of care is antecedent to quality care and positively associated with staff experience outcomes (Parr et al, 2021).

As discussed earlier, when the study there was a plethora of literature on leadership and public engagement but little of relevance from the searches. The scarcity of studies that specifically sought to understand the relational aspects of healthcare leadership with the public was striking. As part of the constant search for relational literature several papers emerged during the write-up of the thesis. Whilst none of these affect the research undertaken (they do not replicate what I did) emerging studies further justify the gap and the path that was followed in my research. To address this issue the theme of relational leadership is re-examined to address implications for research on relational leadership in healthcare.

2.4.8. Theme 8. Relational leadership in the NHS: research implications

The absence of healthcare research focussing on relational aspects of leadership and public engagement had gone unnoticed until recently when it began to receive attention as changes in healthcare support a relational orientation (Fulop and Mark, 2013). In their earlier study Cunliffe and Eriksen (2011) aimed to extend work on relational leadership theory by conceptualising leadership as "*embedded in everyday relationally-responsive dialogic practices of leaders*" (Cunliffe and Eriksen, 2011, p.1425). Consistent with Cunliffe and Erikson (2015) I found myself working in a "*relational-responsive*" orientation (p.1433) which situates leadership and public engagement in a relational ontology of "*relational and embedded experiences"* (p.1433). It is perhaps not surprising that I too discovered that a relationally-responsive orientation brings into focus our reflexive relationship with the world.

Within the leadership literature, researchers have adopted various social constructionist orientations (e.g., Grint, 2005). The studies undertaken have tended to reside largely outside of the UK in Australia, United States of America, and Canada and have tended to focus on shared decision making (Fulop and Mark, 2013) and nursing (Cardiff et al, 2018). A study conducted by Harden and Fulop (2015) addressed the wider challenges of relational leadership and the implications for efficacious decision-making in healthcare. This emerging literature shows the importance of relational approaches, making health professionals more innovative and creative in how they deal with organisational dilemmas, such as public engagement, allowing them to engage in robust, informed, and inclusive decision-making processes. The studies all support the call for greater relationship orientated leadership, enriching the review and justification of the relational research path that this study has followed.

The studies above are illustrative of relational leadership in healthcare. This was not only about relationally-responsive dialogues - such as shared decision-making - but the need for people to be able to express themselves. Such values for my

participants played through leaders' expression of their personal and professional values and their commitment to public engagement (Chapter 4, 5 and 6).

Given the diversity of leadership contexts for public engagement the review shows there can be no one size fits all for leaders establishing collaborative relationships with the public. The literature informing relational work adopts a critical perspective, explores power dynamics and uses post-structural analysis. The relational perspective offers practical theories for research on collaborative relationships of the kind this study seeks to address. It affords a more nuanced understanding of leadership in relation to public engagement practice, which is important given the role of healthcare leaders who are often steeped in a single ontology of science and rational methods (Fulop and Mark, p.222).

Relational leadership is not a different kind of leadership but offers "*a different lens over what counts as leadership"* (Crevani, 2019 in Carroll et al, 2019, p.223-247) through which to explore how healthcare leaders identify with public engagement in the NHS. As a result, this study moved from it early focus on 'collaborative leadership' (a partial and fragmented picture of leaders' relationships with the public) to 'relational leadership' (a more holistic view of the complex phenomena).

2.4.9. Challenges

Like many reviews of complex bodies of evidence getting started with the review search strategy was challenging. First, although the final review includes definitions of key terms, it necessitated working with contested terms within complex contexts, which made it problematic to set clear inclusion criteria. Second, it was difficult to know where to look for good research on collaborative relationships with the public and consequently how to identify quality research.

There was a huge linguistic issue in this review in key word and Boolean searches. A particular challenge was that much literature on collaborative leadership is orientated to collaboration between staff and organisations with less attention to collaborative relationships between health professions and the public. This was not

helpful, and much literature was subsequently excluded. Similarly, much literature on public engagement is orientated towards processes and initiatives for securing direct public engagement with less attention to leadership implications or the relational aspects of public engagement.

An important early finding of the review was the impossibility of organising studies into a single taxonomy for understanding collaborative relationships with the public. The literature was fragmented. The review found that the practice of how public engagement is led across the health system described a broad and complex phenomenon. There was no single, well-defined research that neatly traced the vast literature relevant to collaborative relationships between leaders and the public. Despite reading vast amounts of literature, much was found to be interesting but not helpful. It suggested a new space in the literature, which this review attempts to address by bringing the literature on leadership and public engagement more closely together (table 2.8, p.50).

2.5. Conclusion

Producing a literature review of complex evidence for issues such as public engagement that address policy driven questions is a complex methodological area (Greenhalgh et al, 2005). This selective critical review using narrative synthesis, examined the nature of collaborative leadership relationships with the public in healthcare. The synthesis identified several factors that suggest a gap in knowledge of a holistic understanding of how leaders understand an identity for public engagement and the conditions needed to operate effectively. With continuing inadequacy of research data on the nature of leaders' collaborative relationships with the public, there is still much that is unknown about the relational aspects of how public engagement in healthcare can be better led.

Leaders in the NHS are being asked to engage with the public in order to share an understanding about what kinds of healthcare are important, how these services are delivered and how quality is improved. The literature addresses the imperative to collaborate based on personal reported experience but doesn't evidence the

best approaches to do so across the health care system. The leadership associated with public engagement may necessitate a level of collaboration and genuine relationship that has hitherto been under reported from a relational perspective. This study will contribute to knowledge about how leaders identify as collaborative with the public.

Having reviewed the literature, a common thread is a lack of focus on relationships; how leaders generate collaborative relationships. A methodology and methods were needed that would elicit how leaders engage with others, self, and their context for public engagement to answer the research questions. The following questions remain insufficiently answered:

- How do healthcare leaders identify with public engagement?
- What motivates a leader to be collaborative with the public?
- What conditions are needed to support leaders in collaborative practice?

The current fragmented understanding may be influenced by the types of theoretical perspectives and methodologies underpinning earlier studies. Traditional narrative, textual and linguistic methodologies did not appear adequate for answering these questions, or to tell the complex story of how public engagement can be led more effectively.

Chapter 3 accounts for adopting a relational methodology and methods using narrative interviews combined with participant selected artefacts to provide a holistic understanding of the experiences of a small group of healthcare leaders.

Situating public engagement with regards to healthcare leadership	Exploring the changing nature of relationships: relational leadership: a conceptual frame	Identifying the research gap	Research questions	Relational leadership in the NHS: implications for practice and research
Collaborative leadership - primary focus on inter-professional collaboration (organisational focus) Public engagement perspective - primary focus initiatives-process for securing direct engagement (context specific)	Much has been written on the importance of quality relationships in healthcare. Leaders in the NHS are being asked to engage with the public in order to share an understanding of what kinds of healthcare are important, how services are delivered and how quality is improved.	The literature addressed the imperative to collaborate based on personal reported experience but doesn't evidence the best approaches to do so (generate relationships) across the health care system.	How do healthcare leaders identify with public engagement? What motivates a leader to be collaborative with the public? What conditions are needed to support leaders in collaborative practice?	The scarcity of studies that specifically sought to understand the relational aspects of healthcare leadership was striking. A constant search of the literature revealed the emergence of several papers during the write-up phase of the study (mostly outside the UK).
The work of leadership and public engagement is focussed in the main on process and functionality	Although much has been written on the importance of quality relationships in the NHS very little has been written on how to make collaborative relationships happen, or how leaders generate collaborative relationships with the public. Relational leadership is used as the conceptual frame.	The leadership associated with public engagement may necessitate a level of collaboration and genuine relationship that has hitherto been under-reported from a relational perspective.		The review on relational leadership (conceptual, practice perspectives) justified the gap and relational path described in this research. Relational leadership is not necessarily a different kind of leadership; rather "it offers "*a different lens over what counts as leadership that can lead to different practice" and through which to understand how leaders identify with public engagement*
Challenges: linguistic issues – fragmentation– context				

An investigation about how leaders engage with others, self, and their context for public engagement

Chapter 3

Table 2.11: Route-map to the literature review – justification for the study

3. Chapter Three

Methodology and methods

3.1. Introduction

The aim of this chapter is to describe the methodological framework developed in this study and discuss the methods used to generate, collect, and analyse the data and synthesise the results to answer the research questions. This study is situated on the interpretative paradigm taking a critical perspective. This chapter includes explanation about the ontological perspective, the selection of the epistemology and methodological choices. This study uses a qualitative design with narrative and visual methods and reflexivity (Alvesson and Sköldberg, 2017).

3.1.1. The research questions

The research questions are:

- *How do healthcare leaders identify with public engagement?*
- *What motivates a leader to be collaborative with the public?*
- *What conditions are needed to support leaders in collaborative practice?*

The literature review justified the need to engage in relational methods that elicit leaders understanding of relationships with their self, with others and with their leadership context. This study contrasts with earlier studies that focussed on specific initiatives for securing direct public engagement such as 'patient activation' (Hibbard and Greene, 2013) and 'shared decision-making' (Coulter and Collins, 2011). The specific research questions required an approach that would lead to a holistic understanding of how leaders identify with public engagement.

3.2. Theoretical background

Research methodologies and methods have been greatly influenced by changes in society, tradition, and organisation (Etherington 2004, p.26). Crotty's (1998) scaffolding metaphor is used to explore the relative merits of different research paradigms appropriate for inquiry into relational leadership; positivism, interpretivism and critical theories were also explored (Nicholls, 2009). An adaptation of Crotty's (1998) model (table 3.1) is used to show where the study sits ontologically, epistemologically, and methodologically to explain the interpretative paradigm adopting a critical perspective.

CONTEXT Context is the golden thread that runs through the study	ONTOLOGY relational, interpretativism EPISTEMOLOGY social constructionism complexity, critical theories METHODOLOGY narrative inquiry visual inquiry METHODS narrative interviews, artefacts, voice-centred relational analysis, portraiture	SELF AWARENESS Challenging assumptions, our own and others is essential; developing the reflexivity needed; adapting to complex and changing context for research in the working world

Table 3.1: The research design; based on Crotty's model (1998)

Understanding different philosophical, theoretical, and contextual perspectives was essential for navigating methodological choices and accounting for the implications of the interpretivist stance taken to answer the research questions (Saunders, 2009) (appendix 1).

3.2.1. Ontology

Ontology (being in the world) studies *"the nature of existence and what constitutes reality"* (Gray, 2013, p.19). Different ontological approaches inform how we understand and what we can know about the world both social and physical (Crotty, 1998). In social research, ontology is focussed on how 'reality' is understood within the social world

(Gray, 2013). The aim of this study was to better understand how a small group of leaders, from a range of contexts, understand public engagement.

According to Cunliffe and Eriksen, (2011) a 'relational ontology' (p.1431) causes us to "*radically rethink our notions of reality and who I am in the world, because it suggests the origin of our experience is intersubjective rather than individual and cognitive"* (p.1431). From this relational perspective the nature of public engagement leadership cannot be understood as organisational structures and systems, but rather by attending to people and conversations (Cunliffe and Eriksen, 2011). This contrasts with the focus on process and mechanisms for securing direct public engagement found often in earlier work, discussed in the literature review (Chapter 2). A relational ontology was helpful for this study as it calls for us to attend to ordinary "*experiences in the everyday lives of people,* (*such as health leaders), beginning with recognition that we do not know our way around"* (Clandinin, Caine and Lessard, 2018, p.18).

3.2.2. Epistemology

Epistemology is *"the theory of knowing"* (Orme and Shemmings, 2010, p.84). The epistemological position for this research was framed by Burr (2015) who advocates a humanistic, constructivist approach for the understanding and interpretation of human and social reality. According to Crotty (1998) this approach looks for "*culturally derived and historically situated interpretations of the social life"* (1998, p.67).

Within a subjective position knowledge is constructed and interpreted; we cannot be external to that knowledge. Although the positivist researcher seeks to explain social phenomenon, and the interpretivist researcher seeks to understand social phenomena, it was the critical paradigm that offered approaches for the researcher who seeks to challenge social phenomenon to bring about a change. An objective epistemology of positivism was not congruent with interpretivism and unhelpful to this study aim and research questions.

Epistemologically, as researchers we are part of the knowledge creation, its discovery, and its construction (Cunliffe and Eriksen, 2011). Accordingly, this calls for the researcher to become immersed in the world of the researched and to understand their experience of that world from their perspective. The more that we assume that leaders not only shape the interactions they engage in with the public (and staff) but are also shaped by the social engagement of collaborative leadership, the more that we move towards a constructionist perspective (Darchler and Hosking, 1995 in Crevani (2019, p.223).

Social constructionism holds many helpful characteristics for a relational ontology, so helpful for better understanding the nature of how healthcare leaders identify with the public (Harsch-Porters, 2011). Its focus on language, meaning making and narrative make it particularly relevant for this study (Harsch-Porter in Wildflower and Brennan 2011, p.81). From the research interest in the holistic nature of leaders' experience came a focus on social constructionism, which provided a lens through which to theoretically situate the research. Post-modern philosophy helped to focus the relationship between the ontological and epistemological position, and the methodological choices and methods. Harsch-Porters (2011) work on domains of knowledge shows that theories of social constructionism share certain characteristics that hold relevance to relational inquiry of this kind (p.81-84) - firstly, *knowledge is communally created* - secondly, *language creates our world* - thirdly, *our self and identity are created within relationships*. This is complex. In this study social constructionism was considered necessary to understand the gaps between theory and practice that are understood as socially mediated.

3.2.3. The critical theory perspective

The critical perspective was chosen for this study for several reasons. The leadership space in which collaborative relationships with the public is situated has become increasingly complex (West and West, 2015; Ham et al, 2018). With so many evidenced-based models of leadership and public engagement (Chapter 2) much is written on the importance of quality relationships in healthcare yet very little is written on how to

make quality relationships happen (Koloroutis, 2020), particularly from a leadership perspective (Cardiff et al, 2018). Research methods that attempt to eliminate uncertainty and reduce the complexity of concepts did not appear helpful for this study (Yardley and Bishop, 2008).

The complex nature of leadership and public engagement points to the work of Grint (2010) on 'tame' and 'wicked' issues in organisations. In contrast to tame problems, which may be complex, but solutions do exist, wicked problems tend not to have known answers. Grint (2005) suggests that leaders face many wicked issues. Researchers such as Beech et al (2019) increasingly emphasise the need to find new ways of thinking and working to achieve the desired change of more collaborative and inclusive healthcare (Chapter 2). The real-world, practice-based research environment of leadership in healthcare has been argued to be complex (Edmondson and McManus, 2007; Greenlagh and Papoutsi, 2018). Leadership practitioner communities with responsibilities for patient engagement - experience reflect a variety of professional backgrounds, knowledge and experience derived from multiple perspectives, from sociological and psychological to economic and statistical analysis (Gray, 2013).

The literature (Chapter 2) showed that diverse evidence-based approaches to leadership and public engagement exist; yet there is not a consistently agreed approach to research within this topic. This situation indicated that a methodology and methods suited to this study would need to generate and synthesise complex data from multiple sources. Kincloes' (2004, 2011a) multi-faceted ideas about critical perspectives are significant to leadership studies as there is little critical scholarship that addresses the nature of research on understanding collaborative relationships with the public. Fischer and Eaurat (2011) argue the need for research to move beyond clinical interactions to address the wider conversations between leaders and the public across the healthcare system. An evidence-review conducted by Pederson et al (2013) explored relationships to better understand how different relationships between patients and providers can impact on the quality of care. Data was analysed on conceptual frameworks for understanding relationships more generally. Evidence was found to be patchy and sometimes contradictory suggesting that the dominant focus on process, rather than

relationship in earlier research, was problematic. Achieving a culture of public engagement is viewed as a complex task because the relationship between this change, and the contexts in which leaders are situated, involves multiple discourses often bound by complexities such as power and context.

Critical theories open possibilities for new knowledge development by encouraging multiple layers of data and analysis of discourse and historical understanding. Kincloe (2005) suggests that by taking a critical perspective the researcher "*moves beyond the blinds of particular disciplines and peers through a conceptual window to a new world of research and knowledge production"* (2005, p.323). Kincloe (2005) grounds his thinking in an epistemology of complexity. It challenges the researcher to think about the nature of knowledge production including collaboration and the co-production of knowledge (Rycroft-Malone et al, 2016). Leadership studies in related health contexts such as education offer alternative perspectives when used to explore leaders' experiences of public engagement. The organising vision behind complexity-informed research needs to make sure that we remain critical about our assumptions and methods (Greenhalgh and Papoutsi, 2018, p.1084).

3.3. Methodology

This is a qualitative investigation that uses in-depth narrative interviewing combined with artefacts to explore the nature of leadership with the public in healthcare. The methodology refers to how the research might be conducted in an effort to discover new insights on the nature of collaborative relationships with the public. This section sets out the strategic approach to the research design before moving to the research methods and approaches to operationalise the research. Guba and Lincoln (1994) determine that it is how the researcher goes about their search of whatever they believe can be known.

3.3.1. Narrative inquiry

Narrative methodologies and methods are increasingly recognised as an essential research tool (Chase, 2013). As conceptualised by Clandinin and Rosiek (2007) narrative inquiry begins with a *"respect for ordinary lived experience"* (2007, p.42). It explores both individual experience and *"the social, cultural and institutional narratives within which individuals' experiences were constituted, shaped, expressed and enacted"* (2007, p.42). Narrative researchers such as Clandinin and Connelly (2000) and Reisman (2008) argue that narrative methodologies provide a way to capture individual participants experiences and bring leaders voices to the fore of the research. The literature review (Chapter 2) justified the importance of exploring leaders' experiences holistically to better understand the complex social and cultural issues associated with public engagement.

Humans are storytelling organisms who individually and socially lead storied lives within complex storied landscapes (Clandinin and Connolly, 2000). The social, cultural, and organisational narratives within which individuals' experiences are composed, shaped, and expressed form this landscape (Clandanin and Rosiek, 2007). The use of narrative inquiry emerged from this view of human experience in which humans individually, and socially lead storied lives (Clandinin, 2007, p.282). According to Clandinin (2007) and Nossel (2018, p.3) people shape their daily lives by stories, of who they are, and of others as they interpret their past in terms of these stories (2007, p.282).

In leadership studies, stories are increasingly recognised for their value in opening valuable windows into the emotional and symbolic lives of organisations, offering researchers a powerful research instrument (Gabriel, 2000). Our position within the cultural stories available to us are said by Gabriel (2000) to shape the personal stories that we develop about our lives and experiences. The reciprocal relationship between listening to and telling a story resonates with the relational nature of this study.

Narrative in this study is not simply about conveying leaders' stories but seeking authentic understanding of leaders' experiences by appreciating the influences within

the stories that participants choose to tell (or not), why these stories, and why now, in this way (Greenhalgh, 2016). Clandinin and Connelly (2000) describe the power that narrative has on peoples lived experience, and its partiality (2000). Greenhalgh (2016) re-enforces that storytelling and interpretations belong to the humanistic disciplines. This appears consistent with the views of others such as Coulter (2012) and West (2015) who encourage relational aspects of leadership.

Narrative inquiry has been used increasingly in health research across a variety of professional disciplines. In nursing for example, where it is perhaps most evident, it has been used to explore issues such as patient lived experience and professional development (Moon and Fowler, 2008), rapid and continuous change (McMillan, 2015) and more widely how practitioner engagement can influence patient engagement in rehabilitation (Bright et al, 2017). In medicine narrative research has been used to explore issues such as how medical discourse can disregard patient experience and in patient's narrative accounts (Frank, 2010). Frank's (2010) argument that medical knowledge has failed to help patients deal adequately with suffering is an example of how narrative has been used to address how doctors are regulated. Whilst there is some evidence of narrative approaches in leadership identity research such as Moon and Fowler (2008) there is little evidence of its use to explore leaders' perceptions on their motivations for collaborative relationships with the public, how leaders identify with public engagement, or the support needed to support relational practice.

Literature on narrative inquiry reflects ongoing developments in thinking (Chase, 2018). Clandinin (2007), Riessman (2008), Bamberg (2007), Josselson et al (2007), and (Chase, 2013, 2018) take a range of perspectives including telling stories, identity and story and analysing narrative reality. Narrative inquiry encompasses a range of approaches including, autoethnography, life history, personal narrative, and visual narrative. Chase (2018) explores the expansion in the kinds of data narrative researchers use over recent years; ethnographic observation (Riessman, 2008), autographical writing and photographs (Bell 2002, 2006); interviews and contents analysis of documents (Chase, 2010), storytelling and artefacts (Watton and Parry, 2016). The power that narrative has on peoples' lived experience is acknowledged, but also its partiality (Clandinin and

Connelly (2000, p.17). Chase (2018) suggests using multiple sources of data "*underscores that any view is partial and that narrative environments are multiple layered*" (p.75). Crucially, for this study narrative approaches give insight into leaders' experience of public engagement in their professional practice and insight into the rich array of influences that inform practice. Eventually I was able to craft a methodology that was collaborative, multi-layered and brings leaders' experience to the fore. Like Watton and Parry (2016) this study draws on and adapts visual narrative inquiry, enriching narrative inquiry with artefacts.

3.3.2. Enriching narrative inquiry with artefacts

According to Bach (2007) visual narrative adds another layer of meaning. Creative methodologies (Rose, 2016) are increasingly recognised in healthcare research as having the potential to facilitate self-reflection and self-exploration on professional practice. Several studies were particularly influential to the development of enriching narratives with artefacts. Kolaiti's (2009) research, for example explored the influence of photographic narrative in healthcare dialogue. Pattison (2007) describes the significance of numerous humble artefacts, such as photographs and objects that are found in everyday life but often overlooked.

Artefacts are a valuable way for researchers to help people to connect important events and memories (Clandinin and Connolly, 2007). Combining narrative interviews with artefacts allows participants to select an object that has meaning for them, and to choose which part of their story to tell. The use of personal artefacts, as an object that has leadership significance, is a relatively new area of research in leadership learning (Watton and Parry, 2016). This study showed that the combination of story and artefact is a powerful way to achieve greater understanding of our leadership identity and of others. The combination of artefacts and narrative interviews is an under-researched approach although the telling of a story is so axiomatic to the role of an artefact in leadership and management learning (Watton and Perry, 2016). It is not what the artefacts are that matters most but what they symbolize to participants (Saldaña and

Omasta, 2018). In this way, participants can attribute specific symbolic significance and meaning that may not be readily available in the object.

This research embraced the challenge of combining personal artefacts with narrative interviews as it would allow participant leaders to select an artefact that had meaning for them, and to choose which part of their story to tell in the research. According to Watton and Perry (2016) participants' life experience and emotions are often surfaced through using artefacts. Combining artefacts with narrative interviews offered the potential to bring similar insights into how leaders understand their experience and identify with public engagement. Traditionally, objects are often selected by the researcher, serving as a tool for reflection, but notably within the lived experience of the researcher and associated meanings for the research (Morrison and Dearden, 2013). In this research the pilot study showed the importance of artefacts as a conversational piece and for getting closer to how leaders identify with public engagement, including their motivations (p.56). This is why my research is framed in this way.

Artefacts have "*stories - origins, histories, moments, reasons - about how they were collected, created, inherited, and/or purchased*" (Saldaña and Omasta, 2018, p.74). Despite the core relational ethical principle of narrative inquiry the literature review (Chapter 2) cautioned the limitations of language. Since artefacts cannot speak for themselves, researchers need to use them as a conversation piece with participants "*to learn more about the relationship between to object and humans*" (2018, p.74). Using more than one method by layering data - narrative and visual - appeared helpful for shedding light on contradictory meanings that images (Rose, 2016; Berger, 2008), or words (Bruner, 1997) may express. Rose (2016) conveys a narrative that shows increasing importance of the visual and creative approaches to contemporary Western Society. She highlights that in pre-modern society, visual ways of knowing were not seen as important and she suggests that modern forms of understanding depend on a *"scopic regime that equates seeing with knowing"* (Rose 2016, p.3). It was challenging to find a better way to describe the methodology than narrative interviews combined with artefacts. Narrative interviews are combined with the elicitation of stories from artefacts selected by participants as an example of visual narrative inquiry (Clandinin, 2007).

3.4. Methods

This section provides a more detailed rationale and account of the methods and specific approaches used to generate and analyse the qualitative data created in this study (Crotty, 1998). This qualitative investigation uses in-depth narrative interviews and artefacts to explore leaders' experiences for better understanding how healthcare leaders identify with public engagement, what motivates them, and the conditions needed to operate.

3.4.1. Participant identification and engagement

The sample for this study included leaders from a range of professional and organisational contexts in healthcare; 3 local NHS Foundation Trusts within England and 3 national organisations. Organisations typically had mechanisms for engaging with the public on issues such as service-quality improvement. A purposive approach (Patton 1990, p.177) was deployed to recruit participants, drawing on researcher experience and practitioner networks. According to Patton (2002) the use of intensity sampling allowed the selection of a small number of rich cases that could provide in-depth information and knowledge of the phenomena of collaboration in leadership. The sampling approach sought to provide a variety of leadership perspectives; organisational lead for public engagement-experience (co-ordinator), staff champion for public engagement (operational) and senior leader working at board level (strategic).

Public participation leads were approached from organisations that the researcher had access to but had not worked with to avoid bias. An impersonal approach via email did not work well. Therefore, a snowballing approach was used to connect with NHS public engagement practitioners. In consequence public engagement practitioners (co-ordinator) who agreed to participate then acted as a conduit for the wider engagement of two further participants from their organisation; staff champion for public engagement (operational); senior leader (board level). A total of twelve leaders participated in the study. The characteristics of leaders who participated are summarised below (table 3.2).

Professional background	National	Board	Coordinator	Operational
Nurse	1	2	3	0
Doctor	0	0	0	1
Speech &Language	1	1	0	0
Education	1	0	0	2

Table 3.2: Participant characteristics (one participant commenced nurse training)

The table above reflects that identification and engagement of participants was extended a result of a pilot (discussed below) to include national leader perspectives.

The provider organisations in this study are characterised by the Care Quality Commission (CQC), a government agency who assess the quality of NHS organisations in relation to performance. Specific CQC judgements for the dimensions of 'leadership' and 'caring' were investigated. The unintended consequence of the approach resulted in the three participating NHS Trusts forming contrasting organisational contexts based on CQC review ratings; outstanding (1), good (1) and special measures (1). This provided a further dimension of context for the research.

3.5. Ethical considerations and trustworthiness

3.5.1 Ethics and governance

Ethical issues in the research were considered at each stage, beginning with the formal ethics approval process from the host university. Approval was received from the Sheffield Hallam University, Research Ethics Committee (SHU REC) number 2015/HWB-HSC-DPS-5.

Access to meet participants at their organisation was negotiated to secure a researcher-passport. A participant letter and information sheet were prepared and used to support the process of gaining informed consent. Gaining access to participating organisations, appeared to be determined by the quality of initiating conversations, which took place by phone, before meeting face-to-face. Participants appeared to show an intuitive

response regarding their participation in the study based on these interactions, rather than the more process driven response to the written information anticipated in the process for gaining informed consent.

Despite the importance of adhering to an ethical process, the importance of attending to the relational aspects of the research relationship was vital, influencing the quality and authenticity of data. Anonymisation of interview recordings, transcripts and artefacts aimed to respect confidentiality and protect participants identity. All data has been kept in a password-protected computer in accordance with best practice; National Institute for Health Research; Good Clinical Practice (secondary care); British Educational Research Association, who are committed to advancing research quality https://www.bera.ac.uk

3.5.2. Ethics, data collection and informed consent

The process for informed consent began by providing each participant with information to make an informed choice about whether to consent and participate voluntarily in this study. To ensure that leaders did not feel compelled to participate all participants were sent an invitation letter and information sheet by email including the researcher contact. The consent form was reviewed at the beginning of the first meeting.

Mischler (in Clandinin and Murphy, 2007, p.649) alerts that the increased use narratives, augmented visually, raises questions about how to protect participant images and objects. To protect participant confidentiality, and anonymity of participant artefacts, photographs of the artefact were used, where appropriate with participant consent. Where this was not possible, or where some artefacts were metaphorical representative images were sourced through Shutterstock™ https://www.shutterstock.com in agreement and with participant consent.

At the time of gaining participant consent, it was agreed that pseudonyms would be used. Seeking participant feedback led one participant to request the use of their own name instead of pseudonym as agreed. The words; *"It's about my story and my journey"*

resounded. Paradoxically, in this context using pseudonym was not congruent with their early lived experiences of finding a voice and identity. The initial consent was repeated at the beginning and end of each research meeting.

3.5.3. Ethics and data management

Data for this study was managed and stored in the following ways. A word document was created to monitor the process of data collection; this was updated regularly. According to Creswell (2013) the organisation of data is the first stage in a spiral of data analysis, moving in analytical circles in contrast to a rigid linear approach to the final thesis account. The early organisation formed a foundational framework from which to log contacts, building additional sources including supervision notes and reflective diary.

A Dictaphone and I-phone devices were used, in tandem as a precautionary measure, to record interviews and supervisory meetings. The recorded participant interviews were uploaded to a laptop computer prior to transcription. Codes were established to identify each participant and pseudonyms used to ensure that participant identities were protected in the leadership portraits used to present findings. All study documents and participant consent forms (signed / dated) were stored on a password protected computer. The researcher journal added a further source of data and a starting point for sifting meanings from leaders' stories.

3.5.4. Ethics and data validation

The step of respondent validation (Bryman, 2004) was used to achieve verification of researcher interpretations of the data, synthesised as leadership portraits (Savin-Baden and Howell-Major, 2013, p.477). Allowing participant voices to be heard enhanced credibility of the thesis and recommendations for professional practice (Chapter 8) ensuring a focus on reliability, scrutiny, and trust (Chapter 3, 3.8.1).

3.5.5. Ethics and reflexivity

The need to make the epistemological positioning clear was recognised to enable readers to establish the researcher role in the research process at every stage. Using self-reflection was a way of attempting to balance power between researcher and participants, accounting for the complex power dynamic that exist across public sector (Etherington, 2004). *"This requires a critical stance, towards the research, acknowledging the philosophical stance and efforts toward criticality"* (Savin-Baden and Howell-Major, 2013, p.335). A reflexive approach enabled me to better notice, understand and respond to research conversations.

The research has features of a reflexive approach, systematically designed, and subjected to scrutiny ensuring the evolution and refinement of the methodology at each stage of the research (see for example, the pilot). The qualitative data represents leaders' realities, narratively and visually leading to a synthesis of complex experiences, perspectives and voices including my own as researcher. In searching not for a story, but for the story (Lawence-Lightfoot and Hoffman Davis, 1997) the process of selection and elimination of data for the scaffolding of the twelve leader portraits (Chapter 4) was subjective. It was important to acknowledge the presence of my own interests and values as a fellow leadership and engagement practitioner. Questions reflexivity and the ethics of reflexivity were therefore significant in the methodological process.

The reflexive approach is made explicit in the thesis, interrogating the data collection, analysis and reporting from multiple perspectives. Accounting for the ethics and reflexivity is necessary because the narrative and visual used in the portrait approach developed in this study do not have a single truth, authority, or generalisability. Different versions of participant experiences are accompanied by value judgements, by the leaders as narrator, researcher as listener and interpreter, and by the reader. These are embraced and accounted for rather than eliminated. Matters arising on the ethics of reflexivity are expanded in Chapter 7. In addressing the ethical aspects of the research, the inherent ethical issues of reflexivity in narrative inquiry are addressed. Overall, the aim was to create research that can be read from several perspectives: narrative, visual

and reflexive as a way of contributing to the development of relational leadership in the NHS.

3.6. Pilot

A small-scale pilot was established prior to the main investigation to assess the adequacy of the research design and approach to be used for data collection (Sapsford and Jupp, 2006). Ann (pseudonym) was a leader from a national organisation. This enabled the research questions to be addressed and assumptions about the research design explored, which is recommended in any social research (Rubin and Rubin, 2012). This section is written in the first-person pronoun to capture the reflexive nature of the methodology and recognition that my personal perspectives could have significant influence on the methodological choices (Etherington, 2004). The pilot was formative to my thinking raising interesting issues by bringing the relational nature of the study to the fore of the research design.

The pilot began with a narrative interview. The meeting was framed by the researcher topic guide for interview one using prompts that acted as a springboard for the semi-structured research conversation. The topic guide had been designed through the process of supervision meetings, exploratory dialogue with public participation practitioners, and re-visiting issues raised in the literature review such as the complexity of language and limitation of language in narrative. The use of conversational prompts in the narrative interview were helpful for eliciting more depth to the participant responses. One example was the way Ann began to talk about her experience during our first meeting. Towards the end of our conversation, Ann attributed her understanding of herself as a collaborative leader to a significant life event that she revealed she rarely shared. Ann approached this aspect of her experience through sharing a story on a piece of reflective writing - a poem - as part of a leadership development programme. The process of listening to and transcribing the interview conversation was powerful as the poem itself appeared to a resemble a personal artefact. This was an unintended consequence of the pilot. It allowed the value of combining narrative interviews with artefacts to emerge organically through the research conversation. Consistent with

Watton and Parry's' (2016) research it seemed that emotions and new insights were exposed through the experience of telling her story and sharing her poem.

It was anticipated that the narrative interview may lead to ideas on how to refine the topic guide questions. The topic guide evaluated well and did not change as a result of the pilot. Yet, following the first meeting it appeared that there was something missing that was worthy of pursuit. A second interview was arranged around the mutual availability of the researcher and participant. The nature of research in the working world accounted for a gap of almost six months. The second meeting was framed by a researcher topic guide for interview two. Findings from the first narrative interview were used to further extend questions based on preliminary analysis of the first interview conversation, prompted by what had been said, lines of curiosity and contradiction.

At the second meeting Ann shared her chosen artefact; a published project report. Here Ann emphasised the value creativity in her engagement work. Artefacts appeared helpful as a sypher for meaning making. This was further evidenced by her reflections on creative engagement in her own practice which she said, "*led to freer conversations*" and "*generated really rich conversations"* in practice. This supported the assertion of the limitation of language, and that stories, told narratively and creatively, are an effective way that we can came to make meaning in the social world, that may otherwise not be readily available. The combination of narrative interviews with artefacts, planned (interview 2), and unplanned (interview 1) emerged as a powerful way to help connect important events and memories that leaders constructed stories around to make-meaning (Clandinin and Connelly, 2004). Following the second meeting, and discussion on the selected artefact, the research conversation felt more complete. It showed the importance of talking with leaders about their values, to understand their motivations for public engagement. Ainslie Yardley (2008) draws on the work of Gardner (1985) to show the importance of acknowledging that we all make meaning in our own way and that there are multiple ways in which humans process information and make creative leaps for self-understanding.

The results of the pilot, using thematic analysis, allowed the interview conversations to be approached in a more open, relaxed way, seeking to hear the participant voice more fully. Whilst reflexivity can be interpreted in a variety of ways Webster (2008) draws attention to the 'confessional' nature of meaning-making. Ann illuminated this through her personal reflection on the interview, which she described feeling; "*a bit confessional*". The response from the pilot was confirmatory of this. It showed the importance of attending to the interview conversation as a 'conversational partnership' (Rubin and Rubin, 2012, p.7).

The implications for the research design are summarised below (table 3.3). I began to recognise the significance of the relational perspective and its impact on the researcher view of the socially constructed nature of collaborative relationships. This development in my thinking and researcher perspective was explored through the process of supervision and subsequent decisions around the research design and more widely discussed within my writing on reflexivity in the research (Chapter 7).

Inception of pilot - design focus:	**At the end of pilot - design focus:**
• Research design was grounded by narrative methods as the most appropriate primary method for data collection • Thematic Network Analysis / thematic analysis as the proposed way for data analysis • Local leaders were the focus for the participant sample	• Although narrative interviews remained the primary approach the pilot showed the importance of the artefacts as a conduit for meaning making • Voice-Centred Relational Analysis, based on Mauthner and Doucet (2003) and applied to (Ganz, 2010) • Extension of the participant sample to include national leaders' perspectives.

Table 3.3: Pilot - implications for the research design

The pilot created necessary reflective and reflexive loops that guided the research, its methodological choices and design. It provided a clear sense learning on the relational nature of the research and value of layering data collection, analysis, and interpretation (Riessman, 2008; Denzin and Lincoln, 2018). The research amendment was approved and confirmed from a Faculty Research Ethics Committee (FREC) viewpoint by email in November 2016 - (2015/6//HHB-HSC-DPS-5 – 2.11.2016). The pilot helped me to deepen

understanding of what complexity and critical theories meant in practice in real-world research. Contrary to my initial search for a neat theoretical framework an adaptive description appeared more helpful for practice-based research.

3.7. Data collection

Data was gathered using two semi-structured interviews with each participant, scheduled approximately 2-3 months apart. The interviews took place, from February 2017 until October 2017. Leaders' socially constructed stories were collected and explored to account for how the leadership context, in relation to public engagement, is understood and enacted.

3.7.1. Interviews

Interview conversations were used to explore leaders' perspectives, to show how healthcare leaders understand and identify with public engagement. As the research became more established, it became clear that the nature of the researcher-participant conversation was crucial. In a critique of the 'hygienic' 'textbook paradigm' of research interviewing Oakley (1981) observes that "*what is good for interviewers is not necessarily good for interviewees*" (Oakley, 1981, p.40). Oakley argues that within standard research interviewing practice, the emphasis is traditionally on hierarchical relationships. Instead, Oakley proposes a contrasting model, cited by Mishler (1986; p.40) that emphasises relationship and rapport.

The approach of using narrative interviews combined with artefacts holds congruence for a study of this kind, which seeks to cultivate collaborative practice (Mishler 1986, p.40). As discussed earlier, people share *their lives "of who they and others are and interpret the past in terms of these stories"* (Berger 2008, p.37). However, as Berger asserts, thinking about *"self-identity" can be* difficult and cause anxiety (2008, p.7). The quality of the researcher-participant relationship appeared to be positively influenced by the iteration of two interviews with each leader.

3.7.2. Narrative interviews (interview one)

The first interview used a primarily non-interrupting narrative approach (Clandinin and Connell, 2000; Clandinin, 2007). Interviews began with an overarching question: "*Tell me about what the term leadership for public engagement means to you"?* The interview dialogue was developed, using several supporting prompts around themes that emerged from the literature review; context, leadership journey, values, beliefs, and relationships. One way that the interviews developed was through mutual reformation and framing of questions by which leaders' views took *"particular and context-bound shades of meaning"* (Mishler, 1986, p.53). The interviews were conducted as a '*conversational partnership'* (Rubin and Rubin 2012, p.71-92) rather than a more traditional linear process of pre-determined prompt questions. This approach seemed to lead to trust in relationships and stimulate leaders' stories, which enabled the research design to remain flexible, adaptive, and responsive (Rubin and Rubin, 2012).

Following the first interview an instinctive thematic analysis was undertaken as a route map to guide the second interview (Cassell, 2005). Hand drawn pen-portraits were used to support the process (figure 3.1).

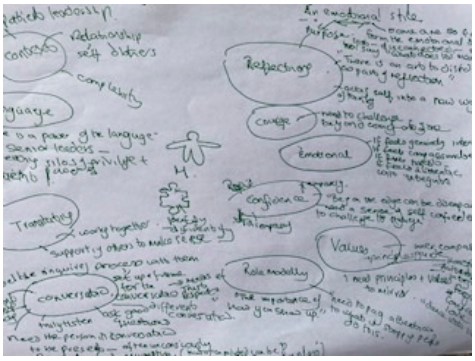


Figure 3.1: Narrative map 1: example from interview one.

The second interview provided an opportunity to explore the participant responses further, *"going into further depth and detail, to ask for clarifying examples, and to clarify concepts and themes*" (Ruben and Ruben 2012, p.117). The process of capturing key words, sketches and participant quotes assisted exploration of nuances of meaning

encapsulating emerging ideas, contradictions, and concepts. It was useful as an approach to *help 'visualise the data, the ideas and relationships that develop as you work through the analytic process*' (Kara, 2015, p.107). Analytical memos were used to inform the second interview, following the guide whilst using the memos to probe, clarify and explore. Although a variety of specialist software is available to support diagramming this research used hand drawn pen-portraits following each interview. This technique was particularly useful for mapping participants perspectives and revealing complex relationships between leaders' perspectives, emotions, artefacts, and concepts (Newman, 2013). This created an aesthetic and imaginative experience in the preliminary analysis.

Holding two interviews with each participant enabled reformation of interview questions and participant responses, making meaning with participants, which was consistent with the researcher value of collaboration (Mishler, 1986). Feedback to individual participants was important to ensure congruence with principles of collaborative relationships. This helped to ensure that the many potential biases that exist due to the characteristics of such qualitative approaches are addressed (Savin-Baden and Major, 2013). The schedule for data collection was adhered to over the period of one year engaging a participant sample of twelve leaders.

The environment for the interviews was important. All interviews with leaders in local organisational contexts took place face-to-face in the leaders' organisation. For leaders in national contexts, it became necessary to adapt the approach. All first national interviews were conducted face-to-face. Two second interviews were conducted online in response to participant requests for practical reasons of time and travel. One interview was conducted at the host University.

Several reasons underpinned choices to manage the adequacy of data breadth (context) and depth (methods). Firstly, this study is not seeking generalisation of findings. Secondly, given the contextual nuances in which the study is situated, narrowing the focus enabled diverse views of leaders in a health specific context, rather than a broad sample in which context may be lost, impeding the quality of the findings. Participant

stories illustrate leaders' experiences and views, leading to new insights on how leaders construct and sustain identity in relation to public engagement. The approach to participant engagement and sampling, was chosen to stimulate rich data of leaders lived experience, to answer the research question(s) with potential for the study design to be applied to future study across wider health and care contexts.

3.7.3. Generating participant selected artefacts

At the end of first interview participants were invited to bring an artefact as a conduit for representing their sense of professional identity in relation to their leadership, as part of triggering the research conversations. The only specific direction given to each participant was to bring an object to the second interview, which represented what they think about leadership for public engagement. Using artefacts as a conversational tool was grounded in learning from the pilot (p. 66).

3.7.4. Narrative interviews combined with artefacts (interview two)

At the second interview each participant shared their artefact and build on the research conversation and experience. Pattison (2007) asserts that the many 'humble artefacts' found in everyday contexts such as healthcare are often overlooked. He encourages research methods to draw on the relationship and sense making, which can be gained through noticing and connecting with artefacts. Some healthcare researchers have considered the use of artefacts. Consistent with Watton and Parry (2016) the use of a personal artefact in this study was chosen by participants as an object that had specific significance for that person.

All participants were offered the choice of beginning the second interview, with either their artefact or their reflections on the first interview. Most participants chose to begin the interview by sharing their artefact. Several participants reflected their engagement in their artefact as a catalyst for their self-reflection. This possibly contributed to putting participants at ease, creating rapport and building trust in the relationship. With the permissions of participants that second interview was again recorded. The second

interviews, with artefacts ranged from 45 minutes to 1 hour 40 minutes. This aspect of data generation was achieved through eliciting the stories of individual participants self-understanding of themselves as a leader being collaborative with the public. Conducting two interviews was useful for several reasons: the research focus on relationship, the complexity of the topic, bridging leaders' stories (narratives) with the inclusion of the visual (artefacts). All interviews were conducted over the period of one year. The timeframe between individual leader interviews ranged from 1 month to 4 months in response to participant availability. A responsive interviewing approach enabled rapport and trust to be built (Rubin and Rubin, 2012). This also reflected the researcher value of reciprocity. The researcher took an active role in encouraging conversations, reacting to what leaders said, and asking questions to follow up initial responses such as clarifications, contradictions, reflections, and themes.

3.8. Data analysis

The principal task was to obtain information to meet the research aims and objectives (Chapter 1, p.16). The research objectives formed the foundation to explore interview questions about leadership and public engagement. The data generated in this qualitative study was based on narrative interviews which generated leaders' stories and personal artefacts. Pickering and Kara (2017) suggest that the ethics of research representation are rarely discussed despite having significant impact on both research participants and audience.

The variation of portrait approach used (Chapter 4) brought participant voices to the fore. One participant reported that the researcher "*modelled engagement principles*" influencing 'what he gave' of himself, or 'didn't give' - something he described as a "mutual reflexive space" (Mark, I.2). This section describes the sources of data and analytical tools used to show the relational journey. Multiple layers of data and data analysis tools enriched reflexivity in the research (Chapter 7). The sources of data and tools used are summarised below (table 3.4):

Research questions	Data required	Data sources
How do healthcare leaders identify with public engagement? *What motivates a leader to be collaborative with the public?* *What conditions are needed to support leaders in collaborative practice?*	Leaders' stories told narratively and visually to gain insights into participant understanding of self in relation to public engagement Researchers' reflexive understanding of knowledge gained over a lifetime and data collection as new experiences	Literature review Policy document analysis 12 semi-structured interviews Narrative analysis (storytelling) Visual analysis (artefacts)

Table 3.4: Sources of data and tools used

For this study choosing data analysis methods that provided a systematic process for exploring relational perspectives within participant stories and the analytical and interpretive responses of the researcher was helpful. Acknowledging the interplay between researcher and researched helped to situate the research findings relationally and contextually (Chase, 2013, 2018).

3.8.1. Transcription and participant validation

The data analysis began as a process of immersion and familiarisation with each participant story. The interview recordings were transcribed as recommended by Tilley (2003). Each transcript was listened to several times for familiarisation, to check for accuracy and make any necessary amendments. Narrative maps conducted after each interview (p.60 & 69) and reflective researcher diary notes fostered confidence in the representations of the research conversations. In this study the transcriptions included nuances such as pauses and repeated phrases to help convey the character and views of participant perspectives authentically. The step of respondent validation (Bryman, 2004) was used to achieve verification of researcher interpretations of the data synthesised as leadership portraits (Savin-Baden and Howell-Major, 2013, p.477). As discussed earlier, allowing participant voice to be heard enhanced credibility of the study by ensuring a focus on reliability, scrutiny, and trust.

3.8.2. Narrative analysis - voice-centred relational analysis

The decision to use Voice-Centred Relational Analysis (Mauthner and Doucet, 2003) as a qualitative analytical tool was made because the approach focuses on voices (perspectives and stories) within participant accounts. The underpinning relational ontology made it particularly useful for this study on relational leadership and public engagement practice in healthcare. This approach attends to how participants speak, or don't speak, of their experience, their self, relationships, and context (Mauthner and Doucet, 2003). Accordingly, the approach also acknowledges the relationship between the researcher and the researched in developing the construction of knowledge (Mauthner and Doucet 2003). This primary analytical tool provided an open yet structured way to systematically attend to aspects of participant experience of relational leadership.

This section details how the approach was developed in this research with participants narratives and artefacts. The discussion provides a practical route map for others who may explore the approach. The process described is primarily guided by Mauthner and Doucet (2003) showing the multiple lenses through which the data was viewed; reading for the broad story, leaders voice, leaders relationships with others and their context, adapted in this study to include reading for leaders selected artefacts (table 3.5, p.76).

Consistent with Mauthner and Doucet (1998) the term 'voice' refers to the perspectives embedded in participant accounts. Inspired by the seminal work of researchers Brown and Gilligan (1992) and Mauther and Doucet (1998) the approach used was further informed by researchers such as Bright et al (2017) and Paliaelis and Cruickshank (2008) who have embraced this approach within their own research across a variety of health contexts.

Reading 1	Reading for story: Attended to the broad story (ies) and context within the narrative. A focus on leader story(ies) told in the data but also the researcher response to the story and how the researcher interpreted and constructed the data analysis.
Each subsequent reading helped to answer the research questions by eliciting new perspectives as the data was explored as though through different lenses; story, self, artefacts, relationship and context.	
Reading 2	Reading for leaders' voice (perspectives): Attended to how leaders spoke of themselves. A focus on how leaders made meaning and how this was influenced and actioned in their perspectives on public engagement.
Reading 3	Reading for leaders' artefacts: Attended to how participants expressed themselves visually in relation to leadership and public engagement. A focus on exploring what participant selected artefacts symbolically represented for participants in relation to their leadership.
The following two readings focussed on participant relationships. Whilst the fourth reading focussed on leaders' personal relationships with others the fifth, final reading focussed on participants relationships with the social, political, and cultural context to show how they "*experience themselves in the relational landscape of human life"* (Brown and Gilligan, 1992, p.29).	
Reading 4	Reading for relationships: A focus on how leaders spoke of others. Attended to the relational dynamics including others, self, and values.
Reading 5	Reading for context: Attended to how participants speak of their surrounding context for public engagement. A focus on connecting micro and macro level structures and processes for public engagement situating participants in their professional, cultural, and social context for collaborative leadership.

Table 3.5: Voice-centred Relational Analysis; (Mauther and Doucet, 2003) adaptation

Each participant transcript was read at least five times, or as many times as needed. A listening guide variation was established to analyse participant accounts based on each reading of the data and guided by methodologically and theoretically informed questions (Gilligan et al, 2005; Mauther and Doucet, 1998). The principles, considerations and questions that guided readings brought to the fore the reflexive loops of the analytical process (Gilligan et al, 2003; Doucet and Mauthner, 2008) - (appendix 2).

The multiplicity of readings involved annotating analytical memos. This began online but turned to Mauthner and Doucet (1998) who suggest using different coloured pens to distinguish the views of the data. Online analysis was found to cloud researcher thinking. In contrast, the simplicity of coloured pens literally infused colour into the leader's

stories bringing to life a sense of participants self, their values, and motivations. The Voice-Centred Relational Analysis approach created a deep sense of leaders' experience, the challenge that one participant expressed as *"dancing with those values"* (participant Mark). The approach allowed each participant story to be heard and ensured that the researcher role was explicit as a co-creator of the analysis and interpretation of data.

Undertaking multiple readings created a rich source of data by weaving participants holistic experiences of leadership, building understanding sense of self, their perspectives on public engagement, and their leadership context. What emerged from leaders' stories was a strong sense of connection of their professional and personal experiences. Each reading of the participant stories revealed the inter-connectivity of data, viewed through the five lenses of analysis.

The way the approach allowed the researcher to explore multiple perspectives within each participant story is shown through colour-coded analytical memos in each transcription. The holistic nature of this approach is illuminated through the leadership portraits (Chapter 4) and respondent validation (Chapter 5). Due to the significance of reflexivity in the research, for researcher and researched, this is addressed in-depth in Chapter 7.

3.8.3. Artefact analysis

As an extension of the Voice-Centre Relational Analysis (Mauthner and Doucet, 1998, 2002, 2008) artefact analysis was not addressed in a traditional sense in this study. Although artefacts were originally of interest to archaeologists for what they could reveal about life in the past, social researchers have become interested in artefacts for what they can reveal about life in the present time, often investigated through interviews enhanced by artefacts (Kara, 2015, p.83). Saldaña and Omasta (2018) assert that artefacts bring peoples' narratives to life illuminating influences on leaders' practice. An example of the artefact analysis is shown below (table 3.6).

Artefact	Words-phrases	How the artefact is represented	Concepts
Candle	"*Vulnerability" ("flickering flame")* *"Confidence" (big/small flames)* *"Kindness" (others, self)* *"Creating the conditions"*	The image of candlelight appears to show the power of collective light as a metaphor for leadership. The flames were conveyed to represent the diversity of leaders; large confident flames (people) shining brightly and smaller flames (people) flickering and more vulnerable. It conveyed the significance of looking after our own leadership light in order to cultivate relational leadership in others.	Vulnerability Confidence Kindness Conditions (preparedness)

Table 3.6: Artefact analysis - adaptation of Saldaña and Omosta (2018, p.72)

Artefacts appear to make it easier for leaders to discuss aspects of their practice that can be *"difficult to articulate and uncover through written or talk-based methods"* (Allen, 2011, p.488). The images presented in this thesis are not necessarily the artefacts shared in the interviews, to ensure that participants remain anonymised. Furthermore, some participants chose to reflect on artefacts metaphorically. The themes and concepts that emerged came directly from participants voices (Chapters 4, 5, 6).

The analytical and interpretive process was complex. Interview transcripts resembled almost 220 000 words (218 000) of what leaders said, creating rich data from over 22.5 hours of 24 interviews with 12 leaders. The data was synthesised into twelve leadership portraits (Chapter 4) because this was a way of showing an accessible interpretation that could be read from different perspectives. The adaption of Voice-Centre Relational Analysis demonstrated the multiple layers of meaning that were woven through leaders' stories (Mauthner and Doucet, 1998). For example, the development of leadership portraits augmented by artefacts (Chapter 4) was chosen in this research because shorter vignettes did not appear to adequately capture the richness of leaders' experiences drawn from the multi-layered data. The leadership portraits were extended in length to approximately 1 000 - 1 200 words. The approach for creating the portraits is described below.

3.8.4. Narrative maps

The iterative process of creating narrative maps was underpinned by Voice-Centred Relational analysis (Mauther and Doucet, 2003), described above. Narrative maps were first sketched following interview one (p. 60). The process was repeated following interview two (figure 3.2). This technique provided another layer of data analysis. It facilitated understanding of the phenomena, of how healthcare leaders identify with public engagement, which assisted in answering the research questions more holistically (Butler-Kisber et al, 2010). It was particularly helpful to visualise the data. Kara (2015) asserts that visual data analysis techniques such as 'diagrams' and 'maps' can be especially useful as an approach to *help "visualise the data, the ideas and relationships that develop as you work through the analytic process*" (Kara, 2015, p.107). Using the visual diagrams, termed narrative maps in this study, was particularly valuable as a way of helping to visualise the data, listening to the audio recording of the first interview, reading the transcription, and preparing for the second interviews for each participant.

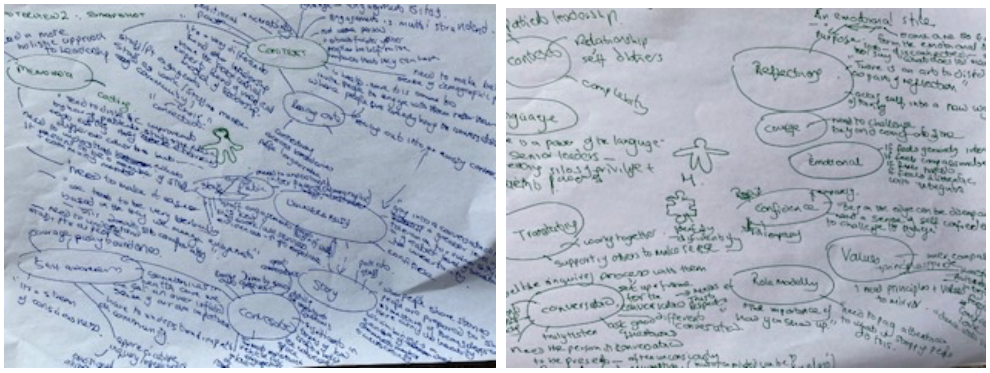


Figure 3.2: Narrative map 2 - example from a participant interview one and two.

The approach enabled flexibility, trusting researcher intuition to follow patterns of interest, uncertainty, or contraction. The approach provided a framework to search patterns of words and themes attending to specific questions in the research topic guide, such as participant values and expressions of what good looks like. It enabled avenues of interest to be followed, such as stories of dis-location (dis-engagement), building iterative connections within individual leaders' stories across contrasting contexts. The visual nature of these maps was particularly useful for revealing complex relationships between leaders' thoughts, emotions, places, objects, and concepts

(Newman, 2013, p.228). The narrative maps did not provide the depth of understanding that came from the Voice-Centred Relational analysis (Mauthner and Doucet, 2003), but this additional layer of data analysis provided reassurance that themes that emerged from the primary data analysis were authentic representations of participant voices.

3.8.5. Leadership portraits

The development of leadership portraits was an emergent process comprising leader's narratives augmented by artefacts. The approach was influenced by the seminal work of Lawrence-Lightfoot and Hoffman-Davis (1997), Rose (2016) and Alvesson and Sköldberg (2013). All leadership portraits (Chapter 4) came predominantly from readings 1 and 2, and were augmented by readings 3, 4 and 5 (table 3.5), thematic analysis, and process of participant verification. The processes involved weaving the narrative, visual and reflexive threads of data through the analytical process (findings presented in Chapters 4, 5, and 6). Scaffolding each leader's portrait was guided by Lawrence-Lightfoot and Hoffman-Davis (1997) (table 3.7). Storyboarding techniques were used to scaffold the portraits individually (appendix 3) and collectively, (appendix 4) with each organisational context. Visual elements were woven through the data analysis and interpretative process. There was an element that portrays faithful descriptions of participants leadership narratives, rather than researcher interpretations of their meaning, which is reflected in the verification process of inviting participant feedback (Chapter 5, 5.7).

Step 1:	Leaders' portraits begin with an introduction and elements of contextual information to draw the reader in.
Step 2:	Emergent themes are used to frame individual leader perspectives guiding the organisation and presentation of the presentation of findings in ways that surface relational aspects of the data. The themes help in forming a metaphorical scaffolding for the portraits; crafting, reading, meaning making.
Step 3:	Extracts from interviews are included to authenticate participant voices.
Step 4:	The inclusion of visual representations of participant artefacts, formed a conduit for representing their sense of professional identity in relation to their leadership are integrated within the leadership portraits and subsequent discussion on the findings - furthermore this comes to reflect one of the key themes that emerged from the data.

Table 3.7: Scaffolding the leadership portraits

The act of interpreting the leadership portraits formed a reflective and reflexive research process. This was enriched by the multiplicity of methods, which *"allowed for a deep, rich, yet fluid analysis of and critical interpretive connections*" (2011, p.159) between the historical narrative of policy rhetoric (the cover story) and textual extractions of leaders' portraits (behind the cover story). Interpretations were triangulated with analytical memos, field notes and researcher diary (reflexivity) (Wickens 2011). Voice-Centred Relational Analysis (Mauthner and Doucet, 2003) with its focus on complexity of voice, illuminates' participant experience through multiple and sometimes contradictory ways of thinking about and understanding leadership and public engagement - relational leadership in the NHS (Brown and Gilligan, 1993).

Mauthner and Doucet (2003) argue that data analysis is infused with theoretical, epistemological, and ontological assumptions including the researcher subjectivity and understandings of how knowledge is constructed and produced (2003, p.413). The presentation of findings in this thesis is embedded with participant quotations and visual and representations, which challenged, informed, and enhanced meaning-making (Yardley, 2008). Voice-Centred Relational Analysis (Mauthner and Doucet, 2003) guided alternative interpretive perspectives and possibilities for discovering the data analysis themes, conclusions, and implications of the research findings for future professional practice.

3.8.6. Pseudonyms

In compiling individual portraits and organisational contexts, pseudonyms were applied for participants and participating NHS organisations:

- Participant pseudonyms: All participants adopted pseudonyms except for one participant who, for personal reasons required their real name to be used. This was acknowledged and accepted through the University ethical procedures.
- Organisational pseudonyms: All organisations are pseudonyms. Any references are generalised to provide context whilst addressing issues of confidentiality.

3.8.7. Presenting the data

The analytical process described in this chapter forms a leader-centred relational chain (appendix 5). The presentation of the data is designed to demonstrate that the themes are not static, but rather in a dynamic relationship (table 3.8).

Leadership portraits	The intention was to create holistic interpretations of participants experiences to convey representations of participants sense of how leaders identify with public engagement in an authentic and accurate way based on the adaptation of Voice-Centred Relational Analysis (Mauthner and Doucet, 2003). Participant quotations are included from the data transcriptions to enrich the authenticity of the findings (Chapter 4).
Stories	Participant stories are included (boxed) to ensure that their voices are clear. Everything boxed represents participants actual words.
Quotations	In addition to participant stories (boxed) participant voice are included in the narrative, in quotation mark and italicised. Quotations are always selected from the raw data transcripts to enrich the authenticity of the findings.
Distilling the themes	Table 5.1 accounts for 6 data analysis themes to show how these were distilled from 12 participants (218 000 words) applying the Voice-Centred Relational Analysis (Mauther and Doucet, 2003). Each theme resembles a core influence for leaders' becoming and being collaborative with the public. Participant's perspectives are explored to address the analysis of evidence that led to the themes woven through participant individual and collective stories.
Re-framing the themes	Ganz (2010) relational orientation on 'telling a public story' frames / re-frames the organisation of the themes adding a further layer of analysis to test my relational approach and enrich perspectives of the findings (Chapter 5). Its focus on how it can inform practice resonates with the nature of practice-based doctoral research.
Quotations	Participant quotations are always selected from the raw data transcripts to enrich the authenticity of the findings.
Ganz (2010) relational process model	Representation of Ganz (2010) model uses circles: 'Story of Self' (voice) - 'Story of Us' (relationships) - 'Story of Now' (context). Each circle is infused with colour to illuminate the relational dynamic of the findings.
Data analysis themes	The discussion on the data analysis themes is supported visual representations seek to illustrate the 6 core themes in their dynamic relationship with each other (figure 5.6).

Table3.8: Presenting the data

This approach provides route-map from distilling the data analysis themes (table 6.1) and re-framing the themes towards a new 'public story' (Ganz, 2010) (table 6.4).

3.9. Limitations

This section reflects on limitations of the core methods used in the research. Whilst acknowledged and discussed throughout the thesis (e.g., Chapter 7.6) several are addressed here:

- Participant selection: One long-standing by researchers and policy makers of narrative approaches is based on small participant samples from which it may be considered impossible to draw generalisable conclusions from the findings. Bottery et al (2009) consider that not everything needs to be generalisable to be meaningful; *" insight into what makes us most human may be gained by attending to the singular"* (p.82). I concur with Bottery et al (2009) view that a larger number of participants may have presented a wider picture but may have failed to help understand what was of greatest concern for leaders, or what matters most for public engagement leadership. For understanding how healthcare leaders identify with public engagement, their motivations and support narrative approaches may be more helpful.

- Narrative: A potential limitation of the narrative approaches using semi-structured interviews (conversation, analysis, portraits) related to whether the narrative approaches could generate enough data to scaffold leadership portraits with sufficient depth and complexity to be meaningful for doctoral research. This concern can be addressed by reading the comments made by participants when they read their individual portrait (Chapter 5, p.161). The participant comments were positive and exemplified how the research method, using narrative combined with artefacts, supported leaders understanding of themselves in practice. For example, one participant Jill said; "*Our conversation and the portrait that emerged from it is an enduring record of a number of different strands that contribute, separately and collectively, to my beliefs about leadership and ultimately to my style of leadership… I find the portrait a very valuable resource in reflecting on, revisiting, and challenging my own leadership style and the values that underpin it*"(Jill, portrait feedback). Narrative analysis also has its critics and required careful attention to

subtle nuances, patterns, and contradictions to acknowledge and address potential researcher bias. Consistent with Bottery et al (2009) combining approaches, such as artefacts encouraged such complexities and more philosophical issues to be addressed.

- Artefacts: Artefacts stimulated creative thinking by acting as a sypher that helped leaders to get closer to how they identify with public engagement. reflect and to connect with 'within' – a contrast to more cognitive thinking, which can miss this. As others, such as (Watton and Parry, 2016) have found there are methodological challenges when using artefacts such as risks associated with protecting participant identity. These concerns were addressed as described earlier. Since visual representations of data can evoke multi-sensory and embodied experiences, the potential limitation of adding more potential interpretations, and potential risk of losing clarity were overshadowed by the significant benefit of achieving a more holistic view of healthcare leadership and public engagement.

3.10. Conclusion

This chapter has reiterated the research questions and shown how the data was generated and analysed to show insights into how leaders understand their self and influences for being collaborative with the public. As an example of practice orientated research, exploration of the methodological landscape opened new ways for understanding how leaders identify with public engagement.

Underpinned by a relational ontology, narrative interviews combined with artefacts provided a way of bringing multiple perspectives into the research conversations. Using multiple lenses in the data generation and analysis required a deep consideration of the context(s) in which leaders' experiences were situated. The methodological path discussed in this chapter, emerged as the most promising way for the researcher to gain a deeper understanding of leaders' perspectives on how they identify with public engagement.

In the next chapter each participant's story is re-told. The intention is to create holistic interpretations of participants experiences to convey representations of their sense of self in an authentic and accurate way and enable the reader to hear, see and feel each story and the perspectives that mattered most to them. This leads to a collective narrative on the data analysis themes (Chapter 5 and Chapter 6) - towards a new 'public story' (Ganz, 2010).

4. Chapter Four

Leadership portraits

4.1 Introduction

In this chapter the Voice-Centred Relational Analysis approach (Mauthner and Doucet, 2003) is used to construct and depict the twelve individual participant perspectives on leadership and public engagement. The data is characterised as relational within the systematic research framework and processes described in Chapter 3. The leadership portraits were written with the intention of creating holistic interpretations of participants experiences to convey representations of how leaders identify with public engagement in an authentic and accurate way.

The data from the narrative interviews, combined with artefacts is presented as leadership portraits, carefully arranged around four contrasting organisational contexts to address the research questions: *How do healthcare leaders identify with public engagement? What motivates a leader to be collaborative with the public? What conditions are needed to support leaders in collaborative practice?* The names of organisations have been changed to protect anonymity and address ethical issues. The language, tone, and inclusion of artefacts as visual representations, differs from more traditional thesis reports. Quotations are used to give authenticity to the portraits and illuminate participant's voices. Additional participant stories are included (boxed) to ensure that their voices are clear. Everything boxed represents participants actual words. In addition to participant voice are included in the narrative, in quotation mark and italicised. Quotations are always selected from the raw data transcripts to enrich the authenticity of the findings. Participants shared often deeply personal accounts. Inviting participants to authenticate the interpretations of their portrait (Chapter 5, 5.6) was important to assure an ethical narrative, authenticity, and trust.

The first section presents portraits of three leaders from a national (policy) perspective. Three further sections present portraits of nine leaders who share their views from contrasting local organisational contexts using the pseudonyms Northern Bay NHS Foundation Trust, Eastern Bay NHS Foundation Trust, and Western Bay NHS Foundation Trust. The portraits represent a variety of leadership perspectives; strategic (board level), patient-engagement/experience (co-ordinator) and champion (operational). This arrangement enables influences on leadership and public engagement to be viewed through different lenses (perspectives). To reflect the iterative nature of data analysis a summary is included following each section. The portraits lead to a synthesis of the twelve participant stories to show similarities, and differences (Chapter 5) before moving to a deeper thematic analysis (Chapter 6) on how healthcare leaders identify with public engagement.

The data is essentially about better understanding the nature of healthcare leaders' relationships with the public. It provides a context through which to help leaders explore their sense of self-identity. One aspect of the research discovery is that through self-understanding leaders are better able to engage others. Consideration is given to the possibility of extending the use of storytelling and artefacts to support the development of relational leadership with the public in Chapter 7 (reflexivity) and Chapter 8 (conclusions, implications, and possibilities).

4.2. National leadership perspectives on public engagement

The three leaders profiled in this section (Tess, Mark, and Jill) are employed by three different national organisations. Organisation One is a national organisation whose fundamental purpose is to work with partners to deliver excellent leadership across the NHS to have a direct impact on patient care. Organisation Two is a national charity, which is viewed as an independent think tank, involved with pioneering work relating to the health and care system in England. Organisation Three is a significant organisation that leads National Health Service (NHS) policy in England. In parallel to local health systems being encouraged to work more collaboratively together, the same is happening

nationally. This is reflected in the NHS People Plan (2020), which is structured around several themes and actions to enable those who work in, and with the NHS to deliver the NHS Long Term Plan (2019b).

4.2.1. Tess's story

Tess is a well-regarded senior leader in an organisation considered a pioneer for leadership development amongst healthcare leaders. In her current role Tess specialises in public engagement from a research perspective. Tess described feeling privileged to have been in her role since its inception, viewing her approach as a form of "*appreciative enquiry"* (Interview 2). With a professional background in nursing Tess was the only registered clinician in her organisation. She made it her mission to; *"stitch public engagement into the organisation"* (Interview 1). It was easy to settle into the conversation as Tess described how she understood her leadership and public engagement.

Early in our conversation, Tess shared her fundamental belief about the importance of co-creation; "*I have a real thing about co-creation; that we don't do something and then ask people afterwards"* (Interview 1). This assertion framed Tess's views on leadership and public engagement. Tess paused periodically, as though searching for memories of experiences, as she considered my questions. She recalled a time, around two decades ago, when she was working on how communities can be engaged; *"It goes back many years"* she said (Interview 1). She felt that no-one appeared to ask people, within the community, what they wanted, reflecting on her learning from families and the community.

> *"All this goes back years and years and years… I was working in a [xxx] project in the [city] in a really deprived part of [city] and my manager had all these wonderful ideas that we were going to do. She came up with all these strategies and plans and we didn't actually ask people what they wanted. All they wanted was for somebody to clear up the dog poo in the parks so their children could go and play safely. They didn't want this cookery class, and that class, and everything else… All they wanted was a clean, safe place for their children to go and play… and the park was filthy. So, all they wanted was the park clearing up… That, to me, was real…you could waste so much time and effort… As a professional, you sometimes think that you have the answers. You don't have the answers"* (Tess, I.1)

She told me; "*it sparked it off"*. This seemed to mark the beginning of Tess's leadership in relation to public engagement. She recalled several "*incidents*", where people around her have been ill, describing contrasts of quality of care and experience*. "I've felt I've had to battle on their behalf"* she reflected; *"each incident … just nudges me that little bit more"* (Interview 1)*.*

> *"… there's been several incidents since then [community story above] with people around me, who've been ill, that I felt I've had to battle on their behalf sometimes… like my mum and dad for example when they both had end of life care - and my husband who was seriously ill last year and wasn't listened to, and all sorts of things like that. So, I think to me, there's very much a thing around asking people what their lived experience of their illness or their condition is, and whether you agree with it, that is their lived experience… It's about transparency, and communication, and partnership, and people being allowed to have destiny over their own condition… I mean, it started all those years ago with, you know, trying to clean up [city] operating park"… I think there have been a number of different things and each incident… it kind of just nudges me that little bit more*" Tess (I.1)

The relationships Tess experienced personally contrasted, from "*heroic"* to "*partnership*". This led Tess to feel; "*personally very aware of how it feels to be dis-empowered by the health service"* (Interview 1)*.* She explained that this led her to "*re-examine"* the professional-patient relationship. Learning from lived experience seemed formative to Tess's leadership for engagement conveying a sense of purpose, her professional and personal experiences inter-woven. As our conversation continued Tess shared her fundamental view on the complexity of the language of public engagement and *"how un-inclusive it is", which* appeared problematic (Interview 2)*.* Tess paused, sharing reflections as they surfaced in conversation. She emphasised her focus on helping people to think about having a "*meaningful conversation"* about what's important to them, concluding*; "conversations really do matter"* (Interview 2)*.* Tess explained that in her role she set out to "*ground the work*" by talking to all the staff about "*<u>what</u> it is [public engagement] and <u>why</u> it matters"*. One way that Tess does this is by asking people to bring a picture of someone affected by care to *"really ground it*" (Interview 1).

> *"I became quite involved with, with [xxx] and I got him to ground the work that we do here - I got him to come and talk to all the staff before we did anything here, about what it [public engagement] really means and why… the patient has got to be right at the heart…We ask people to bring a picture of a loved one with them on the first day - we have all their pictures and why we're here… they bring a picture of the person that's been affected by care"* (Tess, I.1)

Tess created a vivid picture of helping *"people to translate*" (Interview 1). She explained how using visualisation through pictures of loved ones reminds people that because they are cleaning, or in finance, it matters. She described her role as; "*changing that mindset*" (Interview 1). Visualisation seemed important to Tess. This was illuminated at our second conversation where Tess shared her artefact, a piece of driftwood (figure 4.1).

Figure 4.1: Tess's Artefact: Driftwood - Key theme: (loneliness, social dimension)

Artefact:

At our second meeting Tess reached for a piece of driftwood. Resting it gently on the table, she told me it reminded her of her travel scholarship experience. She wanted to discover more about public engagement practice from the experience of a successful organisation abroad; *"It's just a knarred piece of driftwood"* (Interview 2). Tess created a vivid picture of walking on a beach, alone. She described finding this piece of driftwood, cradling it in her hands as she spoke, its meaning unfolding. Tess paused as she reflected on her feeling of loneliness at this time. "*I was really lonely*" she said. As she looked at the driftwood she reflected; *"it reminds me of loneliness*" (Interview 2). Tess described feeling lonely. Her sense of vulnerability appeared to resonate with her leadership. As Tess held her driftwood, she considered that being a patient can be lonely too; *"it's something that patients talk about all the time"*. She explained her belief that "*involvement is a way of overcoming loneliness*". For Tess, involving patients was not only "*a good and noble thing to do"* but also about acknowledging there is *"a whole social dimension"* to public engagement leadership (Interview 2).

"I have got a knarred, wholly piece of driftwood… I picked that up on a beach in xxx and brought it back with me. So, this takes me back to [date] when I had not long started at the [organisation] and we had this phrase of 'patients at the heart of everything we do'. To me it was a bit tokenistic… it could be a lot better. So, I applied for the Travel Research Scholarship [title]… To cut a very long story short I found myself arriving at [xxx] airport really late at night. For the university it was coming up to the easter break, it was exam time and there was nobody about, so I just had to sort myself out. I started to draw parallels instantly about feeling abandoned, and feeling not included… I discovered that if I wanted to involve people, it was up to me to go and involve people, and learn about involvement […] So, the bit of driftwood. It reminds me of my time there. But it also reminds me of a time not long after I'd been there, and I was really lonely. I went for a walk on the beach and that was where I picked that [driftwood] up. It just reminds me, loneliness is something that we [leaders] are, and that patients talk about all the time. So, engagement is a way of overcoming loneliness… It's made me acutely aware that patients suffer acute loneliness, and our engagement with them, especially back at the [organisation], - might be the only interaction that they have in a period of time… they absolutely tell us this. So, there is something about, not only thinking that engaging patients is good and a noble thing to do, but also the whole social dimension… meeting with other patients is part of something that feels important… and just trying to get people thinking like a patient" Tess (I.2)

Tess conveyed a fundamental view that leadership for public engagement "*is hard*". She explained; *"all of my thinking about how good it can be was shaped in [country] hence my driftwood, because I've seen how it [public engagement] can be. It inspired me… And when people say 'it's too hard' - yes it blooming is hard - yes, it's blooming hard being a patient – you know it's not that hard - it takes a bit of effort and it has kind of inspired me to keep going when it does feel hard"* (Interview 2). A strong sense of purpose emerged. This she attributed to motivating her to "*keep going"*. In terms of sustaining relational leadership Tess asserted; "*not doing so is not an option*". It indicated the importance of ensuring the conditions necessary to support relational leadership in the NHS.

Tess described how she uses storytelling in her work with patients, and staff and explained how she encourages people to tell their story and offers help for how to tell their story, drawing on Ganz (2010) work; "*story of self*" (voice) - "*story of us*" (relationship) - *"story of now"* (context). She explained; "*we kind of frame it in that*" (Interview 1). Tess emphasised the importance of attending to people, describing this as "*a whole sort of preparation"* (Interview 1). For Tess, preparedness for public engagement meant; "*taking leadership back to its component parts*"; "*respect",*

"confidence" and *"quality of relationships" - "it's around that confidence… that's how we try to frame it"* (Interview 1). Storytelling appeared important.

> *"It started off when I first sort of saw [xxx] do some work. He got everybody in the group room to just draw a representation of that, that person and we have them all around the room and, you know, why we're doing it, why we're doing it for all of these people. And we just turned that into we'll bring a real picture and we've done that on staff days here. We do it… just to actually remind them… actually why you're here. In the early days, we had a lot of, 'I work in finance, patients are nothing to do with me' or 'I'm a logistics driver it's nothing to do with me'. But actually, if you don't deliver your goods, then the patient doesn't get the supply, which means their operation doesn't happen - so, just helping people to translate"* (Tess, I.1)

When Tess reflected on her values, she told me that "*communication*" is most important as well as "*valuing peoples lived experience*", "*listening", "respecting",* "*not dismissing", "being open to being challenged by a patient",* and "*challenging assumptions*". Tess reflected on a significant moment, a time she discovered public engagement leadership meant *; "get over yourself"* (Interview 1). *S*he considered this important, irrespective of the level of leadership. Tess told me she values "storytelling" as it leads to "*authenticity*". She recalled Don Berwick and Lord Darzi, talking authentically on the importance, and power of storytelling as they asserted, "*we should never stop people telling their story*" (Interview 2). Tess emphasised a preparedness to "*let go of power*". She attributed her scholarly visit, where she picked up her driftwood, to inspiring her leadership in relation to public engagement; "*so just trying to get people out of that mindset*" (Interview 1).

> *"I think that language is the one thing that really hits home with me and how un-inclusive it is… just how you can get it so wrong for your audience… just in the way that we talk, we can get it so wrong [story of poor example]… [in contrast] this year it was Ara Darzi and Don Berwick sitting on the stage between two patients who were being interviewed, unscripted… it kind of lost its way a little bit, but it was the best opening plenary I've ever seen, because it was real. It wasn't Don Berwick telling us how brilliant IHI (Institute for Health Improvement) is, or Ara Darzi talking about whatever he is doing at the moment - it was them looking very nervous, and very uncomfortable… So, they might have said we are going to talk about the importance of storytelling, or we are going to talk about x– but Ara Darzi was acutely self-deprecating when he talked about the Next Stage Review … then they talked about the importance of and power of storytelling, and how we should never stop people telling their story because that experience is their experience in that moment and the effect it has on them lives on forever"* (Tess, I.2)

As our conversation came to an end Tess offered a final reflection, on what she described as the "*golden threads"* of her work; firstly, "*inclusivity*", and secondly, "*wanting to promote the care we would want for people that we love the most*"

Interview 2). She told me she had discovered, that if she wanted to involve people it was up to her to*; "go and involve people".* She told me it was about: *"truly letting go"* (Interview 2). Tess concluded; "*We're not asking people to invest millions of pounds in better leaders - we're asking people to… be more human… we're asking them to be more open, more transparent… getting over themselves a little bit, and just communicating better - and it doesn't cost anything"* (Interview 1).

4.2.2. Mark's story

Mark and I first met in the heart of London at an independent charitable organisation, considered a think-tank organisation amongst health leaders. In Mark's current role he specialises in public engagement from a leadership and organisational development perspective. Mark told me*; "public engagement is at the core and heart of everything I do - it just completely infuses"* (Interview 1). In contrast to other participants, Mark's experience of using health services led him to healthcare leadership, professional and patient leadership identity(ies) intrinsically linked. Mark's story showed the multiple identities that we may shape along our leadership journey. Early in our conversation, Mark shared his fundamental belief that leadership for public engagement is *"firstly relational"* (Interview 1).

> *"it's relational… it's about the quality of the relationship that the organisation builds with the public - and that sometimes leads to very interesting conversations if I'm brought into an organisation that is reflecting on their engagement practices, because many organisations don't see it as relational - they see it as procedural, as a set of tools and techniques in order to collect data, collect information from the patients and public. That tends to be what public engagement has talked about, or is about"* (Mark, I.1)

This assertion framed Marks views on leadership for public engagement in relation to self, organisation, and community. He explained; *"it's about the quality of the relationship that the organisation builds with the community, the public"* (Interview 1). A paradox appeared to emerge as Mark contemplated; *"many organisations don't see it as relational, they see it as procedural, as a set of tools and techniques"* (Interview 1). Mark created a vivid picture of the NHS as a "*complex system",* emphasising that in relation to public engagement *"how we see the world influences our conversations and our behaviours".*

"we don't know how people might see the world. The trouble is… we come with our own prejudices and beliefs and assumptions… my whole raison d'être is to support people to have a conversation based upon a set of principles and practices associated with dialogues, which have a set of principles and practices about how we work together. So, that's… how we lead ourselves and how we lead others." (Mark, I.1)

Throughout our conversation Mark used metaphor often, creating a visual sense of what he described as *"all sort of avenues"* He explained; "*my purpose is to support the system and the individuals within it - the health and care professionals, and the [public] to collaborate, and partner, and have different conversations so we can create a service which is fruitful - and, I don't know where that's going to take me because there's all sorts of avenues… but so the driver is different conversations that help people to have different relationships, and also different conversations with themselves"* (Interview 1).

Mark paused, reflecting on a paradox he observed, that organisations tasked with progressing public engagement, can get caught up developing strategy and policy, sometimes failing to focus enough on translating policy into practice by role modelling. The need for organisations, and people to "*role model behaviours"* and *"qualities* of engagement" seemed important to Mark (Interview 1).

"we are on the cusp… here, in this organisation, which is a charity that is going through a process of really reflecting - thinking about how it works with patients and service users in the community, how it embeds that perspective into their work, how it models and reflects good practice in the wider system. At the moment, we're engaged in a conversation about that. The senior management team has asked a particular group within the organisation to come up with a policy on it, but I've been pushing back on that, saying there's a real danger with coming up with a policy, particularly in an organisation… that has a reputation for being a think tank, having expertise. My challenge to the organisation is to model the very qualities and practises of good engagement within… with how we work on this… which has really challenged the group. So, that's where we're at the moment" (Mark, I.1)

Conversation was peppered with brief pauses, as Mark appeared to search his memories, as he considered my questions. Mark reflected on when he was first diagnosed with a long-term condition. He reflected that; *"how they engaged with me as an individual, and how they didn't engage with me really influenced my work"* (Interview 1). At our second meeting Mark shared an artefact, which represented how he made meaning of his leadership identity in relation to public engagement, a three-dimensional jigsaw (figure 4.2).

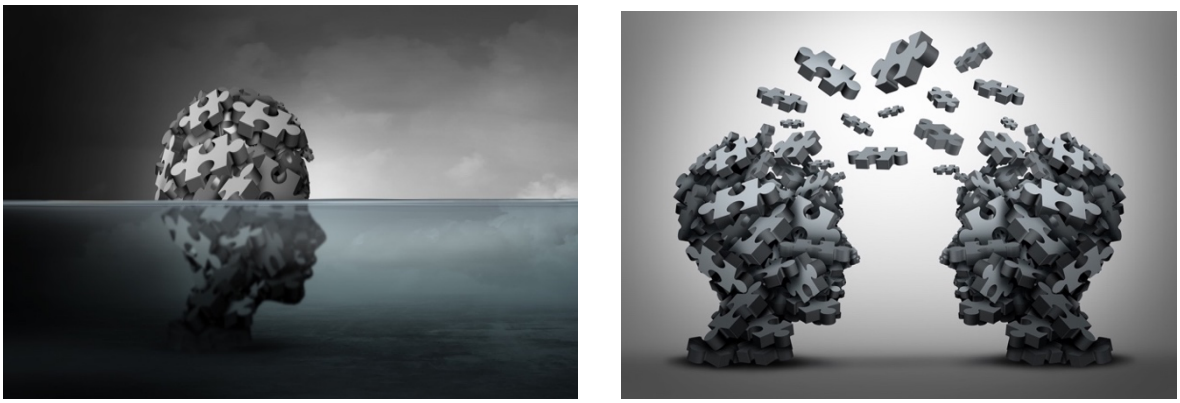


Figure 4.2: Mark' artefact: jigsaw of self (double-sided) - Key theme: (changing identity)

Artefact:

Early in our second conversation, Mark shared his artefact, a metaphorical jigsaw. He told me the jigsaw was double-sided. The first jigsaw portrayed a representation of himself before living with a long-term condition. He told me; *"I hated the representation of illness"* (Interview 2). Mark described an uncomfortable journey, in which he "*put himself outside of the system*", discovering slowly his need to understand more about his 'self', and his resistance to the system.

> *"it's a metaphor… so on the box of the jigsaw puzzle is a picture of me and that picture of me… I'm with me pre-developing the xxx and is an idealised image… the picture is a sense of freedom and space and physical activity and all of this stuff. And, I think one of the things that was very powerful for me was… I went through the usual stuff associated with change, you know, the theory of change… that denial was incredibly powerful so what happened was I had quite a bad experience in the beginning with how they started to make sense - of what was happening to my xxx, in terms of a diagnosis, and I guess, looking back on it, there was a part of me, that in the beginning really couldn't handle the way it was being treated. […] I hated it because of the way I was treated. hated it because of the absolute representation of sickness, and problem and, and the way I was talked to meant it was all horrible. It just signified and symbolised things breaking down, and not working. And so, what I did was I put myself outside of the system… Looking back on it I'm really conscious now, there was a part of me that was desperately trying to re-create, to re-establish that image, that picture I had of me… So therefore, I started to change my attitude and approach, and low and behold I started to get different responses from the people around me. And why am I telling you all of this? I'm telling you all of this because my next step, amongst other things was to say; 'I wonder how I can help others who are working to manage their own recovery but also, influence the system…'* (Mark, I.2)

Mark recalled a coaching conversation - a conversation that he attributed to helping him re-frame how he saw himself, and how he situated himself within a context of recovery and leadership. His story told something of his leadership identity as an on-going process,

which he described as "*identifying", "dis-identifying" and "re-identifying"* at different stages of his leadership journey (I.2). This created a vivid picture of identifying with public engagement from both leader and patient leader perspectives. Mark recalled the significant challenge of self-discovery; "*it is a real art and skill",* something he believes is *"self-awareness"* (Interview 2). He conveyed this as fundamental to how we understand ourselves as leaders.

> *"I think, what I'm aware of is... how language is critical for creating the way in which we make sense of the world. It influences our behaviours. It influences the decisions and choices we make. It even impacts our thinking. Therefore, it continues to influence the world we create for us… I'm also aware that it can be really hard for others to translate that into practice. It's hugely challenging about how we do it [self-discovery] because it's part of how we make sense of the world. It's incredibly difficult to dis-identify, to step back. It's a real art and skill of what I believe is self-awareness; to step out, and look back, and see [conference story]. So, there's a power to the language used by senior leaders in a system, which fundamentally talks about processes and procedures, and works within a machine-like metaphor of logic, rational, diagnostic, expert, fixing… if you are on the edge of that it can be incredibly dis-empowering. I struggle with so much of the NHS leadership because it's all heroic, it's all top down, despite all the stuff that's going on"* (Mark I.2)

The second side of the jigsaw resembled the complexity of the health and care system. Mark's lived experience appeared to foster a strong sense of his purpose. He reminded me that his motivation is; "*different conversations that help people to have different relationships with themselves"* (Interview 1). This reflected his fundamental view on the importance of relationship in leadership for public engagement. He emphasised the importance of the quality of our conversations.

> "*the quality of our conversations is influencing what we're seeing and not seeing and the quality of our decision-making and choices"* (Mark, I.1)

Mark highlighted how the quality our conversations is fundamental to how we understand and identify with public engagement. Coaching played a vital part in Mark's leadership journey. He explained that he applies coaching in his practice; *"coaching and facilitating a leadership style is something I'm very aligned to"* (Mark, Interview 2).

As our conversation continued Mark expressed a clear view that the greatest challenge to public engagement is "*the mindset which perceives engagement as an instrumental mechanistic process, because they're lost within a mindset that sees their organisation as a machine"* (Interview 1) At times Mark paused as though making meaning. *"I wonder"*

he said, "how many *heroic leaders… really lack confidence…"* (Interview 1). When I asked Mark about his values, he described these, and the principles as his *"inner compass"* (Interview 2). He appeared to hold a deep understanding of his values, reflecting that those of love and forgiveness are hard; *"I'm in a constant dance with those values… they must mirror what I think is really important to me"* (Interview 2).

> "*it's about uncovering the habitual assumptions and beliefs that underpin what you do - now there's a balance between doing that, and then taking action, and I've always had this phrase which is 'act your way into a new way of thinking' rather than 'think your way into a new way of acting and that's really important for me, because for many years I've thought myself into doing a whole range of things but that enabled me to actually not do it [yes] because I lived in my world inside my head - I procrastinated, I stopped myself from doing things… so really reflecting on what is behind the decision, the choice I'm making - what am I really saying to myself at the moment, and why?... "I am in a constant dance with those values [compassion and love]… they're more difficult, but they are values that I know I need to keep visiting. It's very easy for me to be very uncompassionate or unloving towards myself. It's very easy to give myself a hard time, to be really quite nasty to myself, to dis-respect myself, and notice what happens then, with others that I come into contact with - So I just need to constantly say, look and notice"* (Mark, I. 2)

Marks views on leadership and public engagement encompassed professional and patient leadership as a continuum; *"that's important because like any leader, the leader needs to start with themselves, I believe before engaging with others"* (Interview 2). Mark described the NHS as a complex system with many intersections; *"how you look at it and how you see it and how you talk about it influences what you will see and what you won't see and what you will privilege and what you won't privilege which will then influence the choices you make"* (Interview 1).

As our conversation came to an end, Mark offered a final reflection, not on the process but on the relational elements of the interview. He reflected on how we showed up together; the quality of our engagement in the process, led by me as the researcher. He told me that how I framed the conversation, and held the conversational space, enabled him to engage openly in the conversation, and quality of sense making. It seemed that what we both brought, was a certain level of shared self-reflexivity, paying attention to how we show up in conversation. This seems to matter greatly when we are thinking about influences on leadership for engagement.

4.2.3. Jill's story

I met Jill in the city of my University. I wondered if meeting away from Jill's workplace, may impact on our conversation. Jill works in a large, complex national organisation, holding responsibilities for engagement policy. She told me that her role as a senior leader, has enabled her to situate staff engagement alongside public engagement, describing her leadership as *"a stream of consciousness"*(Interview 1). Jill paused, reflecting that her "*value of inclusivity and inclusion* have been driven by my experiences as a child, of *being on the edge, so really looking back on my own life journey*". She told me; "*It's driven me to find ways of being included… not just for myself, but also really driven me to ensure that other people are included too"* (Interview 1). This resonated with her professional background. Speech and Language Therapy she told me is about *"enabling people to have a voice and making sure that their messages and choices were heard".* Jill attributed her early lived experience to her leadership for public engagement*; "I think my leadership beliefs, values, style is actually driven by very, very early experiences"* (Interview 1).

> *"Probably one of the most enabling things I've done, that's enabled me to feel confident in just being able to be creative and doing what works to engage people is some work that I was invited to do working with [xxx] in [third world country]. I had no idea it would have such impact. I was invited, quite a while ago now, to join a multi-professional, multi-agency team who are going to go out to [country]… I just learnt you just kind of engage them by being your authentic self really. That for me was really, really, really, really, powerful. And there's nothing quite like you know sitting in the sand in a railway station just with [community]… you are pretty vulnerable... It helped me understand that actually you just need yourself. You don't need kind of tool kits and anything else - fundamentally it's about you. […] So that was really, really, important and connected.*
>
> *Connections are really important for me. It connected right back, for me with the experience I had as a student…[student story]. It makes me go cold just thinking about it - oh goodness - it just set the hairs running on the back of my neck. It was incredibly powerful. She [leader] was saying, 'don't hide behind a toolkit, don't hide behind a set of rules that anyone else has made up'… It was massively powerful. I didn't realise. At the time, I had no idea (whispers) - I thought 'what's she doing to me'; yet actually it's been really significant. What's interesting for me, is that those early career things have actually had more impact than leadership development courses. It's kind of that just what cements your [public engagement] belief"* (Jill, I.1)

Early in our conversation Jill shared her fundamental view that public engagement is *"fairly multi-stranded"*, describing *"we've got a kind of engagement silo that is different from experience"* (Interview 1). This appeared problematic. Jill paused, sharing new thoughts as they surfaced in conversation*; "Patients, staff and the public are cast as if*

they were three entirely separate cohorts, but actually in real life they are all the same people playing different roles at different times." She continued*;* "*there is something incredibly important about understanding and responding to the connectedness of those cohorts*" (Interview 2).

> *"we tend to make some very clear distinctions in the way that we tend to drive health care improvement by having patients, staff and the public are cast as if they were three entirely separate cohorts, but actually in real life they are all the same people playing different roles at different times… there is something incredibly important about understanding and responding to the connectedness of those cohorts… you can't stop being a patient, and likewise if you're a member of staff and are also receiving services you can't kind of suspend the impact that that is having on you"* (Jill, I.1)

Connection was important to Jill. She told me; "*you can't stop being a patient, and likewise if you're a member of staff and are also receiving services you can't kind of suspend the impact that is having on you, but we haven't really kind of embraced that"* (Interview 2). Jill grounded her views with reference to empirical evidence, which was compelling as she asserted; "*the only thing that will ever improve the experience of patients is the experience of staff"* (Interview2).

Jill described how she uses storytelling in her work, with public, and with staff, for understanding *"the interface between what it means to be a member of staff, and what it means to be a member of community"*, reflecting on learning through stories. Jill considered that "*complexity of the vocabularies*" is the greatest challenge. She reflected; "*We tend to be very verbally based in the way that we manage engagement in health"* (Interview 1). Paradoxically, Jill contemplated that; *"although we are perhaps good at talking to people who know what we are talking about, we're less good at actually translating"* (Interview 1).

One reason Jill told me she values storytelling, is noticing "*when people are sharing their story*, *people are prepared to share something of themselves and their own vulnerability*" (Interview 1). She considers; "that brings a sense of deep *commitment* and kind of *authenticity and powerful way of saying 'I am coming here to learn from you… so it's a very different kind of leadership than the kind of patriarchal expert old kind of medical*

model" (Interview 1). These were qualities she considers important. When I asked Jill about her values, she told me that reflection is important to her.

> "*what I've learnt is… there's reflection 'for' action and there's reflection 'on' action. The bit that troubles me most, and I find hardest to manage, is reflection 'in' action. So, I've got a huge inner voice, its constantly, constantly commenting, so sometimes, as a value that's a real positive but it can be distracting"* (Jill, I.1)

When Jill reflected on her values she emphasised "*inclusivity*" but also the *"value of possibility… always maintaining a focus on what is possible and working out what we can do together*" (Interview 2). With this in mind, she valued "*conversation*" closely, viewing this as; *"the most important vehicle for engagement".* Jill described the significance of leadership skills in terms of; *"crafting and holding a conversational space"* (Interview 1). For Jill this means*; "the kind of leadership that is driven by questions more than by answers".* She described "*reaching* out into an existing conversation", reflecting on the quality of conversation. Jill holds a fundamental view, that "*one of the important characteristics of effective leadership is to convey messages for engagement simply"*, telling me; *"make your message simple, make it simple, make it accessible, make it clear, make it memorable"* (Interview 2) . At our second meeting Jill shared an artefact; a candle (figure 4.3).

Figure 4.3: Jill's artefact: Candle

Key theme: (creating the right conditions, power of connection)

Artefact:

Early in our second conversation Jill shared her artefact, a candle. She described how she visualises leadership for engagement using the notion of a candle. Candlelight resembles

the conditions that leaders need for taking care of others, and self. She posited the questions; *"What is it that enables you to keep your own candle burning"?* and*, "How do you manage as a leader, when you feel the flames really flickering and it might be snuffed out?"* (Interview 2). Jill described the individuality of flames as people, from large confident flames to small vulnerable flames. Jill reflected, that if leaders don't pay attention to their own light, and the light of others, leaders, just as the flame are very vulnerable. Attending to relationships seemed important. As though echoing my thoughts, Jill reflected on the importance of; "*understanding what it is that enables people… to shine brightly… creating the leadership conditions that enables them to do that… each individual candle is actually a kind of a small light, and it's an important light, but it's when you bring a collection of candles together you are able to see much more clearly together than you might as an individual"* (Interview 2). Jill used the metaphor of light often revealing; "*really noticing - that ability to re-frame something in a conversation or enable other people to see it differently"* (Interview 1).

> *"my artefact is a candle. I am going to light it . It was really interesting reflecting on your kind of request to bring an artefact because I thought about lots of things and I guess lots of items and it just reminded me of a lot of points I suppose in my career and my leadership journey, but particularly to reflect on a period of time when I was working with a particular colleague and one of the things that became quite significant for us in our conversation… is the kind of notion of a candle, particularly thinking as a leader - what is it that enables you to keep your own candle burning? -and what is it that nurtures and supports that?, and how do you manage as a leader when you feel the flames really flickering and it might be snuffed out? - how do you protect that flame? And also, how do you enable others to light their own candles and then enable them also then to take on that responsibility of protecting their own flame? - and understand what it is that enables others to keep their own candle alight? - and, what is it that just kind of snuffs their candle out? And there is something there about collective - just that kind of sense of collective light […] There's something very engaging, and very uplifting about candlelight, but it's also incredibly vulnerable - so you really do have to work at protecting it. And that also connects back with that sense of vulnerability. If you don't pay attention to your own light, and the light of others, it is very vulnerable. It also connects for me with leadership responsibility. It's your flame, it's your light and it's your responsibility to keep that alight, because if it goes out then it is not always easy to re-light"* (Jill, I.2)

As our conversation moved towards the end, Jill reflected on a recent coaching conversation. She attributed coaching as a way *for "landing so many things - it's only the coaching that has helped me to understand how I had actually chosen"* (Interview 1). She explained how it connected her leadership back to her early speech and language therapy practice and with children, families, staff, and communities she worked with. Jill

emphasised often the importance of connection; "*connections are really important to me*" (Interview 1). She described a sense of belonging, which helped her to develop as a relational leader. It was learning from these early experiences, which Jill seemed to attribute the greatest impact on her leadership. She explained how her experiences helped her; *"it helped me to understand you just need yourself - you don't need toolkits - fundamentally, it's about you"* (Interview 1).

> *"I've had coaching at lots of different points… but have just engaged in some recently. One of the things I've actually identified on a personal level is how far my kind of engagement and my values of inclusiveness have been driven my experiences as a child of being on the edge . So, it's really looking back at my own life journey and that the experience of being on the edge… lots of things happened to me that meant from a very early age, I just used to just inhabit the edge, and not really having my voice heard [school story]. It's only the coaching that helped me understand how I have chosen those places…This brilliant coaching conversation has just landed so many things, and I connect back to when I was working as a Speech and Language Therapist [story] For me that was all just always about letting their voice be heard. So, I think my leadership beliefs, values, style is actually driven by very, very early experiences, very early experiences… that confidence actually comes from just kind of owning who you are and your journey - and noticing how that impacts; how you impact on others, and how others impact on you"* (Jill, I.1)

There appeared to be an emotional dimension to Jill's approach to leadership. Jill described how she had learnt by reflecting on her early experiences, that you can engage by just being your authentic self. Leadership for engagement requires a kind of confidence, which Jill told me "*comes from owning who you are, and your journey*" (Interview 1). Finally, I asked Jill if she had any final reflections on our conversations; she reflected deeply on how the conversation enabled a deeper self-understanding of her leadership identity, which she found helpful, contemplating that paradoxically these kinds of reflective conversations in the healthcare system.

> *"what I've noticed…is how little we have conversations like this in the system, and yet how important they are, and also how conversations like this, certainly speaking personally, really enable an opportunity for me to talk through. And I kind of guess it almost strengthens my own identity, my own leadership identity. So, it's kind of, how having the conversation enables that to happen. But it also enables me to kind of challenge, if there's anything that just isn't quite consistent, or just I kind of voice an inconsistency, or anything I feel I need to explore - it's actually for me kind of verbalising that and surfacing that through these conversations - it's just a really helpful thing to do"* (Jill, I.2)

It seemed that the research conversations created a certain level of space for reflection and reflexivity. This seems to matter greatly for Jill, in thinking about influences on her leadership identity in relation to public engagement.

4.2.4. Emerging perspectives of national leaders

Key words and themes were derived from the initial analysis of the portraits to reflect the emerging perspectives of national leaders from a policy perspective:

- The way that these leaders identified with public engagement did not begin with policy and process but rather self-discovery; dis-identifying, identifying, re-identifying (e.g., Mark).
- A more holistic view of leadership was encouraged to address the inter-connected nature of leader roles at different life stages. Paradoxically engagement work is traditionally presented as separate cohorts, patient, public and staff (e.g., Jill, I.1).
- Storytelling played an important role, as a way of making meaning from experiences, and for connecting with others (Tess, Mark, and Jill).
- These leaders shared deeply personal experiences conveying vulnerability, curiosity, and courage. Their motivations for public engagement did not begin with policy but rather were untapped by their reflection on lived experiences e.g., dis-engagement. Learning from lived experiences influenced the way these leaders understand and identify with public engagement.
- Conversation was viewed as a significant vehicle for engagement - e.g., "*different conversations, different relationships*" (Mark, I.1) - coaching (Tess, Mark, Jill) - creativity, such as visualisation and using metaphor (Tess, Mark, Jill).
- Leadership can be lonely, illuminated by driftwood artefact (Tess, I.2). The candle artefact conveyed the importance of creating conditions, for self and others to "*shine brightly*" (Jill, I.2). These leaders considered self-care important but hard.
- Coaching was described by these leaders as a reflective approach that helped them meaning from experiences, influencing how they understand, and identify with public engagement (e.g., Tess, Mark, Jill). Consistent with their stories Einzig (2017) suggests that coaching is well placed to offer; "*the space for leaders to explore the challenges we face today along with our deepest fears and our greatest dreams"* (p.43).

4.3. Local leadership perspectives on public engagement

In the following sections the leadership portraits are set within three local organisational contexts to reflect patterns of distributed leadership; strategic perspective (board level), patient engagement / experience perspective (co-ordinator), champion perspective (operational).

4.4. Northern Bay NHS Foundation Trust - organisational context

Within the region the Trust manages health and social care services on behalf of the City Council, helping to ensure that patients have a seamless transition between hospital and home, and making sure that they have support in place for them to manage independently, and avoid hospital admission where possible. Teams deliver care from hospitals, in a range of community venues and in people's own homes, providing a wide range of services. The Trust provides a range of health and care services to support people living in the geographical region. It is one of the region's largest employers. Staff satisfaction is reported to be high, and staff consistently rate the organisation as one of the best places to work in the NHS. CQC overall rating 'outstanding' (2016) safe (good) - effective (outstanding) - caring (outstanding) - well led (outstanding).

4.4.1. Anzors story

Anzors works in a large NHS Foundation Trust, beginning her leadership journey there over twenty-five years ago. In her current role she has board level responsibilities for patient experience and quality. It was easy to settle into this inviting conversation as Anzors told me; *"I guess I've always been interested in voice"* (Interview 1).

> *"I kind of reflected on what what's got me to do the roles that I've chosen to do historically. I mean, I'm now in a role of xxx [Director] within the Trust - but I'm a clinician by background... I'm a Speech and Language Therapist, and my clinical expertise and background is in [xxx] services, so I wonder if I've always been interested in voice - and people lose power when they lose language and lose influence…"* (Anzors, I.1)

It appeared uncoincidental that her professional origins rest in Speech and Language Therapy. Anzors shared early childhood memories, of living abroad in a culture where

having voice was a privilege. She attributed her early childhood experiences to her curiosity for *"how do we find voice for people, who through illness, have lost power and influence"* describing this connection as being "*beyond symbolic"* (Interview 1). Anzors story emphasised the importance of relationships; "*shining the light on relationships*" in her leadership for public engagement (Interview 1). Early in our conversation, Anzors shared her fundamental view that leadership for public engagement is about; "*truly listening to the views of people who use services, with the aim of improvement*" (Interview 1). This assertion framed Anzors views on leadership for public engagement as she reflected on early clinical experiences.

> *"I discovered a way of working, that once I'd discovered it, I wasn't really able to let go* - so I became utterly convinced that it was the right approach, and I became curious whether that could look outside of [clinical specialty]*"* (Anzors, I.1)

She became "*curious"* about whether the principles of her approach could be used more widely across the organisation. She paused, reflecting; *"it connected me, if you like, to why I wanted to do this work in the first place*". These experiences appeared important to Anzors in her work. Anzors described feeling *"lucky*" to being part of an organisation that has *"valued the work"* and supported her leadership in relation to public engagement. She reflected; *"what a gift."* (Interview 1).

Anzors described how she had used storytelling in her work, with public, and with staff for many years. She explained how she increasingly seeks to justify the use of stories, and especially the authentic use of stories. This she describes as the *"judicious use of storytelling"* (Interview 2). Anzors paused periodically, as though searching for memories of her experiences as she considered my questions. She re-visited an evening she was working in clinical setting, recalling reading a paper written by Don Berwick called*; What 'Patient-centred' Should Mean: Confessions of an Extremist'* (2009). She vividly described Don Berwick's story in this paper; "*of putting on an anonymous gown when becoming a patient… of suddenly feeling quite powerless on the other side"* (Interview 1).

"he [Don Berwick] described why he was frightened of becoming a patient - he'd done lots of work around patient safety at that time, and it wasn't to do with harm, it was to do with lack of control - it was to do with people not knowing his name - people not asking him his permission for things - people making assumptions about what he wanted… having a history as a paediatrician and an influential medical leader yet suddenly feeling quite powerless on the other side, and feeling uncomfortable with that…" (Anzors, I.1)

This story appeared to blur the boundaries between professional and personal experience in a way touched Anzors, shaping her thinking on her leadership and patient engagement. A sense of vulnerability felt palpable as Anzors recalled her dis-comfort on reading this paper. Her thoughts moved to her response. She told me she shared the paper with her most senior leaders, to highlight the challenge of patient-centeredness.

"although I worked in a good organisation, I recognised that… we were doing that to people, and we weren't involving them, we weren't engaging them as much… we were delivering our services and our systems around what we believe is important and right but it was only one part of that jigsaw… I trusted… the senior leaders that I was approaching with this challenge enough to believe that they would come up with a meaningful response" (Anzors,1.1)

Context, Anzors told me played a crucial part; "*I think context matters, because I think, you know, had I been working in a different organisation, would I have done that? But I felt able to do that [share with senior leaders] from a leadership perspective*" (Interview 1). A sense of reciprocal trust emerged. Anzors used metaphor to describe her organisation as "*family*". Relationships appeared important to Anzors. This was illuminated at our second conversation when Anzors shared two artefacts that represented how she made meaning of her leadership identity in relation to public engagement: a paper written by Don Berwick (2009) and SharePoint (figure 4.4 and 4.5).

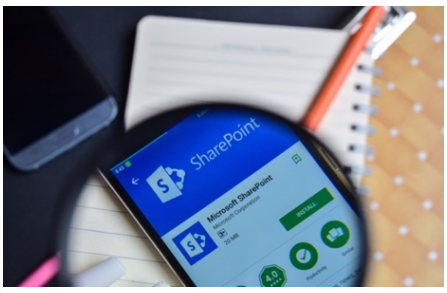


Figure: 4.4: Anzors artefact 1: Paper by Don Berwick: Key theme (vulnerability)

Figure 4.5: Anzors artefact 2: SharePoint: Key theme (personal connection)

Artefact:

At our second meeting Anzors reached for the first of two artefacts, the paper that she described so vividly in our previous conversation on; *"what patient-centeredness should mean: confessions of an extremist"* (Interview 2). She described the essence of Don Berwick's story; "of *putting on an anonymous gown when becoming a patient"* and "*of suddenly feeling quite powerless on the other side".* Anzors paused as though searching for memories. Her story moved direction. She recalled vivid memories of a holiday abroad - of family - an accident - ambulance - high-dependency care - kindness. She traced her journey, challenging her own assumptions and learning from her lived experience.

A "*small act of kindness*" seemed important, considered by Anzors to be a core value. She explained; *"… as a leader, it was that, and don't know if I would've had that level of insight. I might've gone for the evidence surrounding something. I probably would've enquired around the evidence. But I don't think I would've understood, until I was in that situation myself, about what it is that people actually want"* (Interview 2).

> *"this is a great example of when you suddenly are reminded about the things that matter because you cross over yourself. I was on holiday [abroad]… the summer before I took this job. It was the last day of my holiday… It didn't end well… I was transferred to HDU (High Dependency Unit)… and that night, a man came from reception … [story of kindness] - It was that moment that was so critical to me in the process… It was a 'small act of kindness' and empathy of a man that worked in reception... but it was so important. I thought, in my new job, I am absolutely determined to choose measures that matter to individuals when they're lying frightened in hospital beds, and not just the things that we think matter, because they wouldn't necessarily be the same… So, I came back to a new role… with a very, very strong belief that the measures that we'd chosen needed to be grounded in the stuff that patients care about ... So, what would allow us to tap into kindness, trust, and relationship, building the process of delivering health care. And that really helped me…as a leader, it was that [lived experience]. And don't know if I would've had that level of insight. I might've gone for the evidence surrounding something. I probably would've inquired around the evidence, but I don't think I would've understood until I was in that situation myself, about what it is that people actually want"* (Anzors, I.2)

Anzors described her second artefact, 'share-point', metaphorically, explaining how she uses "*share-point"* in her work - a system for capturing the *"real-time* aspect of feedback" (Interview 2). One reason Anzors told me she values share-point is that it*; "grabbed the attention of our staff".* Anzors noticed a shift from; a "*historic focus, on complaints and what's wrong",* to "*a more appreciative approach, of what's working*

gives people energy" (Interview 1). A further reason Anzors values share-point is her belief that "*transparency and improvement are important*" she reflected; *"it takes courage"* (Interview 1)**.** These qualities seemed important for uncovering stories at an organisational level. Anzors reflected; "*speak to enough people and you actually uncover how much emotionally that people are giving every day and the joy of that but, but the flip side is the price of that sometimes"* (Interview 1).

A paradox emerged as Anzors contemplated; "*I don't think as a system, that we've paid enough attention to the emotional price of delivering healthcar*e." She recalled that following the Francis Inquiry (2013) there was a temptation to respond hastily at the risk of a "*knee-jerk reaction"* (Interview 1)*.* She described a contrast in her work; *"we wanted more of a curious discovery of how things actually were*."

> *"Mid Staffs hit us hard. People became far more nervous about black-spots in organisations and uncovering them. So, the complexity of healthcare was always there, but I think post the Health and Social Care Act in 2011 it's become far more complex and accountability, it's harder to spot. With that, we've seen more demands and pressures on the system, and deterioration in some elements of performance. I think that often then triggers a knee-jerk fix, and sometimes that's at odds with the quality improvement, or people with an appreciation of change, and what it takes, leadership of change. So, the command-and-control narrative that dominated within the NHS. For those of us that work in quality improvement, we know how harmful that can be from a leadership perspective (smiles) - and so the 'fix it', 'do it quickly' intolerance of how long it takes… I'm deeply grateful for a context where I was allowed time. So, in that first year, as well as a lot of support by m Chief Exec and the board, I was told to take the time, to really understand what the experience in this organisation was, across our very complex pattern of service delivery and the ten hospitals at that time. I was explicitly told not for a knee jerk reaction - that we didn't want a fake and false assurance that things were okay. We wanted more of a curious discovery of how things actually were… and so what a gift"* (Anzors, I.1)

Anzors shared her fundamental belief that focussing on patient experience has allowed the organisation to "*shine a light on those interactions";* to *"notice excellence",* to *"celebrate staff that are doing it really well"*, to allow staff to "*feel appreciated",* to "*uncover care that is unacceptable that day, and do something about it that day*" (Interview 1). Anzors emphasised the importance of valuing peoples lived-experience; "*it is their expertise, and we will get better as an organisation if we listen to that and listen to our staff... we've invested heavily in hearing that voice".* Anzors illuminated the value she placed on relationships with a phrase she used often; *"shining the light on relationships"* (Interview 1).

Within Anzors approach to leadership for public engagement she appeared to focus on staff engagement too. She told me; *"for good reason staff engagement is one of the key organisational metrics that I think we lose track of at our peril"* (Interview 1).

> *"so based on Don Berwick's paper [artefact] I devised my whole system with patients in mind - the beautiful unintended consequence, but absolutely not designed that way, was that I discovered how much this would mean to staff. But I didn't design it that way. I didn't appreciate it. I was thinking purely of patients. But if you listen, and deliver in healthcare, to respond and improve what matters to patients, you will be dealing with the frustrations that staff look at every day. They want it to be better too. The things that drive patients mad on a ward are the things that also emotionally exhaust our staff. So, I've learnt, I didn't know it - that staff experience precedes patient experience. So, you need, you need to get that foundation right; where staff feel trusted, where they feel safe and feel able to speak up, and where they have a belief that in raising a problem something will happen about it"* (Anzors, I.1)

When Anzors reflected on her values, she considered "kindness" as core value, fundamental to her leadership (Interview 1). She described kindness to others, and kindness to self. The quality of kindness mattered greatly for Anzors. Anzors paused as she reflected on kindness; "*so having a role and a responsibility that allows you to pay attention with kindness - and kindness to yourself, that's a harder lesson"* (Interview 2). Anzors reflected that the role of leadership can be lonely. She described her work in developing a network, viewing this a "*network of support for those individuals who risk being deeply committed to something, burning out with the effort, in a system that doesn't understand and doesn't accommodate*" (Interview 2).

> *"uncover those stories at an organisational level, speak to enough people and you actually uncover emotionally how much emotionally that people are giving every day and the joy of that. But the flip side is the price of that sometimes -what about the deaths when people just finish their shift - or clean up the blood because they don't want families to see it - and just get on with things. So, I don't think as a system, that we've paid enough attention to the emotional price of delivering healthcare day in, day out, when you are dealing with loss, and frailty, and tension between all of that - and a strong desire to make better when you can't always do that. So, I think for good reason, staff engagement is one of the key organisational metrics that I think we lose track of at our peril. We know it's fundamentally linked to organisational outcomes, and I think it should be something that we really invest in"* (Anzors, I.1)

As our conversation came to an end Anzors offered a final reflection on the nature of relationships in her leadership and public engagement. She reflected on her deep appreciation the connectedness between staff engagement and patient experience.

> "*I've learnt, I didn't know, I've learnt it, that staff experience precedes patient experience... so you need to get that foundation right where staff feel trusted, where they feel safe and feel able to speak up*" (Anzors, I.1)

This seemed significant to how Anzors framed her public engagement leadership. Anzors concluded; *"so based on Don Berwick's paper, I devised my whole system with patients in mind - the beautiful unintended consequence, but absolutely not designed that way, was that I discovered how much this would mean to staff"* (Interview 1).

4.4.2. Peggy's story

To seek meaning on leadership and public engagement, for Peggy has been a journey that has spanned almost forty years of working for the National Health Service (NHS), specifically this organisation. Peggy and I met in an airy room at the edge of an out-patient clinic. The comfortable setting seemed to chime with Peggy's warm persona, which permeated the room. In her current role Peggy is Service Improvement Lead for the organisation, nested within the patient experience team. Peggy described her role as; "*fundamentally about quality improvement"* (Interview 1). Her small team talk with over 600 patients a month, to capture feedback on their experience in "*real-time on the day, asking a series of about 25 questions - questions all come from a piece of research from the Picker Institute (2009)"* (Interview 1). Of her commitment to public engagement, she told me; *"I think the draw comes within yourself".* It was easy to settle into this inviting conversation. Early in our conversation, Peggy reflected on her childhood as she situated her professional background in nursing.

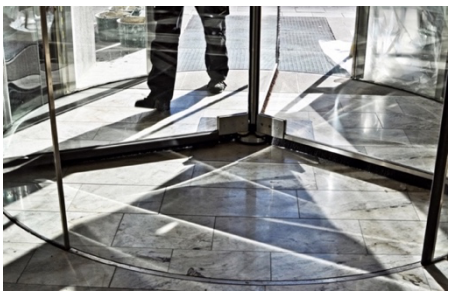
> *"I mean, it's in my bones. It's been there since I was little - my teddies had stitches on, and bandages, when I was a little girl"* (Peggy, I.1)

Her words resonated; re-kindling memories of my own childhood dream of being a nurse. I imagined how Peggy's learning from early experiences in childhood, appeared to influence her leadership journey. She paused, as though searching for further memories, re-affirming that her "*curiosity"* has spanned almost her whole career, over four decades.

> *"I think the draw comes within yourself. I could have been quite tunnel visioned… but because I'm naturally curious and nosy… I can push myself a little bit… I mean it's in my bones. It has been since I was little. My teddies had stitches on and bandages when I was a little girl. And then came to this role in 2010. I thought, "What do I do? What do I do? You're getting older-around two years, I'll be 60... I still want to get my satisfaction. I think, it was innate in me… it's a good job… but I wanted to see the actual patients and see the joy in their faces when they found out that this organisation got involved in this"* (Peggy, I.1)

As our conversation moved forward Peggy framed her understanding around leadership and public engagement. She emphasised attending to her relationships with both patients and staff. She told me*; "it's very, very important to everybody involved, to be inclusive, to be open and honest, to build a rapport because we're working on trust, two-way trust, and we get the best out relationships if you're open and honest with everybody"* (Interview 1). Peggy spoke often about the importance of relationships in her work. She explained that it is not unusual for staff to approach her with problems.

Peggy described her investment in training staff, appearing to foster a sense of preparedness for engagement. She told me; "*I sort of advise them quite regularly. I go and do a lot of supervision and shadowing, and just watch how they're doing, because we've got to be consistent"* (Interview 1). There were notes of pride in Peggy's voice as she continued; "*it's great that we've got that kind of relationship, now that everything is embedded*" (Interview 1). Peggy shared that this is an exemplary organisation for public engagement work. It was clear that this hasn't been an easy journey. Peggy appeared be comfortable with the uncomfortable. She told me; *"I run some of the* workshops and *help to communicate their caring, working better together." Peggy views this as a shared endeavour. She reflected*; *"I think if there wasn't buy-in from the board, and we didn't have that top-down support, it wouldn't work"* (Interview 1). The impact of the complex and changing context in which her work is situated was illuminated in our second conversation, as Peggy shared her artefacts, a revolving door (figure 4.6) and bouncing ball (figure 4.7).



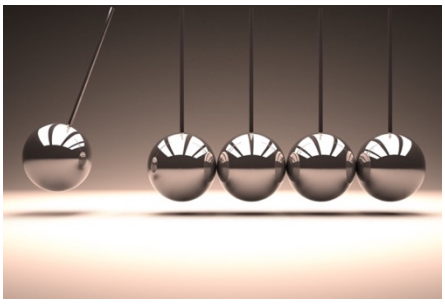


Figure 4.6: Peggy's' artefact 1: Revolving door: Key theme (context, on-going change)

Figure 4.7: Peggy's' artefact 2: Bouncing ball: Key theme (sharing ideas, connecting)

Artefact:

Early in our second conversation Peggy shared two artefacts. She invited me to imagine a revolving door in the room before introducing a second artefact, a bouncing ball. Peggy reflected; *"I've been in that revolving door many times and used that bouncing ball to bounce ideas from staff, take them back, try to implement them; it's bounced back again"* (Interview 2). Peggy recalled changes in the organisation, spanning almost forty years. She created a vivid picture of going, around and around in the metaphorical door.

Of changes in the organisation, she reflected; "*it's quite cyclical, the same things". She encouraged me to "imagine, the whole thing [public engagement] is a big hole, and it's getting smaller and smaller… the hole isn't closed yet, as each revolving door, bouncy balls go around - the hole has got a little bit smaller, but there's still a big gap. I don't think we're really there, completely"* (Interview 2). Complexity appeared to be a significant factor for Peggy - the door resembling changing context - the ball resembling relationships. Pausing to reflect on her public engagement work, Peggy described a "*quantum leap*" in relation to the organisation's improved performance (Interview 2).

Peggy highlighted the importance of communication telling me; *"I think it's communication, and staff are communicated with better than ever they have been in the past"* (Interview 2). The kind of communication that Peggy described in her leadership seemed a stark contrast to her earlier memories as a student nurse; "*we were the worker bees and weren't fed any information, kept like mushrooms, if you like, in the dark, not really engaged with"* (Interview 2). Peggy reflected on a shift, which she suggests is now*; "far more inclusive and encouraging, you know, everybody's contribution is valued".* Peggy described this as "*a big cultural shift".* She paused briefly and shared with me that despite this shift, she remains *"a little bit cynical".* Crucially, it seemed that people (staff and public) are encouraged to be more questioning now. Peggy concluded; *"I love that people have a voice to question"* (Interview 2).

"it's communication and staff are communicated with better than ever they have been in the past… back to when I was a student nurse in 1977 and we were the worker bees, and weren't fed any information, kept like mushrooms, if you like, in the dark, not really engaged with. But this is the big shift... It is far more inclusive and encouraging. You know, [now] everybody's contribution is valued, and that's a big cultural shift I think, in the NHS. I'm a little bit cynical, I'll be honest with you. I wonder how much of that is appeasing, and how much of it is actually real. But then the staff are influential in making changes and influencing their leaders, and engaging with the clients, and listening to their clients, listening to their patients. And the patients are feeding the improvement, which is a big shift, so that's where that hole has got smaller […] We deal with a lot more of that now than ever that we did, we're not prescriptive like we used to be when I first started, when it was, 'the doctor knows best.' We encourage people to be more questioning now, and I love that. I love that people have a voice to question… I love this culture that we have, and... I love that we're encouraging that. This is the bit I struggle with sometimes; the offers there, it's on the table, it's whether that's actually wholeheartedly meant, and that's why there's still holes [in public engagement] for me" (Peggy, I.2)

The importance of relationship was threaded through our conversation. Peggy spoke of her organisation as *'family".* Her thoughts were illuminated as she reflected; *"I think you can relate teams to families…, which brings something funny, everyone calls me "xxx"* (Interview 2). I felt a ripple of Peggy's connection to her professional nursing values as though she held these closely to her work. Peggy considers that a good leader is; "*a good role model and who lives the values*"(Interview 1).

"a good leader is somebody who is focused, involved, open and honest, who is inclusive, whose door is always open, who is always visible, who will be prepared to do anything. There's not one job on the ward that a leader won't do to gain respect of the staff … it's ticked the boxes… being on top of all the safety things that we have to do… I think you can relate teams to families, which brings something funny, everyone calls me xxx in the team. They could have been crueller and said xxx, but they didn't. So, they call me xxx and I think there's element of that [family] but not quite so soft… I think that's what you need. You need somebody who is really compassionate, who is dedicated to the job that they're doing, who has got patients at the heart. They have to be patient centred. And they're always looking to improve because nobody gets better by being patted on the back. You have to listen to your criticism, and take it on board, run with it… you adapt to the change all the time" (Peggy, I.1)

She continued; "*live the values, the team will follow suit"*. I visualised Peggy as the kind of role model that she described, reflecting her values of *"honesty", "compassion", "empathy", "being open", "being respectful to individuals" and "respecting individuality".* As though reflecting her view of "*organisation as family*" Peggy reflected; "*we are an organisation who wants to stick to our values".* Peggy concluded that; *"a good leader is someone who leads like family"* (Interview 1).

4.4.3. Oliver's story

Oliver and I first met at the end of his working day. In his current role, Oliver is a Consultant Surgeon. Oliver is highly regarded as a champion of public engagement by Anzor's in her leader role for patient experience and quality. Oliver shared his fundamental view on public engagement. *"It's a funny set of words"* he told me, asserting*; "the words are over complicated"* (Interview 1). His words, pointed to a paradox. The meanings, which people make from a single word, like 'engagement' can, it appears unintentionally dis-engage.

> *"I think it's a funny set of words - not a set of words I recognise. So it might be the sort of words that are used in, by engagement leads in Trusts, but it doesn't actually mean much to me. I mean, in term of my involvement in this, it's been around championing some of the patient experience work, which xxx has led on. So, that's about trying to get firstly my clinical colleagues [in specialty] involved in that, which they are quite brought into I would say. I'm frequently showing slides. In fact this xxx delegation got the 'patient experience slide', about how much we've improved on the basis of feedback from patients. So, it is fairly much an integral part of how we lead improvement in the department… I guess I'm trying to champion the cause. I do think that what xxxx [clinical specialty] has done through xxx [patient experience project], in the last five years, has been quite outstanding in terms of moving, genuinely moving peoples' perspectives"* (Oliver, I.1)

Early in our conversation Oliver told me that he had, until recently, undertaken a leadership role for Quality Improvement, reaching out beyond his own area of clinical speciality. The learning from this experience appeared to hold significant influence on his public engagement practice. Oliver told me; "*I'm just using it. I'm using it really, to make people behave and realise why they are there"* (Interview 1). As he continued to describe his role three words "*engagement"*, "*quality improvement" and "safety"* appeared to be inter-connected, forming a sense of connection and meaning making. Within the context of quality improvement Oliver had established a clear sense of purpose.

> *"I'm just interested in getting the best results, and then telling everyone about it, and then improving the brand of [the organisation], which helps me professionally; it helps the Trust and then helps our patients, and that is what it's about"* (Oliver, I.1)

Understanding the context of leadership within his role as surgeon and quality improvement champion, appeared to frame Oliver's perspective of public engagement in healthcare. At times, during our conversation Oliver paused, as he considered his responses to my questions.

At our second meeting Oliver shared an artefact; a metaphorical "tap on the shoulder" (figure 4.8).

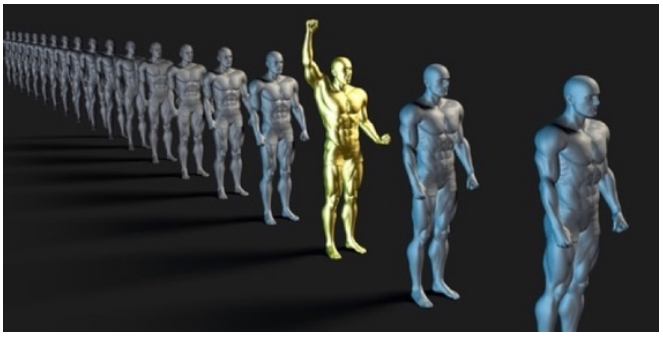


Figure 4.8: Oliver's artefact 1: A tap on the shoulder: Key theme (confidence, awareness)

Artefact:

Early in our second conversation the invitation to bring an artefact prompted a brief reflection on the nature of artefacts. This appeared to act as a catalyst, rekindling memories of a *"tap on the shoulder",* a metaphorical artefact (Interview 2). He recounted a moment some ten years earlier, when he was given the opportunity to undertake an extended role.

> *"I think one of the important things, which is perhaps transferable to other things, is actually someone tapping you on the shoulder and suggesting you've got some skill that is useful. And then you begin, to almost believe that you might have*" (Oliver, I.2)

The metaphorical "tap on the shoulder" had significantly influenced Oliver's leadership practice for public engagement, fostering a sense of confidence, that appeared to come from a greater sense of self-understanding; "*It's okay - you don't have to ask permission to do it."* Oliver explained how he seeks to model the tap on the shoulder with staff and patients, by *"noticing"* and by *"making people know they contribute"* (I.2). *He reflected that; "there's quite a lot of evidence in the literature that says, better patient experience, better outcomes".* Oliver emphasised "*that this link is pretty clear*" concluding; "*it's more connected, it feels real*" (Interview 1). He explained the importance of engaging staff and patients in real-time feedback viewing data from different perspectives.

Oliver attributes public engagement to the organisational success, looking at safety, clinical effectiveness, patient experience on equal merits. He reflected on his motivation

for public engagement; "*we moved from being mid-table, or bottom… to be essentially a top service provider"* (Interview 2).

> *" it's always nice to get good feedback, and not nice to get not good feedback, so that's a motivator. I think the reason I kind of grabbed it with intensity is because, it's because of the link to outcomes. You know, my research interest is improving outcomes in [clinical specialty] and I realise that this actually is a fairly easy way of getting better outcomes, to give better patient experience… You know, quite regardless of being the right thing to do, and all these other things, I think it gives you better outcomes - so what is there not to like about that"* (Oliver, I.1)

As our conversation came to its end Oliver reflected *on a change; "we've got to a point where five years ago this would have been considered to be some sissy kind of metric"* to now *"being something that we are really proud of"* (Interview 1). The complexity of language and its significance for people making meaning resounded. Oliver offered a final reflection.

> *"I think I'm just a jobbing person who tries to do stuff. I don't think there's any inner sign. I wonder inwardly if perhaps this was something I was searching for, almost without knowing".* He continued*; "I'm immensely proud of my department and the quality that they do. And I get great pleasure out of building them up and pushing it on and see colleagues do amazing things. So, I get inspired by that"* (Oliver, I.2)

The challenge of language that pertains to public engagement, it seemed persists.

4.4.4. Emerging local leader perspectives (Northern Bay NHS FT)

Key words and themes were derived from the initial analysis of the portraits to reflect the emerging perspectives of local leaders (Northern Bay NHS Foundation Trust):

- The language of public engagement was viewed complex; paradoxically the very language of engagement was considered to dis-engage people (e.g., Oliver, I.1).
- Recognising and responding to evidence that better staff engagement and experience leads to better patient experience and outcomes for all (emphasised by Anzors, Peggy, and Oliver).
- Significant investment in public engagement (and staff engagement and wellbeing) at board level. These leaders attributed their organisations. outstanding performance for 'leadership' and 'caring' to the relational focus (e.g., Anzors, I.1).
- A culture of kindness was considered important. These leaders used the metaphor of 'organisation as family' (e.g., Oliver) and 'team as family' (e.g., Peggy). Kindness to

self was considered important but hard. The challenge of kindness to self was summed up best by Anzors, (1.2).

- Learning from earlier professional experience (e.g., Oliver, I.2) and personal experience (e.g., Anzors) was a significant influence on how these leaders understood and identified with public engagement.
- A whole-system approach made public engagement feel more real for staff; "*it's more connected, it feels real*" (Oliver, I.2). Evidence from the Care Quality. Commission (CQC) reports are testimony to the individual and collective impact of relational leadership with the public; rated as outstanding.
- The importance of focussing on relationships was significantly emphasised; something termed; "*shining the light on relationships*"(Anzors, I.1).

4.5. Eastern Bay NHS Foundation Trust: organisational context

This NHS Foundation Trust provides acute hospital and community services to a population of more than 350,000 people. The Trust is well established as a combined hospital and community Trust, receiving Foundation Trust status several years ago. The CQC overall rating 'inadequate' (September 2018) - 'safe' (requires improvement) - 'effective' (requires improvement) - 'caring' (good) - 'responsive' - (requires improvement) and 'well led' - (inadequate).

4.5.1. Meghan's story

Meghan is Chief Nurse for this Foundation Trust. She exuded a deep sense of her commitment to public engagement as she welcomed me. As Meghan set the context of her role, she told me that the organisation had been placed in *"quality special measures by NHS Improvement" on the back of the Care Quality Commission (CQC) report*" (Meghan, Interview 1). A sense of personal impact felt present in the room.

> *"it does sadden me, where we're at in terms of the special measures, because it feels like there's a reflection that quality doesn't matter - it does. What we've done though is allowed bureaucracy, and things… and systems, and processes to get in the way, and actually we need to go back to basics"* (Meghan, I.1)

This situation appeared to frame the beginning of our conversation, for exploring influences on her leadership in relation to public engagement.

Early in our conversation Meghan reflected back to early experiences as a staff nurse recalling; "*I felt I could influence my practice. I don't think I felt I could influence on a wider scale other than through kind of role modelling"* (Interview 1). Meghan attributed a metaphorical "*tap on the shoulder*" to helping her move forward on her leadership journey (Interview 1). Meghan's views on leadership and public engagement seemed deeply rooted by strong family values and sense of pride in her professional origins. Her voice rippled with pride as she reflected on her grandmother, creating a vivid picture of her, as a figure of the community, and inspiration to her leadership. Learning from these experiences appeared to have shaped her leadership in relation to public engagement.

Meghan told me that her personal values go right back to childhood*; "never losing sight of why I came into nursing"* (Interview 1). Meghan seemed deeply aware of her personal and professional values in relation to her organisation reflecting*; "that's why I've stayed here so long; because I can see the values that are in people; that people want to work here to deliver their best to patients"* (Interview 1). Meghan paused, briefly reflecting that the organisation is rated *'good' in 'caring'*. She contemplated*; "that bit's never in question - it's how we make it work better in the system, and processes, and then listening to people - that we need to do better"* (Interview 1). As our conversation continued, Meghan described the complexity of translating public engagement in practice.

> *"we've got a real sort of wealth… we need to be able to translate [public engagement] because it's a bit of a treasure really, that we need to un-tap and build into our services going forward… that's real un-tapped potential… we're as challenged as it gets"* (Meghan, I.1)

Context appeared to be an important factor in shaping perspectives and confidence around public engagement. Participating in a leadership programme, illuminated for Meghan a sense of "*privilege and insight… into patients*"(Interview 1). She associated this with being a nurse, contrasting the diverse backgrounds and experiences that sit behind leaders' roles and perspectives on engagement. At our second meeting Meghan

shared two artefacts, a garden rock, and a PowerPoint slide of water ripples (figure 4.9 and 4.10):

Figure 4.9: Meghan's artefact 1: Garden rock Key theme: (everyone can impact, courage)

Figure 4.10: Meghan's artefact 2: Water ripples Key theme: (everyone can impact, simplicity)

Artefact:

Meghan shared two artefacts at our second conversation. Firstly, she reached for a small garden rock. *"It is just any rock really",* she told me, remarking that it can have a big impact; "*It was the effect that a rock, a pebble and a stone can have when you bring them into contact with water and - it's about that kind of ripple".* Meghan reached for her second artefact, a presentation slide image of water, ripples clearly etched. She explained; *"we can all have an impact - one act that creates a rippling effect of impact on another… even the smallest pebble creates a ripple*" - the size didn't seem to matter - it was the ripple mattered. Meghan described the impact of the ripple spreading, aligning this to "*modelling behaviours*" (Interview 2).

> *"that's really powerful for me - that it was a simple image that got stuck in their head, about the difference that they can make - I've seen somebody use this picture out of my slide show and put it on a poster on their wall… a reminder that we can all make a difference, and sometimes it's the smallest things that make the biggest difference - it doesn't have to be a large boulder that causes the ripple, it can be the tiniest pebble. So, I've used it so hopefully that's the way I work, and I want to model that behaviour… I think it was the simplicity of an idea because we are surrounded by lots of complex concepts, analogies, lots of words, lots of policies and papers - and this was about something very tangible - everybody knew what a rock is - everybody knows what the impact is of when you put it in water. I think it was just the simplicity of the concept that people thought 'I' could relate to that"* (Meghan, I.2)

There seemed something significant for Meghan about the simplicity of visualisation, for translating complex concepts such as leadership and engagement into practice. Meghan

described how she had used the image of the pebble and water ripple, and how they helped people to connect. Meghan held a fundamental view that translating public engagement policy into practice needs to be "*simple",* using "*concepts that people could relate to*" (Interview 2). Working visually appeared to impact on the way that Meghan thought about her leadership in relation to engagement.

> *"so I used the two things in conjunction to talk about, you know in healthcare, being role models, you need to sometimes be willing to make a fool of yourself, just to stand up for things that you believe in when other people are, are kind of stood still around you - you've got to be brave and courageous – and look at the difference one person can make"* (Meghan, I.2)

In contrast to the complexity she described, she noticed that visualisation felt tangible for people. At times Meghan paused, as though searching for memories. To role model, she reflected; *"you need to stand up for things you believe in"* asserting "*you've got to* be *brave and courageous"* (Interview 2). Meghan reflected, that although she doesn't like feeling uncomfortable, she likes the fact that "*out of that [uncomfortableness] comes learning. Looking back, it seems a very different approach from when I was a student, and as a newly qualified nurse*, which were *matriarchal"* (Interview 2). Context seemed important.

> *"it's the new kind of quality improvement approach that we're taking with all of our projects, is around you know, talking it to the staff, and to the patients, for them to come up with the solutions and I think, for me, with our quality improvement projects, the patient voice is still the smallest"* (Meghan, I.2)

As our conversation continued, Meghan portrayed a turning-point in her work, focusing on the present time, and research that shows happy staff lead to positive patient outcomes and experience. She explained; "*I can't now talk about patient experience without talking about staff experience"* (Interview 1). She described facilitating conversations, in a different way, spending time with teams so they feel supported and listened to. She reflected; "*they talked about how they felt… and they* felt *vulnerable"* (Interview 2). Meghan told me; *"it's not all about me",* continuing; *"it's my role to empower others to lead, that are closer to patients"* and to *"do staff engagement first"* (Interview 2). Staff engagement was very important to Meghan, increasing in significance in her view of leadership for public engagement.

"we are the NHS and they have absolutely every right to hold us account and ask the questions of us as a leadership team - so, yes I think we've focused on the staff engagement first because we've needed that to kind of start to change the culture in the organisation… my journeys changed… our journey as a leadership team is changing" (Meghan, I.2)

"…how I've then taken that [relationship] forward was more about in terms of with my board and director colleagues, trying to get them to a place where it's not a frightening thing to do, to talk to patients, and talk to staff, and to try to help equip them to do that, and to encourage them to do it… and actually, there's an inter-relationship between patient engagement, patient experience, and staff experience as well… so, we've done an awful lot more work about how we bring that together" (Meghan, I.1)

Listening to Meghan's evolving perspective on the inter-connectedness between public engagement and staff engagement resonated with the literature review where the implications of staff engagement came to the fore (Chapter 2). This profound discussion point is explored in Chapter 5.

For Meghan, making meaning of her leadership, in relation to public engagement, appeared to be a continuum of learning, not at an end. She told me; *"looking back I learned most in that period where I felt most uncomfortable"* (Interview 1). *Meghan* reflected that as her confidence has grown as a leader. She feels more confidence to be open to herself; "*to be more vulnerable", v*iewing vulnerability as a *"leadership tool"* (Interview 2).

"… that's where your learning comes from; it's your kind of in the wilderness experience, just being tested, being made to feel uncomfortable… but it does take a confident character to be able to say that, and to encourage other people to. If it feels uncomfortable that's really normal and embrace that. There's a lot of people that wouldn't, and don't, and therefore probably don't change what they do… they don't want change, you know, in terms of them specifically… I guess that is just a leadership tool that we need to think more about; that actually vulnerability is really, really important" (Meghan, I.2)

The issue of courage and vulnerability she suggested, we need to think more about. As our conversation came to an end, Meghan concluded*; "so, it's about care for patients, care for staff, care for the organisation, and that's sort of threaded through"* (Interview 1). Talking about patients, patient safety, quality and experience is part of every meeting she said; *"it's part of me - it's part of what I breath as Chief Nurse"* Meghan concluded that; *"it's about care for patients, care for staff"* (Interview 1).

4.5.2. Julie's story

Julie and I met at the entrance to the hospital. At the time of first meeting Julie, she was Patient and Public Involvement Manager. Her role, which she commenced three years earlier, marked a transition from her clinical background in nursing. As we engaged in conversation, Julie revealed her husband's need for emergency care in the hours preceding our meeting. Her professional and personal experiences seemed linked, nurse, wife, and leader. Julie described her leadership for public engagement as "*a bit of an evolving journey"* (Interview 1). Early in our conversation Julie conveyed the emergent nature of her leadership journey;

> *"I seem to have sort of ended up with this sort of interest in public engagement… I've ended up really trying to pull it together, a little bit, in my own very small way"* (Julie, I.1)

Julie cast her thoughts back. She paused briefly as she shared a glimpse of self-doubt. Julie recalled; "when *I came into my role, I probably had little knowledge*"(Interview 1). As I looked at Julie, I began to imagine the scale of the challenges that she had faced, sensing her confidence in her leadership role for public engagement unfolding.

As our conversation moved forward, Julie situated her role within the organisational context, as though taking me along her journey with her. Julie reflected on early memories in her role. She recalled feeling a sense of *"silos" of* engagement - *"it's quite fragmented and ad hoc"* - she observed little engagement at the beginning of her journey (Interview 1). Movement in Julies hands seemed to represent the silos she described.

> *"if I'm honest, it's quite fragmented and ad hoc. When I first came into post, one of the reasons… I seem to have ended up with this sort of interest in public engagement was that we had one member of the public who seemed to rotate on all of groups within the hospital. So, we were getting really only one person's voice, and that person was quite a well-informed member of the public; he sat on CCGs, (Clinical Commissioning Groups). So actually, it wasn't really truly representative of anybody… We've got a membership office who work very much on the membership side - we've got myself in patient experience - we've just got now an equality and diversity lead … but, it felt very, very much as if everything was working in a silo"* (Julie, I.1)

Learning from these early experiences in her role appeared to frame Julies leadership approach to public engagement. She described, "*reaching out"* and then "*working alongside*" other departments, organisations, and communities (Interview 1). Patterns of

connection and disconnection surfaced as Julie described her work in relation to engaging patients, staff, and communities.

> *"when you all join up, and the public can see that you're actually all singing from the same agenda, it feels better to them, because what they want is a joined-up approach to their health care services"* (Julie, I.1)

Julie described her work with others as "*really trying to pull it together in my own very small way"* (Interview 1). This term provided a sense of purpose that seemed to arise in response to the sense of *"fragmentation"* that Julie wanted to *address.* (Interview 1). A sense of this importance of connection appeared to emerge ; a profound state of engagement, where Julie was able to understand and value the others experiences at a high level. This appeared to have a positive impact for Julie, for her relationships with others but also impacting positively for her engagement with herself and self and her sense of self-discovery on how she identifies with public engagement.

Julie reflected on the complexity of the language of public engagement. She spoke of the "*masses of terminology that is used*" and of impact on how "*staff make meaning*". She asserted; *"I think sometimes we overcomplicate things for people"* (Interview 2). The tone in Julie's voice wavered as she appeared to contemplate her work quizzically. *"How do we make it easy for staff?"* she pondered. At times Julie paused, as though searching for memories. She recalled; *"I've always been clinical",* continuing*, "I've probably never ever thought of it as engagement"* (Interview 1). Context appeared significant for how Julie came to view and enact her leadership in relation to public engagement. Julie holds a fundamental belief that there is a "*need to make it simpler"* (Interview 2).

> *"… you know, I hope it makes people just stop for a moment and step back and think, why do we do it? Are we doing it for the right reasons? Are we getting it right? Could we do it differently? So, you know, I acknowledge it's only one part of engagement, but I suppose you know, going back to our journey, it's been such a powerful part of it for me"* (Julie, I.2)

It seemed that telling, and sharing, stories became central to Julies leadership approach. The passion in Julie's voice resounded as she told me; "*story is the most exciting part of my job"* (Interview 1). The way Julie identified with public engagement using storytelling was illuminated in our second conversation, as she shared her artefact, a camcorder (figure 4.11).

4.11: Julie's artefact: Camcorder – Key theme (the power of storytelling)

Artefact:

Early in our second conversation, Julie reached for her artefact; a camcorder. Julies' hands gently cradled the camcorder as she spoke. She told me that stories have helped people, from wards to the board, to "*step into somebody's shoes and see it through their eyes*" (Interview 2). Stories seemed important to Julie. They seemed to foster connection in relationships. Julie described her view of the; "*power that, that little tool [camcorder] wields".* She attributed the impact of stories on leadership to arise from several factors; *"seeing that person", "seeing the emotion", "seeing the joy",* and *"hearing in their own language"* (Interview 2).

> "*… it put the patient's voice in the arena, I think for the first time, in a very concrete way for our Trust board. And it made them stop and think what our patients were saying and what they're experiencing. So, this very useful piece of kit is highly significant to me and continues to be really. I think the power that that little tool wields by capturing people talking about what happened to them and what their experiences are is enlightening, and hopefully changes the thought process at times of our Trust board, and the direction of their agenda… I think it has made it [public engagement] real for the Trust board… and for anybody really, who's watched it*" (Julie, I.2)

She explained how she attributes *"stories at the board to result in different choices and ways of leading - "I think it has made it feel real"* (Interview 2). The camcorder sat between us. It seemed to remind us of its presence. It prompted attention to the lens of the camcorder, which I was facing. Metaphorically, the lens appeared to resemble the many perspectives (lenses) within patient stories; as though viewing peoples experiences from different perspectives.

"I think, sometimes to understand the real impact of that when you're reading it but actually to have person in front of you explain it, just adds another dimension and I think that's what's impacted most on people, is seeing that person and seeing the emotion or seeing the joy and hearing in their own language, although we edited it down, it's always given patient approval before we show it so, we never edit it in a biased way. So, I think that's being the power behind this little camera - it's actually brought a person to the room when perhaps we weren't in a position to always bring a person into the room" (Julie, I.2)

It was important to acknowledge that stories are not a panacea of good as defined, and discussed in Chapter 3 to reflect the importance of ensuring an ethical narrative. Although stories can be used in unethical ways (discussed in Chapter 3) evidence of unethical storytelling was hard to trace. Consistent with Julie, Anzors highlighted issues of ethics with her focus on the importance of "*justifying stories" and "authentic use of stories*", which is something Anzors calls "*judicious use of story*" (Anzors, Interview 2). She explained; *"I love storytelling and, I've emersed myself in stories for years, but now I just see stories being used and abused… you know, somebody wheeled out, telling a story, wheeled back again… So now I'm finding myself, justifying stories or authentic use of story… judicious use of storytelling"* (Anzors, Interview 2). Perhaps, one reason why unethical stories didn't form part of the data may be attributed to building trust, where leaders felt safe to tell their 'truth' and not use story to oviscapte, which sometimes stories can do, for example organisational stories.

As we neared the end of our conversation, Julie considered her movement along her leadership journey. She reflected; *"I* suppose *I'm not an overly confident person".* After pausing for a moment, she continued; *"I suppose it's made me more vocal - when you're fighting for somebody else's beliefs and voice… I suppose it's like your children, isn't it, sometimes? You've got much more of a voice when you've got a real cause behind it"* (Interview 1). It seemed that Julie had discovered a sense of her purpose.

"I suppose I feel like that with public engagement, that I've got responsibility, when people have told me things, to make sure that's heard, because I'm in a privileged position. So, I suppose it has shaped me in that respect… you've got to get it heard, and you have to keep batting on about it to get things moved and changed… It's pushed me beyond where I'm comfortable at times" (Julie, I.1)

Discovering a sense of her purpose seemed to foster a sense of courage and her commitment to public engagement in more creative ways.

"I don't think our policies and procedures have helped us in a way because they're very dry and flat, and I think staff need examples. I'm in that sense… it's like making it real for staff so they can see in concrete terms and understand it more" (Julie, I.2)

As our conversation came to an end, I asked Julie if she had any reflections. Her words resonated as she reflected deeply on the research conversation as a "*cathartic*" experience (Interview 2).

"*I suppose for me I've been thinking a lot about our meeting, and to me it was so cathartic in a lot of ways. It made me think an awful lot about where I'd come from at the beginning [public engagement role], raising a profile, to where we are currently, and where I want to go… So, on the back of that I went away and thought, I really need to just take hold of this, and start moving it forward. So, I had a really positive meeting with the trust chairman… so for me it's altered really… it's massive for me… so very much a sort of a reflective process… I don't know whether it's the first time I probably ever sat down with anybody in that time and talked about what public engagement means to me, and sort of where we were… I've never done that*" (Julie, I. 2)

It seemed that leadership for public engagement, can be lonely. She described how she made meaning about her leadership and public engagement within our conversation, framing, and re-framing her thoughts. Julie explained that following our first conversation, she met with the Trust Chair, which led to a new development of her leadership role. With notable pride, and a sense of confidence Julie was beginning a new chapter on her leadership journey, embarking on a role as Matron (acting).

4.5.3. Grace's story

Grace welcomed me warmly into her office. In Graces current role she is the Deputy Chief Operating Officer for this NHS Foundation Trust. Grace told me that her leadership in relation to public engagement followed a geographical relocation almost two decades ago. Her journey began with a temporary role, moving forward over time to her current leadership role. There was a passion in Grace's voice as she began to describe her views on leadership and public engagement. She told me; *"I am still learning every single day"* (Interview 1). Her work appeared to matter deeply to her.

Early in our conversation Grace cast her thoughts to early years at the Trust. She created a vivid picture of a particular service re-design experience, which appeared to hold significance in shaping her views on public engagement. She explained that this

experience was "*based on clinical research, but also based on the feedback from our patients*" (Interview 1). Grace described how she was especially inspired by one leader who she attributed to valuing the lived experience of patients equally to staff. Grace appeared to view this leader as a role model. She told me; *"that set me off really"* continuing, "*it was fundamental, I guess, in developing our model of care"* (Interview 1).

> *"I had a really inspirational senior manager at that point and things didn't happen unless they revolved around the patient - she was absolutely passionate. I'm lucky to have that role model to follow really. She was absolutely adamant that, as we were going through at every single stage when we're working with patients right from the beginning. And I can remember there being lots of debate about when we should bring people in and actually let's not get the public sort of involved at the moment - we don't want to raise our expectations when we haven't got the funding et cetera. I'm talking, over 20 years ago - she was absolutely clear that if we got the community involved in it, we would be able to reach the funding"* (Grace, I.2)

Despite the passage of time Grace held this experience close to her practice, as though modelling the approach for others. At our second conversation Grace shared her artefact metaphorically; a service improvement project. (figure 4.12).

Figure 4.12: Grace's artefact: Memorable service improvement project

Key theme (the power of modelling engagement)

Artefact:

Grace described her artefact, a service improvement project, as the co-design of a new building. She described her pride in the engagement that brought staff, patients, and families together. She created a vivid picture as she recalled her experience, and its influence. She told me; "*You know you're in a hospital… but it doesn't feel like you're in an emergency situation".* Rather, she likened it to "*much more like a hotel bedroom*"

(Interview 2). This appeared to form the foundation of Graces leadership approach to public engagement. She grounded her work by asking herself; "*Am I doing something that's making a difference for somebody? That's what drives me*" (Interview 1). Reflecting on her earlier experiences appeared to foster a sense of purpose for Grace in relation to her leadership and public engagement.

> *… it's shaped how I go forward. Because I think up to that point, I remember when I first, very first got a management position, I thought it was all about managing. (laughter) And this is this and off we go and I know the answers… And clearly that process of the [co-production] and how we went through [service re-design] showed me how differently things could be done and stayed with me… I know that I wouldn't have got to where I've got to if I haven't had that experience at the beginning"* (Grace, I.2)

As our conversation continued Grace talked about the passion that she felt for her role. Her voice appeared musical as she told me; *"I am passionate, absolutely passionate about it and, yeah, it's daft isn't it… I get quite... I love it"* (Interview 1). A wave of emotion felt almost palpable in the room. Grace searched carefully for words. A quietness. A small tear. I invited Grace to pause. After only the briefest moment Grace continued; "*I'm fine*" she said, before continuing. *"It's ridiculous - you don't take the time out, to think about those things do you"*. Grace reflected on what she described as the "*unexpected"* turns in the conversation (Interview 1). This indicated an emotional dimension to Graces leadership and public engagement, a human element. I sensed that we may both have felt unprepared for the emotional elements of our conversation, yet momentary discomfort quickly dispersed.

As our conversation continued, Grace paused, as though searching for, and contemplating memories before verbalising her thoughts; *"I've been in a role before here, and I didn't feel I was making a difference"* (Interview 1). Making a difference to people seemed to matter greatly to Grace. She described a time, of trying hard, but not feel listened to. This appeared profound, as though the enormity of this experience was etched in her thoughts. Grace described how frustrating and upsetting this chapter on her journey was. She recalled*; "Because I care about it so much, it just absolutely floored me, and I had to really fight hard to try and come back from that"* (Interview 1). As I listened to Grace's story, I imagined her courage as she moved forward on her leadership journey. She concluded; "if *I don't feel that I'm being able to make that*

difference and make that change, then I shout about it from the rooftops" (Interview 1). Grace's reflections seemed to surface a sense of vulnerability, which led Grace to show courage in her leadership.

I was curious to understand how learning from her experiences had surfaced, in Grace's awareness of her leadership. Grace told me that she had undertaken formal leadership development some years ago, an MBA, which included self-reflection within the programme design. Grace vividly recalled the uncomfortable nature of understanding more about your 'self', of feedback from peers, and of the new insights that emerged. Grace described how, from a personal perspective she considered this to be *"absolutely brilliant",* seeming to attribute understanding more about herself as a leader to this kind of reflective learning. She also acknowledged the courage that accompanied this; "*I think some people will have struggled with that insight and holding that mirror up to yourself because it's difficult"* (Interview 2).

> *"years ago I did my leadership course… it was a course unlike anything else I've ever done in the way that they approached it. It was all very much through reflexivity… it didn't feel artificial… so every single scenario we were going through, and experience we went through, which included public engagement… What that did, is re-emphasise for me that my role isn't about having an answer. My role is about questioning, and questioning, and questioning, so that we draw out whatever the right thing is to be done. And that's what I'm supposed to do… It was very real. And the feedback that we received from our own action learning… and the real feedback we're able to give each other, which at times was quite difficult, and the insights into my own behaviours and how I react when I'm in a stressful environment, et cetera. I would recommend that course to anybody; it was absolutely brilliant […] the approach was just wonderful, but some people struggled with that… I think some people will've struggled with that insight and holding that mirror up to yourself because it's difficult"* (Grace, I.2)

I was prompted to ask Grace about her values. She told me with conviction that although she could explain her values in a theoretical way, she considers her values come down to one thing*; "doing the right thing; whether that's for the patient, or whether that's for the staff, and treating people as I would expect to be treated myself"* (Interview 1). This fundamental belief appeared to rest at the core of her leadership practice. The leadership stories that Grace on public engagement, showed that the organisational view of public engagement was also shifting, placing greater emphasis on relationships and communications for staff and the public.

As our conversation came to its end, I asked Grace if she has any reflections on our meetings. She explained that when our first research conversation came to an end it prompted her to think hard about her role. She described how she thought about several things including, what she was doing, how she was feeling, what she needed to do to try and support herself in in making better decisions and making the organisation helping her have the time to make considered decisions, and not knee-jerk ones. She reflected on her learning from her self-reflection.

> *"I went home really and for several days afterwards was really mulling it over [reflecting] as to what could be done. It was quite – you don't get a chance to sit down and talk about these things"* (Grace, I.2)

4.5.4. Emerging local leader perspectives - Eastern Bay NHS FT

Key words and themes were derived from the initial analysis of the portraits to reflect the emerging perspectives of local leaders (Northern Bay NHS Foundation Trust):

- A fundamental shift in emphasis, to focus more on relationships; emphasised the importance of staff engagement (e.g., illuminated by Meghan).
- An emotional dimension to leadership and public engagement, including the impact of leading within an organisation in 'quality special measures'.
- A sense of these leaders' motivations for public engagement emerged from reflections on earlier lived experience and experience of feeling dis-location (e.g., Grace).
- Language of public engagement is considered overly complex. Meghan, for example used her artefact to convey an art to translating public engagement policy in ways that foster meaning and connection for others; "*simple", "creative", and "memorable"* (e.g., illuminated by Meghan, I.2).
- Storytelling was considered fundamental to bringing the patient voice to the Board e.g., a human connection, influencing changes in decisions, plans and behaviours (e.g., illuminated by Julie, I.2).
- These leaders reflected on the value of the researcher-participant conversation as a reflective space; reflective conversations were considered important but rare in the

system. The value and challenge of self-reflection and self-discovery was significant, e.g., *"hard to hold the mirror up*" (Grace, I.2).

> *"it was just the benefit of the space to think about what I do and why I do it - in terms of personal growth and focussed on the benefits of patient engagement… knowing what we were going through in terms of CQC (Care Quality Commission) and the benefits of engagement, which I could tell you academically, theoretically* - I guess for me it helped re-emphasise the importance of, of what we are doing, and the need to do more of it - so I think this moving towards the public engagement that we haven't done before - I'm not saying there's a direct correlation with the reflections of that, but it probably contributed for me, to how, to how I feel about the importance of engagement - *I think for me it was the public engagement… but it was also the staff engagement, that's really come home to me - and I think, since we last met because I've seen already the difference that true engagement can make… so it is just changing that mindset for me, but for other people - and kind of, you know it in your head that that's the right way to do it but sometimes it's very easy to let other things get in the way*… so I guess for me personally it's just that time to think about what does it really mean to me, how important it is, it's helped to re-emphasise that to me - and I've seen the benefits of doing both staff engagement and public engagement*"* (Meghan, I.2)

4.6. Western Bay NHS Foundation Trust - organisational context

A major acute NHS Foundation Trust serving a large geographical area. The Trust is dedicated to providing the best possible healthcare for the population it serves - over 300,000 people over several sites. The Trust aim is the continuous improvement of services, facilities and care for patients, staff, and visitors. The Care Quality Commission (CQC) overall rating was: 'good' (March 2018) - 'safe' (good) - 'effective' (good) - 'caring' (good) - 'well led' (good).

4.6.1. Aria's story

Aria is Director of Nursing for a large NHS Foundation Trust. There was passion in Aria's voice, which infused the room. She appeared proud to be a nurse, quickly casting her thoughts back to early experiences, revealing a sense of her professional values and ethos. Aria set her leadership role within the context of her community nursing background, including her experience as Chair of a patient experience group and former role as manager of a patient engagement department. It was easy to settle into this inviting conversation as Aria expressed how she identifies as a patient advocate; *"I see myself as patient advocate on the board"* (Interview 1). I was curious about what had led Aria

to her leadership interest in public engagement. Without hesitation she recalled; *"It was not* one single thing" but rather, *"a couple of appointments… it's stuck in my mind; it wasn't a good experience… so I've picked up things from a patient perspective"* (Interview 2). Learning from personal experience appeared to influence her leadership.

> *"there isn't one single thing, but I've had a couple of hospital appointments myself - well first it was when I was having the children, and some of those experiences weren't very good - the way people were spoken to; not just me but people around me, and that kind of thing. So, I've picked things up from a patient perspective. And then, I had a very minor procedure, probably about five, or six years ago where I felt the treatment was really poor; not the actual procedure itself, but the whole process -from going in there - being ignored - nobody telling me how long I was going to wait - people having a conversation between themselves and not including me - and you know, that kind of thing - so, that kind of reinforces it doesn't it, that it is not what people want… and this was a while ago but its stuck in my mind - I've remembered it - I've remembered it as a really, really, poor experience"* (Aria, I.2)

Connection between Arias' professional and personal experiences surfaced early in our conversation, as she expressed her strong sense of purpose, which appeared to frame her views on leadership and public engagement; "*we've got our sense of purpose as an executive team, we get it, and we all kind of get each other, but the big thing now is how you cascade that down to all levels of staff so that they know what we're about, you know, and, mine's a very short story" she told me;* "*it's all about the patient"* (Interview 1). Aria often wove professional and personal perspectives into the stories she told. As our conversation continued, Aria told me that she takes very seriously the number of local people who work for the organisation as well live in the community.

> "*when you live in the area that you work, your hospital is really important to you" continuing; "it is a big community of staff - it's huge - a really high percentage of them actually live in the area, particularly the lower bands of staff"* (Aria, I.1).

She viewed the organisations staff as a community - staff (and their families), using services along with the communities served. She reflected that as a large employer, the organisation has potential to attract members of the community into the workforce (employment, volunteer, membership). Throughout our conversation Arias sense of herself, and her family never seemed far from sight. She explained that this was because, her family values grounded her leadership perspective, and guided how she understands, and identifies with public engagement. Family values appeared to guide her leadership Aria told me; "*so this is what it's all about for me… it's all about building services that would be fit for your own family, and that's in everything that I do"*

(Interview 2). When I asked Aria about her values, and she told me that *"family values"* are the most important to her (Interview 2). The significance of family values was illuminated when Aria shared her artefact at our second meeting.

Our second meeting was the day of the well reported cyber-attack, affecting NHS organisations in England. Against this backdrop, my journey was accompanied by my own reflections. Aria arrived hurriedly yet committed to our planned conversation. Beyond words, I felt a sense of the values that Aria described enacted. Aria shared her artefact early in our second conversation; a family photograph. (figure 4.13).

Figure 4.13: Aria's artefact: Family photo - Key theme: (family values, lived experience)

Artefact:

Early in our second conversation Aria reached to her desk for her artefact, a family photograph. She told me she always has a photo of family at work. She pointed to a second photo of her grandson, recently born. Aria described her artefact in relation to the influence of family values on her practice.

> *"that's what it's all about isn't it [family photograph] - It's just an average photograph, but I do think I've always had a photograph of my family in some way, shape or form. It's always on my desk. I've always had a picture of my family. I've got a new addition now, because I've got a grandson, so I think I'll add him as well [points]. That is a brand new photograph - I only brought that today, he's five months old now. So, this is what It's all about for me. This is leadership for public engagement because it's all about, as I said before, it's all about building services that would be fit for your own family, and that's in everything that I do"* (Aria, I.2)

Family was important to Aria. It appeared to form a connection to her leadership in relation to public engagement conveying the importance of a culture of kindness and trust. Aria emphasised the importance of the organisational culture and sense of belonging. As if to affirm Arias views, a window cleaner appeared, during our conversation, outside the large office window, elevated on the first floor. My thoughts raced, concerned for distraction and recording. My concerns dissipated. With a brief conversation through the glass, and a friendly smile, the window cleaner changed his planned route for his work, offering to return after the close of our meeting. She described the influence of family values, on how she viewed her leadership, public engagement, her team, and the organisation.

"*it's like the [organisation] family. My team feel like a family, and the people that report to me are very senior people, but we still feel like family"* she concluded; "*this organisation has got a great culture for that; you know, for embracing that kind of family feel; you're ours, you belong to us*" (Aria, I.2)

Stories peppered our conversations. Stories appeared important to Aria as a way of making meaning, but also for connecting with others. Aria described how stories are embedded within Trust board meetings. She said, *"It's just a story. It's kind of everyday stuff for me, but the amount of discussion that it [story] actually generates at the trust board is amazing, and very often, the non-clinical people will ask questions that I would never have thought of asking"* (Interview 1). As though sensing my reflection, that stories seem so much more than the story itself, she described how they helped her to make meaning from experience, build relationships, and connect with others.

"I think the stories are probably the most important thing; I think that's where we learn most. It's the stories that are the most important because it's all about patient stories isn't it - it's all about knowing what what's happening to them, and what's already happened to them - it's about letting them tell their story isn't it – the stories for me are the most important" (Aria, 1.2)

Through the stories that Aria told, professional and personal experiences became inter-connected. She reflected; *"as a leader it is important to have that certain vulnerability, but the thing that strikes me most is how vulnerable patients are when they come into a hospital - so even me as a patient, when I walk into a hospital, even my own hospital. If I had to come here as a patient, I would feel extremely vulnerable and a lot of that vulnerability is not being in control isn't it, it's about losing that control and losing the*

control of yourself to others" (Interview 2). Aria reflected; *"there are times when I feel vulnerable as a leader as well, and I'm not frightened of showing that vulnerability"… "It's important to be human isn't it"* she said (Interview 2). As I listened to Aria talk of her vulnerability and human elements of her leadership a sense of courage felt present.

> *"as a leader it is important to have that certain vulnerability - but the thing that strikes me most, is how vulnerable patients are when they come into a hospital - even me as a patient, when I walk into a hospital, even my own hospital. If I had to come here as a patient, I would feel extremely vulnerable. A lot of that vulnerability is not being in control. It's about losing that control and losing the control of yourself to others. And there are times when I feel vulnerable in my role as patient advocate, when I've got others who don't advocate in the same way that I do. So, there are times when I feel vulnerable, as a leader, and I'm not frightened of showing that vulnerability. It's important to be human isn't it. I won't say that I've not cried with relatives who have come, and sat here, and told me about their experiences, and they've told me about their daughter who's died, who's 21. I've cried with them, not in tears, but I've been visibly upset, and not been able to control it. But I don't think there is anything wrong with that. I've certainly never had anyone have a complaint. And I think that patients, and public who are using services would be glad to know that we care enough to put ourselves in those vulnerable positions"* (Aria, I.2)

As our conversation came towards the end, Aria reflected on the emotional impact of her leadership*; "Sometimes it's not easy to be a patient advocate when there are lots of pressures around in a big organisation"* (Interview 2). She continued; *"There's been times when I've not always had the support that I've wanted but it still doesn't deter me"* (Interview 2). I felt a sense of Aria's commitment to working in relational ways, and her courage to do so. Aria highlighted the importance of kindness to others but also her personal challenge of self-care.

> *"I'm not as compassionate about myself, (laughs)… there is something about looking after you, and where you get your support from?"* (Aria, I.2.)

This seemed important to Aria, for herself, but also in her work to empower other people in her team, and organisation. Aria said; *"I think, if you're fair with people and you are compassionate you build a team that cares about you" … "I do lots of reflection - and my team reflect a lot as well, and the four of us meet together every other week, and we have a reflective session"* (Interview 2). Aria described the value of coaching conversations in her work; *"reflection is very, very, very powerful - you know, along with those coaching conversations reflection is really good"* (Interview 2).

The importance of learning from her lived experience resounded. She told me that patients and family are never far from her thoughts reflecting; "*patients are my conscience.*" She concluded; "*the thing that motivates me is that I like to treat people as I would like to be treated myself as I get older. I think there might be a time when I become a patient in hospital"* (Interview 1).

4.6.2. Harriet's story

Harriet and I met in her office, decked by documents. In her current role, Harriet is Head of Patient and Public Involvement, a role she describes with pride. A wall-mounted visual representation of the organisational values seemed significant in its presence. She explained her organisations enhancement in its Care Quality Commission (CQC) rating, and its recognition amongst health leaders nationally. It was easy to settle into the conversation.

Early in conversation, Harriet recalled vivid memories of embarking on nurse training, stepping away to marry and follow a different path. This seemed to mark the beginning of her leadership journey. Harriet described how, years later she returned to healthcare, progressing to her current role. Her early student nurse experience appeared important. She picked up a framed photograph, guiding her finger to her former team; *"This was my manager"* she said, her finger poised "*this was when we first set the xxx team up*" (Interview 1). Harriet described the loss of her former manager with sadness. She paused periodically, painting a detailed picture of her as an inspirational leader, role-model, and mentor. Her sense of loss of her mentor felt palpable.

> *"you do feel a bit lost… she was our patient voice of the board because she works with the board, or she worked with the board a hell of a lot - and I personally feel that I've lost the patient voice myself at the board, because she would always give her impact in, for that was a part of her role to do that - so I do feel I've lost somebody there, a connection… we've lost somebody good there so - a massive impact"* (Harriet, 1.1)

Harriet shared her fundamental belief about leadership for public engagement, asserting; "*we sell that staff engagement model because it's important - happy staff, happy patients*" (Interview 1).

"we have that connection - we're very close to the board… we're very close. I work a lot with the Director of Nursing. I have two people who I report to, xxx and xxx. So, I have two ways in really. And she does drive things forward as well… she does drive things, and she listens to us … we're like a family really here. That's the ethos of this Trust. You're like a family. And that's only come together with staff engagement; because staff engagement as well as public engagement, go hand in hand" (Harriet, 1.1)

Harriet explained that she holds the term; "*happy staff, happy patients*" closely in her work (Interview 1). She described using approaches, such as experience-based design, and capturing real-time feedback. Bringing public and staff engagement together led to her fundamental belief that staff engagement is vital. She emphasised using simple and visual ways, reflecting; "*if you have low staff engagement it correlates to public involvement results going down"* (Interview 1). When I asked Harriet about her values, she told me that she has; *"a lot of family values".* Family values seemed to matter most to her. She talked warmly of her team describing them as "family". She told me; "*we're like a family really, here".* The concept of her "*team as family"*, and the "*organisation as family*" was woven through our conversation (Interview 1).

"Family values matter most to me and I treat my staff as if they are family, even our governors…that's the ethos of this Trust… you're like a family" (Harriet, I.2)

At our second conversation Harriet shared two artefacts, a team photograph, and an employee of the year award (figure 4.14 and 4.15).

Figure 4.14: Harriet's artefact 1: Photo (team, mentor) - Key theme: (mentor, connection)

Figure 4.15: Harriet's artefact 2: Award - Key theme: (role model, mentor)

Artefact:

Early in our second conversation, Harriet reached for her first artefact, the photograph shared when we first met; a team photograph. She described her former manager, as a role-model in relation to her leadership and public engagement. Harriet paused, reaching for a second artefact, a glass plaque. With a sense of pride, Harriet described receiving the award of 'Employee of the Year' for her public engagement leadership. Harriet considered that this award was less about herself; "*you can't lead on your own, you have a team behind you"* (Interview 2). Harriet described how these objects symbolised her leadership and public engagement. Her eyes glanced towards the photo of her former manager creating a powerful picture of her as a role model, conveying a huge sense of both learning and loss .

> *"she taught me everything about patient and public involvement - she was my line manager, but she taught me everything I know. I led on my own when she left. She gave me that, you know, support really, to lead on my own, and I did. I've lost my right-hand woman".* Harriet told me*; "I feel a little lost"* (Harriet, I.2)

Harriet appeared to greatly value the sense of connection she felt to her team, and her organisation. She re-enforced the significance of her investment in relationships with her team and people she engages with more widely*; "we have a team approach"* (Interview 2). As our conversation continued Harriet reflected on her sense of self-understanding. She said*, "I lead in a quiet way"*. Her mentor appeared to have played a significant part, in paving the way for Harriet on her leadership journey. She appeared to have inspired Harriet, but also exuded confidence to her. Harriet expressed elements of vulnerability and courage, in response to the loss of her mentor.

Against this backdrop, Harriet's public engagement leadership focused on relationships; *"relationships"* she told me *"are important, very important"* (Interview 2). Perhaps reminiscent of her mentoring experiences, Harriet told me that she had recently engaged in coaching. Although her coaching experience was short, she associated this with developing a greater understanding of herself. She told me; *"that bit of coaching was good for me" and continued; "I think that has taught me a lot. I've got stronger"* (Interview 2).

As our conversation came to an end, Harriet reflected; "*I think, when you talk about leadership you don't realise what you do you really - so it was nice to get things out and talk about the things in that leadership role for patient and public involvement - I really enjoyed it, I thought it was really, really good"* (Interview 2*).* For Harriet the research conversational space seemed important for making meaning on her leadership. She conveyed an emotional element to her leadership for public engagement, which resounded as she described the importance of connection that she felt with her team and her organisation. Harriet concluded; "*we all have a connection*" (Interview 1). Connection was important to Harriet.

4.6.3. James story

To harness the potential for public engagement in healthcare has become James's work. I met James at the beginning of the day. His current role of Membership Manager forms an established part of the organisations Patient and Public Involvement department, of which he talks of with pride. James told me that he had not always worked in healthcare, situating his leadership role against the backdrop of an early career in sports education. I was curious about what led James towards his work in healthcare. He told me that a conversation with his mum, first led him to an introductory role within the Patient Advice and Liaison (PALS) team, around the time of the hospitals transition to Foundation status. It was easy to settle into this inviting conversation as James told me, of public engagement; *"It's something that we've always done"* (Interview 1). James experiences showed how a single conversation came to have a lasting influence on his leadership journey towards public engagement.

Early in our conversation, James shared his fundamental belief that happy staff lead to happy patients. He told me; *"without happy staff you are not going to get happy patients; it's as simple as that"* (Interview 2). James appeared to make a connection between public (patient) and staff engagement and experience, in a way that appeared central to his leadership approach. He described how experience-based design had become embedded in his work, reflecting that; *"with involvement we would involve both patients and staff, so you get both sides of the development going through a pathway"*

(Interview 1). James views experience-based design as a way of "*just getting staff on board - happy staff, happy patients*" describing how he welcomes good and bad experiences alongside each other (Interview 1). James paused as though re-visiting his experiences, recalling how he noticed that "*the patients feel more open if they have staff there to speak too*" (Interview 2).

> *"with engagement we would involve both patients and staff, so you get both sides of the development going through a pathway… It was just getting staff on board. So, this is 'happy staff, happy patients' or so they say. I mean, it is two ways of working… We have a whole staff engagement department that's separate to ourselves. But we do work closely together. It just makes more of an event. The patients feel more open if they've got staff there to speak to… which makes it a generally happier atmosphere"* (James, I.1)

As James continued to share his views on leadership and public engagement, a paradox seemed to surface, staff and public involvement departments sitting separately in the organisational design. Any sense of dis-connection seemed to be dispelled by a collaborative approach. The boundaries that James described so vividly appeared almost illusionary as he continued; *"we have a whole staff engagement department that's separate to ours, but we do work closely together, and it just makes more of an event"* (Interview 1). Bringing together patient and staff engagement, and experience seemed to form the foundation of James wider work.

As our conversation continued, James moved his attention to describe the organisations commitment to real-time feedback, attributing these conversations to team achievements, and enhanced performance of the organisation. He told me; *"we can monitor those and track improvements throughout the year, and it's been seen to improve the national survey results to the next year"* (Interview 1). His views were further compounded by his noticing that, at times when staff morale had been lower, patient feedback on the quality of their experience also lowered. Our second meeting appeared to signify a turn in our conversation. At the second conversation James shared two artefacts, a medal, and a family photograph (figure 4.16 and 4.17).

Figure 4.16: James's artefact 1: medal - Key theme: (purpose, connection)

Figure 4.17: James's artefact 2: Photo (family) - Key theme: (values, role model)

Artefact:

James shared two artefacts early in our second conversation. James reached to his pocket revealing first one, and then a second artefact, each representing his leadership for engagement in different ways. James began by holding a medal, graced by a brightly coloured ribbon as though reflecting its glory. With a smile on his face, James recalled vivid memories of a charity race. He described how he ran with his mum who was a senior healthcare leader. James described a reciprocal relationship. He recalled leading his mum around the stadium, drawing parallels with his leadership role for engagement.

> *"its' all about getting up and getting involved and trying to get people to engage with you. And then once people start that journey, trying to maintain and keep them with you, which is a bit like the journey around the stadium - giving them encouragement to keep going on that pathway, on that journey"* (James, I.2)

Tones of pride and sadness were notable, as James shared that his mum, who was a senior leader in healthcare had sadly died, just before the recent birth of his son. A wave of emotion washed over the room. The unfolding of James story seemed to resemble the unfolding of his leadership journey. Within the pause, there was a quietness. James continued, taking his hand to his phone, guiding me to photograph.

"upon the birth of my new boy recently, the team, the engagement team I am part of, got together, and they made this for me, which is a photo of my mum, with my new baby - it's absolutely amazing - it's overwhelming… "part of the leadership there for me is passing on leadership in essence… and pulling on the knowledge and experience that my mum lent to me… she [Mum] *was an inspiration to me, and again, she was always patient champion for the Trust - so an inspiration for lots of other people as well"* (James, I.2)

The nature of the photo shared seemed incredible in its significance. James personal and professional experiences seemed intrinsically linked to his leadership journey. I recalled our first conversation, in which James described his Mum first leading him towards his role for public engagement, a contrast to his early career in education. Reflecting on his early and lived experience, appeared significant in influencing James leadership journey - his mum, an inspiration and role model, her values touching James leadership journey, and beyond. Together James chosen artefacts; a medal and photograph, seemed to form a conduit for representing a sense of James professional identity in relation to his leadership for public engagement and meaning making around this. The influence of James's mum, on his leadership and public engagement practice resounded.

As our conversation came to an end, James seemed to portray a metaphorical picture of his team and organisation, as a family. James illuminated his appreciation of the value of kindness which he described of his team, of their gift of a remarkable photo. James described this act of kindness simply; "*it's absolutely amazing, overwhelming*" (Interview 2). Thus, the quality of relationships formed a fundamental aspect of James leadership journey; not at an end, but rather a series of new beginnings. James concluded; "*we are very transparent in this Trust - we don't like to hide anything so we will literally say it as it is*" (Interview 2). As our conversation came to an end James reflected on the fundamental role of staff engagement in his public engagement leadership role.

"without happy staff, you're not going to get happy patients - it's as simple as that" (James, I.2)

It appeared that the quality of relationships was vital. Our conversation was at an end; I wondered, if we only had one conversation; would this have been a different story told, a different portrait.

4.6.4. Emerging local leader perspectives (Western Bay NHS FT)

Key words and themes were derived from the initial analysis of the portraits to reflect the emerging perspectives of local leaders (Western Bay NHS Foundation Trust):

- Recognition of the evidence that better staff engagement and experience leads to better patient experience and outcomes for all. All expressed the mantra "*happy staff, happy patients*" (Aria, Harriet and James).
- A strong sense of connection with the communities served, viewing the organisational staff as a "*community*" -many staff work and live in the area, thus a personal, vested interest (e.g., illuminated by Aria, I.1).
- A strong sense of 'family values'. All these leaders used metaphor to describe their team(s) and / or "*organisation as family*". This was summed up best by Aria; "*this organisation has got a great culture for that; you know, for embracing that kind of family feel; you're ours, you belong to us*" (Aria, I.1).
- A fundamental focus on the importance of relationships; for example, a) coaching conversations (e.g., illuminated by Aria) and b) culture of kindness (e.g., James, I.2).
- In contrast to stories of policy, these leaders shared deeply personal experiences of vulnerability and courage. Their motivations for public engagement did not begin with policy or professional practice but rather, were untapped often by deeply personal experiences of dis-location, learning from lived experience.
- Self-discovery appeared important for these leaders, situating their self within a leadership context for public engagement.

4.7. Summary of participant selected artefacts

In total 17 artefacts were shared by the 12 participants. For each participant the artefact shared, and the context of each artefact is summarised below (table 4.1).

Participant	Participant artefact	Number
Tess	Driftwood	National 3
Mark	Jigsaw (double-sided)	
Jill	Candle (lit)	
Anzors	Article (Don- Berwick) SharePoint	Northern Bay NHS FT 5
Peggy	Revolving door Bouncing ball	
Oliver	Tap on the shoulder	
Meghan	Garden rock Water ripple (PowerPoint)	Eastern Bay NHS FT 4
Julie	Camcorder	
Grace	Co-production (project)	
Aria	Photograph (family)	Western Bay NHS FT 5
Harriet	Photograph (team) Award (organisational)	
James	Photograph (family) Medal (charity)	

Table 4.1: Participant selected artefacts summary

Of the 12 participants only one opted not to bring an artefact initially. For this participant, the terminology clouded their understanding of what an artefact is. Once the concept of artefact was discussed in conversation this participant immediately shared an artefact, which he described metaphorically. Participants chose which artefacts they wished to share within the second interview and how they wished to share these; by bringing objects or describing virtually. Permission was requested at the interview to photograph the artefacts. Where this was not possible, for virtual artefacts, permission was sought to source a representational image. Copies of the photographs representing the participant artefacts were printed. These were shared with participants as part of the member-checking process.

4.8. Conclusion

This chapter has presented the data collected through narrative interviews combined with participant selected artefacts. The leadership portraits show interpretive insights on how participants identify with public engagement from a variety of perspectives. Each leadership portrait conveys the individual nature of their leadership journey in relation to the views they hold on relational leadership in healthcare. Leaders' artefacts were key

to getting closer to leaders' construction of identity. Artefacts were viewed as a 'metaphor of self' (Hoskins, 1998, p.198) appearing to foster connection, with the artefact, self, and others.

The chapter shows that modelling relational leadership practice through the process of the research conversations, and scaffolding leadership portraits, is not only a research tool, as described by Lawrence-Lightfoot and Hoffman Davis (1997) but acted as a development tool too for participants. For some leaders this was the first time they had the opportunity to experience this kind of conversation. In contrast other leaders had engaged in reflective conversations but still viewed the portrait as a development tool. Jill is an example of this. She reflected that; "*while I have had conversations about some of the contributing elements, I cannot recall a previous circumstance where I had talked 'out loud' about so many strands and influences within a single conversation. In essence the conversation and the portrait have created, for me another level of connectedness."* (Jill, portrait feedback). The leadership portraits provided a space for participants to reflect on their self, their leadership perspectives, and their contribution to public engagement. The research conversations, using narrative combined with artefacts were considered by Mark to reflect; *"the hallmarks and principles of effective collaborative engagement."* The relational approach described in this study is not only a research tool but emerges as a potential leadership development tool too (discussed in Chapter 8).

The following chapter provides a synthesis of the twelve leadership portraits bringing together emerging themes from participants stories. The synthesis acts as a bridging chapter before moving to the data analysis themes, which are discussed in-depth in Chapter 6.

5. Chapter Five

Synthesis of the stories

5.1. Introduction

The previous chapter presented each participant portrait to show their individual leadership perspectives on how they identify with public engagement. Using narrative interviews combined with participant generated artefacts enabled layers of interpretation to be made. This chapter provides a synthesis of the twelve leadership portraits bringing together emerging themes from participants stories. As discussed in Chapter 3, Voice-Centred Relational Analysis (Mauthner and Doucet, 2003) with its focus on complexity of voice, illuminated leaders experience through multiple and sometimes contradictory ways of thinking about, and identifying with public engagement. With the complexity of voice in mind the synthesis of findings is organised to consider leader perspectives relation to their self, their relationships with others, and their leadership context.

The synthesis of stories is inevitably conceived through the subjective lens of a qualitative researcher. As discussed earlier (Chapter 3) there were many ways that the research evidence could be organised to address the research questions as framed by the methodological discussion. There are multiple truths, and many stories that could be told. The leadership portraits (Chapter 4) already represent an interpretation of leaders' experiences, their perspectives, and ideas, which are developed further through the synthesis (Chapter 5). This leads to the data analysis themes (discussed in Chapter 6). Chapter 6 adds a further layer of analysis to the work undertaken with participants stories, using Ganz (2010) relational orientation to provide a frame, to test my analysis and enrich perspectives of the findings.

5.1.1. Research interview

The research interviews began with an overarching question; "*Tell me about what public engagement means to you"?* All the participants shared the fundamental view that leadership for public engagement is *'relational'.*

> *"Fundamentally it's relational - it's about the quality of the relationship that the organisation builds with the community… many organisations don't see it as relational instead seeing it as ' process…how we see the world influences our conversations and our behaviours… the trouble is we come with our own prejudices and beliefs and assumptions"* (Mark, I.1)

5.2. Perspective of self

How leaders described self from a relational perspective.

*In this view of the data: a focus on leaders' individual **stories** - their **vulnerabilities** - their **motivations** sparked often by stories of **dis-location** (experience of **dis-engagement)** - their sense of **curiosity** (purposeful curiosity, courageous vulnerability) - their **courage** (understanding values, dancing with those values, reaching out to others). Participants confidence for collaborative practice appeared to come **self-discovery** (reflection, self-understanding) and owning who they are on their leadership journey (**connection**, connectedness, belonging).*

I was nervous as I approached the data as each participant transcript felt akin to holding a piece of treasure, a gift. It was important to trace the points of connection and contradiction with a deep care to capture the multiplicity of perspectives authentically. In contrast to other participants Oliver (p.114) was surprised that he had been asked to contribute to this research about how healthcare leaders identify with public engagement. He was primarily concerned with quality improvement and motivated the scholarly research, which evidences the link between engagement and performance; fewer errors, improved wellbeing, and morale engagement improve his organisations performance (discussed in Chapter 2).

Whilst many participants were able to express often deep-rooted motivations for public engagement, all were able to describe how they identify with public engagement. It is worth noting that most of the participants were able to identify with a memory, or incident(s) that ignited their **curiosity** about public engagement. This appeared to foster

a deep sense of **purpose** and **connection**. Tess for example, reflected; "*it [community story] sparked it off… there's been several incidents since then with people around me, who've been ill, that I felt I've had to battle on their behalf sometimes… and each incident… it kind of just nudges me that little bit more*" (Tess, I.1). Consistent with Tess, significant moments came to signify self-understanding. This kind of self-understanding was summed up by Jill who reflected on a recent coaching conversation, which she attributed to grounding her leadership; *"my leadership beliefs, values and style is driven by very, very early experiences*" (Jill, 1.1).

> *"I had this brilliant coaching conversation… I think this has just landed so many things and I connect back to when I was working as a speech and language therapist [story] But for me that was all just always about letting their voice be heard. So, I think my leadership beliefs, values, and style is actually driven by very, very early experiences, very early experiences… [story of 'being on the edge at school]…I think that confidence actually comes from just kind of owning who you are and your journey - and noticing how that impacts - noticing how you impact on others and noticing how others impact on you"* (Jill, I.1)

It was interesting that when I set out on my doctoral journey, I expected to hear stories of engagement. What I heard often were stories of dis-location (dis-engagement), personal and professional; e.g., childhood, *"being on the edge*" (Jill, I.1), "*cultural*" differences (Anzors, I.2) - caring for loved ones, "*personally very aware of how it feels to have been disempowered by the health service"* (Tess, I.1) - living with a long-term condition, "*the way it was treated… just signified and symbolised sort of things breaking down, and not working, so what I did was I put myself outside of the system*" (Mark, I.2). Several participants shared stories of dis-location in their professional practice, reflecting the leadership of others in ways that influenced their public engagement work. Tess described the early influence of her manager (former) who she explained; "*had all these wonderful ideas that we were going to do, and she came up with all these strategies, and plans, and we didn't actually ask other people what they wanted*" (Tess, I.1). Grace illuminated the emotional impact of "*trying hard but not feeling listened to*" (Grace, I.1).

Thus, in these twelve leaders' stories issues such as vulnerability and courage came to overshadow those of policy and process. It indicated that the starting point was not with process but rather a focus on **self-discovery**. Participant selected artefacts (summarised in Chapter 4, 4.8) were key to getting closer to participants construction of

identity. How stories and artefacts contributed to leaders identifying with public engagement is addressed later (see 5.4.1 and 5.4.2) and discussed in Chapter 6 (6.3).

It is perhaps not surprising that leaders' stories on motivations for public engagement, were often deeply personal, spanning their life cause. The act of connecting with significant experiences seemed to ground their understanding of public engagement and ground their desire for relational practice with the public - and staff. When participants described moments of this kind most experienced a heightened sense of connectedness (e.g., Jill's leadership portrait). Consistent with Jill, expressions of connectedness seemed to be bound by their willingness to lean into their **vulnerability**. As one participant put it; *"there are times when I feel vulnerable as a leader… I'm not frightened of showing that vulnerability. It's important to be human*" (Aria,I.2). In that sense it might be said that vulnerability was important. One participant re-framed her view of vulnerability, seeing this as; *"a leadership too that we need to think more about*" (Meghan, I.2).

The aspect mentioned most frequently and passionately was 'feeling' engagement. This implied an emotional dimension to building collaborative relationships. The following are several typical examples; "*it's a feeling thing*" (Jill, I.2); "*how your staff are feeling*" (Jill, I.1); "*the feeling of powerlessness*" (Jill, I.2); "what a good conversation feels like" (Jill, I.2); "*feeling included is important*"(Jill); "*feeling real*" (Oliver, I.1). This seemed to go hand in hand or be associated with leaders view that is okay to lean into vulnerability. Here vulnerability did not emerge as a sign of weakness but rather a quality of relational leadership that was closely associated with **curiosity** and **courage**. Mark reflected on the "*whole language, and their metaphors that were all about systems and procedures and processes… and, and the challenges that were going on*" He posited that some leaders may become "*divorced from the emotional feeling part of what was going on for them as a leader, and then I realised that they were dis-connected … people were completely lost*". He attributed this to when process overshadows the relational aspects of leadership. Mark encouraged self-reflective questions; '*so what does this mean for you, personally, as a leader'? - 'how are you feeling about what you are doing'? And that to me is critical*" (Mark, I.2).

In sum, the picture that emerged in the twelve stories was of a very human leadership. The desire of these leaders to make a difference to public engagement took them through extraordinary professional and personal challenges. Most participants associated their curiosity about building collaborative relationships with acknowledging their vulnerability, in ways that came from their sense of **self-discovery**, and self-understanding. Only once they had **connected** with their own sense of self-discovery did they feel confident in their leadership for public engagement. The following was a typical example; "*I just learnt you just kind of engage them by being your authentic self really - it helped me understand that you just need yourself. You don't need kind of tool kits and anything else, fundamentally it's about you… that confidence comes from owning who you are on your journey*" (Jill, I.1).

One of the significant discoveries was the importance of leaders' **self-discovery**. These leaders showed that how we engage with ourselves as leaders acts as a gateway to being able to engage others (e.g., Mark, I. 2). The significance of self-understanding was illuminated by Grace. She shared her own journey of reflection and reflexivity using the metaphor of mirror. More widely, she concluded; "*some people really struggled with that insight*" (Grace, I. 2). This resonated with the seminal work of Gillie Bolton (2005) who uses the metaphor of mirror in her writing on reflexivity, which is viewed as in-depth reflection on reflection (Bolton, 2014). This is discussed in Chapter 6.

However, leaders depicted a starker impression of the emotional impact of becoming, being and sustaining relational leadership (e.g., Anzors leadership portrait). The issue of the conditions for supporting collaborative practice is discussed in participants perspectives of context. This was where artefacts came to the fore - for example; the 'driftwood' story shared by Tess conveyed the "*loneliness of leadership*" (Tess, I.2) - the 'jigsaw' story shared by Mark conveyed the complex and ongoing nature of "*identifying*", "*dis-identifying*" and "*re-identifying*" as a leader (Mark, I.2) and Jill used her 'candle' story to convey the importance of attending to creating the conditions that support self and others to "*shine brightly*" (Jill, I.2).

5.3. Perspectives of relationships

How leaders described relationships with others.

*In this view of the data: participants focus was on **relationships** with public and staff (‘**shining the light on relationships’**) - **role modelling** behaviours (**curiosity, courage**, presence, **kindness**, creating emotional safety) - **different conversations, different relationships** (**creativity** dialogically, visually) - being a catalyst for change (relational approaches, **relational depth**, helping people translate**,** preparedness, relational maturity).*

This view of the data was an attempt to get in touch with leaders’ relationships by not just listening to, but searching for, the story leaders wanted to tell (Lawence Lightfoot and Hoffman Davis, 1997). In this view, I sought to explore the twelve leaders’ perspectives of their relationships with the public, capturing their ideas about what motivated and excited them, their concerns, their cares, and aspects of their leadership in which they chose to invest most heavily. Scholars such as Cunliffe and Erikson (2011) and Koloroutis (2020) suggest that not enough attention has been paid to the relational aspects of leadership and public engagement, but this based on the assumption of hegemony (Chapter 2). Consistent with this view, participants reported how public engagement led to a level of collaboration and genuine relationship that has hitherto been under-reported and relational leadership is discussed as a perspective.

All participants emphasised the importance of **relationships** in their work. This was summed up by Anzors who used the metaphor; “***shining the light on relationship***” (Anzors, I.1)**.** Here, leaders spoke passionately of the ways they worked with the public, but also with staff, formerly and informally. The intensity of public engagement work was summed up by one national leader; “*it is at the core and heart of everything I do… it just completely infuses”* (Mark, I.1). Mark found the dominant discourse on policy and strategy contentious. Rather, than be driven by policy he advocated “***role modelling** engagement principles and behaviours*” (Mark, I.1). Similarly, Anzors reflected on how **role modelling** relational qualities came to matter so deeply. This is because she likened her approach not as process, but rather a more “***curious discovery***” (Anzors, I.1).

"He [CEO] absolutely got the business case for it [public engagement] and knew what healthcare should be about and we've lost that sometimes in places where there, well in Mid-Staffs where the financial bottom line, at all costs, blinded people to the importance of relationships, and shining a light on relationships, and the impact of staff, and staff experience and its impact on patient experience" (Anzors, I.1).

One of the discoveries in the data was the emphasis the participants placed on staff engagement in their public engagement work. One way that participants fostered this deep sense of connection was through their resounding belief that; "*staff engagement as well as public engagement go hand in hand"* (Harriet, I.1). As discussed in Chapter 2, organisations that engage both public and staff, are found to achieve better outcomes. (Section 2.4.7). This **connectedness** between public engagement and staff engagement was widely held as a component of relational leadership, cultivating collaborative relationships with the public. This was summed up by Jill who asserted; *"the only thing that will ever improve the experiences of patients is the experiences of staff"* (Jill, I.1).

Participants, such as Mark suggested; "*how we see the world influences the quality of our relationships and behaviours*" (Mark, I.1). Specifically, many participants emphasised the complexity of the language as a barrier to public engagement. Consistent with this view Jill contemplated a paradox around the complexity of language. She highlighted that as leaders we tend to be "*very verbally-based*" positing that we are "*less good at translating*" (Jill, I.1).

"we tend to be very verbally based in the way that we manage engagement … although we are perhaps good at talking to people who know what we are talking about, we're less good at actually translating" (Jill, I.1).

Findings concur with the All-Parliamentary Report on Creative Health (2017) that "*the arts can be enlisted in addressing a number of difficult and pressing policy challenges"*, such a public engagement (p.5). As discussed in Chapter 3 **creativity** was found to help connect these leaders to memories and significant events. Several leaders described how using **creative approaches,** such as visualisation supported **self-understanding** for others (e.g., Meghan, 1.2). This is because it stimulated emotional engagement, and connection between policy, regulatory requirements (espoused values) and leadership behaviours in everyday practice. Meghan was one leader who described the use of

visualisation in her work (Meghan, I, 2). As another participant, Tess said her work was "***helping people translate***" (Tess, I.1) and "***frame***" their understanding (Tess, I.1).

With the complexity of language in mind, several leaders, like Tess emphasised the importance of helping others "*translate*" (Tess, I.1). In this respect cast themselves as catalysts of change, choosing to engage in what they perceived as **relational approaches** such as; storytelling (e.g., Julie, I.2, Aria, I.2), coaching (e.g., Jill, I.1), experience-based design (e.g., Harriet, I.2) and real-time feedback (e.g., Anzors, I.2). Creativity showed up in leaders dialogic, narrative, and visual practices. This means the nature of leaders' conversations were central to their relational work. This is something Mark called; "***different conversations, different relationships****"* (Mark, I.1). With the focus on conversation, it is perhaps not surprising several participants discussed coaching in their practice. Coaching was viewed as a positive source of relational support (e.g., Jill, I.1). However, what became evident was that coaching was more accessible to more senior leaders; access to coaching was not equitable for all leaders.

> *" language is critical for creating the way in which we make sense of the world - it influences our behaviours - it influences the decisions and choices we make - it even impacts our thinking and therefore it continues to influence the world we create for us… I'm also aware that it can be* ***really*** *hard for others to translate that into practice - (pause) and its hugely challenging about how we do it - because for people - because it's part of how we make sense of the world its incredibly difficult to dis-identify - to step back - it's a real art and skill of what I believe is self-awareness - to step out of and look back and see this going on - the STP process and that conference was an absolute classic example of that - so there's a power to the language used by senior leaders in a system which fundamentally talks about processes and procedures – works within a machine like metaphor logic, rational, diagnostic, expert, fixing um - so that if you are on the edge of that it can be incredibly dis-empowering"* (Mark, I.2)

Being a **role model** appeared to be testimony to leaders' perspectives on the potential for transformation by shining the light on the relational aspects of their work, which sparked peoples' thoughts, ideas emotions and action for public engagement. For these leaders role modelling **relational behaviours** was about how they showed up and the value they placed on making connection, often at a deep level (**relational depth**). The data conveyed the reciprocal nature of modelling relational behaviours suggesting that for leaders modelling public engagement, we get back what we give (Marks portrait feedback, 5.7).

In sum, in the case of my participants, public engagement leadership was seen not as a process or policy commitment. Rather, it emerges as a natural part of their identity as a person and as a healthcare leader. Findings suggest it is important for leaders to understand public engagement approaches, not as good or bad, or right or wrong but rather as a relational endeavour with a relational sensitivity in the way that they work. A typology emerged from the data (discussed in Chapter 6). Each approach described adds value if it is conscious and contextual. How public engagement leadership looks in practice is nothing sophisticated or complex; it is contextual. It emerges as an expression of **relational maturity**, a kind of mastery of leadership for public engagement - not technical mastery of public engagement process but conscious relational approaches resulting from reflexivity in their practice.

A final view was achieved by synthesising the part of participants stories that expressed leaders' ideas around what they felt was important about what they had to do and in relation to their leadership context. The next section represents my synthesis of leaders' roles and identities according to their understanding of the influence of context.

5.4. Perspectives of context

How leaders described their leadership context-the importance of relational depth.

*In this view of the data: participants focus was on the power of **connection - connectedness** (coherence of personal, professional, and organisational **values** - their emphasis was on **kindness**s (cultures of kindness, sense of belonging) - **emotional safety** (investment in staff engagement and wellbeing - **reflexivity** (these kinds of reflexive conversations are shown to be important yet considered rare in the NHS system, reflexive space).*

There was a widely held view on the complexity of language. Oliver for example, began from the firm assertion that; "*it's a funny set of words*" (Oliver, I.1). The paradox around the language of leadership and public engagement resounded as Tess so aptly put it; "*the language - the one thing that really hits home with me and how un-inclusive it is*" (Tess, I.2). In contrast to the fragmented picture of leadership and public engagement in the literature review (Chapter 2) many participants in my study expressed their

experiences holistically. Professional and personal experiences appeared intrinsically linked. A more holistic view of leadership and public engagement was encouraged, to address the relational dynamic of leaders' social world. This was best captured by Jill who contemplated the **inter-connectedness** of our roles at different points of our life, as patient or leader.

> *"Patients, staff and the public are cast as if they were three entirely separate cohorts, but actually in real life they are all the same people playing different roles at different times… there is something incredibly important about understanding and responding to the connectedness of those cohorts… you can't stop being a patient, and likewise if you're a member of staff and are also receiving services you can't kind of suspend the impact that that is having on you"* (Jill, I. 1)

Many participants made direct reference to 'family' and the influence of detailing values, such as family as a significant aspect of enacting their leadership role with the public across organisational contexts. Participant set out strategies that they used to help them to develop and sustain collaborative ways of working in their role. From a local leader perspective many participants expressed strong family values conveying their influence in relation to their organisation. Leaders like Aria (Western Bay NHS FT) and Peggy (Northern Bay NHS FT) consistently expressed their identities within their organisational context as "***organisation as family***" *and/or "****team as family****".*

The metaphor of family was conceived sometimes in terms of improvements in quality as reviewed by the Care Quality Commission (CQC). Although this research was not interested in analysing the organisations it appeared important to acknowledge a contrast with Eastern Bay NHS FT where the organisation, which had been placed in special measures around the time of the research interviews. Meghan was acutely aware of her responsibilities in this respect. At the Eastern Bay NHS FT Meghan, a Trust Board member, chose to direct her energy towards staff engagement and wellbeing, displaying creativity in her practice. Her own philosophy of change had a powerful influence over the ways in which leaders Julie and Grace conceived their identity and the extent they felt trusted and empowered.

Despite the impact of external requirements for public engagement, these leaders were encouraged by the relational focus of their work. For example, six of the nine local

leaders talked of their teams and **organisation as family** revealing a positive impact on their organisation's performance better (reflected in the CQC). In these organisations the importance of a **culture of kindness** was conveyed. If the concept of 'kindness', 'kinship' and 'intelligent kindness' as defined by Ballatt and Campling (2011), are important we need to consider ways to develop this *exercise*. This is discussed in Chapter 6.

Looking across the participant stories highlighted the importance of attending to the relational dimension of their practice relationships with others, self, and context. As discussed in Chapter 7, the picture that participants painted in their stories was of a very human leadership where their desire to make a difference to public engagement has been able to flourish and take them through extraordinary professional and personal challenges. Leaders' stories often reflected earlier experiences of **dis-location** (dis-engagement). Their stories showed how, through their leadership they have tried to make engagement work for those they are responsible for and through policies they deliver. One of the greatest challenges to public engagement was viewed as mindset. As one leader put it the greatest leadership challenge for public engagement is mindset.

> *"The greatest challenge to public engagement is the mindset which perceives engagement as an instrumental diagnostic transactional, mechanistic process, because they're lost within a mindset that sees their organisation as a metaphor for a machine"* (Mark, I.1).

Perhaps less predictable but crucial was the strength of participants reference to the challenge of kindness and self-care, emerging from leaders' stories as kindness to self - e.g., Anzors, acting on a wider basis… *"building a network of peers"* (Anzors, I.2) - Tess, never allowing herself to give up - contemplating that public engagement leadership can be hard, but "*stopping was not an option*" (Tess, I.2). The contours of participant leadership contexts brought to the fore the importance of attending to creating the conditions for supporting collaborative practice.

Participants emphasised the importance of a safe **reflective space**. As participant, Mark said it enabled him to "*move into a more self-reflexive space"* (Mark. I.2). Similarly, Jill reflected on how a coaching conversation helped her to understand her identity in relation to public engagement; *"I had this brilliant coaching conversation… I think this has just landed so many things and I connect back to when I was working as a speech and*

language therapist [story] But for me that was all just always about letting their voice be heard" (Jill, I.2).

These leaders reflected on the importance of having **safe space** for **reflection** and **reflexivity** (n11). One leader, Julie reflected that this was the first time. Several leaders reflected in their feedback on the value of the research conversation as a safe reflexive space (n6). Meghan, for example, reflected on re-framing her understanding and how she identifies with public engagement. Leaders associated strongly with the feeling of vulnerability, which appeared to act as a catalyst for curiosity and courage, joining together with their sense of **self-discovery**. Many spoke of connecting with untapped part of themselves. Only then can they feel confident to engage others. Jill attributed her leadership beliefs, values, style to her very early experiences, very early experiences *school.*

> *"that confidence actually comes from just kind of owning who you are and your journey - and noticing how that impacts – noticing how you impact on others and noticing how others impact on you"* (Jill, I.1).

These untapped parts were often experienced as significant and influential. As participants went on to describe their experiences of public engagement leadership, they also attributed their ability to delve into their experience in this way to the nature (quality) of the research conversation as a reflective space. Several described the research conversation as though a "*safe container*" (e.g., Mark, I.2.) conveying a kind of **emotional safety** net. This would seem to be an aspect of Cooper (2005) experience of **relational depth**. An interesting aspect of how leaders feel supported to practice collaboratively was that many did not feel that there was time to sit down and reflect. Jill created a visualisation using the concept of a candle to show the importance of **creating the conditions** for leaders to "*shine brightly*" (Jill, I.2).

> "*understanding what it is that enables people, to shine brightly - creating the leadership conditions that enables them to do that"… "each individual candle is actually a kind of a small light, and it's an important light, but it's when you bring a collection of candles together you are able to see much more clearly together than you might as an individual"* (Jill, I.2)

This study highlighted the complexity of how healthcare leaders identify with public engagement. Findings highlighted the importance of attending to the relational

dimension of their practice; relationships with others, self, and context. The opportunity to share their story impacted leaders' motivations for public engagement. This was viewed as significant by them because "*when people share their story, people are prepared to share something of themselves and their own vulnerabilities*" (Jill, I. 1). The willingness of these leaders to "*rumble with vulnerability*" (Brown, 2018, p.19-43) was a golden thread that ran through the core themes that emerged: **curiosity** - **courage** - **creativity** - **role modelling** - **kindness** and **reflexivity** (connectedness). It suggests that creating spaces to have different conversations is an entry point to cultivating collaborative relationships. The act of telling and reflecting deeply on their story in a **reflexive space** helped leaders to develop an understanding of how they identify with public engagement.

5.4.1 . How stories contribute to leaders identifying with public engagement

Stories, according to Ganz (2010) are *"a way to communicate our identity, the choices that have made us who we are, and the values that shaped those choices - not as abstract principle, but as lived experience"* (Ganz, 2010). Consistent with this view, several factors emerge from the data to show how stories contribute to how leaders identify with public engagement. The act of telling, and listening to stories, may help leaders to reflect on their experiences, share experiences, validate experiences, and make new meanings:

- Stories create a space for leaders to reflect of their experiences and make-meaning around their practice e.g., purpose, commitment, authenticity.
- Stories can be uncomfortable, yet the greatest learning came from their willingness to rumble with moments uncomfortableness e.g., deep reflection.
- Stories foster an emotional, human connection e.g., leading to different conversations and decisions at NHS Trust Board (Julie, I.2).
- There was a clear view that everyone needs to be able to tell their story.
- There are potential risks highlighting "*judicious use of stories*" (Anzors, I.2.) - investing to "*help people tell their stories*" (Tess, I.1).

Many participants pointed to the complexity of language as a barrier to public engagement. As one experienced national leader put it; "*we tend to be very verbally based in the way that we manage engagement"* (Jill, I.1). She suggested a paradox, discussed earlier; *"although we are perhaps good at talking to people who know what we are talking about, we're less good at actually translating"* (Jill, I.1). This is where artefacts were found to enrich how leaders identify with public engagement.

5.4.2. How artefacts contribute to leaders identifying with public engagement

As evidenced above (and discussed in Chapter 3) stories, whether written or told, are increasingly recognised for their value in opening windows into the emotional world of individuals, offering a powerful tool for inquiry (Gabriel, 2000, Grey, 2007, Bolton, 2014). Books such as the children's tales *Alice in Wonderland* and *Through the Looking Glass* resonated as I began exploring how leaders identify with public engagement. "*What is the use of a book*" thought Alice, "*without picture or conversation*" (Carroll, [1865], 1954, p.1). Combining stories with artefacts offered an opportunity for learning through the research conversation. Bolton (2005, p. XVII) reminds us that wise Alice knew that texts have to capture hearts, imagination and spirit, as well as mind in order to communicate relational leadership effectively. Artefacts, according to Clandinin and Connolly (2004) are valuable ways for people to link important events and memories that they can construct stories around. Consistent with this view my participants showed that artefacts contributed to how leaders identify with public engagement:

- Artefacts, combined with stories helped leaders to get closer to how they identify with public engagement.
- Selecting a personal artefact acted as a reflective tool for leaders. It encouraged leaders' self-reflection on their leadership and public engagement practice in advance of the research conversation.
- Artefacts enabled leaders to choose what stories to tell, and what not to tell – this was congruent with the principles of relational-practice (Chapter 2).
- Artefacts acted as a cypher, for helping leaders to make meaning, as a catalyst for reminding leaders of memories and significant events.

- Healthcare leaders are surrounded by complex concepts (see for example, Meghan, I.2). Several participants encouraged messages to be "*clear", "simple"* and "*memorable*" - visualisation helped to connect significant professional and personal memories, and incident that stories were constructed around.

5.5. Comparison between the stories and literature review

Findings from the synthesis of stories were compared with findings from the literature review (Chapter 2) to authenticate the final findings (Chapter 6) and recommendations for practice (Chapter 8). A high-level summary can be viewed below (table 5.1). Although there were similarities in the themes there was a difference in emphasis across several.

Literature review	Study findings
The literature showed the challenge of definition reflecting the complexity of the language of engagement and complexity of the context in which public engagement and collaborative practices more widely are situated.	• It was not surprising that leaders in this study shared this view of complexity. • What was interesting is the ways that leaders conveyed that policy needs to be translated into practice in ways that are 'simple', 'clear' and 'memorable' showing creativity and innovation e.g., visualisation.
The literature focussed often on processes and initiatives for securing direct engagement and less attention had been given to the relational aspects especially beyond clinical interactions.	• Leaders in this study placed emphasis on investment on relationships with the public and staff; relational depth. Identifying with public engagement bean not with process but self-discovery. • Although this research was not examining the organisations the Care Quality Review rankings confirmed leaders' perspectives.
The literature showed empirical evidence that staff engagement is fundamental for improving engagement, experience and outcomes for the public as well as staff. However, despite strong empirical evidence public engagement and staff engagement were often bi-located in the literature.	• Leaders in this study conveyed recognition and response to the importance of staff engagement and their leadership. • Leaders encourage more holistic approaches to engagement practice. • Staff engagement as essential to their leadership approaches to public engagement.

Table 5.1: Comparison between the literature and qualitative data-portrait synthesis

5.6. Validity, authenticity, and trust

This research never intended to achieve generalisability of the data. However, it was important to ensure that the data presented was an authentic representation of leaders' views. Therefore, participants were invited to authenticate the interpretations of their portrait. As suggested by Savin-Baden and Howell-Major (2013, p.477) this enabled participant voices to be heard, enhancing credibility of the study by attending adequately to the reliability and trust of the research findings. The early response from James was reassuring; *"I am very happy with the content and on reflection I feel a sense of pride in the conversations we've had, how you've illustrated them, and that I opted to take part in this research opportunity"* (James, portrait feedback).

The leadership portraits seemed to prompt a balance of professional, personal, emotional, and analytical responses (Denzin and Lincoln, 2013). Holistic interpretation was evident in several responses. The responses, which for some leaders were deeply personal, were an indicator that the portraits achieved the intended holistic accounts of how leaders identify with public engagement. This added further insight into the research questions. Leader authentication on the portraits added a further layer of un-anticipated data, included in this chapter. Several leaders engaged, not only in reading their portrait for authentication but in conveying reflective and reflexive comments on feelings, and benefit stimulated by this process.

> *"I value highly the opportunity to read, re-read and reflect on the leadership portrait that so authentically captures both the essence and the detail of our conversation. It represents a rare opportunity for me to reflect… Our conversation and the portrait that emerged from it is an enduring record of a number of different strands that contribute, separately and collectively, to my beliefs about leadership and ultimately to my style of leadership… I find the portrait a very valuable resource in reflecting on, revisiting, and challenging my own leadership style and the values that underpin it."* (Jill, portrait feedback)

Participants appeared to view the process of the research interviews and leadership portrait development as a catalyst for self-discovery. Several participants (6) expressed the importance of having a safe space for reflective conversation. The reflective nature of the research conversations was considered important by leaders. Not only did some leaders reflect that there is little reflective time within the NHS, but Julie also pointed to

the *"cathartic"* value of the research interview (Julie, I.2). Julies words resounded as I read; *"I didn't expect to get this from the interview; it was a pivotal moment"* (Julie, portrait feedback). A reciprocal element to the research seemed evident. Leaders at all levels appeared to share this view. Mark, for example described the research conversation as "*a safe container"* (Mark, participant feedback). To fulfil the original aim of producing authentic narratives it seemed necessary for the leadership portraits to be expressed in the language of participant. This appeared allow true meanings to surface. Participant commentary shows that the data generation was much more than having an interview with someone; it is about modelling the engagement principles and practice.

> *"I wanted to say that I found it particularly helpful to reflect on the questions you (the researcher) asked because of how you 'showed up' during our call. You created a safe container for me. Your thoughtful questions enabled me to reflect and make sense of my own thoughts. I was very conscious that the dialogue we engaged in felt very generative in nature. This was facilitated by your presence and holding of the space. I believe that as the researcher the attention you paid to what I was saying (and not saying) enabled me to move into a more self-reflexive space. In our conversation I believe that the quality of my sense making was a direct consequence of how at ease I felt, and this sense of ease was facilitated by the attention you paid to our work together. The very content of the conversation was being reflected in the quality of the interview which had at its heart the hallmarks and principles of effective and successful collaborative engagement. You, the researcher, I felt, consciously modelled the principles and practices of the kind of dialogue that supports collaborative generative conversations"* (Mark, portrait feedback)

The process of respondent validation indicated that to see our self purely as researcher in relational inquiry is at our peril. These highly personal leader responses suggest the interpretive leadership portraits fulfilled a purpose beyond traditional analytical thesis report. The approach indicated several distinctive benefits for healthcare leaders. Firstly, the approach was shown to act as a safe space for personal reflection on their leadership practice; evidenced in participants feedback on their portraits and reflections on the research process in conversation (e.g., Mark (I.2), James (I.2) and Jill (I.2). Secondly, the approach was found to act as a reflexive tool, forming a catalyst for self-discovery influencing public engagement leadership thinking and practice. Such benefits indicate the potential value of the approach as a development tool for leaders wanting to build a relational practice, specifically contributing to the third research objective; creating the conditions for supporting leaders' collaborative practice with the public engagement. This is discussed in Chapter 8.

5.7. Conclusion

This chapter has presented a synthesis of the twelve participant stories. The stories show that modelling relational leadership practice through the process of the research conversations, and scaffolding leadership portraits, is not only a research tool, as described by Lawrence-Lightfoot and Hoffman Davis (1997) but also acted as a leadership development tool for participants (Chapter 4 and discussed in Chapter 8). The picture that participants painted in their stories was of a very human leadership where their desire to make a difference to public engagement has been able to flourish and take them through extraordinary professional and personal challenges. Leaders' stories often reflected earlier experiences of dis-location. Their stories showed how, through their leadership they have tried to make engagement work for those they are responsible for and through policies they deliver. Part of the problem of relational leadership and public engagement is that people need to understand themselves, and their own identity as leaders in order to bridge the gap between the healthcare system, leaders, and the public (Chapter 1). The synthesis here suggests that feeling connection through self-reflection and reflexivity is vital for healthcare leaders be able to understand and identify with public engagement.

The following chapter begins with a brief re-cap on the relational perspective that underpins this study. The chapter then discusses six core themes woven through individual and collective participant stories to capture key influences on how healthcare leaders identify with public engagement: curiosity, courage, creativity, role modelling, kindness, and reflexivity. Ganz (2010) model on telling a 'public story' (p.14) provides a route-map for organising the data analysis themes, from first, distilling the data analysis themes (table 6.1) to re-framing the themes, towards a new 'public story' (table 6.4).

6. Chapter Six

Data analysis themes

6.1. Introduction

The previous bridging chapter (Chapter 5) provided a synthesis of the twelve leadership portraits bringing together emerging themes from participants stories. Each leadership portrait (Chapter 4) showed participants individual perspectives on how they identify, as healthcare leaders with public engagement. Using narrative combined with artefacts enabled layers of interpretation to be made, moving towards a more collective view of the data analysis themes. To give a systematic basis for the interpretation of research findings the twelve leadership portraits were organised around the four contrasting organisational contexts to situate participant perspectives within their social world.

This chapter begins with a brief re-cap on the relational perspective that underpins this study, overlaying Ganz (2010) relational process. The chapter provides analysis of evidence that resulted in the six key themes: curiosity, courage, creativity, role modelling, kindness, and reflexivity. Each theme represents influences on becoming and being a relational leader with the public. The focus of analysis moves to the idea of visualisation to present themes arising from participant selected artefacts shedding further insight on how healthcare leaders identify with public engagement. Finally, the chapter moves to a thematic discussion on participants' collective experiences, framed by Ganz (2010) relational process for telling a 'public story' (p.14).

6.1.1. The relational perspective: overlaying Ganz (2010)

As a professional doctorate it was important to make the study findings transferrable into practice. There were many ways that the research evidence could be organised to address the research questions as framed by the methodological discussion (Chapter 3).

This theoretical discussion provided justification of the relational perspective that underpins this study.

The data presented in Chapter 4 reflected participant perspectives in relation to their self, their relationships, and contexts within their social world of leadership. Each portrait portrayed the individual participant experiences including their personal motivations, values, relationships, leadership practice and context for public engagement as expressed through the narrative interviews and participant generated artefacts (Chapter 3). The Voice-Centred Relational Analysis approach (Mauthner and Doucet, 2003) helped to trace the complexities of participant worlds to better understand the nature of collaborative relationships with the public. The analytical and interpretative process was emergent establishing reflexive loops in the process (appendix 2). The analytical steps taken in this research were tabulated forming a route-map to guide the process (appendix 5).

"A person's identity is achieved by a subtle interweaving of many different threads" (Burr, 2015, p.123)

As discussed in Chapter 3 there appeared to be a connection between the Ganz model (2010) and the work undertaken with participants stories using the Voice-Centred Relational Analysis (Mauthner and Doucet, 2003). Its relational orientation provided a valuable frame to add a further layer, to test my analysis and enrich perspectives of the findings - figure 6.1. The discussion in this chapter focuses on the three inter-connected areas; leaders' self, leaders' relationships, and leaders' contrasting contexts. Marshall Ganz talked about these three areas in his work on leadership, organisation, and social movements for telling a 'public story' (Ganz, 2010, p.14).

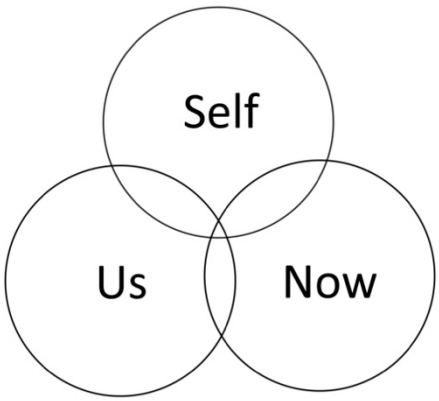


Figure 6.1: Telling a 'public story' (Ganz, 2010)

The first: the story of *self* (leaders' voice) is concerned with leaders' own perspectives on their role and sense of their self in their relationships with the public. Here the narrative on motivations for public engagement is considered, which is inevitably in relation to influences on both their relationships and practice (being) the contexts in which they operate (system). This section has a focus on individual participants understanding of their self.

The second: the story of *us:* (leaders' relationships) offers insight into the influences on relationships and practices that shape participant perspectives on their approaches to public engagement and how they identify as a collaborative leader with the public. This shines the light on the nature of relationships and how leaders identify with being collaborative with the public in practice.

The third: the story of *now*: (leaders' contrasting contexts) offers insight into the contexts in which leaders engage with the public taking a wider system perspective on the conditions needed to support collaborative practice. This takes account of the contrasting organisational contexts in which participants experiences are situated acknowledging influences of the wider health system and call to action.

Ganz model on 'telling a public story' (2010, p.14) provided a frame for the organisation of the data analysis themes; from distilling the data analysis themes (table 6.1, p.168) to re-framing the themes, towards a new 'public story' (Ganz, 2010) (table 6.4, p.190). The

themes are both fixed (as shown in table 6.4) but also found to dynamically move. The diagrammatic representations in this chapter seek to illustrate the six core themes in their dynamic relationship with each other (figure 6.6).

The importance of reflexivity in the research is addressed separately (Chapter 7) to acknowledge the influences of myself on the study and consider the development of my thinking and participants' reflexivity. The conclusions, challenges, and implications of the research for practice and further research are then discussed in Chapter 8.

Table 6.1. Data analysis 1: distilling the themes

<table>
<tr><th></th><th>Words-phrases</th><th colspan="2">Applying Voice-Centred Relational Analysis</th><th>Core themes</th><th rowspan="5">The importance of relational depth</th></tr>
<tr><td rowspan="4">12 Participants

24
Interviews

218 000
Words (data)</td><td rowspan="4">It's a funny set of words
Engagement silos
Helping people translate
Framing conversations
Quality of the relationship
It's a feeling thing
Values "moral compass"
Willingness to feel uncomfortable
Crafting and holding conversational space
Never stopping people from telling their story $
When people tell story, they give something of themselves and own vulnerability
Aware of what it feels like to be dis-empowered
Letting go of power
It takes courage
Modelling the enquiry process
The power of connection
Being human
Preparedness</td><td>1: Voice
Story
Valuing lived experience
Vulnerability
Sense of purpose
Curiosity and courage
Understanding values
Dancing with values
Reflection and reflexivity
Need to understand self before you can engage with others
Self-discovery (important - hard)</td><td>2. Relationships
Shining the light on relationships
Translating
Helping frame meaning
Reaching out
Investing in hearing voice
Different conversations, different relationships
Being appreciative
Happy staff, happy patients</td><td rowspan="4">Curiosity

Courage

Creativity

Role modelling

Kindness

Reflexivity</td></tr>
<tr><td colspan="2">Core challenges
complexity of language - fragmentation - mindset</td></tr>
<tr><td>3. Contexts
Public engagement is contextual
Professional ideologies
Confidence (own, others)
Values and organisational fit
Emotional and social dimension; it's a feeling thing
Organisations as family (relationships) - versus organisation as machine (procedural, tools, techniques)
Staff engagement precedes public engagement
These kinds of conversations are rare in the system</td><td>4. Artefacts
Complexity
Loneliness
Self-discovery
Confidence; tap on shoulder
Vulnerability-confidence
Creating the conditions Self-care
Keeping it simple, clear, memorable
Connection
Power of stories
Human connection
Family values
Role modelling
Connection</td></tr>
</table>

6.2. Core Themes

6.2.1. Introduction

In this section participants perspectives are explored to address the analysis of evidence, which led to the six core key themes woven through participants individual and collective stories: 'curiosity', 'courage', 'creativity', 'role modelling', 'kindness', and 'reflexivity'. Each theme resembles a core influence for leaders' becoming and being collaborative with the public. The leadership portraits (Chapter 4) were a stage in this analysis. Participant voices are shown in these data analysis themes through selected quotations.

6.2.2. The influence of curiosity

Sub-themes: story (lived experience), vulnerability, sense of purpose

In this study all leaders conveyed a deep sense of curiosity, expressed through their stories of engagement. Their curiosity about public engagement was "*sparked*" at different points of their leadership journey. Curiosity is commonly defined as *"the recognition, pursuit and desire to explore novel, uncertain, complex and ambiguous events"* (Kashdan et al, 2017, p.130). Consistent with their view, by curiosity I mean where people "*seek out, explore, and immerse [themselves] in situations with potential for new information and/or experienc*e" (Kashdan et al, 2017, p.130). My participants found ways to listen, reflect and experiment through self-understanding and preparedness practices. These leaders were willing to open a line of inquiry into what's going on in their practice and why. Their stories were closely associated with acting as a catalyst for developing deep sense of purpose. Purposeful curiosity appeared to emerge where leaders found ways to reflect and experiment through self-discovery.

At a system level it is evident that whilst leaders operate within the political discourse created by government policy all participants shared the fundamental view that public engagement was relational. The political imperative that underpins public engagement in healthcare was scarcely mentioned by participants in this study. The issue of curiosity about public engagement was evident in the data on leaders' self, their relationships,

and their leadership contexts. One national leader reflected on the profound impact of his curiosity about the quality of the relationship… "*we come with our own prejudices and beliefs and assumptions*" (Mark, I.1).

> "*it's about the quality of the relationship…many organisations don't see it as relational, instead seeing it as process… how we see the world influences our conversations and our behaviours*" (Mark, I.1)

Being curious was found to have a positive impact for leaders personally but also impacted professionally on how leaders identify with public engagement. The discussion in this respect didn't begin with policy or process but rather on leader's motivations for public engagement (appendix 6). It was acknowledged that leaders' personal experiences of engagement - and dis-location (dis-engagement) - can impact on leaders' motivations for being collaborative with the public. The stories participants told often reflected experience of not getting that sense of belonging and cohesion, and how they are trying to make that work for people they are responsible for through the policies they deliver. One leader reflected that she is *"personally very aware of how it feels to be dis-empowered by the health service"* which led her to "*re-examine professional-patient relationships"* (Tess, I.1).

There appeared to be a strong relationship between the theme of curiosity and leader's association with their vulnerabilities, motivations, and sense of purpose. This is best summed up Mark who contemplated; *"how they engaged with me, and how they didn't engage with me really influenced my work"* (Mark, 1.1).

> *"it just crept up on me... it's made me more vocal... you've got more of a voice when you've got a real cause behind it… it's shaped me… it's pushed me beyond where I feel comfortable"* (Julie, I.2)

The quality of curiosity appeared to matter greatly to leaders ranging from 'attending', 'noticing' and 'challenging assumptions' to modelling "*appreciative enquiry"* (Tess, 1.1). Anzors termed her appreciative approach a *"curious discovery"* (Anzors, 1.1). Leaders conveyed a deep sense of curiosity about being collaborative with the public and appeared to believe that this was possible even if they did not know what that was (confidence, resource). These leaders conveyed curiosity about their self (beliefs, values,

ideas) but also curiosity about others (public, staff, communities). The transformations that participants described reflect a kind of curiosity, where leaders found ways to engage, listen, reflect, and experiment with public engagement practice. Being curious about themselves and their relationships (public, staff, communities) sparked unexpected '*emotional turns'* in the conversation (Grace I.1), new understandings (Meghan, I.2) and actions (Peggy, I.1) over time. When participants inhabited this space with vulnerable curiosity they made new connections - such as the role of staff engagement. Focussing on the relationship of curiosity, vulnerability, and courage could be an important move for the system to make for creating the conditions for leaders to establish as sense of connection with their motivations for being collaborative and genuine sense of purpose.

6.2.3. The influence of courage

Sub-themes: vulnerability, curiosity, self-discovery, dancing with values, reaching out

Participants conveyed the theme of courage strongly in their leadership experiences. By courage, I mean the ability to push themselves beyond where they felt comfortable. Courage was closely aligned to the theme of curiosity. It enabled leaders to question some underlying assumptions on public engagement, sparking creative insight and connectedness. These leaders emphasised their willingness to feel vulnerable. Vulnerability did not show as a weakness in the data but rather a sign of courage. This is something Brown (2018) terms "*rumbling with vulnerability*" (p.17-43).

> *"There are times when I feel vulnerable as a leader … I'm not frightened of showing that vulnerability. It's important to be human"* (Aria, I.2.)

The issue of courage was evident in many leaders' stories. It showed up in many forms such as understanding values and *"being in a constant dance with those values*" (Mark, I.2), *"to stand up for things you believe in when other people are stood still around; you've got to be brave and courageous"* (Meghan I.2) and "*reaching out*" (Harriet, I.2). In contrast to discussing policy or process leaders emphasised the importance of role-modelling qualities of public engagement such as "*vulnerability*", "*curiosity*" with a sense of purpose. One leader reflected on the profound impact of what she termed "*finding* courage" (Julie, I.1).

"*I suppose it's made me more vocal - when you're fighting for somebody else's beliefs and voice, I think that makes … I suppose it's like your children, isn't it, sometimes? You've got much more of a voice when you've got a real cause behind it*." (Julie, I.1)

Being courageous was found to have a positive impact for leaders personally but also impacted positively on their relationships with the public and staff. The discussion in this respect focussed on leaders understanding their personal professional and organisational values. It was acknowledged that congruence between values can impact on leader's perspective on how they identify with public engagement. Participants showed a tension between who they are as a leader and how their organisation is perceived in regulatory measures of performance. Given the complexity of leader identity, NHS values play an important part in creating congruence between NHS, organisational, professional, personal values, and expectations. An experienced national leader in the study made the association with maintaining understanding of self by re-visiting values over time. Mark described his curiosity but also courage in "*dancing with values"* (Mark, I.2). This deep reflection and reflexivity conveyed curiosity but also a sense of courage.

"your head almost acts as a self -contained frame of which it's very difficult to move beyond. And that's really powerful for me because as a metaphor it really tells me, that is also my comfort zone, but if I really want things to be different, and change I have got challenge myself to go beyond my comfort zone" (Mark, I.2)

The quality of courage appeared to matter greatly to leaders. Participants in this study displayed courage, for example attending to the nature of their relationships in their engagement work. Jill viewed conversation as "*the most important vehicle for engagement*" describing the importance of "*crafting and holding a conversational space"* (Jill, I.1). Consistent with other participants views "*although we are perhaps good at talking to people who know what we are talking about we are less good at translating*" (Jill, I.1). For Jill this meant courage to reach out, "*towards a conversation"*, starting conversations where people are (Jill, I.2). Several factors for what constituted a "*meaningful conversation*" emerged in the data including "reaching out", "started where people are", *"listening", "noticing", "feeling", "not dismissing*", "*challenging assumptions*", "*valuing peoples lived experience*" (Jill. I.1). Tess summed this up best; "*conversations really do matter*" (Tess, I.1). When considering what good leadership

looks like, several leaders, like Aria emphasised the importance of "*showing up*", "*presence*" and acknowledging our own "*vulnerabilities*" (Aria, 1.1). The data suggests that leading in this way "*takes* courage" (Anzors, I.2).

Exploring leaders' values expanded interpretations of leaders understanding of their self, their leadership role for public engagement and their sense of their leadership identity through their own lived experiences. This was captured best by one national leader, Jill whose vivid story of personal growth changed her view fundamentally on how she practiced "*you don't need a rule-book - you just need your-self*" (Jill I.2). Jill attributed her confidence to coming from owning who she was on her leadership journey. Focussing on this relationship between leaders' stories, curiosity, and courage
could be an important move for the system to make for creating the conditions for leaders to operate.

6.2.4. The influence of creativity

Sub-themes: different conversations, different relationships, visualisation, coaching

The importance of creativity emerged from the data, reflected in leaders' stories. By creativity I mean approaches that helped connect people to memories and significant events, reflect critically, and make new meaning on their practice. Creativity helped move leader's self-understanding on public engagement from process to an emotional connection. Creativity showed up in leaders' narrative, dialogic and visual practices, such as coaching (Aria, I.2) and visualisation (Meghan, I.2) activities. The theme of creativity influenced how leaders understood the nature of their relationships. Mark summed this up best with his encouragement of doing things differently (Mark, I.1)

At a system level it is evident that leaders operate within a complex landscape illuminated by the complexity of the vocabulary. This was viewed as one of the greatest challenges in their public engagement work. One national leader proclaimed that "*the language is the one thing that really hits home"* and "*how un-inclusive it is"* (Tess, I.2). Similarly, a local leader reflected on the profound impact of the complexity of language

Consistent with many participants he asserted that "*the words are too complicated"* (Oliver, I.1). This suggested a paradox that "*the very language of engagement can unintentionally dis-engage people"* (Oliver, 1.1). The issue of creativity appeared to come from this complexity encouraging different conversation. This was evident in the data ranging from 'conversation' to 'visualisation' (Jill, I.2). Several leaders reflected on the profound impact of what Mark termed "*different conversations, different relationships*" (Mark, I.1).

> *"We tend to be very verbally based in the way that we manage engagement… although we are good at talking to people who know what we are talking about, we are less good at translating"* (Jill, I.2)

Creativity was found to have a positive impact personally for participants in this study but also impacted positively on their work in engaging other staff in being collaborative with the public. The discussion in this respect focussed on a kind of preparedness. This is best summed up by Tess who described her role to "*ground the [engagement] work'* by talking to staff about; *"<u>what</u> it is [public engagement] and <u>why</u> it matters"* (Tess, I.1). The importance of creativity resounded for leaders in this study who associate with the metaphor of "different conversations, different relationships" (Mark, I.1). There appeared to be a strong association for these leaders between staff engagement and why public engagement matters by making *"it feel[s] as if it has personal meaning to every member of staff. It's not a distance*" (Oliver. I.2).

Participant's engagement in creativity didn't mean investment in systems and process. It seemed to happen where leaders felt that they had the curiosity, courage, and confidence to experiment with new engagement approaches in trusted environments (Anzors, I.1). This is evidenced by a leader in from the Eastern Foundation Trust and the positive impact on engaging staff in why public engagement matters.

> *"[visualisation] a memorable concept that everyone can relate to… it was the simplicity…because we are all surrounded by complex concepts, lots of words, lots of policies and papers"* (Meghan, I.2).

The quality of creativity appeared to matter greatly to leaders as a way for fostering a sense of connection by helping people connect important events and memories. Tess reflected a paradox that "*engagement"* can feel "*dis-connected"* (Tess, 1.2). Several

leaders showed that creativity in their leadership "*helped people to con*nect" (Meghan 1.2). Creativity was reported to make public engagement "*feel real*" (Tess, I.1). This was captured best by Jill who encouraged; "*make your message simple, make it accessible, make it clear, make it memorable*" (Jill, I.2). Evidence suggests that creativity needs a level of courage to experiment. The focus on relationships with the public, and staff is shown to be fundamental; leadership is an outcome of *"the quality of the relationship"* (Mark, I.1). Focussing more on creativity could be an important move for the system to make for creating the conditions for leaders to operate; storytelling, effective dialogue, coaching, visualisation, experimenting with new creative ways for cultivating collaborative relationships.

6.2.5. Theme: The influence of role modelling

Sub-themes: shining the light on relationships, presence, confidence

Leaders in this study imparted a deep sense of the influence of role modelling, conveying themselves as being a catalyst for change. By role modelling, I mean being a leader who lives the values of public engagement in everyday interactions by enacting relational qualities Being a role model, was testimony to the potential to transform leadership for public engagement, by shing the light on relationships, sparking peoples' thoughts, emotions, and actions over time. For leaders in my study, role modelling relational behaviours was about how they showed up in each interaction, un-tapping shared understanding, and sense of connection. Peggy summed up the essence of being a good role model for others to follow.

> *"a good role model who lives the values… live the values, the team will follow suit"* (Peggy, I. 2)

Role modelling relational behaviours was viewed as an important quality for leaders. For example, one participant described role modelling in his work, challenging the traditional discourse in developing his organisational strategy.

> "*[leaders] can get caught up in strategy and policy - sometimes failing to focus enough on translating policy and practice by role-modelling qualities and behaviours"* (Mark, I.1)

Many participants described the influence of role modelling in their leadership.

Closely associated with role modelling was courage. For example, one leader, whose organisation was in 'special measures' reflected on her effort to role model relational behaviours with her staff; "*you need to stand up for what you believe in… be brave and courageous… out of all of that comes learning*" (Meghan, I.2).

At a system level it is evident that leaders operate as catalyst for change in different ways according to their context. The challenges to becoming and being a catalyst for change were scarcely mentioned by participants in this study. Challenges evident in the data encompassed three issues: 'the complexity of the vocabularies', 'fragmentation of context' and 'mindset'. One leader reflected on the powerful impact of "*trying to change the mindset of others*" (Mark, I.1). He described the challenge of; "*the mindset which perceives engagement as an instrumental mechanistic process"* contemplating that some people may be *"lost in a mindset that sees the organisation as a machine"* and contemplating "*how many leaders lack confidence*" for public engagement. (Mark, I.1). Rather than focus on challenges, these leaders emphasized relational approaches in their work. One leader reflected on the profound impact of what she termed: "*shining the light on relationships*" (Anzors, I.1).

Being a role model was found to have a positive impact on leaders personally but also on developing collaborative practices. From the evidence (Chapters 4, 5) a typology emerged, which identifies some important aspects of how leaders identify with public engagement (table 6.2, p.184).The typology addresses what is means to be a catalyst for cultivating collaborative relationship by role modelling behaviours. This typology provides a sense of first, 'how leaders identify with public engagement'- second, 'approaches in context' and third, the 'relational qualities' that participants conceived as 'good leadership for public engagement'. It demonstrates that there is no single way for enacting the role. These leaders identify with public engagement in different ways according to context. How leaders identify with public engagement, at any point in time, influences their public engagement practice and their confidence for being a catalyst for change. An important aspect of data conveyed the reciprocal nature of being a role model suggesting that, as relational leaders, we get what we give. This was especially illuminated through participant reflections on the nature of the research conversation.

In this sense finding's show that being relational is important regardless of the leadership context.

> *"the quality of your presence and engagement in the process, really facilitates the quality of the conversation – so you model some of the qualities and the skills that support conversations at this level of reflection. So, I think you could benefit by reflecting on what you are actually doing – on how you show up in these conversations because they are integral. So, you are absolutely integral to the conversations and what's been said. How you show up, and how you work, absolutely is inseparable from what you get back"* (Mark, I.2).

Findings suggest that even without formal structures my participants found their own ways to engage in reflective practices that support self-discovery and understanding. However, findings show the importance of attending further to the conditions required for leaders to operate as a catalyst for change.

> *"Different conversations, different relationships"*
> (Mark, I,1)

Focusing on the relationship of framing understanding (discussed in Chapter 5) could be the most important move for the system to make towards ensuring leaders preparedness for public engagement. Given relational dynamics often take place in conversation, communication, dialogue, and language are central aspects to attend to for cultivating relational leadership in the NHS (Fairhurst and Uhl-Bein, 2012).

6.2.6. The influence of kindness

Sub-themes: emotional safety and wellbeing, team-organisation as family

Leaders in this study conveyed the importance of kindness and compassion, in their leadership experiences of being collaborative with the public. Expressions of kindness evoked feelings of importance in transforming leaders' relationships with the public. Kindness challenges leaders to be self-aware and shows relationships with staff to be central to public engagement. Kindness was felt and expressed in different ways; kindness to self (self), acts of kindness (relationships) and cultures of kindness (context). According to Ballatt and Campling (2011) "*to fail to attend to the promotion of kinship, connectedness and kindness between staff and with patients is to fail to address a key dimension of what makes people do well for others"* (p.3). They remind us that kindness

evokes feelings of importance in transforming relationships with the public as kindness challenges leaders to be self-aware. Here, kindness is felt and expressed in different ways; 'cultures of kindness' (context), 'acts of kindness' (relationships) and 'kindness to self' (self).

At a system level it is evident that leaders operate within the political discourse created by government policy. The political imperative that underpins public engagement in health policy and regulation was scarcely mentioned by participants in this study. Rather, in contrast to policy or process for public engagement these leaders emphasised the importance of role-modelling qualities of public engagement such as kindness.

> "When you speak with enough people and you actually uncover how much emotionally that people are giving every day, and the joy of that… but there is a flip side – I don't think we've paid enough attention to the emotional price of delivering healthcare" (Anzors, I.2).

At an organisational level, kindness was found to have a positive impact for leaders personally but also appeared to impact positively on their organisation's performance. The discussion in this respect focussed on the importance of 'cultures of kindness'. As discussed in Chapter 3 participants organisational context varied, as evidenced by Care Quality Commission (CQC) reviews. Although the focus of the research was on participants experience, organisational performance was found impact on leader's perspective of self in relation to confidence and wellbeing. Some organisations had focussed heavily on processes around public engagement as opposed to focussing on relationships. One local leader reflected on the leadership challenge, of what she described as "*allowing bureaucracy and systems and processes to get in the way"* (Meghan, I.1) This was where processes appeared to be counter-productive to public engagement work - a traditional culture of engagement.

The cultural dimension of 'organisation as family' and 'team as family' appeared vital for leaders in cultivating collaborative practices. This is best evidenced by leaders from Western Bay NHS Foundation Trust and Northern Bay NHS Foundation Trust and the positive impact on performance. The importance of 'cultures of kindness' resounded for participants in this study who, at a local level often used the metaphor of 'organisation

as family' and 'team as family'. In her account Harriet said, *"we are like a family"* (Harriet, I.1). There appeared a strong relationship between cultures of kindness and leader association of this with positive organisational performance. This is best summed up by Oliver "*it feels more connected - it feels real… we've moved from being mid-table or bottom… to be essentially the top service provider"* (Oliver, 2.1).

Kindness showed up in relationships in a variety of ways, viewed here as 'acts of kindness'. Meghan, for example described a shift towards relational focus where she is discouraging "*silo working"* and encouraging "*staff engagement*" and how they are going to "*give everyone a voice*" (Meghan, I.1). This seemed to happen when leaders felt that they could trust their leadership context; feeling valued. Such 'acts of kindness' spanned from the 'small' act of kindness described by Anzors (I.2) to 'monumental' acts described acts by James (1.2). The very 'act of kindness', small or large, seemed to hold significant impact for how these leaders identify with public engagement. Whilst 'cultures of kindness' and 'acts of kindness' were widely encouraged by participants, 'kindness to self' was shown to be considered as both important yet the greatest challenge.

"Kindness to self is a harder lesson to learn" (Anzors, 1.2)

Several participants reflected that the role of leadership for public engagement can be lonely. This brought the issue of 'kindness to self' to the fore. Anzors, for example described her work in developing a network, a "*network of support for those individuals who risk being deeply committed to something, burning out with the effort, in a system that doesn't understand and doesn't accommodate"* (Anzors, 1.2). Evidence suggests that kindness to self needs a level of preparedness.

Where leaders developed a strong sense of purposeful curiosity it was evident that whilst collaborative leadership can be hard for leaders stopping was not an option. This was captured best by Jill; "*I've noticed again how little we have conversations like this in the system, and yet how important they are… it almost strengthens my own identity… it's a really helpful thing to do*" (Jill, I.2). Focussing on this relationship could be the most important move for the system to make for creating the conditions for leaders to

operate. Consistent with Ballatt and Camping (2011) findings suggest that kindness challenges leaders to be self-aware as takes us to the heart of relationships where things can be messy, difficult, and uncomfortable. This brought the issue of reflexivity to the fore.

6.2.7. The influence of reflexivity

Sub-themes: presence, feeling real, connection

Despite variations, most reflexivity definitions share a common theme of referring to a kind of "*bending back of thought upon itself*" (Webster, 2008, p.68). Here, reflexivity was expressed by participants as a feeling of contact, engagement, and connectedness. It resembled leaders understanding of their own reflexive leadership. These leaders described reflexivity as being how they connected with understanding their inner sense of values and their motivations for public engagement.

> *"I've noticed again is how little we have conversations like this in the system, and yet how important they are, and how conversations like this, certainly speaking personally really enable an opportunity for me to talk through. And I kind of guess it almost strengthens my own identity - my own leadership identity, so its kind if, how having the conversation enables that to happen, but it also enables me to kind of challenge, if there's anything that just isn't quite consistent, or just I kind of voice an inconsistency, or anything I feel I need to explore - it's actually for me kind of verbalising that and surfacing that through these conversations - it's just a really helpful thing to do*" (Jill, I.2)

The kind of reflexivity that leaders described was found to have a positive impact for how leaders understood and identified with public engagement, their motivations and support, a sense of self-discovery. The discussion in this respect focussed on practising reflexively and brought to the fore the importance of creating emotional safety for leaders. It was acknowledged that being reflexive can influence leader's perspectives of relational leadership.

> *" I found it particularly helpful to reflect on the questions (you the researcher) asked because of how you 'showed up'… you created a safe container for me. Your thoughtful questions enabled me to reflect and make sense of my own thoughts. I was very conscious that the dialogue we engaged in felt very generative in nature. This was facilitated by (your) presence and holding of the space. I believe that as the researcher the attention you paid to what I was saying (and not saying) enabled me to move into a more self-reflexive space"* (Mark, I.2)

Reflexivity, for these leaders was closely associated with a strong sense of connection between discovering their sense of purpose and belonging. Connection is described as *"a state of profound contact and engagement between two people in which each person is fully with each other, and able to understand and value the others experiences at a high level"* (Mearns and Cooper, 2005, p.xii). The sub-theme of connection was particularly significant in participants association with profound moments of connection, described as; *"feeling more real"* (Oliver, I.2), "*making a difference for somebody*" (Grace, I.1), *sense of "worth*" (Aria, I.1), "*self-acceptance"* and "*connecting with your own authenticity*" (Jill, I.1). This is best summed up by Anzors who attributed her sense of connection to reflecting on both her professional and personal experiences; *"it connected me, if you like, to why I wanted to do this work in the first place*" (Anzors, I.1).

The power of connection that came from understanding of their own reflexive leadership was confirmed when a main motivation for public engagement emerged as a response to participants experience of dis-location. The discussion in this respect focussed on leaders' motivations for public engagement as evidenced in Chapter 4. There appeared to be a strong relationship between leaders feeling a sense of connection and emotional safety and wellbeing allowing leaders to explore and make meaning. This is best summed up by Anzors described her work in developing a network, seeing this a "*network of support for those individuals who risk being deeply committed to something, burning out with the effort, in a system that doesn't understand and doesn't accommodate"* (Anzors, I.1). This theme of reflexivity was best summed up by one national leader as "*the power of connection"* (Jill, portrait feedback).

6.2.8. Summary: core themes

The data showed that encouraging relational approaches according to the leadership context was most helpful for understanding how these leaders identify with public engagement: curiosity and courage, creativity, role modelling and kindness and reflexivity. These themes are summarised below:

1. **Curiosity:** Curiosity about public engagement emerges where leaders find ways to listen, reflect and experiment through self-understanding and preparedness practices. Leaders were willing to open a line of inquiry into what's going on and why. Their narratives were closely associated with being curious about their experiences. Purposeful curiosity emerges where leaders find ways to reflect and experiment through self-discovery.

2. **Courage:** Courage was closely aligned to the concept of curiosity enabling leaders to question some underlying assumptions on public engagement, for example sparking creative insight and connectivity. These leaders emphasise the importance of a willingness to feel vulnerable. Vulnerability did not show as a weakness in the data but rather a sign of courage.

3. **Creativity:** Creativity helped connect people to memories and significant events. It helped move people's self-understanding on public engagement from process to an emotional connection. Creativity shows up in leaders' narrative, dialogic and visual practices, e.g., coaching. This means, different conversations, different relationships.

4. **Role modelling:** Being a role model is testimony to leader's potential for transformation by 'shining the light on relationships' to spark peoples' thoughts, emotions, and actions over time. For healthcare leaders in my study, role-modelling relational behaviours was about how they showed up in each interaction, un-tapping shared understanding, and sense of connection. The data conveyed the reciprocal nature of being a role model suggesting that, we get what we give.

5. **Kindness**: Kindness evoked feelings of importance in transforming leaders' relationships with the public. Kindness challenges leaders to be self-aware and shows relationships with staff to be central to public engagement; it drives people to pay attention to each other. Kindness is felt and expressed in different ways; kindness to self (self), acts of kindness (relationships) and cultures of kindness (context).

6. **Reflexivity:** Despite variations, most reflexivity definitions share a common theme of referring to a kind of "*bending back of thought upon itself*" (Webster, 2008, p.68). Here, reflexivity was expressed as a feeling of contact, engagement, and connectedness. It resembles leaders understanding their own reflexive leadership. These leaders described reflexivity as being how they connected with understanding their inner sense of values and motivations for public engagement. Connection emerges where leaders find ways to reflect deeply and discover self-acceptance or belonging.

The participants' selected artefacts were shown to form a conduit for representing participants sense of how leaders identify with public engagement. The artefacts were key to getting closer to participants construction of identity. The following section moves to the idea of visualisation to show keys findings from the artefact analysis.

	How leaders identify with public engagement	Approaches in context	Relational qualities
Role-modelling behaviours: inspiring others, building confidence (tap on shoulder) BEING A CATALYST FOR COLLABORATIVE RELATIONSHIPS	Being a translator: *helping people frame meaning* Being a facilitator: *managing processes, challenging assumptions, un-tapping blind-spots* Being an explorer: helping leaders explore new ways of thinking and working for public engagement Being a connector: connecting people, organisations, policy, and practice Being an advocate: ensuring patients voices are heard directly and in-directly e.g., at the organisations Board *Being supportive:* having courageous conversations, advocate for patient and staff voice, kindness, supporting resilience and endurance	Being relational Storytelling Visualisation Effective conversation Public engagement process Peer networks Coaching Reflection and reflexivity Self-care practices Presence Research e.g., evidence-base, appreciative enquiry	Curiosity (listening, questioning, noticing, feeling) Courageous vulnerability (willingness to lean into dis-comfort) Open to challenging assumptions; (own and others) Being present (truly showing up) Holding a safe reflective conversational space

Table 6.2: Typology on how leaders identify with being collaborative with the public

6.3. Artefact analysis

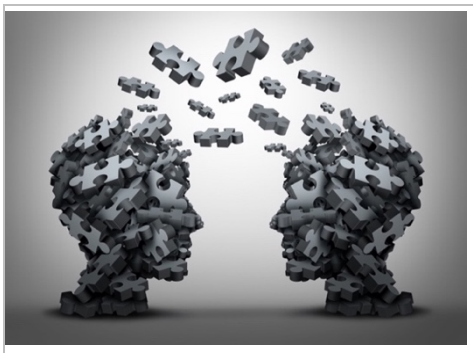
6.3.1. Introduction

In this section the focus of analysis moves to the idea of visualisation (Chapter 3). Leaders accounts were analysed from the perspective of participant selected artefacts shared in the second interview. The artefacts provided further insight into how leaders understood and identified with public engagement. The images presented in this research are not necessarily the exact artefacts shared in the interviews to ensure that participants remain anonymised (table 6.3). To re-cap, participants were invited to bring an artefact as a conduit for representing their sense of professional identity in relation to their leadership as part of triggering the research conversations. The only specific direction given to each participant was to bring an object to the second interview, which represents what they think about leadership for public engagement.

6.3.2. Participant selected artefacts

The artefacts below are selected as examples that bring to the fore participant voices and to show participants collective characterisation of how leaders identify with public engagement (table 6.3).

Participant selected artefacts	Participant representations of identity
	A revolving door: "*it's quite cyclical, the same things" "imagine the whole thing, [public engagement] is a big hole and it's getting smaller and smaller… the hole isn't closed yet… the hole has got a little bit smaller, but there's still a big gap"* (Peggy, I.2)
	A piece of driftwood: *"it reminds me of loneliness*". "*there is a social dimension to leadership for public engagement"* "*it's hard" "it takes effort"* "*not doing so is not an option*" (Tess, I.2)

	Double-sided jigsaw: On-going process of "*identifying, dis-identifying and re-identifying*. It is *"hugely challenging about how we do it because it's part of how we make sense of the world and its incredibly difficult to dis-identify to step back" … "a*n *art and skill"* Important to "*help people have different relationships and different conversations with self"* (Mark, I.2)
	A tap on the shoulder: *"noticing"* and *"making people know they contribute.* *"I think I'm just a jobbing person that tries to do stuff. I don't think there's any inner sign. I wonder inwardly if perhaps this was something I was searching for, almost without knowing"* (Oliver, I.2)
	A garden rock and water ripples: The image of the pebble and water ripple helped people to connect. *…. it was the simplicity because we are surrounded by lots of complex concepts, lots of words, lots of policies and papers"* Translating policy into practice needs to be "*simple"* using "*memorable concepts that everyone can relate to*". (Meghan, I.2)
	Photographs (family, team): *it's all about building services that would be fit for your own family, and that's in everything that I do"* "*It's like the [organisation] family. My team feel like a family, and the people that report to me are very senior people, but we still feel like family… this organisation has got a great culture for that"* (Aria, I.2)
	A paper by Don Berwick (2009): "*putting on an anonymous gown when becoming a patient* …. of *suddenly feeling quite powerless on the other side".* *"as a leader, it was that, and don't know if I would've had that level of insight. I might've gone for the evidence surrounding something. I probably would've enquired around the evidence, but I don't think I would've understood until I was in that situation myself about what it is that people actually want" (*Anzors, I.2)

	Camcorder: *"story is the most exciting part" … "step into somebody's shoes and see it through their eyes*" "*power that that little tool [camcorder] wields - "seeing that person", "seeing the emotion", "seeing the joy", "hearing in their own language" … "human connection"* (Julie, I.2)
SharePoint	SharePoint: "*a more appreciative approach of what's working gives people energy"* (Anzors, I.2) *Focus on;* "transparency and improvement." - "L*eading in this way takes courage".* "*I don't think as a system, that we've paid enough attention to the emotional price of delivering healthcare*" (Anzors, I.2)
	A candle (lit): It is important to attend "*understanding what it is that enables people - I guess to shine brightly - creating the leadership conditions that enables them to do that"… "each individual candle is actually a kind of a small light, and it's an important light, but it's when you bring a collection of candles together you are able to see much more clearly together than you might as an individual"* (Jill, I.2)

Table 6.3: Participant selected artefacts

The combination of artefacts with narrative interviews enabled participants to connect with their experiences and their understanding of leadership. The participant selection of an artefact was an opportunity for participants to share something of themselves and their leadership practice in a personal way. Gauntlett (2007) describes this as "*a way in which people can, and do, communicate messages or impressions to others about themselves*" (Gauntlett, 2007, p.2).

One of the ways that the value of artefacts was illuminated was through the shared perspective of all participants in this study on the complexity of the language, which was viewed as the greatest barrier to public engagement. This was best summed up by Meghan who encourages that this needs to be "*simple*" using "*memorable concepts that everyone can relate to*" (Meghan, 1.2). One of the reasons that she viewed this as

important was because; "*we are surrounded by lots of complex concepts, lots of words and lots of policies and papers*". Similarly, Jill emphasised the need in her work using visualisation to; "*keep it clear", "keep it simple" keep it memorable"* (Jill, I.2).

Stories told around participant artefacts resonated with participants' values and sense of self-discovery about how leaders identify with public engagement. Some participants told stories, which illuminated aspects of their role that are important to them, consistently placing a focus on relationships at the fore of their work (see for example, Anzors). Other stories, such as Jill's provided a further layer of insight into leaders' contexts for collaborative relationships with the public and the importance of attending to the conditions necessary for leaders to operate in collaborative ways. Several leaders, however, playfully shared their experiences of using visualisation techniques within their work. Meghan described the way that she had used her artefacts in her engagement work. Similarly, Tess described how in her work participants are invited to bring an image of someone who they care about to the training. One of the benefits of using artefacts such as images is that it helped people to connect important memories, incidents, and events that they constructed their stories around (Clandinin and Connolly, 2004).

6.3.3. Summary

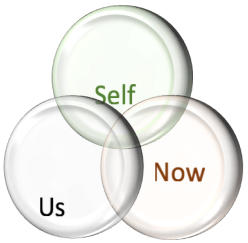
The act of selecting, analysing, and interpreting artefacts formed a reflective and reflexive process for both the researcher and the participants (Chapter 7). The artefacts appeared to act as a cypher for getting closer to how leaders identify with public engagement with a depth to those experiences that have motivated or inspired, influenced, and crafted their values and practices for becoming, and being a collaborative leader.

These insights are supported by Bolden (2006) in his integration framework for leadership development effectively utilised by Watton and Parry (2016). Consistent with Ganz, 2010), Bolden (2006) describes the need for people to consider '*who I am'* and

'*why I am here*' within a *'context'* of role and lived experience. A paradox emerges as collaborative leadership is conceived through its outward focus on relationships with others, yet findings illuminate the need to first engage with self-understanding and self-discovery. This was summed up aptly by Mark; *"the leader needs to start with themselves… before engaging with others"* (Mark, I.2). Artefacts were key to getting closer to leaders' sense of understanding of their self-identity.

The following section moves to a thematic discussion on participants collective experiences. Having completed the analysis via the themes that emerged from Voice-Centred Relational analysis (Mauthner and Doucet, 2003) the discussion on the findings is re-framed following the Ganz (2010) model, leading to a new 'public story' (p.14) (table 6.4).

Table 6.4. Data analysis 2: re-framing the themes, towards a new 'public story' (Ganz, 2010)

Towards a new public story	Core themes	Applying the themes to Ganz (2010)			Analysis of the theme
 Ganz (2010) Organising themes: Story of self (Leader's voice) Story of us (Leader's relationships) Story of now (Leader's contexts)	Curiosity Purposeful curiosity	**Story of self** Curiosity and self-discovery	Story of us Curious discovery, being appreciative	Story of now Curiosity and feeling real, feeling connection	Curiosity about public engagement emerges where leaders find ways to listen, reflect and experiment through self-understanding and preparedness practices. Leaders were willing to open a line of inquiry into what's going on and why. Their narratives were closely associate with being curious about our experiences. Purposeful curiosity emerges where leaders find ways to reflect and experiment through self-discovery.
	Courage Rumbling with courage	Story of self Courage and understanding values, self-discovery	Story of us Courage and reaching out, starting where people are	Story of now Courage and letting go of power, being human, dancing with values	Courage was closely aligned to the concept of curiosity enabling leaders to question some underlying assumptions on public engagement, for example sparking creative insight and connectivity. These leaders emphasise the importance of feeling vulnerable. Vulnerability did not show as a weakness but rather a sign of courage.
	Creativity Creative engagement	Story of self Creativity and self-understanding, emotional connection, opening new perspectives	Story of us Creativity and different conversations, different relationships	Story of now Creativity and keeping messages clear, visual, memorable	Creativity helps connect people to memories and significant events. It helped move people's self-understanding on public engagement from process to an emotional connection. Creativity shows up in narrative, dialogic and visual practices e.g., coaching. This means different conversations, different relationships.
	Role modelling relational behaviours	Story of self framing understanding and situating self in context	Story of us Role modelling – being a catalyst for change and shining the light on relationships (public and staff)	Story of now Catalyst for change and role modelling relational behaviours – staff engagement is catalyst for public engagement	Being a role model is testimony to leader's potential for transformation by shing the light on relationships to spark peoples' thoughts, emotions, and actions over time. For healthcare leaders in my study, role-modelling relational behaviours was about how they showed up in each interaction, un-tapping shared understanding, and connection. The data conveyed the reciprocal nature of being a role-model suggesting that, we get back what we give.
	Kindness Creating cultures of kindness	Story of self Kindness to self (a leadership challenge)	Story of us Acts of kindness	Story of now Cultures of kindness	Kindness evokes feelings of importance in transforming relationships with the public. Kindness challenges leaders to be self-aware and shows relationships with staff to be central to public engagement. Kindness is felt and expressed in different ways; kindness to self (self), acts of kindness (relationships) and cultures of kindness (context).
	Reflexivity The power of self-discovery	Story of self Connection and self-discovery and self-acceptance	Story of us Connection and relational depth and emotional safety-it's a feeling thing	Story of now Connection and personal values, identity, and organisational fit (safe reflective space)	Reflexivity is a feeling of contact and engagement. It resembles leaders understanding their own reflexive leadership. Leaders described this as how they connect with their inner sense of values and motivations. Their narratives on connection, with themselves and others were closely associated with being fully present and a willingness to value lived experiences at a deep level. Connection emerges where leaders find ways to reflect self-acceptance or belonging.

6.4. Discussion

6.4.1 Introduction

This section moves to a thematic discussion on participants collective experiences. Having done the analysis via the themes that came from Voice-Centred Relational Analysis (Mauthner and Doucet, 2003) the discussion on my findings is framed by the Ganz (2010) model. The relational process of Ganz (2010) discussed earlier provides a frame to re-analyse the data analysis themes, to test my relational approach, and enrich the perspectives of the findings. The discussion focuses on the three inter-connected areas; leaders' voice (story of self), leaders' relationships (story of us) and contrasting contexts (story of now) - figure 6.2.

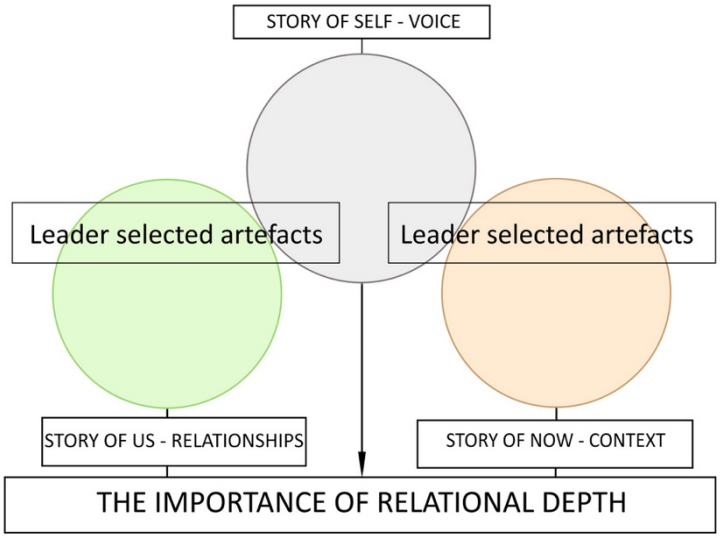


Figure 6.2: Organising frame – an adaptation from Ganz (2010) model

Its relational orientation provides a valuable frame for the data analysis themes and discussion - telling a 'public story' (Ganz, 2010, p.14). As a relational process the approach is not just looking at the data point leading to a new 'public story' (Ganz, 2010) - and how it can inform professional practice, directly informing my recommendations (Chapter 8).

6.5. Story of self: becoming a relational leader

6.5.1. Introduction

In this view of the evidence attention is given to leaders' sense of their self and their motivations for becoming collaborative with the public. The aim was to explore leaders own understanding of their leadership, to capture their motivations for public engagement, and to gain insights into their understanding of their self-identity. Within the literature review (Chapter 2) it was acknowledged that self-identity is a concept that continually develops throughout a leader's practice. According to Mead (1934) the process of developing self is through socialisation as a dynamic and ongoing process.

Ganz (2010) suggests that telling our story of self is *"a way to communicate our identity, the choices that have made us who we are, and the values that shaped those choices - not as abstract principle, but as lived experience"* (Ganz, 2010, p.14). Participants were found to discuss aspects of their past and conveyed significant moments in their experiences, which they associated with making meaning around public engagement and their motivations. This is something Jill described as *"a stream of consciousness"* (Jill, I.1). Participants shared often deeply personal insights into their experiences of engagement - and experiences of dis-location. I was interested in determining what these leaders have in common.

> *"A story of self communicates the values that call one to action"*
> (Ganz, 2010, p.14)

This contrasted with the literature (Chapter 2) which focussed primarily on public engagement process and initiatives for securing direct engagement, and less on the relational aspects of leadership. For some participants reflecting on their lived experience reached back to childhood. Jill for example, recalled vivid memories of*; "being on the edge" and "really looking back at my own life journey*" (Jill, I.1). Understanding values, personal and professional, conveyed a sense of self-

discovery. Self-discovery emerged as a fundamental step towards becoming a relational leader.

6.5.2. Dancing with values

Exploring participants' values expanded interpretations for leaders understanding of their self, their leadership role for public engagement, and understanding of their leadership identity through reflection on their own lived experiences. Expressions of their professional identity were expressed within leaders *"ecologies of practice"* (Evans, 2008). It moved however, beyond "*enacted*" professionality defined primarily by external policy, and imposed by organisations in ways bound by health and professional regulatory requirements such as nursing, medicine, and speech and language therapy. The most vivid story of personal growth was Jill - changing her view fundamentally on how she practiced "*you don't need a rule-book - you just need your-self*" (Jill 1.2). Jill attributed her leadership confidence to "*owning*" who she was on her leadership journey (Jill, I.2).

The literature supports approaches to *becoming a relational leader* that encourage self-reflection (Bolton, 2014), emotional intelligence (Goleman, 1995) and social intelligence (Goleman, 2007). Emotional intelligence, for example is identified as a pre-requisite for effective leadership described as; "*personal insight and awareness of their own strength, blind-spots, possible pitfalls and untapped resources and potential*" (Leslie and Canwell, 2010, p.303). Hefferman (2011) concurs with this encouragement of personal insight and self-awareness as a way of addressing *"wilful blind*ness" pointing to risk of leaders "*ignoring the obvious at our peril*" (2011, p.1). Participants appeared to resemble those "*who have had the* courage *to look and a fierce determination to see*" (Hefferman, 2011, p.5). This is what made participants accounts particularly remarkable; they were all at different points on their leadership journey - "*they are not especially knowledgeable, powerful, or talented. They're not heroes, they're human"* (Hefferman, 2011, p.5). When participants confronted facts and fears and understood their values, they were able to unleash their capacity to act as a catalyst for change, essentially role modelling relational behaviour for others (see typology, table 6.3). This is where reflexivity came to the fore.

6.5.3. Reflexivity and self-discovery

In routine contexts, self-identity has been conceived a something relatively unchanging and stable. However, in contexts of late modernity identities are viewed as relatively open rather than closed or given (Alvesson and Willmott, 2002). Alvesson holds the view that identities must be constructed and secured (2000). Leaders in this study show that leadership identity in relation to public engagement is on-going. Mark described this as ongoing process of "*identifying", "dis-identifying" and "re-identifying*" (Mark, I.2). The issue of self-identity was magnified by Grace who contemplated the challenge of self-reflection; "*I think some people will've struggled with that insight and holding that mirror up to yourself because it's difficult"* (Grace, I.2).

> *"when you do hold that mirror up to yourself, you can think - 'I need to change the way that happens' … and 'I need to do this another way'. You discover, you can't possibly change who you are as a person. What you have to do, is accept that you know when you are failing in the way that you're behaving, and be able to recognise that"* (Grace, I.2)

The focus on reflexivity illuminated the importance of leaders having the opportunity to share their story and creating safe reflexive spaces. The participant selected artefacts (6.3.2) were key to getting closer to leaders' construction of identity. As discussed in Chapter 4, artefacts came to be viewed as a "*metaphor of self*" (Hoskins 1998, p.198); this appeared to foster connection, with the artefact, self, and others.

6.5.4. The power of curiosity, courage, and connection

This study was interested in how experience influences us; our potential to influence ourselves, and others as we develop into leaders. One participant, Anzors spoke of her early childhood emphasising she had "*always been interested in voice"* (Anzors, I.1). She attributed her cultural context in childhood to becoming curious about public engagement, specifically; "*how to find a voice for people who through illness have lost power and influence"* (Anzors, I.1). She described her experience as akin to "*curious discovery*" emphasising the importance of being part of an organisation that valued public engagement (Anzors, 1.1). Argyris (1990) suggests that most leaders may find relational ways of being challenging as early childhood experiences, such as school trained us not to admit that we do not know the

answer; "*we learn to protect ourselves from the pain of appearing uncertain"* and *"that very process blocks out and new understanding which might threaten us"* known as *"skilled incompetence*" (Argyris, 1990 in Senge, 2006, p.233).

In this study it was expected to hear stories of engagement, policy, and process. Paradoxically, participant stories often didn't reflect that sense of belonging, but rather a sense of dislocation. This provided a glimpse of their motivations for public engagement, often deep-rooted and their commitment to make this work for people they are responsible for and through policies they are trying to deliver.

6.5.5. Summary: becoming a relational leader

The predominant themes of 'story of self' are reflected below (figure 5.3).

Figure 6.3: Story of Self predominant themes

What became clear in the data is the impact that leaders own lived-experience has on their thinking around developing collaborative relationships with public - and although beyond the scope of this research - collaborative relationships with staff. Findings showed that issues such as curiosity, vulnerability, and courage overshadowed policy and process in their practice. Becoming a relational leader with the public was found to work best if there is a kind of preparedness, something Tess described as "*framing*" understanding (Tess, I.1). The participant portraits (Chapter 4) demonstrate how the act of telling (and listening to) stories may help leaders to reflect on their experiences, share experiences, validate experiences, and make new meanings. Combining stories with artefacts, helped

leaders get closer to how they identify with public engagement, evidenced through the stories they shared (Chapter 4) e.g., Oliver's metaphorical "*tap on shoulder*" conveyed the concept of confidence (Oliver, I.2) - Tess's knarred piece of "*driftwood*" conveyed the loneliness of leadership, pointing to the social dimension of relational leadership (Tess, I.2) - Mark created a vivid picture through his virtual "*jigsaw*" of identifying with public engagement leadership as an continuum of identifying, dis-identifying and re-identifying (Mark, I.2). He reminds us that is takes both curiosity and courage to step back, to dis-identify. With the personal challenge of identifying with public engagement in mind, Jill used the concept of "*candle"* to conceptualise the fundamental qualities of creating the conditions for leaders to "*shine brightly*" (Jill, I.2). The artefact analysis is presented in Chapter 6 (section 6.3.2).

Consistent with Ganz (2010) findings suggest that stories told narratively and visually are a way for leaders to make meaning about their motivations and self-understanding. How much leaders know about collaborative relationships, and their motivations for public engagement is significant to how leaders choose to operate, establishing a sense of connection. As discussed earlier, leaders described the benefits, but also the challenge of engaging in reflection, reflexivity, and self-discovery. A participant's use of the metaphor "*holding the mirror up*"(Grace, I.2) chimed with Bolton's (2014) work on reflection and reflexivity (discussed in-depth in Chapter 7).

My participants had thought deeply about their public engagement practice before our first research interview, and their choice to work in relational ways. How leaders are supported in becoming prepared for relational practice across the health system was less clear. Not everyone will have the motivational experiences that appear to connect leaders to public engagement practice or the reflective spaces to make-meaning on their experience. As discussed in Chapter 4, findings suggest the 'leadership portrait' approach, used in this study, may be helpful as a reflexive process, and development tool to support relational leadership in the NHS. This discussion point is expanded in Chapter 8.

6.6. Story of us: being a relational leader

6.6.1. Introduction

Participants 'stories of self' were found to overlap with their 'stories of us' reminding us that we have many 'us'; our relationships, family, professional, organisation and community (Ganz, 2010). In this section attention is given to leaders' perspectives on public engagement in practice. It was important to understand participants' experiences of public engagement to establish a holistic view of how leaders identify with public engagement, and the conditions needed to operate effectively. The investment in the quality of relationships emerges as a crucial factor for cultivating collaborative relationships in healthcare. Findings demonstrate a compelling case for using relational approaches to public engagement rather than earlier formulaic approaches and initiatives for securing direct engagement, discussed in the literature review.

A distinctive feature of relational leadership is an ability to communicate (Pinker, 1995). In my study this is evidenced through the emphasis that participants place on relational aspects of their public engagement work. Participants emphasised the importance of helping people to have space to think and, reflect critically; "*to have more meaningful conversations*" about what is important to them (Tess, I.1). Along with this emphasis on relationships, participants expressed the qualities that they valued within leadership relationships; trust, noticing, feeling, reaching out and letting go of power and kindness. This resonated with research on 'the puzzle of changing relationships' (Pederson, 2013) and wider literature on relational leadership (Chapter 3). With this evidence came an appreciation of other perspectives on the nature of conversations in healthcare beyond the clinical interaction.

> *"A story of us communicates the values shared by those in action"*
> (Ganz, 2010, p.14)

6.6.2. Shining the light on relationships

One of the discoveries in the data was the emphasis participants placed on staff engagement in their public engagement work, fostering a sense of connectedness. This view, which was shared by many participants was summed up simply; "*happy staff, happy patients*" (James, I.1). One way that participants fostered their sense of connection was expressed through their resounding belief that; "*staff engagement as well as public engagement go hand in hand*" (Harriet, I.1). This was interesting as the literature (Chapter 2) created a compelling case that good staff engagement and experience lead to better patient experience, outcomes, and organisational performance (West and Dawson, 2012; Maben, 2015).

Organisations that engage both public and staff are found to achieve better outcomes and patients report better experience. (Kings Fund, 2012). Staff report improved wellbeing, better morale, and fewer errors (Laschiger and Leiteir 2006; Prins and Hockstra-Weebersta 2010; Maben et al, 2012; Maben, 2015).

> "*there is such a focus on the patient experience - but now that there is an increasing level of understanding and evidence [staff engagement] that actually the only thing that will ever improve the experience of patients is the experience of staff - nothing else is ever going to deliver that* (Jill, I.1)

For many leaders in my research, this relational dynamic was profound. This was illuminated by Anzors who said; *"for good reason staff engagement is one of the key organisational metrics that I think we lose track of at our peril"* (Anzors, I.1). Similarly, Jill asserted; *"the only thing that will ever improve the experiences of patients is the experiences of staff"* (Jill, I.1). Anzors summed this up beautifully as; "*shining the light on interactions*" (Anzors, I.1). Her work used *"real-time feedback" to "notice excellence" to "celebrate staff that are doing it really well*" and "*uncover care that is unacceptable that day and do something about it*" (Anzors, I.2). Like Anzors, many participants conveyed the importance of truly valuing lived experience; *"it is their expertise, and we will get better as an organisation if we listen to that and listen to our staff - we've invested heavily in hearing that voice… shining the light on relationships"* (Anzors, I.2).

6.6.3. Different conversations, different relationships

Conversation was a significant aspect of leaders' public engagement work. Such is its significance that Jill described conversation as; "*the most important vehicle to engagement*" (Jill, I.1). She emphasised that there is something significant in leadership skills in terms of "*how you craft, and then hold that conversational space*" (Jill, I.1). Crafting and holding conversational space was considered vital to genuine collaboration; *"credibility in terms of peoples belief and trust and confidence that you actually, that this is a genuine engagement - you genuinely want to know so, for me there is something really significant in leadership skills in terms of how you craft, and then hold that conversational space so that you actually say what you are going to do you do what you say you are going to do and that there's what next, but there's that coherence so there's something really important about the conversational space"* (Jill, I.1).

There is a large research base that justifies the use of conversation in creating a level of shared meaning (Rubin and Rubin, 2012). Paradoxically however, Jill suggests leaders are more *inclined to; "invite people [in] to engage with them* rather than *[reach out] to conduct the engagement where people are already having a conversation*" (Jill, I.1).

> *"as a whole it is common, in health care, particularly healthcare, it is common for people to invite people to engage with them rather than to conduct the engagement where people are already having a conversation so for me that is another real kind of principle of engagement - rather than say, 'I've got something really interesting I want to talk to you about, come and talk to me' - it's actually to say where are those conversations already happening?... to reach into an existing conversation, and join and learn… from a leadership perspective, and leadership skills… going to an existing conversation requires a greater level of tolerance for vulnerability and a greater level of tolerance for uncertainty"* (Jill I.1).

Mearns and Cooper (2005) use the term 'relational depth' to refer to specific moments of an interaction and as a quality of relationships (discussed, p. 97). In the article 'Fear is Nothing to be Feared' (Schpancer, 2017). it suggests that the long-term solution to how healthcare leaders identify with public engagement is learning to manage fear and yourself in fearful territory. Consistent with this view participants showed this takes time and "*it's uncomfortable*" (Meghan, I.2). Consistent with Meghan several participants pointed to the importance of

confidence. Meghan and Oliver both for example shared stories that used the metaphor of a "*tap on the shoulder*" to symbolise confidence (Meghan, I.1 and Oliver, I.2). Mark posited that fear can overshadow engagement reflecting some leaders lack of confidence for public engagement;

> *"this is about me and who I am. At times when I lack confidence, I want people to love me. I want people to recognise me. II want people to notice me. I want people to like me, which I would do anyway - but because I am my work, it's my work, it took me ages to realise that in a different way, in a different mirror, it's the heroic leader - it's the same conversation...which made me wonder, how many of these heroic leaders actually, really lack confidence and self-esteem in some very important areas of their life.* (Mark, I.1).

Schpancer (2017) cited by Lewis (2020, p.33) reminds us that 'fear' is not 'us' and it doesn't entirely represent reality; it's only part of the experience of identifying with public engagement. He encourages us to remember that while we may feel fear we can also tap into our values, courage, logic, our past experiences, and general view of the leadership world to get a more holistic view. This is where creativity came to the fore.

6.6.4. Embracing creativity

Creativity, such as participant selected artefacts was found to help participants connect with significant experiences and memories (Bach, 2007). Taylor and Ladkin (2009) suggest that by making [or using] art about our own experience we can enhance self-awareness and understanding. They assert that; *"an object that can contain contradictions (logical or moral) as well as unrecognized possibilities that are not constrained by logic or limitations of our current lives"* (Taylor and Ladkin, 2009, p.58). In this study the artefacts helped to get closer to how healthcare leaders identify with public engagement.

According to Grint (2005) relational leadership enables exploration of the aesthetic. This addressed my observation regarding knowledge created by sensory experiences such artefacts, which. helped these leaders to reflect on their experiences and connect with significant memories, events, and ideas. Consistent with Watton and Parry (2016) findings showed that using participant selected

artefacts evoked a sense of connection for leaders around their understanding of self, which appeared crucial for cultivating collaborative relationships with others.

Ganz (2010) acknowledges that some believe that stories don't matter, or that we shouldn't talk about ourselves so much. However, he suggests that if we do public work, such as healthcare leadership and public engagement "*we have a responsibility to give a public account of ourselves - where we came from, why we do what we do, and where we think we're going*" (Ganz, 2010, p.15). One participant described this as a "*stream of consciousness"* (Jill, I.1), pointing to challenges that accompanied self-discovery; "*once you discover your authentic self, there is no going back*" (Jill, I.1). Findings suggest relational leadership and public engagement require the ingredient of confidence to flourish.

"… a kind of leadership confidence that comes from owning who you are and your journey" (Jill, I.2.)

It is perhaps not surprising that these leaders conveyed a strong sense of the value they saw in creativity through practising reflexively (discussed in the story of self). Despite the diverse nature of leadership contexts each participant reflected the power of creativity through approaches that fostered "*connection*" (Jill, I.1) and "*making it feel real"* (Oliver, I.2). The data demonstrates relational leadership approaches for public engagement rather than earlier formulaic approaches discussed in the literature review and specific initiatives for generating direct engagement.

6.6.5. Role modelling relational behaviours

Role modelling relational behaviours was viewed as an important quality for leaders, discussed earlier. One participant emphasised role modelling in his work, deliberately challenging the traditional discourse of public engagement strategy development in his organisation (Mark, I.1). The typology (table, 6.3) that emerged from the data provides a sense of how leaders identify with public engagement and the relational qualities of what participants viewed as 'good' leadership for public engagement (p.180). It shows that there is no single way for enacting the role.

Rather these leaders identify with public engagement in different ways according to context. How leaders identify with public engagement, at any point in time, influences their public engagement practice and their confidence for being a catalyst for change.

Consistent with scholars such as, Uhl-Bein (2006), Cunliffe and Erikson (2011) and Koloroutis (2020) the relational qualities that participants described often included, being fully present, (listening, noticing, feeling), being curious, (good questions, challenging assumptions, leaning into dis-comfort) and creating a safe reflexive space (emotional safety) (table 6.2). Mark summed this up "*showing up*" (Mark, I.2) re-affirming this through his feedback on the research conversation (I.2) and feedback on his leadership portrait (Chapter 5) . This resonated with the theme of reflexivity, which is expanded further in Chapter 7. Closely aligned to the issue of presence is the relational concept of 'Ubutu', an ancient African word meaning "*humaneness*" and "*I am what I am because of who we all are*" (Magadlela, 2019, p.85). His work touches why this approach to human relationships is needed in fields such as leadership development, where leaders experience issues of uncertainty, complexity and ambiguity in contexts such as healthcare. It offers an alternative relational lens to see human interconnections that are present in every interaction between leaders and the public.

6.6.6. Summary: Being a relational leader

The predominant themes of 'story of us' are reflected below (figure 6.4).

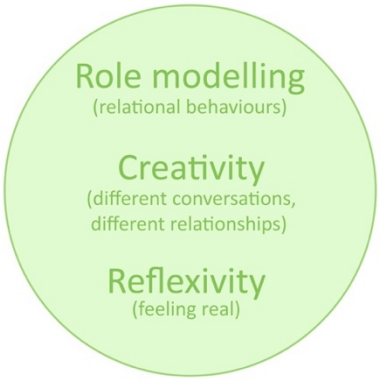


Figure 6.4: Story of Us predominant themes

By exploring approaches, tools and techniques for public engagement participants are shown to; "*embark on a creative adventure through the glass to the other side of the silvering"* (Bolton, 2014 p.116). Through their deep reflection and reflexivity these leaders challenged taken forgranted assumptions and opened new insights into their leadership and public engagement from a range of perspectives.

Findings suggest an emotional cost to relational leadership in the NHS (Chapter 4). Reflecting the view of several participants Anzors emphasised the importance of noticing the emotional cost of engagement work; "*this has been overlooked"* (Anzors, I.2). Several participants pointed to the importance of reflective conversations. Some leaders used reflective practices, such as coaching in their work. For example, Jill considered that coaching; "*helped to land so many things*" (Jill, 1.2). Yet, although many participants had some experience of coaching, this did not appear to be widely accessible to leaders across all contexts. The research conversation(s) themselves offer a further example of a reflexive space. This is because it supported leaders' self-understanding on how they identify with public engagement, their motivations and conditions to support their collaborative practice (see participant feedback, Chapter 5). Never-the-less, what is evident, and what the data captures is that reflective conversations are considered rare within the healthcare system.

It is important to remind ourselves that there is no single leadership theory that can be depended on to help leaders establish collaborative relationships with the public (Chapter 2 and Chapter 3). The evidence (Chapter 4) shows us that neither is there a single recipe of public engagement tools or techniques. For this reason, relational approaches, used with curiosity and courage, creativity and kindness appear the most helpful way to foster the kind of connection that leaders need for cultivating genuine collaborative relationships with the public. Regardless of the public engagement practice participants show that before we can be collaborative with others, it is necessary first to understand our self.

6.7. Story of now: sustaining relational leadership

6.7.1. Introduction

In the previous section the discussion focussed on the nature of participants' relationships and their engagement practice. Across all organisational contexts participants' narrative and visual expressions of how they identify with public engagement shows a continuum leadership identity. As we have seen this is hugely challenging, summed up best by Mark; *"it's hugely challenging about how we do it - because it's part of how we make sense of the world and its incredibly difficult to dis-identify - to step back"* (Mark, 1.1). The stories participants told in this study related to different leadership roles and contexts, but each similarly describe looking back (values and learning from lived experience) and looking forward (exploring approaches in practice). It is at this point participants appeared to form a sense of connection between 'being' collaborative and 'sustaining' collaborative relationships.

> *In the story of now we are the "protagonists", and it is the choices that shape the story's outcome* (Ganz, 2010, p.18)

In this section story and strategy overlap. According to Ganz (2010) we must draw on our "moral sources" to respond. The researcher hope was to move to a credible view of findings that are transferable into practice; moving from 'here' (data analysis) to 'there' (future possibilities) for cultivating collaborative relationships in healthcare (Ganz, 2010).

This section attends to the dynamics of context for healthcare leaders sustaining public engagement. It was beyond the scope of this study to analyse leaders' organisations or the organisational issues. However, discussion on the findings was not possible without consideration of the wider system and contrasting contexts within which leaders' practice. The ways these leaders identify with relational practice is shown to be socially constructed and pliable. It is not something that simply comes from within (Burr, 2015). The self-narrative determines leader's way

of interpreting the world of public engagement (De Vries 2006, p.12); of what influences how leaders make meaning from their lived experiences, what leaders' value most deeply, and how leaders understanding influences leaders' beliefs, behaviours, and practice.

6.7.2. Personal values, identities, and organisational fit

The discussion on leaders' values was implicit within the interview topic guide and was strongly represented in the data. It showed the importance of understanding personal and professional values as an influence for collaborative practice. The research interview design was flexible enough to enable leaders to visit and re-visit their values as the research conversations evolved over two interviews. For this part of the analysis leaders are referred to identify examples of their most closely held values in relation to their perspectives on their collaborative practice. Beyond their own personal and professional values several leaders reflected on their sense of value to their organisational context as a foundation for cultivating their relational work; *"I am lucky to be part of an organisation that values the work… what a gift"* (Anzors, I.1).

Exploring leaders' values expanded interpretations of leaders understanding of their self, their leadership role for public engagement and their sense of their leadership identity through their own lived experiences. The expressions of their professional identity were expressed within leaders *"ecologies of practice"* (Evans, 2008). Leaders' stories moved beyond "enacted" professionality, defined primarily by external policy, and imposed by organisations in ways bound by health and professional regulatory requirements such as nursing, medicine and speech and language therapy. Jill attributed her confidence for public engagement, to owning who she was on her leadership journey, fundamentally changing how she practiced - "*you don't need a rule-book - you just need your-self*" (Jill 1.2). She explained both the importance and problem of connecting with your own authenticity.

> *The problem of connecting with your own authenticity is you can't dis-connect with it once its there… it's the point beyond which I can't compromise and I think that's really helpful - although its painful and its difficult, it's actually quite helpful as a leader to have hit that bottom line… at least I know what it is now - before I knew what it was, but I didn't know what it felt like - but now I've connected with it that's actually quite helpful"* (Jill, I. 1).

Central to understanding leaders' values was the use of stories and artefacts as 'topographical maps' to navigate the characteristics of how healthcare leaders identify with public engagement across organisational contexts and how this is sustained. The work of Van Maan and Barley (1984) suggests that health leaders tend to establish inter-related cultures, based on issues such as professional background (nurse, doctor, speech and language therapist, and non-clinical roles) that are distinct yet related to an organisations culture influencing the lenses through which public engagement is viewed. They can also influence the values and beliefs that form a "*moral compass*" (Mark, I.2) and impact of how leaders come to see themselves and others and the contrasting contexts that they operate in. Essentially it was about "*being human*" (Aria, I.2).

The knowledge system for public engagement is based on NHS core values (NHS, 2015). Ontologically it echoes leaders' and identify aspects of significance by allowing leaders to make meaning for themselves - e.g., professional values of trust, respect, fairness, and kindness that many leaders in this study expressed. Central to understanding leaders' values was the use of stories and artefacts as 'topographical maps' to navigate the nature of relationships across organisational contexts and how this is sustained.

6.7.3. Cultures of kindness: organisation as family

Many participants made direct connection to family, conveying the influence of family values, and detailing that such values were a significant aspect of enacting their leadership role with the public. Participants set out strategies that they used to help them to develop and sustain collaborative relationships with the public in their leadership role. This view of the organisation and team as a family was evident in the accounts of Harriet who reflected; *"we are like a family"* (Harriet, I.1), and James who echoed this view, recounting the mantra "*happy staff, happy patients"* (James, I.1). Anzors made a similar connection between her family (personal world) and her leadership role (professional world) through her story on the development of her organisational approach using "*real-time feedback*" (Anzors, I.1).

The metaphor of "*organisation as family",* as an example of a culture of kindness was extended by Anzors (I.1), Peggy (I.1) and Oliver (I.1). Peggy built on the metaphor of family through her visual description of the mother-like role that she adopts, creating a safe conversational space for staff in her organisation. In contrast Oliver drew a clear distinction between his personal life and professional life, choosing only to display certain aspects of his persona around confidence in his public engagement role, which he has used as a catalyst for supporting others in cultivating public engagement. What was appealing to Oliver (I.1) was the positive impact that better public engagement and better staff engagement afforded his organisation.

Some organisations appeared to have traditional culture of engagement. Meghan, for example, conveyed an emotional journey, of her experience of an organisation, which she cared for deeply. She attributed being placed in quality special measures, and navigating a cloud of bureaucracy to a shift her focus, towards a more relational endeavour with patients and staff. Creating the conditions described didn't mean investment in systems and process. Rather, it seemed to happen when leaders felt that they could trust their leadership context. The cultural dimension of 'organisation as family' - 'team as family' appeared vital for leaders in cultivating collaborative practices. This was best evidenced by leaders from Western Bay NHS Foundation Trust and Northern Bay NHS Foundation Trust - reflecting a positive impact on performance. According to Tess this requires "*confidence*", which reflected the kind of courage that participants described and a willingness for "*letting go of power*" - and "*being more human*" (Tess, I.2).

6.7.4. The emotional cost of relational leadership

For healthcare leaders to enact public engagement across participants pointed to the emotional cost of relational leadership in the NHS. The technique of using narrative interviews combined with artefacts was found to be particularly valuable in understanding relational aspects of healthcare leadership practice; self, others, and context (Ganz, 2010). These leaders show how, through telling, and re-telling stories on their public engagement practice they make new connections and understanding on their practice. The iterative process taken to understand leaders'

sense of their self, led to a rich kind of learning through holistic self-discovery across a range of contexts. This allowed deep reflection values that underpinned participants' professional leadership and engagement practice. Their personal lived experiences were found to be intrinsically inter-connected to their professional leadership practice.

The research conversations and development of leaders' portraits (Chapter 4) were useful as an approach as it was found to support leaders' self-discovery and in-depth self-awareness (Wall and Rossetti, 2013). According to Bolton (2014) stories can be used to illuminate the iterative nature of leaders understanding their self as a leader and their values, enabling participants to explore experiences more deeply from different perspectives. Although participant experiences were varied, what all the leaders' narratives shared was the theme of opening new ways of thinking about public engagement, untapping blind-spots in practice. Bolton (2014) shows us how by capturing people's stories experiences can be explored and re-visited over time. Similarly, researchers such as Wall and Rossetti (2013) have encouraged the purposeful analysis of stories to generate insight, including aspects of leaders understanding of self, their values, their character, relationships, context - points of connection and dis-connection.

Several participants portrayed that the role of public engagement and leadership can be lonely Tess created a visual representation of loneliness through her chosen artefact of a piece of driftwood (Chapter 4). Similarly, Anzors described her work in developing a network, seeing this a "*network of support for those individuals who risk being deeply committed to something, burning out with the effort, in a system that doesn't understand and doesn't accommodate"* (Anzors, I.1). Focussing on this relationship could be the most important move for the system to make towards creating the necessary conditions for supporting leaders to operate Jill conveyed a powerful visualisation of creating the conditions through her chosen artefact of a candle (Jill, I.2)

6.7.5. Summary: sustaining becoming and being a relational leader

The predominant themes of 'story of now' are reflected below (figure 6.5).

Figure 6.5: Story of Now predominant themes

In contrast to the 'story of us', which provided a view of leaders' relationships, the 'story of now' section has looked at leaders' how leaders sustain public engagement in context. Particular attention is given to the vacillation of leaders' values and organisational contexts to show insights into the conditions needed for leaders to effectively operate collaboratively: becoming, being and sustaining their practice. There is more work left to be done. We are confronted with the fact that values for public engagement are not necessarily enacted in practice (Chapter 2). Participants stories (Chapter 4) offer specific examples of how leaders identify with public engagement, their motivations and the conditions needed to support collaborative relationships in practice. Participants identified with engagement but also connected deeply with their own experiences of dis-engagement. Participants showed how becoming and being collaborative with the public can be achieved; curiosity and courage, being a catalyst for change (role modelling) and embracing creativity and cultures of kindness. This showed the power of connection that came from the quality and depth of their relationships with others and their self.

These highly committed leaders show also that there is an emotional cost to leading in this way. This challenge demands action to move beyond the process for public engagement by attend further to the relation dimension of public engagement and attend to the conditions that support leaders to cultivate public

engagement for themselves and others - "*to shine brightly*" (Jill, I.2). In routine contexts self-identity has been conceived a something relatively unchanging and stable. In contexts of late modernity identities are viewed as relatively opened rather than closed or given (Alvesson and Willmott, 2002). Alvesson suggests identities must be constructed and secured (2000). The way leaders identify with public engagement is on-going, described as an ongoing process of; *"identifying, dis-identifying and re-identifying*" (Mark, I.2). Participant selected artefacts, were key to getting closer to participants sense of how they identify with public engagement. From this perspective, artefacts can be viewed as a "*metaphor of self*" (Hoskins 1998, p.198).

6.8. Conclusion: the importance of relational depth

The secondary analysis (Ganz approach) of the healthcare leaders in my study showed the importance of relational depth. The leadership described by participants was not formulaic. Rather, the way leaders identify with public engagement emerged as a relational chain, beginning with curiosity and self-discovery. The adaptation of the Ganz (2010) model is represented visually below with the themes from the data (figure 6.6)

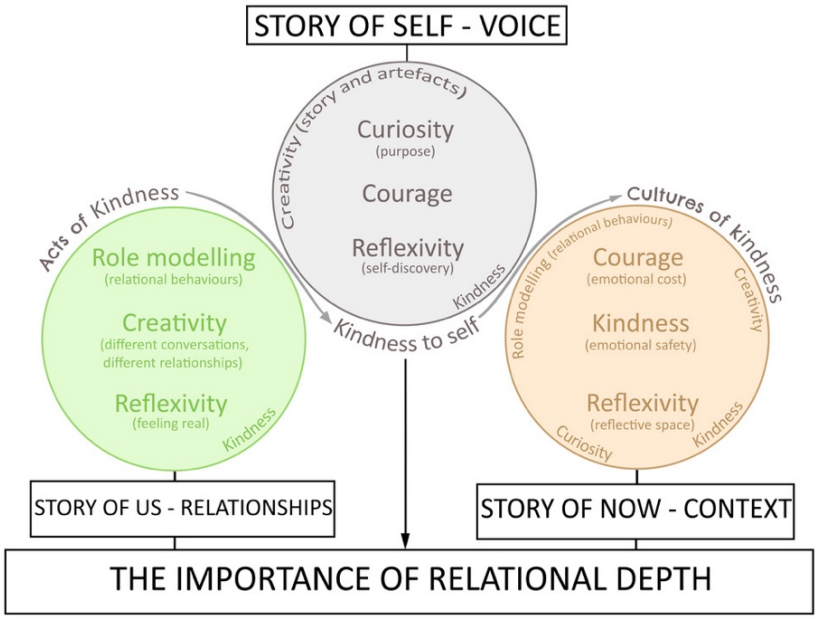


Figure 6.6: Ganz (2010) model – adaptation with themes from the data

The diagram above represents the way the six core themes relate to the model of Ganz (2010). Each theme is both fixed yet moves dynamically. The themes are better described as being in a dynamic relationship e.g., the theme of kindness. The diagram attempts to show this dynamic relationship. The 'story of self' (voice) emphasises 'kindness to self'. The 'story of us' (relationships) emphasises 'acts of kindness'. The 'story of now' (context) emphasises the positive impact of 'cultures of kindness'. Each theme may have a dominant presence in the model of Ganz (2010) but is pulled relationally as the themes are dynamic. The data showed that encouraging relational approaches according to the leadership context was most helpful for understanding how these leaders identify with public engagement: curiosity, courage, creativity, role modelling, kindness, and reflexivity - being a catalyst for change (summary of core themes, p.181).

Consistent with the literature, analysis of the healthcare leaders in my study showed there is rarely time to listen deeply to the sense that they are making of their experiences of public engagement, or the ways that they are not making sense even to themselves. Looking across the interviews these participants highlight the importance of attending to the relational dimension of their practice relationships with others and self. One of the things that was helpful from the relational process described in this chapter is Ganz (2010) view of leadership, organisation, and social movement. My findings suggest that encouraging healthcare leaders to think about public engagement as a social movement may be a more helpful way for thinking about leadership.

The following chapter addresses the importance of reflexivity in the research to acknowledge the influences of the researcher on the study (myself) and consider the development of my thinking.

7. Chapter Seven

Reflexivity

7.1. Introduction

This study has always been as much a personal endeavour as a scholarly attempt to show new insights into how healthcare leaders identify with public engagement specifically; what motivates a leader to be collaborative with the public, and what conditions support leaders' collaborative practice. This chapter addresses the importance of reflexivity in the research to acknowledge the influences of myself on the study and consider the development of my thinking. The chapter also addresses the importance of participant reflexivity as noted in the discussion on the data analysis themes.

Whilst my biases have been declared at points within this thesis, personal reflexivity is illuminated here through selected aspects of the doctoral journey to convey influences and impacts on the research. Reflecting on my personal experiences ignited my interest in how the cultural and behaviour changes that are needed to effectively embed collaborative practice might be achieved, driving why I am here (section 7.3). This chapter is guided (and framed) by Mauthner and Doucet (2003) comprehensive account of reflexivity in research, which shows the inseparability of epistemology, ontology, and research process.

7.2. Reflexivity, essence, and complexity

Rooted in ancient philosophy, reflexivity has been operationalised in research from a wide range of philosophical and disciplinary perspectives (Cunliffe and Jun, 2005). Emerging as "*the new gold standard for qualitative researchers"* (Gabriel, 2018, p.137) reflexivity is of central importance in research in the social sciences (Bryman, 2008; Finlay, 2012; Bolton, 2014). Trying to capture the essence of reflexivity reveals complexity as the many definitions on the concept of reflexivity

are *"coloured by the context within which they are written sociological, philosophical and /or researcher-related perspectives"* (Doyle, 2013).

Scholars and thinkers who have developed reflexivity theories, discourse and applications offer contrasting views. Giddens (1991) problematised reflexivity as a consequence of developing society, suggesting that the constant flow of new knowledge and information creates a kind of collective perspective and perpetual revisioning of social life. This view resonates with Bourdieu's contention that reflexivity is located qualitatively in different and more diverse ways by researchers (Gray, 2008; Deer, 2008). One area where sociological researchers have drawn links between epistemology and research practice concerns the research relationship (Mauthner and Doucet, 2003). However, in practice there were few reflexive accounts that address the issue of reflexivity in data analysis. Rather, the complex process of representing participants experiences appeared often to be overly simplified and overly personalised.

The 'reflexive turn' in the social sciences has encouraged greater understanding of theoretically and empirically based knowledge construction processes in qualitative research; yet these discussions remain underdeveloped in the literature (Mauthner and Doucet, 2003). Scholars and practitioners continue to conceptualise reflexivity in different ways with little consensus. Despite variations most definitions share a common theme of referring to a kind of conceptual "*bending back"* of thought "*upon itself*" (Webster, 2008, p.65). Bryman (2008) helpfully situates reflexivity in the world of social research defining it as; *"reflectiveness among social researchers about the implications for the knowledge of the social world they generate of their methods, values, biases, decisions and mere presence on the very situations they investigate"* (p.698).

7.2.1. Reflexivity for qualitative health research

Researcher reflexivity in qualitative health research is woven through the ontological and epistemological research framework and interactions between

researcher and researched (Doyle, 2013). The theoretical implications raised questions on how to demonstrate reflexivity in my research. Literature on organisational studies show the importance, role, and contribution of researcher reflexivity (Weick, 2002; Cutliffe, 2003; Cunliffe and Jun, 2005; Hibbert et al, 2014). Scholars such as Hibbert et al (2014) argue the need for more relational conceptions of reflexivity. Similarly, Cassell et al (2020) encourage; *"a more relational conception of reflexivity that moves away from a researcher-centric perspective"* (p.5).

According to Mauther and Doucet (2003) reflexivity should not be confined to issues of social location, theoretical perspective, emotional response to participants, or need to document the aspects of reflexivity in the research process. They consider more neglected factors such as interpersonal-organisational contexts and ontological-epistemological assumptions associated with analytical approaches, to show how these influence the research process and outcomes. Against these conceptual issues Rae and Greens' (2016) reflexivity matrix offered a basis for exploring reflexivity across my doctoral journey (appendix 7). These theoretical implications raised questions not only about researcher reflexivity (Etherington, 2004) but participant reflexivity (Doyle, 2013; Cassell et al, 2020).

Participation in my study appeared to act as a catalyst for reflection and reflexivity for both the researcher and researched. Participant reflexivity is therefore addressed this chapter. If the intersubjective nature of reflexivity is accepted, it follows that participants play a key role. Cassell et al (2020) assert three characteristics of research design that support participant reflexivity; opportunity for reflexive space, participant anticipation of the requirement to share with the researcher, and participant control in a relational dialogue. The notion of self-reflexivity (Cunliffe, 2002) is shown by Cassell et al (2020) to be an important form of internal dialogue and connection between emotion and reflexive practice.

This snapshot of reflexivity in health research suggests that; *"a person is not born into reflexive practice; it is a cultural pattern for interpreting the world that one has to learn"* (Myers, 2010, p. 21). The challenge according to Finlay (2002) is to

"*negotiate a path through this landscape - one that exposes the traveller [researcher] to interesting discoveries while ensuring a route out the other side*" (p. 212).

The review of reflexivity in my research begins with my 'professional and personal biographies' to acknowledge own story and show how my reflexive lens was constructed. A discussion then follows to address reflexivity at different stages of the research journey accounting for; organisational and inter-personal context (7.4.1), ontological and epistemological conceptions of the study (7.4.2), navigating the methodological terrain (7.4.3), social location and emotional response to participants (7.4.4), creating a reflexive space (7.4.5), knowing through artefacts (7.4.6), leader experience as a reflexive partnership (7.4.7), and reflexivity, quality, validity and trust (7.4.8). The focus on the importance of relational depth (discussed in 7.5) leads to a final section on re-imagining reflexivity (7.6).

7.3. Professional and personal biographies

7.3.1. My story

Being a nurse is a huge part of who I am. My personal and professional values form a metaphorical mirror, acting as a moral compass. My fascination with collaborative relationships with the public, and embodiment of an identity for public engagement spanned over two decades of my professional practice. Reflecting on my own story was formative guiding me to work in leadership, engagement, and change. I became interested in how the cultural and behavioural changes to embed collaborative ways of working in everyday practice might be achieved, which is reflected in my earlier writing (Hawley, 1997).

This led me to consider potential limitations of traditional academic boundaries within the disciplines of healthcare leadership and public engagement. Consistent with participant reflections on their portraits (Chapter 4) reflexivity can be struggle and can foster vulnerability (Armstrong, 2018). The data suggests that reflexivity influences how leaders identify with public engagement. My professional and

learning practice has continued to evolve, moving from chronological accounts, to layering reflective accounts, towards more reflexive practice. My identity, as a relational leader, accounts for the interconnectivity between my personal, professional, and academic biographies. My thinking on reflexivity in research is premised on notions of post-modernism and social constructionism (Chapter 3). I am influenced by my training as a nurse, accommodating humanistic models of care alongside scientific and technological competences (Kleiman, 2007). I am also influenced by my own lived experience of healthcare. I value stories expressed narratively and visually, knowing the world as socially constructed. My story resembles a journey through which I have learnt to connect my interest in leadership and public engagement (collaborative relationships) together with storytelling (narrative interviews) artefacts (visualisation) to achieve a more holistic understanding of how leaders identify with public engagement.

> *"If you want to know me, then you must know my story, for my story defines who I am. And if I want to know myself then I too, must come to know my story (McAdam, 1993, 11). I must come to see all its particular – the narrative of self – the personal myth – that I have talking, even unconsciously, composed over the course of my years. It's a story I continue to review and tell of myself (and sometimes to others) as I go on living"* (McAdams, 1993, p.11).

7.3.2. My reflexive lens

About halfway through my doctoral journey I had the opportunity to explore the nature of reflexivity more deeply when I undertook research for a book I was invited to co-author on values and ethics in coaching (Iordanou, Hawley and Iordanou, 2017). According to Finlay (2002) *"the process of engaging in reflexivity is full of muddy ambiguity and multiple trails as researchers negotiate the swamp of indeterminable deconstruction, self-analysis and self-disclosure"* (p.209). Through my research on practising reflexively I discovered that becoming a reflexive practitioner helps us see our 'self' more completely and notice ethical dilemmas in research and professional practice from different perspectives. This underpins my professional practice, shaping my journey by enabling me to differentiate more

clearly between reflexivity and reflection in my research (Webster, 2008). An example is shown in the following extract from my researcher diary:

The term reflection derives from the Latin verb reflectere, which literally means to bend back. This compound word is made up of the prefix re, which means 'back', and the stem flectere, which means 'to bend'. This definition was first applied in the context of light itself bending back on reflective surfaces (Stedmon and Dallos, 2009, p.1). It is, therefore, no surprise that, just as others before, I have been drawn towards the metaphor of 'mirror', reflecting, quite literally, our own image back to us. This metaphor readily springs to mind as a way of exploring ourselves and our professional practice. Considering for a moment the hunter Narcissus who, according to Greek Mythology, fell in love with his own reflection is helpful for considering if this is really self-indulgence, as it may first seem. I concur with Gillie Bolton that we need to cast this view to one side. This is because reflection is purposeful, as it opens 'explorative and expressive' avenues for critically evaluating ourselves within specific contexts (Bolton, 2014, p.16-17). *By extension, reflecting on our practice as leaders in healthcare is 'not narcissist as rather than falling in love with our own beauty, we bravely face the discomfort and uncertainty of attempting to perceive how things are'* Bolton (2014, p.17). *Facing this kind of discomfort in my practice has played an important role in my journey towards ethical maturity, which is illuminated through my recent writing on the topic of values and ethics in coaching* (Iordanou, Hawley & Iordanou, 2017). *Thus, 'far from trapping us in a state of self-adulation, the discipline of engaging in reflective practice activities enables us to be self-critical, nurturing us in our professional development'* (Stedmon and Dallos, 2009, p.1).

My experiences motivated me to cultivate the discipline of reflection within my daily practice. I have learnt that becoming a reflective practitioner helps us see ourselves more completely, and to see the ethical dilemmas we face in our professional practice from different perspectives, as though through another person's eyes. Together these factors underpin my work on leadership and public engagement in healthcare shaping my journey to, and along my doctoral study.

Rachel Hawley: extract from researcher diary (2016)

When I started to critically reflect on my practice more deeply, such as my reactions to literature, participants, and supervision, I reached a tipping point in my understanding of reflexivity. This was where the process of reflexivity began. Reflexivity was not a linear process (figure 7.1); rather the art of practising reflectively and reflexivity in the research ebbed and flowed (Iordanou, Hawley & Iordanou, 2017). The challenge was to develop the personal mastery to recognise the difference between the two processes. Reflexivity is viewed as in-depth reflection on reflection (Bolton, 2014). This understanding of my reflexive lens was interwoven in my developing ethical maturity as a researcher.

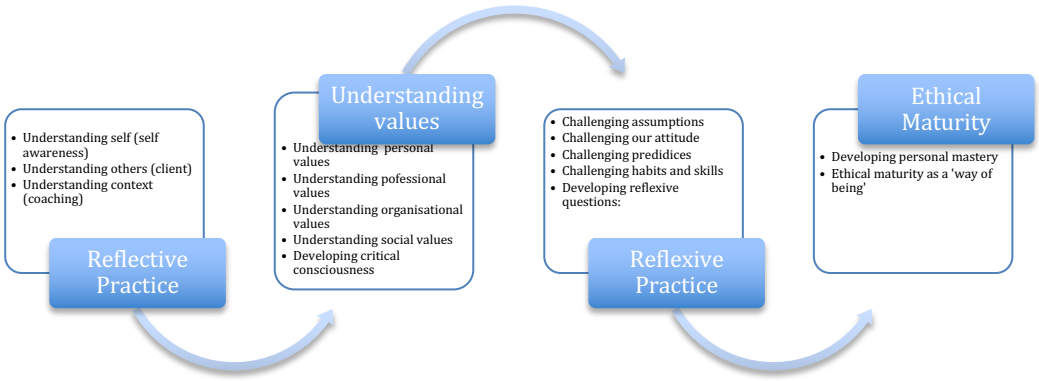


Figure 7.1: The reflexivity chain (adapted on Iordanou, Hawley and Iordanou 2017).

Reflexivity was present in my researcher diary, notes, and supervision conversations. It was this combination that brought reflexivity to life, connecting theory and practice, in the spirit of a practice-based Doctorate in Professional Studies programme (Yee and Brenner, 2011). As there may be limits to reflexivity and awareness on influence, Mauthner and Doucet (2003) suggest it may be more helpful to think in terms of "*degrees of reflexivity*" (p.425) with some influences being easier to identify and express than others in the review of reflexivity.

7.4. Reflexivity in the research

The research took a consciously reflexive stance. As part of the methodological selection, it was important that I included my pre-understanding of reflexivity, leadership, and engagement, acknowledging personal bias in relation to my own story. A reflexive stance enabled me to challenge myself as a researcher, leader,

and public engagement practitioner. Specifically, it enabled me to ensure that the research remained close to the voices of participants.

The subjective lens, held in this study is therefore embraced. There are many stories that could be told, not one story; not one truth but many truths (Alvesson and Skoldberg, 2009). This section explores reflexivity in the research.

7.4.1. Organisational and inter-personal context

This study was primarily interested in leaders' experience, as a basis for establishing new insights into how healthcare leaders identify with public engagement. According to Mauthner and Doucet (2003) the 'choices' about; "*ontological and epistemological positioning, methodological and theoretical perspective, and the adoption of particular research methods are bound up not only with our personal or academic biographies, nor are they motivated exclusively by intellectual concerns"* (p.421). Instead, they encourage acknowledgement that the interpersonal, political, and organisational contexts in which the researcher is embedded is a key factor for addressing reflexivity in the research.

With this issue in mind it was important to account for the organisational contexts in which healthcare leaders experience was situated. This was based on information in the public domain via the Care Quality Commission (CQC) who report overall ratings for leadership and care. Leaders' stories illuminated their motivations for public engagement and how they are trying to make engagement work for people through the policies they deliver. Within this context I valued the experiences and encouragement offered by public engagement practitioners and leadership networks shaped my thinking on my methodologies.

7.4.2. Ontological and epistemological conceptions of the study topic

As this study was focused on relationships, I was drawn to a relational world view. The inclusion of a relational ontology (Chapter 3) was a basis for holistic

exploration around how healthcare leaders identify with the public. The Voice-Centered Relational Analysis approach to data (Mauthner and Doucet, 2003) was especially appealing as it is informed by ontological and epistemological assumptions that were congruent with a relational study. The approach holds at its core the notion of a relational ontology (Mauthner and Doucet, 1998). The conception of the separate, self-sufficient, independent, 'rational self' or individual are rejected in favour of 'relational being' (Jordan, 1993, p.141). Leaders in this study are viewed as interdependent, embedded in a complex web of relations within an NHS system; cultural, organisational, professional, and personal.

Using narrative interviews combined with artefacts opened space to engage in a relational exploration around how leaders identify with public engagement, and forage holistic views as a relational issue that involved professional and personal conceptions of self. The approach appeared to contrast with earlier research that had often emphasised processes and initiatives for securing direct engagement. Conceiving leaders holistic understanding of self, using narrative interviews and participant selected artefacts drew attention to aspects of earlier research that appeared to have been overlooked in favour of more functionalist debates. This enabled me to make original contributions to knowledge, research, and professional practice (Chapter 8).

7.4.3. Navigating the methodological terrain

I understand relational leadership with the public as a form of inquiry that takes place in diverse settings across the healthcare care system. As I said in Chapter 1 relational leadership in this study, is considered, not as a different kind of leadership but rather "*a different lens over what counts as leadership"* (Crevani, 2019 in Carroll et al, 2019, p.223-247) through, which to explore how healthcare leaders identify with public engagement in the NHS (Chapter 1, 1.5.3). A variety of approaches were needed to adequately address the complexities of the phenomenon - relational - narrative - visual - reflexive. Drawing multiple perspectives into the research design became central to the methodological choices generating multiple layers of data and ways to make meaning (Chapter 3).

The overall aim of the Voice-Centred Relational Analysis (Mauthner and Doucet, 2003) approach is to enable to social researcher to access an authentic understanding of participant accounts. For example, Mark emphasised the importance of authentic understanding in his practice by; *"really reflecting on what is behind the decision, the choice I'm making - what am I really saying to myself at that moment, and why, and that honesty then linked to... authenticity and integrity*" (Mark, I.2).

At times I struggled with the tension that my researcher story and participant stories were resonant with the often-used 'journey' metaphor (Delamont 2002, cited by Durrant 2013, p.63). Aspects of my story are shared selectively to illuminate the reflexive nature of my own research journey. Potential limitations of academic boundaries were considered within the disciplines of research, leadership, and engagement. Navigating the methodological terrain deepened my researcher curiosity and inspired me to flex the boundaries, to achieve a holistic approach to this study. Mauthner and Doucet (2003) argue that "*time, distance and detachment*" (p.415) allow more reflexivity in the research process. An example of this arose from a change in my supervision team during the write-up stage of my study. A change of role to a new organisation and a retirement were the reasons for this change. The initial challenge transpired as a hidden jewel in my reflexive doctoral journey. This was because it acted as a necessary catalyst to trace reflexivity and the influences on my choices along each stage of the study. Losing the security of my initial team undoubtedly made it easier for me to challenge bias by articulating certainties and uncertainties, tensions and strengths.

7.4.4. Social location and emotional response to participants

Within the literature on reflexivity, attention is often drawn to the importance of recognising the social location of the researcher as well as the ways in which our emotional responses to participants can shape interpretations of their accounts (Mauthner and Doucet, 2003). Consistent with their approach my utilisation of Voice-Centered Relational Analysis (Mauthner and Doucet, 2003) provided a

practical tool to address social location and emotional responses to participants. Few methods offer such concrete ways to do this. Reading 1 involved reading for both 'story' and 'researcher response'. This encouraged me to read for my 'self' in the text, situating my researcher self in the analytical process emotionally and intellectually (Brown, 1994, p.394). Situating myself emotionally and socially, in relation to participants was an important aspect of reflexivity in the research. For example, I used 'reading one - reader response' to explore that fact that I am a nurse, which might influence my interpretations of leaders' narratives. The reflexive loops, cultivated in each reading (Chapter 3) showed the importance of recognising the social location of the researcher, and ways in which both emotional and intellectual responses to participants can shape interpretations of their accounts (Armstrong, 2018) through the creation of a safe reflexive space.

7.4.5. Creating a reflexive space

Within the genre of relational research, the Voice-Centered Relational Analysis method (Mauthner and Doucet, 2003) was a particularly helpful way of accessing reflexivity. It provided a practical tool to address the reflexive element of analysis accounting for narrative and visual data generated from researcher and researched perspectives. Reflexivity was encouraged through five readings of the transcriptions (Chapter 3); story-researcher response, participant voice, artefact, relationships, and context. Understanding of the data was emergent, making sense of what I learned through each reading (Bogdan and Biklen, 2003). My adaptation of this analytical tool provided a helpful reflexive tool for navigating technical, narrative, and visual aspects of the research. This adaptation, discussed at length in Chapter 3 was tabulated to guide the approach and show the reflexive loops through each reading of the data (appendix 2 and 5).

7.4.6. Knowing through artefacts

Anticipation that participants would share their experiences, in different ways, was important (Riach, 2009). Participants were invited to think, in their own time, before meeting for the second interview, about their identity as a leader.

Participants were invited to choose an artefact, which represented what they think about their leadership in relation to public engagement, to discuss at the second research meeting. This focus on participant preparation for the research interviews appeared to facilitate participants reflexive thinking by encouraging stories as self-narratives, leading some participants to question previous assumptions (Casswell et al, 2020).

The use of artefacts encouraged a participant-led element of the research process (Riach, 2009). This was illuminated by inviting participants openly to choose an artefact. Rather than feeling 'loss of control', which my earlier experiences prepared me for, I felt a sense of collaboration within the research relationships. At the beginning of the second interview participants were invited to start either with reflections from the first interview or their artefact. Many participants chose to begin by sharing their artefact, and in consequence became the director of the conversation. This appeared to lead to a trusting interview, viewed as conversational partnership (Rubin and Rubin, 2012). In that regard Denzin (1994, p.503) notes *"[R]epresentation… is always self-representation… the others presence is directly connected to the writer's self-presence in the text"* (p.503).

The artefacts formed an alternative way for expressing 'self', helping participants make meaning, thus representing participants' sense of how they identify with public engagement. Each artefact told a story woven into the individual leadership portraits (Chapter 4). The stories were more than the object and came to resemble significant concepts discussed in the six data analysis themes: curiosity, courage, creativity, role modelling, kindness, and reflexivity (Chapter 6, 6.2).

The set of participants selected artefacts, presented in Chapter 5, was therefore built into the research design with confidence. Whilst recognising potential limitations that artefacts may put ideas in leaders' minds that may emanate from my own assumptions and biases in using artefacts. This was reflected in participant validation of the complexity of language. Participants feedback also showed that the invitation to select an artefact cultivated self-reflexivity - a safe developmental space to reflect on their own practice and bias. For example, Meghan said; *"when*

you said to me about bringing an object, I knew exactly what it was that I was going to bring with me - it was the first thing that for me I'd retained in my head… I can be very poetic about it, but I think it was the simplicity of it as an idea… and the difference that I could make as one individual" (Meghan, I.2). This is an example of where the engagement in selecting and bringing an object appeared to make them feel safe and more connected to the discussion on their leadership and public engagement.

7.4.7. Leader experience as a reflexive partnership

The use of narrative interviews and participant selected artefacts enabled both participants and researcher to find an authentic voice. A different methodological journey may have led to different stories and study outcomes.

The research interviews provided a dialogic space between researcher and researched. A characteristic that supported participant reflexivity was the opportunity for a reflective space as part of the research design (Riach, 2009). Cunliffe and Juns' (2005) notion of self-reflexivity focusses on the need for participants to be able to access their own dialogic process signifying the importance that participants felt supported to be able to think about the topic of public engagement. In terms of the research design meeting twice was helpful.

Establishing a conversational partnership with participants is an important element of self-reflexivity. For example, I used participant validation on my interpretation of their stories, which showed the importance of the dialogic space, as a reflexive space. This was something that participant Mark called a "safe container" (Chapter 5, 5.6). Mark reflected; *This was facilitated by your presence and holding of the space. I believe that as the researcher the attention you paid to what I was saying (and not saying) enabled me to move into a more self-reflexive space"* (Mark, 5, 5.6).

7.4.8. Reflexivity, quality, validity, and trust

Quality and scrutiny of my research was not determined simply by a compartmentalised form, but by practising reflexively. Reflexivity enriched my awareness of different ways to address the study objectives of methodological choices to explore the complex concepts authentically, within the changing landscape of healthcare (Kinchloe, 2001; Finlay, 2002, 2012; Doyle, 2012). Seeking participants feedback on their leadership portrait enabled these leaders to be part of the analytical process. Participant reflections, as part of this verification process conveyed a sense of collaboration in the research that was resonant of *"co-creation as at the heart of reflexivity"* (Gabriel, 2018, p.137-157). The fact that I chose to share back my portrait with participants is an example of reflexivity - a reflexive loop. It allowed me to reflect of what they said and re-enter their stories with new understanding .

The stage of respondent validation (Bryman, 2004) led one participant to request the use of their real name rather than pseudonym as agreed at the time of consent. One participant asserted that this was his story, it was about him. He told me; *"It feels at odds with the quality and content matter of our conversation and the portrait that emerged from that for me to be anonymised".* Mark explained; "*the use of pseudonym renders me invisible in the conversation. I become an object of study, and this resonates with previous experiences in the history of my relationship with the healthcare system where I was viewed as a collection of symptoms to be treated and fixed"* (Mark, email). Paradoxically the pseudonym surfaced feelings that resonated with earlier experiences of "*battling with the system"*, "*identifying", "dis-identifying" and "re-identifying*" (Mark, I.2). He reflected; *"the journey of me taking up my leadership role was one of re-discovering, cultivating, and developing a clear sense of who I now was, living with my new identity of someone living with a range of health conditions. Being seen, heard, and therefore recognised (and named) is central to my journey and my story of my own self leadership and the role I play as a leader in the healthcare system"* (Mark, email). This situation resonated with Janet Sauers' (2012) research on portraiture and agency. Navigating such

ethical dilemmas ensured fulfilment of ethical standards in parallel with being authentic to values of engagement.

The process of respondent validation suggests that to see our self purely as researcher in relational inquiry is at our peril. This was illuminated by Mark who emphasised the importance of "*the conditions created*", of how I "*showed up"*, of "*thoughtful questions", "presence" and "holding of the space*" (Mark, I.2). He considered the researcher approach to "*model engagement principles and practice*" viewing this as *"modelling the values and principles of collaborative engagement* of the kind of dialogue that supports collaborative generative conversations*"* (Mark, I.2). The highly personal responses from participants suggest the interpretive leadership portraits fulfilled a purpose beyond traditional analytical thesis report. The fact that I have used, adapted, tried, and tested models of data collection and analysis supported me to follow 'steps' in a process that kept me 'honest' and reduced bias and 'self-indulgence' that can happen if the methodological framework is too loose. Ensuring quality and trust in the interpretive research is evidenced by the application of 'Eight Criteria for Excellent Qualitative Research (Tracy, 2010) to conceptualize how qualitative rigor has been understood and enacted in the study. This quality tool was used alongside the review of reflexivity to show how quality markers have been achieved and evidence the core values of the research (appendix 8).

7.5. Learning from the reflexive process

I have learned, in this study, that the way we use language narratively and visually enables the construction of meaning. I have grappled with the tension of balancing traditions of academic writing and reporting. Writing in the third person and first person appeared necessary to show my appreciation of the thesis as both an academic product and a personal artefact arising from the research. It encouraged me to take a step back and view the thesis from a more independent perspective. Scholars such as Douglas and Carless (2013) reflect limitations of traditional thesis reporting by addressing how richness of learning could be captured, and shared, through more creative approaches; "*the unsaid, the lost voice, movement, colour,*

and those parts of life or relationships that don't fit neatly into a traditional report" (2013, p.53). The leadership portraits (Chapter 4) formed an alternative way of expressing holistic impressions narratively, and visually. on how healthcare leaders identify with public engagement. The approach was shown to help leaders make meaning around their leadership.

In this study, by taking a reflexive relational approach, it provided new insights into the research aim and objective to address the research questions - how healthcare leaders identify with public engagement - what motivates leaders to be collaborate - what supports leaders collaborative practice. Feeling connected to the work that I have done, and the implications for policy and practice, was an important part of the reflexive process. For example, having the privilege join a panel discussion of senior leaders, including Sir Robert Francis author of the Francis Inquiry (2013), at NHS England 'Starting With People' conference (2021) re-connected my study back to the Francis Inquiry (2013). Sir Robert Francis reflected on what he described as his extraordinary experience - both difficult and a privilege - where he saw first-hand on a collective basis of what happens when organisations don't listen to people. His words resonated; "*people need to have their story listened to… the starting point is building relationships*".

Leaders on the conference panel collectively emphasised the importance of working to create more safe spaces for leaders to have this conversation. For example, one panel member said: *"everyone I know who has taken an active role in public engagement is because it matters deeply to them - usually because they have a story, a personal story behind it".* This resonated with the voices of my participants and my own reflexive journey in the study. It is an example of a safe reflective, and reflexive space that enabled the research findings (Chapters 4, 5, 6) and implications for practice (Chapter 8) to be traced back to the Francis Inquiry report (2013). It brought to the fore the importance of reflexivity and relational depth.

7.5.1. Reflexivity and relational depth

It became important to take seriously both the narrative and visual elements of making meaning. Consistent with Durrent (2013) having explored my own identity in some depth, in earlier writings (Hawley 1997), as part of the professional doctorate journey (2013, 2015), and in research on reflexivity (Iordanou, Hawley and Iordanou, 2017) I struggled with an unforeseen tension, of revealing something of my 'self' but not to over-emphasise the 'me-search' (Ely et al.,1991). Relevant elements of my own story are included, deliberately bringing my voice to the fore in this chapter, to acknowledge the importance of reflexivity in qualitative research.

My engagement with particular texts on my doctoral journey informed, inspired, intrigued, and challenged me. Yee and Bemmer (2011) challenged me to face up to both the concept and practicalities of qualitative research as bricolage, as a characteristic of contemporary practice-based research questions. Alongside engagement in the academic literature were several factors. Firstly, my curiosity in understanding the nuances of reflective and reflexive practice (Iordanou, Hawley and Iordanou, 2017). Secondly, my attempts to maintain my researcher journal and field notes. Thirdly, my supervision team(s) brought a richness of perspectives, challenge, humour and support that infused my thinking in unexpected ways, stimulating reflexive questions about my understanding of my self-identity as a practitioner-researcher.

Holding two interviews with participants illuminated the potential for delving deeper under the surface of findings. It provided a sense of relational depth and sense of connection for researcher and participant. The explanation of Mearns and Cooper (2005), seeing this as a phenomenon relevant to the whole spectrum of human encounters is encouraging in seeking portability into relationship working (Lewis, 2020, p.89). There were moments that I came to view reflexivity in my researcher diary as a deep sense of engagement between the researcher and researched. The reflexive nature of the doctoral journey process has changed me. The following example is an extract taken from my researcher journal:

"It has taken me on 'a creative adventure, right through the glass to the other side of the silvering' (Bolton, 2005, p.4) *helping me perceive my professional practice from a range of perspectives. There is no single theory that accounts for my entire journey. Indeed, there is little agreement amongst researchers about what learning is (Brockbank and Gill 2006). In its simplest form learning can be viewed as having the potential to transform (Law et al, 2007), shifting from linear learning and progression, to increasingly dialogic ways of knowing. Such a transformational journey I believe, was made possible for me through my own development of reflection and action (praxis), so that a new consciousness could emerge; 'conscientization'* (Freire, 1992). *This kind of learning process can free people from their self-limiting beliefs, just as I was (Mezirow, 1990a,b). The integration of professional and personal experience is a significant integral aspect of my practice. To make meaning it is vital to make sense of an experience (Mezirow, 1990). Practising reflexively liberated my learning and my ability to help others, creating a shift from amassing information in silos, towards developing chains of association. With each step, I have taken along the way, my understanding of new concepts has grown, slowly bridging the gap between relevant theory and my practice".*

Hawley (2017) - researcher journal

This chapter has aimed to show reflexive loops at different stages of the research to illuminate reflexivity in my work as a practitioner-researcher. How I did this on my journey provides an interesting example of "*dancing on the threshold of meaning*" (Berger, 2004, p.336). Berger (2004) pays attention to moments when people reach the edges of their meaning making. It suggests that the role of a relational leader is to help people find the 'edge of their understanding', to 'be company at that edge', and to 'help people make a new, transformed place' (Berger, 2004, p.336). Berger (2004) uses thinking and data to map the terrain of transformation, particularly the threshold of transformation.

As discussed in Chapter 6, Bergers' (2004) suggestion that the work of a transformative teacher is first to help learners find *'the edge of their understanding*' (p. 336) was consistent with my experiences on my doctoral journey. Being company at this edge of knowing resonates with my researcher

experiences as new meanings were constructed at each stage of the study. This '*edge of knowing'* is described as the most precarious and transformative space - '*the liminal space*' (p.336). My reflexive journey shows how I came to terms with the limitations of knowing, and not knowing. But making this space, between knowing and not knowing, is also shown to be difficult in the data where policy, context and sense of self are constantly moving.

Whilst the literature review (Chapter 2) shows healthcare leaders may not be able to get a clear vantage point of public engagement when immersed in the complexities of healthcare, the reflexive space offered through the narrative interviews combined with participant selected artefacts appeared to provide a frame for re-imagining reflexivity. Berger (2004) describes this as holding onto vulnerability of the kind leaders described in this study, and their willingness to feel uncomfortable with the uncertainty of not knowing (Chapters 4, 5, 6). This suggests we can create a space for developing this kind of not knowing. This relational perspective starts to provide a sense of when we get consciousness about understanding our self as leaders in relation to public engagement; where people start to connect with their self, with others, and with their contexts.

7.5.2. Re-imagining reflexivity

In the light of the theories and discussion on reflexivity I concur that a person is not born into reflexive practice; *"it is a cultural pattern for interpreting the world that one has to learn"* (Myers, 2010, p.21). It is evident from my study that narrative interviews combined with artefacts seemed to take leaders to places they were not expecting. It is important that we know how to create and hold this kind of reflective and reflexive space. Methodologically this study has used multiple sources of data to arrive at a holistic view for understanding how healthcare leaders identify with public engagement. The attempt to bridge the gap identified in Chapter 2, which showed that the leadership associated with public engagement necessitated a level of collaboration and genuine relationship that has hitherto been under reported from a relational perspective.

Exploring ideas on reflexivity resonated with the relational nature of the research methodology and methods; narrative and visual. This led me to re-imagine reflexivity as a bricolage. The reason why this makes sense to me is that as the study progressed, I began to identify as; *"a maker of patchwork, a weaver of stories; one who assembles a theoretical montage through which meaning is constructed and conveyed according to a narrative ethic"* Yardley (2008, p.12). I considered that a way for addressing the complexity around reflexivity might be found by blending Bourdieu (1992) theory of epistemic reflexivity with Denzin and Kincloe (1999) theory of bricolage. In this way my methodological choices were not chaotic, but rather considered a relational approach that stimulated inclusive and dynamic dialogue between my researcher self, participants, and readers of this research.

7.5.3. Bricolage

Bricolage as conceptualised by Denzin and Lincoln (1999) and further theorised by scholars such as, Kinchloe (2001, 2004a,b, 2005) and Berry (2004) can be considered a critical, multi-perspectival, multi-theoretical approach to inquiry (Rogers, 2012). However, the theories that underpin bricolage make it complex leading to misunderstanding and criticism. For Denzin and Lincoln (2012) bricolage can help researchers "*respect the complexity of meaning-making processes and the contradictions of the lived world"* (2012, p.3). They suggest; "*the combination of multiple methodological practices, and empirical materials, perspectives, and observers in a single study is best understood as a strategy that adds rigor, breadth, complexity, richness and depth in any inquiry"* (2012, p.6). Denzin and Lincoln (2018) distinguish five types of bricoleur to embrace rigor and complexity: the interpretative bricoleur, the theoretical bricoleur, the political bricoleur, the narrative bricoleur and the methodological bricoleur.

Bricolage shares key features of a relational ontology, which in the world view of the researcher, places emphasis on 'self' as a way of making meaning within the

context it occurs. When used as part of a bricolage issues can be addressed by examining tensions and interfaces that were created between my chosen narrative and visual methods. By adopting the concept of bricolage, it is possible to consider, and re-visit the experiences of leaders' experiences through a variety of lenses to form a more holistic view.

7.5.4. Reflexive bricolage

Denzin and Lincoln (1999) consider bricolage to be more than multi-method research, rather a; *"combination of multi-methodological practices, and empirical material, perspectives and observers" that "adds rigour, complexity, richness and depth"* (p.6). The approach enables researchers to respect the complexity of meaning-making and the contradictions of research in the social world. My experimentation with the concept of reflexivity led me to consider my practice as an example of reflexive bricolage. This signifies a profound shift in my thinking and learning on my doctoral journey. It accounts for why I struggled with the tension, that at times this study bordered on being autoethnographic. It was much about my own researcher story as that of the participants, resonant with the often-used "*journey"* metaphor (Delamont 2002, cited by Durrant 2012, p.63).

In his critical text on reflexivity Webster (2008) draws attention to the complex nature of reflexivity. He shows that classifications can only go so far in addressing reflexivity in practice. In his effort to address this issue he identified the concept of confessional reflexivity. Webster's emphasis on "*shifting our thinking about thinking"'* (Webster, 2008, p.65) was helpful for framing my approach to reflexivity in the research. It emerged as a powerful tool that enabled assumptions in the research to be challenged, with a sense of self-awareness and critical consciousness. The capacity to become, and be, reflexive as conceptualised in this study, moves beyond processes for reflexivity to attend to reflexive loops that convey holistic understanding for the researcher and researched. Paradoxically my attention shifted through the exploration of this chapter; from viewing the research as bricolage to a realisation that the bricolage that emerges is from the researcher journey rather than necessarily the research.

With the benefit of hindsight, I can see that I have been interested in aspects of bricolage for some time. According to Wibberly (2012) it could be argued that my professional-researcher background has been something of a bricolage –-being a nurse - my lived experience of failure in quality of care - my leadership in public engagement across professional contexts. I have drawn inspiration from rich sources of learning from literature discussed in the thesis (Chapter 2) and from the richness of participants stories (Chapter 4). Although this chapter marks the end of this study it also signifies a new beginning beyond the study. The concept of self-identity, as an example of reflexive bricolage, needs to be developed in a more profound and broader sense of possibilities as a way for discovering profound moments of shift in researcher and professional leadership practice.

7.6. Conclusion

This chapter emerges as an example of reflexive bricolage. The reflexive nature of the chapter seems to match and extend the theories and definitions of bricolage. More widely, it resembled what I attempted to achieve with my research participants; positing that this study is an example of bricolage. Reflecting on the reflexive nature of my doctoral journey has taken me on "*a creative adventure, right through the glass to the other side of the silvering*" (Bolton, 2005, p.4) helping me perceive my professional and research practice from a range of perspectives. There is no single theory that accounts for my entire journey. Rather, I am humbled by the changes I observe as researcher and relational leader. It is a privilege to research one's professional and doctoral learning journey.

The following chapter draws together what has been learnt from this study to address its contribution to knowledge. Consideration is given to the implications and possibilities arising from the research to make recommendations for professional practice and further research.

8. Chapter Eight

Conclusion, implications, and possibilities

8.1. Introduction

In drawing this thesis to a conclusion this chapter reports on the insights gained from this qualitative, relational study on how healthcare leaders identify with public engagement. The chapter begins with a brief re-cap on the research before addressing the research questions. Consideration is given to the contributions that the research makes to knowledge, research, and professional practice. Finally, recommendations are made to inform how healthcare leaders can begin a relational journey for public engagement rather than being trapped in a policy world of process.

8.2. Summary of the research

The aim of this study was to better understand how a group of twelve healthcare leaders, from a range of contexts, understand public engagement. All these leaders had an existing perspective on public engagement. What became clear in the literature was that the leadership associated with public engagement necessitated a level of collaboration and genuine relationship that has hitherto been under-reported from a relational perspective. The study used relational methods to elicit leaders understanding of relationships with themselves, with others and with their leadership context. Data was gathered using narrative interviews combined with artefacts. Participants selected artefacts formed a conduit for representing their sense of self in relation to their leadership practice. Data was analysed using a variation of Voice-Centred Relation Analysis (Mauthner and Doucet, 2003) involving multiple readings for story, voice, artefact, relationship and context. A secondary analysis was undertaken using the Ganz (2010) model, which enriched the findings and led to a new 'public story' (p.14). I have attempted to recognise

both the narrative and visual ways that healthcare leaders identify with public engagement to provide new insights on relational leadership in the NHS.

8.3. Research findings

From the data analysis six core themes emerged: curiosity - courage - creativity - role modelling - kindness and reflexivity. Re-framing the themes using the Ganz (2010) model showed that the themes are both fixed but also move dynamically in relationship with each other (Chapter 6, figure 6.6). Looking across the participant findings highlighted the importance of attending to the relational dimension of their practice relationships with others, self, and context.

This study yielded a comprehensive understanding of how healthcare leaders identify with public engagement from a relational perspective. The picture that participants painted in this research was of a very human leadership where their desire to make a difference to public engagement has been able to flourish and take them through extraordinary professional and personal challenges. Leaders' stories often reflected earlier experiences of dis-location (dis-engagement). Their stories showed how, through their leadership they have tried to make engagement work for those they are responsible for and through policies they deliver. The opportunity to share their story impacted leaders' motivations for public engagement. This was viewed as significant by them because "*when people share their story, people are prepared to share something of themselves and their own vulnerabilities*" (Jill, I.1). This finding suggests that reflecting on their story helps leaders to establish a sense of purpose, commitment, and authenticity.

There was a strong association between leaders reflecting on their story and connecting with lived experiences, which appeared to foster curiosity around their public engagement work. Closely associated with curiosity was courage; understanding values and reaching out to others. These leaders associated feeling uncomfortable with positive learning. The uncomfortableness these leaders described was viewed by them as taking courage. The importance of attending to

how we engage with ourselves was viewed by them as a gateway to engaging others. This finding suggests that how we identify with public engagement begins not with sterile procedure but with self-discovery. This contrasts with the literature that had focussed primarily on process and initiatives for securing direct public engagement.

The study also yielded information about what types of approaches leaders used, conveying themselves as role modelling relational behaviours to inspire and build confidence for others. This was discussed at length in Chapter 6. The greatest challenges were language, complexity, and mindset. Participants observed that traditionally public engagement has been managed linguistically. Yet the data showed that keeping messages simple and memorable helps people make meaning around public engagement. Their practice focussed on relationships and the quality of conversation. This is something one participant termed: "*different conversations, different relationships"* (Mark, I.1). This fostered a sense of connection and belonging.

Leaders identified with public engagement over time, suggesting multiple, contradictory, and changing identities; professional and personal. The work of Ganz (2010) reminds us that how we identify with public engagement is an active dynamic process between ourselves, our relationships, and our leadership context - (table 8.1).

Self (voice) In this view of the data: a focus on leaders' stories - their vulnerabilities and motivations sparked often by stories of dis-location - their sense of curiosity (purposeful) – their courage (understanding self, values, dancing with values, reaching out to others) – leaders confidence came from owning who they are on their journey.
Us (relationships) In this view of the data: a focus on relationships, shining the light on relationships (public and staff) - role-modelling behaviours (curiosity, presence, courageous conversations, creating emotional safety) - different conversations, different relationships (dialogic, visual, creative) - being a catalyst for change (relational approaches)
Now (context) In this view of the data: a focus on the power of connection (personal, professional, organisational values) - kindness (cultures of kindness) - emotional safety and wellbeing (these kinds of reflective conversation are shown to be important, yet considered rare in the NHS system)

Table 8.1: Summary of findings through Ganz (2010)

Several leaders reflected that there is rarely time to reflect on their experiences. Having a safe space for reflection was viewed by them as important to make sense of their experiences and support resilience to "*keep going*" (Tess, I.2). This was summed up by Anzors who contemplated; *"I don't think we've paid enough attention to the emotional cost of delivering healthcare"* (I.2). A strong and consistent relationship was found between leaders' public engagement practice and the theme of kindness. This shows that leaders who operate in a culture of kindness appear to flourish, described as '*organisation as family'* or '*team as family'* by six local leaders. I call this relational leadership. This concept can be re-imagined as relational practice. Re-imagining the future for leadership and public engagement puts relationships at the heart of it. One thing that was illuminated by the secondary analysis was the Ganz (2010) perspective on leadership, organisation, and social movement. It showed the importance of relational depth.

The following section sets out the main contributions that this research makes to knowledge, research, and professional practice.

8.4. Contributions to knowledge, practice, and research

Narratives and artefacts provided a glimpse into participant experiences and understanding of how healthcare leaders identify with public engagement by eliciting understanding of their relationships with themselves, with others, and with their leadership context. This raises the question of "*so what*?" The following section describes the main contributions that this study makes to knowledge, research, and professional practice.

8.4.1. Contribution to the literature

The first contribution that this study makes is to bring the literature on leadership and public engagement more closely together. There was a huge linguistic issue in the literature review (p.47). The review emphasised the historical, contextual, and social perspectives that may influence how leaders identify with public engagement. The literature found the leadership associated with public

engagement, necessitated a level of collaboration and genuine relationship that had hitherto been under-reported from a relational perspective. This study contributes to new knowledge through its critique of traditional functionalist and linguistic practices highlighting the neglect of relational and non-linguistic practices. The novel approach to defining 'relational' makes an important contribution to the literature on leadership and public engagement conceptualising leadership and public engagement as relationally dynamic. Relational leadership brings leaders' reflexive relationship with themselves, with others and with their context into focus. My definition differs from others in the literature by bringing leaders' reflexive relationship with themselves to the fore. The active relational dynamic between 'self' (leaders' voice), 'us' (leaders' relationships) and 'now' (leaders' context) projects relational leadership in the NHS as action orientated.

8.4.2. Contribution to narrative inquiry methodology

The second contribution that this study makes is to narrative inquiry. Applying this approach in a new way, resulted in multiple layers of analysis. The first layer of analysis was 'portraiture', which is viewed in this study as the ability to take the raw data and turn participants words into a narrative portrait augmented by artefacts. This was guided by my adaptation of Voice-Centred Relational Analysis (Mauthner and Doucet, 2003). Early interpretations were verified with participants, ensuring their voices remained at the fore of research. The final leadership portraits represented participants words, but they were also an interpretation of public engagement. This is significant because the approach provided a space for leaders to reflect on themselves, their perspectives on leadership, and their contribution to public engagement. The relationship between the researcher, participants, and their leadership portraits meant that raw data was represented in a holistic way.

The use of portraiture concurs with Lawrence-Lightfoot (2005) description as she sought; *"a text that came as close as possible to the realms of painting with words [that] capture[s] the texture and nuance of human experience"* (p.6). In this

research this idea has been taken further, in the adaption of the approach, and augmentation of the narrative portraits with artefacts. The portraiture described in this thesis was rooted by Voice-Centred Relational Analysis (Mauthner and Doucet, 2003) and then extended further by applying the Ganz (2010) model of 'telling a public story' (p.14). This indicated several distinctive benefits of the approach as a safe container for leader reflections. Participants valued the opportunity to read, re-read, and reflect on their leadership portrait. This was described by one participant as "*a valuable resource for reflecting on, revisiting and challenging my own leadership style and the values that underpin it*" (Jill, portrait feedback). The process of respondent validation indicated that to see ourselves purely as researcher in relational inquiry is at our peril (Chapter 5). Having a safe space for reflective conversation was significant, demonstrating contribution to research but also to participants professional practice as a potential leadership development tool.

8.4.3. Contribution to data analysis

The third contribution that this study makes is to relational data analysis. The approach was multi-layered by nature. This section briefly outlines my variation of analysis to show how Voice-Centred Relational Analysis (Mauthner and Doucet, 2003; Brown and Gilligan, 1992) was adapted, and extended, by utilising the Ganz (2010) model. As described above 'portraiture' was a way to transform data into twelve leadership portraits. The adaptation of the Voice-Centred Relational Analysis (Mauthner and Doucet, 2003) involved at least five readings for story, voice, artefacts, relationships, and context. This enabled holistic understanding of leaders' experience. The second stage of the approach entailed checking the authenticity of the portraits through a verification process. This allowed participants to have a collaborative voice in scaffolding their portrait. The third stage of the approach then centred on the data analysis themes to distil the knowledge from the Voice-Centred Relational Analysis (Mauthner and Doucet, 2003). The fourth stage was undertaken using the Ganz (2010) model, which tested the findings and led to a new 'public story'. This enriched the study findings and originality of my contribution to knowledge.

The relational nature of the analysis enabled narrative and visual data to be explored through multiple lenses, achieving a holistic understanding of leaders' experiences: story, self, artefacts, relationships, and context. It helped to trace the complexities of participants worlds to better understand the nature of their relationships with the public. It also allowed the researcher role to be made explicit within the multiple lenses through which data was analysed and interpreted. This is described as reflexive loops. This was interesting as the analytical model used were not just accepted. Rather the relational and reflexive processes described were used to push the models of Voice-Centred Relational Analysis (Mauthner and Doucet, 2003) and Ganz (2010) individually and collectively**.**

Applying the Ganz (2010) model to the research context of relational leadership in the NHS makes a further contribution. Using his work in this way, illuminated the relational dynamic of the research findings, and considerations for future professional practice. Furthermore, this study gives Ganz (2010) model a place in healthcare leadership and engagement research; this is addressed below. My approach is described at length so that others, who may wish to adopt the model I used, can trace the necessary steps (appendix 2 and 5).

8.4.4. Contribution to practice-based research

The fourth contribution that this study makes is through the way that I used the Ganz (2010) model as a conceptual frame and applied this to the earlier work undertaken with participants using Voice-Centred Relational Analysis (Mauthner and Doucet, 2003). In this section the adaptation of the model, discussed in Chapter 3, is accounted for to show my contribution to practice-based research. There appeared to be a connection between Ganz (2010) and the work undertaken with participants stories using the Voice-Centred Relational Analysis (Mauthner and Doucet, 2003). Its relational orientation provided a valuable frame to add a further layer to the analysis, to test my analysis and enrich perspectives of the findings. I began with Ganz (2010) concepts of 'self', 'us' and 'now' and contextualised these by overlaying my work using Voice-Centred Relational Analysis (Mauthner and Doucet, 2003); leaders voice, artefacts, relationships, and context. The visual

representations (figures 6.2 & 6.6) show how this expanded Ganz (2010) model and added colour to it to enrich the relational dynamic of the findings. This is described below:

- Leaders' voices corresponded to Ganz (2010) view of 'self'. This was concerned with leaders' own perspectives on their role and sense of their self in their relationships with the public. Here the narrative on leaders' motivations for public engagement was considered. This was inevitably in relation to influences on both relationships and the contexts in which they operate. This view had a focus on individual participants understanding of their self.
- Leaders' relationships corresponded to Ganz (2010) view of 'us'. This offered insight into the influences on relationships and practices that shaped participant perspectives on their approaches to public engagement. This view shone the light on the nature of relationships and how these leaders identify with public engagement in practice.
- Leaders' contexts corresponded to Ganz (2010) view of 'now'. This offered insight into the dynamic of contexts for leaders sustaining public engagement, taking a wider system perspective on the conditions needed to support leaders' relational practice. This view took account of situating participant experiences, acknowledging influences of the wider health system and focus on a call to action.

Ganz (2010) model on telling a 'public story' (p.14) provided an organising frame for the data analysis themes; from distilling the themes (table 6.1) to re-framing the themes, towards a new 'public story' (Ganz, 2010) (table 6.4). My adaptation showed how the themes are fixed but also dynamically active. This was illustrated in the visual representation of the themes, using the example of kindness (figure 6.6). My approach provided a reflexive process, to enrich the data analysis themes, and validate findings. The process added a further layer of analysis to the research. It enriched the findings by testing the approach. The relational orientation of the Ganz model (2010) was particularly helpful for a practice-based professional doctorate because of its focus on leading to a 'public story' (action). The most important aspect is the relational dynamic.

8.4.5. Contribution to practising reflexively

The sixth contribution, which related to practice is partly my reflexive understanding of practising reflexively. This is how, through the research, I have contributed to the practice of public engagement leaders. The thesis has been structured to show reflexive impact, from researcher and researched perspectives to evidence what I have learnt as a doctoral researcher. The importance of reflexivity in the research was addressed in-depth in Chapter 7 to acknowledge the influences of myself on the study and consider the development of my thinking.

The concept of reflexivity has manifested itself as useful in my study for the researcher but is also noted in the data as a core theme. One discovery was that multi-layered data collection and analysis enriched the understanding of how leaders identify with public engagement. The reflexive processes described in the thesis enabled leadership portraits that represented peoples' experiences in a holistic way. My reflexivity has developed over time, rooted in my earlier professional practice (Chapter 7). When I began my doctoral journey, I thought I knew my story well, yet as I explored my professional and learning journey I observed layers of reflection that appeared significant to reflexivity in my research (table 8.2):

1982-1992	My early clinical practice resembled linear learning and progression
1992-2002	Patterns of non-linear practice, collaborative working, and learning crept into my practice over the period of a decade from 1992 to around 2002. This was a time of notable reflection (Hawley, 1997). It also signified my transition into leadership and public engagement practice.
2002-2012	My discovery of dialogic ways of knowing and learning over the next decade from 2002 developed my reflective practice. Undertaking my MSc in Mentoring and Coaching is an example of this.
2013-2021	Doctorate in Professional Studies (DProf) modules 1-5, supervision, researcher diary, research for book chapter 'practising reflexively' in Iordanou et al (2017).

Table 8.2: Awakening reflexivity in my professional practice (module 5 assignment)

The contribution to practising reflexively spans from an early chronological approach of non-linear learning and progression, to evolving layers of reflective

practice, which developed over time, awakening my reflexivity. It has helped me to delve more deeply in the research to understand the complexities, connections, and contradictions in the data. Undertaking a sustained study gave me the curiosity and courage to push reflexivity in the research. The participants were willing to share their stories. Reflexivity was shown by them to be crucial for leaders identifying with public engagement. The approach to the leadership portraits might be a way to support leaders in developing their public engagement practice.

Reflexivity in the research could not have flourished without reflective practices such as supervisory conversations, my researcher diary, professional networks and reading the works of scholars and thought leaders referenced in the thesis. My development as a practitioner researcher could be viewed as an example of reflexive bricolage. Reflexive bricolage is shown to be a process of re-visiting experiences through a variety of lenses to form holistic understanding, and as a way for discovering profound moments of self in professional leadership and engagement practice. This contribution is evidenced through discussion on the concept of self-identity, which is offered as an example (Chapter 7, p.230-233). Addressing reflexivity in the research has sparked my interest in reflexive bricolage, which I will research further.

8.4.6. Contribution: typology on leadership and public engagement

The fifth contribution that came from the evidence was a typology on how healthcare leaders identify with public engagement (table 6.2). Although somewhat emergent this typology identifies some important aspects of how leaders identify with public engagement practice. The typology, discussed in Chapter 6 centres on 'being a catalyst for change'. It comprises approaches for supporting professional practice; how leaders identify with public engagement and contextual approaches. Being relational is important regardless of the leadership context. Even without formal structures these leaders found their own ways to engage in reflective practices that supported their self-understanding and practice. This is something discussed at length in Chapter 7. The need to attend further to the conditions required for leaders to operate is crucial. My typology offers a new frame for

leadership and public engagement in healthcare. It defines how leaders identify with public engagement, in a variety of ways including; acting as, role model, translator, facilitator, explorer, connector, advocate, and support. It also sets out exemplars of approaches that these leaders use according to their leadership context for public engagement.

8.4.6.1. Implications for practice:

I have been challenged by this research as a leader and public engagement practitioner to explore the implications of the study for my practice, not in response to the findings, but as a reflexive dialogue between my research and my work with practice-based organisations, professional and regulatory bodies, academic institutions, healthcare leaders and public engagement practitioners.

This work is now part of a national review of leadership and management across health and social care, led by General Sir Gordon Messenger, for Vice Chief of the Defence Staff and Dame Linda Pollard, Chair of Leeds Teaching Hospital NHS Trust. One aspect of the review is on 'how to help health and care leaders collaborate for more integrated care for citizens'. This is where this work on relational leadership sits and will be taken forward.

My research is relevant to a range of national organisations responsible for health policy, leadership development and public engagement such as NHS England and NHS Improvement, NHS Leadership Academy, Health Education England and Healthwatch England. An example is reflected in collaborative dialogue with NHS England regarding how my research can be shared with the public engagement practitioner community and inform future policy and developments e.g., statutory guidance on public engagement.

Research projects are now utilising the narrative and portraits approaches described in this thesis. For example, '*Creating Collaborative Stories in a Time of Covid 19'* is a collaborative project commissioned by the NHS Leadership Academy in collaboration with Sheffield Hallam University. It builds on earlier work on 'how-

breaking-down-organisational-barriers-is-leading-to-better-public-engagement-in-sheffield' (Hawley et al, 2020).

The following recommendations describe how leaders can begin a relational journey for public engagement rather than being constrained by policies and administrative processes.

8.5. Recommendations for professional practice and further research

From the contributions of the study to knowledge, practice, and research several recommendations are made for professional practice that others may wish to consider. My research shows that twelve healthcare leaders from a range of public engagement leadership contexts, identify the importance of engaging with ourselves as a gateway for leaders to engage others. The diagram below (figure 8.1) offers a guiding framework, through which leaders can progress on their journey to meaningful public engagement. Its' use is recommended to show how leaders can begin their relational journey and achieve genuine collaborative relationships with the public rather than being trapped in a policy world of process.

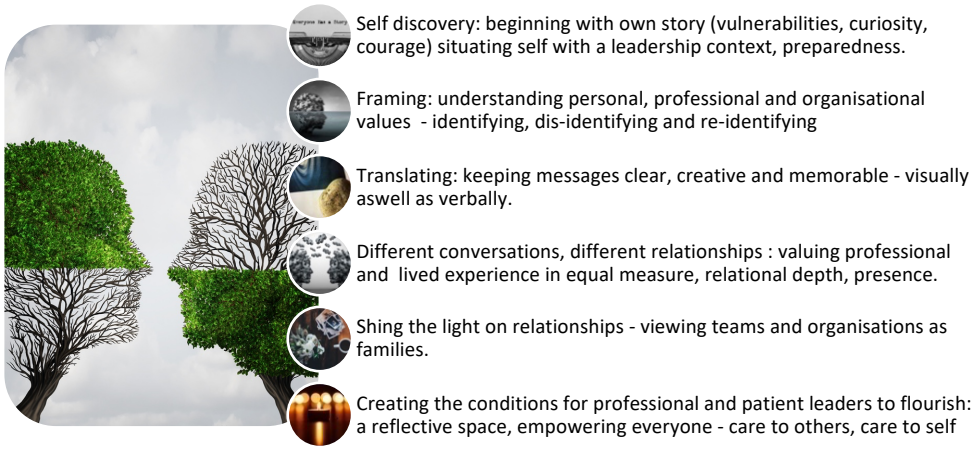


Figure 8.1: Guiding framework recommended to achieve public engagement

It is recommended that relational leadership in the NHS is viewed, not as another model, but as an alternative lens through which to understand public engagement:

- Everyone should have the opportunity to tell their story, a catalyst for self-discovery
- Recognising the power of leaning into vulnerabilities, framing understanding for public engagement
- Engaging in different conversations, for different relationships
- Encouraging creativity to enrich relational practice, making messages simple, visual, and memorable
- Creating the conditions through safe reflexive spaces and cultures of kindness

The recommendations above mean:

- *Everyone should have the opportunity to tell their story, a catalyst for self-discovery*:
  Not everyone has had the opportunity to tell their story. The opportunity to share their story impacts positively on leaders' motivations for public engagement. This is important because when people share their story, people are prepared to share something of themselves, and their own vulnerabilities. The act of reflecting on our story helps establish a sense of purpose for public engagement, humanising leadership. This is important as it sparks curiosity rooted in self-understanding not policy or organisational imperative. How we engage with ourselves is a gateway to engaging with others. Public engagement does not begin with sterile process but with self-discovery.

- *Recognising the power of leaning into vulnerability, framing understanding for public engagement*:
  Leaders identify with public engagement over time suggesting multiple, contradictory, and changing identities, professional and personal. How we identify as leaders, with public engagement is an active and dynamic process between ourselves, our relationships, and our leadership context. The concept of 'reflexive bricolage' (Chapter 7) was introduced as a process for re-visiting experiences from a variety of perspectives, as a way for discovering profound moments of self. Vulnerability in leadership emerges, not as weakness but as a

symbol of courage. This brings creativity to the fore using approaches such as visualisation. It frames how leaders understand and identify with public engagement as an ongoing process, shining the light on relationships with, ourselves, others, and with our leadership context.

- *Encouraging creativity to enrich relational leadership, making messages simple, visual, and memorable:*
  The greatest challenge to relational leadership and public engagement are language and mindset. Traditionally, public engagement has been managed linguistically. Findings encourage creativity. As one participant said one of the important characteristics of effective leadership is to convey messages simply; "*make it simple, make it accessible, make it clear, make it memorable"* (Jill, I.2). Visualisation helps people to connect with significant memories, moments, and events. Combining stories with artefacts can act as a cypher for getting closer to how leaders understand and identify with public engagement. Helping others to translate public engagement policy and practice suggests a change in mindset, encouraging both non-linguistic and linguistic ways of engaging with others and ourselves. This may only be a small part of relational leadership in the NHS but can influence how healthcare leaders are able to identify with public engagement; as one leader aptly put it; "*shining the light on relationships*" with the public and staff (Anzors, I.1).

- *Engaging in different conversations for different relationships*:
  Cultivating relationships with the public, and with staff is fundamental. Our conversations are conceived as the most powerful vehicle for engagement with the public and staff. As one leader aptly said; "*staff experience precedes patient experience ... you need to get that foundation right where staff feel trusted, where they feel safe and feel able to speak up"* (Anzors, I.2). The nature of conversation described held several distinctive qualities, dialogically, narratively, and visually. Reaching out and starting conversations where people are, rather than simply inviting people in. The quality of conversation was

determined by factors several including, good questions, truly listening, challenging assumptions, leaning into vulnerability and being truly present. Being truly present emerges as a human aspect of leaders 'being' relational, rather than leaders 'doing' public engagement. As discussed in Chapter 1, we can tick the box for public engagement but not feel engaged (e.g., Mark). First, this means thinking about the nature of conversations we have with ourselves (reflective and reflexive). Second, it means thinking about the nature of our conversations with others (encouraging creativity). Third, it means thinking about cultures such of kindness as a conduit for relational depth.

- Creating the conditions through safe reflexive spaces and cultures of kindness: There is rarely time to reflect on our experiences in the challenging context of healthcare. The picture leaders painted in this research was of a very human leadership where their desire to make a difference to public engagement has been able to flourish and take them through extraordinary professional and personal challenges. Leaders' stories often reflected earlier experiences of dis-location. Their stories showed how, through their leadership they have tried to make engagement work for those they are responsible for and through policies they deliver. As one participant reminded us; *"uncover those stories at an organisational level, speak to enough people, and you actually uncover emotionally how much emotionally that people are giving every day and the joy of that but, but the flip side is the price of that sometimes* (Anzors, I.1).
  To have a safe space is important for leaders first in supporting leaders in becoming a relational leader (preparedness) and second in 'being' a relational leader (resilience, keep going). Whilst desire to make a difference to public engagement can flourish and take leaders through extraordinary professional and personal challenges leaders who operate in a culture of kindness appear to flourish; '*organisation as family'* or '*team as family'* (e.g., Aria). The notion of a candle was particularly helpful thinking as a leader: *"what is it that enables you to keep your own flame burning, what is it that nurtures and supports that, and how do you manage as a leader when you feel the flame really flickering and might be snuffed out*" (Jill, I.2).

Finally, I return to the concept of 'reflexive bricolage' (Chapter 7), which is offered as a process for re-visiting experiences from a variety of perspectives, as a way for discovering profound moments of self. Creating the conditions is dependent on creating the kind of safe reflexive spaces described by these leaders who shared their experiences so generously to enable us to see glimpse of the paths we might follow to identify with relational leadership in the NHS and how healthcare leaders can identify with public engagement.

Given the contributions to knowledge and practice the following recommendations are made for further research:

- Further refinement of the typology for becoming and being a relational leader and exploring other professional contexts where collaborative relationships with the public are needed.
- It is important to explore if leaders in other health and social care contexts share the value of relational leadership for being collaborative with the public e.g., primary care, social care or professional health and social care education.
- Further research is needed across health and social care contexts to help understand whether all leaders may be motivated for public engagement given the right conditions to prepare for and sustain collaborative practice.
- The concept of reflexive bricolage was introduced in Chapter 7 as a process for re-visiting experiences from a variety of perspectives, as a way for discovering profound moments of self. This sparked my interest to undertake more research to explore this type of impact, particularly for professional practice-based doctoral programmes but also as a development tool for healthcare leaders.

Finally, it would be interesting to know if this research is pertinent only to health and social care professionals. Research with the growing community of patient leaders would add a further layer of understanding on the nature of relational leadership in the NHS, but further research is needed to understand the public perspective about relating to leaders.

8.6. Limitations of the study methodology

The challenge of practitioner-based research was to ensure the engagement of participants in a way that enriched the data without slipping into researcher bias, anecdotes, or loss of research focus (Rubin and Rubin, 2012). Chase (2018) warns of the dangers that narrative inquiry can have around validity. Traditional health studies would typically sit in a more positivist paradigm but my need to explore in detail how leaders identify with public engagement led to the methodological choices within this study. The variations of Voice-Centred Relational Analysis (Mauthner and Doucet, 2003) and the Ganz (2010) model captured leaders experience on public engagement but also risked missing things.

This study adopts a reflexive perspective to capture both my own and my participants reflexivity. This has been a strength to this study, which is evident in the reporting on participant and researcher reflexivity. The approach however precludes making generalisations in relation to change in practice. Positivists may dismiss the approach taken as being based on anecdote or bias and many healthcare professionals come from this tradition.

8.7. Concluding thoughts: relational leadership in the NHS

This thesis has been structured to show the relational dynamics of how healthcare leaders identify with public engagement. Supportive facilitation is essential for supporting leaders' relational work. In this study healthcare leaders emerge as relational agents of change, which can be considered as a relational chain. Relational leadership provides a lens through which to understand healthcare leadership and public engagement. The study did not begin as research on relational leadership in the NHS - rather this is where it ended as an outcome of the reflexive doctoral journey - so, the study contributes to a relatively new area of research.

The research aligns to current government health policy including the NHS People Plan (NHS, 2020). The plan set out actions to support transformation across the whole NHS, at a time that action from the Interim People Plan (NHS, 2019b) was already underway. The global pandemic, Covid-19 came long, around the time of this policy landmark and changed everything. Colleagues and loved ones were lost and it was recognised that people gave more of themselves that ever before. The NHS People Plan (NHS, 2020), which includes Our People Promise set out what people can expect (behaviours and actions) from NHS leaders and each other. The policy focus on the importance of fostering "*a culture of inclusion and belonging*" and its encouragement to "*work together differently to deliver patient care*" (NHS, 2020, p.6) chimes with my research focus on leaders' sense of self, their relationships, and their contexts, discussed at length in this thesis.

By recognising both linguistic and non-linguistic practices, this study provides new insights on how leaders identify with public engagement. Using narrative approaches combined with artefacts permitted the foregrounding of leaders' voice. Discussion on public engagement policy and process hardly featured in this research. It showed that leaders identify with public engagement over time. Crucially, it showed that before we can engage with others, we need first to engage with ourselves. The way in which leaders identify with public engagement begins with self-discovery - different conversations, different relationships.

There is now more work to do, to share the learning, and its contribution to 'relational leadership in the NHS'. My hope is that the thesis contributes by bringing to the fore the leaders' holistic stories. If it sparks curiosity and courage, creativity and kindness, and new connections for others it has served its purpose.

Three Minute Thesis 2018 (3MT®)

competition finalist and commended

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Appendix 1: Researcher interpretation of the research process

Epistemology	Objectivism		Constructivism / Constructionism social constructionism		Subjectivism
Ontology **What is real?**	Objectivist; findings = truth Realism	Modified objectivity; findings probably true Transendental realism	Co-constructed realities; subjective objectivity Relativism	Historical realities; virtual realism shaped by outside forces with material subjectivity	Constructed realities; based on the world that we live in
Theoretical Perspectives	POSITIVISM	Pot-Positivism	INTERPRETIVISM **Interpretivism**	CRITICAL THEORY	Pragmatism
What is true?	The only knowledge is scientific knowledge, which is taken to be 'truth'	Findings approximate the truth	Co-created **multiple realities** and truths; self-knowledge and **reflexivity**	Findings are based on values, local examples of truth	Objective and subjective points of view
Synonym	Verify	Predict	Understand / Interpret	Emancipate	Dialectic
Key Theorists and Influences (shaping my research approach towards methodology for involvement and leadership; 'making every conversation count')	- Auguste Comte: Positivism - Galilao: Scientific Method	- Karl Popper: Post Positivist - Freyerabend: Against Method	- Edmund Husserl, Arthur Schultz (Phenomenology) - Hann-Georg Gadamer (Hermeneutics) - Herbert Blumer, Symbolic interaction) - Jerome Bruner, Vlagoski (story, learning, conversation)	Habermas (Critical Theory -ideal speech) Frierre – pedagogy of the oppressed Foucault (Structuralism – power and inequality, discourse analysis) Derrida (Post modernism, de-constructionism)	Habermas – The Ideal Speech
Research Approach	Deductive			Inductive	
Methodology **How I might examine what is real?**	Quantitative Primarily experiment e.g. randomised controlled trials Surveys, Observation	Usually quantitative Often experimental with elements of validity e.g. Case Study	Qualitative (and / or quantitative) **e.g. Relational,** Phenomenology (CP), Ethnography / Auto-ethnography Participative Approaches Grounded Theory	Usually qualitative but also quantitative e.g. Action Science, Discourse Analysis	Qualitative and quantitative e.g. Appreciative Inquiry
	Towards Method				

Appendix 2: Voice-Centred Relational Analysis (Mauthner and Doucet, 2003) (adaptation) - guiding principles and considerations

Reading	Perspective	Guiding principles	Questions-considerations	Colour coding
1.	Focus on the broad **story** (ies) and **context** within the narrative. Thinking of the **researcher response** to the story	Guiding principles: • Attending to the participant story(ies) told in the data. • Attending to my response as researcher • How I interpret and construct the data analysis • Summarise the story in the form of a memo – micro narrative portrait	Questions include: • What is going on in the story? • What is the participants role? • What are the main events? • What is my response to the story I hear? • What are the key words and recurrent phrases?	Black
		Reflective loop – following intuitive pathways of curiosity		
2.	Focus on how the person speaks of self - **relationships** with **self and others**, thinking about their values (personal and professional)	Guiding principles: • Attending to the voice (perspective) of participants • How meaning are made, influenced and actioned • Attending to body language, tone of voice and multiple realities (Gergen and Green 2007, Cuilliganetal et al 2005)	Questions include: • How does the participant speak of themselves in relation to their leadership role and professional, political, organisational, personal? • How do participants create meaning in relation to leadership for public engagement? • What body language do I notice? • What fundamental perspectives are reflected through the story?	Green
		Reflective loop – following intuitive pathways of curiosity		
3.	Focus on how the person expresses themselves **visually** in relation to	Guiding principles: • Attending to what the artefacts	Questions include: Why was the artefact was chosen?	Blue

	leadership for public engagement	• Attending beyond what the artefacts are to explore what they symbolically represent for participant in relation to their leadership. • Considering artefacts as a variety of forms; objects, images; real and metaphorical -it was important to view in different ways:	Why is this important? What words / phrases / metaphors are used to describe the artefact? How does the artefact symbolize identity (ies) in relation to leadership for public engagement?	
		Reflective loop – following intuitive pathways of curiosity		
4.	Focus on reading for leaders' **relationships** and ***how*** these are enacted and influenced	Guiding principles: • A focus on relationships – how they lead and how they have developed underpinning knowledge? • Who do they engage? How do they engage?	Questions include: • participant is playing? • Who is spoken of in the stories? • How are people positioned in the interactions described? Is there any change in the nature of relationship(s)?	Orange
		Reflective loop – following intuitive pathways of curiosity		
5.	Focus on **context** in which participants have come to construct and sustain their leadership identity for public engagement	Guiding principles: • A focus on linking micro and macro level structures and processes	Questions include: Questions include: • What is the broader story and interpretations; professional, social, cultural, contextual • What values underpin their practice for lpublic engagement; value system • What is privileged; noticing talk and action	Red
		Reflective loop – following intuitive pathways of curiosity		

Appendix 3: Scaffolding leadership portrait (individual)

Tess Scaffolding Portrait - Key Points

Introduction-context:

- Fundamental belief – public engagement relational (co-production)
- Research role – background in nursing
- Purpose

Themes:

- Learning from early lived experience
- Insight in feeling dis-empowered, vulnerability, purpose, courage
- Nudges, re-evaluating professional-public relationships
- Appreciative (travel scholarship)

Helping people to translate

- Modelling behaviours, connecting
- Helping people have a meaningful conversation, mindful of language
- Framing it, visualisation, confidence, preparedness
- Storying engagement (starting point – everyone has a story)

Relationships:

- Reaching out, connecting, valuing lived experience
- Modelling behaviours (appreciative, not having all the answers)
- Letting go of power, getting over self, noticing
- Understanding self, “a lot of self-discovery work”, shaped in Canada
- Kindness – inspiration to keep going

Values: inclusion, fairness, courage (authentic, willingness to feel uncomfortable)

Artefact: Driftwood: loneliness, a social dimension

Appendix 4: Storyboarding planning (setting organisational context - national perspective)

Leadership portraits – central wing (storyboard)

Tess

Learning from lived experience: care of family members, series of incidents (professional/personal) nudges, purpose

Relationships: letting go of power, getting over self, valuing lived experience], appreciative, mindful of language, helping people have meaningful conversations

Translating: helping people translate,

Story: starting point 'everyone has a story to tell, preparedness

Self-discovery work: patient lens, travel scholarship (shaping thinking), understanding self, values, noticing, loveliness, noticing, coaching

Mark

Learning from lived experience: long-term condition

Relational: complex system-language; how talk influences what see-act, helping others to make sense (translate)

Conversational: different conversations, different relationships; self/others

Understanding self: values; inner compass, dancing with values, reflection, dis-identify/re-identify, reflection, coaching, presence, leadership begins with self

Jill

Casting: silos-holistic view

Learning from lived experience: childhood, on the edge; professional ethos; vulnerability

Translating: simple, memorable, visualization

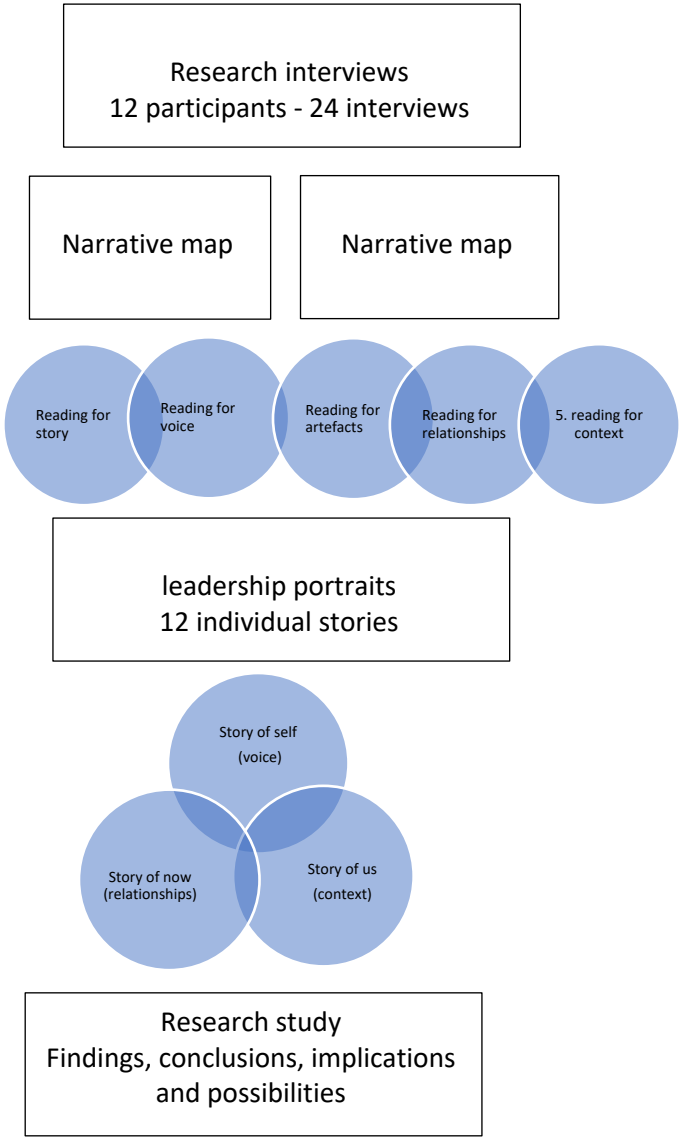
Conversational space: reaching out, appreciative, questions, framing, story

Understanding self: values, coherence, inner voice, coaching, conditions (care, light)

Appendix 5:

The analytical process:

leader-centred relational chain



Conducting research interviews as 'conversational partnerships' (Rubin and Rubin (2012)

Sketching hand-drawn narrative maps after interview 1 as an organising tool – repeated after interview 2 – iterative sense-making

Undertaking multiple readings of the data using Voice-Centred Relational Analysis (Mauthner & Doucet, 2003) as a relational analytical and reflexive tool (reflexive loops between readings)

Scaffolding leadership portraits as a way of capturing participant stories as a way of representing the 12 individual stories of leaders holistically

Using the social movement perspective of Ganz model (2010) for telling a 'public story' to act as a way of interpreting the results of the analysis

Establishing a compelling 'public narrative' to lead to action and change

Appendix 6: Motivations for public engagement (exemplar organising table)

Name of organisation	Participant	Context	Voice	Attribution
National	Tess	Personal experiences of care-caring; husband, mum Loneliness story (as leader, as patient)	*"I discovered that if I wanted to involve people it was up to me"* *"Truly letting go"* *"Getting over self"*	Each experience nudges her more. Research on relationships- "re-examine the whole doctor nurse thing".
	Mark	Diagnosis of long-term condition (early adulthood) Loneliness story (outside of the system)	*"Looking back on how they engaged with me and how they didn't engage with me really influenced my work"*	Transition of career into the NHS based on lived experience
	Jill	Feeling on the edge at school Student nurse stories Loneliness story	*"..it's driven me to find ways of being included, not just for myself but also really driven me to ensure that other people are included too"*	Attribute's professional role of Speech and Language Therapist (giving voice and choice) to childhood experience – attributes 'leadership beliefs, values and style' to be 'actually driven by very early experiences'.
Northern Bay NHS Foundation Trust	Anzors	Early childhood experiences	*"it connected me if you like to why I wanted to do this work in the first place, and reminded me about people without voice and influence"*	Attribute's professional role of Speech and Language Therapist (giving voice) to childhood experience – attributes to values of fairness and equity and the importance of kindness (others and self)

Additional tables are available on request: values - what good leadership for public engagement looks like - barriers - suppo

Appendix 7: Facilitating and accessing participant reflexivity methodologically in the research design (Rae and Green, 2016)

Research design characteristic	Methodological facilitators	Participant excerpts (examples)
An opportunity for reflexive space – facilitates reflexivity	The allocation of two interview over a period of time providing a "window of opportunity" between the research conversation and specifically the participant choosing an artefact and the discussion of their data with the researcher opening reflection. Time is required for participants to have their own internal conversation (Archer, 2007).	*"Because you're busy… you don't sit back and reflect on it because you don't have the time"* (Grace) "Conversations like this are rare" (Jill)
Participant's anticipation of the requirement to share with the researcher – facilitates reflexivity	Some activity by the participant without the researcher present, the output of which is shared with the researcher. In this study participants considered and selected a personal artefact that was shared with the researcher. Other examples include; taking a photograph, completing a diary…….	"*I'm thinking that's really good. I chose the candle because…"* (Jill) *"that's why I – when you said to me about bringing an object, I knew exactly what it was that I was going to bring with me." (*Meghan)
Participant control – facilitates reflexivity	Participant control over the data provided, for example using semi-structured interviews, beginning with an opening question and using prompt questions to build a conversational partnership. Requires a participant-led data collection method where participants think what they will focus on, for example choosing a personal artefact. Perception of a safe, comfortable environment for reflection and reflexivity.	"*This was…this is a great example of…of when you suddenly are reminded about the things that matter because you cross over yourself".* (Anzors) *"… I went home after we had a discussion and really, really thought hard about my role and what I was doing and how I was feeling and what I needed to do to try and support myself in making better decisions and making the organisation help me have the time to make considered decisions and not knee jerk ones as a result of, yeah I went home really and for several days afterwards was really mulling it over as to what could be done. It was quite …you don't get a chance to sit down and talk about these thing".* (Grace)
Relational dialogue – enables access to reflexive thinking,	Less structured, more open narrative style interviews that permit participants some control, opportunity, and	

	space to share personal stories and perspectives. Listening actively and summarising key parts back of participants stories. Asking participants explicit questions about internal conversations, self-narratives, and self-presentation, e.g., *"how did you decide what artefact to share"*? Emotional awareness, paying attention to participant emotions, being aware of links between emotions and their impact of reflexivity where appropriate.	"*I wanted to say that I found it particularly helpful to reflect on the questions you (the researcher) asked because of how you 'showed up' during our call. You created a safe container for me. Your thoughtful questions enabled me to reflect and make sense of my own thoughts. I was very conscious that the dialogue we engaged in felt very generative in nature. This was facilitated by your presence and holding of the space. I believe that as the researcher the attention you paid to what I was saying (and not saying) enabled me to move into a more self-reflexive space. This was enhanced and mirrored by your own self-awareness. In our conversation I believe that the quality of my sense making was a direct consequence of how at ease I felt and this sense of ease was facilitated by the attention you paid to our work together. The very content of the conversation was being reflected in the quality of the interview which had at its heart the hallmarks and principles of effective and successful collaborative engagement. You, the researcher, I felt, consciously modelled the principles and practices of the kind of dialogue that supports collaborative generative conversations. thank you for a very inspiring and thought-provoking conversation!"* (Mark) "*So, it was really interesting reflecting on your kind of request to bring an artefact because I thought about lots of things and I guess lots of items and it reminded me – it just reminded me of a lot of points I suppose in my career and my leadership journey, but particularly to reflect on a period of time"* (Jill)

Appendix 8: Eight 'Big Tent' criteria for excellent qualitative research (Tracy, 2010)

Criteria for quality (end goal)	Means, practices and methods through which to achieve the criteria	How and where evidenced in the thesis
Worthy topic	The topic of the research is: • relevant	Studies on collaborative leadership have focussed at an organisational level (focus on staff-organisational collaboration) and studies on public engagement have focussed on initiatives for securing direct engagement. Studies have taken a post-structuralist or functionalist perspective. The relational perspective to had hither-to under-reported.
Worthy topic	• timely	This study responds to the ongoing call for research to address the relationship between the public and the NHS and between staff and the public (Ham et al, 2018l Kings Fund, 2011, 2012, 2013). This study therefore responds to this gap by taking a social constructionist relational perspective of how leaders identify with public engagement using the multi-layered methodology and methods to explore the research issue and data from multiple perspectives. The leadership associated with public engagement necessitated a level of collaboration and genuine relationship that had hitherto been under-reported from a relational perspective. This study contributes to knowledge about how healthcare leaders identify with public engagement.
Worthy topic	• significant	From a government policy and practice perspective the relational research methodology, and methods combining narrative interviews with participant selected interviews present a unique perspective in further understanding the concept of 'public engagement' from a 'leadership' perspective. The study highlighted how the participants drew on their lived experience (professional and personal). The relational approaches allowed linguistic and non-linguistic interpretations through the use of participant selected artefacts which enabled the researcher and the researched to be dynamic. In particular this study highlights how influential relational ideas are compared to more formulaic approaches to leadership and public engagement for leaders in this study.
Worthy topic	• interesting	The leadership associated with public engagement necessitated a level of collaboration and genuine relationship that has hitherto been under-reported from a relational perspective. This study contributes to knowledge about how leaders identify as collaborative with the public.

Rich rigor	The study uses sufficient, abundant and complex: • theoretical constructs	As this study was focussed on relationship I was drawn to a relational view. The inclusion of a relational ontology, described in Chapter 3 was a basis for a relational inquiry around healthcare leadership and public engagement – relational leadership in the NHS; specifically, how healthcare leaders identify with public engagement. A variety of theoretical constructs and approaches were needed to adequately address the complexities of public engagement as a multi-facetted phenomenon – relational - critical theory - narrative - visual - dialogic - social movement and reflexive ways of knowing and being.
Rich rigor	• data and time in the field	By taking a multi-layered approach to the data interpretations were drawn from a variety of sources and perspectives. Data was gathered via two interviews with each participant enabling reflective-reflexive loops for the researcher and researched. Participant selected artefacts. Participants were interviewed on the site of the organisation where possible.
Rich rigor	• sample(s)	The participant sample consisted of 12 leaders from a variety of contrasting organisational and leadership contexts. Leadership context included: 3 national policy, 3 board level, 3 public engagement coordinator, 3 operational. Organisational contexts included: 3 national, 1 NHS Trust (outstanding), 3 NHS Trust (good), 3 NHS Trusts (inadequate) It was important to take account of the organizational contexts in which leaders experience was situated and characterized. This was based on information in the public domain, specifically the Care Quality Commission (CQC) report on overall ratings for leadership and care.
Rich rigor	• context	At the time of conducting the research all of the participants were from healthcare organisations in England. The participants came from a variety of organizational contexts (3 national - 3 local) and range of leadership levels (national policy, board level, organizational coordinator for public engagement-experience, operational) offering diversity in sample.
Rich rigor	• data collection and analysis process	The semi-structured interviews produced a total of 2018 000 words gathered over interviews with 12 participants. Each participant was interviewed twice. The inclusion of artefacts appeared to help participants to get closer to significant experience and memories and understanding of how these healthcare leaders identify with public engagement. The relational approaches (narrative and visual) and variation of voice-centred relational analysis opened space for me to engage in relational exploration around leaders' public engagement practice and forage holistic

		view on public engagement as a relational issue that involved professional and personal conceptions of self. This provided a contrast to earlier research on public engagement in healthcare that has often emphasised processes and initiatives for securing direct engagement.
Sincerity	The study is characterised: • by self-reflexivity about the subject values, biases, and inclinations of the researcher(s)	The research was deliberately reflexive in its approach. As part of the methodological and method selection it was important that I included my own pre-understanding of where I sat ontologically, epistemologically and methodologically. The importance of reflexivity in the research is addressed in Chapter 7 to acknowledge the influences of myself on the study and consider the development of my thinking. Personal researcher reflexivity is illuminated through selected aspects of the collaborative leadership story to convey impacts on the research journey.
Sincerity	• transparency about methods and challenges	This study has always been as much a personal endeavour as a scholarly attempt to show new insights into nature of collaborative leadership with the public, specifically; what motivates leaders, how leaders understand an identity for public engagement and the conditions needed to support leaders' collaborative practice with the public. Some elements of my own lived experience are shared in the thesis report. Interview transcriptions were undertaken, and participant quotations included within participant leadership portraits with the aim of reflecting participants spoken words and selected artefacts authentically.
Credibility	The research is marked by: • Thick description, concrete detail, explication of tacit (non-textual) knowledge and showing rather than telling	The research uses multiple layers of data and analysis to bring together the experiences of twelve participants holistically taking account of multiple ways of knowing (perspectives). Relational approaches enabled the complex phenomena to be investigated from multiple perspectives. Data was gathered using narrative interviews combined with participant selected artefacts. The artefacts, which formed a conduit for representing their sense of professional identity in relation to their leadership were key to getting closer to participants construction of identity. Data was analysed using a variation of voice-centred relation analysis. By recognising both the linguistic and non-linguistic ways of identifying with public engagement this study provides new insights for building collaborative practices.
Credibility	• triangulation or crystallization	Participants were invited to authenticate their individual leadership portrait and their reflective feedback on the research process. In addition, reflective researcher diary notes were taken to reflect on the research journey and

		consider implication for professional practice – my own and others (Chapter 5).
Credibility	• multivocality	Data was analysed using a variation of voice-centred relational analysis. By recognizing both the linguistic and non-linguistic ways of identifying with public engagement this study provides new insights for healthcare leaders building collaborative relationships with the public. The use of artefacts encouraged a sense of the participant-led element of the research process (Riach, 2009).
Credibility	• member reflections	Following the research interviews participants received a copy of the individual leadership portrait so that each participant could ensure that the interpretations were an accurate and authentic representation. The study prompted consideration of the concept of the researchers' self-identity as an example of reflexive bricolage (as a process of re-visiting experiences through a variety of lenses to form a more holistic understanding). This needs to be developed in a more profound sense, as a way for discovering profound moments of self in professional healthcare leadership and engagement practice.
Resonance	The research influences, affects, or moves particular readers or a variety of audiences though: • aesthetic, evocative representations	Data was presented in the form of 12 leadership portraits (Chapter 4). Individual participant leaders spoke of how they identify with public engagement. Leaders' stories often included very personal insights into their motivations for becoming and being collaborative with the public and strategies for sustaining their practice. We are reminded by one participant (Jill) that patients, public and staff are caste as separate cohorts, yet they are the same people playing different roles at different stages of life. The participant selected artefacts, formed a conduit for representing their sense of professional identity in relation to their leadership were key to getting closer to participants construction of identity. Data was analysed using a variation of voice-centred relation analysis. By recognising both the linguistic and non-linguistic ways of identifying with public engagement this study provides new insights for building collaborative practices. A reflexive approach enabled me to better notice, understand and respond to research conversations. Overall, the aim was to create research that can be read from multiple perspectives as a way of contributing to professional practice in the NHS.
Resonance	Transferability and naturalistic representations	To achieve 'transferability' and 'naturalistic generalization' the use of Voice-Centred Relational analysis (Mauthner and Doucet, 2003; Brown and Gilligan, 1992) aimed to bring participants voices to the fore of this study. The twelve portraits acted as reflexive accounts within the research. The approach offers potential beyond the research as a reflexive tool for

		leaders of public engagement to enhance professional practice. The attention to linguistic and non-linguistic representations showed the connection between leaders professional and personal experiences suggesting resonance for professional and patient leaders across the health and social care system more widely. Transferability and naturalistic representation were further illuminated through the application of Ganz (2010) relational processes. This re-framing of the finding (Chapter 5) showed that the data analysis themes were not static but rather dynamic in relationship.
Significant contribution	The research provides a significant contribution: • conceptually / theoretically	The study prompted consideration of the concept of the researchers' self-identity as an example of reflexive bricolage (as a process of re-visiting experiences through a variety of lenses to form a more holistic understanding). This needs to be developed in a more profound sense, as a way for discovering profound moments of self in professional healthcare leadership and engagement practice.
Significant contribution	• practically	As a Doctorate in Professional Studies I sought to contribute to both knowledge and practice. The leadership associated with public engagement necessitated a level of collaboration and genuine relationship that has hitherto been under-reported from a relational perspective. This study contributes to knowledge about how leaders identify as collaborative with the public. Findings from the research will be disseminated through professional and academic networks.
Significant contribution	• relational significance	The relational approach developed in this research – a variation of the voice-centered relational analysis (narrative and artefact) has the potential to be considered novel within healthcare leadership research contexts. The use of multiple layers of data collection and analysis using relational approaches enables the approach to be applied to wider professional practice (such as a leadership development tool). A reflexive approach enabled me to better notice, understand and respond to research conversations. Overall, the aim was to create research that can be read from several perspectives: narrative, visual and reflexive as a way of contributing to the development of relational leadership with the public in the NHS.
Significant contribution	• methodologically	Methodologically this study contributes to knowledge about how leaders identify with public engagement – relational approaches –combining narrative interviews with participant selected artefacts - variation of voce-centred relational analysis – application of Ganz (2010) relational processes. A further contribution is offered as an example of reflexive bricolage; a process for revisiting experiences through a variety of lenses to form holistic

		understanding and as a way for discovering profound moments of self in professional leadership and public engagement practices. The act of seeing and thinking about our self in relation to research is widely acknowledged as complex. This is where using artefacts came to the fore. Within the creative frame of visual narrative inquiry, I considered how artefacts formed a reflexive tool to support participant and researcher reflexivity. The artefacts formed an alternative way for expressing self, helping participants make meaning and thus representing participants sense of how they identify as a leader in relation to public engagement. Each artefact tells a story, woven into each individual leadership portrait.
Ethical	The researcher considers: • Procedural ethics (such as human subjects) • Situational specific • Relational ethics • Existing ethics (leaving the scene and sharing the research)	As discussed in Chapter 3, ethics have been addressed at every stage of the research. Despite the importance of adhering to an ethical process, the importance of attending to the relational aspects of the research was vital, influencing the quality of the data. About half-way through my doctoral journey, I had the opportunity to explore the nature of ethics, reflection, and reflexivity more deeply when I undertook research for a book that I was invited to co-author on values and ethics in coaching (Iordanou, Hawley and Iordanou, 2017). This influenced my ethical research practice, for example through reflexivity discussed in Chapter 6. The need to make the epistemological positioning clear was recognized, to enable readers to establish the researcher position and role in the research process at every stage. Using self-reflection is a way of attempting to balance power between researcher and participants (enacting collaborative relationships), and accounting for the complex power dynamic that exists in the NHS. I have committed to share the final research report with participants and to share the learning from the study more widely. One example, as I near the end of the study is presenting my research at the SHU Creating Knowledge Conference (2021) on the conference theme of 'Doing Things Differently'.
Meaningful coherence	The study: • achieves what it purports to be about	The use of two narrative interviews using semi-structured interviews allowed for the research conversations to emerged as conversational partnerships. This was achieved using participant selected artefacts. The variation of Voce-centred relational analysis resulted in multiple readings of the data; story, voice, relationships, artefact and context. Chapter 4 presented the individual portraits. Chapter 5 resulted in the data analysis themes remaining true to ensuring the participant voices were at the fore of the research and drawing in theory to explore the seven themes that emerged. The final reflexive loop

		was to look at the whole to address the research questions presenting the conclusions and implications for practice in the final Chapter 8.
Meaningful coherence	• uses methods and procedures that fit its stated goals	Participant's reflections and their transitions around their multiple perspectives on collaborative relationships with the public explores points of synthesis and confliction. The relational approach taken brought new insights for understanding the nature of healthcare leaders' collaborative relationships with the public – influences on how leaders identify with public engagement, their motivations and conditions needed to support collaborative practice. The approach allowed the analysis to develop from the individual narrative to a collective public narrative (Ganz, 2010) to establish a synthesis of the participant perspectives. Participants collective experiences were explored focusing on the three inter-connected areas; leaders' self, their relationships and their contrasting contexts. As discussed in Chapter 6 Marshall Ganz (2010) talked about these three areas in his work on leadership, organisation, and social movements for the telling a new public story (Ganz, 2010). The relational orientation of the approach provided a valuable way to frame the data analysis themes - it added a further layer of analysis (re-framing the themes) - it tested my relational approach – its focus on practice and leading to action resonated with a practice-based doctoral study, informing the contributions to knowledge, practice and research and recommendations for professional practice (Chapter 8)
Meaningful coherence	• meaningful and interconnects literature, research questions and foci, findings, and interpretation with each other	A particular strength to this study was the relational approaches to bring together multiple perspectives and to create new understanding on how leaders identify with public engagement. It shows the social meaning of how leaders understand their self as dynamic and changing over time; professional and personal experience intrinsically linked. Combining narrative and visual practices offers new insights in a system that has historically managed public engagement linguistically.