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COMPONENT I : REFLECTIONS ON PERSONAL LEADERSHIP STYLE

What is the definition of leadership? This is the perennial question that many have tried and failed to define accurately. A simple definition is that leadership is the art of motivating a group of people to act towards achieving the common goal. The leader is the person in the group that possesses the combination of personality and leadership skills, that makes others want to follow his or her direction. Additionally, it could be described as the activity of leading a group of people or an organisation, which involves stating a clear vision, sharing that vision with others so that they will follow willingly and providing information, knowledge and methods to realise that vision (Stogdill 1950). These words are all self-explanatory but they don't actually provide an epiphany which provides anyone with the appropriate 'tools' to enable them to lead successfully.

Inherently, defining leadership means understanding oneself from an inward perspective, as well as translating our own tendencies, strengths and approaches into the way one interacts, communicates and influences others (Winston and Patterson 2006).

There are many leadership styles that people either naturally or deliberately adopt ,some of which are endemic in the National Health Service.

There are classically six types of leadership styles described by Goleman (2000):

Directive: the primary objective of the directive style is immediate compliance. This relies on directives rather than direction. Close monitoring is supported by negative corrective feedback with an implied, if not explicit, threat. Efforts to motivate are focused mainly on consequences of non-compliance. This is classically the fallback position of many clinical managers within the NHS.

Visionary: this style provides long-term direction and vision, relying on dialogue. The manager keeps others engaged by assuring them the direction is the long-term best interests of the group and organisation and providing balanced feedback to employees.

Affiliative: the objective of this style is to create harmony and avoid conflict. Relationships with employees requires cultivating. This style tends to reward personal characteristics and avoid performance related confrontations.

Participative: the objective is to build commitment through consensus. It relies on the ability of employees to establish their own direction and resolve their own conflicts.

Pacesetting: the objective is task accomplishment to high standards of excellence. Managers using this style tend to lead by modelling, establishing themselves as a standard of excellence, apprehensive about delegating.

Coaching: the objective of this style is the long-term development of others, helping individuals identify their unique strengths and weaknesses.

I believe every manager would like to think that they exhibit all of these styles at some point, at the appropriate times. However, this of course is never the case. As mentioned, the fallback position for many clinical managers in the NHS is to adopt the directive leadership style. Historically, I have felt antipathy towards management within the NHS due to this approach and this exasperation was one of the reasons for entering into the world of clinical management.

In the clinical setting it is very common for me to have to become 'directing' in certain respects, but this is necessary in a time sensitive clinical emergency. Therefore, I would like to think that the directive leadership style is far removed from my style. The King's Fund (2011,2012) produced research that showed that top down leadership is counterproductive. Furthermore the King's Fund in 2014 moved to extol the virtues of collective leadership within the National Health Service: "Collective leadership means leaders and teams working together across boundaries within and across organisations, in the interests of patient care and community health, this requires us to change the way we think about leadership by seeing leadership as the responsibility of all ...".

However, everyone has a 'rose tinted' impression of how they see themselves and quite often there can be a significant reality gap. As mentioned previously, defining leadership means understanding oneself from an inward perspective as well as translating our own tendencies, strengths and approaches into the way one interacts, communicates and influences others. I believe, the key to successful leadership today is influence, not authority.

Throughout the medical leadership course (see learning log) we have been exposed to a number of self-assessment 'tools' such as the Myers Briggs type indicator(MBTI) questionnaire, Belbin team role and MTQ 48, which have been invaluable, remarkably accurate and surprising at the same time. These have allowed me to understand how my personal characteristics can influence the way I lead. Furthermore, exposure to a 360° assessment has provided an 'eye-opening' perspective.

The MBTI Personality assessment is an in-depth personalised description of personality preferences. The MBTI instrument was developed by Isabel Myers and Katherine Briggs as an application of Carl Jung's theory of psychological types. This theory suggests that we have opposing ways of gaining energy (Extraversion or Introversion), gathering or becoming aware of information (Sensing or iNtuition), deciding on or coming to conclusions about that information (Thinking or Feeling) and dealing with the world around us (Judging or Perceiving).

The four personality preferences attributed to me are Introversion, iNtuition, Thinking, Judging (INTJ). INTJ's have a number of classic characteristics.

INTJ's are typically described as being able to trust their own innovation and understand how things fit together, spending time on what they perceive as important, rather than what's popular with others. They are independent and individualistic and others may see them as stubborn at times. They move ahead with or without the support of others and have a single-minded concentration. Logic is used to solve complex challenging problems. Routine everyday tasks bore them. They analyse and attempt to fit pieces together in a coherent way. They sometimes ignore details that do not fit with their vision. INTJ's are likely to be most satisfied in a work environment that values their insights and ideas and lets them work independently. The above descriptions are all strongly recognisable in me, some of which can be advantageous, some not so.

Most of my strongest personality facets are within 'Introversion' and 'Thinking' which, I think, play a huge role in my leadership style and in the way I am perceived.

'Introversion' contains a number of facets which I can strongly identify with.

As mentioned, introversion refers to the directing of energy towards the inner world of experience and ideas. Four of the main facets refer to 'receiving', 'contained', 'reflective' and 'quiet'.

Some classic descriptions from these facets are uncannily accurate with regards my personality: hate small talk, seen by others as quiet and shy even aloof, consider social obligations unimportant, keep feelings to self, seen by others as hard to get to know, assuming others uninterested in my thoughts, prefer to solve problems on own, find it hard to discuss what upsets me, prefer detached observation, more secure writing down ideas than giving an oral presentation, prefer to stay in the background. All of the above are extremely accurate which obviously manifests in my leadership style and can also be strongly identified within my 360° leadership report which I will go onto discuss.

Furthermore 'Thinking' contains facets such as 'logical', 'reasonable', 'questioning', 'critical' and 'tough' which results in basing conclusions on logical analysis with a the focus of objectivity, which may have some disadvantages with regards to empathy and tolerance to failure.

The health care leadership model 360° individual report collects and evaluates perceptions of leadership behaviour in the workplace. The Ratings are based on self assessment and the assessment of raters, consisting of line manager, peers and others. The report is made up of nine leadership dimensions and each dimension is presented against five levels of performance.

On a personal level I was very pleased with the feedback, receiving exemplary or strong in all dimensions, especially 'influencing for results', 'connecting our service', 'inspiring shared purpose' and 'holding to account'. However there were very interesting observations. The first thing to notice is the marked disparity between the self-assessment and the raters assessment, indicating a gap in perception. I have consistently rated myself lower in all dimensions. This would suggest a lack of confidence or self belief, but also correlate with my introvert personality preference. The report also provides a comparison of my performance relative to dimensions that are important in my role. Here I am rated the same in performance as importance, that shows appropriate balance. Additionally, there is an assessment regarding hidden strengths/ blind spots. Fortunately, the assessment did not pick up any blindspots, but I would be very naive to think that none existed.

As mentioned the raters had provided a higher rating than myself especially in areas such as 'developing capability' and 'evaluating information', which may identify areas of potential 'hidden strengths'.

The rater comments are very complimentary, but also include very constructive advice such as allowing team members more responsibility and embracing delegation. This was also highlighted in my Belbin team role report, which identifies my preferred team roles as a monitor evaluator (ME), specialist (SP) and Plant (PL). One of the disadvantages is that there is a danger I could become too isolated from colleagues, and one of my least preferred roles was as a team worker which suggests that I do not appear to fit comfortably into a supportive role. This also corresponds with the MBTI 'Thinking' preference which suggests I have 'tough' and 'critical' facets and don't pay much attention to people's emotions.

Therefore, from the information, I would assess that my leadership style is most closely aligned to the 'pace-setting' style as mentioned earlier. The primary focus of a pacesetter style is task accomplishment, to high standards of excellence. Managers using this certain style tend to lead by modelling, establishing themselves as the standard and are apprehensive about delegating. Their concern with the immediate task accomplishment makes them disinclined to collaborate with peers except when needing to obtain or exchange resources.

My professional development plan involves a number of areas to develop.

Overall, from the 360° review, it is obvious that I need to start believing in my own abilities and to overcome the introvert side of my nature and resist the temptation to remain in the background.

With regard to communication I need to recognise when it's important to say how I feel and then speak accordingly. Additionally, I must recognise that my message may not get across unless I'm willing to say it out loud. Being reserved, I must be aware that others will think I am disinterested and therefore I should selectively let people know what really interests me. I must be selective in choosing questions to ask, so as not to intimidate people and recognise that others may make mistakes. It is also important that I recognise that others may mistake me critiquing for personal criticism. Additionally, I must be aware that sometimes my way of moving ahead may be wrong for a situation.

With regard to managing change, I tend to keep feelings about the change to myself and how to handle it on my own, I therefore need to talk to someone I trust and embrace the input. I tend to actively embrace or resist change depending on whether I agree with it. I, therefore, need to step back and consider whether my stance will really be advantageous in the long run.

When managing conflict, I need to be aware of trying to solve problems on my own which may be successful, but others may be a help. I must be aware that people may take my questioning as challenging, rather than helpful, in resolving an issue and so I need to be clear about my intent. Additionally, I have to realise that my style may upset others and I need to try to pull back and be more accepting. It is also important to realise communication is visual as well as verbal. I am conscious that physical presence (1.83m, 100kg, ex rugby player) can be intimidating. This this can obviously be useful when confronting an aggressive bullying surgeon, however, I must be mindful that this can be counter-productive for most interactions.

In summary, it is important to understand the assets and liabilities of my typical reactions. Also, I must recognise that other people may be different, to embrace these differences and to tolerate honest mistakes. It is important that I further appreciate the legitimacy of others points of view. This will prevent me from the destructive thought process of believing my way is the only way. Finally' the main goal of my development will be to improve my powers of influence. As mentioned' I believe the key to successful leadership today is influence not authority. Influence is often described as manipulation, but it is important to influence with integrity, so people do not feel as though they are being manipulated. I will achieve this through utilising an ethical reputational approach, based on logic and evidence, rather than emotion.

MEDICAL LEADERSHIP PROGRAMME LEARNING LOG

DATE	TITLE	LEARNING POINTS
24-25/10/18	Introductory workshop	Programme structure, service change project planning
20/11/18	Political and strategic workshop	Public service and NHSwales architecture
11-12/12/18	Leading improvement, change management, improvement.	Organisational change tools, understanding variation
10/1/19	Skills workshop/action learning	Introduction to action learning/ active listening, MBTI feedback
30/1/19	Leading engagement collaboration	Differing cultures within organisations and NHS
20-21/2/19	Residential Learning	Belbin Team Roles, Teamwork
12/3/19	Action Learning/academic skills	De Bono's Thinking hats
3/4/19	Coaching for performance	OSCAR technique, drama triangle
30/4/19	Skills workshop/action Learning	Influencing styles for leading/ active listening/ paradigm shift
16/5/19	Leading Quality and safety	Duty of Candour
18/6/19	Leading and communicating with impact	Media training , delivering precise information, setting agenda
4/7/19	Action Learning/ skills workshop	Mental toughness/resilience/ walking and talking
12/7/19	360 feedback	Self reflection

PROFESSIONAL DEVELOPMENT PLAN

	SKILL	CURRENT PROFICIENCY	TARGET PROFICIENCY	PLAN	EVIDENCE OF IMPROVING PROFICIENCY
PRIORITY 1	Communication	Naturally introverted. Fail to clarify aims/goals. Lack structure.	Clarify requirements/needs.	Actively engage in meetings. Resist temptation to retire to the background. Utilise coaching techniques e.g. OSCAR	Re-do 360 feedback. Regular 1 to 1 feedback from line manager (medical director) and directorate manager.
PRIORITY 2	Confidence	Large disparity between how I perceive my abilities and other's perception.	Realise potential and utilise skills.	Put ideas to forefront. Resist the fear of failure.	360 feedback.
PRIORITY 3	Managing conflict	Try to solve problems on my own. Can become embroiled in the 'drama triangle'	Be open to help from others. Active listening.	Embrace input. Utilise OSCAR technique.	Feedback from individuals involved.
PRIOTITY 4	Managing change	Tend to keep feelings/ideas to myself and attempt to address issues. Resist input.	Open up. Embrace input.	Utilise de bono's six thinking hats and OSCAR coaching model.	360 feedback
PRIORITY 5	Teamworking skills	Belbin roles of monitor evaluator, specialist, plant. Resist team input. Can be critical and intolerant of mistakes.	Be less critical and more tolerant of mistakes. Realise that my way is not always the best way.	Embrace and appreciate others' input.	Redo Belbin's team role questionnaire.

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COMPONENT II: REFLECTIONS ON INFLUENCE WITHIN NHS ORGANISATIONS

The service development project I chose to undertake was the development of a Cardiopulmonary Exercise Testing (CPET) Service. This would bring numerical risk stratification to colorectal patients requiring surgery at the Princess of Wales hospital, Bridgend, which would enable, among other things, the ability to appropriately triage patients with regards to the location of post-operative care.

However, it has to be understood that this service would be an entirely new service and that none of the expertise, premises, infrastructure, nor equipment existed within the anaesthetic department. Therefore, as the expertise did not exist within the department, this would require recruitment of consultant anaesthetists accredited in CPET delivery and analysis, as well as other vital staff, such as a physiologist. These challenges would obviously require a huge amount of interaction, influence and negotiation on a multidisciplinary level, as well as interaction and persuasion within my directorate management team and of course multiple stakeholders within the health board.

Fortunately, my position as a clinical director within the health board provided a 'head start' to gain access to the individuals and groups, who needed to be engaged to ensure this project came to fruition.

There is often a polarisation or demarcation of the definitions of leadership versus management and such delineation can often be unhelpful, but it is obvious that any person in a position of responsibility or who wants to invoke change, must exhibit characteristics of both to ensure success. It must be remembered that 'manager' and 'leader' are often utilised as titles but really should be seen as behaviours.

Hersey and Blanchard (1969) conducted research looking at what constitutes a good leader, with the main factors being concern for people and concern for the task. One would expect those leaders that show high levels of concern for both people and the task, would be the exemplary leader.

However, extensive research involving over 15,000 subjects provided an interesting observation that a successful leader could not be 'pigeonholed' into one group and that the expected results showed no correlation with the actual results. The conclusion was that effective leadership is individually determined by the followers and their unique situations and is not a consistent characteristic of the leader. Furthermore, effective leaders are those who are able to select and deliver a style or approach that meets the current needs of each follower, even if that differs for different people and at different times.

In summary, to ensure success I would need to exhibit flexibility in my approach, with regards my interactions with various groups and over time, within my own team, moving from directing to coaching to supporting and finally delegating.

The King's Fund (2011,2012) produced research that showed that top down leadership is counterproductive. Furthermore the King's Fund in 2014 moved to extol the virtues of collective leadership within the National Health Service: "Collective leadership means leaders and teams working together across boundaries within and across organisations, in the interests of patient care and community health, this requires us to change the way we think about leadership by seeing leadership as the responsibility of all ...".

Finally when undertaking such a project, it was important to understand the type of organisation or culture that I was trying to work within. Charles Handy (1985) famously classifies various organisations into Zeus (Power), Apollo (Role), Athena (Task) and Dionysus (Person).

Therefore, it is important to understand the culture or type of organisation the National Health Service constitutes and indeed any health board in such a large organisation, and also any sub-cultures that may exist. It is difficult to classify any Health board into one of these categories. In fact, it is more than apparent that when attempting to introduce any project, one will encounter various groups that could be classified into different categories. For example, my directorate team could easily be classified as Athena, which has a task culture, where team working is natural. The relationship between the service manager, the directorate manager and myself was very good which led to regular and easily made decisions coming to fruition.

However, the doctors and surgeons that need to be engaged, could easily be described as sitting in a Dionysus culture, whose initial reaction would be to reject anything they are asked to do. Furthermore, when leading change, it is very important to gain support and acceptance from colleagues. It is not uncommon for colleagues to have quite extreme reactions to the concept of change and many of them exhibit characteristics of Kubler Ross's stages of grief, most commonly denial and anger.

Additionally, the NHS as a whole, could easily be described as having an Apollo culture, which is made up of varying committees which maybe slow to react and respond. I encountered this regularly, having to present at the Theatre efficiency Committee, Quality performance and safety Committee, quarterly performance review and also Finance committees.

Finally, interactions needed to be made with the health board executives, who may have individuals (Chief Executive, Medical director, Chief operating officer) or a culture that could be described as Zeus like, where access to the dominant individual may prove difficult. Fortunately the Chief Executive and chief operating officer were very accessible and supportive throughout.

However, it is important to realise that I was in a position (clinical director) which allowed me regular access to these individuals and committees. The development of this Service would have been significantly more difficult prior to taking up the clinical director role.

Clinical management in the National Health Service (NHS) presents a multitude of challenges. The main responsibility of the clinical director in any hospital is to ensure patient safety, at the same time as maintaining a functioning and efficient service. This requires careful attention to detail to ensure appropriate systems and processes are in place and that the individuals working within the systems are functioning to a high level. This is obviously 'easier said than done'.

All staff at some point in a career can encounter difficulties within the workplace and at home which can produce challenges to the organisation that they work within and additionally to their line managers. However, every organisation has one or two individuals that appear to want to produce difficulties at any opportunity. The rationale for this behaviour is often difficult to determine and often even more difficult to curtail or resolve.

The role of clinical director requires the attributes of leadership and management. There is often a polarisation or demarcation of the definitions of leadership versus management and such delineation can often be unhelpful, but it is obvious that any person in a position of responsibility, must exhibit characteristics of both to ensure success. However, one of the most difficult challenges that a clinical director is faced with, or any manager for that matter, is dealing with a difficult colleague.

Although many managers may feel equipped with the necessary leadership or managerial attributes to deal with such individuals and may also feel they have sufficient 'life skills' up to that point, the awareness and knowledge of coaching techniques are absolutely essential to avoid misunderstanding, confrontation and exacerbation of difficult behaviours.

During my time on the medical leadership course, shortly after starting, I was confronted with a very difficult situation in my role as clinical director, involving one of my consultant colleagues. The individual concerned, who is an experienced consultant, had been known to produce challenging behaviour for several years, since appointment. However, as I had a good relationship with this individual, and I felt there was a pre-existing level of mutual respect between us, I felt I was equipped to address any issues brought forward by this colleague and to resolve the situation.

The main issue presented by my colleague was that she was no longer able to work with the consultant surgeon on her main surgical list, due to a breakdown in relations between them. Although it is a basic expectation any doctor must maintain professional relationships with colleagues to ensure delivery of service and patient safety, it is a reality that individuals will sometimes disagree resulting in an irretrievable breakdown in the relationship. My consultant colleague therefore requested a job plan review to change her sessions. Many departments do not entertain such requests and expect professional relations to continue and take the view that 'we are all professionals and we don't always like the people that we work with'.

However, I feel it is important to note that it has been well-documented that poor teamwork results in increased morbidity and mortality (Manser 2009). Therefore, we were happy as a directorate to accommodate her request and we expedited this for her benefit. In summary, this should have been a simple job plan process.

The appointment was scheduled at the time of her convenience and we arranged for the directorate manager, my deputy and myself to be available and formal invites and notification sent and received.

However, on the day, my colleague initially arrived late and also invited another consultant to join without prior notification. Additionally, the most obvious factor was that her attitude was aggressive and confrontational. It is accepted that colleagues may wish to be accompanied by a representative or another colleague, however prior notice is expected. Furthermore, this was a minor meeting that had been requested by her, accommodated and expedited for her convenience, as a favour. The attendance of an additional consultant and the confrontational tone adopted, suggested a lack of trust on her part and we were totally taken by surprise by this approach.

As we thought that this meeting would be very straightforward, we had not planned a strategy or structure to facilitate the meeting. It quickly became apparent that the real aim of the meeting was slightly different to previously stated and the rationale for the change had been evidently exaggerated. In fact, the change of lists, requested by my colleague, had developed additionally into a change of days to accommodate her availability for private practice. Additionally, it became evident that the tensions with the surgeon had been greatly exaggerated and the meeting had been requested on false pretences. Without a structure and prior plan and faced with a confrontational approach, the atmosphere turned from facilitation to fractious and the meeting deteriorated. However, my colleague felt that the situation she found herself in was having a detrimental effect on her well-being and that her perceived predicament was not of her making. Furthermore, it became evident that she expected me to address the issues and produce a solution to her satisfaction.

In retrospect it was evident that I was allowing myself to become embroiled in my colleague's 'Drama triangle'. The Drama Triangle, first described by Karpman in 1968, is a social model of human interaction and maps a type of destructive interaction that can occur between people in conflict. The Karpman drama Triangle models the connection between personal responsibility and power in conflicts and the destructive and shifting roles people play. He defined three roles in the conflict; persecutor, rescuer (the one up positions) and victim (one down position). Karpman placed these three roles on an inverted triangle and referred to them as being the three aspects of drama. Karpman had interests in acting and was a member of the screen actors Guild, choosing the term 'drama Triangle' rather than the term 'conflict triangle', as the victim in his model is not intended to represent an actual victim, rather someone feeling or acting like a victim. Initially, the drama Triangle arises when a person takes on the role of victim or persecutor and this person feels the need to enlist other players into the conflict. As often happens a rescuer is encouraged to enter the situation. These enlisted players take on roles of their own, that are not static and therefore various scenarios can occur. For example, the victim might turn on the rescuer, the rescuer then switches to persecuting.

This is exactly what happened in our scenario. The consultant colleague presented a list of problems that she expected me to address and to provide her with a final solution which was presented to me as a fait accompli. The whole reason I had agreed to set up a meeting was to help her and alleviate her problems. Therefore, I was initially being dragged into the drama Triangle as a rescuer. However, part of her expected solution was simply not possible, which led her to perceive me as the persecutor, which probably wasn't helped by my obvious frustration and exasperation. Subsequently, the consultant who had accompanied her, took on the role of the rescuer, which further exacerbated the perception of me as the persecutor.

The victim's stance is 'Poor me!' The victim feels victimised, oppressed, powerless and is quick to fall back to defensive, disruptive behaviour including accusations, threats and recriminations. The rescuers line is 'let me help you'. A classic enabler, the rescuer feels guilty if they don't go to the rescue. Yet this has negative effects, keeping the victim dependent and reinforcing the victim's behaviour. The persecutor is perceived as controlling, blaming, authoritarian and superior.

As described the situation deteriorated and although an outcome of sorts was achieved, this was at the expense of a feeling of acrimony.

Subsequently, on the leadership course, exposure to Karpman's model has equipped me with the knowledge and understanding to avoid being embroiled in individuals' 'Drama Triangles'. Furthermore, it is important to turn the triangle literally on its head. Emerald (2009) recommends that the victim is encouraged to adopt an alternate role of 'creator' and be encouraged to be 'outcome orientated' rather than 'problem orientated' and take responsibility for choosing the response to the problem. Furthermore, the victim should be encouraged to see the persecutor as a person that's encourages them to clarify, as a 'challenger' and the rescuer to be perceived as 'coach' who is encouraged to ask questions to help the individual make choices.

REFLECTIONS ON COACHING TECHNIQUES FOR MANAGING DIFFICULT CONVERSATIONS

The role of clinical director requires the attributes of leadership and management, as mentioned in one of my previous reflections. There is often a polarisation or demarcation of the definitions of leadership versus management and such delineation can often be unhelpful, but it is obvious that any person in a position of responsibility, must exhibit characteristics of both to ensure success.

There is much debate regarding the characteristics, and indeed definition, of a good leader. Endless literature and comment has been produced, claiming to define and clarify the necessary attributes. Furthermore, it is probably true that leadership comes more naturally to certain individuals compared to others. However, no matter how 'natural' an individual is at leadership, I believe it is entirely false to suggest that learning coaching techniques could not produce improved leadership.

What is coaching? There are a number of definitions, however, there is widespread agreement incorporating some of the following descriptions. Coaching could be described as the art of facilitating another person's learning, development and performance. Through coaching, people are able to find their own solutions, develop their own skills and change behaviours and attitudes. It can be used appropriately when a person has the ability and knowledge, but the performance may not be maximised. Coaching can therefore maximise performance and deliver performance management. In summary, my assessment of coaching, is a tool that can enable others to achieve goals by their own inner resources.

It is important to note that coaching differs from training, mentoring and counselling. I feel training is a structured process that provides employees with knowledge and skills to enable them to perform tasks. Mentoring is often provided by an experienced and trusted advisor. The role of the mentor provides advice guidance and support. Finally, counselling could be described as a skill that helps people who have lost the ability to resolve their own issues. Counselling therefore tends to focus on the past, whereas coaching assumes people have the ability to resolve issues and therefore tends to focus on the future.

However, coaching and mentoring shouldn't be thought of as being mutually exclusive or indeed being different from one another at all. A mentor will use a lot of coaching techniques. With regard coaching, subject knowledge is not necessary, whereas the mentor uses that past experience and knowledge to help guide a person. The manager can use a coaching style which is less directive and encourages team members to take responsibility for performance and effectiveness. Both coaching and mentoring are proactive. However more advice and guidance is usually provided in the mentoring relationship, but techniques and approaches are fundamentally the same to both coaching and mentoring. However, I do believe that one should not mentor someone one manages, as this can lead to a conflict-of-interest at some point.

Coaching therefore provides a 'vehicle' to the manager which deviates from a top-down, dictatorial method, often adopted by managers within NHS, and criticised by the King's fund. Coaching is the opposite of telling someone what to do. An effective coach uses questions to help raise awareness and understanding in the person they are coaching. Coaching is basically the art of asking good questions, knowing when and how to ask them and, of course, to actively listen to the answer. In essence, coaching creates an opportunity for an individual to come and find answers to the questions: "The mind that has the problem has the solution".

There are many attributes to Coaching which include showing empathy, building a rapport, remaining detached and nonjudgemental, showing patience and support. However, I feel the three key attributes which we were introduced to on the course were to ask effective questions(what?and how?), actively listen and reflect back and to give and receive feedback. Coaching is widely recognised as a method of developing employees to enhance organisational performance and one of the most effective ways of unlocking potential and creating an empowering atmosphere. It is important to remember for coaching to be beneficial, it must be regarded as a sustained intervention. This is where the realities of the NHS undermine coaching. In reality,

managers within the NHS simply do not have enough time to engage in a sustained manner for all employees.

Throughout my professional career, prior to becoming a clinical director, I have obviously come into contact with multiple managers. I believe one of the main reasons for disgruntlement in the workplace is often the relationship that exists between employees and their manager. Those managers that have exhibited to their colleagues a feeling of appreciation and value, along with trust and support in difficult times, have consistently shown an improvement in well being of staff and improved efficiency. However, as mentioned, there is only a finite amount of time in the NHS to be able to ensure these positive feelings are provided to colleagues.

Many difficulties within the NHS encountered by individuals obviously need to be dealt by the individuals themselves. We learnt on the course that the ultimate aim of coaching is to raise awareness that problems can arise and can be dealt with, due to the choices that we make. It is important to allow and empower individuals to make choices and to be aware that they can control these choices. The leadership course provided an introduction to a number of coaching models and techniques that help to generate awareness and responsibility and are particularly suited to managing performance within organisations. A coaching model that I have found extraordinarily helpful and one that is now completely invaluable to me on a day to day basis is the OSCAR coaching model.

OSCAR is an acronym for Outcome, Situation, Choice, Actions, Review. This coaching model can be utilised in the number of ways. It can be used to provide a simple structure when discussing a distinct problem. It can be used in a coaching capacity knowingly and can also be used when dealing with an unwilling/unaware colleague.

‘OUTCOME’ refers to the desired destination: appropriate questions such as what is the long-term outcome? what would success look like? what would you like to achieve? This is where the team member is helped to clarify the outcome around the issue raised.

‘SITUATION’ refers to the starting point: appropriate questions being: what is the current situation? what's actually happening? This is the clarification around where the team member is at that moment.

‘CHOICES’ refers to the options available. This is where the team member can be helped to generate many alternative choices as possible and raise awareness around the consequences of each possible choice.

‘ACTIONS’ referred to the detailed plan. This is where a team member can be helped to clarify the next steps and to take responsibility for their own plan.

‘REVIEW’ refers to the ongoing process of reviewing and evaluation. This is where the team member can be helped to continually check that they are on course. It also enables transparency around the actions of the team member, what the team member is doing and why they are doing it.

The OSCAR coaching model would have been invaluable in dealing with the scenario described in the previous reflection. This involved a colleague requesting a meeting to make a job plan change due to a breakdown in relations with the surgeon she was working with.

As we thought that this meeting would be very straightforward, we had not planned a strategy or structure to facilitate the meeting. It quickly became apparent that the real aim of the meeting was slightly different to previously stated and the rationale for the change had been evidently exaggerated. In fact, the change of lists, requested by my colleague had developed additionally into a change of days to accommodate her availability for private practice. Additionally, it became evident that the tensions with the surgeon had been greatly exaggerated and the meeting had been requested on false pretences.

Without a structure and prior plan coupled with a confrontational approach, the atmosphere turned from facilitation to fractious and the meeting deteriorated. However, my colleague felt that the situation she found herself in was having a detrimental effect on her well-being and that her perceived predicament was not of her making. Furthermore, it became evident that she expected me to address the issues and produce a solution to her satisfaction.

In retrospect it was evident that I was allowing myself to become embroiled in my colleague's 'Drama triangle'. The Drama Triangle, first described by Karpman in 1968, is a social model of human interaction and maps a Type of destructive interaction that can occur between people in conflict. The Karpman drama Triangle models the connection between personal responsibility and power and conflicts and the destructive and shifting roles people play. He defined three roles in the conflict; persecutor, rescuer (the one up positions) and victim (one down position). Karpman placed these three roles on an inverted triangle and referred to them as being the three aspects of drama.

The consultant colleague presented a list of problems that she expected me to address and to provide her with a final solution which was presented to me as a fait accompli. The whole reason I had agreed to set up a meeting was to help her and alleviate her problems. Therefore, I was initially being dragged into the drama triangle as a rescuer. However, part of her expected solution was simply not possible, which led her to perceive me as the persecutor, which probably wasn't helped by my obvious frustration and exasperation.

This meeting took place prior to me learning about the Oscar coaching model. In retrospect, this model would have allowed me to provide a structure to manage this interaction and to performance manage the individual. I would have been able to clarify the outcome required and turn the situation around, leading to the individual having to take responsibility for the situation and realise herself the limitations of her requests. Additionally, the model would have negated the development of the drama triangle.

Following exposure to the OSCAR coaching model and reflecting on the unsuccessful interaction just described, I have utilised this model multiple times. As mentioned, this model can be used on an unaware individual, and is especially useful for those difficult conversations with colleagues who are not performing.

The OSCAR coaching model proved invaluable recently in dealing with a poorly performing colleague with very little insight. Unfortunately this colleague is coming toward the end of his career and has become deskilled in recent years. There have been a number of critical incidents involving his care of patients, often centred around a lack of situational awareness. The colleague had been placed on supervised duties, which is obviously difficult for an experienced clinician. The lack of insight was leading to the colleague becoming increasingly challenging, as he felt there was nothing wrong with his care.

A meeting was set up to discuss the current situation and the plans going forward. I planned in advance to utilise the Oscar coaching model and wrote down appropriate questions. The meeting was also attended by our directorate manager. The structured format provided by the Oscar model enabled us to clarify the situation and what was needed to be done. It also clarified the lack of insight possessed by our colleague, but did provide the opportunity for our colleague to reflect and realise that the problem and solution were through his own choices. The meeting remained amicable and did not allow any opportunity for individuals to be dragged into a drama Triangle. I now utilise this model virtually everyday

REFLECTIONS ON MENTAL TOUGHNESS/RESILIENCE IN A LEADERSHIP POSITION

During the medical leadership program we received a very interesting lecture from Stuart Gray, a Professional training and coaching consultant. A discussion developed around the vital attributes for leadership. There are multiple attributes, however, he focused on six of the most essential, in his opinion. These included the ability to 'think on one's feet', to remain politically astute, to always have a plan B, be able to 'nip problems in the bud', to be media 'savvy' and finally, possess common sense.

However, I feel one of the most underestimated, but necessary qualities, is to possess mental toughness or resilience. This can be for a number of reasons. Anyone who has done a clinical leadership role will state that as soon as the role is even considered, colleagues will immediately begin changing their attitude towards you, for no apparent reason. This is just the beginning. Some colleagues may become actually antagonistic. This is the first hurdle any clinical manager will face and can be very difficult to deal with, especially considering you may have worked with these colleagues for many years and may have considered some of them as friends. This is often followed with comments such as 'poacher turned gamekeeper' and 'turning to the Dark side'. This can be a very difficult introduction to clinical management which immediately clarifies that these positions can be very 'lonely' in some respects. Therefore, it has to be remembered, a certain degree of mental toughness and resilience is required from the outset, even before the challenges that the role will provide, when dealing with other disciplines/professionals and attempting to invoke change.

Some people will obviously be more resilient or mentally tough than others. However, there are ways of improving mental toughness. How could mental toughness be defined? There are many ways to define mental toughness but it has been suggested by Peter Clough (2012) as a personality trait which determines in large part how people deal with challenges, stresses or pressure irrespective of prevailing circumstances.

Many authors throughout the world have attempted to define mental toughness. The definition is very subjective and influenced by a range of experiences and influencing factors. However the idea of resilience appears as a common theme and is often associated with the idea of mental toughness.

Many attempts at defining originate from sports psychology. Jones Hanton and Connaughton (2002), following research with elite athletes, define mental toughness as:

“the natural or developed psychological edge that enables you to generally cope better, be more consistent and better than your opponents in remaining determined, focused, confident and in control under pressure.”

Furthermore, Gucciadi, Gordon and Gimmick (2008) also following work on the sports field state:

“mental toughness is a collection of values, attitudes and behaviours that enable you to preserve and overcome any obstacle, adversity, or pressure experienced but also to maintain concentration and motivation when things are going well to consistently achieve your goals.”

This suggests that mental toughness can have both reactive and proactive qualities i.e. Mental toughness can be important when things are and are not going well.

The analogy with sport is very useful and having played and held leadership roles in various sports at a high level this has certainly helped to a certain extent. However, the NHS is an ever increasingly complex and challenging environment with multiple competing demands. Therefore, exposure to sport, although helpful, is insufficient, certainly speaking personally, to take on a leadership role in the NHS today. I therefore feel it is necessary to further understand the concept of resilience and mental toughness and also techniques to improve this poorly understood attribute.

As mentioned Peter Clough has proposed a mental toughness model that is more a personality trait with connections between resilience and mental toughness. Additionally individuals can develop proper coping techniques. Clough has extended Maddi and Kobasa's characteristics of commitment, control and challenge by adding confidence to create the four C's of Clough's model. Awareness of this model has provided me with awareness of my strengths and weaknesses in these areas. Understanding how mental toughness underpins what I may or may not do is important and useful in assisting when working life becomes challenging. Additionally understanding mental toughness has helped me to think about the balance of my behaviour, ensuring that in excess, it is important to be mindful that mental toughness can have a negative effect on relationships.

REFLECTIONS ON THE IMPACT OF ACTION LEARNING ON MY LEADERSHIP ROLE

One of the main targets during my role as clinical director has been to introduce a cardiopulmonary exercise test (CPET) Service, as described in my leading service development project. To institute this project, I needed to set up meetings involving the major players needed to build the service which included the service director, directorate manager, the clinical lead for pre-assessment, the two new consultants anaesthetists that I had recruited to conduct the tests and myself (Clinical director).

The aim of these meetings was to thoroughly explore various plans and options required to introduce the service. It became very evident early on that some individuals were more enthusiastic than others. For example, I had been the instigator of this new project and the two new consultants were very enthusiastic about the process, extolling the virtues and advantages of the proposed subject. However, the directorate manager was interested in the evidence and data available, to ensure she was making the correct decision before committing any finances. Surprisingly the lead for pre-assessment was very cautious. Finally the Service manager was taking an over arching view of the perspectives. However we were able to work through the advantages and disadvantages and come to an agreement for a way forward.

Although, I did not know this at the time, the methodology used was almost identical to the excellent action learning tool 'The six thinking hats' (De Bono 1985) and in retrospect, we had inadvertently utilised this method. As the medical leadership program progressed we were introduced to Edward de Bono's method. The basis of this refers to the habitual thinking of individuals and attempts to encourage issues to be looked at from differing perspectives. De Bono describes six different colour hats to represent different attitudes or viewpoints.

In the scenario described above, I have obviously taken on the green hat, associated with the new ideas and possibilities. The Two new consultants had taken on the Red Hat(intuitive, emotional, instinctive) and the yellow hat (optimistic, positive). This was countered somewhat by the lead clinician for pre-assessment, whose view was a little more sceptical, pointing out the risks, difficulties and problems. As would be expected, the directorate manager adopted the white hat, requested information and being data focused. Finally, the service manager naturally adopted the blue hat, attempting to summarise and coalesce everyone's thoughts.

As the service development progressed the cardiopulmonary exercise test Service was developed which has resulted in some very encouraging data. The natural progression of the CPET service, is to develop a pre-habilitation program. Information from the CPET process is utilised to prepare patients for surgery. Basically this is a program that insures patients are fit for surgery. However, this would require further financial input to purchase are required number of exercise bikes as well as the necessary professional input.

Therefore, to plan the next step in the evolution of our service, we reconvened the same individuals (and others) for a meeting. This time, however, we formally introduced De Bono's thinking hats and took on the same roles. This was overseen by the service manager, who adopted the blue hat. Additionally, we also deliberately changed roles in the middle of the meeting and tried to adopt a diametrically opposite role to see if a deliberate attempt to change a viewpoint would have benefits or new ideas. Some of the group felt quite liberated in some respects and others started to see alternate viewpoints. However, the lead clinician for Pre-assessment who had apparently relinquished the Black hat role, adopted the yellow hat role, but could not bring himself to see any advantage in the project. In retrospect, this individual may still be at a depression point in Fisher's transition curve.

In summary, this excellent tool provided an invaluable method to clarify advantages and disadvantages, which saved significant time by avoiding mistakes and setting unrealistic goals.

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