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THE IMPACT OF LEADERSHIP AND MANAGEMENT APPROACHES ON THE DELIVERY OF EXCELLENCE IN SOCIAL CARE SERVICES

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Abstract

This research examines the impact of leadership and management approaches on the delivery of excellence in social care. It focuses on four residential care homes with nursing, operated by a national Third Sector provider of services for disabled people. The purpose of the study was to investigate how services defined quality and to examine the extent to which leadership and management approaches facilitated staff engagement in quality improvement and contributed to 'Good' or 'Excellent' Care Quality Commission ratings.

This multi-method, qualitative study was underpinned by a phenomenological research philosophy. Data collected from semi-structured interviews with managers and care supervisors was triangulated through the analysis of opinion data from rating questionnaires completed by frontline nursing, care staff and non-care staff. Data was analysed using methods adapted from Interpretative Phenomenological Analysis.

The study did not establish a clear association between leadership and management approaches and the achievement of a 'Good' or 'Excellent' CQC rating. The collaborating organisation's comprehensive operational policy framework and ethos of service user empowerment appeared to be higher determinants of service quality than leadership and management approaches. However, findings did indicate that, where leadership and management approaches help followers to feel valued and psychologically safe, managers can engage staff successfully in the quality improvement process.

An unexpected outcome of the study was that it identified a possibility that an individual's leadership and management approaches may change when they are highly stressed, causing a negative impact on their followers, the working environment and the service culture. It was beyond the scope of this research to take forward an exploration of these issues. However, it provides the opportunity for further research to examine the ways in which managers respond to high stress levels, how followers are affected when managers are overly stressed and the overall implications for staff welfare and service quality in the social care context.

Declaration

This work is original and has not been submitted previously for any academic purpose. All secondary sources are acknowledged.

Signed:

Christine Barker

Date: 28 May 2010

Table of Contents

Table of Contents continued

Chapter 1 Introduction

1.1 Preface

Any organisation that is involved in the provision of social care services should be interested in delivering high quality outcomes to the individuals it supports. The social care industry is highly regulated and the Care Quality Commission (CQC) awards ratings based on the quality of the outcomes experienced by service users. CQC publishes its ratings so that the general public can see whether a service in their area is rated as 'Poor', 'Adequate', 'Good', or 'Excellent'.

The best social care providers will see the delivery of high quality outcomes as central to their value base, but there is also a commercial imperative for organisations to achieve the highest CQC ratings. Local authorities, which commission care and support services, monitor the performance of providers with whom they contract and CQC ratings are an important performance indicator. Some authorities have increased or reduced contract prices in accordance with the ratings achieved, creating a financial incentive for organisations to maintain high quality standards.

The Labour government's transformation of adult social care has led to a reduced role for local authorities in commissioning services and there has been a move away from traditional contracting arrangements for the provision of social care. This approach has had cross-party support and the new Conservative/Liberal Democrat coalition government is likely to take the transformation forward. It is envisaged that this will lead to greater competition in the social care market because people will have the opportunity to purchase social care services on their own behalf, rather than accept services from a provider chosen by their local authority.

In this environment, potential customers are likely to view the CQC rating of a service as an important consideration, so it will be crucial for providers to demonstrate, through their CQC ratings, that they can deliver high quality outcomes. Quality management will become even more important in the context of these changes and organisations will need to focus on the role that managers play in promoting quality within their services. Managers will need to use the most effective leadership and management approaches so

that the frontline staff who work face to face with service users and their families are motivated and well supported to deliver quality services. It is this interface between leadership and management approaches and the delivery of excellence that provides the focus for this study.

1.2 Background to the Research

The author is the Chief Executive Officer of a medium-sized charity, based in Greater Manchester, which provides care and support services for people with learning disabilities, physical disabilities and mental health needs. She has overall responsibility for the organisation's operational and financial performance and leads on the development and implementation of organisational strategy. For five years prior to taking up her post in September 2009, the author held a senior regional management role within a large national disability charity. Before this, the author was the Chief Executive of a Sussex-based charity, which provides community based support services for vulnerable adults and children with a diverse range of needs. This work experience in the Third Sector, coupled with her learning from relevant modules from her MBA, provides an excellent background to this piece of research.

The author chose her previous employer, the national disability charity, as the collaborating organisation for this research study. The charity is the UK's largest voluntary sector provider of care and support services for disabled people, offering a range of different service types including residential care homes, supported living, domiciliary support, day services, rehabilitation, respite care and programmes of support for disabled people who want to access education, training and work. This study focuses on four care homes in the North West of England that have achieved 'Good' or 'Excellent' CQC ratings.

The care homes provide individualised programmes of care and social support to people who have physical disabilities, which may also be associated with a learning disability, or a cognitive impairment resulting from an acquired brain injury or a specific health condition. Residents are likely to have profound or multiple disabilities and complex needs. The care homes are categorised as 'residential care homes with nursing' but there is some variation between the levels of nursing care that are provided. One of the

services offers specialist end of life care to people who are at the final stages of such conditions as multiple sclerosis or motor neurone disease.

The care and support packages for residents are commissioned by local authorities and/or Primary Care Trusts (PCTs). All four care homes are registered with the CQC and operate within the framework of the Care Standards Act 2000 (CSA 2000) and the National Minimum Standards for residential services. The service managers hold CQC registration, which means that they have legal accountability for service delivery.

The research assesses the position of the four care homes in relation to academic models of quality, as well as the relevant National Minimum Standards, and associated Key Lines of Regulatory Assessment (KLORA), which are set out within the Care Standards Act 2000 (CSA 2000). The focus of the research is an exploration of the leadership and management approaches that were used by Registered Managers and an assessment of the extent to which these contributed to the delivery of high quality services and the achievement of 'Good' or 'Excellent' CQC ratings.

1.3 The Research Issue

The collaborating organisation has robust operational policies and procedures to ensure that services operate in accordance with CQC requirements, which are designed to ensure that service users experience high quality outcomes. A key performance indicator for any service is its CQC rating and the organisational expectation is that all its services should achieve 'Good' or 'Excellent' ratings. Although all the organisation's services are bound by the same regulatory requirements and operate within the same internal policy frameworks, there is a degree of inconsistency in terms of the CQC ratings that are achieved across the organisation. Whilst the majority of services have a track record of achieving 'Good' or 'Excellent' ratings, CQC have assessed a minority of services as 'Adequate'.

Where it is accepted that there are serious deficiencies in services, the organisation has placed them under 'special measures' and, in some cases, a National Locum Manager has been brought in on a temporary basis in a 'troubleshooting' role. The National Locum Manager has either replaced a service manager or worked alongside them and

their staff teams to identify the reasons for the deficiencies and make the necessary improvements to move the service back to a 'Good' rating. Where this approach to 'failing' services has been taken, they have eventually achieved the necessary improvements and the CQC rating has moved back up to 'Good'. This gives rise to a question about whether there is any association between the approaches that managers of 'Good' and 'Excellent' rated services use in their services to promote quality and achieve the positive outcomes that are associated with 'Good' or 'Excellent' ratings.

The issue for this research was the impact of leadership and management approaches on the delivery of excellence in social care services for adults with a physical disability. A model illustrating the focus of the research is set out in **Figure 1**. The aims of the research were:

- To analyse and evaluate contemporary thinking about the nature of leadership and management
- To investigate how quality is, and may be, defined in relation to social care services for adults with a physical disability
- To examine the leadership and management approaches that were used by managers of 'Good ' and 'Excellent' rated services and establish whether there was any commonality of approach
- To establish whether any inferences could be drawn about an association between leadership and management approaches and the achievement of a 'Good' or 'Excellent' CQC rating
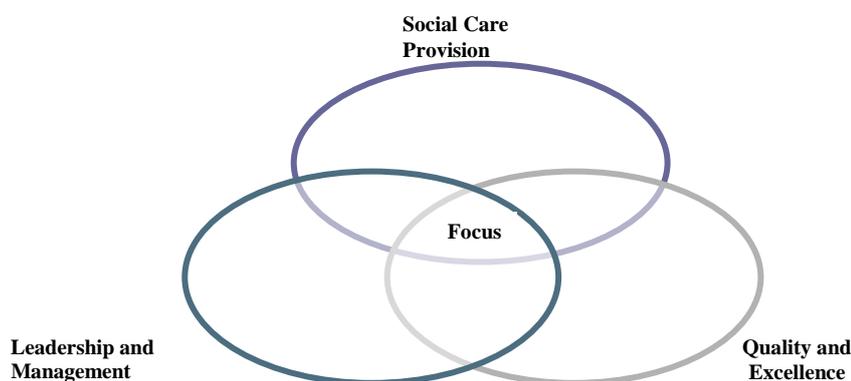

Figure 1: Model demonstrating Research Focus:

The author agreed to share a summary of the findings of the study with the collaborating organisation so that any examples of good practice could be disseminated.

1.4 Justification for the Research

CQC ratings are key quality indicators for the collaborating organisation's services and the achievement of a 'Good' or 'Excellent' rating is the expected standard within the organisation. This expectation reflects long-held values relating to the empowerment of disabled people and a commitment to providing care and support that enables people to maximize their well being, independence and choice. However, there has also been a commercial imperative for the achievement of 'Good' or 'Excellent' ratings because the delivery of high quality services has been a justification for the organisation's costs, which have been at the higher end of the cost spectrum, compared with some other providers of residential care.

Changes to the organisation's external operating environment are now bringing commercial considerations to the fore. Local authorities and PCT's are facing serious financial challenges as a result of the recession and are seeking to drive the cost of social care services downwards. At the same time, in the context of Putting People First: *A Shared Vision and Commitment to the Transformation of Adult Social Care Services'* (December 2007), the Labour government has driven forward a major transformation of social care services. Central to this transformation has been the implementation of 'personalisation' or self-directed support, whereby disabled people can have an individual resource allocation that is based on 'outcomes' that they want to achieve in their lives, rather than just their care and support 'needs'.

Historically, local authorities have purchased social care services for disabled people from providers through 'block' contracts or 'spot purchasing' arrangements. Packages of care and support have been determined on the basis of a needs assessment, carried out by a local authority and/or PCT, which determines the level and type of support that is purchased. In this traditional model of social care, disabled people have had no choice other than to accept the provider that is selected by the statutory commissioner.

Self-directed support allows people to have an individual budget through which they can purchase flexible care and support from individuals or service providers of their choice. Local authorities across the UK have targets for the delivery of self-directed support in domiciliary and community settings and they are engaging with service providers to implement the new ways of working. Although local authorities are still responsible for allocating the individual budgets, they no longer have to be the commissioners of services, unless an individual asks them to purchase care and support on their behalf. Currently, self-directed support principles are only being applied to the commissioning of domiciliary care services, where people are supported in their homes or in community settings. However, local authorities and PCTs are developing joint working protocols that could lead to the possibility of health and social care funding being pooled in the future, with a potential impact on residential and nursing services.

Although there is uncertainty about if, when, or how, self-directed support will affect its residential care homes, the collaborating organisation is reviewing its business strategy in response to the transformation agenda. The organisation recognises that it is becoming even more important for all its services to achieve 'Good' or 'Excellent' CQC ratings to maximise the organisation's competitive advantage in a changing social care market.

This research examines the impact of leadership and management approaches on the achievement of 'Good' and 'Excellent' ratings in a group of residential care services, offering the potential to contribute the knowledge base that informs quality management within the collaborating organisation. A summary of the research findings will be offered to the organisation and this information may be relevant to manager development and quality improvement programmes that are being developed in the context of its current business strategy review.

1.5 Methodology

This exploratory study was undertaken in the context of a values-driven organisation and was framed within the author's values and knowledge about quality in social care provision. These factors align the research philosophy to interpretivism or phenomenology. The approach was largely inductive, in the sense that it was based on

qualitative data. However, a hypothesis emerged from the literature review, relating to concepts of authentic and inclusive leadership and their potential to facilitate successful quality improvement processes. Therefore, there was an element of deduction in the sense that the author attempted to test this hypothesis and explain causal relationships between variables (Saunders, Lewis and Thornhill 2009).

The literature review identifies current thinking about the nature of leadership, management and quality. Four of the collaborating organisation's 'Good' and 'Excellent' rated services in the North West of England were used as case studies to explore the research issues. The study was conducted by means of semi-structured and in depth interviews with managers and care supervisors who reported directly to them. The key themes for the interviews were quality, leadership and management. In order to triangulate the data collected from the semi-structured and in-depth interviews, questionnaires to test perceptions about the same themes were issued to nurses, care staff and non-care staff within the services. These individuals were selected at random by the author from staff lists held in the services. This piece of research can, therefore, be defined as a multi-method qualitative study.

Senior managers within the collaborating organisation gave permission for the author to carry out the study on the basis that a summary of the findings would be shared with the organisation. Service users did not participate in the research, so there were no ethical considerations in relation to service user confidentiality. However, consideration was given to the confidentiality, safety and comfort of managers and other staff who participated.

The main limitation of the research was the small scale of the study, which only focused on a limited number of managers and followers. It would have been preferable to interview frontline nursing and support staff, rather than gather data from questionnaires, but it was not possible to do this because there would have been disruption in services, and a cost implication for the collaborating organisation, if staff had been taken off shift to participate in the study.

1.6 Outline of the MBA Dissertation

Chapter 1 sets out the background to the research and provides an overview of the research issue, the research aims and the methodology for the study.

Chapter 2 reviews relevant and contemporary literature relating to leadership, management and quality management and sets out the theoretical foundation that underpinned the research.

Chapter 3 describes and justifies the methodology that was used to collect the data for the research study.

Chapter 4 presents the findings of the research and analyses them in terms of their relevance to the research issue.

Chapter 5 sets out the conclusions of the research, reviews the research issue, evaluates the methodology of the study and highlights opportunities for further research.

1.7 Definitions

- **Care Quality Commission (CQC)** - the regulatory body for social care services
- **Service Manager (SM) –** has overall responsibility for services, holds CQC registration and usually has a senior nursing background
- **Care Supervisor (CS) –** a qualified nurse, supervises other nurses, reports directly to the SM and deputises in their absence
- **Registered General Nurse (RGN)** – reports to the care supervisor, provides nursing input on each shift, supervises and oversees the work of care staff
- **Care Standards Act 2000 (CSA 2000)** – the legislative framework for social care delivery
- **National Minimum Standards –** standards that govern the operation of social care services
- **Key Lines of Regulatory Assessment (KLORA)** – provide the framework for CQC inspections
- **Annual Quality Assurance Assessment (AQAA)** – an annual self-assessment document that CQC requires service managers to complete
- **Personalisation/self-directed support –** the key element in the Labour government's transformation of adult social care
- **Primary Care Trusts (PCTs)** – commissioners of health care services

1.8 Summary

This chapter places the research in context and sets out the background to the study. It introduces the research issue and the research aims and presents the justification for the study. The chapter provides a brief description of the methodology, noting the limitations of the research, and presents key definitions relating to its context. The chapter provides a foundation for a more detailed description of the research.

Chapter 2 Literature Review

2.1 Introduction

This study is grounded in literature and research relevant to leadership and management theory and quality management theory, with a particular focus on material that places these issues in the context of health and social care. A range of journals and texts were reviewed alongside relevant legislative and government policy documentation and electronic publications such as the Internet.

2.2 Leadership Overview

Within the literature and research, there are many different definitions and conceptualisations of leadership and management. A review of these is relevant to this study, which focuses on the impact of leadership and management on the delivery of excellence in social care. Lee and Cummings (2008) comment that most definitions of leadership show that it can be found in the traits, behaviours, and practices of individuals and that it involves exchange between leaders and followers in a complex relationship. However, the various researchers have had different areas of focus.

Traits theorists, such as Northouse (1997, 2010) and Costa and McCrae (2004) focus on recurring regularities or trends in the behaviour of leaders, whereas contingency theorists such as Fiedler (1981) focus on context, situation and followers. Daft (2008) asserts that situational variables such as task, structure, context and environment are most important to leadership style. Hughes, Ginnet and Curphy (2006) suggest that the leader's knowledge is an important component of leadership and define a leadership skill as consisting of a well defined body of knowledge, a set of related behaviours and clear criteria of competent performance.

Daniel Goleman (1995) proposes a model of emotional intelligence, which is based on a set of competencies that are distinct from professional knowledge and competency. *Personal competencies* relate to how leaders manage themselves and *social competencies,* determine how leaders handle relationships. Northouse (2010) describes the concept of *authentic* leadership*,* which is defined at an *intrapersonal* level as being

connected with self-knowledge, self regulation and self concept, at a *developmental* level, as being something that can be nurtured and at an *interpersonal* level, as being relational and created through the interaction of leaders and followers.

Within the literature and research, leadership approaches are examined within a range of organisational contexts. Thach and Thompson (2006) analyse leadership in public and private sector organisations and report significant similarities in the highly rated leadership competencies, signifying the universality of these skills regardless of organisation type. Collins (2001) suggests that there are different levels of management and leadership capability, which are applicable within any organisational setting, and that these capabilities, if sustained over time, can move a service or an organisation from 'good' to 'great'. Cherniss and Goleman (2001) assert that leadership style seems to drive organisational performance across a wide span of industries. Jago (1982) reviews the various trends in leadership research and organises theoretical perspectives into a four-fold typology **(Figure 2)** based on the dominant assumptions of the various theories of leadership.

2.2. 1 Leadership versus Management

The managers who were the focus of this study lead large staff teams and are required to manage a range of financial, physical and human resources to deliver high quality services in the residential care homes for which they are responsible. They must ensure that care and support to service users is delivered in accordance with the collaborating organisation's values and the performance of their services is measured through a range of internal and external indicators. It could be argued that their role involves aspects of both leadership and management, as defined by theorists.

Kotterman (2006) states that conceptualising and defining leadership and management has always been difficult and that the terms are often used interchangeably in the workplace, creating confusion. Nebecker and Tatum (2002) describe management as the process of continual planning, organising, supervising and controlling resources to achieve organisational goals. They assert that managers are responsible for implementing and improving these processes, whereas leaders are looking into the future in anticipation of the organisation's global needs and long-term future.

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A   i │ B     │     Lead by          │       Lead by         │
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H   s │ h     │  Right Things        │   to Fit the Situation│
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Adapted from Jago, Arthur. G. (1982). "Leadership: Perspectives in Theory and Research." *Management Science* 28(3): 315-336.

Figure 2: Leadership Perspectives

Kotterman asserts that it is unusual for one person to have the skills to service as both an inspiring leader and a professional manager. However, he argues that managers can demonstrate leadership qualities through project and team management and suggests that all employees have the opportunity to show leadership at some point. He concludes that it is important to understand the differences between leadership and management so that employees know when and how to apply each set of characteristics for given processes.

Bruch and Ghosal (2004) suggest a distinction between managers, who are involved with the production of products or delivery of services, and leaders who are more concerned with the organisational environment and culture. Bruch and Ghosal assert that leaders must ensure that the autonomous actions of managers are aligned to the overall goals and direction of the company and they urge leaders to develop in their people a shared commitment to an overall direction, as well as to a set of common values and mutually agreed-upon norms of behaviour.   Schein (2004) links the imposition of a leader's values to the culture in an organisation and suggests that leadership and culture are 'two sides of the same coin'. He suggests that culture in organisations is shaped by leadership behaviour and a set of structures, routines, rules and norms that guide and constrain behaviour.

 In an examination of leadership and nursing care management, Huber (2006) explores similar themes, arguing that, while leadership and management are not the same, they are related, can be integrated and may be the same at an area of overlap. Related leadership terms, according to Huber, are *leadership styles, followership* and

empowerment. 'Leadership styles' are defined as different combinations of task and relationship behaviours used to influence others to accomplish goals. 'Followership' is defined as an interpersonal process of participation and 'empowerment' is defined as giving people the authority, responsibility and freedom to act on what they know. Huber suggests that these approaches encourage people to have belief and confidence in their own ability to achieve and succeed.

Mintzberg (2009) questions the value of trying to distinguish leaders from managers and comments that while it may be possible to make the distinction conceptually, it is more difficult to make it in practice. He proposes a model of management where activity takes place on three planes, which are the *information* plane, the *people* plane and the *action* plane. He asserts that two roles are performed within each plane. He states that, on the *information* plane, managers communicate inside and outside their specific unit and have control within it. On the *people* plane, they lead inside their specific unit and link to environments outside it. On the *action* plane, they 'do' inside their unit and deal with issues outside it. Mintzberg's model has some resonance for service managers in the collaborating organisation, whose services operate within the framework of a national organisation and an external regulator.

Service managers are responsible for leading their own services and also provide a conduit for the dissemination of information from senior management. Their actions are governed by an internal policy framework, local authority procedures and a range of regulatory requirements. They have to communicate and liaise effectively with a range of external professionals and also have to meet the expectations and demands of service users and their families, who play an important role in determining how care and support is provided. They have an active role in 'setting the tone' for their service and for ensuring that there is a positive service culture. They must create an environment where service users are happy and safe and where staff can flourish so that service users have positive experiences and achieve a good quality of life.

2.2. 2 Task-orientated versus People-orientated Leadership

Cowshill and Grint (2008) assert that the point of leadership is collective mobilisation to achieve some collective goal. They suggest that managers and leaders have been

divided between those who are task-orientated and those who are people-orientated. However, they argue that to differentiate between task-orientated and people-orientated leadership is to confuse an analytic division between task and people. They comment that tasks can only ever be achieved through people and if there are no collective tasks, there is little point in leadership.

Daft (2008) defines *task behaviours* as those involving planning, setting objectives, clarifying tasks and monitoring operations and performance. *Leadership behaviours* involve supporting followers, giving them recognition, developing their skills and confidence and empowering them to contribute to decision-making and problem-solving. Cowshill and Grint express the view that leaders who over-focus on building relationships without a purpose, or who over-focus on securing task completion at the expense of concerns for their followers, are unlikely to succeed in the long run. At the same time, they note that short-term success in completing tasks at the expense of long-term relationships is a common phenomenon.

Managers of residential care homes with nursing work in a highly 'people' orientated environment where staff need to develop positive relationships with service users so that they can provide care and support in line with each individual's stated preferences and in accordance with regulatory requirements. This requires social care managers to maintain an appropriate balance between task and relationship behaviours to ensure that staff are confident and competent to meet the expected service standards.

2. 3 Quality Overview

Literature and research offers many different definitions and conceptual models for defining quality in service delivery operations. Johnston and Clark (2005) define quality as the combination of the customer's experience, and their perception of the outcome of the service. Pycraft (2000) focuses on customer expectations and suggests that to define quality on the basis of these can be problematic because the expectations of individual customers may be different. Past experiences, individual knowledge and history will all shape their expectations. This is pertinent to managers working within the collaborating organisation who must ensure that service users have a positive experience of living in residential care homes. At the same time, they must manage the

expectations of service users and families who may have varying levels of knowledge about residential care, differing experiences that have led them to residential care provision and differing perceptions about the outcomes that can be achieved.

2.3.1 The Four 'V's of Operations

Slack, Chambers and Johnston (2007) assert that, while all operations transform input resources into output products and services, they differ in a number of ways, four of which are particularly important: the *volume* of their output, the *variety* of their output, the *variation* in the demand for their output and the degree of *visibility* that customers have of the production of the product or service. All four dimensions have implications for the cost of creating the product or service with high volume, low variety, low variation and low customer contact usually helping to keep costs down. Conversely, low volume, high variety, high variation and high customer contact typically creates higher costs for organisations. Residential care settings align with the low volume, high variety, high variation and high customer contact dimensions and the provision of individually tailored support for disabled people comes at a price. In an operating environment where social care providers are under pressure to produce high quality outcomes with minimum resources, managers have to continually balance what is often referred to in the social care industry as the 'cost versus quality' dynamic.

2.3.2 Assessing Quality in Service Operations

Slack, Chambers and Johnson (2007) assert that there are five basic performance objectives that can ensure customer satisfaction and competitive advantage. These relate to the areas of *quality, speed, dependability*, *flexibility* and *cost.* These performance objectives are applicable to all types of operation but the things that organisations need to do will vary according to the nature of the business. The quality of a service or product is the most visible part of what an operation does and is something that customers find easy to judge. Quality is, therefore, a major influence on customer satisfaction or dissatisfaction.

Parasuraman's model cited in Slack, Chambers and Johnson (2007) suggests that customers' expectations and perceptions are influenced by a number of factors and that

this can result in *quality gaps* from the customer perspective.   For example, a gap may be created by a mismatch between the organisation's internal quality specification and the specification that is expected by the customer, or if the concept for the product or service does not match the organisation's internal specification of quality. A gap may occur if there is a mismatch between the actual quality of the service or product and the organisation's internal specification, or if the organisation's market image is not consistent with the actual quality of the product or service. Therefore, it is proposed that organisations should implement quality planning and control activity that will prevent quality gaps and perceptions of poor quality.

2.3.3 Total Quality Management and Continuous Improvement

Deming (2008) sets out fourteen points for Total Quality Management (TQM), many of which have resonance for social care settings. Deming's direction to *'create constancy of purpose toward improvement of product and service, with the aim to become competitive and to stay in business, and to provide jobs'* is highly pertinent to both the collaborating organisation's regulatory framework and its business imperatives.

The notion that organisations should *'cease dependence on inspection to achieve quality, eliminate the need for inspection on a mass basis by building quality into the product in the first place'* is consistent with the CQC requirement for social care providers to self assess, which aims to ensure that quality is embedded in services.   The notion of *'driving out fear, so that everyone may work effectively for the company'* links to the imperative for social care providers to create safe environments for vulnerable people where any poor practice will be reported.

In social care environments that provide nursing, the notion of *'breaking down barriers between departments'* is relevant because of the potential for a hierarchical divide between professionally qualified nurses and care staff. Guidance to *'institute a vigorous program of education and self-improvement'* is relevant to the collaborating organisation's comprehensive staff development and training programmes.   Deming's assertion that *'the transformation is everybody's job'* is consistent with the collaborating organisation's expectation of staff engagement in quality improvement, which is shared and monitored by its regulatory body.

Slack, Chambers and Johnson (2007) note that TQM philosophies place considerable emphasis on the contribution of individual staff members to quality and that empowerment of staff is seen as a support to quality improvement. This may occur by means of *suggestion involvement*, which allows staff to present ideas about how an operation may be improved, *job involvement*, which provides opportunities, within limits, for staff to be involved in redesigning their jobs and *high involvement*, which means that staff contribute to overall strategy. They define *continuous improvement* (C1), sometimes known as *Kaizen,* as an approach to operations that assumes many, relatively small, incremental improvements in performance, which can be followed up relatively easily by other small improvements. The momentum of improvement is stressed rather than the rate of improvement, as is the involvement of staff at all levels in an organisation.

Organisations working within the CQC quality framework are, of necessity, taking an approach that is akin to TQM and the assessment and inspection processes that CQC undertake place great emphasis on continuous improvement. The Key Lines of Regulatory Assessment (KLORA) cover all aspects of the management and operation of services and managers are required to provide an Annual Quality Assurance Assessment (AQAA). They must report on action that has been taken to address requirements or best practice recommendations from the previous inspection and identify further areas for improvement.

CQC inspectors talk to service users, managers and frontline staff as well as making detailed examinations of personnel files, service users' care plans and complaints files. This means that the AQAA cannot be a tokenistic paper exercise and continuous improvement must be a genuine priority for services that seek to maintain 'Good' and 'Excellent' CQC ratings.

2.3.4 Quality in Health and Social Care settings

Ovretveit (2000) asserts that health service quality is centred on *patient quality*, or providing patients with what they want, *professional quality*, or giving patients what they need, and *management quality*, which is about delivering these effectively with the minimum resources, while eliminating errors, delays and waste. Quality in social care

is assessed by means of the CQC quality framework, which is based on the National Minimum Standards within the CSA 2000. The CQC framework places service users at the centre of quality planning and control activity. Residential care services are assessed against 'outcome groups', which allow inspectors to judge how well providers are delivering outcomes for service users. These cover such issues as whether or not individual needs and choices are being met, whether people are protected from abuse, whether the management and administration of the service is competent and whether the physical environment encourages and facilitates independence.

CQC inspectors make one overall judgement for each outcome group, based on what they see during the inspection process. Services that are judged as 'Excellent' are defined as having substantial strengths and a sustained track record of delivering good performance and managing improvement. Where areas for improvement are identified, 'Excellent' rated services will be judged as recognising these and to be managing them well.

To achieve an overall rating of 'Excellent', a service will need to demonstrate that the essential elements found in each outcome are 'Good' and that there are additional areas of strength, particularly in the qualitative aspects of practice. For example, a service might demonstrate a high commitment to promoting dignity, a focus on valuing diverse needs, and an innovative approach to care practices (CQC Key lines of regulatory assessment for Care Homes for Younger adults 18-65 and older people 2010).

Pilling and Watson (1995) assert that quality assurance in social care should ensure that services meet people's common, basic needs, that people are protected from abuse and exploitation, that service providers collaborate with service users to set and monitor standards and that there should be regular independent monitoring and evaluation by professionals and service users. Pilling and Watson stress that all aspects of quality assurance findings should be in the public domain and that staff should challenge routine and traditional practices to provide the best service they can. It is argued that, no matter what kind of services are under consideration, or the extent of the disability of the people using them, service users can and should set the agenda for assessing all aspects of quality. Both the CQC framework and the collaborating organisation's internal quality assurance processes are strongly aligned with this approach.

2. 3.5 The Role of Management and Leadership in Quality Improvement

Chilgren (2008) suggests that without satisfied and confident employees, quality practices in healthcare settings have no hope of being successful. Echoing the assertions of Huber (2006) and Bruch and Ghosal (2004), Chilgren argues that empowering staff who have direct contact with patients is an important step towards the goal of improving quality, as perceived by the patient or service user.

Deming (2000) asserts that managers should be concerned with leadership, rather than supervision. He argues that managers need to work on sources of improvement and ensure that intentions to improve quality are translated into actuality. Deming suggests that leaders must know the work they supervise and that they must be able to inform more senior management about necessary improvements. This is relevant to all social care settings where managers who hold CQC registration are required to be professionally qualified. It is pertinent to the collaborating organisation where service managers who lead service teams are several tiers down in a hierarchical structure.

Nembhard and Edmondson (2006) describe the concept of *leader inclusiveness*, where leaders encourage and value others' contributions. They assert that leader inclusiveness can help multi-disciplinary teams to overcome effects of status differences, allowing members to collaborate in quality improvement. They suggest that staff who are directly invited to contribute will develop *psychological safety* that will allow them to speak up about quality concerns. Nembhard and Edmondson argue that this is important in health care settings where there are hierarchies and the views of high status or clinical staff are paramount. In these environments, lower status or non-clinical staff may not feel valued and may be undermined by higher status individuals. Furthermore, they may perceive it as risky to speak up about mistakes or poor practice and fear negative repercussions if they highlight areas for improvement.

Wong and Cummings (2009) assert that trust between staff and their leaders is a key element of a healthy work environment. They propose that *authentic leadership* approaches build trust between leaders and followers because they focus on clear communication and positive role modelling of honesty, integrity and high ethical standards. Like Nembhard and Edmonson (2006), they make the link between

psychological safety and the likelihood of patients, staff and health care professionals speaking openly about issues that may concern them.

The idea that leadership approaches have the potential to create psychological safety and facilitate quality improvement is highly relevant to this study, which took place in the context of working environments where care is provided by clinical and non-clinical staff and the hierarchical issues highlighted by Nembhard and Edmonson (2006) and Wong and Cummings (2009) could exist.

2.4 Conceptual Model

The conceptual model for this study was constructed following a review of leadership and management theory, a review of definitions and conceptualisations of quality and a subsequent application of these reviews to the particular context of residential care homes for people with physical disabilities. The study focused on the impact of leadership and management approaches on the delivery of excellence, so the conceptual model for the study was one of 'cause and effect' as defined by Fisher (2007). The conceptual model shown in **Figure 3** proposes that, in services that are required to implement the CQC quality standards, the use of inclusive and authentic leadership approaches may lead to staff feeling psychologically safe.

Figure 3: A Conceptual Framework of 'cause and effect' as defined by Fisher (2007)

The model links psychological safety to a high level of staff engagement in the quality improvement process, on the basis that staff who feel psychologically safe are more likely to speak up about problems and concerns and contribute to resolving them. Services where staff are engaged in quality improvement processes are likely to maintain high standards of quality and the conceptual model illustrates the likely effect of successful quality improvement processes, which is service user satisfaction and 'Good' or 'Excellent CQC ratings.

2.5 Summary

This chapter provides an overview of leadership and management theories that are explored in the literature and research and also reviews definitions and conceptualisations of quality that have been put forward by theorists and researchers. A conceptual framework of 'cause and effect' is, described, which is based on the notions of *inclusive* and *authentic* leadership approaches and how these may contribute to successful quality improvement processes in residential care services that achieve 'Good' and 'Excellent' CQC ratings.

Chapter 3 Methodology

3.1 Introduction

The research was undertaken in the context of a large Third Sector social care organisation that is values driven, in terms of its commitment to providing care and support to disabled people in ways that maximise their well being, independence and choice.   The study was framed within the author's values and knowledge about social care provision, gained from her experience of operational and strategic management in social care organisations, including the collaborating organisation where she previously worked as a senior regional manager.

3.2 Research Philosophy

The research philosophy that underpins this study is aligned to the interpretivist ontology. Saunders, Lewis and Thornhill (2009) state that *interpretivism* arose from the intellectual tradition of *phenomenology*, which refers to the way we make sense of the world around us. Fisher (2007) describes two dimensions, which relate to the relationship between the knowledge it is possible for us to have about our external world and the world itself. At one end of the spectrum is the idea that our knowledge is an exact reflection of the world and at the other is the idea that the world is largely unknowable. Fisher asserts that phenomenology falls between these two dimensions because it explores the processes groups and societies use to make sense of their world and because it is based on the idea that the real world is subject to the interpretation of human thought.

Saunders, Lewis and Thornhill (2009) use a theatrical metaphor to explain that researchers need to understand differences between people in their roles as 'human actors'. Their metaphor suggests that people play a part on the stage of human life and, like actors in a theatrical production, they act out their roles in accordance with a particular interpretation, which may be their own, or directed by others.

Saunders, Lewis and Thornhill (2009) note that interpretivism concerns the way people interpret their every day social roles in accordance with the meaning they give to these

roles and interpret the social roles of others in accordance with their own set of meanings. It is argued that, for researchers who adopt an interpretevist philosophy, it is crucial for them to have an empathetic approach, enter the social world of their research subjects and understand their world view.

In their discussion of axiology, the branch of philosophy that studies judgements about value, Saunders, Lewis and Thornhill (2009) assert that it is important for researchers to be aware of the value judgements they may be making in drawing conclusions from data and to take these into account to deliver credible research. Fisher (2007) makes a similar point, suggesting that we cannot understand how others may make sense of things unless we have an insightful knowledge of our own values and thinking processes.

The author's own values and definitions of quality, in the context of social care provision, were strongly aligned to those of the collaborating organisation, so there was an inevitable element of subjectivity in the study, which was taken into account throughout the research process. In epistemological terms, the study focused on the collection of qualitative data, which was based on how managers and followers defined quality in the context of residential care services and how both managers and their followers described the leadership approaches used by the managers and assessed the impact of these on the achievement of a 'Good' or 'Excellent' CQC rating.

3.3 Research Strategy

The research strategy was developed on the basis of the research aims, which related to an examination of the impact of leadership and management approaches on the delivery of excellence in social care provision. Consideration was given to the author's existing knowledge of social care provision, particularly within the context of the senior regional management role that she held within the collaborating organisation between 2005 and 2009. This experience provided an extensive knowledge of both the regulatory framework within which the organisation's residential care services operate and the internal quality management systems within the organisation.

Although the author had never been responsible for overseeing the particular services that were studied, the managers and followers who participated knew her from her previous role in their organisation. This had dual benefits, to the extent that the author was welcomed into the services to carry out the research and, because she no longer worked for the organisation, managers and followers were able to speak openly about the research issues and their experiences.

The research strategy was influenced by consideration of the time and resources that both the author and the collaborating organisation could contribute to the study. At the time the study commenced, the author was in the first six months of a new role as Chief Executive Officer of a smaller social care organisation. Inevitably, this presented some constraints in terms of the time that was available to travel to the collaborating organisation's services to carry out interviews, but the managers of these services had equal constraints in terms of the time they had available to participate. At the time they were asked to participate in interviews, they were dealing with the effects of a major restructure within their organisation, which had removed a tier of senior regional management and reduced the support they had previously benefited from in the areas of human resources, health and safety and finance. Consequently, they reported a significantly increased workload, coupled with uncertainty about how they would cope with the effects of the change programme.

There were operational and financial constraints in terms of the collaborating organisation's ability to release front line staff to participate in the study. Frontline staff were not able to participate in individual or group interviews, so a mechanism for obtaining their perspective on the research issue was put in place so that they did not have to take any time away from their working shift.

The author identified a preference for an interpretivist research philosophy following consideration of the research issue in the context of the ontological, axiological and epistemological perspectives. These were applied to *positivism, realism, interpretevism* and *pragmatism,* as defined by Saunders, Lewis and Thornhill (2009). The author identified a preference for an exploratory approach to the collection of qualitative data and the use of a case study approach was decided upon as the most appropriate strategy to the achievement of the research aims.

Saunders, Lewis and Thornhill (2009) contrast inductive and deductive research approaches and highlight that induction is about gaining an understanding of the meanings people attach to events, having a close understanding of the research context and collecting qualitative data. They describe induction as allowing a flexible structure to permit changes of research emphasis and stress that the researcher is part of an inductive research process, in contrast to researchers in deductive research processes who have a high level of independence.

The research approach used in this study could be defined as exploratory and inductive, in the sense that it was based on qualitative data and explored the perceptions of managers and followers. However, a hypothesis emerged from the literature review, relating to concepts of authentic and inclusive leadership approaches and their potential to facilitate successful quality improvement processes.

Maxwell J. (2005), states that the use of explicit research hypotheses is often seen as incompatible with qualitative research, but argues that there is no inherent problem with formulating qualitative research hypotheses. He suggests that the difficulty has partly been a matter of terminology and partly a matter of the inappropriate application of quantitative standards to qualitative research hypotheses. Maxwell asserts that the distinctive characteristic of hypotheses in qualitative research is that they are usually formulated after the researcher has begun the study and are *grounded* in the data so they are developed and tested in an interaction with the data, rather than being prior ideas that are simply tested against them. Maxwell states that there is a widespread view in quantitative research that unless a hypothesis is framed in advance of data collection, it cannot be legitimately tested by the data, which is necessary for the statistical test of a hypothesis.

In the case of this study, the emergence of a hypothesis from the literature review places it somewhere between the two positions that Maxwell describes. The hypothesis was formulated during the process of the study, but was derived from the literature review and the author's knowledge of the research context, rather than from data that had already been collected. This allowed the author to take the emergent hypothesis into account when designing the research instruments and include questions to test the extent

to which theories of authentic and inclusive leadership were applicable to the services that were the focus of the study.

The emergence of a hypothesis during the study aligns this research with exploratory and inductive approaches. However, the study became, to some extent, explanatory in nature because there was an element of deduction and the author decided to test the hypothesis and explain causal relationships between variables (Saunders, Lewis and Thornhill 2009). These relationships were illustrated in a 'cause and effect' conceptual model that was developed to provide a framework for the research.

3.3.1 Justification for the Selected Paradigm and Methodology

The research operated within the interpretive paradigm, as defined by Saunders, Lewis and Thornhill (2009) and the approach was largely inductive, in the sense that it was based on qualitative data. The research methodology, and the use of a case study strategy, reflects the exploratory nature of the research issue and is justified by the author's identified philosophical preferences and the value base that she brought to her consideration of leadership and quality in the context of social care provision for disabled people.

The study was conducted by means of semi-structured interviews with managers and care supervisors who reported directly to them. A justification for this approach can be found from discussion of research methods in Saunders, Lewis and Thornhill (2009). They assert that semi-structured interviews are helpful to exploratory studies and note that they can also be used in explanatory studies. Fisher (2007) comments that semi-structured interviews provide the respondent with latitude to respond to questions in ways that seem sensible to them, which in this study was felt to be an important way of maximising the range of qualitative data that was obtained.

Silverman (2006) suggests that researchers using semi-structured interviews require the skill to develop rapport with participants and do some probing and prompting to elicit information. Silverman makes a distinction between semi-structured interviews and 'open ended' interviews, asserting that an open ended interview is more flexible and involves a high degree of active listening on the part of the interviewer. Silverman

argues that both semi-structured and open ended interviews require the interviewer to develop rapport with the interviewee, but suggests that, in an open ended interview, both parties collaborate and the interviewer is an active participant. However, the interviewer maintains a level of control by deciding when to follow up on comments and or close various elements of the discussion. Although the interviews with managers and followers are described as semi-structured, as defined by Saunders, Lewis and Thornhill (2009), the author's approach had much in common with the open ended interviewing approach as defined by Silverman (2006).

The key themes for the semi-structured interviews were issues relating to quality, leadership and management. However, it was necessary to introduce a method of evaluating whether the perceptions of these issues, as expressed by people interviewed, were shared by frontline staff in the services. Saunders, Lewis and Thornhill (2009) describe *triangulation* as the mechanism for ensuring that the data a researcher collects is telling them what they think it is telling them. Webb et Al (1966) assert that once a proposition has been confirmed by two or more independent measurement processes, the uncertainty of its interpretation is greatly reduced.

Flick (2009) refers to the four types of triangulation that were distinguished by Denzin (1970). These were *data* triangulation, which refers to the use of different data sources, *investigator* triangulation, where different observers are used to detect bias, *theory* triangulation, which approaches data with multiple perspectives and hypotheses in mind and *methodological* triangulation, which refers to the use of more than one method for gathering data.

In order to triangulate the data collected in this study from the semi-structured interviews with managers and care supervisors, questionnaires were issued to a small number of frontline nurses, care staff and non-care staff to test their perceptions about the research themes. These individuals were selected at random by the author from staff lists within the services. The author's approach would be defined as methodological triangulation, and specifically as *between-method* triangulation, which Flick (2009) describes as a combination of methodological approaches that are distinct in their focus and in the data they provide.

This research can be defined as a multi-method qualitative study and can be viewed in the context of a model for qualitative research design, which has been adapted from Maxwell (2005), which is shown as Figure 4. A radial cycle is used to show that there is interaction between the researcher's goals, the conceptual framework for the study, the research methods used and the validity of the data. Central to the study are the research questions. Maxwell argues that it is essential to have coherent and workable relationships among all these components.
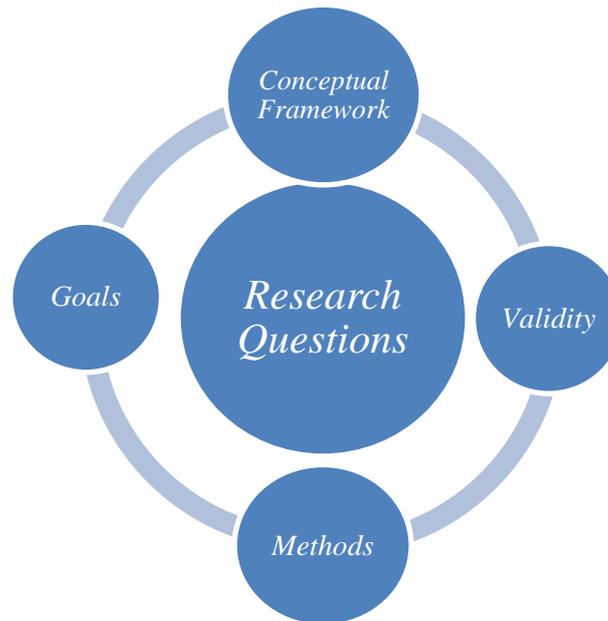

Figure 4: A Model for Qualitative Research – adapted from Maxwell (2005)

3.3.2 Rejected Methods

The author considered the issues relating to the use of individual or group interviews in order to obtain the perspective of a larger number of frontline followers in the services that were the focus of the study. Saunders, Lewis and Thornhill (2009) note that group interactions may lead to a highly productive discussion, but also caution that certain participants may try to dominate the interview whilst others may feel inhibited. They argue that this may create unreliability of data because a reported consensus may not, in reality, be a view that is wholly endorsed by the group.

This would have been a concern in this study because of the possible existence of power imbalances between nursing and non-nursing staff, which could have created barriers to the participation of non-nursing staff. In practice, the consideration of using group

34

interviews in this study was not an option. The collaborating organisation would not have been in a position to release front line staff to be interviewed on either an individual or a group basis. There would have been a need to 'back fill' their posts on shifts and this would have been unacceptable on grounds of cost as well as operational impact.

3.4 Research Design

The author chose to undertake this study in her previous organisation rather than the organisation she joined, as Chief Executive Officer, in September 2009. She had originally considered applying her research issue to her new organisation because all of its care and support services for people with learning and physical disabilities have achieved an 'Excellent' CQC rating. However, it was decided that it would have been inappropriate for a new Chief Executive to have undertaken a research study of this nature within six months of coming into post.

A key reason for this decision was that the author planned to conduct an exploratory study based on the collection of qualitative data from semi-structured and in-depth interviews with managers. The purpose of the interviews would be to examine different leadership and management approaches and ways in which these may be linked to the delivery of excellence within services. The author felt that it would have been potentially intimidating for service managers to be interviewed about their leadership and management practices by a new Chief Executive, particularly as she was replacing an individual who had been in post for the previous 16 years and she was aware that staff were anxious about the change.

Another factor was that the author did not want to put herself into the role of a researcher at a time when she was becoming established in her role and building new working relationships with senior managers and the wider management team. A collaboration with her previous organisation felt more appropriate and comfortable and the research issue was, therefore, explored in the context of residential care homes with nursing.

3.4.1 Design of Instruments

The study was undertaken using semi-structured interviews and a questionnaire. These research instruments were designed to gather qualitative data relating to the research issue and the research aims, which would subsequently be analysed.

3.4.2 Semi-structured Interview Questions

A series of interview questions was devised and used to provide an interview guide for semi-structured interviews with managers and care supervisors The questions linked to the research issues and the research aims and were derived from the literature review.

Interviews with service managers were structured around the following questions and references are shown to enable the author to demonstrate their relevance to the conceptual model:

1) **What does quality mean in this service?** Links to definitions of quality in health and social care (Ovretveit,2000; Chilgren, 2008; Pilling and Watson, 2005; CQC quality framework/NSA 2000)

2) **How do you measure quality?** Links to models of quality and quality improvement (Slack, Chambers and Johnson, 2007; Chilgren, 2008; Pilling and Watson, 1995)

3) **If you asked your staff what quality meant in this service what do you think they would say?** Links to models of management and the ability of managers to promote commonly understood values and practices (Bruch and Ghosal, 2004; Nebecker and Tatum, 2002; Kotterman, 2006)

4) **In your role, do you see yourself as a manager or a leader?** Links to conceptual frameworks for distinguishing leadership from management ((Kotterman 2006). Nebecker and Tatum, 2002;Bruch and Ghosal, 2004; Huber, 2006; Mintzberg, 2009)

5) **How would you describe your approach to leading the team?** Links to conceptual frameworks relating to leadership and leadership style (Hughes, Ginnet and Curphy, 2006; Goleman, 1995; Northouse, 2010; Thach and Thompson, 2006; Cherniss and Goleman, 2001)

6) **How do you think your approaches have contributed to the achievement of a 'Good/Excellent' CQC rating?**

7) **How do you engage staff in making quality improvements?** Questions 6) and 7) relate to approaches to continuous improvement and the link between management interventions and quality improvement (CQC quality framework/NSA 2000; Huber, 2006; Slack, Chambers and Johnson, 2007; Bessant and Caffyn, 1997; Nembhard and Edmondson, 2006; Wong and Cummings, 2009; Northouse, 2010)

8) **Do you think staff in the service feel confident to report mistakes or poor practice and, if they did this, what sort of outcome might there be?**

9) **How would you describe the culture within the service?** Questions 8) and 9) link to concepts of authentic and inclusive leadership and the impact of these approaches on quality improvement (Nembhard and Edmondson, 2006; Wong and Cummings, 2009; Northouse, 2010)

Interviews with care supervisors included the following questions, which explored the same themes as those put to managers, but from the perspective of a follower:

1) **What does quality mean in this service?** Links to followers' perceptions of quality in health and social care (Ovretveit,2000; Chilgren, 2008; Pilling and Watson, 2005; CQC quality framework/NSA 2000)

2) **How do you measure quality?** Links to followers' understanding of quality improvement (Slack, Chambers and Johnson, 2007; Chilgren, 2008; Pilling and Watson, 1995)

3) **If you asked nurses or support workers what quality meant in this service what do you think they would say?** Seeks to corroborate managers' perceptions about how they promote service values and working practices (Bruch and Ghosal, 2004; Nebecker and Tatum, 2002; Kotterman, 2006)

4) **How would you describe the manager's role?** Links to conceptual frameworks for distinguishing leadership from management, from a follower perspective ((Kotterman 2006). Nebecker and Tatum, 2002;Bruch and Ghosal, 2004; Huber, 2006; Mintzberg, 2009)

5) **How would you describe the manager's approach to working with the team?** Links to conceptual frameworks relating to leadership and leadership style (Hughes, Ginnet and Curphy, 2006; Goleman, 1995; Northouse, 2010; Thach and Thompson, 2006; Cherniss and Goleman, 2001)

6) **How do you think the manager's approaches have contributed to the achievement of a 'Good/Excellent' CQC rating?**

7) **How does the manager engage staff in making quality improvements?** Questions 6) and 7) test the followers' perspectives of continuous improvement and the link between management interventions and quality improvement (CQC quality framework/NSA 2000; Huber, 2006; Slack, Chambers and Johnson, 2007; Bessant and Caffyn, 1997; Nembhard and Edmondson, 2006; Wong and Cummings, 2009; Northouse, 2010)

8) **Do you think staff in the service feel confident to report mistakes or poor practice and, if they did this, what sort of outcome might there be?**

9) **How would you describe the culture within the service?** Questions 8) and 9) link to concepts of authentic and inclusive leadership and the followers' views about the impact of these approaches on quality improvement (Nembhard and Edmondson, 2006; Wong and Cummings, 2009; Northouse, 2010)

3.4.3 The Questionnaire

A series of rating questions were used to collect opinion data using the *Likert-style rating scale* (Saunders, Lewis and Thornhill, 2009). The questionnaires were issued to small groups of nursing staff, care staff and non-care staff who were all frontline followers of the managers who were interviewed. The questionnaire **(Appendix 6)** aimed to test their perceptions of quality, leadership and management in their service. The author chose staff from staff lists provided by the managers and the questionnaire was sent to them with an explanatory letter **(Appendix 5)** explaining the purpose of the questionnaire and their role in the study.

3.5   Research Procedures

In order to gain permission to carry out the research study in the collaborating organisation, the author contacted the operational director with responsibility for services in the North West of England. The nature and purpose of the study was explained and permission was sought to approach service managers in four residential care homes with nursing to invite them to participate in the study.

3.5. 1 Administration of the Research Instruments

When formal agreement had been obtained from the collaborating organisation to carry out the study, the author contacted the relevant managers by email to explain the nature and purpose of the study. Information was provided to clarify what the managers and care supervisors were being asked to contribute. It was explained that semi-structured interviews would be carried out to find out their views about themes that were pertinent to the research issue.

The time commitment that was required was specified and it was made clear to the interviewees that they would not need to take any additional time to prepare for the interviews. However, in advance of the meeting, they were given an overview of the research issue and the broad themes that would be discussed. Dates and times for the semi-structured interviews were agreed and the managers were asked to identify a quiet space in their service where the interviews could take place uninterrupted.

The initial approach to the four managers did not mention the questionnaire because, at that time, the author had not made a final decision about the research instrument that would be used to triangulate the data that would be collected from the semi-structured interviews. However, by the time the interviews took place, the author had decided to use a questionnaire to test the opinions and perceptions of frontline nurses, care staff and non-care staff in relation to the research issue.

The managers in each of the four services were asked to provide relevant staff lists and the author selected two nurses; two care staff and two non-care staff from each service. The manager was then asked to give staff an envelope containing the questionnaire, a covering letter explaining the nature and purpose of the study and instructions for completing and returning the questionnaire. It was agreed with each manager that the frontline staff would fax the completed questionnaires directly to the author from the office in their service to a number that the author had provided.

A total of seven staff participated in semi-structured interviews. The staffing structure for all the services was the same in all four services and is shown as **Figure 5**.

Figure 5: Staffing Structure in the residential care homes with nursing

Four of the seven staff who were interviewed were registered managers who had overall responsibility for the operation of their services and legal accountability for service delivery in accordance with the requirements of CQC and the CSA 2000. Three of the interviewees were care supervisors, who supervise nurses and deputise for the service managers. Nurses supervise care staff while they are on shifts, although the care supervisor has overall responsibility for the formal line management of care staff.

It was not possible to interview the care supervisor in one of the services because she had not completed her probationary period successfully and the manager informed the author that her employment was going to be terminated. The questionnaire was issued to a total of 24 staff across the four services, of whom eight were nurses, eight were care staff and eight were non-care staff.

3.5.2 Reliability of the Data

Saunders, Lewis and Thornhill (2009) highlight that the lack of standardisation in semi-structured interviews may lead to concerns about reliability, and in particular, interviewer bias. Holloway (1997) states that the researcher is the most important instrument in qualitative research, which means that they can influence the study, both positively and negatively depending on their stance and assumptions. The author's own values and definitions of quality, in the context of social care provision, were strongly aligned those of the collaborating organisation, which bases its quality management activity around the requirements of CQC, the regulatory body for its services. Therefore, the author's own perspective on the nature of quality in social care presented a degree of subjectivity in the study which was taken into account during the process of conducting the interviews and in analysing the data that was collected.

Saunders, Lewis and Thornhill (2009) identify the need to create a full record of an interview and contextual data immediately after it has taken place. This helps to control bias and produce reliable data for analysis. They argue that, if this is not done, there is the possibility of data becoming mixed up, leading to concerns about the trustworthiness of the data that has been collected. They suggest that the use of an audio recorder is more helpful than note-taking because the interviewer can concentrate more fully and listen attentively to what is being said and notice the interviewee's non-verbal cues.

They note that researchers usually have their own styles of note taking, ranging from taking verbatim notes to noting key words, all of which can be demanding. However, they recommend that brief notes should be made in addition to the audio recording to record facial expressions and other non-verbal cues that cannot be captured and to provide a back up in the event of technical failure.

The author considered the use of audio equipment to record the interviews with managers and care supervisors, but rejected this on the basis of her own comfort during the interview process. Although Fisher (2007) states that researchers undertaking semi-structured interviews will normally prefer to record the interview, the author decided that the use of audio equipment would be inhibiting to her because of a particular issue relating to a neurological condition she has. She trusted her own ability to listen attentively and record the content of the interviews at speed and in a manner that would not be off-putting to interviewees and that would capture both the content and the tone of the interview.

The author explained to the interviewees that she would be taking notes throughout the interview and confirmed that they were comfortable with this method of recording. Her rapport with the interviewees facilitated easy discussion about this issue and the author was able to make comprehensive records throughout the interviews. The author typed up her notes immediately after each interview when the process was fresh in her mind and she had recent recall to assist in the process of transcribing handwritten records fully.

3.6   Ethical Considerations

The author considered the ethical issues that were pertinent to the study and took steps to address these throughout the research process. Saunders, Lewis and Thornhill (2009) suggest that one of the key stages for the consideration of potential ethical problems is when a researcher seeks access to an organisation. In this study, these potential problems were minimised by the author's previous history with the collaborating organisation and her understanding of the research environment.

The collaborating organisation's senior management gave permission for the study to be carried out within four of its 'Good' and 'Excellent' rated services in the North West. A summary of the findings was offered to the organisation so that any good practice or learning points could be disseminated. Although managers are currently under pressure because of a major re-organisation of the business, it was envisaged that each manager, and any followers who participated, would only be required to allocate a maximum of two hours to the study and that this would not be an unreasonable demand, even in the pressurised situation that prevailed.

The study did not require the participation of service users so that were no ethical considerations in relation to service user confidentiality. However, consideration was given to issues relating to the privacy of staff who participated and to how data could be collected in ways that did not cause discomfort or harm to anyone who participated. Fisher (2007) highlights the issue of informed consent as being a key issue in relation to research ethics. The author did not prepare a formal participant information sheet or a consent form but, at the start of each interview, she gave a clear overview of the research study, which had already been explained in emails and in telephone conversations with each manager. Each manager had been asked to pass the information about the research study on to the care supervisors who were to be interviewed. The author then sent follow up emails to the care supervisors to ensure that they were fully aware of what they were being asked to be involved in.

At the start of each interview with managers and care supervisors, the author explained the process that would be used. It was explained to them that what they said would be confidential, in the sense that nothing they said would be ascribed to them in the write up of the study without gaining their permission. It was explained that information provided by a manager would not be shared with a care supervisor and information shared by a care supervisor would not be fed back to a manager. It was made clear to interviewees that they had the right not to answer any question, or to stop the interview at any stage.

The author explained how she would collect, store and analyse the data that had been collected from the interviews. After providing this overview, care was taken to check that the interviewees were comfortable and happy to proceed.

A covering letter was produced to explain the nature of the study to the nurses, care staff and non-care staff who were asked to complete the questionnaire. It was made clear that the information they provided would be treated in confidence. People were told that they did not need to give their name and only needed to indicate their job role and the service they worked in. This meant that the questionnaire was not completely anonymous as defined by Fisher (2007) who suggests locations of participants should not be divulged if a study is to be anonymous. The nature of the research issue was such that it was important to know where staff were located and, without this information, it would have been difficult to use the questionnaire to triangulate the data that had been collected from the interviews. At the writing up stage, the author decided not to state the name of the collaborating organisation because some of the information provided by interviewees was considered to be sensitive.

3.7   Summary

This chapter provides an overview of the methodology for the study. The research philosophy that underpins the research is referred to and the research strategy is explained and justified. There is a discussion of the research design, including the design of the research instruments, and the research procedures are described. Ethical considerations are explored and the approaches that were taken to address these considerations are described.

Chapter 4 Findings

4.1 Introduction

This chapter presents the key findings of the study. These are based on the analysis of data gathered from semi-structured interviews with managers, semi-structured interviews with staff who reported directly to them and opinion data from other followers. The chapter provides an overview of the data that was collected, an explanation and justification of the data analysis methods that were used and a discussion of the findings.

4.2 Overview of the Data

The research instruments were designed to gather data relating to quality management approaches used in a group of residential care homes with nursing, all of which have been awarded either 'Good' and 'Excellent' CQC ratings. Data was also gathered to allow an examination of the leadership and management approaches that were used by managers of these services and to establish whether there was any commonality of approach. The most recent CQC Key Inspection Reports for each service provided a source of secondary data that was also used as part of the analysis. These are not shown as appendices because they would identify the collaborating organisation.

4.3 Data Analysis Method

The analysis used methods adapted from *Interpretative Phenomenological Analysis (IPA.)*, which is concerned with trying to understand the experience of participants and exploring how they make sense of their personal and social world. (Laverty 2003) explains that IPA has its roots in phenomenology and *hermeneutic phenomenology*, which are concerned with the exploration and understanding of 'human experience as it is lived'. Fade (2004) recommends IPA for research that has adopted a case study approach, suggesting that it is important for qualitative research reports to give enough methodological detail to enable readers to understand what has been done and make a judgement about the quality and usefulness of the work.

Smith and Osborn (2007) emphasise that, in IPA, the research exercise is a dynamic process in which the researcher has an active role. This notion is consistent with the research approach that was used in this study and the author decided that IPA would provide a helpful framework for her to analyse the primary data gathered from semi-structured interviews and rating questionnaires. Smith and Osborn suggest that there is no single, definitive way to do IPA and urge newcomers to the method to adapt it to suit their own particular way of working and the topic they are investigating. However, the author's starting point was the guidelines they illustrate for transcribing interviews, identifying emerging themes, clustering themes and finally connecting the themes to provide a narrative overview of the findings.

4.4 Analysis of Participants, Respondents and Non Respondents

The participants in the semi-structured interviews were four service managers and three care supervisors. Three of the service managers had worked for the collaborating organisation for more than five years and one had been employed by the organisation for three years. Of the three care supervisors interviewed, two had held their posts for more than five years and one had been in post for three years. It was not possible to interview the care supervisor of one service because she had not completed her probationary period of employment successfully and her contract was to be terminated.

Six frontline staff from each service were selected at random from staff lists supplied by the service managers. The author asked for the names of Registered General Nurses (RGNs), care staff, domestic and kitchen staff, administrative staff, therapy staff and activities enablers. The author selected two RGNs, two care staff and two staff from other categories in each service and a total of twenty four staff were invited to complete questionnaires that related to the research issue.

Twelve questionnaires were returned from three care staff, three RGNs, one therapy assistant, one domestic supervisor and two activities enablers. Two further respondents returned their questionnaires but did not state their job role. These questionnaires were included in the analysis as it was decided that although it would have been useful to have known the job roles of the respondents, not knowing what these were did not negate the responses that had been provided. The questionnaires used the *Likert-style*

rating scale was used to gauge opinion on the questions included and it was apparent from the ratings given by three respondents that they had reversed the numbers on the scale. However, the content of the questions was such that their intended responses were clear, so the incorrectly completed questionnaires were included in the analysis.

4.5 Findings

The data gathered from the semi-structured interviews with service managers and care supervisors was analysed to identify emerging themes, which were then 'clustered' in accordance with themes that were pertinent to the research issue and the research aims.

The clustered themes were:

- How quality is defined in the service
- Measuring quality in the service
- How the service manager engages staff in quality improvement
- What leadership means in the service
- What management means in the service
- Dynamic between nursing and care staff
- Service culture
- The service in the context of the wider organisation

The opinion data was organised into three sections to gauge the staff's views about:

- What quality means in their service
- The way the service manager works
- What it is like to work in their service

Work was then undertaken to compare and connect the themes that had emerged from the semi-structured interviews and the questionnaires to provide a narrative overview of the findings from each service.

4.5.1 Narrative Overview of Findings - Service 1 ('Excellent' CQC rating)

There was a high degree of correlation between the themes that were highlighted by the Service Manager (SM) and the Care Supervisor (CS) in Service 1. The opinion data gathered from five questionnaires that had been completed by frontline staff suggested that their definitions of quality, their views about the SM's approach and the working environment in the service were also consistent with the SM's perceptions. The culture within the service was found to be extremely positive, with an emphasis on comradeship, shared responsibility and team-working to achieve the highest standards and the most positive outcomes for service users. The SM's open and empathetic leadership style appeared to have created an environment where staff felt motivated and engaged with quality improvement. They felt able to report mistakes or poor practice and these were seen as learning experiences.

The SM had been proactive in breaking down the hierarchical divide between nursing and care staff by implementing a project that enabled these staff groups to work together and learn from each other. The formal frameworks for managing quality, provided by the CQC standards and the collaborating organisation's policies and procedures, supported and underpinned the work in the service, although feedback from service users gained through formal and informal processes was seen as the most important way of measuring quality.

4.5.2 Narrative Overview of Findings - Service 2 – 'Good' CQC rating

The themes highlighted by the SM and the CS showed very similar perceptions about issues of quality management and leadership in Service 2. Only two questionnaires were returned from frontline staff, but the opinion data the questionnaires provided was consistent with the SM's perceptions. The CS and the frontline staff who responded to the questionnaire believed that quality in the service is compromised by what they consider to be inadequate staffing ratios. Although care staff were seen as being able to provide 'the basics', they were unable to take time to do 'little things that mean a lot', such as spending extra time helping someone put on their make-up.

Whereas the SM in Service 1 had been proactive, and successful, in breaking down the potential divide between nursing and care staff, the SM in Service 2 was proactive in

maintaining clear boundaries between professionally qualified nursing staff and care staff. Although good relationships between the two groups of staff appeared to exist, respect for the professional roles in the service was expected and the SM and CS both indicated that they would have preferred nurses to wear uniform so that the professionals could be clearly identified. This was in direct contrast to the views of the other SMs and CSs. This preference for the service to resemble a more obvious healthcare environment was consistent with the SM's emphasis on a high standard of health care as being the key determinant of quality, rather than service user empowerment and choice, which was more of a focus for the SM in Service 1.

There was strong evidence that the SM in Service 2 had created an environment where staff felt good about coming to work and his supportive, relaxed, but quietly authoritative leadership style was appreciated by his followers. The CQC standards were seen as providing a framework that underpinned the work of the service, and the collaborating organisation's comprehensive policies and procedures were seen as a source of support for staff in dealing with any situation that might arise.

4.5.3 Narrative Overview of Findings – Service 3 – 'Excellent' CQC rating

In Service 3, there was a high level of agreement between the SM and the CS about the definition and measurement of quality and both had the view that the formal CQC standards and the collaborating organisation's policy framework provided the basis for quality management in the service. The SM and the CS talked about shared responsibility for quality improvement, clear delegation of tasks and the need for ongoing staff training.

There was a discrepancy of view about how the SM engaged staff in quality improvement. The SM talked about positive initiatives, such as group work focusing on particular aspects of care. The CS acknowledged that the SM set high standards in the service but did not mention group work initiatives. She perceived the SM as negative and over critical of staff, sometimes raising issues with them at inappropriate times. There was also some inconsistency of view about the SM's leadership, the SM describing herself as democratic but the CS stating that she was controlling and negative about suggestions from staff. The SM acknowledged that she was poor at delegating

and that she habitually worked over and above her contracted hours. The CS felt that the SM did not provide a good role model for other staff by overworking in this way.

The SM described the high levels of stress she was experiencing as a result of major organisational changes and the responsibility she had recently acquired for an additional service in the locality. The CS said that she was aware of the pressure the SM was under and that her state of mind 'set the tone for the mood' in the service. The SM described her ongoing efforts to change an 'antiquated' culture, which she had inherited, where some staff were resistant to new ways of working that were consistent with the organisation's expectations. It was not possible to corroborate the views of the SM and the CS with opinion data from frontline staff because no questionnaires were returned. However, on the evidence of the interviews with the SM and CS, it appeared that there were some negative aspects to the working environment in this service that did not feature in other services that were studied.

4.5.4 Narrative Overview of Findings - Service 4 ('Good' CQC rating)

In this service, it was only possible to interview the SM, but six questionnaires from frontline staff were returned, providing some insight into the views of the SM's followers. The SM provided a clear view of how she defined quality, with service user empowerment and choice being paramount. She described her commitment to ensuring that service users' expectations were met and she cited high standards of care as being a key determinant of quality in the service.

The SM felt that the collaborating organisation's values and strong policy framework, together with the CQC standards, helped to ensure that service users received high quality care and achieved positive outcomes. She noted that the residents in her service generally had lower levels of nursing support needs than service users in the other services that were studied and reported that there was good team working between nursing and care staff. She gave practical examples of how she had engaged staff successfully in quality improvement initiatives and said she had a high level of awareness of how staff were feeling. She was confident that staff would speak up to report mistakes or poor practice. The SM described the culture and working

environment of the service as 'laid back', but emphasised her high expectations and insistence on professionalism.

The opinion data gathered from six frontline staff who returned the questionnaire indicated that the SM's perceptions about her approaches to leadership were accurate but two of the six respondents did not think that staff were confident to report problems and one was neutral on the issue. There were three neutral responses to a question about whether staff felt valued and four neutral responses about whether staff felt motivated. Respondents had the opportunity to add further comments at the end of the questionnaire and two respondents said that care staff were feeling devalued because of poor pay rates. It is possible, that this issue of remuneration may have had more to do with the neutral responses than the approaches used by the SM.

5. Summary

This chapter discusses the findings of the study that was carried out in four residential care homes with nursing for adults with physical disabilities. The chapter discusses the approach that was taken to the analysis of the qualitative data that was gathered, which was adapted from a framework set out by Smith and Osborn (2007) for the use of interpretative phenomenological analysis (IPA). The chapter provides a narrative overview of the findings from each service, which is supported by information shown in **Appendices 1 - 6**

Chapter 5 – Analysis and Conclusions

5.1 Introduction

This chapter analyses the findings of the study, which sought to establish whether any inferences could be drawn about an association between the leadership and management approaches used in four residential care homes with nursing, and the achievement in those services of a 'Good' or 'Excellent' CQC rating. The chapter presents a critical evaluation of the research methodology that was adopted and the findings are considered in the context of the literature that was reviewed in Chapter 2. Conclusions are drawn about the research and overall conclusions are presented about the implications of the findings to the research issue. The limitations of the study are explained and the opportunities that have been identified for further research are described.

5.2 Critical Evaluation of Adopted Methodology

This multi-method qualitative study was underpinned by an interpretivist or phenomenological research philosophy. It was undertaken in the context of a large national charity, which provides social care services to disabled people, and four of its residential care homes with nursing in the North West were used as case studies to explore the research issue. Although the approach was largely inductive, in the sense that it was based on qualitative data, there was an element of deduction, relating to an attempt to test a hypothesis that emerged from the literature review, which identified current thinking about the nature of leadership, management and quality. This hypothesis formed the basis of a conceptual model that was used successfully to steer the research exercise and inform the conclusions that were drawn about the research issue.

The use of semi-structured and in depth interviews with managers and followers was consistent with the research philosophy. An interview guide was developed out of the literature relating to the research issue and this provided an appropriate framework for understanding the experiences of the interviewees and relating these to relevant theory about leadership, management and quality.

The reliability of the data collected from the semi-structured interviews was considered adequate but it is possible that certain situational factors may have influenced the interviewees' responses. They were feeling the effect of a major change programme within the collaborating organisation and this featured highly in one of the seven interviews. A manager spoke about the negative impact of the changes and there was evidence to suggest that her high stress levels and low mood were affecting the way she was engaging with staff. It is possible that, if the interview been undertaken prior to the implementation of the organisational change programme, a different picture may have emerged, but it was not possible to determine whether or not the manager's poor morale was leading her to deviate from a default leadership style or whether the approaches that were described were, in fact, her default style.

It would have been more consistent with recommended practice to have used audio equipment to record the interviews, but the author decided that this would potentially inhibit her own comfort and have a negative impact on her ability to facilitate the discussion. Although the transcription of the interviews immediately afterwards was time consuming, the handwritten notes included a high level of detailed content, as well as comments about non-verbal cues that were observed during the interviews. Therefore, it is reasonable to argue that it was the correct decision not to introduce audio equipment into the interview process and that the accuracy of the data was reasonable.

Frontline staff could not be interviewed, so six staff were selected from each service and asked to complete rating questionnaires. There was a variable response rate, with services ranging from a 100% return to a 0% return rate. Despite this variation, and a small number of respondent errors in using the rating system, the questionnaire achieved the aim of triangulating data from the interviews in three services. This was particularly important in the service where the care supervisor was not interviewed. It can be argued that responses to questionnaires are dependent on the respondent's interpretation of questions and their attitude towards what is being asked. Therefore, opinion data may be less reliable than data from face to face discussions, where the interviewer can offer clarification and further exploration of themes. However, with this caveat, it is reasonable to suggest that the data from the questionnaires provided an effective mechanism, in this study, for highlighting areas of consistency and discrepancy between the perceptions of managers and their frontline followers.

There were no ethical considerations in relation to service user confidentiality, but due care was given to the comfort and safety of the staff who participated in the study. One manager said that she had enjoyed the process and that it had been a rare opportunity for her to reflect on her own leadership and management approaches and how these link to quality improvement in her service.

One of the most difficult aspects of the study, from the author's perspective, was the selection of an appropriate data analysis method. After reviewing a number of approaches, the data was analysed using a framework for *interpretative phenomenological analysis* (IPA), which is described by Smith and Osborn (2007). This method of analysis emphasises that research is a dynamic process and that the researcher has an active role in the interpretation and understanding of people's experiences.

It had been acknowledged that the author's history in the collaborating organisation, together with her own values and understanding of social care quality, would present a degree of subjectivity in the study. It could be argued, therefore, that the use of the IPA framework legitimised the author as an interpreter of data in a dynamic, qualitative research process and that it also provided a clear methodology for her interpretation, which allowed proper comparison of the services that were studied.

5.3 Analysis and Conclusions

The literature review in Chapter 2 analysed and evaluated contemporary thinking about the nature of leadership and management and the distinctions that have been made between the two. The findings from the study suggested that the participants generally saw management as involving the mobilisation and co-ordination of resources and leadership as involving setting standards for the service and working with staff to support, develop and bring out the best in them. Bruch and Ghosal (2004) distinguish between managers who deliver products or services and leaders who are more concerned with organisational environment and culture. The managers who participated in the study are concerned with delivering services and ensuring that care and support is provided in accordance with organisational standards and values. However, they can be defined as leaders in Bruch and Ghosal's terms because they are responsible for maintaining a positive environment and culture within their own services.

The findings of the study indicate that the managers' leadership styles had an impact on the working environment and culture in services. It was notable that the themes relating to the service culture and working environment in services often mirrored those that related to the managers' leadership and management approaches. In one service, the manager was described as 'setting the tone for the mood' in the service'. The association that was found between the leadership approaches and the working environment, or service culture, is consistent with the assertion of Schein (2004) that leadership and culture are intrinsically linked.

Bruch and Ghosal (2004) comment that leaders should foster in their people a commitment to a shared sense of direction and to shared values and norms of behaviours. There was evidence that all the managers had been successful in doing this within their services, although the sense of shared direction and cohesion with the wider organisation was being tested by a major restructure. One manager felt that this would potentially result in a decline in the quality of service delivery because additional responsibilities were diluting her role and making it difficult to maintain the focus on standards of care.

There was evidence that all the managers were actively encouraging their followers to contribute to decision making and participate in problem solving within their services, aligning their approaches to the notion of 'suggestion involvement', as defined by Slack, Chambers and Johnston (2007) in relation to TQM. One manager, however, was perceived to be negative about the ideas staff put forward. Two of the managers placed emphasis on building people's confidence and giving credit to staff for their achievements, which is consistent with the notions of followership and empowerment, described by Huber (2006) as mechanisms for strengthening people's belief in their ability to succeed. All the managers were qualified nurse managers and had significant knowledge, experience and expertise in their field, demonstrating an important component of leadership that is suggested by Deming (2000) and Hughes, Ginnet and Curphy (2006).

The findings of the study showed that three out of the four managers were using a highly appropriate balance of task and leadership behaviours as defined by Daft (2008) with their followers indicating that they felt good about coming to work and that their

contributions were valued. In one service, there appeared to be a less appropriate balance between task and leadership behaviours. The manager had had inherited a service were there were long-standing difficulties among the staff group, which she was attempting to overcome. In the context of wider organisational change, she was experiencing significant stress and, at the same time, she was striving to maintain the highest standards of care in her service. There was some evidence to suggest that she may have been focusing on task behaviour at the expense of leadership behaviour, thereby contributing to a perception that she was hard on staff and overly controlling.

The study sought to test a hypothesis based on theories put forward by Nembhard and Edmonson (2006) and Wong and Cummings (2009). These researchers propose that authentic and inclusive leadership approaches result in followers having a sense of psychological safety. They suggest that these approaches create environments where there are strong ethical values, open and honest working relationships and trust between leaders and followers. In these environments, people are respected whatever their role and their contributions are welcomed. It is argued that in cross disciplinary teams, particularly in healthcare settings, these approaches ensure that staff who are at the lower end of the hierarchy feel able to speak up about mistakes or poor practice and will be actively engaged in the quality improvement process. This small study of residential care homes with nursing provided some evidence that authentic and inclusive leadership approaches can facilitate staff engagement in quality improvement processes.

It was evident that all the managers involved in the study were aiming to manage and lead their teams in ways that were consistent with the definitions of authentic and inclusive leadership. However, there was one service that stood out as an example where the 'cause and effect' conceptual model that is described in Chapter 2 could be seen in action. The application of authentic and inclusive leadership approaches, in the context of the CQC and internal policy frameworks had apparently created psychological safety and staff engagement in quality improvement.

 The manager of the service said that, for her, an important aspect of quality was ensuring the 'psychological safety and well being' of both service users and staff. It was clear that she had fostered shared values and a commitment to very high standards in her service. Her own perception that she displayed fairness, openness and empathy,

was corroborated by responses from her followers and it was clear that there was a high level of motivation, comradeship and trust among the staff. The manager was respected as a role model and as a clear communicator who involved other people in decision making and problem solving. She had taken proactive steps to break down professional hierarchies in her service, staff were highly involved in the quality improvement process and reported that they were confident to speak up about any problems or concerns. The service had been rated as 'Excellent' by CQC. Although it was beyond the scope of the study to test service users' perceptions, there was strong anecdotal and documentary evidence from the CQC inspection report, that service users were experiencing excellent outcomes.

5.4 Overall Conclusions

The findings supported the view that, where managers use authentic and inclusive approaches, they can create environments where staff, who feel valued and psychologically safe, are actively engaged in the quality improvement process. However, the study did not establish any clear association between leadership and management approaches and the achievement of a 'Good' or 'Excellent' CQC rating.

The research highlighted two extremes in terms of how managers were perceived by their followers. In one case, the manager of a service was perceived as a very positive role model whose leadership and management approaches had contributed to high levels of motivation and staff engagement in the quality management process. The service had achieved an 'Excellent' rating. At the other extreme, there was a manager who was not perceived so positively and whose approaches were seen as contributing to lower staff morale and less successful engagement of staff in the quality improvement process. The service had achieved an 'Excellent' rating.

To have achieved an 'Excellent' CQC rating, both of these services had been through a rigorous inspection process and must have demonstrated very high standards of care provision, effective staff management and high levels of service user satisfaction. In other words, although the manager's approaches were evidently quite different and staff morale appeared to be higher in one service than another, both services were clearly operating in accordance with the highest regulatory standards.

It would be reasonable to conclude that the leadership and management approaches used by the two managers were less important to the delivery of high quality provision than the organisation's ethos of service user empowerment and choice, combined with strong operational policy and procedural frameworks, which have been developed to ensure compliance with the CSA 2000 and CQC best practice guidelines.

5.5 Limitations of the Study

The issue for this research was the impact of leadership and management styles on the delivery of excellence in social care services for adults with a physical disability. A key limitation was that it was a very small study, involving only four managers, three care supervisors and eighteen other followers who provided opinion data by completing a rating questionnaire. A further limitation was that the study focused only on services that had 'Good' or 'Excellent' ratings, so there was no possibility of comparing the approaches used by managers of highly rated services and those who were operating 'Adequate' or 'Poor' services.

Arguably, this comparison could have provided further insight into the impact of leadership and management approaches on CQC ratings achieved. Although this is highlighted as a limitation, it would have been beyond the scope of this study to have looked at 'Adequate' or 'Poor' services because the collaborating organisation does not have any 'Adequate' services in the North West and has no 'Poor' services.

5.6 Opportunities for Further Research

The study highlighted that the managers of two services with 'Excellent' CQC ratings used different leadership and management approaches, with the approaches of one being perceived very positively and those of the other being perceived negatively by followers. The manager whose approaches were perceived more negatively was experiencing high levels of stress, which were largely attributable to the impact of an organisational change programme. There was some evidence to suggest that this was affecting the way she was engaging with staff but it was beyond the scope of this research to explore whether the manager's poor morale was leading her to deviate from a default leadership style or whether the approaches that were described were, in fact, her default style.

An unexpected outcome of the study was, therefore, that it raises questions about the ways in which organisational change may contribute to high stress levels in managers. It identifies the possibility that an individual's leadership and management approaches may change when they are experiencing high levels of stress, leading to a negative impact on their followers, the working environment and the culture in their services. It was beyond the scope of this research to take forward an exploration of these issues, but it has highlighted the opportunity for a more extensive and in depth study to examine the ways in which managers respond to high stress levels, how followers may be affected when managers are overly stressed and the overall implications for staff welfare and service quality in the social care context.

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Appendix 1

Analysis of Findings from Service 1

Contextual Data

The interview took place on 2 March 2010 at Service 1, which is located on the outskirts of a small town in the North West. The service provides a home for 27 disabled people who have very high requirements for personal care and nursing support. People living in the service have a range of physical and sensory impairments, acquired brain injuries or progressive neurological conditions. The service specialises in providing end of life care, particularly for people at the end stage of such conditions as Multiple Sclerosis and Motor Neurone Disease, who are not traditionally catered for within hospices. Where possible, residents are encouraged to participate in the running of the service and volunteers are deployed to support them in undertaking activities inside and outside the service.

The first interviewee was the Service Manager who has been in post for 6 years. She is a Registered General Nurse with a background in senior nursing in the NHS. As Service Manager, she holds CQC registration for the service in line with the requirements of the Care Standards Act 2000. She has overall responsibility for the performance of the service. Meeting spaces within the service are limited so a comfortable reception space, adjacent to the administration area, had been made available. The space was quiet and the interview could not be overheard. However, the interview was interrupted once by a visitor who required access to the office.

The interview with the SM was very relaxed, which she attributed to the fact that the interviewer had previously worked in the collaborating organisation. The Service Manager commented that she had really enjoyed the process of the interview as it is not often that she has the opportunity to reflect on her own practice as a manager. She expressed interest in the outcome of the study and commented that it would be very interesting to compare her approach with that of her other colleagues in the North West region.

The second interviewee was the Care Supervisor at the service who reports to the Service Manager and has supervisory responsibility for Registered General Nurses and Care staff at the service. She has been in post for 11years. She is a Registered General

Nurse. The interview took place in the reception space adjacent to the administration area. The space was quiet and the interview could not be overheard. There were no interruptions. .The interviewer and the Care Supervisor had only had limited contact previously and the interviewee was initially somewhat tense. However, the interviewer was able to put her at her ease so she relaxed quite quickly and spoke openly.

Table of Emergent Themes (Service Manager)

Theme	Reference from transcript
Achieving good outcomes for service users	*'..getting the right mix of aspects so that we can deliver the best outcomes'*
Good care plans with service user involvement	*'..very good care plans which service users are empowered to be properly involved in'*
Tension between service users' wants and what can be delivered'	*'..a level of compromise sometimes in terms of the quantity of what we can offer, but not in doing it well'*
Safety for service users and staff	*'..you need to have controls so that you can ensure people's safety at all levels, from their physical safety to their psychological safety and well being'*
Supporting service user choices	*'..we always want to promote service users' choices, responsibilities and rights and we support them to make choices and decisions, no matter how outlandish'*
Setting standards and reviewing them	*'It's all about setting standards and reviewing them...you need to monitor what you're achieving'*
Looking at the service user's experience	*'..you can write a care plan but if you don't look at what the service user is experiencing, it's not worth the paper it's written on'*
CQC standards	*'..you should utilise these standards in our day to day work, and we do, this is your level of achievement and it's a useful measure'*
Strong framework of policies and procedures in the organisation	*'...it's very strong and I use the policies all the time to check whether we're doing the right thing'*
How staff view quality	*'..the nurses are better at the theory, the care staff can tell me the practical aspects of quality'*
Relationship between nurses and care staff	*'..nurses can be precious, there can be a divide, nurses versus care staff'*
Two-pronged approach to management and leadership	*'..it's about managing resources...but I think I have a leadership role, it's about working with people to motivate them...it's all about comradeship and getting on'*

Good principles	*'..none of us would be here if it wasn't for the service users...what we want is good outcomes for the service users'*
Empathy	*'..you're not a good leader if you terrify people...you have to have empathy with people'*
Atmosphere makes staff feel safe and supported	*'..it's about working with people so they feel safe and supported...it's about giving people emotional support too'*
Setting standards and promoting values of the organisation	*'..the service manager sets the standard..people have to know what the values of the organisation are'*
Mistakes as a learning experience	*'..it's not about beating people, we're all human....they need to understand the consequences and I always say, 'what can we learn?'*
Meeting objectives and achieving targets	*'..I set objectives and targets...I give people a list of what we have to achieve and say 'this is what we all have to do'..it's about breaking it down into manageable bits and being clear about who needs to do what...it's a team effort'*
Continuous improvements	*'...we'd had a Good rating but it's now Excellent...we're picking up on the best practice recommendations...I always try to have a control loop so that there is continuous monitoring'*
Positive culture	*'I'd say it's very good...people are motivated...there is team cohesion'*

Table of Emergent Themes (Care Supervisor)

Theme	Reference from transcript
Customer perception of quality	*'..It's what the customer says it is. We have care standards criteria, but it's really what each person thinks it is'*
Good care plans with service user involvement	*'..the care plans are very important and service users and their families are heavily involved in developing them'*
Having enough time	*'..nurses would say it's (quality) is all about having good staffing levels and having time to do the job properly'*
Importance of having good training	*'..they'd (nurses) would say it was important to have the induction and training that staff get here '*
Speaking up about mistakes or poor practice	*'..staff here are very vocal and they know what should be happening to give service users a good experience..they'll always come and say if they think there's anything wrong'*
Dynamics between nursing and care staff	*'I think the non-uniform helps to make us*

	a team and gets rid of the demarcation lines...the care staff have a very holistic view and know the service users better than the nurses...there's no hierarchy'
Perceptions of the SM's approaches to management	*'..she manages by supporting people...she's a very good manager, she's made my role a lot easier and I've learned a lot from her'*
How the SM leads the team	*'..she's really approachable and speaks her mind so you know where you are...she creates a very relaxed atmosphere...she wants our service to be the best, she says 'I want Beacon Status',...she sets the tone'*
Involving staff in quality improvement	*'..she's thorough, where I'd skim over something she goes deep and then delegates....everyone knows what they have to do....we have clear timescales and everyone knows who's doing what.....she always gives praise for good work and people are motivated'*
Mistakes as a learning experience	*'..As a nurse herself, she knows what can go wrong and can support people through the error. Her approach is 'I'm not endorsing what's happened but let's look at how we can learn and avoid this happening again'*
Positive culture	*'It's a very supportive culture, staff aren't afraid to speak to people higher up...we all have the same aim which is to give a really good experience to the service user'*
Organisational policy framework	*'they create so many policies we can refer to...you name it, it's there...as a staff team we understand our responsibilities and the policies are there to back us up'*
CQC	*'...they come with the aim of ripping you to shreds...this is how you see them.....staff here aren't working to impress CQC, they're working for the service users...'*

Table of Clustered Themes (Service Manager and Care Supervisor)

Cluster	Themes
How quality is defined in the service	- *Positive outcomes for service users (**SM and CS**)* - *Service user empowerment and choice (**SM and CS**)* - *Service user expectation (**SM**)* - *Psychological safety (**SM**)* - *Customer perception (**CS**)* - *Time to do the job properly (**CS**)* - *Good training (**CS**)*
Measuring quality in the service	- *Service users' experiences (**SM and CS**)* - *Review processes (**SM and CS**)* - *CQC standards (**SM and CS**)*
How the SM engages staff in quality improvement	- *Objective/ target setting (**SM and CS**)* - *Delegation(**SM and CS**)* - *Shared responsibility (**SM and CS**)* - *Clarity of task (**SM and CS**)* - *Praising staff for good work (**CS**)* - *Staff motivation (**CS**)*
What leadership means in the service	- *Motivation (**SM and CS**)* - *Approachability (**SM and CS**)* - *Support for staff (**SM and CS**)* - *Fairness, openness and empathy(**SM**)* - *Being a role model (**CS**)* - *Setting the highest standards (**CS**)*
What management means in the service	- *Resource management (**SM and CS**)* - *Learning environment (**SM**)* - *Driving the quality agenda (**SM**)* - *Support (**CS**)* - *Empathy (**CS**)* - *Professional knowledge (**CS**)*
Dynamic between nursing and care staff	- *Mutual learning (**SM and CS**)* - *Lack of hierarchy (**SM and CS**)* - *Teamwork (**SM and CS**)*
Service culture	- *Motivation (**SM and CS**)* - *Shared values (**SM and CS**)* - *Team cohesion (**SM and CS**)* - *Comradeship (**SM**)* - *Supportive and relaxed atmosphere (**CS**)*
The service in the context of the wider organisation	- *Strong policy/procedural framework (**SM and CS**))* - *Commitment to service user empowerment (**SM and CS**)*

Responses from 4 out of 6 Questionnaires sent to Frontline Staff

5 = Strongly Agree 4 = Agree 3 = Neutral 2 = Disagree 1 = Strongly Disagree

Questions about the staff's view of quality

Providing high standards of care	5 (4)
Putting the service user first	5 (4)
Having staff who are well trained and supported	5 (4)
Having clear policies and procedures to guide staff	5 (4)
Following the CQC standards in day to day work	5 (3) 4(1)
Providing good food and a pleasant environment	5 (4)
Ensuring the service user's safety and well being	5 (4)
Carrying out large numbers of audits and checks	5 (3) 4(1)
Giving service users the power to make their own choices	5 (4)
Staff having enough time to spend with service users	5 (4)
Following the care plan for each service user carefully	5 (4)
Working well with professionals involved with the service user	5 (4)
Everyone playing a part in giving service users a good experience	5 (4)
Service users knowing how to complain and give feedback	5 (4)

Questions about staff's view of the way the Service Manager works

Everyone knows that the SM sets high standards	5(4)
The SM is approachable	5 (1) 4 (3)
The SM involves staff in making changes and improvements	5 (2) 4 (2)
Staff and service users see the SM as the person who is in charge	5 (4)
The SM treats staff fairly	5 (4)
The SM is good at motivating staff in the service	5 (3) 4 (1)
The SM is supportive to staff if they have a problem	5 (4)
The SM welcomes suggestions and ideas for improving things	5 (4)

The SM lets people get on with their jobs without interfering	5 (4)
The SM sets a good example to others	5 (3) 4 (1)
The SM communicates clearly with staff	
The SM lets staff know what is expected of them	5 (4)
The SM has the main responsible for quality in the service	5 (4)

Questions about what it is like to work in the service

It feels good to come to work	5 (2) 4 (2)
Staff are not afraid to speak up if they make a mistake	5 (1) 4 (3)
There is good teamwork in the service	4 (4)
Everyone feels valued, no matter what their role is	4 (4)
Everyone is involved in making changes and improvements	5 (1) 4 (2) 3 (1)
Staff trust each other and have positive working relationships	5 (1) 4 (2) 3 (1)
Staff feel confident to tell someone if they see any poor practice	5 (3) 3 (1)
Staff have the time to do their jobs in the way they want to	4 (2) 2 (2)
Staff feel motivated and enjoy their jobs	4 (4)

Appendix 2

Analysis of Findings from Service 2

Contextual Data

The interview took place on 17 March 2010 at Service 2, which is located in beautiful, but isolated rural location in the North West. The service provides a home for 29 disabled people who have a range of physical and sensory impairments, acquired brain injuries or progressive neurological conditions. There is an even spread of dependency levels with some people having high dependency levels, needing total care, some people with medium dependency, needing some nursing input, and some people with lower level needs, requiring assistance only with personal care. Residents are encouraged to participate in the running of the service and volunteers are deployed to support them in undertaking activities inside and outside the service.

The first interviewee was the Service Manager who has been in post for 5 years. He is a Registered General Nurse and, as Service Manager, he holds CQC registration for the service in line with the requirements of the Care Standards Act 2000. He has overall responsibility for the performance of the service. The Service Manager made his office available for the interview and the discussion could not be overheard. There were no interruptions and the interview was very relaxed, which the interviewee attributed to the fact that the interviewer knew him and the service well.

The second interviewee was the Care Supervisor at the service who reports to the Service Manager and has supervisory responsibility for Registered General Nurses and Care staff at the service. She has been in post for 15 years. She is a Registered General Nurse. The interview took place in the library room within the service, which was quiet and the interview could not be overheard. There were no interruptions. The interviewer and the Care Supervisor had only had limited contact previously but the atmosphere of the interview was relaxed.

Table of Emergent Themes (Service Manager)

Theme	Reference from transcript
Quality of care and standards	*'....we've got plenty of tools but I go a lot on what I see...and I know what I'm looking for in terms of the service users' health'*

Staff perceptions of quality linked to their own employment environment	*'...the first would be all about standards of care and the second would be all about how things in the service affect them...the things their employer provides for them'*
CQC standards	*'..CQC send out surveys to service users but I think they're biased in the way they ask the questions...the questions aren't always applicable to the service'*
Strong framework of policies and procedures in the organisation	*'..there's a massive policy structure...it gives us a framework for letting staff know what is expected of them'*
Management v leadership	*'..I've never really split it like that...I try to lead by example but the role dictates that I'm a manager and people need to be managed'*
Management/leadership style	*'..I'm not autocratic but I think I have 'hidden' authority...I try to do it in a fatherly way..it's about having some respect....I always try to bring out the best in people but they're in no doubt who they're talking to'*
How management/leadership approaches may have contributed to CQC rating	*'...by looking after the staff and their welfare as well as the service users...it's settled the group down and the staff feel valued and it's a good place to work'*
Staff engagement in quality improvement	*'...it's about giving them respect and credit for good work...I don't interfere with the day to day running of any of the departments........when we had a safeguarding issue we shared it with the appropriate people so they knew what the issues and the outcomes were'*
Staff reporting mistakes or poor practice	*'...they're reluctant because there are negative connotations about 'dobbing people in'...but they do it, especially if there's bad practice... they know I'm not going to crucify anyone if they make a mistake...I try to help them so that they learn'*
Relationship between nurses and care staff	*'..the RGN has the ultimate accountability for nursing care...sometimes the carers think they know best, but they don't...I've instilled the boundaries here...I would rather the nurses had uniforms so people would see who was who and there would be no doubt about who the professionals were'*
Service culture	*'...it's hard to say...it's very different than before...it's got much more relaxed..I'd say now that there's a very quiet nature of management'.*

Table of Emergent Themes (Care Supervisor)

Theme	Reference from transcript
Quality care	*'.it's about giving people the best care we can give them....people living their lives to the best of their ability'*
Measuring quality through service user satisfaction	*'..by how happy the service user is with the service they're getting'*
Having enough quality time	*'..the staff ratios are too low to give quality...people are getting the basics but you can't spend a quarter of an hour helping someone to put their make up on.. these are the things that mean a lot to people in an environment like this'*
CQC inspections	*'..people can get the wrong impression if they only have a snapshot of what's going on'*
Staff perceptions of quality	*'they'd say the same as me...they'd talk about the lack of time, especially the carers'*
How the SM manages and leads the team	*'..he keeps things running smoothly...people can speak to him if they have any concerns...he puts trust in the Heads of Departments...he takes the 'softly softly' approach but it works...*
Involving staff in quality improvement	*'...he'll say what is needed and ask us to report back on what we're going to do...he's very approachable....I think liaison with people is the biggest things so that people know what their role is in making the improvement and knowing exactly what they need to do*
Speaking up about mistakes or poor practice	*'..they would bring it to me...we always try to look at the reasons why mistakes or poor practice happen'*
Relationship between nursing and care staff	*'...it's pretty good......there have to be boundaries but there's no animosity...I think if you asked any trained nurse, they'd tell you they prefer wearing a uniform...a year ago we weren't getting the respect from some of the carers and it might have helped if we'd been wearing uniforms'*
Service culture	*'...it's good....it feels very good to come to work...people respect the SM and like the informal style, people are ok with that'*
Organisational policy framework	*'...if you're stuck on anything, there'll be a policy on it...if you know it's there to help you, you feel secure'*

Table of Clustered Themes (Service Manager and Care Supervisor)

Cluster	Themes
How quality is defined in the service	- *High standards of health care for service users (**SM**)* - *Good employment environment for staff* - *Service user achievement and ability (**CS**)* - *Time to do more than the basics(**CS**)*
Measuring quality in the service	- *SM's observation of service users' (**SM**)* - *Service user satisfaction (**CS**)* - *CQC and organisation standards (**SM and CS**)*
How the SM engages staff in quality improvement	- *Giving credit for good work (**SM**)* - *Delegation(**SM and CS**)* - *Good information sharing (**SM and CS**))* - *Shared responsibility (**SM and CS**)* - *Clarity of task (**SM and** - **CS**)*
What leadership means in the service	- *Hidden authority (**SM**)* - *Respect for SM role (**SM**)* - *Bringing out the best in people (**SM**)* - *Approachability (**SM and CS**)* - *Support for staff (**SM and CS**)* - *Taking a 'softly softly' approach (**CS**))*
What management means in the service	- *People management (**SM**)* - *Keeping everything running smoothly (**CS**)*
Dynamic between nursing and care staff	- *Respect for nurses' professional role (**SM and CS**)* - *Need for clear boundaries (SM and CS)* - *Preference for nurses to wear uniforms (**SM and CS**)* - *Carers can pick up on things nurses may miss (**CS**)*
Service culture	- *Relaxed (**SM**)* - *Quiet nature of management (**SM**)* - *Informal (**CS**)* - *Relaxed (**CS**)* - *Good to come to work (**CS**)*
The service in the context of the wider organisation	- *Strong policy/procedural framework to support quality (**SM and CS**)*

Responses from 2 out of 6 Questionnaires sent to Frontline Staff

5 = Strongly Agree 4 = Agree 3 = Neutral 2 = Disagree 1 = Strongly Disagree

Questions about the staff's view of quality

Providing high standards of care	5 (2)
Putting the service user first	4 (2)
Having staff who are well trained and supported	5 (2)
Having clear policies and procedures to guide staff	5 (1) 4 (1)
Following the CQC standards in day to day work	5 (1) 4(1)
Providing good food and a pleasant environment	5 (1) 4 (1)
Ensuring the service user's safety and well being	5 (2)
Carrying out large numbers of audits and checks	5 (1) 4 (1)
Giving service users the power to make their own choices	5 (1) 4 (1)
Staff having enough time to spend with service users	5 (1) 3 (1)
Following the care plan for each service user carefully	4 (2)
Working well with professionals involved with the service user	4 (2)
Everyone playing a part in giving service users a good experience	4 (2)
Service users knowing how to complain and give feedback	4 (2)

Questions about staff's view of the way the Service Manager works

Everyone knows that the SM sets high standards	4(2)
The SM is approachable	5 (1) 4 (1)
The SM involves staff in making changes and improvements	5 (1) 3 (1))
Staff and service users see the SM as the person who is in charge	4 (2)
The SM treats staff fairly	4 (2)
The SM is good at motivating staff in the service	4 (2)
The SM is supportive to staff if they have a problem	5 (1) 4 (1)
The SM welcomes suggestions and ideas for improving things	5 (1) 4 (1)

The SM lets people get on with their jobs without interfering	5 (1) 4 (1)
The SM sets a good example to others	4 (1) 3 (1)
The SM communicates clearly with staff	4 (2)
The SM lets staff know what is expected of them	4 (1) 3 (1)
The SM has the main responsible for quality in the service	4(2)

Questions about what it is like to work in the service

	S/A = Strongly Agree A = Agree
It feels good to come to work	5 (2)
Staff are not afraid to speak up if they make a mistake	5 (1) 4 (1)
There is good teamwork in the service	5 (2)
Everyone feels valued, no matter what their role is	5 (1) 4 (1)
Everyone is involved in making changes and improvements	5 (1) 4 (1)
Staff trust each other and have positive working relationships	5 (2)
Staff feel confident to tell someone if they see any poor practice	5 (2)
Staff have the time to do their jobs in the way they want to	1 (1) 3 (1)
Staff feel motivated and enjoy their jobs	5 (1) 4 (1)

Appendix 3

Analysis of Findings from Service 3

Contextual Data

The interview took place on 15 March 2010 at Service 3, which is located in a beautiful rural setting on the outskirts of a very pleasant town in the North West. The service provides a home for 27 disabled people who require personal care and nursing support. People living in the service have a range of physical and sensory impairments, acquired brain injuries or progressive neurological conditions. Residents are encouraged to participate in the running of the service and volunteers are deployed to support them in undertaking activities inside and outside the service. The service operates a day support service for disabled people who are non-residents, which adds an additional dimension to the work.

The first interviewee was the Service Manager who has been in post for 3 years. She is a Registered General Nurse and, as Service Manager, she holds CQC registration for the service in line with the requirements of the Care Standards Act 2000. She has overall responsibility for the performance of the service. The Service Manager had made her office available for the interview and the interview could not be overheard. The interview was not interrupted. The interviewer had not worked closely with the Service Manager previously, but knew her well enough to detect a change in her appearance and demeanour, which reflected how much stress and pressure she was under. Throughout the interview, she reflected on this and attributed her unhappiness to a very difficult culture within the service that she was managing, combined with major organisational changes that were impacting on her negatively and increasing her workload.

The second interviewee was the Care Supervisor at the service who reports to the Service Manager. She has been in post for 3 years. She is a Registered General Nurse. The interview took place in the Care Supervisor's office and the interview could not be overheard. There was one interruption from a visitor. The interviewer and the Care Supervisor had never met previously but the interviewee talked openly.

Table of Emergent Themes (Service Manager)

Theme	Reference from transcript
Quality of care and standards	*'....doing things to the best of our ability to achieve maximum benefit for service users....it's about people's emotional and psychological needs as well...staff are a close second priority...'*
Measuring quality	*'you can't do it formally...it's more about what you see and hear...I chat to service users...I get feedback from supervisors'*
CQC standards	*'we have regular quality meetings..I'm having to do things that aren't about quality now...I'm spread so thin and I feel worried that my ability to set standards in the service will be diluted'*
Staff perception of quality	*'..staff hate that they can't spend as much quality time with service users, they're asking us to do as much as you can in the shortest time'*
Strong framework of policies and procedures in the organisation	*'..there's a massive policy structure...it gives us a framework for letting staff know exactly what is expected of them'*
Management versus leadership	*'I manage systems and crises...it's crisis management...if I was a leader things would be much calmer....leadership has to involve you in being able to look at how things are going and setting the tone'*
Management/leadership style	*'..it's a very democratic form of leadership...sometimes you have to dictate....my neck is on the block...I'm seen as the manic person who's tolerated...I'm crap at delegating'*
How management/leadership approaches may have contributed to CQC rating	*'..To be honest, I'm doing everyone else's job because they can't do it...I'm having to change the culture....I'm plugging away, pinpointing wrongdoing when I see it and using the disciplinary process'*
Staff engagement in quality improvement	*'..quality starts at the bottom not the top...I set up mini peer groups based on people's interests..staff have to take responsibility, not just listen to me'*
Staff reporting mistakes or poor practice	*'..they didn't used to....I have told staff that they are the ones to blame if they don't whistle blow...staff have realised that certain things are not ok...when there is a problems I try to find out who's involved and resolve it by talking*
Relationship between nurses and care staff	*'..certain nurses regard care staff as*

	beneath them...some staff need to build their awareness and confidence and be given credit to extend their expertise'
Service culture	'..It's antiquated and resistant to change, but you have to be satisfied with small seeds that turn into big oak trees.

Table of Emergent Themes (Care Supervisor)

Theme	Reference from transcript
Quality care	'delivering standards of care in the best possible way, having the best staff, best training, best team-working and best practice throughout'
Measuring quality through service user satisfaction	'....we have all the audits and the policies and procedures but we need to make sure they're being carried out.....it's about getting good feedback from service users about what's working and what we can improve'
Staff perceptions of quality	'care staff wouldn't understand the jargon, nurses would say the same as me'
Definition of the Service Manager role	'..she oversees the care, manages the budgeting and all the different departments to make sure the service maintains standards...she's responsible across the board'
How the Service Manager leads the team	'....she's quite controlling and negative about suggestions.. what she says is best goes, she's stern and I have quite a lot of negative feedback from staff...she's under a lot of pressure and stress and overworks...she's not a good role model in this way...she sets the tone for the high standards, but she can come across as interfering and tackles things at the wrong times'
Involving staff in quality improvement	'...she says what she wants and then I do it...we sing from the same hymn sheet – we want to be the best....she uses the service users' views as a consensus about what needs to improve....she's good at giving ideas and devising formats....people put forward good ideas but they often get knocked back....she sees staff training as very important and is very forward thinking in that way..she encourages people to do lots of training'
Speaking up about mistakes or poor practice	'..staff aren't as good as they should be...we had an issue that a staff member didn't report and when we asked him why,

	he said he thought nobody would know...I'd like to think that most of them would admit to a really major cock up'
Relationship between nursing and care staff	*'...some RGNs and carers get on well and some tolerate each other...some older care staff think the RGNs are useless...some of the nurses are a bit above their station...I suppose to a point there is a hierarchy'*
Service culture	*'...it's good on the whole....but it can depend on what mood the SM is in, she sets the tone for the mood...most people really care about the service users...we try hard'*

Table of Clustered Themes (Service Manager and Care Supervisor)

Cluster	Themes
How quality is defined in the service	- *Maximising benefits for service users (**SM**)* - *Addressing service users' emotional and psychological needs (**SM**)* - *Best practice (**CS**)* - *Best team-working (**CS**)* - *Best training (**CS**)*
Measuring quality in the service	- *SM's observation (**SM**)* - *Service user feedback (**SM and CS**)* - *CQC and organisational standards (**SM and CS**)*
How the SM engages staff in quality improvement	- *Setting up interest groups (**SM**)* - *Staff taking responsibility (**SM**)* - *Delegation (**SM and CS**)* - *Criticising (**CS**)* - *Sharing information (**SM and CS**))* - *Shared responsibility (**SM and CS**)* - *Staff training(**CS**)*
What leadership means in the service	- *Democracy (**SM**)* - *Controlling and negative (**CS**)* - *Setting the tone for high standards (**SM and CS**)* - *Interfering (**CS**)* - *Overworking (**CS**)*
What management means in the service	- *Crisis management (**SM**)* - *Being responsible across the board (**CS**)* - *Working very long hours(**CS**)*
Dynamic between nursing and care staff	- *Hierarchical (**SM and CS**)* - *Lack of respect for each other's roles (**CS**)*
Service Culture	- *Antiquated and resistant to change*

	(SM) - *Good on the whole but dependent on the SM's mood (CS)*
The service in the context of the wider organisation	- *Strong policy/procedural framework to support quality (SM)* - *Negative impact of major organisational improvement programme (SM)* - *Lack of infrastructure to services (SM)* - *Unreasonable expectations of Service Managers (SM)*

Responses from Questionnaires sent to Frontline Staff

No questionnaires were returned from this service.

Appendix 4

Analysis of Findings from Service 4

Contextual Data

The interview took place on 12 March 2010 at Service 4, which is located on a large and extremely pleasant site in an 'urban village' near a large coastal town in the North West. The service provides a home for up to 35 disabled people who have a range of physical and sensory impairments, acquired brain injuries or progressive neurological conditions. Although some service users require high levels of nursing input, the majority of people have lower needs for nursing care and the focus is mainly on provision of support with personal care. Residents are encouraged to participate in the running of the service and volunteers are deployed to support them in undertaking activities inside and outside the service. The service operates a day support service for disabled people who are non-residents, which adds an additional dimension to the work.

The first interviewee was the Service Manager who has been in post for 12 years. She is a Registered General Nurse and, as Service Manager, she holds CQC registration for the service in line with the requirements of the Care Standards Act 2000. She has overall responsibility for the performance of the service. She had made her office available for the interview and the interview could not be overheard.

The Service Manager explained that it would not be possible to interview the Care Supervisor of the service because after the interview the she was going to meet her to inform her that she was not going to be confirmed into post after an extended probationary period. The interviewer asked whether the Service Manager was happy to continue with the interview in these circumstances and she confirmed that she was. The interviewer and the Service Manager had previously worked closely with each other on several projects so, despite the Service Manager expressing her feelings of stress about the situation with her Care Supervisor, the interview was very relaxed.

Table of Emergent Themes (Service Manager)

Theme	Reference from transcript
Service users' needs as top priority	*'... our service users come first...they give me a lot of feedback...they demand a lot and they get it'*

Shared values	*'....for me it's all about the residents' power and choice.. I tell staff that the service users pay our wages...I tell the kitchen staff that they should be aiming to run our dining room like a restaurant'*
Measuring quality	*'..I keep all the staff supervisions up to date and I'm keen that we address any issues of concern......I attend monthly service users' meetings to give them feedback about what's going on and I take away their issues for action'*
Location of the Service Manager's office	*'...I'm in the middle of the building and I can hear a lot because my door is pretty much always open....I can hear the conversations at mealtimes as well*
Dealing with problems at an early stage	*'..I can tell if there's a problem brewing, I may get a niggle or hear snippets and I deal with it straight away when it's a concern rather than a big problem'*
Staff perceptions of quality	*'..the care staff wouldn't get the jargon but when I explained, they'd focus on things like high standards of personal hygiene, satisfaction levels of the residents and the social input from the activities enablers'*
Managing quality of care under pressure	*'..we have a problem delivering the highest quality when we're under pressure because of staff vacancies*
Management versus leadership	*'I manage more than I lead....I don't get the opportunity to show people how to do things now,'*
Management/leadership approaches	*'..it's all about discussion, listening to people's input and looking around...I try to step back so that people can really contribute....I rarely make a decision without input from all the people who are affected....I'm very firm but I always try the 'gently gently' approach first...'*
Learning and impetus of new ideas and situations	*'...we like hearing different perspectives and points of view...we like the impetus of new ideas and new situations to deal with'*
CQC standards	*'..we're not so good at dealing with the paperwork side of things and we keep missing out on the Excellent rating'*
Relationship between nurses and care staff	*'...there's no divide here...our service isn't as 'nursey' as some of the others...when they have time, nurses will do care work as well'*
Staff reporting mistakes	*'...people are confident to bring things to me...staff support each other well and watch each others' backs...'*
Engaging staff in quality improvements	*'I've asked care staff to help identify the*

	problems...staff are always happy to work with you if they feel you're trying to solve a problem...I take ideas from everyone and make it clear who should be doing what'
Service culture	*'...it's laid back, I try and make sure that people can have a laugh and a joke but if they cross the line they'll be told...I don't accept people who are unprofessional and the staff know that'*

Table of Clustered Themes (Service Manager)

Cluster	Themes
How quality is defined in the service	- *Service user empowerment and choice* - *Service user expectation* - *High standards of care*
Measuring quality in the service	- *Service user feedback* - *Staff feedback* - *Staff supervision* - *CQC standards and internal audits*
How the SM engages staff in quality improvement	- *Asking staff to identify problems* - *Taking ideas from everyone* - *Delegation* - *Clarity of task*
What leadership means in the service	- *Listening and discussing* - *Encouraging staff contribution* - *Being firm* - *Taking a 'gently gently' approach* - *Being straight with people* - *Being a role model* - *Demanding professionalism*
What management means in the service	- *Resource management* - *Being at the centre of the service* - *High level of awareness of how service users and staff are feeling*
Dynamic between nursing and care staff	- *No divide* - *Teamwork*
Service Culture	- *Laid back atmosphere* - *Professionalism* - *Shared values*
The service in the context of the wider organisation	- *Strong policy/procedural framework* - *Commitment to service user empowerment and choice*

Responses from 6 out of 6 Questionnaires sent to Frontline Staff

5 = Strongly Agree 4 = Agree 3 = Neutral 2 = Disagree 1 = Strongly Disagree

Questions about the staff's view of quality

Providing high standards of care	5 (5) 4 (1)
Putting the service user first	5 (4) 4 (2)
Having staff who are well trained and supported	5 (2) 4 (4)
Having clear policies and procedures to guide staff	5 (3) 4 (2)
Following the CQC standards in day to day work	5 (3) 4(3)
Providing good food and a pleasant environment	5 (5) 4 (1)
Ensuring the service user's safety and well being	5 (4) 4 (2)
Carrying out large numbers of audits and checks	5 (1) 4(2) 3 (3)
Giving service users the power to make their own choices	5 (1) 4 (4) 3 (1)
Staff having enough time to spend with service users	5 (2) 4 (2) 3 (2)
Following the care plan for each service user carefully	5 (3) 4 (1) 3 (2)
Working well with professionals involved with the service user	5 (3) 4 (3)
Everyone playing a part in giving service users a good experience	5 (2) 4 (2) 3 (2)
Service users knowing how to complain and give feedback	5 (3) 4 (3)

Questions about staff's view of the way the Service Manager works

Everyone knows that the SM sets high standards	5(2) 4 (4)
The SM is approachable	5 (3) 4 (3)
The SM involves staff in making changes and improvements	5 (1) 4 (5)
Staff and service users see the SM as the person who is in charge	5 (3) 4 (2) 3 (1)
The SM treats staff fairly	5 (2) 4 (4)
The SM is good at motivating staff in the service	4 (4) 3 (2)
The SM is supportive to staff if they have a problem	5 (3) 4 (3)

The SM welcomes suggestions and ideas for improving things	5 (2) 4 (2)
The SM lets people get on with their jobs without interfering	5 (2) 4 (4)
The SM sets a good example to others	5 (2) 4 (4)
The SM communicates clearly with staff	5 (1) 4 (2) 3 (3)
The SM lets staff know what is expected of them	5 (1) 4 (5)
The SM has the main responsible for quality in the service	5 (2) 4 (4)

Questions about what it is like to work in the service

	S/A = Strongly Agree A = Agree
It feels good to come to work	5 (3) 4 (3)
Staff are not afraid to speak up if they make a mistake	5 (2) 4 (2) 3 (2)
There is good teamwork in the service	5 (3) 4 (2) 3 (1)
Everyone feels valued, no matter what their role is	4 (3) 3 (3)
Everyone is involved in making changes and improvements	4 (1) 3 (4) 2 (1)
Staff trust each other and have positive working relationships	4 (4) 3 (2)
Staff feel confident to tell someone if they see any poor practice	5 (2) 4 (1) 3 (1) 2 (2)
Staff have the time to do their jobs in the way they want to	2 (5) 3 (1)
Staff feel motivated and enjoy their jobs	4 (2) 3 (4)

Appendix 5 – Explanatory Letter to Frontline Staff

12 March 2010

Dear Colleague

Research Study

I am carrying out a Masters Degree in Business Administration at the University of Chester and your employer has given me permission to carry out a small research project in some of its residential services in the North West.

I am trying to find out whether the way Service Managers work with their staff has any bearing on the Care Quality Commission (CQC) rating for their service.

Your Service Manager has given me staff lists for your service and I have chosen, at random, the names of a number of staff who I am inviting to help me with the study. As you are one of the people I have chosen, I would be very grateful if you would complete the attached questionnaire.

The questionnaire should only take you about five or ten minutes to complete. You will notice that you are not asked to give your name, but it is important to state your job role and the service you work in.

The information you provide will be anonymous and will be treated in absolute confidence. The answers you give will be analysed alongside information I have gathered from carrying out interviews with Service Managers and Care Supervisors.

I hope you will find the questionnaire interesting to complete. Please fax your completed questionnaire to me, Christine Barker, by Friday 26 May 2010. My fax number is:

If you have any questions or would like any further information, please contact me on the telephone number or email address at the top of this letter.
Thank you very much for your help.

Yours faithfully

Christine Barker

Appendix 6 Rating Questionnaire to Frontline Staff

The Questionnaire

Please state your job role: **Please state the service you work in:** **Date:**

Instructions
For each question listed below, please select the following responses to indicate the strength of your opinion and circle the number that corresponds with your opinion. Please take care to circle the correct number.

5 = Strongly Agree
4 = Agree
3 = Neutral
2 = Disagree
1 = Strongly Disagree

1. Please circle the number that reflects your view about what quality service means in a residential care home:

Providing high standards of care   1 2 3 4 5

Putting the service user first   1 2 3 4 5

Having staff who are well trained and supported   1 2 3 4 5

Having clear policies and procedures to guide staff   1 2 3 4 5

Following the CQC standards in day to day work   1 2 3 4 5

Providing good food and a pleasant environment   1 2 3 4 5

Ensuring the service user's safety and well being   1 2 3 4 5

Carrying out large numbers of audits and checks   1 2 3 4 5

Giving service users the power to make their own choices 1 2 3 4 5

Staff having enough time to spend with service users   1 2 3 4 5

Following the care plan for each service user carefully   1 2 3 4 5

Working well with the professionals who are involved   1 2 3 4 5

Everyone helping to give service users a good experience 1 2 3 4 5

Service users knowing how to complain and give feedback 1 2 3 4 5

2. Please circle the number that reflects your view about the way the Service Manager (SM) works

Everyone knows that the SM sets high standards	1	2	3	4	5
The SM is approachable	1	2	3	4	5
The SM involves staff in changes and improvements	1	2	3	4	5
Staff see the SM as the person who is in charge	1	2	3	4	5
The SM treats staff fairly	1	2	3	4	5
The SM is good at motivating staff in the service	1	2	3	4	5
The SM is supportive to staff if they have a problem	1	2	3	4	5
The SM welcomes suggestions and ideas	1	2	3	4	5
The SM lets people get on with their jobs	1	2	3	4	5
The SM sets a good example to others	1	2	3	4	5
The SM communicates clearly with staff	1	2	3	4	5
The SM lets staff know what is expected of them	1	2	3	4	5
The SM has the main responsible for quality in the service	1	2	3	4	5

3. Please circle the number that reflects your view about what it is like to work in your service

It feels good to come to work	1	2	3	4	5
Staff are not afraid to speak up if they make a mistake	1	2	3	4	5
There is good teamwork in the service	1	2	3	4	5
Everyone feels valued, no matter what their role is	1	2	3	4	5
Everyone is involved in making changes and improvements	1	2	3	4	5
Staff trust each other and have good working relationships	1	2	3	4	5
Staff feel confident to speak up about poor practice	1	2	3	4	5
Staff have the time to do their jobs in the way they want to	1	2	3	4	5
Staff feel motivated and enjoy their jobs	1	2	3	4	5

4. If you would like to make any comments about any of the questions above, please do so below.

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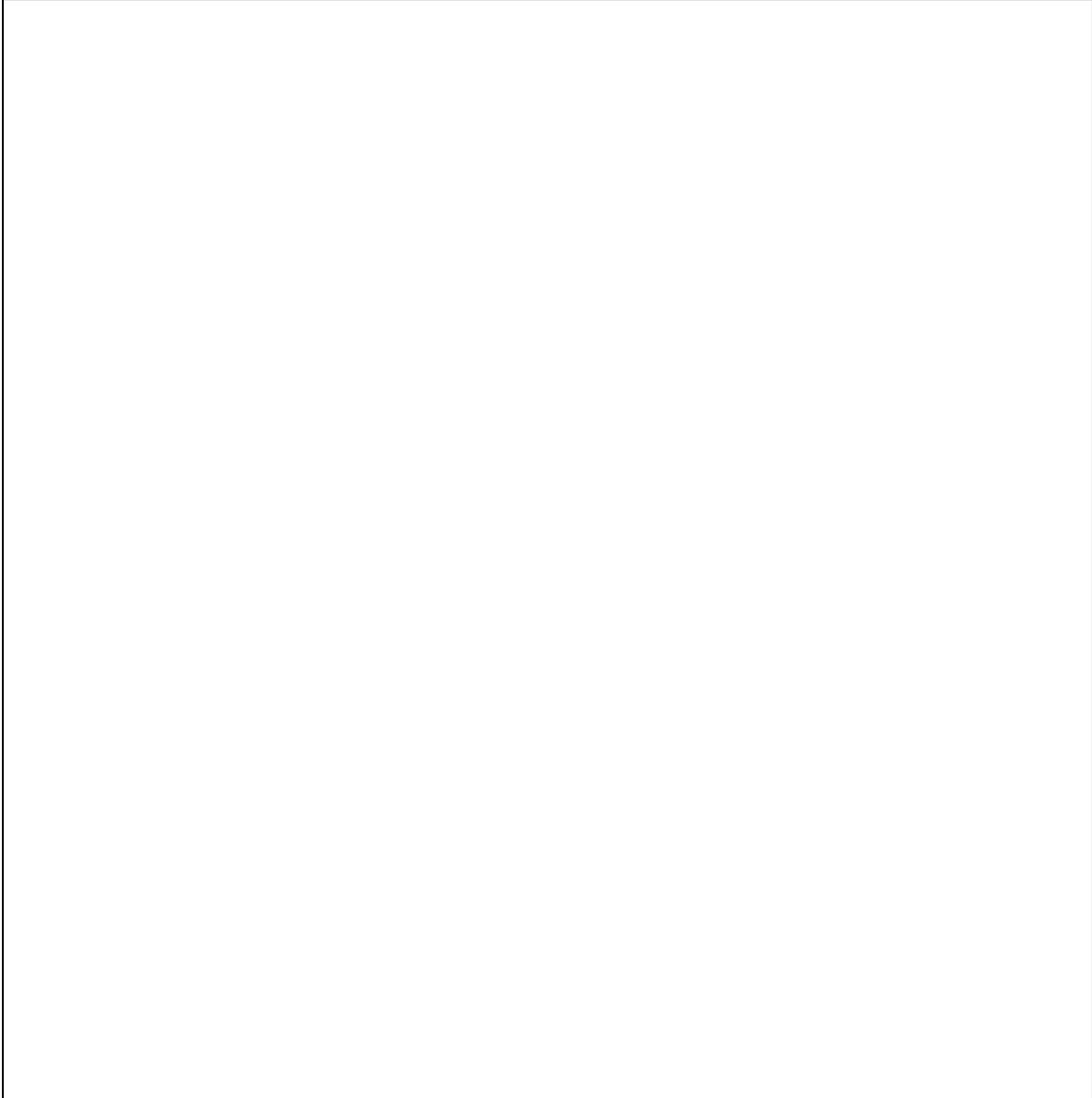
Thank you for completing this questionnaire.

Please fax it to Christine Barker on: **by 12.00pm on Monday 29 March 2010.**