An IPA Study Exploring the Lived Experiences of Operational Leaders Working in the NHS During the COVID-19 Pandemic

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Acknowledgements

Abstract

Introduction: COVID-19 (C19) has significantly impacted healthcare services and professionals in the NHS. There is currently limited research on the experiences of working as an operational leader – those leaders that plan and deliver required clinical services from a senior leadership position – since the onset of C19. Most of the literature focuses on the psychological wellbeing of patient-facing professionals and clinical leaders such as doctors and nurses. There is limited literature exploring operational leader experience, which this study will address.

Aims: To capture the lived experiences of holding an operational leadership role in the NHS since C19 and to capture the lived experiences of operational leaders' wellbeing during this time.

Methods: Eight semi-structured interviews with NHS operational leaders were conducted. Interpretative Phenomenological Analysis (Smith et al., 2022) was used to analyse the data.

Results: Five Group Experiential Themes (GETs) and 17 group-level sub-themes were found. The findings highlighted operational leaders' intrapersonal experiences (GET one: *reacting to the power of a global pandemic*) and experiences of working within a pressured NHS environment (GET two: *exerting power within a powerful system)*. The findings also highlighted participants' close working relationships (GET three: *being protected and protecting within the NHS),* experiences of navigating the UK public narratives of being an NHS 'hero' in relation to their roles (GET four: *being a public NHS 'hero'*), and personal development and reconnection to what they value 'post' C19 (GET five: *the nourishing and growing of the self*).

Discussion: The results are discussed in relation to the existing literature on other healthcare professionals since the onset of C19 and theoretical ideas in relation to workplace wellbeing. The implications for operational leaders' wellbeing and ways of working during times of high pressure are discussed. The chapter closes with considerations of study strengths and limitations, and a conclusion.

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Chapter One: Introduction

The Context of the Project

Coronavirus-19 in the NHS

The World Health Organisation (WHO) first identified cases of a new version of coronavirus called SARS-CoV-2 on December 31, 2019 in Wuhan City, Hubei Province, China (UK Health Security Agency, 2021). The WHO then labelled the disease associated with this new virus as 'COVID-19' (UK Health Security Agency, 2021), henceforth 'C19'. Since then, C19 has been transmitted all over the world, with significant impact on people's way of life and the systems that we live in.

It is therefore not a surprise that the pandemic has been and continues to be the topic of discussion in relation to the impact it has had on the global economy (Siddiqui, 2020), cultural sectors (Council of Europe, 2021), social care (Comas-Herrera et al., 2020), education (Daniel, 2020) and health and wellbeing outcomes both globally (World Health Organisation, 2021) and in the UK (Groarke et al., 2020; O'Connor et al., 2021).

There have been just under 7 million reported deaths worldwide as of June 28, 2023 related to C19 (World Health Organisation, 2023). It is therefore unsurprising that healthcare systems and professions are at the forefront of discussions about the pandemic, such as the UK's National Health Service (NHS).

Anderson et al. (2021) set out to overview the way UK public health and social care services have responded and argued that, at least in some ways, the institutions showcased strength. This included being able to adapt to new ways of working (such as using technology to deliver care), managing service reorganisation, expanding critical care resources and opening temporary hospitals to address the impact of the pandemic while already managing longstanding issues around limited resources (Anderson et al., 2021).

Still, C19 has also bought much adversity to the NHS. In 2020, the UK ranked seventh highest out of 22 European countries on excess death rates related to C19 and had highest excess death rates for those under 65 years of age in Europe, apart from Bulgaria (Raleigh, 2021). In the UK, since June 16, 2023, there has been a total of 192,228 death certificates identifying C19 as one of the causes of death (UK Government, 2023).

The pandemic resulted in significant increase in demand within acute services due to sickness related to C19 (Propper et al., 2020) as well as in services not directly managing C19. The British Medical Association (BMA) estimated that between April and June 2020, there has been a reduction of 1.5 million elective surgeries, and up to 2.6 million fewer first outpatient appointments attended and thousands fewer being referred for and starting cancer treatment (BMA, 2020).

The C19 pandemic also happened within the context of other ongoing issues within the NHS. This included concerns over staffing levels (Propper et al., 2020) and how this may be interlinked with socio-political events such as Brexit, which likely affected skilled professionals from countries in the European Union supporting the running of the NHS (Fahy et al., 2017). Brexit might also have negatively

impacted on the trading (of pharmaceuticals, medical devices, human tissue transplants), training, research (Fahy et al., 2017; Hervey & Speakman, 2018) as well as the anticipated reduction in UK's economic wealth more broadly (Fahy et al., 2017).

In the 'post' C19 era, there are also pressures for the NHS to 'recover' and regain full capacity to address priorities such as elective care backlogs (Mallorie, 2023). There is also a pressure to 'renew' services to do better based on learning from C19, including the need to focus on staff wellbeing and address the public health inequalities (Charles & Ewbank, 2021). As such, the NHS has and will likely continue to face operational pressures that in some ways have been exacerbated by the C19 pandemic (Turner & El-Jardali, 2020) and that will most likely take time recover from (Mallorie, 2023).

C19 in the NHS: Command-and-Control

During the onset of C19 in the UK, an NHS England national framework called Emergency Preparedness, Resilience and Response (ERPP) was set out. ERPP is strategic guidance and principles that all NHS funded organisations must follow to prepare and manage emergencies (National EPRR Unit, 2015). This framework directly affects the way the NHS is led.

Depending on the incident (e.g., mass casualty due to extreme weather conditions, transport accidents and infectious diseases) a level of severity from one to four is assigned. The framework sets out a response for each level. In January 2020, NHS England deemed C19 to be a level four national incident (Pritchard, 2021) that triggered a Command-and-Control response to the emergency (National EPRR Unit, 2015).

A Command-and-Control response is based on giving direction (command) and applying authority (control) to work toward the needed objectives (National EPRR Unit, 2015). The strategy can be applied at one or more of the organisational levels depending on need (National EPRR Unit, 2015). As noted by Smith (2012), which level the strategy is implemented follows in an ascending order from operational (the 'bronze' level who are responsible for resource management of given clinical areas), tactical (the 'silver' level who are responsible for implementing tactical plans in line with strategic direction) and strategic (the 'gold' level who are responsible for the overall event and usually set the strategic objectives for the organisation).

The framework and creation of various Command-and-Control centres (bronze, silver, and gold) has meant leadership in the NHS since the onset of the pandemic has been more hierarchical and top-down to reduce ambiguity (Dalton, 2020). C19 changed the way the NHS was 'led' and thus far, there is limited research on the experiences of operational leadership posts in the NHS since C19. The next section provides a definition of operational leaders.

Who are Operational Leaders and why are they Important?

Within healthcare "operational management is the design, operation, and improvement of the processes and systems that create and deliver the organization's products and services" (p.21) in the most efficient and effective way in a context of limited and further reducing resource (McLaughlin & Hays, 2008).

As defined by NHS Careers, senior healthcare operational management are responsible for ensuring "that…staff have what they need to deliver effective patient care through the successful planning and delivery of service and resources" (Operational management, n.d.) of the clinical areas they oversee. Within the NHS, operational leaders of clinical services do not have any day-to-day clinical responsibilities in healthcare settings, but do have a more 'hands on' job in comparison to the highest strategic levels of the organisation (National EPRR Unit, 2015).

Senior operational leaders sit within the Triumvirate leadership model conventionally found across UK Trusts (Baylis & Homa, 2017) at the divisional level. The divisional Triumvirate is responsible for overseeing a group of clinical services, departments, or specialities within an NHS Trust. Ham and Dickinson (2008) noted the Triumvirate is made up of a group of three professionals: the medical lead (typically a doctor); the clinical lead (typically a senior nurse) and the managerial lead (an operational manager). Whilst the three leaders in the Triumvirate model work collaboratively to provide a form of 'three-way' leadership, this study is primarily concerned with separating the individual experiences of the third category: the operational leader.

Each professional has different roles and responsibilities. For instance, the head of nursing professional addresses work in a more clinically direct manner (e.g., addressing rates of falls in their division, vacancy rates of staff). The operational leaders, in comparison, take responsibility for overall performance and the effective management of resources that thereby enable clinical work to happen safely. Their roles typically include planning and being responsible for service budgets, meeting Key Performance Indicators, Human Resources responsibilities (such as incident investigations and line management), day-to-day resource operations (such as bed management) as well as future service planning and transformational work.

Operational leaders were likely operating under strain given pressures on the NHS prior to C19 with staff shortages and presenteeism, underfunding, and long waiting times to access NHS services (The King's Fund, 2022; West, 2019). C19 bought about additional strain on operational leaders with, for instance, the noted increase in elective care backlogs (The King's Fund, 2022).

There is currently a lack of literature on the experience of operational leaders having to navigate their posts given such operational strains. This project aims to capture these underexplored experiences.

The next section of the introduction will discuss ideas of leadership and culture in the NHS that may contextualise operational leader experiences. It will acknowledge that the NHS traditional ways of leading have been hierarchical and based on ideas of heroic leadership but that these ways of working are aiming to be replaced by more shared and distributed leadership. The section will also use theory from crisis literature to critique ideas of distributed leadership at times of strain, such as during C19.

NHS Culture and Leadership

Leadership matters because it is linked with organisational culture, innovation, cohesiveness, job satisfaction and the quality of goods and services delivered by an organisation (Van Wart, 2003). As such, academics (and practitioners) have studied the role of leadership within organisations (Gordon & Yukl, 2004) and the way changes in ideology within organisations and societies have affected the way

we think about leadership, how leadership should be done (Van Wart, 2013) and what we understand it to be. Leadership could be understood in terms of tasks and skills set a person has (such as being able to influence and organise others) or the style in which the person approaches their work (Gandolfi & Stone, 2020).

It is recognised that leadership is interweaved within the context in which leadership happens (Gordon & Yukl, 2004; Vogel & Masal, 2015). As such, the next two sub-sections consider leadership in the NHS prior to C19 and during C19.

NHS Leadership Prior to C19

Prior to the pandemic, the importance of NHS leadership had been well recognised. The West et al. (2015) review specifically captured leadership literature in healthcare over the last 10 years. They highlighted that leadership was important for delivering and improving care for service users and making the NHS a place where employees are engaged and satisfied with their work.

West and Dawson (2012) published a review, commissioned by The King's Fund, that looked at the relationship between staff engagement (collected by the NHS staff survey since 2009) and organisational outcomes. Staff engagement was linked with patient outcomes (such as death rates, infection rates, and reported satisfaction with service), staff absenteeism and staff turnover. Factors that were noted to affect staff engagement (and therefore, linked to patient outcomes) included staff feeling their workload was manageable, having clear work-related goals that were meaningful to them and staff perceiving that they were appreciated by their employer (West & Dawson, 2012).

West et al. (2022) used the yearly national staff survey data (N = 63, 156) to illustrate a positive correlation between staff perceived support from their leaders and their perceived influence over decisions (b = .74, p <. 001) and the latter was negatively associated with perceived work pressure (b= -.84, p = .04). A negative relationship was also seen between work pressure and reported patient satisfaction (b = -17.5, p < .001). West and Dawson (2012) and West et al. (2022) can be used to highlight how leadership and leaders affect staff and patient outcomes in the NHS.

A study by Shipton et al. (2008) with N = 17, 799 UK healthcare staff highlighted that perceived senior leader effectiveness within their own organisation (such as whether they perceived the organisation to be effective in meeting patients' needs and safety, whether it offered exciting opportunities, and considered staff needs when implementing changes) was positively and significantly associated with higher clinical governance review ratings (b = .42, p <. 05) and lower patient complaints (b = -.57, p < .05). Gilmartin and D'Aunno (2007) systematic review highlighted a link between leadership and work satisfaction, performance, and staff turnover.

It is evident that professionals in leadership positions affect staff, patient, and overall organisational outcomes. As such, there are ideas about how leadership in the NHS 'should' be done and one of the key ideas is distributed leadership (West et al., 2014). Distributed leadership is also the approach that has influenced the projects understanding of leadership in the NHS. This is because this way of leading has been adopted as the key current policy approach that aims to improve services and create a patient-centred culture in the NHS (Martin et al., 2015). It also supported the project to consider the possibility of leadership being present (and needed) at all levels of the system.

Distributed leadership is the idea that leadership is shared at all levels of the NHS organisation, rather than relying on the great and 'heroic' actions of leaders in authority positions or Command-and-Control ways of leading (The King's Fund, n.d.). The latter align with early ideas of the Great-Man theory of leadership that assumes some people are born with a greater propensity to be leaders than others (Benmira & Agboola, 2020; Khan et al., 2016) meaning leadership is restricted to few people that possess natural leadership abilities and 'do' leadership to other people. The framework also notes that structures that empower only a few 'heroic' leaders is no longer be suitable for the NHS; there is a need for multiple collaborative relationships within NHS structures, and with many external organisations and stakeholders to deliver service goals (The King's Fund Commission, 2011). Thus, having a few 'great-man' leaders no longer fits with the complexity of NHS functioning.

Instead of the traditional heroic ideas of leadership, distributed leadership in the NHS aims to support everyone to be invested and committed to learning and improving at all levels of the system (West et al., 2014). This collective leadership approach in the NHS allows the system to benefit from the full expertise of professionals that make up the NHS (The King's Fund, n.d.). As an alternative to the traditional few leaders taking the 'hero' status, or conversely being blamed for failures (Martin et al., 2015), one of the proposed strengths of distributed leadership is that an emphasis on collective effort would mean staff welcomed feedback and used errors as opportunities for organisational learning rather than directing individual blame (West et al., 2014).

The next sub-section will use crisis literature to note that distributed leadership at a time of uncertainty, such as C19, may have its limitations (e.g., lack of direction when there is no clear leader). While the study is not focussed especially on what makes up 'effective' leadership at a time of crisis, the section aims to offer important conceptual context for the experiences of operational leaders captured in this study.

NHS Leadership During C19

What constitutes a 'crisis' can be varied based on the discipline that is studying it, such as management literature, business, psychology, and public administration (Wu et al., 2021). However, some common characteristics of a crisis appear to include the event happening quickly, unexpectedly and in a way that threatens an organisation's goals (Firestone, 2020). This appears to fit with the C19 pandemic being an unexpected event that meant NHS systems had to be reactive to the threat it posed to the delivery of healthcare services.

Crisis literature explores the type of organisational leadership that is important during a crisis, mainly focusing on transactional or transformational leadership. These are leadership theories that emphasise leadership being an *interaction* between a leader and a follower (Gordon & Yukl, 2004; Vogel & Masal, 2015) unlike the Great-Man ideas of leadership.

Transactional leadership acknowledges there are leader and follower exchanges (Khan et al., 2016) and that these exchanges are based on a reward (praise) and punishment (avoidance of disciplinary actions) based on the follower's ability to succeed or fail in reaching a clear organisational goal that had been set for them by their leader or organisation (Bass et al., 2003; Van Wart, 2003; Wright & Pandey, 2009).

Transformational leadership is about inspiring and motivating followers (Antonakis & House, 2014) through optimism, innovation and creativity while also considering the unique needs of the followers to support them with achievement and growth (Avolio et al., 1999 as cited in Bass et al., 2003). Transformational leaders share compelling and charismatic influence that results in shared goals held by leader and follower (Khan et al., 2016) resulting in followers feeling empowered to move toward organisational values (Wright & Pandey, 2009).

Some crisis literature suggests that there is a need for transactional leadership (Vera & Crossan, 2004) while others suggest more transformational approaches (Dwiedienawati et al., 2021; Joniaková et al., 2021; Wu et al., 2021). Vera and Crossan (2004) argued that during organisational crises where there are high levels of uncertainty and risk, transformational leadership behaviours were most suitable. This is because leading through vision and using charismatic traits will support people to see the need for change and also frame the change as an opportunity (Vera & Crossan, 2004).

However, some researchers suggest that such transformational leadership could be seen as unhelpful or destabilising if the followers are unable to see a need for change, which is actually more likely to be true within unstable organisations (Geier, 2016; Vera & Crossan, 2004). Thus, transactional leadership with clear expectations and goals might be more valuable in such a context.

It is important to note limitations of using crisis leadership theory in the NHS. Some of the crisis literature is based in the field of applied psychology meaning it encompasses various settings including looking at terrorist attacks, presidential elections, relatively short-term crises (e.g., fires), and businesses experiencing financial crises. Moreover, their understanding of crisis appears to be a single event that threatens organisational goals. It could be argued that the NHS has been in 'crisis' since before C19 given the longstanding challenges of the NHS aiming to meet rising demands on services with limited resources (Newitt, 2022).

Nevertheless, ideas from crisis literature acknowledges that when uncertainty and destabilisation are high (as could be argued was the case in C19), usual ideas of distributed leadership may not offer enough direction or order needed to mobilise an effective response in a 'crisis' (Collins, 2020). Clear direction and expectation from a leader may be reassuring and containing at times of uncertainty. C19 triggering a Command-and-Control response in the NHS aligns itself with transactional leadership and traditional Great-Man ways of leading that emphasises externally-set top down compliance with performance and targets (Ham, 2016). The very existence of the Command-and-Control response is perhaps a legacy of the traditionally hierarchical ways of working in the NHS.

While Command-and-Control may offer a direction, the inflexibility of such top-down ways of working can discourage the processes of, for instance, identifying and amending errors, accessing support outside of this structure, and can leave frontline demoralised (Collins, 2020). This study may be able to provide lived-experiences of leaders navigating an NHS Command-and-Control response among ideas of the NHS culture needing to be based on collaboration and distributed leadership (Ham, 2016).

Given the pressures that have faced the NHS since the beginning of the pandemic, it is also important to consider the wellbeing of leaders during this time. The next section will highlight that despite the general acknowledgement that these leaders form an important part of the healthcare

service, there is much less known about the wellbeing of underrecognized leadership roles such as operational leaders.

The section will suggest that leaders' wellbeing is important given the possible strain and pressure of being in leadership posts even prior to the pandemic. The section will then overview the theoretical ideas around wellbeing that contextualises the study before considering empirical evidence of psychological wellbeing of professionals working in healthcare since the onset of C19. It will be noted that the empirical literature often focuses on patient-facing roles such as doctors and nurses and thus far has not acknowledged UK NHS operational leaders. This is the research gap that this project seeks to address.

The NHS and Workplace Wellbeing

Workforce Wellbeing: What's it like to work in the NHS?

Employee wellbeing has been highlighted in the NHS by C19 (Newitt, 2022). However, this consideration is not entirely new. A landmark report by Boorman (2009) into NHS wellbeing noted that NHS staff sickness (average 10.7 days per year for a professional in a whole time equivalent post) was higher than other public sector departments (average of 9.7 days per year). Just over 45% of staff sickness rates was accounted for by musculoskeletal disorders and just over 25% was accounted for by emotional distress, such as anxiety, depression and stress (Boorman, 2009). While sickness rates is only one way to conceptualise wellbeing, Boorman used this data to note that staff wellbeing should not be an afterthought given the implications of financial costs of sickness and turnover, poorer quality and disrupted patient care, staff disengagement with work (BMA, 2018; Boorman, 2009), and of course poorer wellbeing of the individuals themselves.

Since then, some have suggested that staff wellbeing in the NHS appears to have seen limited change (Bajorek & Holmes, 2020). The national average NHS sickness absence rate for 2023 is nearly double (4.5%) that of the overall UK labour market (2.6%) and still higher in comparison to other public sector workers (3.6%) and the private sector (2.3%) in the latest 2022 statistics (NHS Digital, 2023; ONS, 2023).

Even prior to the pandemic, stress, anxiety, and depression were the named primary reasons for sickness absence in the NHS (NHS Digital, 2019) and this remains true with the latest data showing these to account for 25.5% of all absences or 472, 500 full time equivalent days lost (NHS Digital, 2023). The most recent NHS staff survey results from 2022 (NHS Staff Survey, 2023) acknowledged a continuing need to think about staff wellbeing in the NHS with 44.8% of staff reporting experiences of work-related stress, which is a small reduction from the 2021 staff survey data (46.9%), and experiences of feeling worn-out (46.3%), frustrated (39.9%), emotionally exhausted (37.4%) and burnt-out due to their work (34%) in the last 12 month period. As such, there is a clear need to improve working conditions given the implications for the professionals' health and organisational outcomes.

The next sub-sections will highlight that while leaders have a role in improving these working conditions of the NHS, overall, the literature (in and outside of the C19 pandemic) has offered less consideration to the wellbeing of these leaders themselves. As part of this, considerations will also be

made for the challenges faced by healthcare leaders as well as relevant workplace wellbeing theories that may be used to understanding NHS leader experiences.

Workforce Wellbeing: NHS Leaders

Although the research specifically on operational leaders is limited, leaders in general are acknowledged in the NHS as important not only for service delivery but also for improving NHS staff wellbeing through initiatives such as the NHS operational planning guidance 2021/22 (NHS England, 2021a), the NHS Long-Term plan (NHS England, 2019) and the NHS People Plan (NHS England, 2020).

These initiatives recognise that NHS employees are working under strain. They also offer plans that aim to improve the NHS as a place of work and to also attract others into NHS professions. The NHS Health and Wellbeing Framework (NHS England, 2021b) specifically highlights the role of leaders and managers in creating and sustaining a health and wellbeing culture, demonstrating the impact that they have on the wider system and teams they oversee. Leader roles include ensuring that wellbeing remains on senior leaders' agendas, and leaders and managers having the right skills to support the wellbeing of others and themselves.

Overall, though, there has been less acknowledgement of operational leaders' own wellbeing despite the NHS seeking to be a 'good' place of work for all (NHS England, 2020). Thus, this is an important area to study because wellbeing of those in leadership positions matters as much as any other employee. Moreover, while this is beyond the scope of the study, there is some suggestion of a bidirectional relationship between leader wellbeing and leadership behaviours and styles (Bachman et al., 2023). This, set against the acknowledgement that leadership impacts staff wellbeing and service outcomes, further emphasises the importance of considering leader wellbeing in the NHS.

There is some evidence suggesting that leadership positions in the NHS, even prior to the pandemic, are difficult to hold. For instance, a 2015 poll by The King's Fund and collaborative partners, as cited in (Darzi, 2018), found one in six NHS Trusts to have a vacancy at the chief executive officer (CEO) role and retention for this role was 2.5 years, with one in five professionals staying in the role for less than a year.

A report by The The King's Fund (2018) recognised that these recruitment and retention issues in NHS leadership positions may be related to leaders having to manage significant pressures. Leaders must navigate and are responsible for meeting significant demands and targets within the NHS Trusts that they work in. Leaders are also often provided with limited funding to achieve these demands and targets (Darzi, 2018). Thus, the high pressure and expectations with restricted means to achieve them perhaps leaves leaders feeling disempowered (Darzi, 2018). Leaders are also having to navigate these systemic NHS challenges within a culture where they may feel overly responsible for failures of service performance (The King's Fund, 2018).

NHS managers and leaders are also responsible for managing multiple competing and complex demands (Jones et al., 2022). C19 has placed additional work-related pressures alongside these longstanding demands such as increased need for care with waiting list backlogs (Jones et al., 2022). There has also been some recognition that pressure and change was especially present in acute Trusts

(Propper et al., 2020), which in part could be related to C19 resulting in many patient admissions (Mahase, 2020).

Given these potential work-related pressures and possible impact on leader wellbeing, the next section will consider key theoretical wellbeing frameworks that may be relevant for this project. This will then be followed by a summary of empirical literature into the wellbeing of healthcare professionals in C19. It will be concluded that despite these potentially pressured roles there is limited research on certain leadership positions in the NHS since C19 including operational leaders' wellbeing.

Wellbeing: Definitions and Theories

Occupational wellbeing literature acknowledges that better wellbeing at work means that people are engaged and satisfied within their roles, resulting in better individual mental and physical health (Sethi, 2022). However, defining workplace wellbeing can be challenging in itself (Simons & Baldwin, 2021) and there is a variety of theoretical conceptualisations contextualising this project.

A key marker of wellbeing in occupational research is job satisfaction (Bakker & Oerlemans, 2011). There are several theories aiming to explore and explain this marker of workplace wellbeing (Thangaswamy & Thiyagaraj, 2017). One theory is the motivational two-factor theory of job dis/satisfaction by Herzberg et al. (1959) that suggests job satisfaction is based on a person's intrinsic and extrinsic values (Aryanti et al., 2020). Dissatisfaction factors were related to external factors (such as wages, working conditions and policies) and higher job satisfaction was present when aspects of the job met the intrinsic needs of the employee such as personal and career growth, enjoyment of achievement at work, and recognition.

Another theory that has been used in the workplace wellbeing literature is the Self Determination Theory (STD) by Ryan and Deci (2000). This theory proposes a person has inherent psychological needs (autonomy, competence, and relatedness) that enhance their development and wellbeing when met. West (2019) highlighted that all three STD factors are needed for workplace wellbeing and suggested that NHS professionals often do not experience autonomy within NHS systems because NHS ways of working can emphasise hierarchical and bureaucratic processes. Thus, considerations of autonomy may be important for the experiences of operational leaders' wellbeing at the time of the pandemic where hierarchical Command-and-Control mechanisms were emphasised.

Some limitations of the two-factor theory (Herzberg et al., 1959) and STD (Ryan & Deci, 2000) is that these models do not account for the influence of context and culture (Ahmed, 2016). For instance, in the former theory, factors that lead to workplace dis/satisfaction may vary depending on culture and context, which is considered in the Job Demands-Resource (JD-R) model.

The JD-R model proposed by Bakker and Demerouti (2007) aimed to explain occupational stress through an imbalance of job 'demands' and job 'resources'. It is based on the motivation theory of Conservation of Resources (Hobfoll, 1989, 2001) that assumes a person wants to seek gains, prevent losses of resources, or when this is not fully possible, minimize loss (Bon & Shire, 2022).

Bakker and Demerouti (2007) defined job demands as "physical, psychological, social, or organizational aspects of the job" (p.312). Job resources are factors that support to manage job demands and can be motivational in their own right. They can be "located at the level of the

organization at large (e.g., pay, career opportunities, job security), the interpersonal and social relations (e.g., supervisor and co-worker support, team climate), the organization of work (e.g., role clarity, participation in decision making), and at the level of the task (e.g. skill variety, task identity, task significance, autonomy, performance feedback)" (pp.312-313).

JD-R suggests occupational stress occurs if there is threatened or actual loss of resources or a person is unable to acquire resources after investing a significant number of said resources, leading to experiences such as burnout (Hobfoll, 2001), with burnout being defined as the a response to prolonged job stressors leading to perceived lack of efficiency or accomplishment, depersonalisation and detachment from work, and physical and mental exhaustion (Maslach et al., 2001). On the other hand, when job resources exceed job demands, there is improved engagement with work, job performance, and positive wider morale (Bakker, 2015; Demerouti et al., 2001).

The JD-R model has been critiqued for not offering enough explanation into how, for instance, significant job demands may lead to exhaustion, and that other additional explanatory models may be needed to explore interactions between specific resources, demands, and outcomes (Schaufeli & Taris, 2014). However, the JD-R is a salient model that has informed this project's conceptualisations of workplace wellbeing. This is in part because the JD-R model has been recognised as a well-researched model that helps to consider positive and negative outcomes and can consider many 'resources' and 'demands' (Schaufeli & Taris, 2014). This may offer scope to understand the variety of possible work-related experiences of operational leaders, which may be important given the relatively exploratory nature of the project.

The model also offers flexibility to consider context (Schaufeli & Taris, 2014). Hobfoll (2001) recognised that a person's resources will be culture-dependent (e.g., how important some of these resources are) and that, for instance, a Western workplace may emphasise and include resources of possessions (e.g., income), and conditions of work (e.g., stable employment) to name a few. Culture can also include the organisational culture because the beliefs, rules, and values shared among an organisation's members can impact job demands and resources and so wellbeing and work-related stress (Lopez-Martin & Topa, 2019). For operational leaders in the NHS since the onset of C19, their experiences of demands and resources could be affected by contextual expectations around work patterns, Command-and-Control ways of working, and increasing workloads in the NHS more widely (BMJ, 2018; Ravalier et al., 2020; West, 2019).

Interestingly, the literature acknowledges that the wellbeing of leaders has been largely neglected even within the wider occupational research (Barling & Cloutier, 2017; Byrne et al., 2014; Geibel et al., 2022; Li et al., 2018). There are speculative reasons for this. One of the possibilities is the assumption that leader's work-related stress is buffered by their personal resilience and 'strength' which is an assumed part of their role and an additional resource they have (Barling & Cloutier, 2017; Cloutier & Barling, 2023). This assumption may be incorrect for some leaders and thus affect their abilities to access support for their wellbeing (Cloutier & Barling, 2023).

There is also some suggestion that leaders already have 'better' wellbeing before they are recruited into leadership posts (Asselmann & Specht, 2023; Cloutier & Barling, 2023) and that once in a leadership position, their wellbeing is in part supported by having more power within the leadership role

but and also negatively affected by the stress of those positions (Asselmann & Specht, 2023). The proposed relationship between leader wellbeing and the possible increase of power and stress within leadership roles may be explained by the Job Demands-Control (JD-C) model.

The JD-C model (Karasek, 1979), as an extension of the JD-R model, aims to account for occupational stress. It focuses on job characteristics to explain and predict mental stress at work using concepts of job 'demands' (such as psychological stress and pressure of completing work, conflicting or unexpected tasks) and job 'control' (such as authority to make decisions and ability to influence). Job control appears to have been an emphasized as a job 'resource' that leaders may have easier access to as suggested in the JD-R model. While it is unclear why autonomy may act as a resources for leaders (Bakker & Demerouti, 2007), there is evidence to suggest that that when job demands are high, and control over how to meet those demands is low, 'job strain' is the result. Job strain is linked to sleep issues, depression, anxiety, and exhaustion (Karasek, 1979). The JD-C, or considering autonomy as 'resource' in the JD-R, may offer an understanding into experiences of working within a Command-and-Control context of the NHS.

Empirical Literature

Empirical literature on healthcare staff wellbeing since the onset of C19 is provided next. The empirical literature is separated into patient-facing professionals (generally doctors and nurses) and other healthcare leadership roles. The section will highlight a lack of literature exploring operational leaders' wellbeing since C19 in the UK.

Patient-Facing 'Frontline' Staff Wellbeing Since C19. The literature has captured the experiences of work and psychological distress of patient-facing health professionals, mainly focusing on doctors, nurses, and healthcare assistants across the world. For instance, a scoping review by Chemali et al. (2022) summarised 161 qualitative papers on the experience of being a healthcare professional working during C19 and highlighted staff experiences of anxiety around C19 transmission, changes to daily work routines, and experiencing a work life imbalance.

Gilleen et al. (2021) conducted a survey specifically with UK healthcare professionals with the aim of capturing wellbeing during the pandemic. The authors used social media, approached professional networks, and contacted all 262 UK NHS Trust Research and Development departments. Fifty-two Trusts agreed to disseminate the survey meaning the results may be impacted by a possible self-selection bias in the Trusts represented and staff captured via social media. The final sample comprised of *N*= 2,773 healthcare workers with 91% of the sample working in the NHS and the rest in private hospitals or unspecified 'other' areas. The NHS professionals captured in the study were mainly in hospital settings (51%), followed by community services (21%) and then mental health trusts (14%).

The results of the study echoed those above by Chemali and highlighted the psychological distress experienced by the patient-facing professionals. A third of healthcare professionals experienced anxiety and depression ranging between moderate to severe (as measures by Generalised Anxiety Disorder-7 and Patient Health Questionnaire-9 scales, respectively) and fell in the top quartile on the Perceived Stress Scale, which measures the person's perception of stress in the last month (Cohen et al., 1983). Of the sample, 14.6% scored above the cut-off score for 'high' Post-Traumatic Stress Disorder

(PTSD) as was indicated by a score of ≥26 on The Impact of Event Scale-Revised. As part of the survey, authors asked the participants to recall their wellbeing from pre-to-during C19 via a non-standardised self-reported measure of stress, low mood, and anxiety. All ratings increased from pre-to-during C19. It is important to note that the pre-pandemic scores are retrospective rather than longitudinal meaning there are effects of recall bias. Nevertheless, they are still helpful in telling a story about the difficulties experienced by health professionals during C19 and links to psychological distress.

The role of anxiety within professionals' experiences during C19 was further explored by Beck and Daniels (2023) who conducted a more recent study on healthcare professionals (mainly doctors and nurses) in the UK (N = 342). The findings noted experiences of, for instance, psychological distress being significantly associated with fear of contamination (r = .50, p < .05) and social support (r = -.23, p <. 05). The results also demonstrated a positive correlation between intolerance of uncertainty and psychological distress (r = .50, p < .01). Psychological distress was measured by the Depression Anxiety Stress Scale (Lovibond & Lovibond, 1995) and uncertainty was captured by an Uncertainty Scale (Carleton et al., 2007). As identified by Beck and Daniels, the study is limited by its cross-sectional design and their data being collected at a time when there was a lack of clarity over how C19 was transmitted. Given the multi-wave nature of the pandemic, the results only capture a snapshot of possible experiences.

Alongside 'negative' emotional experiences associated with wellbeing, Aughterson et al. (2021) noted some more 'positive' factors in their interviews with 25 UK health and social care staff. The sample included hospital-based doctors (6), nurses (3), general practitioners (4), social workers (3), and psychotherapist (1). The authors explored the psychosocial impact of C19 on these professionals. Some of their findings highlighted work related stressors such as fearing transmitting C19 to family and increased workload. The results also highlighted themes of 'support structures' (such as experiences of unity through C19), 'individual resilience' (such as accepting uncertainty and connecting to the purposefulness of contributing at work), and 'personal growth' at this time of pressure (such as participants reflecting on what mattered to them in their lives such as time with family). While the diversity of the sample used by Aughterson and colleagues may provide a breadth to the results, the specificity of certain work contexts and job roles may have been lost. This is an important consideration given that job roles may have emphasised different demands and responsibilities that are not captured.

Healthcare Leader Wellbeing Since C19. Clinical professionals (such as doctors and nurses) can be considered clinical leaders as they may have organisational management responsibilities (NHS Improvement, 2019) thus there is overlap between 'patient-facing' staff and leaders. There is literature specifically acknowledging experiences of clinical leaders (such as nurse managers) and other leader positions (such as operational and strategic leadership and management posts). However, these are generally non-UK studies as summarised next.

Leppäkoski et al. (2023) conducted a systematic review looking to capture the experiences of nurse managers in C19. The review included 14 studies: 11 qualitative, two quantitative, and one mixed method (none were UK based). The Joanna Briggs Institute Critical Appraisal Tool Catalogue (Joanna Briggs Institute, 2020) was used to systematically evaluate the quality of data. The studies were deemed

'good' quality with all scoring between 65%–85% of the total (Leppäkoski et al., 2023), supporting the results' trustworthiness.

The study's content analysis yielded five themes. The theme of 'expanding and changing of role' encompassed the quick changes at work during C19 and thus the need to be adaptable. For some nurse managers, C19 resulted in their leadership values being threatened through the top-down decision-making processes bought about the pandemic (Hølge-Hazelton, Kjerholt, et al., 2021).

The second theme was 'safeguarding the wellbeing of staff' where nurse leaders had to provide PPE and took the responsibility of acknowledging the anxieties and stresses of their personnel to keep them resilient. The third theme referred to 'communication': the need to ensure concise and relevant information is shared with their staff. Theme four acknowledged the 'support received from the staff and coworkers' such as their experience of peer support, support from their own superiors, and greater collaboration with others in their work, although this experience did not feel universal with some feeling isolated (Hølge-Hazelton, Zacho Borre, et al., 2021).

The last theme acknowledged the 'development and learning' of their managerial performance, and recognition of their abilities to manage crises. They also noted their ability to learn new skills (such as mastering technological skills) and be innovative and adaptable during C19. There was some recognition of how pandemic experiences led to perceived professionals' strength and development, such as being able to delegate more.

Aydogdu (2023) reviewed 12 qualitative and quantitative primary data studies to explore experiences of nurse manager roles in C19 (none were UK based). The key findings noted the changes in nurse managers' experiencing greater 'workplace demands' such as greater emphasis on staff and safety (e.g., infection prevention), resource availability (e.g., staffing) and difficult decision making. The findings also noted the negative 'impact on physical and psychological health' of work on these nurse managers. These included experiences of tiredness, worry and anxiety about being infected and infecting others with C19, depression, significant emotional labour, and a perceived lack of recognition for the roles and tasks they took on.

There were also some key 'positive' experiences highlighted by Aydogdu such as the theme of 'coping measures and resilience' which included being able to be creative, using their abilities to plan, feeling pride in their roles, organising training, and sharing knowledge with others (e.g., via social media). The findings also noted how C19 allowed for some self-development of, for instance, leadership skills and an improved ability to work together as was also noted in Leppäkoski et al. (2023). Although the study by Aydogdu (2023) is limited by the process of integrating studies with various methodologies resulting in the authors analysis being more descriptive rather than analytic, it highlights a range of possible experiences of healthcare leader work and wellbeing in C19.

Other non-UK empirical evidence has included: experiences of 27 senior and executive leaders in a tertiary Australian health service captured via interviews (Smithson, 2021); 18 healthcare leaders and organisations in Canada captured via interviews (Hartney et al., 2022); 12 hospital managers and

administrators in Arizona, USA via focus groups and interviews (Frank, 2023); and a survey with Swedish hospital managers (Björk et al., 2023). The key findings of these are summarised next.

Hartney et al., (2022) used Grounded Theory analysis to explore what practices are needed in healthcare leadership. The results included: being responsive to emotional experiences (e.g., anxiety) of themselves and others, being decisive in their communication, and being adaptable and integrative of a variety of views to accelerate innovation at this time. These ideas were based on interviews with healthcare leaders (such as senior leaders) and also leaders and organisations involved in working on healthcare decision-making, such as academics. These findings offer ideas how a leader 'should' behave in C19 but do specifically look to capture lived experiences of leading.

Frank's (2023) study noted that healthcare leaders experienced a need to be visible and supportive of their staff, have a flexible and creative approach to adapt to changes in their work, and emphasised needing to be relational by sharing information, collaborating, connecting with others, and relying on mutual support. Alongside the study only capturing a specific region of leaders (Arizona), the study used thematic analysis which the authors noted to be descriptive rather than interpretative. This likely limited the depth of the findings.

Smithson (2021) acknowledged that Australian leaders led with directive Command-and-Control principles (which may have been similar to UK Command-and-Control mechanisms) and that they experienced a discomfort in leading in such a way if this was not their usual leadership style. Similarly to Frank's (2023) study, the depth and analytic nature of the findings may be limited; the findings are based on a Thematic Analysis from researcher notes that were made during the interviews rather than interview transcriptions from recordings. As such, there is scope for researcher bias affecting the results through the sole use of researcher notes, and retrospective recall.

Despite Smithson (2021) study's limitations, it did acknowledge possible experiences of discomfort in using directive leadership. Another study that emphasized leader experiences of work was Björk et al. (2023) who focused on wellbeing of Swedish healthcare leaders using the JD-R model (Bakker & Demerouti, 2007). The author's survey method noted that leaders experienced an increase in 'demands' at work (such perceiving a more unreasonable quantity of work), reduced job 'resources' (having less emotional support at work and being unable to plan their work day), reduced job motivation (such as not looking forward to going to work), and poorer work-life balance (such as having less energy to engage in other activities in their lives after work, and feeling less rested from work after a few days off). These patterns were more prominent in departments where there was high C19 exposure.

Björk and colleagues were able to capture a large sample of managers ($N = 647$) and explored leader workplace wellbeing, which has been less recognised. However, the study is limited by its survey method, which offers limited depth and opportunity for exploration through the pre-determined nature of surveys. Moreover, the sample captured included operational managers, strategic managers, and managers with 'limited' managerial responsibilities. The authors do not operationalise this further, thus limiting applicability and specificity of the findings as leaders may have had different experience of their work conditions given their different roles and responsibilities in systems.

Overall, UK healthcare leaders appear to have received much less attention since the beginning of the pandemic. The aforementioned Gilleen et al. (2021) survey with N= 2,773 respondents across 52 UK NHS Trusts also collected some empirical data on the psychiatric symptoms experienced by 'management' specifically during the pandemic in the UK. The authors reviewed some stable risk factors (such as occupation) and compared wellbeing measures between doctors and all non-doctor roles. They found that non-doctors (this included managers and healthcare workers) had higher PTSD symptoms. Authors noted that 'high' PTSD symptoms were 5.2 times (p < .0001) more likely to be self-reported by managers (in comparison to doctors). That is not to say that doctors did not experience symptoms of PTSD, although Gilleen et al. (2021) speculated that PTSD rates might be higher in management due to pressures and changes brought about by C19, threats to self and others, and management of ethical dilemmas, such as being aware of the difficulties with treating patients while also struggling to keep their own staff safe.

An important limitation to the survey method used by Gilleen and colleagues is that professionals labelled as managers had self-identified as such, meaning there is likely variability in the roles included in the sample. It is unclear who the 'management' sample is and thus, who else in the NHS the findings may be applicable to.

In summary, much of the evidence captures the experiences of nurse leaders (e.g., Aydogdu, 2023) and where the literature does acknowledge other leadership positions, such as operational and strategic leaders, the evidence exists only outside the UK (e.g., Frank, 2023).

Considering the UK context is important because the leadership of the UK healthcare systems may differ to that of other countries due to pre-existing healthcare organisational structures, the cultural and social norms of different places, and variations in the governments' responses to the pandemic (Sumner & Kinsella, 2021). For instance, while Sweden and UK both had high mortality rates in comparison to other European countries, Sweden's control measures around C19 were voluntary rather than mandatory like in the UK (Mishra et al., 2021). It is possible that healthcare professionals' experiences and sense making of work may have been affected by such differences in government approaches to C19.

Moreover, the evidence captures *what* leaders had to do or 'should' do as part of their leadership roles, such as communicate and collaborate with others (e.g., Hartney et al., 2022) however, there is less literature into lived experiences of these roles and where literature is available, it has several methodological limitations. This includes studies capturing a variety of leadership positions that are sometimes not well defined (e.g., Björk et al., 2023), which limits the applicability of the findings. Some studies also use descriptive rather than analytic research methods (e.g., Frank, 2023; Smithson, 2021) or offer survey results (e.g., Björk et al., 2023; Gilleen et al. 2021). While this gives us some ideas about the experiences of holding these leadership positions, such findings may have limited depth. For instance, reliance on researcher pre-determined surveys does not give leaders the opportunity to express complexity of lived experiences that are important to them.

Thus, this project aims to clearly operationalise the operational leadership position it is interested in to gain specificity. There is also a need to explore leader experiences in the UK context.

Finally, the project aims to take an analytic and explorative approach to capturing the lived experiences of holding operational leadership positions and leader personal wellbeing since the C19 pandemic as thus far this is missing from the literature.

Rationale for Current Study – How will the Study Address the Research Gap?

The key points from the introduction and rationale for this project are summarised below:

- Leaders are important for the functioning of NHS services and for promoting their staff wellbeing and retention, and in turn, for effective service delivery.

- The C19 pandemic has bought on further strain onto the NHS system and changed ways of working (such as greater Command-and-Control), which has likely affected leaders' experience of their roles during this period. Leadership theories contextualising the project offer ideas about what leadership could look like in and outside of a 'crisis' (e.g., distributed leadership versus more traditional directive ways of working). Using an explorative qualitative methodology may capture the complex experience of holding and navigating such ways of working at an unprecedented time such as C19.

- Thus far within the NHS, there is less known about the experience of operational leaders, who are defined as those leaders responsible for the performance and safety of clinical services but who are not delivering direct patient care. Thus, this project aims to capture these professionals' experiences of holding leadership roles in the NHS (research question one).

- Moreover, operational leader roles likely include significant operational pressures and strain, some of which have been longstanding prior to the C19 pandemic. Thus far, there has been limited consideration of NHS operational leaders' wellbeing within the literature which mainly captures experiences of patient-facing professionals and clinical leaders such as doctors and nurses. Other research into healthcare leaders' experiences of work and their wellbeing since C19 have been non-UK based. The available literature exploring ideas of wellbeing of healthcare leaders is also limited by methodological considerations including capturing diverse sets of healthcare leaders (e.g., Björk et al. 2023), and the use of less in-depth methods of research such as surveys (e.g., Gilleen et al. 2021), and descriptive qualitative analyses (e.g., Frank, 2023). As such, there is an opportunity and a need to take an analytic and a rich explorative research approach to understand the UK operational leaders' experiences of wellbeing since the onset of C19 (research question two).

Research Questions

1) What have been the lived experiences of working as an operational leader in the NHS since the beginning of the COVID-19 pandemic?
2) What have been the lived experiences of wellbeing of operational leaders in the NHS since the beginning of the COVID-19 pandemic?

Chapter Two: Method

The chosen methodology for this project is Interpretative Phenomenological Analysis (IPA). This section will cover the rationale for using this methodology, and where this project sits in relation to its epistemological and ontological positions. It will also provide further information on IPA and alternative methodological approaches considered, describe the methods used in this project including procedure, followed by the process of analysis and steps taken to assure quality.

Qualitative Approach

Qualitative approaches can offer an understanding and insight into the meaning, experience and viewpoint of the participant within their unique social world (Hammarberg et al., 2016; Mason, 2002). Such research is becoming an important method of exploration within psychology and is moving away from being considered just as the pre-cursive stage to quantitative research (LaMarre & Chamberlain, 2022). Qualitative research can also be used to capture the rich and complex experiences of those who are rarely otherwise heard (Sofaer, 1999).

There are many different types of qualitative research. For this project, IPA was chosen because it is concerned with taking an in-depth approach to understand a person's subjective experience and meaning making in-relation-to a phenomenon (Smith et al., 2022). This is in line with the aims of the project to understand the lived experience of holding an operational leadership position in the NHS and their sense-making of their wellbeing since the onset of C19.

Ontological and Epistemological Position

There are two key concepts that are important to acknowledge within research: ontology and epistemology. Mason (2002) stated ontology "involved asking what you see as the very nature and essence of things in the social world" (p.15). That is, ontology is concerned with exploring existence and what makes up reality. Epistemology is the philosophical study of knowledge: what knowledge is and when and how can we acquire it (Willig, 2013).

Ontology and epistemology are intrinsically linked because our understanding of the very nature of what reality is will in turn affect what knowledge (or research data) we believe we can capture (Mason, 2002). Ontological and epistemological positions sit on a continuum and are outlined next.

Ontology

At the furthest ends of Ontology are positions of Positivism (or sometimes called Realism) and Relativism (or sometimes called Anti-Realism). Positivism assumes that one can directly access the world, meaning there is something real and objective that can be captured without it being affected by the processes and contexts of the individual perceiving this reality (Willig, 2013), such as the researcher or participant. This position does not account for subjective interpretations that may affect the process of research and the acquirement of knowledge (Andrews, 2012).

Relativist positions assert that we are unable to capture any 'truth' or any knowledge of the world at all because they see the essence of reality as always being subjective and 'relative' to the

person. (Willig, 2013). A limitation of this position lies with the suggestion that it is impossible to really capture or 'know' anything and that no one reality can be prioritised over another as they are all subjective (Andrews, 2012).

A position somewhere in between these two ends is Critical Realism (CR). This position assumes there is an external reality, but that we are unable to access this reality without it being affected by a person's own interpretation and sociohistorical context (Danermark et al., 2002). This is the position the project aligns with because it avoids the pitfall of assuming the world can be accessed without subjectivity, as in the Positivist position, but does not suggest the scepticism of 'everything is relative', as in the Relativist position (Danermark et al., 2002; Patel & Pilgrim, 2018).

Epistemology

Epistemological positions also exist on a continuum and relate to ontological stances. Positivist ontologies take a Positivist epistemology: knowledge of the world can be accessed through objective, measurable and verifiable observations (Vanson, 2014). Relativist ontological positions can link to Interpretivist (Vanson, 2014) or radical constructionist epistemological positions. That is, realities are entirely subjectively created by individuals that are affected by culture, history, and the use of language (Willig, 2013) and thus data captured focuses on people's personal experiences and creations of meaning (Vanson, 2014).

The epistemological position that aligns with CR, and the position of this project, is Contextual Constructionism. Contextual Constructionism asserts "knowledge, while validated with reference to the world, remains relative and incomplete" (p. 67) and that humans actively make sense of their realities within a context (Jaeger & Rosnow, 1998). 'Contexts' may include the researcher and participant factors around culture, time, ethnicity, age and gender (Jaeger & Rosnow, 1998; Madill et al., 2000). This is congruent with the aim of this research because it is not aiming to seek an 'objective' reality or one 'truth' and instead aims to understand the subjective viewpoint to participant experience of their leadership roles and wellbeing. This is in line with IPA, which also emphasises subjective meaning making and aims to capture an experience of a phenomenon (Smith et al., 2022).

Alternative Methodologies Considered

Grounded Theory (GT)

GT (Glaser & Strauss, 1967), similar to IPA, can also be used when little is known about the area of interest (Tie et al., 2019) and aims to draw out the participants' experiences and stories (Starks & Trinidad, 2007). However, unlike IPA, one of GT's primary aims is the development of a theory that is based on the information that is collected (Tie et al., 2019). The research questions for this study do not align with capturing specific processes or concepts within a formalised theoretical framework and therefore, GT was not thought to be appropriate.

Discourse Analysis (DA)

DA (Edwards & Potter, 1992) is based in the framework of discursive psychology which proposes the idea that researchers can access people's internal cognitions not just by capturing what they *say* but

thinking about the social context of spoken language (Goodman, 2017; Starks & Trinidad, 2007). DA is primarily concerned with understanding the bidirectional relationship between language and the social world (Johnson & McLean, 2020) and how this process shapes individual / group identities, social norms and wider socio-political processes (Goodman, 2017; Starks & Trinidad, 2007). This is not the primary focus of the project. This research will consider social context but will primarily look at participants subjective experience of being a leader and wellbeing. Therefore, IPA appeared to be a more appropriate approach.

Thematic Analysis (TA)

TA (Braun & Clarke, 2006) aims to extract patterns and themes that are present in the qualitative information (Nowell et al., 2017). One of the significant draw-backs of TA is that there is less literature on the method and it is not attached to any particular epistemological position meaning that there can be significant inconsistencies in the way it is conducted (Nowell et al., 2017). As very little is known about the experience of being an operational leader in the NHS, IPA gives an opportunity to explore these experiences in a methodology that had solid theoretical grounding.

Interpretative Phenomenological Analysis (IPA)

Theoretical Underpinnings of IPA

The key philosophical aspects of IPA, Phenomenology, Hermeneutics, and Ideography are outlined below.

Phenomenology, the study of experience, emphasises the person's subjective understanding of the phenomenon through the way the person talks about an event or said experience (Smith et al., 2022; Smith & Osbor, 2008). IPA uses hermeneutic phenomenology where hermeneutics, the theory of interpretation, refers to the ideas that people actively engage in a process of sense-making of the experience being studied (Smith et al., 2022).

A key aspect of phenomenology and hermeneutics in IPA is the recognition that while the participant is making sense of their experience, the researcher also is engaged in their own process of interpretation of the participant's sense-making. This is called double hermeneutics (Smith et al., 2022). IPA acknowledges that researcher interpretations will be affected by their own preconceptions and that the process of reflexivity is key.

A further theoretical underpinning of IPA is ideography. Ideography is concerned with purposefully looking at selected individuals to gain depth and detail, rather than about exploring overarching and generalisable ideas at group levels (Smith et al., 2022). The focus on detail shows up in IPA through the thorough and systemic analysis process and its aim to contextualise the phenomena being studied within individuals (Smith et al., 2022). As ideography emphasises subjectivity of internal processes, ideography links us to the hermeneutic phenomenology in IPA; this project aims to capture the people's subjective (ideography) sense-making (hermeneutics) of an experience (phenomenology).

Reflexivity

Qualitative approaches generally acknowledge that the researcher is not separate from the data or analysis they are conducting (Mason, 2002). IPA assumes that the researcher will bring their own interpretations and subjectivity into the analysis process, meaning that transparency and reflexivity are key in conducting 'good' quality qualitative research (Reid et al., 2005; Smith et al., 2022; Starks & Trinidad, 2007). Reflexivity allows the researcher to not get distracted by their own interpretations and preconceptions in a way that obscures the phenomenon that they are trying to capture (Smith et al., 2022).

The intentional reflexivity within this project included a reflective log and using research supervision throughout the research process. This acknowledged that we may become aware of other relevant ideas or experiences to the research process once we begin to interact with the data (Smith et al., 2022) highlighting that reflexivity is a continuous process. CR also emphasises the role of researcher reflexivity given its focus on 'context' such as our own personal characteristics (Lauzier-Jobin et al., 2022) and thus aligns with IPA. A reflexive statement can be found at the end of the chapter.

Methods

Sample

As IPA studies involve detailed analysis and in-depth understanding of the studied experience, sample sizes are generally small, typically falling between six to ten participants for doctorate programs (Smith et al., 2022). As cited by Pietkiewicz and Smith (2014), Turpin and colleagues (1997) suggested a sample of six to eight for doctorates would provide sufficient depth without feeling overwhelming. In IPA, a larger sample size does not mean better quality work (Smith et al., 2022). However, I aimed to capture a sample of eight to ensure the project had enough in-depth data.

Alongside practical considerations, Malterud et al. (2016) proposed an idea of 'information power' that could be used to determine sample size in qualitative research; the more information power a sample holds relevant to the study, the fewer participants are needed. The authors suggested that larger samples may be required if: (1) the study aims and (2) sample characteristics are broad, (3) there is limited theoretical background in the study, (4) lower quality of interviews, and (5) the study uses an exploratory cross-case analysis.

The need for a larger sample is indicated by this project's explorative research aims, its emphasis on lived-experience rather than a theory, and the use of cross-case group analysis in IPA. Malterud and colleagues also acknowledge that determining information power is a dynamic process across the five overlapping factors. Higher information power, and thus the need to have fewer participants, is supported by the project's purposeful sampling method that was used to gain sample specificity. Moreover, during the research process, considerations were made over the quality of interviews, which were supported by the participants being able to articulate and engage in the process of reflection, the interviewers' ability to form relationships during data collection, and interviewers' ability to direct the interview dialogues in line with research aims. These were aspects identified and discussed in research supervision (e.g., post-pilot interviews, feedback from research supervisors

reading the interview transcripts). Thus, while collecting more data was possible, a sample of eight was thought to hold sufficient information power for the purposes of the study.

Inclusion and Exclusion

Samples used in IPA aim to capture people that have shared experiences (Alase, 2017; Starks & Trinidad, 2007) and are thus purposefully selected to offer insight of the phenomena the research is interested in (Smith et al., 2022). This research made several considerations regarding what may constitute a relatively homogeneous sample of operational leaders.

In line with the introduction section highlighting the significant pressures on NHS services, such as high numbers of patients being admitted into hospitals during C19 (Mahase, 2020), the project focused on operational leaders in acute Trusts. This is also because it is likely that different Trust types (e.g., acute versus mental health) may have been impacted by the pandemic differently. Homogeneity of sample was also supported by including operational leaders that predominantly oversaw adult rather than children's services. This also fits with adults representing most of the population that access NHS services (NHS Digital, 2020) and the C19 virus mainly affecting adults rather than children (Ludvigsson, 2020). For the project to capture participants from a similar operational role within the NHS, the divisional Triumvirate structure was part of the inclusion criteria: participants needed to be responsible for a group of clinical services.

The participants also had to have held such operational positions for at least three years to ensure they held a relevant post during the onset of C19 and thus also held a relevant post at the time of the interview. This allowed to capture the experience of leaders who have remained in the NHS.

Based on this, the inclusion criteria were as follows:

- Operational leaders that are responsible for a *group* of clinical services that are part of the Divisional Triumvirate within an acute NHS hospital.
- Have been in this relevant post for a minimum of 3 years.
- Are responsible for predominantly overseeing adult services.
- Currently working and continuing to hold such a post in an acute NHS hospital in UK.

Exclusion criteria included:

- Professionals in jobs that predominantly involve clinical contact with patients (e.g., deciding and delivering clinical interventions to patients) or overseeing the patient-facing daily running of wards and departments (e.g., healthcare assistants, nurses, doctors, matrons).
- Executive and non-executive board of directors that includes statutory roles (e.g., financial director) among other non-statutory roles (e.g., directors of strategy, HR, communications).

One of the participants captured in this study was overseeing a collection of services in her current role but not in the role she held during C19 as she oversaw a single clinical area. However, her role during still held multiple strands of services within the clinical area she was in. This was bought to

research supervision, and it was decided to keep the data in the analysis because the participant held similar tasks and responsibilities to offer homogeneity among the captured sample.

Recruitment

The sample was accessed through a UK national network called 'Proud2bOps' where this research project was advertised (Proud2bOps, n.d.). The network has been operating since 2017 and was directly set up for operational leaders working in health and care provisions seeking support and a space to think about their personal and professional development. At the time of advertising the project, the network was made up of around 750 members and of those, 700 were operational leaders in the NHS. Despite the majority of the 'Proud2bOps' members being NHS professionals, the network itself is independent from the NHS.

Professionals wishing to join the network can contact the administrators via email where they were then asked for their title and some information about their job role and area of work. This information was screened by an administrator that supported the running of the network and held an operational role. If at screening it was unclear whether someone held an operational role, a further email exchanges or telephone consultation was completed to gain more information before the person was able to join as a member.

Procedure

The recruitment process began in January 2023 when the study was advertised via email to the 'Proud2bOps' members (Appendix A). Interested participants contacted the researcher via email. The researcher then provided further information including the participant information sheet (Appendix B) and consent form (Appendix C) which they were asked to return via email if they wished to take part (Appendix D). The participants were encouraged to ask any questions they had about the project or their participation. The first eight participants that returned the completed consent forms were offered an interview date and time. An email explaining that full capacity for the project had been reached was sent out to anyone interested after this (Appendix E). See Figure 1 for recruitment process flow chart.

A suitable date and time for a one-to-one semi-structured interview was arranged with each participant. Interviews lasted between 72 and 85 minutes. The interviews were conducted online, and Microsoft Teams was used to record audio and video information.

Interview Schedule

Semi-structured interviews can capture rich information of someone's experience and offer a flexibility and responsiveness within real-time dialogue (Pietkiewicz & Smith, 2012). Interviews also support the research process to remain participant-oriented, which is a key part of the IPA methodology (Alase, 2017). Interviews allow participants to verbally share their thoughts, feelings, senses, and behaviours that give the researchers a rich insight into the participants' understanding of their own experiences (Pietkiewicz & Smith, 2014; Reid et al., 2005), thus interviews were the chosen method of data collection. I used a semi-structured interview schedule to allow me to include key areas that the

Figure 1

Recruitment Flow Chart

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┌─────────────────────────┐        ┌──────────────────────────────────┐
│   Recruitment email     │───────▶│ Contacted with questions regarding │
│                         │        │ inclusion criteria (N = 4) and none│
└─────────────────────────┘        │ met criteria due to: no longer    │
             │                     │ occupying an operational role (N = │
             ▼                     │ 2) and not working in an acute NHS │
┌─────────────────────────┐        │ Trust (N = 2)                      │
│ Initial interest        │        └──────────────────────────────────┘
│ expressed (N = 18)      │
└─────────────────────────┘
             │
             ▼
┌─────────────────────────┐        ┌──────────────────────────────────┐
│ Participant information │───────▶│ No further contact from possible   │
│ and consent forms sent  │        │ participant (N = 4)                │
│ (N = 18)                │        └──────────────────────────────────┘
└─────────────────────────┘
             │               ┌──────────────────────────────────┐
             │──────────────▶│ Not meet criteria (N = 1) as no    │
             │               │ longer in Triumvirate              │
             │               └──────────────────────────────────┘
             │
             │               ┌──────────────────────┐  ┌──────────────────────┐
             │──────────────▶│ Returned completed   │  │ Interest expressed in │
             │               │ consent form after   │  │ the project after     │
             ▼               │ first eight          │  │ initial eighteen      │
┌─────────────────────────┐  │ participants (N = 2) │  │ (N = 8)               │
│ First participants that │  │ and agreed to take   │  └──────────────────────┘
│ returned completed      │  │ part but not         │
│ consent forms were      │  │ attached a consent   │
│ invited to interview    │  │ form after first     │
│ (N = 8)                 │  │ eight participants   │
└─────────────────────────┘  │ (N = 3)              │
             │               └──────────────────────┘
             ▼                          │            │
┌─────────────────────────┐             ▼            ▼
│ Participants            │      ┌──────────────────────────────┐
│ interviewed (N = 8)     │      │     Full capacity email       │
└─────────────────────────┘      └──────────────────────────────┘
```

research is interested in and prompts to support the interview to have an experiential focus. See Appendix F for the interview schedule.

My research supervisors supported me with the iterative process of developing an interview schedule. The early versions of the schedule had too many questions, and were often too leading and specific, as is a common feature of IPA beginners (Smith et al., 2022). The schedule was reworked to be more expansive and open-ended to allow for a better understanding of how participants saw their world (Smith et al., 2022). The idea of 'funnelling' was used to think about starting of the interview asking a broad question before 'funnelling' down to more specific detail of lived experiences (Smith et al., 2022).

Experts by Experience

The preparation for the interview process was also supported by an expert by experience: an operational leader that was a part of running the 'Proud2bOps' network. Her input allowed for a recognition that the sample may be more comfortable with discussing operational events (what they did) rather than their personal and more emotional perspectives of this. As such, the interview schedule (and participant information sheet) was amended to ensure prompts supported an experiential focus. Moreover, the recognition that the more personal experiences may be challenging to discuss, the wellbeing questions occupied the latter half of the interview. This allowed time for the participant to familiarise themselves with the interview process and the level of detail required from the interview, and an opportunity to build more rapport and trust that would allow for greater self-disclosure.

A Consultant Clinical Psychologist also supported this project and acted as field expert throughout various stages of the research process. During the onset of the pandemic, the field expert led an NHS staff wellbeing service in a Yorkshire Trust. In early 2021 the field expert also held a part-time post as a Clinical Lead for one of 40 regional staff mental health and wellbeing hubs, which aimed to offer support to health and social care during the onset of the pandemic (Rimmer, 2021). Their input supported the project with defining operational leaders within the NHS structures and acted as a credibility check for the project's findings in the latter stages of data analysis.

Pilot Interviews

I was able to conduct two pilot interviews with two leaders in the NHS (one a program leader for a project, and an operational leader) as part of the process of finalising the interview schedule. This helped me to be more flexible with the use of prompts and to be more curious about the person's experiences during the flow of the interview. When asking for more information, I felt it was helpful to use the participants' own words as much as possible to minimise my bringing in new concepts or interpretations and to use non-verbal cues to acknowledge and encourage participants to share.

Ethical Considerations

Ethical approval was sought and gained from the University of Leeds, School of Medicine Research Ethics Committee on 11[th] November 2022 (reference number: MREC 21-066). See Appendix G for confirmation email.

Informed Consent and Withdrawal

All participants were provided with a participant information sheet and given opportunities to ask questions about the project and their participation via email. Prior to beginning to record the interview, verbal consent was rechecked, and they were reminded that their participation was voluntary, and that they could stop the interview at any point without giving a reason and withdraw their data. Participants were aware they would be able to withdraw their data for up to two weeks after the interview by emailing the researcher but that after two weeks, this would no longer be possible.

Emotional Distress and Risk

There was a possibility that participants would experience distress at recounting potentially difficult experiences. This was managed in several ways: participants were made aware of this possibility via the participant information sheet; that they could choose to not answer questions and pause or stop the interview process at any time; and that they could discuss any concerns with the researcher. I could then have offered reassurance during the interview and signposted participants to relevant sources of support. I would be able to seek support for myself through research supervision as the interviews may have included sensitive or emotional information.

There was also a small possibility of participants disclosing concerns about unethical or unprofessional practice. The participants were made aware that, should this happen, this would be discussed as part of the interview and we would consider what action should be taken, such seeking support from their line management and being guided by their Trusts' Freedom to Speak Up policy. The research supervisors would have also been sought out for support and advice. However, there were no such concerns raised during the interviews I conducted.

Confidentiality and Privacy

The University of Leeds security protocol for collection, handling, and storage of research data was followed. The Microsoft Teams software that was used to record the interviews directly saved the audio and visual data and the software generated transcript into the researcher's encrypted 'OneDrive' as permitted by the University Information Security Policy. Any additional electronic documents (such as completed consent forms) were stored in a separate folder in the same encrypted space.

The first interview was transcribed by the researcher and the next seven by two University of Leeds approved transcribers who completed Leeds Institute of Health Science Confidentiality Statement for Transcribers. The interview recordings and software generated transcripts were securely shared with transcribers via 'OneDrive'.

Upon completion of the interview transcription process, the interviews were anonymised by removing or changing identifiable information such as replacing participant names with pseudonyms and removing places of work and third-party information.

Data Analysis

Qualitative research often includes taking a rigorous and systemic approach while also allowing exploration and flexibility within the analytic process (Mason, 2002; Smith et al., 2022). While Smith et

al. (2022) recognise that IPA can be thought of as an approach and a way of thinking rather than something prescriptive, they do offer a step-by-step guide through the analytic process. This process was followed in this research and is summarised in Table 1. Further information on the process is provided below.

Table 1

Overview of the Analysis Steps of IPA on based on pages 78-104 in Smith et al. (2022)

Step	Process
1	Reading and re-reading of the transcript
2	Exploratory noting of content of the transcript in a line-by-line manner
3	Developing experiential statements of the key experiences and sense-making of the phenomena being studied
4	Searching for connections across experiential statements that form Personal Experiential Themes (PETs)
5	Naming of the PETs
6	Repeating steps 1-5 for each individual case
7	Search for similarities and differences across individual case PETs that then develop into Group Experiential Themes (GETs)

Step One

The aim of this step is to immerse in the data. Before reading and re-reading the interview transcript, I began this process by listening to the interview audio. I made notes on key reflections or points in their experience as I went along in a separate Microsoft Word document.

Step Two

I then organised the transcript into a table with three columns. The first column was the interview transcript, the middle column held the exploratory notes, and the third included the experiential statements.

Exploratory noting was a deliberate line-by-line process that involved attending to each part of the interview to avoid superficial engagement with the data (Smith et al., 2022). I started this process by first reading a section of the transcript and underlining what I thought were key parts of the text, then taking a closer look at the data and noting down reactions, and my initial thoughts on participant experiences.

Smith et al. (2022) suggest it is possible to develop descriptive, linguistic, and conceptual notes. Descriptive notes aim to summarise key concepts and content in the data. Linguistic exploratory noting is about focusing in on features of language that may provide insight into participant experience such as flow of speech, pauses, laughter, repetition, and use of specific words. Conceptual noting aims to ask questions of the data that then begin to form the initial interpretation of meaning of an experience based on what the participant had said. Appendix H provides an example of exploratory noting illustrating the different types of coding.

Step Three

The experiential statements aim to use the exploratory noting to create initial interpretative statements of the person's experience in a way that summarises sections of the text (Smith et al., 2022). I used the participant's words where I thought this would allow the statements to remain close the data but also addressed participant experience. I also paid attention to how the experiential statements remained grounded in the detail of the transcript to allow for richness and context, while also offering some of my own interpretation. I ensured that page numbers were included with each experiential statement to allow me to follow the statement back into the original data as the analysis continued, supporting the process of credibility.

Once I had created experiential statements for the full interview, they were copied and pasted into a separate Microsoft Word document in preparation for step four and five.

Step Four and Five

All experiential statements were printed off, cut up, and randomly distributed on a surface to allow me to see all the statements. This can support with avoiding emphasising some statements over others in importance (Smith et al., 2022). It also supported me to move away from the order in which the experiential statements appeared in the interview and instead take a more open-minded and conceptual approach in trying to construct and deconstruct 'groups' of experiential statements that I thought were related.

The process of trying to find connections was iterative as I tried out different smaller 'groupings' that would then become sub-themes. These 'grouping' would then be further 'clustered' together if I thought they were interconnected. These together would then become a Personal Experiential Theme (PET) with sub-themes. At times, experiential statements come together in an overarching 'cluster' of a PET that I then them broke down into smaller 'groupings' of sub-themes.

Throughout the process of looking for connections, some experiential statements were discarded as irrelevant to the research question. I also 'stacked' some statements on top of each other if I thought they conveyed a very similar experiential meaning. At this stage, I also began creating names for the emerging sub-themes and overarching PET titles. See Appendix I for an illustration of this process.

After creating an initial structure, I typed up it up into a table in a Microsoft Word document and selected a quote to illustrate each experiential statement. This process sometimes resulted in

adjustments to the structure of PETs, individual placement of experiential statements, and reworking of sub-theme and PET names (See Appendix J for an illustration of PET table).

Step Six

Steps one-to-five were repeated for each individual interview before analysis moved to looking across cases.

Step Seven

After individual analysis was completed, I began the process of looking for shared experiences across the whole data set. I began this by re-reading individual participants PET tables which supported me to have an overview of the data.

I reorganised the individual PET tables to be more print-friendly and printed off individual PETs, sub-themes, and experiential statements (without quotes) for each participant. I numbered the participants one-to-eight and used different colours to support me to return to the full PET tables and individual research transcripts as needed.

An initial structure was created by looking at the individual sub-themes to create group-level sub-themes and overarching GETs by looking for similarities and differences across individual cases. As part of this process, I created initial names for group-level sub-themes and GETs. An illustration of this process can be found in Appendix K.

The initial structure was then typed up to provide a preliminary structure of group-level sub-themes and GETs. I then further zoomed into the experiential statements and quotes that constructed the individual sub-themes, returning to individual research interviews to check context and detail. This prompted further reconstruction of the initial GET structure. Smith and colleagues suggest that a group-level sub-theme was thought plausible if it appeared in half or more participant's interviews. This was used as a rule of thumb throughout this process to condense large amounts of data.

I continued this iterative group analysis process and naming of sub-themes and GETs through discussions and feedback from research supervisors, and the process of writing up the Results section. See Appendix L for extract of final GET table.

Quality Assurance

Smith and colleagues noted that Yardley (2000) and Elliott et al. (1999) both offer relevant frameworks for assuring quality in qualitative research such as IPA. The framework proposed by Elliott et al. (1999) is used to think about quality of this project. Table 2 provides an overview of areas of 'good' qualitative research and how this project aimed to meet them.

Table 2

Overview of Good Quality Qualitative Research by Elliott et al. (1999) and Steps Taken in this Project.

Feature of 'good' qualitative research	Steps taken in this project
Researcher owning their perspective	• Reflective log and research supervision notes to capture my own experiences and views regarding the project and data (see Appendix M for an example extract of reflections). • Providing a reflexive statement on relevant background, interests, and characteristics. • Use of the pronoun 'I' to emphasise my active role as an interpreter in the analysis stages.
Situating the sample	• Providing descriptions of the sample and individual 'pen portraits' to allow the reader to judge the relevance of the project's results to other situations or persons.
Grounding in examples	• Ensuring that the analysis process was grounded in the data using page numbers and quotations. This also supported the analysis to remain ideographic, a key underpinning of IPA. • Providing quotations in the Results chapter to illustrate group-level sub-themes.
Providing credibility checks	• Utilising research supervision to discuss and seek feedback on the analytic process and moving from descriptive to interpretative. • Utilising research supervisors to review anonymised and analysed research interviews and PET tables to ensure analytic annotations could be followed back to the transcript. While research supervisors themselves were not operational leaders, meaning the credibility check in relation to operational experiences is somewhat limited, the supervisors acted as additional analytical 'auditors' that reviewed the data. This allowed for the opportunity to identify, for instance, overstatements and errors as discussed by Elliott and colleagues. • Input from peers also using IPA to act as additional 'auditors' that reviewed sections of anonymised and analysed interview transcripts and individual PET tables. • Input from field expert at group analysis level. The field expert did not have lived experiences of holding an operational leadership position however, they supported the

	project's credibility to an extent through their experiences of working alongside operational leaders since the beginning of the C19 pandemic in an acute Trust. The field expert also supported the project to contextualise the research findings with their knowledge and experience of the NHS systems.
Coherence	• A thematic map is provided to support the reader to see how the GETs from the group analysis fit together in the Results. • The group analysis was re-worked multiple times to present the GETs in a coherent manner. • Providing context and quotes of individual experiences to illustrate detail in the narrative story of the Results section.
Accomplishing general vs specific research tasks	• Effort was taken to ensure that the sample selected could provide an understanding into relevant experiences to meet the project aims. • Discussion section acknowledges applicability limitations of the findings, such as, to other professionals.
Resonating with readers	• Selecting quotations and creating names of GETs and sub-themes that allow the data to remain connected to the experience it is aiming to capture. • Providing detail of the analytic process in the Results section to illustrate how I have aimed to add to what the participants have said.

Researcher Reflexivity Statement

I am a 27-year-old, White, Lithuanian female. I spent the initial 10 years of my life living in Lithuania before moving to the UK and beginning my education that eventually led me to my current position as a trainee Clinical Psychologist.

I approach this research with my own experiences of living through the onset of the C19 pandemic. I also hold my own ideas and preconceptions about leadership and psychological wellbeing.

As a person that lived through a pandemic, I experienced my position as comparatively safe: I am relatively young, currently able-bodied with no underlying physical health conditions, and have the protections afforded by Whiteness and a relatively high socioeconomic status. For me the C19 pandemic emphasised a focus on public health and the need to talk about social inequality. This focus has been furthered through my training experience.

My interest in and development of this project stemmed from a clinical placement as part of my training. I held a 6-month post between November 2020 and April 2021 in an acute hospital trust within an Occupational Health department.

My clinical placement also provided me the opportunity to witness how the pandemic has impacted the running of the NHS and the system's reliance on the Occupational Health department. For me, this highlighted the way the onset of the pandemic affected professionals' roles and thus their wellbeing. In my placement, I mostly interacted with doctors, nurses, and healthcare assistants who were working with patients unwell with C19. My role as a mental health professional was to normalise these professionals' distress and support them to navigate through their experiences. I was mindful that I held a post where I heard more 'negative' rather than 'positive' stories of working within the NHS since the beginning of C19. Keeping this in mind, I aimed to ensure I was open to hearing more balanced views from the research participants of this project.

My placement experiences allowed me to interact with professionals (such as doctors and nurses) who shared their experiences of their roles after the onset of C19 including redeployment, changes to how services were run, and extra demands at work such as long shifts. Some professionals highlighted the role of leaders at this time who affected the way the system was operating even though they were not on the 'shop floor'. This highlighted the role of leadership in the NHS since the beginning of C19. Thus, this sparked a curiosity of wanting to capture the voice of 'leaders' because their experiences since the beginning of C19 appeared to be missing from discussions taking place around me and my own narrative of the pandemic. Capturing the unheard perspectives is congruent with the clinical training principles and the sort of clinical work that I find most rewarding.

Chapter Three: Results

Firstly, some demographic information will be provided including clinical areas that participants worked in and a summary of their operational responsibilities. This will be followed by individual pen portraits and a reflection on the research interview for each participant. The chapter will then provide a thematic map and a table of Group Experiential Themes (GETs) and group-level sub-themes across individual participants before providing a narrative overview of the results from the group analysis.

Demographics

The sample all identified as White British. It included five females and three males. Their ages ranged between 30-52 years (median of 41.5 years). Their career length in operational leadership ranged between 6-31 years (median of 12.5 years).

Participants held operational roles over a variety of services. These included:

- Hospital medicine, such as stroke, intermediate care, care of the elderly, maternity, diabetes, gastroenterology, and pharmacy services.
- Community medicine, such as District nursing, Intermediate care, and allied health therapy services such as Physiotherapy and Occupational Therapy.
- Critical, and emergency care, such as surgery and intervention for life-threatening conditions and injuries including first point of contact services such as Emergency Departments.

Operational leadership roles and responsibilities as described by participants in these areas included:

- Setting and overseeing the strategic direction and development of services, including supporting and writing of business cases for projects (e.g., service expansion plans).
- Monitoring and meeting Key Performance Indicators as set by national and local performance targets.
- Financial oversight and budget management.
- Quality, safety, and risk management for their clinical areas, including incident investigations and patient complaints.
- Human Resources responsibilities, such as recruitment, policies, workforce issues, appraisals, mandatory training, disciplinary processes, and other line management responsibilities.
- Problem solving day-to-day clinical issues, such as staff rotas and management of resources such as faulty equipment.

Pen Portraits

Pen portraits aim to provide an overview of the participant context to allow the reader to situate the interview data and consider the relevance of this research to other contexts (Elliot et al., 1999). A pseudonym has been allocated to each participant using a random name generator for all participants bar one who provided ideas for their preferred pseudonym.

Each pen portrait will include participant motivation for wanting to take part, brief context of their experience, some key points from their individual data analysis, and a reflection on the process of the interview.

Sub-themes from the individual analyses are in **bold** and direct quotes from the interview transcripts are in *italics*.

Katy

Katy wanted to contribute as she anticipated having a more positive experience during the pandemic than others and wanted to represent this experience in this project. This parallels Katy's descriptions of herself as a *"positive character"* with a hopeful *"glass half full attitude"*.

Katy worked her way into leadership within the NHS after starting her career in a non-registered entry level job. Katy occupied an occupational role in hospital medicine during and 'post' C19.

During the interview, Katy shared her experiences of **feeling successful at work** through being able to have **a new sense of speed, focus, and freedom** to 'do' as was the *"direction from the government"*. Katy emphasised **strength** through being able to **be together through C19** and that operational management teams were able to get *"stuck in"* into facing C19. Katy also shared some of the costs of getting 'stuck in' such as **balancing conflicting pulls of her identities** of being an operational leader, mother, wife, and how she thought she was *"looking after"* herself at work.

Katy was the first participant I interviewed. Despite my own worry about taking the interviewer role, I felt there was an ease and openness during the interview. Katy herself noted the interview felt like a *"counselling"* session. I wondered if the process of the interview highlighted how there has been little time to reflect on her experiences of work during C19. I was also more aware of my own gender when Katy spoke about the difficulties of being an operational leader and a mother (and body image in extension of this). I wondered whether being female myself meant there was a visible cue that I could share in her experiences of this and so allowed her to share more freely.

Amanda

Amanda's own struggle to recruit participants during a further education project motivated her to give back some time to someone else doing research.

Amanda entered NHS leadership through the graduate scheme and shared she has worked in various areas. At the time of the pandemic, she oversaw services in community medicine although for a short time was redeployed into surgical, critical, and emergency care, a clinical area she has worked in before.

During the interview, Amanda talked about the **uncertainty, fear, and demands** posed by C19 at work. This included experiencing and adopting the NHS systems *"strong regime"* of **Command-and-Control measures to survive C19.** Amanda shared that she has *"been around a long time"* in the NHS and thus had effective ways of *"dealing"* with stressful work situations to keep herself well. This allowed

her the freedom to **adopt the responsibility of keeping others around her well** and "*keep an eye on the team*".

The interview at times held a faster pace with multiple points in a short space of time. I wondered if this paralleled some of the fast-paced work during the pandemic. I also wondered if this pace affected the reflectiveness of the interview because at points, there was more emphasis on describing events more broadly than on personal behaviours, thoughts, and feelings. This shifted throughout the interview as we were able to find a slower tone and return to earlier points of the interview to gain more detail.

Erin

Erin volunteered some of her time as she empathised and recalled struggling to gain participants for her own research during a further education qualification. She also said that she felt she had "*not really been affected by the pandemic*" and so wanted to use the interview process to "*explore*" this.

Erin entered the NHS leadership through the graduate scheme and emphasised how "*passionate*" she is about the NHS in part due to the role of the NHS in supporting her and her family when they were in need. She also shared that a close family member had a "*long and successful career*" and how she wanted to carry on the "*legacy*".

At the time of the pandemic, Erin was starting a new job within surgical, critical, and emergency care but was redeployed to "*lead a PPE team*" for a period of four months. Erin shared her experiences of **anxiety in navigating the new post and tasks** but also a **pride in being able to contribute** via her redeployment. Despite her redeployment that placed her relatively close to C19, she acknowledged feeling **grateful** and **humble in comparison to the 'frontline'** clinical staff who "*were putting themselves at risk*" in a way she did not have to.

I felt the interview had a slow and calm emotional texture as Erin and I found a steady rhythm. I appreciated the conscientious and considerate manner in which she thought about and answered questions. During the interview she noted an unfamiliarity of talking about herself and her wellbeing at work and said that "*no one else has ever asked*" about her workplace wellbeing. This was perhaps reflected in the latter part of the interview feeling less smooth.

Lauren

Lauren was interested in participating because the pandemic was such a "*huge time*" for everyone and thus far, "*there has been such a lack of, you know, viewpoint from an operational perspective*" of what it was like to hold such positions.

Lauren began her working career in a registered clinical role before moving into more leadership roles. In the early part of 2021, Lauren moved between holding an operational post in community medicine to a post within surgical, critical, and emergency care.

Lauren shared her experiences of leadership such as needing to take a **directive even if inauthentic leadership** style and a **freedom to make change happen** quickly and efficiently within her

role. She acknowledged the fear she experienced around contracting C19 while still needing to turn up at work. As such, she proactively **distanced and desensitised herself from the realities of C19** by avoiding *"triggers"* such the *"doom and gloom"* of the media and using her **expertise of her own wellbeing** to know when she needed rest and to engage in enjoyable activities. Lauren also shared some experiences of her role within the NHS, such as feeling like a **humble and helpless leader** compared to the distressed clinical teams, and personal roles such as **the pressure** and **guilt of being a mother** to a teenage son *and* an operational leader.

I felt the interview went well and held a reflective tone throughout. The interview felt comfortable, and I had a sense of connection to Lauren. Lauren was the first participant to mention how C19 disproportionately affected racialised minorities and I was aware I guided the conversation back to this topic, given my own interest in it. For me, this clearly highlighted how the interviewer and interviewee co-create what happens in the research interviews.

Teddy

Teddy noted this research overlapped with his own interest in thinking about the *"currently exhausted"* workforce of the NHS. He also shared he will be leading on conducting research in the near future into this area as part of a further education qualification.

Teddy shared that he served in the army medical services for a number of years before starting his career in the NHS in a registered clinical role. Over time he entered more leadership posts. During the pandemic, Teddy worked in a specialist hospital, within the area of hospital medicine. As part of this post, he supported the set up of *"a trauma and a COVID center"* within the hospital he worked at and was also involved in the set up of *"vaccination hubs"* in the UK area he was based in.

Teddy shared being able to work *"methodically"* and emphasised **'doing' rather than 'feeling' to survive the relentlessness and fear of C19**, and part of this involved *"swith[ing] off"* his emotional part of the brain as he did during his time in military. He shared his excitement of **the freedoms afforded by less 'red tape'** and fewer **financial restrictions** that allowed him to just *"go and do"*. He experienced feeling **appreciated** by work colleagues and the public, and a sense of **momentousness of being and succeeding together** through C19 which is *"something that changed the world literally forever"*.

I felt that having a shared interest in research within the NHS setting supported Teddy and I to build rapport. The interview felt reflective and comfortable. During the interview Teddy shared with me his determination to *"make the most difference"* for NHS patients and services. I wondered if some of that commitment was in part illustrated by Teddy's thoughtfulness and engagement with the interview process.

Chris

Chris wanted to participate in the project to *"give something back"* given his own difficulties of recruitment in past research.

He shared how he began his career in a register clinical role before moving into general management posts in the NHS. During C19, he held an operational post in hospital medicine.

During the interview, Chris shared experiencing a **freedom to quickly do what was needed.** For him this was linked with a sense of **achievement** and **pride at work** during this time. Chris shared experiencing being an **important part of the system** that was facing the threat of C19**.** He shared feeling **protected through the distance from C19:** he acknowledged that in relation to frontline staff, he did not need to step into the *"full horror of COVID"* and that his personal life carried on in a *"relatively normal way"*.

Toward the end of the interview, it became apparent that a colleague was in the room with Chris. It is possible that this may have affected how comfortable Chris felt sharing some of his experiences. However, I think the interview felt like it held depth, and a comfortable and well-paced tone. I also noted a tone of lightness at points. I thus aimed to model a slow and deliberate manner when, for instance, I asked questions to support with creating a reflective space.

Jess

Jess shared she was interested in participating because narratives of what the C19 pandemic was like was focused on the doctors and nurses and so far, has missed out "*the operational voice*". Jess noted operational leaders are often the *"ones that put everything in place to get it all working together"* and likened operational leaders to be the *"beating heart of the organisation"*.

Jess entered NHS management through the graduate scheme. She shared how in the early days of the pandemic she acted up into the senior operational position above her due to staff sickness. During C19, she occupied a role in hospital medicine.

She shared some of her experiences of having to **meet insistent pressures to 'do' during C19** and feeling like **she was needed to do her job** for "*this period of history as it will go on to be"*. She shared her sense of responsibility to **protect staff and patients** as a leader but also a sense of **humbleness in her own protected role** in comparison to the clinical staff. She also spoke warmly of being able to **achieve and survive by being together** with others and noted the strength of C19 to bind her and her colleagues as *"friends for life"*.

I identified with Jess the most out of everyone that participated, partly due to sharing many visible overlapping demographic characteristics that perhaps allowed us to build a comfortable rapport quickly. I felt this was important given that Jess described herself as not being an "*emotional person*". I wondered if the early rapport we built allowed Jess to feel safe and to take a more personal and emotive perspective in the interview.

David

David wished to use the interview process as an *"opportunity to reflect"* and share some of his experiences during the pandemic.

David began his leadership career in entry level management posts. Despite not being a clinician, David shared that he came from a scientific background given his further education qualification in a science-based course. During the onset of the pandemic, David began a new role within surgical, critical, and emergency care.

He shared his experience of entering a new job in C19 and how he initially felt *"intimidated"* by this. David also noted how C19 allowed him to **discard frustrating and meaningless bureaucracy** meaning he gained the **satisfaction** of being able to **collectively achieve** and use a clinician-led **bottom-up way of working.** This was in line with how he thought *"healthcare should work"*. He shared a sense of **pride in being able to have a collective purpose** to *"contribute to society"* and do *"something meaningful"* during C19. David also shared the stress of the **return of service pressures** outside of lockdowns that resulted in executive oversight of his and the clinical areas' performance and having to **disconnect from emotions to survive** some of this experience.

David was the last person I interviewed, and I noticed feeling more comfortable within the interviewer role. I felt the interview was led by David and we captured what he thought was important to talk about. At times I thought David found it trickier to take a more personal and emotive viewpoint. I found being able to return to initial points raised in latter parts of the interview, once David got a sense of the depth needed in this process, was a helpful interview skill that I had developed.

Results of Group Analysis

Figure 2 provides an overview of the GETs and sub-themes that make up each GET. A breakdown of each group-level sub-theme by participant name is summarized in Table 3.

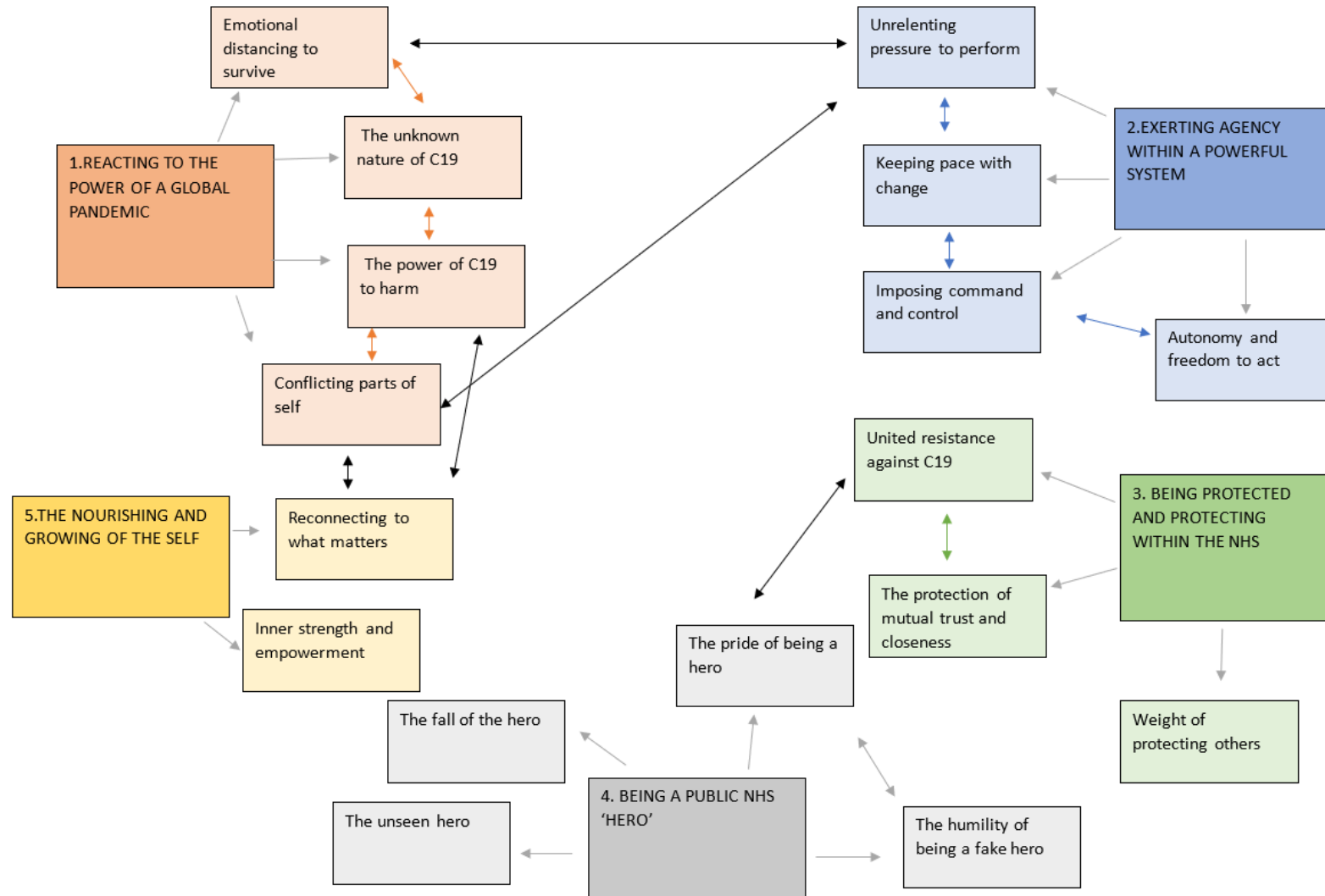*Figure 2*

Thematic Map of GETs and Group-Level Sub-Themes

Table 3

Overview of the GETs and Group-Level Sub-Themes for Individual Participants

GET	Sub-theme	Participant							
		Katy	Amanda	Erin	Lauren	Teddy	Chris	Jess	David
1. REACTING TO THE POWER OF A GLOBAL PANDEMIC	The power of C19 to harm	X	X	X	X	X		X	X
	The unknown nature of C19	X	X		X	X	X	X	X
	Emotional distancing to survive		X	X	X	X		X	X
	Conflicting parts of self	X	X	X	X	X		X	X
2. EXERTING AGENCY WITHIN A POWERFUL NHS SYSTEM	Unrelenting pressure to perform	X	X	X	X	X		X	X
	Keeping pace with change	X	X	X	X	X	X	X	X
	Imposing command and control		X	X	X	X			X
	Autonomy and freedom to act	X	X		X	X	X		X
3. BEING PROTECTED AND PROTECTING WITHIN THE NHS	United resistance against C19	X	X	X	X	X	X	X	X
	The protection of mutual trust and closeness	X	X		X	X	X	X	X
	Weight of protecting others		X		X	X		X	X
4. BEING A PUBLIC NHS 'HERO'	The pride of being a hero	X	X		X	X	X	X	X
	The humility of being a fake hero	X		X	X		X	X	X
	The fall of the hero	X		X	X				X
	The unseen hero			X	X			X	X
5. THE NOURISHING, AND GROWING OF THE SELF	Reconnecting to what matters	X			X	X	X	X	
	Inner strength and empowerment	X			X	X	X	X	X

GET One: Reacting to the Power of a Global Pandemic

This GET refers to the experience of participants recognising the power of C19 and the unknowns around the pandemic. The power and suddenness of C19 left participants worried about what C19 would mean, having to distance themselves from some of their personal experiences and roles to meet the demands of work as illustrated across the four sub-themes. See Appendix N for a reflection on the naming of GET One.

Sub-theme One: The Power of C19 to Harm. This sub-theme aims to reflect the group's shared sense of fear of what C19 meant for them and the world. A key shared aspect of this experience was the participant worry of the power of C19 to result in harm to self and others. Some participants held a sense of suspense around this. For instance, David, who was entering a new role at the time of the pandemic shared how he was: *"very nervous, actually, very nervous about what was coming"* and wondered:

> *"what would it be like to, to be in that job... Er, but then to see then the pandemic coming over the horizon" (p.11).*

There is a sense of distance and motion in the way David described C19 over the horizon: C19, which had the power to harm, was perhaps far away from him but was coming nearer. Katy described a similar sense of distance and suspense that was even more justified as the expert clinicians held the same fear:

> *"even our clinicians were worried about it. And there was all the media going on about this, that and the other." (p.22)*

Amanda described a sense of C19 nearing and the unexpected power that it had:

> *"there's this bit of a virus over in China somewhere. To oh my God! And we, and that had been drip fed and then just suddenly it was like drip, drip, drip of a tap. And then the tap was just turned on full and that was it." (p.17)*

Amanda also mentioned distance and the gap between her and C19 closing quickly. There was simplicity in her comment 'that was it', as if there was little that could be done to stop C19, which further implies its full power.

A quiet anticipation of the harm that C19 could bring was also shared by Lauren and Jess in the way they talked about the virus resulting in death. For instance, Lauren worried for her own safety in C19:

> *"it was like if I catch COVID, what's gonna happen? Am I going to end up on ICU? Will there be enough respiratory equipment for me? Will there be a space for me? You know, is my need gonna be judged, greater than somebody else's because of my, my age and my ability to, to survive. It, you know it was, it was that level of Russian roulette, really" (p.31)*

Working in the surgical, critical and emergency side of the hospital perhaps gave her an insight into the decisions around how resources (such as respiratory equipment) were being allocated to the

extremely poorly, and that age was being taken into consideration on chances of survival. There is a sense of powerlessness to decide whether resources would be allocated to her, like a player in a 'Russian roulette' game. In such a game the players are powerless in comparison to the lethal and deadly nature of the gun and sit with the anticipation of when it may go off.

Teddy talked about the lethal nature of C19 when he saw an intensive care unit and how:

"it felt like a war zone. I mean, it was literally people, 24-year-old, on the ventilator probably going to their end game. And that was a real... And I remember that time is a bit fuzzy, but that's how you felt about it and feeling big rough-ty tufty army soldier, nothing could faze me in the civilian life, I'll never have to be worried about that again. And it did. And it really shocked me" (p.10)

Teddy's description of seeing a young life that usually held strength, *"cut very short really quickly"* illustrated some of the power of C19 to harm. Teddy shared a sense of naiveness in the assumption that he couldn't be fazed or shook by anything in his civilian life given his experiences of death in the military but seeing it *"really happening again"*, acknowledged the real threat and power of C19 to bring harm.

Sub-theme Two: The Unknown Nature of C19. A shared feature of seven participants' experiences was a sense of the 'unknown' surrounding C19 and how they may have to react as leaders. For some this was linked with the fear and 'the power of C19 to harm' sub-theme. This sense of 'unknown-ness' came up for participants in slightly different ways. Jess described how:

"*No one knew really what they were doing. We didn't know how bad it was going to be"* (p.10)

Katy described a similar sense of shared unknown:

"we didn't know what was coming. We didn't know what this thing was" (p.22)

The use of the word 'thing' to describe C19, rather than calling it C19, suggests her and her team's shared lack of understanding and lived experience to make sense of what turned out to be a global pandemic and, as commented by Amanda, no one had "e*ver witnessed or managed [their] way through anything like this"* (p12).

Amanda and Lauren shared a similar sense of the unknown regarding what will happen at a population level. Upon a colleague sharing that the C19 virus was in the UK, Lauren described asking:

"What's it going to mean for the, for the country, you know, all these questions are going through your heads. And absolutely you know, fear. I think it was, was the fear and confusion of or what? What? What? What do you mean? What, what? What is this?" (p.11)

In repeatedly asking 'what?', it is as if Lauren is aiming to find an answer or gain some clarity over C19 but being unable to see it clearly yet, gave rise to a sense of panic and fear of the unknown. David, starting a new role during C19 was not sure what to expect and thought:

"bloody hell, this is gonna be absolutely horrendous and I don't know what I'm gonna be able to deal with this. I'm gonna be like a rabbit in the headlights" (p.11)

Teddy and Chris also shared experiencing the unknown nature of C19, and the initial worry around this. However, they both noted a sense of comfort within this unknown. When Teddy realised how C19 bought a 'war zone' into his civilian life, he initially experienced:

"it was a bit of fear, being honest, feeling out what your depth and then feeling strangely comfortable that you knew what to do and how it was gonna go, which is really weird feeling!" (p.11)

He recognised that the unknown nature of C19 echoed some of his military experience. He had experience of creating and executing *"battle plans"* and repeatedly *"tweaking"* them as he went along, which he had to do in C19. He demonstrated an adaptability that allowed for movement within the uncertainty of C19.

Similarly, Chris described a situation where the chief executive of the NHS Trust with a 40-year long career in the NHS said:

"'I don't know, I don't know what the answer is. I don't know whether what we're doing is the right thing, but we need to do something. Let's try this, and then let's change it if we need to'. Erm I think that was quite refreshing." (p.18)

The use of the word refreshing perhaps gives rise to a sense of invigoration and excitement, as if pre-C19 work was a period of stagnation at work. Conversely to Teddy and Chris, Lauren described:

"someone's normally got a plan somewhere, but when literally the person that you looked to goes, yeah, we're not being told anything either. It's just like, wow, OK, this is, this is really serious." (p.14).

When seeking guidance from her leaders, the sense of 'unknown-ness' increased her fear around C19, rather than experiencing it as 'refreshing' in the way that Chris did.

Sub-theme Three: Emotional Distancing to Survive. Participants shared experiences of aiming to emotionally distance themselves from some of the experiences of fear that C19 bought about (linking this to 'the power of C19 to harm' sub-theme). This need to gain emotional distance was also related to needing to meet the 'unrelenting pressure to perform' during C19 as is presented in GET two.

Erin talked about how C19 felt distant at the time of the interview because:

"every day is different and you just have to get on with it, there's no time or space or anything to reflect" (p.17)

This emphasis of needing to 'get on' and continue completing tasks, over potentially being emotionally and cognitively connected to what is happening was also described by Lauren:

"I suppose I built up a bit of a kind of almost like a bit of an immunity, I guess. So you kind of like have to build up a bit of a a shell of like, OK. It's happening. But I don't need to kind of get myself too embroiled in it" (p.14)

Lauren built a protective shell that allowed her a distance and a level of desensitisation from the surrealness and painful information about C19. Lauren said it was the:

"getting used to hearing the statistics around cases and number of deaths; and having to discuss things like, you know, mortuary capacity and having extra chiller capacity at [local airport] in case we needed to use that. And things that were just you never thought you'd have to have conversations about" (p14)

As part of this, Lauren aimed to prepare herself for "*battle".* This included getting rest between her long days at work to "*to be able to fulfill the role that I need to do for others".* Teddy also talked about coping with C19 service pressures, such as increased need for bed capacity with many people getting unwell with C19 by:

"it's just triaging. So who can you save the quickest the most and do the most for with the amount of resources you have to plough into it? It's very, sounds a bit macabre, but it's very methodical like that" (p.12)

There is a methodical 'doing' in Teddys approach and the *"switching off"* his brain to be able to survive the pressures of the job, like he did in the military, rather than connecting to the loss and pain of C19.

Jess shared that during C19 senior leaders around her were off work due to the pressure of the job and she noted needing to *"swim"* rather than *"sink".* There is an element of needing to move and fight to complete the tasks of her role than connect to it emotionally which may make her 'sink'. She experienced a continuation of needing to avoid emotional pain of C19 at the time of the interview because:

"you kind of want to block it out because it was such an awful time. And at the time I was talking about it but like, not, like I haven't like spoken about it since when we were in it, if that makes sense until now" (p.20)

David shared:

"I was going to say I kind of feel like I came out of it unscathed. But I looked back at some of the stuff that we went through like and I actually when you describe it, it was quite bad at times" (p.45)

This may suggest that David recognized that his work during C19 included the presence of hurt and loss that he perhaps detaches from, such as when his performance was managed at work which resulted in him distancing his emotional energy from work and not putting his "*heart and soul"* into the organisation. Amanda shared her experiences of being redeployed for a short time and noted:

"I didn't want to do that job. I absolutely didn't want to do the job. But...I knew I was really good at it...you just felt that you somehow had to contribute. And that was going to be it for me." (p.11)

Her preferences and emotional experiences were deprioritized and overshadowed by the need to contribute and 'do' in the C19 effort.

Sub-theme Four: Conflicting Parts of Self. Several participants experienced how their operational leader responsibilities overshadowed their other roles, values, and parts of self since the beginning of C19. This links in with 'unrelenting pressure to perform' as C19 emphasised their operational responsibilities. This sub-theme refers to the experience of competing, conflicting and balancing of these roles and responsibilities in relation to the powerful C19.

Some participants (Katy, Erin, Lauren) experienced a conflict between roles associated with their identities as leaders and mothers. For example, Lauren shared how she was absent for a period of her son's life due to the demands of work resulting in her being less able to support her son to continue with his GCSE education at home. She noted:

"I absolutely will be guilt-ridden because of the fact that I wasn't there when everybody else's parents were able to sit down and nag them to do some work. I wasn't around for it. I couldn't, you know I couldn't do that for him" (p.33)

Lauren labeled her *"absolute mothers' guilt"* that exacerbated the stress of that time. Demands of work meant she had less resources to give to her son, which made her feel like an absent parent. Katy shared the same sense of *"total guilt"* of putting her child in the childminders but also emphasised how she felt she was unable to be a person in her own right rather than a person in relation to others:

"I felt so guilty for being out at work all day long and I then focused all my attention on my husband, my son, and my dog. And then there was no time for me, no time whatsoever" (p.45)

After meeting the demands of others expecting her to be an operational leader, wife, mother, and pet owner, there was little time for her at the end, as perhaps illustrated by her being the last aspect of self she lists. In trying to meet the expectations of others, the toll of this was evident at work: *"I lost my cheeky personality at work a little bit"*. For Katy, going to work despite the guilt she experienced as a mother for potentially putting her child at risk at the childminders was in some ways contrasted by her seeing this personal conflict and sacrifice as her "*doing the right thing from [her] country really"*.

Erin experienced a similar loss of time for self however this was 'post' C19 as there was added pressure to achieve. She noted that she has lost "*valuable time at home*" with her daughter as the world was no longer in lockdown meaning she also depriorisited herself and what nourished her:

"I probably just need some time out to just check in and, and do some, yeah, self-love or whatever you want to call it" (p.33)

The reoccurring mention of time across these three participants illustrates an awareness of this finite resource and having to balance and allocate said resource to different parts of the self. However, their work identities and demands placed on them via C19 (whether during or 'post') skewed that balancing act. Jess echoed that there was an:

"expectation was that work comes first and work is more important. And that seemed normal in my head" (p.37)

She described always being at work and joked about setting up a *"camp bed"* in her office with the time she spent there, again echoing a loss of a finite resource she could not spend anywhere else and invest in the other parts of self. Interestingly, Jess explained that she *"didn't have any kids"* and how in part this made her *"lucky"*, as if there is an unspoken expectation around how leaders who were women and mothers during C19 would have had to divide their time differently.

Teddy and David were both operational leaders from a clinical (Teddy) and scientific (David) background. Teddy, shared how being a clinician left him with a thought about needing to put some *"scrubs on and do a shift and turn some patients"* given that he had the skills to do that but experienced a conflict between going into the wards as a clinician and needing to *"lead the team, manage the processes, give [his staff] what they needed"* in a more operational sense. Unlike David, Teddy was able to make a choice about which part of himself to align with.

David's shared tension and helplessness of being unable to give out the highest level of PPE, which given his scientific background he knew was safest when dealing with a respiratory disease, but recognising that this clashed with national guidance:

"it was my job to say, look can't, we can't provide these masks that that, you know, you know, I'm science, science background. So I read all the papers and what have you and you know, read them all on Twitter" (p.18)

David connected to his 'scientific' part of self but was unable to act in line with this and instead had to be guided by the roles and responsibilities of an operational leader, which was led by national and organisation policies during C19.

GET Two: Exerting Agency Within a Powerful System

This GET is about participants' relationship with the systems of the NHS. It focuses on how this relationship is experienced through the theme of power and autonomy. The GET is made up of four sub-themes.

Sub-theme One: Unrelenting Pressure to Perform. A shared experience among participants was the system pressures to perform and meet targets amongst changes during C19 (linking with the 'keeping pace with change' sub-theme). This pressure was emphasised slightly differently across participants over the course of time as they either talked about this pressure during C19, 'post' C19 or a continuation from during to 'post'.

Amanda emphasised how during C19:

"everything worked at such a pace. And you had to deliver. Everything was recorded. So, if you were asked to do something, there's no prevaricating. No excuses." (p.45)

There is little sense of choice in work demands as she felt she had to meet expectations and perform because there was no prevaricating or hiding in idleness. This transparency and not offering excuses suggests a level of rigidity of needing to perform during C19 and that this meant she was:

"working weekends, weekends went … completely. You just, it was just like a bit of a 24/7 cycle... even if you're going to work Saturdays and Sundays, cos every day was the same" (p.35)

Katy, Erin, and David all shared a sense that the pressure to work and perform was increased 'post' C19 to some extent as services were being reopened between national lockdowns. Katy shared how during a phone call with a patient whose appointment she had to cancel, a client suggested C19 was over and so services needed to *"get back on track"*. In response to this Katy noted thinking:

"we can't just click our fingers and overnight transform back to no waiting list, no backlog or anything like that" (p.33)

Katy shared a sense of pressure to provide a service for patients that need it. She was exasperated with the suggestion that there is a magic way to erase the impact of C19 with a simple click of a finger, suggesting that there is much more complexity and required sustained, hard work. Erin and David also felt this pressure to perform at work 'post' C19. For example, Erin described having to provide and catch up on previously cancelled services:

"it feels like it's never ending and that you, you see the target, you achieve it, but then the goal posts move." (p.26)

There is frustration and lack of satisfaction with her 'post' C19 recovery work never ending, and a powerlessness to the NHS system that set and then kept moving the goal posts. When I asked her what it was like to have this need to perform, Erin shared an unseen tiredness and hard work:

"It's kind of the swan looking all graceful and calm and collected on the surface, but then struggling underneath the surface" (p.30)

Three participants, Lauren, Teddy and Jess, described a continuation of pressure to perform from 'start' to 'finish' of C19. Lauren described how exasperated she felt by moving from performing during C19 and the pressure to just carry on, for instance, in their service expansion plans to open a new hospital:

"So, we went straight from COVID to alright then, you've done that. Let's get on with this. And you're like, for God's sake!" (p.44)

Jess worked in a division where some part of the service remained opened during C19 and she had to continue meeting the need to perform by having to:

"...set up a rota for this, or set up a rota for that, or this person's gone off sick, so now this needs covering. All of that kind of thing was still ongoing... everything just keeps moving, doesn't it? The train never stops... there's always people coming through the front door: [Emergency care provision] never closes... Services never close" (p.20)

The tone in which Jess shared her experiences echoed the position she had to take of continually moving and doing as the train never stopped, meaning she could not stop either. Jess described some of the toll of her long days which often ended with emails from home as *"there was no cut-off"* and that this relentless need to keep going and perform meant she felt like a *"zombie"*, illustrating the tiredness and mindlessness of the pressure to just keep showing up at work. This pressure has continued 'post' C19 as now she is expected to:

"get things going... And it was like you need to achieve 120% of last year's activity by tomorrow almost, like that's the instruction we got: there's like, you need to catch up your backlog and you need to deliver 120% of what you were doing in 19 / 20 in 2021. And then you start to be held to account and all those meetings going. And the pressure just gets tougher and tougher and tougher" (p.20)

The repetition of the word tougher suggests that pressure to perform escalating and perhaps a shared sense of exasperation toward the expectation that effects of C19 need to be erased with ease.

Sub-theme Two: Keeping Pace with Change. All participants shared some experiences of having to react to change around them. This is linked with needing to be reactive to the 'unknown nature of C19' as they did not know what to expect and thus perhaps needed to be reactive. A group of the sample talked about how once C19 began, their jobs entirely changed. Katy and Erin used the concept of time to illustrate the sudden nature of this change. For instance, Katy stated:

"my whole my my role changed completely changed overnight. So I went from doing one role within my NHS OPs job to literally go in in first thing on that Tuesday morning and as a team, we just sat there and thought, right, we've got to completely reinvent our whole service just like that" (p14)

Erin also described her redeployment:

"our roles changed quite quickly overnight because there was nothing to do. Our day jobs kind of cease to exist the way we knew it" (p.7)

There is an immediacy to the use of the word overnight, which showcases that speed of their regular tasks, such as getting patients that required surgery, stopped. Jess also illustrated a similar speed of change by referring to the concept of time:

"we basically within a couple of days flipped an entire outpatient...umm, unit into like a COVID assessment unit" (p.10)

The use of the word flipped gives a sense of the swiftness and hurriedness with which 'normal' work stopped in C19. In all these instances there is a sense of needing to be responsive to C19, which meant discarding the carefully crafted usual ways of working. Jess described:

"[she had to] cancel all these clinics and theatre lists. And I'm talking like months worth that you've, that you've worked so hard and so meticulously to make sure everybody is in, in the right amount of time, on the right day" (p.23)

While Jess found this quick-change shocking, David found an excitement in this way of working:

"you really felt like you were at the front cutting edge of like change in service, how people were responding to the challenges of the pandemic" (p.13)

His use of the phrase cutting edge suggests some pride of having to be responsive, creative, and innovative to keep up with the pace of C19 and how quickly work changed.

Participants also noted there was a continuous need to respond to change within work. For example, Lauren described quick changes in direction at work:

"Wear a mask. Don't wear a mask, you know vaccinate. Don't vaccinate. It-it literally changed by the hour. Test. Don't test. That was the, that was the big thing with us. Swab patients. Don't swab patients." (p.26)

Lauren's use of the short, punctuated and succinct sentences suggested how quickly the guidance changed, sometimes in opposing directions, and the perhaps effortful attention that was needed to keep up with this change. Teddy described a similar situation:

"So once you just set up a whole protocol and SOP and a policy and a, and a system and then it would change the next day. Everything from don't wear masks for this; do wear masks for this. Follow this protocol. Follow this testing regime. And three days later it changed" (p.15)

Teddy illustrated the constant presence of change and the need to *"roll with it"* and responsively adapt his plans to keep up with it. Chris shared a similar sense of ease within the change and said he *"quite liked the fact that as [he] got new information, new data"* he had to use to adapt. Katy shared a familiarity in this way of working:

"*operational managers we're used to it being up and down, and I know everyone is but I think we are used to being told one thing one day and then actually it's the completely opposite direction of travel the day after. That's what we're [operational leaders] geared up for. That' what we've experienced through our whole working careers probably (laughing), it's just heightened in COVID" (p.62)*

Chris, like Katy, shared that speedy change at work, even outside the pandemic, was familiar to him because it was *"the nature of the beast"* in operational leadership.

Sub-theme Three: Imposing Command-and-Control. Participants shared experiences of needing to take on the more directive leadership style of Command-and-Control to be able to meet the

'unrelenting pressure to perform'. Amanda, Lauren, Teddy, Erin, and David all recognised a need to work in a Command-and-Control style rather than the usual collaborative leadership behaviours. However, for Amanda, Lauren, and Teddy there was more emphasis on embodying some of the Command-and-Control systems in comparison to Erin and David.

For example, Amanda shared how the NHS "*went into a real command and control, nationally. Quite rightly*" and described a situation where she asked a colleague to review hospital patient bed capacity. Amanda shared her frustration at this person not completing this important task: *"When I ask you to do something, I expect you to do it!"*.

She acknowledged that it would be *"rare"* for her to take such a directive and inflexible approach and that during C19, she instead recognised the need to and adopted a message of:

"*I'm not asking you to do something, I'm telling you to do it! And I know that's not comfortable for you. It's not comfortable for me. What I don't expect is you to question it.*" (p.20)

Amanda highlighted that there was discomfort within her and her colleague of working this way, but also suggests that that there was little alternative as there was a need to quickly respond to C19. Teddy also acknowledged actively adopting a directive approach to his leadership:

"*this is your orders. Go and get on and make it work. And people were disgruntled, but they got on with that and that was the thing. And I changed my brain to civilian life of, could you please do this and would you like to do this?... but to going back to 'no, we're going to do this today because that's the best plan, otherwise we have no plan'*" (p.17)

The use of the word military word 'orders' highlighted the unquestioning nature of directions that he had to give. Lauren described that her usual leadership style was collaborative but that her and her team:

"*didn't have that luxury. It was like we need to do this and we need to do XYZ. ABC 123*" (p.36)

There is an echo of inflexibility to the tasks that had to be done and the use of the word luxury highlighted the perceived necessity of taking on Command-and-Control ways of working, despite naturally being more collaborative in her approach*:*

"*I forgive myself for that because the circumstances needed it so that, that was absolutely fine*" (p.36)

Erin described the same lack of a *"forum to collaborate or to share ideas or to or to listen and to voice anything",* illustrating the powerful and imposing oppressive nature of the Command-and-Control mechanism. When I asked Erin how she felt about having to lead in such a way, she shared:

"*Um, it was, it was OK, because you were, you were, you were protected in the sense that you were, you were taking the lead from the top of the organisation. And and so I didn't get much kind of push back or, or resentment in terms of that way of working.*" (p.22)

The use of phrases such as 'protected' and 'taking lead' by the unnamed professionals at the 'top' of the organisation, is suggestive of the power of the system that meant she had to be more directive in her approach. This perhaps highlights a ripple effect of the Command-and-Control mechanism present in the NHS during the time of the pandemic that Erin enacted, and others (such as Amanda, Lauren, and Teddy) actively adopted and emphasised in their leadership roles.

Sub-theme Four: Autonomy and Freedom to Act. The participants shared experiences of the pleasure of holding autonomy and freedom to complete tasks during C19. This sub-theme poses a contradiction as it refers to having freedom in an otherwise restricted system (as illustrated by the 'imposing command and control' sub-theme) that was goal oriented (as illustrated by 'unrelenting pressure to perform' subtheme). However, this freedom still sat within parameters dictated by the NHS system: participants were given instruction to adapt and deliver services safely in C19 and then were given the freedom to engage with this task quickly in whatever way necessary. Part of this experience was the removal of 'red tape' that allowed for greater satisfaction at work. For instance, Katy said:

> "*we actually achieved much more than you would normally because it was we don't have to worry about finance. We don't have to worry about annual leave processing and this, that and the other*" (p.17)

Katy identified an absence of the usual multiple barriers around her (this, that and the other), which restrict her from achieving. Amanda illustrated this also by sharing how once C19 started, they were able to quickly implement needed change in relation to online working:

> "*we talked about in, implementing video conferencing and all the rest of it for two plus years! And within two weeks the organisation had got Teams up and running!*" (p.11)

The tone of excitement in how Amanda speaks about this shows her satisfaction being able to make changes quickly: she shared how "*absolutely marvellous*" this was. Some participants shared a sense of freedom from their seniors during the C19 pandemic. For instance, Chris said:

> "*So, it, it wasn't one of those things where you have to write a paper and it had to go through 5 committees. And everyone said "oh I'm not really sure that that option is better than that option. Maybe we need to think about it again and go back round again. It was just, just get on and do it and make it happen!*" (p.9)

Chris shared experiencing a sense of laboriousness and slowness to the usual decision-making processes, and a sense of frustration that he often had to 'go back round again' making for unsatisfying progress that involved many of the same stops. This was replaced with a satisfying simplicity to just "*make it happen!*" so decisions and outcomes were *"tangible"* and *"immediate"*, such as *"going down to hardware stores and buying roles of tape to mark things out on the floor".* Teddy echoed a similar sense of freedom and excitement:

> "*I was given a lot of responsibility to go, right. You know what you're doing. Go and do that*" (p.13)

There is a simplicity to just being able to 'go' and flourish by being trusted by their seniors to know what he is doing. In Teddy's manner of speaking, there was a sense of feeling energised through being able to *"give the best care"* they could as there were few restrictions. David shared a similar sentiment of pre-C19 bureaucracy being a kind of a *"treadmill"* where someone else set the pace but that during C19, him and his team were:

> *"setting [their] own sort of agenda about what was needed and what was required and, and that was quite fulfilling" (p.37)*

Like Chris, David also emphasised being able to make tangible changes such as getting *"a big marquee because our waiting room was far too small"* and the simplicity and satisfaction of being able to do this quickly. David also shared how he *"thrived"*, especially in the early days of the pandemic through quick decision making and being able to work in his preferred way which was:

> *"very bottom up. It was very like, you know the we're listening to the clinicians who are on the shop floor who are dealing with these patients... reading the evidence. And we were listening to the m- you know, the virologists and the microbiologists" (p.15)*

During C19, David was given more autonomy to work how he wanted which included empowering the clinicians who he saw as the key people that *"drive"* a service forward. In the 'post' C19 world, Chris acknowledged a return of the bureaucratic processes "*it felt like being sort of handcuffed again"* and needing to seek *"permission"* through these processes, as if he was not trusted.

GET Three: Being Protected and Protecting within the NHS

This GET refers to the experience of relationships within the NHS: C19 united the health service professionals, which allowed for collective strength, while participants also navigated their own leader responsibilities to protect those they work with. The GET is made up of three sub-themes. See Appendix O for reflection on the naming of the GET.

Sub-theme One: United Resistance Against C19. A sense of C19 uniting everyone was a shared aspect of all the participants' experiences. As part of this sub-theme participants talked about needing to collaborate together and contribute to the collective effort to manage C19 in healthcare services. For instance, when Erin talked about being redeployed, she described having to:

> *"muck in; you still had to push trolleys and move stock and deliver to the ward." (p.9)*

The use of the phrase 'muck in' supports the idea of needing to collaborate and actively embroil yourself in the 'mess' of it all alongside the clinicians. Erin highlighted she was *"pleased"* in her redeployment because it felt like she was *"value adding"*, illustrating the pride of being a part of this collective effort. This same sense of pride of contributing to the joint effort in C19 was echoed by David: *"I felt like we were really contributing" (p.13)*

David's use of the pronoun 'we' emphasized the sense of being joined. This same sense of being joined in the bigger C19 effort was shared with Katy, Amanda, Lauren, Chris, and Jess. However, their experiences held a more combative energy and joint determination to fight C19. Lauren described how:

"there was a general team spirit; it was like, yeah, come on, we can do this. It's gonna be difficult, but you know all the stuff that makes you proud to be in the NHS." (p.24)

The use of the phrase 'team spirit' illustrated a sense of camaraderie and energy held between people to manage the difficulties of C19. Jess shared the same determination to not be beaten by C19 any uniting against it:

"we have to put things in place like there was no giving up at that point" (p.13)

Jess shared how it was a shame *"we couldn't like go out and celebrate like at the end of each week!"* with the word 'celebrate' illustrating a sense of pride, energy and excitement to the team winning against C19. Teddy shared a similar experience:

"then the numbers are starting to come down for the COVID and inpatient [admissions]… And there's the first time you felt, crikey, we've actually done something. It feels like we're winning. It was the first time and there was a lot of plateaus and peaks and troughs after that point. But it's the first time that everyone felt like, you know, it was a bit of like those action movies where all, Yeah! and you felt a bit like that." (p.20)

Teddy's use of this simile supports the interpretation of an oppositional relationship between C19 and the united efforts of the NHS to defeat what Amanda called the *"common enemy"*.

Sub-theme Two: The Protection of Mutual Trust and Closeness. This sub-theme refers to the participant's experience of being able to manage and survive C19 through the strength and protection provided by being together with other NHS colleagues (thus linking this to sub-theme 'united resistance against C19'). David referred to this sense of togetherness when I asked him to tell me about his wellbeing through C19:

"when you say that I think of the team that we had, who I was like, closely working with and like we'd have a laugh and you know, we'd have, you know a joke" (p.39)

There is a sense of unitedness in being able to be together by sharing humour and lightness, illustrating a comfort and safety present in the group. Katy, Amanda, and Jess also shared how being together meant you actively protected each other. For example, Jess shared that it felt like *"you were in the trenches together",* fighting C19, but also that:

"you never felt let down, ever. You felt like everybody had each other's back" (p.28)

The metaphorical description of other people 'having your back' illustrates the safety and trust that was there between the people she worked with, allowing her to feel protected even from angles you yourself are not able to see. The sense of trust and closeness was further illustrated by two participants using the word 'family'. For example, Lauren talked about her *"working family"* and Amanda shared:

"We're family. We can call each other, we can have our arguments, but nobody will criticize us as a family. You protect each other. You look after each other. You represent each other. But if

we've got problems, we come and have that argument internally... we really stand by each
other." (p.33)

Family suggests closeness and strong bonds, even where there are arguments. A similar sense of being able to rely on those close and trustful relationships is illustrated by 'standing by each other'. The physical proximity of standing shoulder to shoulder illustrates a closeness and strength of perhaps being able to prop each other up if this is needed. Amanda shared how staff sickness was a threat to this togetherness but that retired colleagues came back to work:

"very experienced managers that had recently retired before Covid. They both came, two of
them both came back. Worked full time. All I had to do was pick up the phone and say, we, we
need some additional resilience because if we start going off with Covid. And just their
experience of managing services. And they both came back." (p.33)

The ease with which Amanda picked up the phone illustrated the far-reaching sense of protection of family. For Amanda, her work family was never far away.

Teddy also described experiencing a similar sense of strength in being together:

"It's like I can do this. Yeah, we can do this. This is this is easy. We've gone all of that and all of
that support; we can do anything here and take on any challenge. That's what you felt. You're
unstoppable" (p29)

Teddy's use of 'unstoppable' brings up an image of how being united together meant they were a force that was unyielding and unbreakable, as if there were no gaps between the individual people that allowed for this momentous strength of 'unstoppability'.

Sub-theme Three: Weight of Protecting Others. Five participants described experiences of aligning themselves with the responsibilities of supporting the clinical staff around them. David, Jess, and Lauren acknowledged the risk that the clinical staff dealt with as part of their role, and all three shared a worry around being a leader who made decisions that could affect the wellbeing of their staff. For instance, Lauren shared how a pregnant clinical staff member within her service became poorly with C19:

"it was that element of, like, we've let her down. You know, what, if and if anything happens to a
baby, you know, that's, that's almost on our consciences, really" (p.29)

The use of the word 'on' suggests a weight and heaviness to her position: she had to make decisions (such as whether staff were sent home if they were pregnant during C19) that affected the wellbeing and lives of others. Jess shared how early on the pandemic two colleagues had sadly died of C19 and she described being *"so risk averse"* in subsequent decision-making processes because of this. She described how her management team decided to send the medical secretaries to work from home before there was technological equipment available to them because:

"we'd lost two staff members that were young, fit and healthy. And I think that is such a memorable moment because that then was in the back of all of our heads that every decision that we made" (p.12)

Both Lauren and Jess shared a sense of helplessness to truly protect the patient-facing clinicians. For instance, Jess shared that clinicians were making difficult decisions, such as deciding whether to perform necessary surgery on patients that were unwell with C19 where there is a higher chance of complications and death of patient. She said:

"it was seeing our clinicians everyday having to deal with that because you're the first person as an Ops manager. They come and knock on your office. And like I said, Jack of all trades, master of none, offloading" (p.16)

Jess highlighted her role in hearing about clinical decisions being made by clinical staff, which illustrated a distance between her and the clinical care in the service. The use of the word 'offloading' also highlighted a passivity to being on the receiving end of the *"sad stories"* she heard from clinicians. It was as if she was a container for clinicians' emotional stories. Jess perhaps felt worried about her inexperience of being able to hold such stories as part of her job (a 'master of none') or what difference it could make for her staff.

Lauren illustrated a similar distanced bystander position when she witnessed a clinician telling a family member of a dying patient that they were unable to come onto the ward and say goodbye. When Lauren talked about her reaction and thoughts in this situation, she said:

"I felt that heaviness of . . .these are, say they're your people. These are the people you're now responsible for. This is your area of responsibility. And Oh my God, what are these guys gonna need when they come off these shifts? You know what? What support are they gonna need?" (p.17)

The use of the multiple questions, without providing answers to them, highlighted the sense of helplessness in what her role is in supporting *her* staff but also that may be little that she could do to genuinely alleviate the pain and loss that clinicians were interacting with.

Teddy also described an acceptance of having to support clinical staff given his expertise in the military. He shared how he knew there would be an *"end game"* to C19 and that all he could do was *"treat it like a war zone"* but that not everyone had the same military experience:

"very senior, senior clinicians with 30 / 40 years [experience], in tears [saying] 'I don't know what to do. I'm so scared to come to work.' There was a real period when people did not know what to do. There were really experienced people that were, you rely on them to make decisions and they couldn't. So yeah. And they didn't have anything else to compare it to; except for 30 years of normal, and that was a real yeah challenge to, 'how do I support this person correctly?...' (p.12)

He took an active part in protecting others by asking how he could meet the demands of this responsibility given the circumstances.

GET Four: Being a Public NHS 'Hero'

This GET refers to participant sense-making of the common public narratives around the NHS professionals being 'heroes' and how participants experienced these narratives based on their own roles and work. The GET is made up of four sub-themes.

Sub-theme One: The Pride of Being a 'Hero'. This sub-theme aims to capture the sense of pride that most participants had in relation to their work and efforts during the pandemic. This links to 'united resistance against C19' sub-theme because pride was contextualised by participants' experiences of meaningfulness to the united C19 effort and their contribution within it. This sense of pride was also related to the process of being recognised for this work, either by themselves as individuals, other people at work, and, most commonly, by the UK public.

David, Chris, Teddy, Lauren, and Katy all shared instances of feeling valued by the public. For instance, Chris shared:

> "*the feel good factor was obviously, people knew that I worked in the NHS. And em, you know the, the clapping on the, on the doorsteps and, and stuff like that was em … It seems a very distant memory now, but em that was … em the appreciation that people showed" (p.29)*

The happiness and positivity of national acknowledgement allowed for warming 'feel good' moments and being proud to be a part of the NHS. David also talked about the nation clapping and how *"everyone got quite a buzz out of that"* as if the warmth of the public appreciation energised him and his team. Teddy shared how members of the public would recognised him as an NHS professional in a supermarket:

> "*'Hey, these two are in the NHS', you know and it was like, 'yeah, I am actually. Yeah. Thank you'." (p.30)*

The way Teddy talked about this conveyed a modest pleasure and pride in being recognised and seen by the public in this way. For him, this recognition of his efforts motivated him because he was being relied upon:

> "*if you can get a genuine sense of whoever it is, valuing, and really valuing what you do, respecting what you do, you can crack on and do it." (p.30)*

Jess shared a similar sense of feeling needed and relied upon:

> "*if there was, I don't know, 1000 people on the train before. And now there's one, those 999 people are not influencing what's gonna happen in that hospital right now... there wouldn't be anybody doing this" (p.21)*

Jess experienced being alone on the train and thus saw how much power she had to influence by being the one that reliably showed up to work, in comparison to other staff that were off sick from work. There is heroic pride in being able to say she was being relied upon because there was no one else on that train and being a part of what Lauren termed to be the *"healthcare army"*.

Katy, Amanda, and Teddy all linked this sense of feeling appreciated was a shift in how managers and leaders in the NHS are usually perceived. Teddy noted there is *"bad press"* around management and Katy described how the public thought that the NHS was:

> *"overrun with managers that are paid too much and don't do much, they just sit at desks and twiddle their thumbs... but through the pandemic, I don't think that public perception, it wasn't like that. It was, it didn't, they didn't matter.. if you were a nurse or a doctor or receptionist, an operational manager, you work for the NHS so it was 'thank you for everything you're doing'"* (p.28)

Katy shared a sense of pride of being acknowledged this way by the public:

> *"feel good that we were acknowledged as a, as a, as I suppose as experts in our own right and field and, and acknowledge that we, we worked hard you know"* (p.29)

The use of the word 'experts' by Katy suggests a level of legitimacy to her being able to feel proud, that was achieved through public recognition. Teddy noticed a similar shift:

> *"I know it's not always seen as a proper profession. It's like you drift into management by mistake... Whereas now there's a bit of a focus to be, you can train to be"* (p.40)

Being able to choose to go into NHS leadership, rather than drift into it, allows for a similar sense of professional and career legitimacy that was shared by Katy. Amanda did not talk about feeling appreciated by the public, but instead shared how her and her team was appreciated by work structures around her:

> *"I think we get a lot, a lot of positive attention in our organisation, to the point where I think some of the other clinical divisions get a bit fed up of it. We had to set up a Covid virtual ward, for example. And we did it just because of our brilliant, my team are, and like I say, it was just that can do attitude. So as soon as we knew we had to set up a Covid virtual ward, my team said, yeah, we can do that. Yeah, we can absolutely do that. And they lead on it. And they've won national awards."* (p.30)

Her sense of pride is emphasised in her team (they've won) rather than herself, however, is still underpinned being seen and recognised by others. This recognition allowed for that pride of the heroics of achieving and perhaps feeling like they in some way won in the C19 war.

Sub-theme Two: The Humility of Being a 'Fake Hero'. Despite the public recognition that allowed for some of that personal and professional pride (as illustrated in above sub-theme), six participants shared a sense of being a *"fake hero"* (Lauren). Fakeness linked with feeling underserving of the public praise because they held relatively protected and humble positions in comparison to the 'frontline' patient-facing staff. David illustrated some of this:

> *"I didn't really feel they [the public] were clapping for me. I felt like they were clapping for the clinical teams. And that's right, because they are the people who deserve the recognition"* (p.41)

David suggested that the clinical staff had it worse than him and Lauren, similarly, shared feeling in awe of the perseverance of the patient-facing staff when she entered her new role:

"I felt very, very, very humbled by them. You know, they've been doing this for 12 months" (p.14)

Lauren compared her somewhat protected position in comparison to the patient-facing staff who had to witness patients "*having to, to, to die without their loved ones around them*". Lauren shared she was motivated to support this group of staff from a less obviously heroic position. A similar experience was shared with Erin seeing patient-facing staff on wards:

"it kind of grounded you, humbled you. It humbled me anyway... if the doctors and nurses were able to do it, turn up each day and not be scared or not show that they're scared. Then the least we can do is work um, and and find solutions for providing the right levels of PPE in the right quality." (p.10)

The PPE (Personal and Protective Equipment) procurement included *"a lot of collaboration and things that went unseen. Um, quite right. It didn't need to be seen"*, evidencing the humbleness of her position and an admiration of the patient-facing staff. As such, the least she could do was do the best possible job around PPE procurement in the background. Jess shared the same sense of her contribution, in comparison to the patient-facing staff, being *"a small bit"* that she could do to help:

"I'm not there giving the clinical care, but it's being that shoulder for people to come back on." (p.15)

This suggests Jess took the position of being the unseen strength for the clinical staff. She noted her own support and strength was needed for the sake of the staff that were making difficult decisions *"every day for that awful period"* of time. Chris directly echoed the experience of being in the background to the true heroic of the patient-facing 'frontline' staff:

"I was getting praised over something that actually wasn't something that I was doing. Hence kind of it, it being fraudulent. But knowing that you have a part in the machine, em that needs to keep everything else going." (p.38)

He acknowledged that his contribution was not in the spotlight and that, despite feeling *"guilt"* for not having to face the *"trauma"* of the clinicians, there was an acceptance that he played an important part in the system.

Sub-theme Three: The Fall of the 'Hero'. Half of the participants shared an experience of the 'hero' narrative shifting to a more critical tone as operational leaders' clinical areas no longer met expectations around performance in the 'post' C19 time. Katy described this in relation to shifts in expectations from members of the public:

"I would say that it it was a much more negative experience when we're coming out of it and I think it was because publics perception changed. So they went from 'well done, you're brilliant, you're working hard, thank you for all your efforts' to 'Why have I waited 12 months for my appointment?'" (p.31)

The public thankfulness was replaced with an impatience to be seen by the service that was paused during C19. Katy illustrated the quickness of this shift by the opposing messages of 'thank you' being replaced with ones of 'not good enough' within the quote. Erin shared a similar sense of the performance of her clinical area no long being good enough:

> *"there was clearly a lull during the kind of the height of the pandemic when people didn't turn up, didn't have access to hospital services or limited primary care services. But then that lull soon went, and patient complaints came, came back in kind of a vengeance" (p.27)*

The use of the word 'lull' suggests a stillness that was juxtaposed with use of the word 'vengeance' to highlight the quick and forceful return of more patient complaints than ever before, as if aiming to hurt her in retribution for lack of services provided during C19. David shared in the experience of the quick shift of his work no longer be good enough by his workplace:

> *"you know the culture was very positive and it was very much like thank you for anything that you doing, and it was... and then as that kind off switched into, you're now not performing. You know, performance needs to be better. Erm, and a kind of switched totally back on to performance. And people were like, found that well, you know, that was quite difficult to deal with and you know like...I think we're all quite disillusioned by that" (p.30)*

Describing this 'disillusioning' moment, David suggests the heroics during C19 were not real, like an illusion, and that he perhaps naively trusted in the initial praise of his work. There is a hurt to finding out the fragile nature of being a hero: the validity of his heroics was dependent on other people. Lauren described a similar sudden ending to the *"heady days"* of being a 'hero' to having *"all this recovery to do"* now C19 is over but that unlike David, she had already anticipated that praise could turn to criticism:

> *"I do remember saying at the time to the managers and the people that are I was managing. People have got short memories and hindsight is a wonderful thing. So, whatever decisions you're making right now, make sure you keep the evidence for it somewhere." (p.26)*

Sub-Theme Four: The 'Unseen Hero'. Half the participants described a sense of feeling unseen by the workplace, which contrasted with their experiences of being made to feel like a 'hero' (even if a 'fake' one). Erin and Lauren both shared an experience of their wellbeing not being considered by their workplace in the same manner as the patient-facing clinical staff. For example, when I asked Erin to tell me about her wellbeing since the onset C19 she noted:

> *"no one else has ever asked that question in the last few years... I guess when I say it out loud, it's it's pretty bad" (p.37)*

This highlighted Erin's experience of her emotional wellbeing being ignored despite how much staff wellbeing has entered conversations in the NHS. Lauren shared in this sense of shock and incredulity of her wellbeing being unrecognised by the workplace while having a meeting over the lunch break:

> *"You know, you're eating your lunch while you're telling us about staff, staff wellbeing. It's like, can no, can anybody else see the irony of this!" (p.44)*

Jess and David on the other hand described feeling unrecognised for the extra hours of work they put into their jobs during C19 and a frustrating dichotomy between how the workplace rewards and recognises the clinical staff but not management, despite how they are meant to be united by the same goal. Jess said:

> *"But we were also here trying, doing the same thing. Umm, and every single minute and hour and day and week that we worked overtime... you don't get any kind of like recognition in terms of like, 'Ohh, amazing you worked 20 hours over this time'" (p.47)*

The repetition of the use of time (minutes, hours, days, weeks) gives the sense that there is a lack of recognition over extended periods, not just during C19 and that despite the efforts (or 'heroics') during C19, managers of the NHS continue to be *"an afterthought"* (David) in comparison to some clinical staff.

GET Five: The Nourishing and Growing of the Self

This GET captures some of the intrapersonal experiences of participants prioritising doing what mattered to them as individuals, as well as personal growth at work due to experiences of C19. The GET is made up of two sub-themes.

Sub-theme One: Reconnecting to What Matters. This sub-theme aims to capture the shared experience of participant seeking a better 'work/ life' balance and boundaries (as referred to by Katy, Teddy, Chris, and Jess) and focusing on doing things that nourished and supported their wellbeing and allowed them to live a life that they find meaningful in 'post' C19. For some this was due to the amount of time and effort that work demanded of them during C19 (linking to 'conflicting parts of self' sub-theme) and for some it was the realisation of their own mortality (linking this to 'the power of C19 to harm' sub-theme). Lauren shared how as the pressure of C19 come down in 'post' C19, she:

> *"got back to my fitness. I've lost weight. It's almost like two years of my life like doing that, and then it's like, right, OK, coming back down. Umm, getting back into a routine of looking after myself more" (p.39)*

Jess was doing the same:

> *"... go for a walk every single night. I go to the gym. I see friends. I go out for a drink." (p.38)*

Katy, Teddy, and Chris all shared in trying to prioritise and *"really cherishing the time of having with friends and family"* (Chris) and Teddy aimed to protect his energy and time with meaningful human connections at work because "*not everyone's nice in the NHS. Some people are just robots"*. For all three of these participants this reprioritisation and gratefulness for life was underpinned by a new or renewed connection to their own mortality and finite time on the earth as humans. For example, Chris described:

> *"I used to be of work very early in the morning and leave very late at night. Em and em, actually it showed me that, you know, that there's not necessarily … em that many years on, on this planet, so make the make the best of them that you can" (p.8)*

Connecting to his own mortality, allowed him:

"time to listen to the birds sing. Or notice that the sun is out. And all of those kind of things, I think em ... It, it is almost like a bit of a 'duh' moment. Like, oh God, you should have been aware of this stuff anyway and, and sort of enjoyed life for the little things" (p.32)

Chris' use of the birds and sun are often used to illustrate the romanticised simple beauty of the world that one can take for granted. Chris emphasised connecting to and finding contentment in those simplicities of life because, as commented by Katy, *"life's too short"* to do anything else.

Sub-theme Two: Inner Strength and Empowerment. Six participants shared a sense of development and gaining of strength and self-confidence from some of their difficult pandemic experiences. Both Katy and David acknowledged their unpleasant emotional experiences have resulted in knowledge and expertise in how they respond to such experiences in the future. David shared that the stress of having his work and clinical area performance managed meant:

"that stood me in good stead and had to be able to you know to, to manage my own emotion" (p.33)

David highlighted a new mastery of his emotions that may stand him in 'good stead' in the future. This is supported by him sharing how any strain on his sense of resilience *"steels [him] to do better, in a way to kind of respond"*. There is a suggested strength and inner solidity to be able to face and withstand ripples of stress.

Jess shared experiencing the fear and panic of having to "*sink or swim"* during C19 as her seniors were off sick meaning in some sense she felt alone in the job. Jess was able to acknowledge how because she was able to swim rather than *"break"*, she felt empowered enough to seek a challenging new job now:

"a job that I'm in right now [prior to C19]... I would have gone, no, thank you, nowhere near; do not want to have such a challenging ride. And actually instead I've gone, yes. Thank you very much. I'd love, I'd love a challenge where I feel like I can make a difference" (p.29)

She demonstrated a confidence and inner strength to withstand a challenge and still be able to positively make an influence in a new service that is struggling with its performance. She shared:

"now things that may have fazed me before, when you're faced with challenges day-to-day, actually seem like hills rather than mountains now" (p.27)

That she is no longer bothered by such challenges suggests a similar 'steely' strength that David took from his experiences as a leader in the pandemic. Jess suggested a change in perspective where big challenges are no longer seen as so significant (mountains become hills), suggesting a strength gained from knowing that she was able to manage a pandemic, and that most other future professional challenges will not compare.

Chris shared how during C19, he uncovered the same sense of being human as his seniors because despite their expertise, they also did not know the 'right' answer. Chris described a shift in how he related to and worked with power within senior relationships:

> *"what that's given me, is to be able to say … in a nice way, you, you don't really have the answer here. Erm I have an answer. You may not like my answer. But I think this is a better way of doing something compared to what you're suggesting we should do." (p.19)*

He *"constructively challenges"* rather than taking a position of *"Yeah, sure, I'll I'll do that'"*, supporting that he feels more empowered within himself to potentially have difficult conversations within the power structures that previously he was easier influenced by.

Chapter Four: Discussion

The research project set out to explore the following research questions:

1) What have been the lived experiences of working as an operational leader in the NHS since the beginning of the COVID-19 pandemic?
2) What have been the lived experiences of wellbeing of operational leaders in the NHS since the beginning of the COVID-19 pandemic?

The five Group Experiential Themes (GETs) and their sub-themes are summarised into four key findings: (1) the experiences of the NHS system, (2) the experiences of NHS relationships, (3) the experiences of being a 'hero', and (4) the experiences of the self 'post' C19. The findings are set out against existing literature. This is then followed by considerations of the strengths and limitations of this study and suggestions for future research. The chapter ends with some implications and a concluding statement.

Summary of Findings

(1) The Experiences of the NHS System: Performing under Pressure and Exerting Agency

It is perhaps unsurprising that participants shared experiences of an *'unrelenting pressure to perform'* as part of their roles since the onset of C19. The pressure to perform was emphasised and present for participants during and 'post' C19. Some of the challenges during C19 included needing to stop day-to-day tasks, managing staff sickness, cancelling routine clinical services, and continuing to provide emergency care provisions that did not entirely shut down in C19. For a time, the pressure to perform was largely about addressing the impact of the pandemic on how their clinical services were run. Challenges 'post' included recovering service provision that was reduced or stopped during C19, such as hospital outpatient appointments and elective care. Other participants noted a continuation of this performance pressure from during to 'post'.

This pressure to perform was linked with the experience of '*keeping pace with change'*. This sub-theme captures the abrupt experience of needing to stop usual NHS operations at the start of C19 but also the ongoing role of change as part of operational leaders' roles and responsibilities. This appeared to be prominent for participants in relation to the frequently changing infection prevention and control guidance around use of Personal Protective Equipment (PPE), isolation and C19 testing which affected the running of clinical services. The rapid guidance changes fit with the idea of '*the unknown nature of C19'* sub-theme in GET One: healthcare systems needed to adapt to new information about C19 as it developed. These changes were dictated by national guidance and executive leadership within the NHS. The role of the operational leader was to 'keep up' and implement the necessary changes and ensure alignment with the guidance.

The demands and nature of change at work is similar to the findings of the systematic review of nurse managers in C19 by Leppäkoski et al. (2023). Although none of the studies were UK based, the findings noted the need to quickly adapt to the changes brought about by C19. Aydogdu (2023) reviewed 12 studies on nurse manager experiences of the pandemic and noted increases in demands at work,

especially around infection prevention, which was also emphasized by some operational leaders in this study.

Operational leaders' experiences of their work roles could be understood as an increase in the workplace related demands (the tasks of job roles that workers are expected to meet) within the Job Demands-Resources (JD-R) model (Bakker & Demerouti, 2007). For operational leaders, the demands of work changed to have a greater focus on C19 and these work demands emphasised the need to quickly respond to change.

Participant experiences of *'unrelenting pressure to perform'* was also set within a context of Command-and-Control functioning (National EPRR Unit, 2015; Pritchard, 2021). Participants shared some experiences of this in this study. *'Imposing command and control'* meant that operational leaders led in a more directive way, even if their preferred style of leadership was more collaborative. This links to Smithson (2021) study in which Australian senior leaders in healthcare noted a discomfort in Command-and-Control ways of working if this was not their usual way of leadership. While one participant noted a similar discomfort in leading in an unusually directive way, operational leaders emphasised an acceptance of needing to use Command-and-Control during the pandemic to support their services to perform. Gruenfeld (2020) suggested that if decisions were not made quickly, the workforce may have experienced powerlessness and a lack of direction, thus highlighting the need for directive, top-down Command-and-Control ways of leading in crises. One participant agreed with this as the directive way of working allowed them to offer a plan for service delivery where there would not have been one had a slower, more collaborative approach had been taken. Operational leaders' use of this directive leadership approach sits more in line with the use of transactional rather than transformational leadership in times of crisis (Vera & Crossan, 2004).

To facilitate quick decision making and implementation of needed changes, operational leaders experienced the usual 'bureaucracy' and 'red tape' present in the NHS being removed. This allowed them to experience the satisfaction of having the *'autonomy and freedom to act'* and to see quicker and more tangible outcomes resulting from their leadership actions. This autonomy was at least in part facilitated by the removal of barriers such as access to additional funding at the time of the pandemic (UK Government, 2021). The reduced 'red tape' was experienced as exciting, energising, and empowering. Operational leaders' increased job satisfaction associated with this freedom to act could be understood through the Job Demands-Control (JD-C) model (Karasek, 1979): leaders experienced greater control and ability to exert autonomy in *how* the demands of their job were completed. The model suggests greater control can result in reduced occupational stress which has been linked with anxiety, depression (Karasek, 1979) and experiences of burnout (Korman et al., 2022). Work place satisfaction, as experienced by operational leaders, is also a common marker of wellbeing in the occupational literature (Bakker & Oerlemans, 2011).

The experiences of autonomy within the NHS system also links to Spence et al. (2023) who interviewed 11 Irish healthcare staff to explore service changes implemented during C19. While the Irish healthcare systems may be different to the UK, one of the findings from this study noted that C19 was regarded as a medium for change because staff had to quickly develop initiatives and adjust these as they went along. This may imply a similar increase in levels of autonomy as found in this study. Spence

and colleagues highlighted how these innovations, and the removal of traditional bureaucratic processes, as also seen in this study, was underpinned by devolved power and collective leadership. Most operational leaders noted a sense of holding more decision-making agency within their roles than before, which may suggest power was devolved to some extent. Conversely to Spence and colleague study, participants' directive (rather than collaborative) ways of leading others may indicate a less collective approach to leadership may have been experienced by operational leader clinical teams, although this was beyond the scope of the study to capture.

While operational leaders experienced a pressure to perform at work and had more freedom than pre-C19 to do so, their experiences of work also included needing to protect themselves from the demands of their roles. This is reflected in the sub-theme *'emotionally distancing to survive'.* This experience included operational leaders potentially emotionally distancing from the emotive aspects of their operational work and the fear that C19 bought up for them. For instance, when they had to cancel clinical services for patients even though patients needed treatment, or when having to think about service capacity for the significantly unwell or dying patients. Some participants shared how emotional distancing allowed them to continue to perform and contribute at their pressured work environments.

The experience of emotional distancing can be linked to the literature around trauma reactions. C19 bought along potentially 'traumatic' events (events that are highly distressing) such as high death rates, ethical dilemmas in decision making, and lack of effective treatment in the initial stages which are related to trauma reactions in healthcare staff such as doctors, nurses and healthcare workers (Benfante et al., 2020). A reaction to trauma can be linked to concepts such as Post Traumatic Stress Disorder (PTSD). In PTSD, emotional avoidance is a key part of the reaction to trauma that aims to provide short-term relief from psychological distress (Bardeen, 2015). That leaders experienced emotional avoidance and possible links to trauma is supported by a UK study which found that PTSD symptoms were 5.3 times more likely to be seen in healthcare 'management' than doctors (Gilleen et al., 2021). While the experiences of operational leaders may not be classified as PTSD, the similarities in responses do highlight that some operational leaders emotionally distanced themselves to help cope with the distressing and possibly traumatic aspects of their work.

Emotional distancing may also be linked to 'organisational trauma' reactions. Organisational trauma is the idea that systems, just like people, can have traumatic responses to threatening and distressing events (Treisman, 2020). Some identified signs of organisational trauma of the system, teams, and people in it include becoming emotionally avoidant and detached and being too busy to feel in order to protect and survive from the trauma-related pain and anxiety (Treisman, 2020). Operational leaders' experiences of emotional distancing may in part be a trauma reaction to the wider painful events that healthcare professionals, teams, and systems were managing at the time.

Operational leaders also shared some of their sense-making of working in an environment where they were expected to perform and keep up a quick pace of work with limited or quickly changing information. For instance, one participant noted being aware that there was no 'right' answer which gave them the freedom to do their best with what they did know. There were also some participants that noted a comfort and familiarity of working in a pressured, uncertain, and reactive way in C19. This is

because such work environments were also common experiences in operational management even prior to the pandemic, which perhaps gave them an ability to tolerate these work conditions.

However, there was also a cost associated with such work demands. The participants shared that due to their effort to meet the pressure to perform, they needed to work long hours, leading to fatigue and loss of time to attend to other important relationships and values outside of their operational responsibilities. Some participants experienced a need to align with their operational roles rather than, for instance, take on a patient-facing clinical role as was the case for one participant. For other participants, this experience came up as their operational identity being in conflict and competition with other interpersonal parts of the self, such as having a sense of self outside of work, and personal roles, such as being a mother.

The latter finding is similar to the Chemali et al. (2022) review of qualitative studies (not specifically UK) that noted that healthcare professionals experienced a greater work-life imbalance during C19, as also experienced by operational leaders in this study. Although Aughterson et al. (2021) did not specifically identify experiences of conflict between work identity and other parts of self, the findings did note that UK health and social care professionals experienced an increase in workloads as echoed in the *'unrelenting pressure to perform'* that contextualised the *'conflicting parts of self'* for operational leaders.

The competing of work and personal identities can be thought about in relation to the work-life balance literature. The interface between work and life has been a difficult one to define (Shivakumar & Pujar, 2018) with no single unified definition of the construct (Brough et al., 2020). In this study, participants talked about not having enough time to allocate across important identities and roles. This fits with the definition of work-life balance as "an overall level of contentment resulting from an assessment of one's degree of success at meeting work and family role demands" (p.1512) as noted by Valcour (2007).

Valcour (2007) found a statistically significant negative relationship between satisfaction of work-family balance and longer hours spent at work. This fits with operational leaders giving many additional hours toward their operational roles and less time to other roles such as being a parent. Literature has previously acknowledged the interrelated nature of work demands impacting on professionals that have family responsibilities (Cooper & Cartwright, 1994). This is supported by the finding that gender appeared to play a role in operational leaders' experiences of *'conflicting parts of self'*. Most of the female participants acknowledged either the additional pressure of what it would have been like to be a working mother during C19 or talked about actual experiences of guilt and strain associated with participants perceiving to neglect their roles and responsibilities as mothers.

Alon et al. (2020) discussed how working women (compared to working men) were unequally affected by the way C19 reduced access to childcare. Increased childcare responsibilities were taken on by women in line with gendered childcare expectations (Alon et al., 2020) and this remained true for women who were in partnered relationships (Zamarro & Prados, 2021). Machín-Rincón et al. (2020) suggested that when there is an incompatibility between work and family, women leaders may experience poorer wellbeing. Machín-Rincón et al. (2020) suggested that the 'demands' in the JD-R

model (Bakker & Demerouti, 2007) could be expanded to include additional personal demands that may be placed by women leaders on themselves (Barbier et al., 2013), which may be linked to gendered social narratives. Women leaders may face greater pressure to be committed to work and their families simultaneously (Machín-Rincón et al., 2020), giving rise to the strain and guilt experienced by some female operational leaders in this study.

(2) The Experiences of NHS Relationships: Being Protected and Protecting

The findings of this study highlighted relational experiences of operational leaders as healthcare workers in the NHS at the time of the C19 pandemic. The participants shared a sense of *'united resistance against C19'* through feeling that all healthcare professionals were unified in trying to manage C19. Participants expressed how purposeful and meaningful their operational roles were at this time in relation to this 'united resistance' and how they experienced a sense of being able to contribute to the wider collective effort in 'fighting' C19 together. The findings include the use of combative language, which echoed some of the war metaphors and narratives that were commonly used to describe healthcare experiences in C19 (Varma, 2020).

Similar to this finding, Aughterson et al. (2021) interviews with 25 UK health and social care staff also noted increase in team unity, team closeness, and cohesion over the common cause of C19. The authors also noted that professionals connected with the purposefulness of their contributions to the C19 effort as was also shared by operational leaders.

Operational leader experiences of unity, collaboration and contribution are also in line with the published guidance by the UK C19 trauma response working group (Billings et al., 2020). The guidance noted that team cohesion ('we are all in it together') can support individual mental health and that team resilience may be related to these interpersonal bonds (rather than individual coping styles). This also fits with operational leaders' experiences of unitedness, trust, and closeness, as if they were a single family during C19, which allowed them the strength, protection, and ability to withstand the C19 war together.

Ideas of 'resilience' have generally been explored at an individual level. However, team resilience is now increasingly being considered in the literature (Hartwig et al., 2020). Resilience in teams and systems can be defined as the team and system being able to function in changeable and difficult conditions and challenges (Wiig & O'Hara, 2021) such as shortages of PPE, staff, and managing infection risks as was seen in the C19 pandemic. Hartwig et al. (2020) conducted a systematic review into the conceptual nature of workplace team resilience. Factors that mediated team resilience in their proposed theoretical model were states of team cohesion, trust, collective confidence in the team being able to succeed (collective efficacy) and having a team identity. This is mirrored in operational leaders experiencing a protection through relationship with other healthcare colleagues, and a shared cohesive purpose as a healthcare team to fight C19. Two participants noted experiences of excitement and at points, that the whole healthcare team were 'winning' against C19. This could have contributed to a sense of confidence, or collective efficacy to manage the pandemic.

Hartwig and colleagues proposed processes behind team resilience. These included collaboration and coordination which were also found in this study. The author and colleagues noted

that collaboration allowed teams to support each other through adversity and can function as 'resources' as suggested by the Conservation of Resources (COR) theory (Hobfoll, 2001), which underpins the JD-R model. The COR theory suggests that we are motivated to avoid losses of our physical and psychological resources and that we seek to gain them. Operational leaders' experiences of the combative unitedness and collaboration against C19, and the protection afforded by being together, may have acted as a resource factor that supported them to meet the demands of work at the time.

Operational leaders recognised and connected to being a part of the collective 'resistance' against C19 and simultaneously perhaps experienced their roles as separate from the patient-facing staff due to the leadership responsibilities they held. Some of this was illustrated through the *'weight of protecting others'* sub-theme referring to leaders experiencing the 'weight' their decisions that could affect their teams negatively. For instance, they felt the significance of their colleagues potentially contracting C19 due to how they had decided to run the clinical services in relation to infection prevention and control guidance. That operational leaders recognised their role in supporting their followers was also noted by Leppäkoski et al. (2023) review, where nurse managers perceived their responsibilities to include the acknowledgement of the anxieties of their teams. Frank (2023) qualitative study with USA hospital managers noted that healthcare leaders acknowledged the need to be supportive of their staff as was also seen in this study, such as one operational leader noting how they were present in the office so patient-facing staff could access them.

Some participants also shared a helplessness in their efforts to adequately support the clinical staff within their divisions. This could be understood through ideas of a lower sense of self-efficacy which is defined as the person's belief about their ability to influence and accomplish a task in certain situations (Bandura, 1977). Some participants shared experiences of feeling like a bystander to some of the challenges faced by patient-facing staff who, for instance, had to manage complex and often emotionally challenging clinical decisions. Operational leaders recognised their responsibilities to protect their teams and colleagues, but perhaps also noted the limitations of their abilities to truly help and alleviate the emotional distress experienced by them.

(3) The Experience of Being a Hero: A Position of Ambivalence

Public narratives around the heroics of the NHS were common in the media. This included often idealised 'hero' narratives, with messages of the NHS being thanked for saving, caring, and working throughout C19 (Day et al., 2021). A key finding from this study was leaders' sense-making of their roles and positions in relation to these 'hero' stories. For operational leaders, their status as a 'hero' seemed ambiguous; they experienced the *'pride of being a hero'* due to the public's praise, *'the humility of being a fake hero'* compared to patient-facing professionals, and *'the unseen hero'* and *'the fall of the hero'* when pre-existing pressures and targets returned at work. These experiences are discussed next.

Operational leaders experienced being a hero through recognising the pride of being able to contribute and collaborate in the *'united resistance against C19'*. This pride was mainly related to feeling appreciated by the public through, for instance, the UK public clapping on their doorsteps. For some, this gave rise to experiences of 'feel good' emotions and feeling valued for their work.

Iszatt-White and Davey (2003) define feeling valued as "a positive affect response rising from confirmation within a congruent set of criteria, or an individual's possession of the qualities on which worth or desirability depends" (p.228). The definition highlights the role of 'confirmation' of desirable qualities, with public appreciation and gratitude of their 'heroics' potentially being a form of confirmation of their valued roles within the organisation. This is perhaps an uncommon experience for operational leaders. Participants noted experiencing 'bad press' prior to C19 such as perceiving being thought of as an idle manager and a drain on financial resources in the NHS by the public. This is a narrative that can be seen in the media and political headlines (Kirkpatrick & Malby, 2022). During C19, operational leaders experienced a change in this narrative and instead, felt appreciated for their contribution and recognised as legitimate experts that were an important part of the NHS.

White (2014) suggested that authentic appreciation from others at work (through verbal praise and personalised attention) can lead to greater staff commitment to the work and thus greater organisational success. There has been some empirical literature linking feeling appreciated at work with work engagement (Bakker & Demerouti, 2007; Groeneveld, 2018), work satisfaction (Waters, 2012), motivation to work (Manzoor et al., 2021) and self-reported work performance (Beck, 2016; Manzoor et al., 2021). Locklear et al. (2022) conducted a review of relevant literature and proposed a workplace process model of gratitude. Locklear and colleagues linked gratitude of organisations with higher personal wellbeing (as marked by levels of engagement, absenteeism, and burnout), better interpersonal relationships and prosocial behaviour (such as ethical decision making and commitment to work). It is possible that operational leaders' feeling appreciated for their work could have supported them to manage the pressures of their work.

Miller (2018) proposed that feeling appreciated within an organisation can lead to 'organisational citizenship behaviours'. This refers to employees going beyond their defined roles to benefit the organisation and the people that it is made up of. This is based on a theory of gratitude by Gordon et al. (2012) that identified when people feel appreciated by others, they will engage in maintenance behaviours, such as being more responsive, that will then further bond and provide security within the relationship. For some operational leaders, the experience of feeling the 'pride' of being an NHS hero included experiences of feeling motivated and energised to engage with work tasks and feeling needed to be at work. This could be understood through the bonding mechanism of gratitude proposed by Gordon et al. (2012) and Miller (2018).

Operational leader experiences of pride in their work shifted through seeing their positions as relatively protected in comparison to the patient-facing professionals that were much closer to the threats of C19. Social Identity Theory (Tajfel, 1978; Tajfel & Turner, 1979) proposed that we create our identities through social comparison through the groups we do and do not belong to (Abrams, 2001). As such, in comparison to the patient-facing professionals who were closer in proximity to the trauma of C19, operational leader actions did not seem heroic. Thus, operational leaders experienced their roles as humbler, and also felt like they were 'fake' or 'fraudulent' heroes. This is in line with the need for appreciation at work to be personalised and proportionate to the perceived event it is referring to (Beck, 2016).

There is a possible dissonance between experiencing the positive feelings associated with the recognition and pride of being a hero while also feeling fraudulent for seeing their roles as heroic. This could be understood through Cognitive Dissonance theory (Festinger, 1957). The theory proposed that cognitions that are dissonant will result in psychological discomfort that the person either aims to avoid thinking about or aims to reduce dissonance by, for instance, devaluing dissonant cognitions and emphasising consonant ones (Harmon-Jones & Mills, 2019).

It is possible operational leaders aimed to reduce the psychological discomfort of these two opposing experiences by aiming to emphasise their part in the collective effort: as part of overcoming feeling like a fake hero some participants talked about aiming to do the best possible job they could (e.g., in PPE procurement) and being supportive of the clinical staff. This may have been an attempt to become more consistent with the hero cognitions. Moreover, some participants acknowledged an 'admiration' of the patient-facing professionals that perhaps reduced the importance of the dissonance of being fake: their experiences of discomfort for being fake heroes were less important than the real-life difficulties being faced by the patient-facing staff, as perhaps echoed by operational leaders' experiences of humility.

The findings of the study also highlighted a sense of the short-lived nature of holding the 'hero' position through their experiences of 'falling' from it. One participant talked about the disillusionment of no longer being considered 'heroic' once pre-existing '*unrelenting pressure to perform'* from the public and the workplace in the 'post' C19 stages returned. There was also an acknowledgement that, despite feeling 'pride' in their work to some extent, leaders highlighted they also felt like an '*unseen hero'* within their working environments. Some participants reflected not being asked about their wellbeing at work since C19 until the research interview for this study took place. Two participants noted feeling like their efforts at work (such as additional hours) were ignored and they felt like an afterthought to the patient-facing professionals despite all healthcare workers being united by the same goal to deliver care to patients safely in or outside of the C19 pandemic. This finding supports the justification for this research project, which sought to capture the experience of leaders who appeared to be less 'seen' at work in comparison to the professionals in the clinical services as was a key finding of this study.

(4) The Experiences of the Self 'post' C19: Growth and Reconnection to Meaningfulness

The findings of this study also noted operational leaders experienced having and seeking a better work-life balance once there was a reduction in pressure to perform and more routine work in their clinical services had resumed. Participants emphasised *'reconnecting to what matters'* to them such as nourishing their own wellbeing through physical activity, engaging in opportunities to socialise, and investing and being mindful of valuing meaningful relationships such as with family. Operational leaders emphasised the importance and commitment to having more time and energy for activities and relationships within their personal lives, rather than heavily investing in their work.

For some, the process of *'reconnecting to what matters'* was linked to the acknowledgement of their own mortality (and fear of this) that was highlighted by C19. Some operational leaders noted feeling fearful that C19 had '*the power to harm'* them and other people. This finding is similar to UK healthcare professionals' experiences of anxiety during C19 (Gilleen et al., 2021) and fears around

transmitting the virus to others (Aughterson et al., 2021). For some participants, this fear was contextualised by their roles offering them opportunities to hear and witness how contracting C19 may result in significant illness and so intensive treatment (such as being on a ventilator) and death.

The fear of C19, for some operational leaders, was also linked to experiences of *'the unknown nature of C19';* a lack of previous personal or professional experiences of living or leading through a viral pandemic meant participants' experienced uncertainty in relation to what C19 may mean for them and their roles. This was especially present at the start of the pandemic. These experiences of uncertainty are in line with Freeston et al. (2020) who acknowledged C19 as a threatening and unknown phenomenon, giving rise to heightened uncertainty which is "the subjective negative emotions experienced in response to the as yet unknown aspects of a given situation" (p.2).

Some have suggested that being reminded that the world is unsafe, uncontrollable, and unpredictable can prompt people to seek meaningfulness in their lives (Chang et al., 2021). Operational leader experiences of fear, uncertainty, and awareness of their own mortality may have meant they aimed to reconnect and reestablish an emphasis on other meaningful parts of their lives, alongside their work identity. Similar to this finding, Aughterson et al. (2021) also noted UK health and social care professionals' reviewing and reconnecting to what was important to them in life, such as family relationships.

Post-traumatic growth (PTG) literature may help explain some of these findings, especially where trauma is inherent within certain areas of work, such as perhaps in healthcare during C19. PTG can be defined as the interpersonal 'growth', development and additional benefits that are gained (such as increased life awareness or subjective changes in psychological functioning) from experiencing challenging life crises that were not there before (Tedeschi & Calhoun, 2004; Zoellner & Maercker, 2006). Tedeschi and Calhoun (2004) proposed a process PTG model with five domains that make up PTG: a closeness within relationships; seeing new possibilities in their life; spiritual development; personal strength; and appreciation and reprioritisation in one's life (Tedeschi & Calhoun, 1996).

The latter domain of the model refers to the appreciation and reprioritisation in one's life which may offer a PTG interpretation of the *'reconnecting to what matters'* sub-theme. This is because some operational leaders talked about 'cherishing' time with family members and noticing the beauty of the world and held an awareness that as humans they were only alive for a limited time.

'Post' C19, participants also expressed a personal growth in confidence and strength, such as feeling empowered and believing in their own ability to withstand and master difficult emotional experiences and future work-related challenges. The role of learning due to C19 experiences has been acknowledged by some literature, for example non-UK nurse managers learning new skills, such as using technology, and a sense of a developed ability to be innovative and be adaptable as this was part of their role in C19 (Leppäkoski et al., 2023). Operational leaders in this study also shared experiences of learning and emphasised a sense of emotional mastery and strength within themselves.

This could also be understood through personal strength discussed in PTG literature (Tedeschi & Calhoun, 1996). PTG suggests that the personal strength domain comes with the acknowledgement that

a person is vulnerable to potentially experiencing 'bad' things as part of life, while also suggesting they are in possession of the personal strength to manage these challenges (Tedeschi & Calhoun, 2004). In line with this, some operational leaders recognised that they are going to face future work challenges. One participant even sought out work-related challenges where they may experience more 'vulnerability' and they believed they could manage these through their own personal strength, confidence, and the skills they had developed in emotional management and leadership as a result of their experiences during C19.

There are some ideas about the processes through which experiences of traumatic events can lead to PTG. As already acknowledged, operational leaders experienced an *'autonomy and freedom to act'* as part of their operational roles. This ability to act may link to an idea related to PTG: Locus of Control (Zoellner & Maercker, 2006). An internal Locus of Control (LoC) refers to the belief that one has control and influence over outcomes in one's life (Buddelmeyera & Powdthaveeb, 2016; Rotter, 1966). There is some suggestion that internal LoC may determine where the person directs their energies to cope with potentially traumatic events (Zeligman et al., 2019), such as trying new coping strategies (Zhang et al., 2014), with internal LoC also predicting PTG in the general population that have self-identified as trauma survivors (Zeligman et al., 2019). Operational leaders were able to see the outcomes of their leadership more quickly, which perhaps further emphasised the internal LoC they could have experienced as part of this role. Thus, this could have promoted experiences of wellbeing, and personal confidence and strength that are markers of PTG.

Furthermore, Tedeschi and Calhoun's (2004) model also acknowledged the influence of individual differences, such as personality, and how the presence of a supportive social network can support cognitive processing of traumatic events into a meaningful narrative needed for PTG. While it was beyond the scope of this study to capture some of these processes, it could be argued that operational leaders' experiencing '*the protection of mutual trust and closeness'* could indicate close work-relationships that could in part have supported them to engage in some of that cognitive processing leading to some of their experiences echoing PTG.

Nevertheless, it is interesting to note that themes of growth in themselves 'post' C19 (as seen in GET five) is overall less comprehensively developed relative to the other themes. It is possible that this key finding may expand if the interview schedule specifically focused on, for instance, exploring learnings from their experiences of C19. It may also reflect that changes in the self 'post' C19 were less prominent for participants at the time of interviews. A possible reason for this could be that despite feeling supported in their work relationships during C19, which could have facilitated the processing of some of their experiences in the pandemic, they have still had limited opportunity to reflect and think about themselves as individuals. This processing may have been in part overshadowed by a continued or returned pressure to perform at work 'post' C19. Thus, it is possible that they have had fewer occasions to pause, make-sense of their own experiences, and notice changes in themselves, with some participants identifying that the research interview for this study was one of the initial opportunities to do so.

Implications

Operational Leader Wellbeing. The Health and Wellbeing Framework (NHS England, 2021b) acknowledged the role that leaders and managers have in implementing and embodying a positive wellbeing culture. Senior leaders' responsibilities included being skilled at supporting their own wellbeing and that of others. This study highlighted that operational leaders were aware of and identified with the need to support their staff with their wellbeing, especially during a pressured time such as C19.

However, overall, there was less recognition of leaders thinking about their own wellbeing as part of their work experiences since the beginning of C19. This may be due to operational leaders choosing to emphasise the wellbeing of others over their own and their experiences of pressure at work, leaving little time for the acknowledgement of their own emotional experiences. The implication is that the NHS could more readily acknowledge the need to support operational leaders' wellbeing in and outside of situations like the pandemic, especially given the likelihood of persistent NHS pressures (Charles & Ewbank, 2021). Acknowledging and normalising wellbeing discussions for operational leaders, and potentially throughout the levels of senior management, may highlight the importance of their own wellbeing as NHS employees, not just a necessary factor for maintaining the wellbeing of others.

Moreover, the interview process showed that some operational leaders found it difficult to discuss their wellbeing, perhaps due to this being an unfamiliar topic of conversation. For some participants, wellbeing appeared to be conceptualised through the absence of unpleasant emotional experiences in comparison to those of patient-facing staff. A possible implication from this finding could be to further explore and support leaders to think about how they may be conceptualising wellbeing for themselves and others at work. This is important because how leaders understand emotional wellbeing and experiences may affect how they address and support their own and the wellbeing of others.

Leaders being able to reflect on their own wellbeing, and what wellbeing in the workplace could look like, will likely support the creation of a positive NHS wellbeing system through leaders' modelling behaviours (NHS England, 2021) and is going to be needed in the face of ongoing issues with staff wellbeing (NHS Staff Survey, 2023).

Work-Life Balance and Wellbeing. Operational leaders shared how they rebalanced work and life and how being able to emphasise other meaningful aspects of personal life nourished them. There is a recognition that organisational culture and job-related stressors and support affect the work-life balance (Varma et al., 2016). If NHS workplaces normalise working allocated hours, this may support operational leaders to continue to hold a more nourishing balance between work and life. Senior operational leaders modelling a balance between work and life may also support and normalise followers doing the same, which is likely to be an important part of prioritising staff wellbeing in the NHS.

The study also highlighted the possible role of gender in operational leadership positions and the unequal competing roles of work and family during times of pressure. This could be used as an important point to think about the role of parenthood. Professionals with caring responsibilities, such as working parents, may benefit from further flexible working arrangements. This could in part be facilitated

through use of digital technologies that have been used more frequently in the NHS since C19 (Hutching, 2020).

Legitimacy and Appreciation of Operational Leaders. For a time, operational leaders' felt more seen, praised, valued, and appreciated rather than criticised, especially in relation to the public. Operational leaders in this study were aware of the narrative in the public and political spheres identifying them as unnecessary for healthcare delivery (Kirkpatrick & Malby, 2022) and a drain on NHS resources. For a time, the UK public's appreciation shifted participants' experience of these critical public narratives around management and NHS leaders. An implication of this may be to develop more positive narratives of leaders and managers. This could be about continuing to recognise their roles as important in relation to delivery and improvement of NHS services, and as desirable, and legitimate professions to occupy. This could include operational leaders being shown they are appreciated within their own line management structures. Highlighting operational leaders' work as meaningful may buffer the stress and emotional demands in the workplace (Pace et al., 2022) that may be especially present in the 'post' C19 recovery stage. The acknowledgement of the importance of NHS leaders and managers may help to attract and retain professionals in the field (Jones et al., 2022) and support existing leaders to experience greater work-related satisfaction and wellbeing at work.

Entering Operational Leadership. The study acknowledged the diverse ways professionals can enter management and leadership roles in the NHS: development from clinical and non-clinical professions and direct entry into leadership roles through the management scheme.

A practical implication from this acknowledgement is that experiences and skills may be different across these 'sub-groups'. For instance, the assumption that clinicians entering management roles will easily take to leadership responsibilities given their knowledge of clinical decision-making (Jones et al., 2022) can leave professionals from clinical backgrounds with little grounding in practice or theory of leadership and operational management where there is more emphasis on efficiency and productivity (Jones et al., 2022; Warwick, 2011). While this has not been explored in this project, the variety of ways to enter leadership could in part explain some of the suggested variation in performance within management (Jones et al., 2022). This may highlight an NHS organisational responsibility to offer person-centred support (e.g., training opportunities) for this diverse section of NHS professionals.

Moreover, operational leaders are potentially having to navigate the possible complimenting-nature of co-occurring identities (e.g., clinical operational leaders may understand specialist clinical knowledge quicker) and the tension between them (e.g., differences in priorities and systems limitations to implementing 'best' clinical practice) and that the balancing of these identities may be more present at times of strain as was seen in this study. The possible implications of this could be about line management acknowledging and supporting operational leaders to navigate these identities. It is also possible that operational leaders that have held clinical posts may be perceived differently by their clinical colleagues (e.g., their input valued more through the existence of shared experiences). As such, operational leaders from non-clinical backgrounds could invest time in understanding experiences of their clinical staff. This will likely support mutual understanding, and collaboration, and promote a culture that invites opportunities to learn from, trust and respect the input from various professionals which can be used as a collective strength of the NHS.

The Protection of Cohesiveness in the NHS. For operational leaders, the public 'hero' narrative may have set unattainable expectations leading to experiences of, for instance, feeling fake. It may be more helpful to rely on creating cohesiveness and shared meaningfulness at work that appear to be associated with feeling trust, protection, and closeness. Being able to collaborate, feel safe and connected to colleagues at work can support team-level resilience (Hartwig et al., 2020). Health Education England (HEE) has acknowledged how there is a need to emphasise team resilience rather than relying on individual resilience alone through the creation of supportive organisations (HEE, 2019). There is also some suggestion that supportive work relationships may also be important to create organisational cultures that can survive, manage, and regulate difficult emotive and potentially traumatic experiences (Maitlis, 2020), which would also be true for an organisation like the NHS.

Freedom to Lead in the NHS. The findings noted that operational leaders experienced greater job satisfaction and meaningfulness at work during C19. This was in part related to reduced 'bureaucratic' processes which meant that decision making was less centralised. Instead, operational leaders were given the autonomy to 'act' decisively and encouraged to take more directive leadership styles. This allowed for a satisfying responsiveness that some participants wished to hold onto, which may be an important implication for the *way* the NHS systems are to operate in the long run. For operational leaders, their sense of work-related satisfaction could be increased by supporting them to hold more control within their roles rather than for most of the power to sit at the 'top', such as at the executive board member levels.

This implication should be considered within the context of the NHS. The NHS will likely continue to face target-driven pressures and for instance, budget restrictions. Thus, there are likely to be limits around the freedom and control that operational leaders are likely to gain, which means there may be a process of navigating the satisfaction of freedom from bureaucracy and realistic limits of influence. Moreover, it is important to consider how operational leaders' holding more control within their roles may impact how much they devolve power to their colleagues and teams that may be a part of distributed leadership that has been identified as important for the NHS (West et al., 2014).

Strengths

The Sample and Interviews. This project explored senior operational leader experiences in the NHS during a significant time. This sample group has received limited attention in the research. Liaison with the Proud2bOps network, and this study's findings, further confirmed that there has been limited recognition of operational leader roles and wellbeing within NHS settings since C19. Thus, this project is an important contribution to research and the acknowledgement of these leaders that have significant influence in leading within the NHS.

Given the limited recognition of this sample's personal experiences of their roles and wellbeing, another important strength of this study was the use of qualitative research interviews. The interview process and use of a semi-structured interview schedule allowed them to hold the expert position, share what they felt was important within their lived experience and capture in-depth and rich data. This felt important because overall, this is not a process that has been afforded within the research or the workplace for these operational leaders.

Recruitment. Moreover, the study included a variety of operational leaders that were working in several clinical areas and NHS Trusts. While the study does not aim to generalise its findings, the study was able to note both convergence and divergence of shared experiences among leaders occupying operational roles in these different settings. It is possible that this may mean experiences captured in this study also echo across other operational leaders while also retaining the individuality of each participant experience.

The study could have considered exploring single specific contexts, for instance only capturing a specific clinical area or collection of services. This would have meant the study would have potentially been limited to a speciality. Although this might have given greater depth for a particular area, capturing multiple different clinical areas and settings allows the findings to resonate more widely.

Transparency and Credibility. Another strength of the project was the consideration of transparency and other markers of quality in qualitative research (Elliott et al., 1999). This included a description of the analysis to illustrate rigour, providing detail on important participant context to support the reader to situate the sample, and the use of a reflective statement and ongoing reflexivity during analysis to acknowledge my active role within the process of the research.

Nevertheless, IPA acknowledges the unavoidable impact of researcher (Smith et al., 2022) meaning that different results may have been found with a researcher from a different background and experiences. This was held in mind when thinking about the processes of credibility. Research supervisors and peer input (also using IPA in their research) were used to ensure they were able to follow my interpretations from the original transcripts. The project has used quotes in the Results chapter to allow the reader to engage in their own sense-making process and carry out credibility checks of the interpretations made based on the data that was captured.

The credibility of the project could have been further supported by checking my interpretations with participants that were interviewed in this study. However, this was not possible due to time constraints and practical implications for participants who would have had to commit more of their time to the research. Instead, the project was supported by an expert-by-experience that worked with Occupational Health pre-C19, during and 'post' C19. The expert supported the project to consider how credible the findings were in relation to their experiences and knowledge of the NHS since the beginning of the C19 pandemic.

Limitations and Reflections

The Sample and Recruitment. The sampling method may have captured only a particular set of operational leaders. That is, those who actively sought out a professional development and reflective space through the Proud2bOps network. This could have meant that they have (or were seeking) a particular affinity or closeness to their operational leadership identity. Moreover, the nature of the inclusion criteria also meant that it did not capture professionals that left the profession or moved to occupy a different role within the NHS, which may have been due to their experiences of what it was like to be an operational leader during C19. There is a possibility that the project captured a sample that had

a more 'positive' experience of leading in C19 because of certain individual, team, and contextual factors that were beyond the scope of the study to capture.

It is also possible that the project captured participants that wanted to take time to think and reflect on their experiences of their roles and wellbeing, as was identified as a motivation factor by some participants in this study. This may mean the study has not captured experiences of operational leaders that chose to not participate due to, for instance, current pressures at work and possible discomfort and unfamiliarity of taking a more personal perspective in relation to their roles and workplace wellbeing. While the aim of IPA studies is not to have a representative sample, these are important to note because they limit the applicability of these research findings.

My Position as a Mental Health Professional. Part of being a mental health professional means that I often witness psychological distress and hear problem-saturated accounts and stories of people's lives. This was acknowledged and held in mind as part of the research process. For instance, the interview schedule aimed to ensure the interviews allowed for space for a variety of experiences to be heard based on what was important for operational leaders to share. As a mental health professional, I in part expected to find operational leaders to be facing many challenges. While this is true based on the findings of the study, the results have also captured positive experiences of operational leadership. This may suggest that the study was not biased by my expectation of only capturing the challenging parts of participant experiences. However, it is still important to consider my role as a mental health professional in relation to what I may have represented to the participants that took part in this study, and how this may have influenced the interviews.

The participants were aware of my role as a trainee Clinical Psychologist. Although this was not explored as part of the research, it is possible that being a mental health professional meant that some participants could have been more aware of, for instance, existing cultural norms around the expression of psychological distress or stigma around mental health. This could have affected how comfortable participants' felt talking about their wellbeing. It is possible that participants could have monitored their responses or avoided talking about certain aspects or examples of their personal experiences at work (e.g., emphasising enjoyable changes to their work and sharing less of their experiences of worry). My role and background may have also affected who volunteered to participate in the project, thus the project could have captured participants that felt comfortable to express personal views to a mental health professional.

Time of the Research. The interviews were conducted in early 2023 and were interested in capturing lived experiences of operational manager roles and wellbeing since the beginning of C19. Operational leaders generally referred to the 'start' of C19 to be the first UK lockdown in March 2020 and considered the research interviews to be taking time in the 'post' C19 times where recovery of clinical services was taking place. As such, participants had to retrospectively recall their experiences across an extended period that held three national lockdowns among other restrictions (Institute for Government, 2022) all of which affected healthcare services and operational leaders as individuals.

While IPA does not aim to capture an objective truth, a longitudinal approach may have captured how operational leaders' sense-making of their roles and wellbeing changed over the course of time. This

would have been a more complex research process and was beyond the scope of the resources available for this research. It is possible that it may have been unethical to conduct a potentially time-intensive research project given the threats and pressures that participants faced in C19. As such, the timing and interview study design was appropriate. Nevertheless, this highlights that the findings of this study would have been different if they were conducted, for instance, closer to the time of the onset of C19, which operational leaders noted was more characterised by uncertainty and anxiety. This highlights that there are multitude of experiences of operational leaders' roles and wellbeing that have not been captured in the shifting nature of experience and sense-making over time.

Future Research

      The Sample and Method. This study considered experiences of operational leader roles and their wellbeing since the onset of C19. As highlighted by the limitations, the study may have only captured a particular subset of operational leaders. Future research could capture professionals who changed roles and had time away from work due to sickness related to their occupation at this time. Insight into this would allow for the exploration of a greater diversity of operational leaders' wellbeing and experiences of work than has been captured by this study.

      Moreover, while the study captured some diversity of gender, age, and years of experience in operational leadership, the sample was all White. This is consistent with senior positions in the NHS being predominately occupied by White people (Kline, 2014) likely linking to the discrimination of racialised groups in the NHS (Ross, 2019). This research does not capture the experience of operational leaders from racialised backgrounds within the NHS during and since C19. This is an important consideration and limitation, especially given that C19 disproportionately affected racialised minorities (Szea et al., 2020).

      Future research could also use different methodologies (such as quantitative research) to explore experiences of work and wellbeing for this wider population, which could be used to understand the possible wellbeing and work-related needs of the professionals occupying these positions. Had the research been conducted by researchers from different backgrounds and experiences, it may have gained different perspectives and a fuller picture of operational leadership and wellbeing.

      Operational Leaders and Identity. The findings of this study highlighted the possible tension of operational roles and other identities important to operational leaders. One possible identity to consider is professionals' routes into operational leadership positions. Operational leaders that were, for instance, clinicians before entering leadership may have a different experience to those entering NHS operational leadership through graduate schemes due to the former holding an overlapping group membership between being a clinician and operational leader. This may offer some understanding into the process of how operational leaders navigate leadership and management in a clinical setting and how their own training and experiences may affect these roles.

      The findings also noted the possible implications of being a parent, and in this study specifically being a mother, alongside being an operational leader in the NHS. There is scope for further depth in relation to this finding. For instance, how these roles and identities of operational leadership and

parenthood are navigated within the NHS workplaces. There is scope to consider the possible gendered expectations of female operational leaders' caring for families while also holing a leadership post in a caring profession and how professionals make sense of this.

Growth After C19. The findings of this study noted participants experienced learning and growth as professionals and as people since the beginning of C19. Future research could explore the possible processes through which this may have happened within this sample. For instance, if and how operational leaders' experiences of supportive and protective relationships with colleagues at work may have led to experiences of growth, development, and wellbeing.

The presence of supportive relationships in this study also highlights the need to think about the NHS organisational culture. There may be scope to focus on the organisational and collective healing conditions and processes that may be needed within organisations after experiencing highly distressing events at work (Maitlis, 2020) such as C19. It is possible that supportive relational experiences may relate to organisational PTG (Maitlis, 2020), which is defined as an increased organisational functioning or learning from experiences of adversity such as C19 (Olson et al., 2020). Given that the NHS healthcare system interacts with often distressing events, this may be an interesting and important point of future research.

Conclusion

The C19 pandemic was a significant event that impacted healthcare services in the UK. This included how services were led and operated as well as the psychological wellbeing of NHS professionals. Operational leaders, professionals that hold the responsibility for the planning and running of clinical services, have thus far received little attention on their experiences of holding potentially pressured roles and their psychological wellbeing during this time. As such, a qualitative approach using IPA allowed this study to explore the experiences of this important but underrecognised group.

The study found five GETs that reflected intrapersonal experiences, experiences working in the NHS systems during C19, and relationships with other NHS healthcare professionals and the public since the beginning of C19.

This study shows that operational leaders, like many other health professionals, experienced worry, and anxiety around how C19 could affect their personal and professional lives. This was linked to the initial uncertainties surrounding the impact C19 may have on them and those around them. For some leaders, there was a sense of distancing from the emotional experiences related to their roles and C19, which some noted allowed them to attend to the demands of work at this time.

Operational leaders in this study shared experiences of needing to safely deliver services. They noted that for a time, these pressures at work were largely focused on C19 and some emphasised the role of adapting to the infection prevention guidance to keep patients and staff safe from the virus. Some operational leaders acknowledged the time and energy they put into their roles and how this led to tensions between their responsibilities as operational leaders and other valued parts of self, such as being a parent or even having time for themselves outside of work. As part of their operational roles,

they held the 'weight' of being responsible for their clinical teams' functioning and wellbeing, and thus their roles encompassed a need to support the colleagues within their areas of responsibility.

Despite these challenges since the onset of C19, operational leaders also experienced some of their work to be satisfying. They shared that even though there was a pressure to perform quickly at work, this need for adaptability afforded them an empowering opportunity to use directive leadership approaches. This appeared to be related to having fewer bureaucratic processes and constraints when compared to before C19. This allowed leaders to perhaps experience a sense of control through being able to implement needed change in their services. They found this to be satisfying and gave them a sense of contributing to the wider shared effort of fighting against C19. Their sense-making around this contribution was linked to their experiences of navigating the healthcare 'hero' narratives.

Operational leaders shared experiences of pride for their contribution and collaboration with other healthcare professionals fighting C19, and a sense of closeness and protection within their work relationships. Operational leaders specifically noted a sense of unity with others in the NHS, and some emphasised a sense of pride for being recognised by the UK public. There was a complexity in their sense-making of being heroes. Some noted a discomfort as they perceived themselves not to be truly heroic (in comparison to their patient-facing colleagues). Some participants noted that others' appreciation of their heroic efforts in C19 did not last long, or conversely, were unacknowledged by their workplace.

When looking back at their pandemic experiences, operational leaders aimed to make sense of their learning, growth, and development. As noted above, some operational leaders felt the pressures of meeting C19 demands at work meant a loss of other valued parts of self. In response, most sought to rebalance their work and personal lives, and intentionally reconnect with what they valued and what nourished them. For some, this reconnection was also related to acknowledging their own mortality and a wish to connect to important aspect of life beyond their work. Operational leaders also emphasized their personal gains from C19, such as a more apparent sense of their own strength that could be used to withstand future work challenges and difficult emotional experiences.

Some key implications include considering the role of team cohesion and supportive relationships in the NHS and the possible impact of this on individual experiences of wellbeing, and overall organisational resilience at times of pressure. Operational leaders noted a satisfying sense of autonomy in comparison to the usual ways of working as they were able to adopt a more directive leadership approach. It may be worth exploring how greater control in decision-making could be more present at the operational level given the workplace satisfaction this gave the sample.

This study noted operational leaders' experiences of pressure to perform at work (during and 'post' C19) and that overall, they have experienced limited acknowledgment of the impact of this on their wellbeing in particular. There is a need to continue to consider the leadership experiences and wellbeing of such leaders within the NHS, as they are likely to continue to face future operational pressures, and themselves likely play an instrumental role in creating the positive wellbeing culture that the NHS as a whole is currently seeking.

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Appendices

Appendix A
Pre-Written Email Advertising the Study

Email subject: Study exploring the experiences of operational leaders

Hi,

I am Jovita, a Clinical Psychologist in Training at the University of Leeds. Over the last year or so, I have been liaising with Proud2beOps on developing a research study, which has been approved by the Medicine and Health Faculty Research Ethics Committee at University of Leeds (application reference: MREC 21-066).

The aim of the study is to is to explore and capture what is has been like for professionals to hold an operational leader role in the NHS during the COVID-19 pandemic.

This will include capturing any changes to the role of being an operational leader and leadership. It will also include an in-depth exploration and reflection of how the role and the context has impacted your well-being as a person.

You will be eligible to participate if you are:

- An operational leader within a Divisional Triumvirate, meaning you are responsible for the operations of a *group* of clinical services / departments.
- Have been working as an operational leader for a minimum of 3 years.
- Are predominantly responsible for overseeing adult services.
- Are currently working and holding a position in an acute NHS hospital in the UK.

If you wanted to participate, you would be invited to a one-to-one interview lasting between 45–90-minute over Microsoft Teams.

If you are interested in finding out more about the study, please email me (umjv@leeds.ac.uk). I will then send over some more information about the study, what the interview process may look like and give you an opportunity to ask some questions. You can then make your decision about whether you wish to take part.

I really hope you consider participating and please don't hesitate to get in touch if you have any questions or comments!

Thank you and I look forward to hearing from you,

Jovita Valuckaite (she/her)
Clinical Psychologist in Training

umjv@leeds.ac.uk

j.valuckaite@nhs.net

Appendix B
Participant Information Sheet

10 October 2022

<u>An IPA study exploring the lived experiences of operational leaders working in the NHS during the COVID-19 pandemic</u>

Please take time to read the following information and discuss it with others if you wish.

What is the purpose of the study?

The aim of this study is to explore and capture what is has been like for professionals to hold an operational leadership role in the NHS during the COVID-19 pandemic.

This will include talking about your personal experiences of holding an operational leadership role during the pandemic. It will also include exploring and reflecting on your personal well-being.

Who is the study for?

To participate, you must meet the following criteria:

- You are an <u>operational leader within a Divisional Triumvirate</u>, meaning you are responsible for the operations of a group of clinical services / departments
- You have worked as an operational leader for a <u>minimum of 3 years</u>
- You are predominantly responsible for <u>overseeing adult services</u>
- You are currently working in an <u>acute NHS hospital</u> in the UK

If you are unsure or have questions about the criteria, please get in touch with the lead researcher Jovita (contact details below).

What do I have to do?

You would be invited to take part in one interview lasting between 45-90 minutes. This will be a one-to-one interview with the lead researcher (Jovita) and it will be conducted and recorded over Microsoft Teams. In total, the project is aiming to conduct around 8 individual interviews.

Who is conducting the project?
The lead researcher is Jovita Valuckaite (Trainee Clinical Psychologist at the University of Leeds umjv@leeds.ac.uk).

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The project is part of the Clinical Psychology Doctorate qualification at the University of Leeds and is being supervised by Dr Jan Hughes (Clinical Psychologist) and Dr Fiona Thorne (Clinical Psychologist).

Ethical approval for this project has been sought from the School of Medicine Research Ethics Committee (SoMREC project number: MREC 21-066)

Do I have to participate?

No. You participation is voluntary. During the interview, you will also be able to share as much or as little information as you feel comfortable with. You can also decline to answer a question at any point without providing a reason.

You can also withdraw from the interview at any time without providing a reason. If you no longer wish to carry on with the interview, the recording of the interview will be immediately stopped. Then there will be an opportunity to check in with the researcher and discuss if you are happy for your data up to the point of stopping the recording to be used as part of the project. If you do not wish for any of your data to be used as part of the project, all your data will be deleted immediately.

Can I withdraw my data after I have finished the interview?

You will be able to withdraw your data for up to two weeks following the interview. After this time, the analysis of the data might have already begun meaning removing your data from the collated analysis might not be possible.

Will my data be anonymous?

Yes. Personally identifiable information (such as names, job titles, specific place of work, etc) will be anonymised throughout the process. However, to ensure that the study sample is appropriately contextualised, a demographic summary of the sample (known as 'pen portraits') will be included in the write up of the study. This might include pseudonym, age, gender, ethnicity, how long you have worked as on operational leader and the broad area in which you are an operational leader (clinically and geographically). This means there is a very small chance of you being identified.

Quotes from the interview will be used in the final write up of the project however, these will remain anonymous.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for participating, it is hoped that this study will capture the under-recognised experiences of what it has been like to be an operational leader in the NHS during the pandemic.

It is also hoped that the process of an in-depth and reflective process may be interesting, helpful, and perhaps enjoyable to participate in.

What are the possible disadvantages and risks of taking part?

It is possible that talking about ~~your~~ what it has been like for you to be in the role of an operational leader in the NHS at the time of the pandemic might be distressing. You will be able to pause or stop the interview at any point should you become distressed or no longer wanted to participate. You can discuss any worries about this with the Clinical psychologist in Training.

You are also able to contact support available through line management, your employer (Occupational Health services) and your GP. You are also able to access support through Samaritan's by calling 116 123. If you have immediate concerns about your safety, you can seek support by calling NHS 111, NHS 999 ambulance service or presenting at A&E.

Will I be recorded and how will the recorded media be used?

The interview will be audio-and-video recorded using Microsoft Teams on a laptop. To ensure that all the interviews are conducted in a standardised manner, it will not be possible to have audio-only recordings. The recording will then be saved on a secure and encrypted folder in line with the University of Leeds data protection guidance.

Interviews will then be transcribed by Jovita and a University of Leeds approved transcription company to ensure that data protection standards are adhered to. Once the interviews have been transcribed, they will be anonymised.

What will happen if I take part?

If you decide to take part, you will be asked to sign a consent form (electronically) and send that back to the lead researcher via email. Then, a convenient time / date for the interview will be agreed.

You will be asked to have access to a device with access to Microsoft Teams and have a quiet and private space to take part in the interview to ensure you are able to share your experiences freely.

Before the interview you will be given the opportunity to ask any further questions and verbal consent will be reviewed before the recording begins.

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You will be asked to focus on your own personal experiences, but this might involve talking about other relevant services / professionals. You will be encouraged to not use identifiable information of third parties. If this does happen during the interview, Jovita will remove and / or anonymise this data from the final study write up.

Who will see my data?

The recordings of the interview will be seen by the lead researcher and the University of Leeds approved transcription company. Anonymised extracts will be used as part of supervision and analysis but all identifying information will be removed.

The University of Leeds, the NHS trust and other regulatory bodies might need to see data collected as part of this project to ensure the project was carried out appropriately. However, data that might be shared in this instance will be anonymous.

What will happen to the results of the study?

Interview data will be analysed and written up into a paper that will be used as part of Jovita's academic assessment on the Clinical Psychology Programme. Upon completion, overall findings of the study may be published in an appropriate journal or presented at research conferences.

The overall findings may also be used a briefing paper and / or presented by the lead researcher to Proud2bOps members.

At the end of the interview, you will also be asked if you wish to receive a copy of the research report detailing the overall findings of the project via email.

Will my taking part in the study be kept confidential?

Yes. Consent forms and demographic information will be stored separately from the interview data.

Data from the survey will be handled in confidence and all transmissions and storage of data will comply with current relevant University of Leeds security standards. More information on the University guidelines can be found here:
https://dataprotection.leeds.ac.uk/research-participant-privacy-notice/

Interview recordings and transcriptions will be used as part of the analysis process by the lead researcher and project supervisors. Once the analysis of the data is completed, the interview recordings will be deleted. As such, the data that will be kept at the end of the project includes securely stored demographic data, consent form, interview transcripts, and the lead researcher's notes. This data will be securely kept for 3 years. After 3 years, this data will be securely disposed of.

The only time your data may be shared with others is if there is an immediate risk of harm to yourself or other people. You will also be oriented to appropriate sources of immediate support as detailed above.

There may also be significant concerns about someone else's practice being unethical and / or unprofessional. If such concerns arise, you and Jovita may discuss what support is needed next such as seeking support from your line manager and, if this is not possible, using your Trusts' Freedom to Speak Up policy to guide any subsequent action.

If you're interested in participating but have additional factors that might affect your ability to engage (hearing impairment, verbal communication difficulties, dyslexia, etc.), please get in touch with Jovita to discuss this via email: umjv@leeds.ac.uk.

Researchers contact information

If you have any questions or comments, please get in touch with either:

Jovita Valuckaite (Clinical Psychologist in Training): umjv@leeds.ac.uk

Dr Fiona Thorne (project supervisor on Doctorate in Clinical Psychology programme, School of Medicine): f.m.thorne@leeds.ac.uk

Dr Jan Hughes (project supervisor on Doctorate in Clinical Psychology programme, School of Medicine): j.hughes@leeds.ac.uk

Thank you for reading this information sheet. Your time and thoughts would be valuable, and I hope that you will take part!

Appendix C
Participant Consent Form

School of Medicine (Clinical Psychology)
Version 2 – 10 October 2022

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Consent Form

Interview Consent Form – Version 2 **An IPA study exploring the lived experiences of operational leaders working in the NHS during the COVID-19 pandemic**	Add your initials next to the statement if you agree
I confirm that I have read and understand the information sheet dated 10th October 2022 (Version 2) explaining the above research project and I have had the opportunity to ask questions about the project.	
I understand that my participation is voluntary and that I am free to withdraw at any time during the interview without a reason. After the interview is completed, I understand I can still withdraw my data for up to two weeks. I understand my withdrawal will have no negative consequences. In addition, should I not wish to answer any question, I am free to decline. To discuss withdrawal, get in touch with the lead researcher (Jovita Valuckaite) via email: umjv@leeds.ac.uk	
I understand that members of the research team may have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the reports or any quotes used as part of the research.	
I understand that the data collected will be stored and used only for the purpose of this project.	
I understand that relevant sections of the data collected during the study may be looked at by individuals from the University of Leeds or from regulatory authorities where it is relevant to my taking part in this research.	
I understand the above information and agree to take part in the research project.	

Name of participant	
Date	
Email address	

Appendix D
Pre-Written Email sent with Participant Information Sheet and Consent Form

Email subject: Study exploring the experiences of operational leaders

Hi,

Thank you so much for indicating you might be interested in participating in this study.

In this email, I have attached the participant information sheet that gives some more detail on what your involvement may look like and how the data will be used.

Please think about the information and feel free to ask me any questions!

If this is something you can and would like to participate in, please reply to this email with the completed consent (also attached in this email). We will then arrange a convenient date and time for the interview to take place.

If I don't hear from you within 2 weeks from me sending this email, I will email you once more to see if you're still interested in offering some of your time or you have any questions.

Thank you and I look forward to hearing from you!

Jovita Valuckaite (she/her)
Clinical Psychologist in Training

umjv@leeds.ac.uk

j.valuckaite@nhs.net

Appendix E
Pre-Written Full Capacity Email

Email subject: Study exploring the experiences of operational leaders

Hi,

Thank you so much for indicating you might be interested in participating in this study.

At this moment in time, we have reached full capacity on a first-come-first-served basis and are no longer seeking participants for the interviews.

If this should change, I will get back in touch with you via email with the participant information sheet to see if you're still interested in potentially offering some of your time.

I really appreciate you taking some interest in this. I would be more than happy to share with you the results of the study if you would like?

Best Wishes,

Jovita Valuckaite (she/her)
Clinical Psychologist in Training

umjv@leeds.ac.uk

j.valuckaite@nhs.net

Appendix F
Semi-Structured Interview Schedule

Research questions:

- What has been the lived experience of working as an operational leader in the NHS since the beginning of the COVID-19 pandemic?
- What has been the lived experience of personal well-being of operational leaders in the NHS since the beginning of the COVID-19 pandemic?

Introduction:

"Thank you for offering some of your time to share your experiences. The aim is to capture what it has been like for *you* to have an operational leadership role during the COVID-19 pandemic. We will focus on the impact of this work on *you* by taking a more personal perspective and considering your wellbeing.

As it is about *your* experience, there is no right or wrong answer, and you can take your time to think over the questions. I am here to listen and ask questions so I can better understand your experiences. I have some ideas about what we could cover however, I would like the interview to be guided by you."

Ensure participant meets the inclusion criteria.

Demographic information:

- How old are you?
- How would you describe your gender?
- How would you describe your Ethnicity?
- How long you have worked as an operational leader?
- In what clinical area and NHS Trust do you work in now?
- Is there is anything else you would like to share about yourself or your background that feels important?

Interview Schedule:

Introduction
Q1. Can you tell me a bit about your current role as an operational leader? • What responsibilities and tasks make up your role? • As I may be unfamiliar with the language used in your role, I may ask you some more questions to ensure I understand… Can I check what you mean by X? **Q2. Can you tell me a bit about how you got to your current role of operational leader?** • Any other previous careers /qualifications / roles?

- What did you do before this role?

Q3. What influenced you to want to take part in this research?

Main Questions

Q4. I am going to ask you to tell me about some memorable moments of your experience of being an operational leader during the last two years. I'll give you some time to think about what experiences you might want to talk about... Can you begin by describing a memorable experience?

Possible prompts:
- Could you focus on a specific event that could illustrate this experience?
- What were you thinking about at the time?
- When this happened, how did it make you feel then?
- What did you do / how did you react? What was the impact of this at the time?
- What is the meaning of that for you? What do you think that means?
- Do you think there is anything you would have done differently now?
- How does it make you feel talking about this now?
- Why do you think this something that is memorable for you?

Q5. Can you describe another memorable moment...
Possible prompts (as above)

[Aim to get 2-3 specific examples]

Q6. Is there anything else that you might want to share that could illustrate a different aspect of your experience?

"Thank you. The next part is about focusing in on your wellbeing. We might have already touched upon this a little so we might see if we can expand on what you have mentioned already. So..."

Q7. Can you tell me about your wellbeing as an operational leader during the last two years?

[Aim to get 2-3 specific examples]

Possible prompts:
- Have you noticed a time where work has had more of an impact on you / emotional well-being / how have you been in yourself?
- Could you focus on a specific event that could illustrate this experience? / Can you give me an example of that?
- What was happening at that time / when you noticed your emotional well-being?
- What were you thinking?
- What did you do / they do? What happened then?
- How does it feel now to talk about your wellbeing over the last two years? / How do you think about this now?

• Why is that important / an example that stood out to you?
Ending
"Thank you so much for sharing your thoughts and experiences…" **Q8. Is there anything you would like to share that we have not covered in relation to your experience of being an operational leader and your wellbeing during the last two years?**

Ask if there is a pseudonym they would like.

Ask if they would like a copy of the completed research report / findings to be shared with them via email (check preferred email address).

General prompts (from Bradley-Cole, 2021; Flowers et al., 2022)

- "What do you mean when you say that?" (to check intended meaning)
- "Can you give me an example of that? What did you / they do?" (to gain concrete examples)
- "Why is that important? How does that make you feel?" (to access beliefs)
- Focus on eliciting actions, thoughts, and feelings.

Appendix G
Ethics Confirmation Email

Medicine and Health Univ Ethics Review
To: Jovita Valuckaite

Fri 11/11/2022 10:08 AM

Dear Jovita

MREC 21-066 - An IPA study exploring the lived experiences of operational leaders working in the NHS during the COVID-19 pandemic

NB: All approvals/comments are subject to compliance with current University of Leeds and UK Government advice regarding the Covid-19 pandemic.

We are pleased to inform you that your research ethics application has been reviewed by the School of Medicine Research Ethics Committee (SoMREC) and we can confirm that ethics approval is granted based on the documentation received at date of this email.

Please retain this email as evidence of approval in your study file.

Please notify the committee if you intend to make any amendments to the research as submitted and approved to date. This includes recruitment methodology; all changes must receive ethical approval prior to implementation. Please see https://ris.leeds.ac.uk/research-ethics-and-integrity/applying-for-an-amendment/ or contact the Research Ethics & Governance Administrator for further information fmhuniethics@leeds.ac.uk if required.

Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, risk assessments and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

I hope the study goes well.

Best wishes
Sou Chung
On behalf of Dr Naomi Quinton, CHAIR, SoMREC

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Sou Sit Chung, Research Ethics Administrator, The Secretariat, University of Leeds, LS2 9NL, s.chung@leeds.ac.uk
Please note my working hours are Monday to Friday 9am – 12.30pm
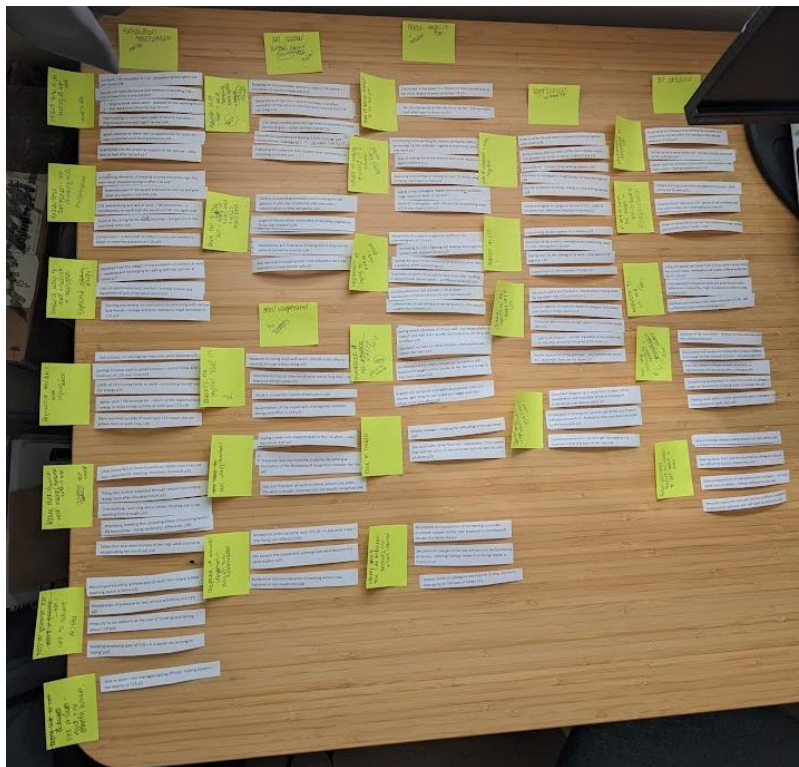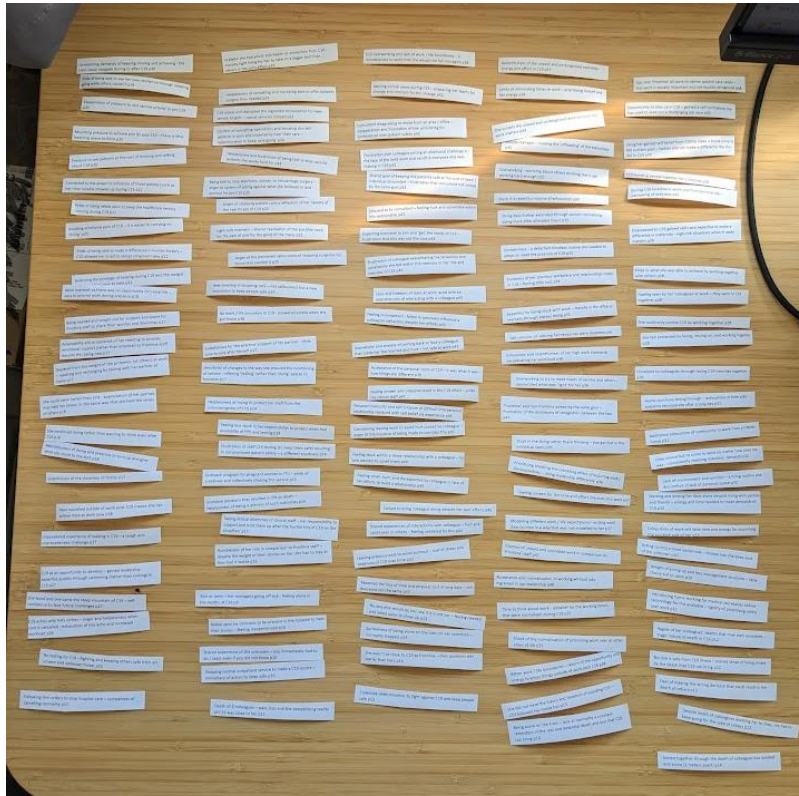
Appendix H

Example of Exploratory Noting and Experiential Statements for Jess

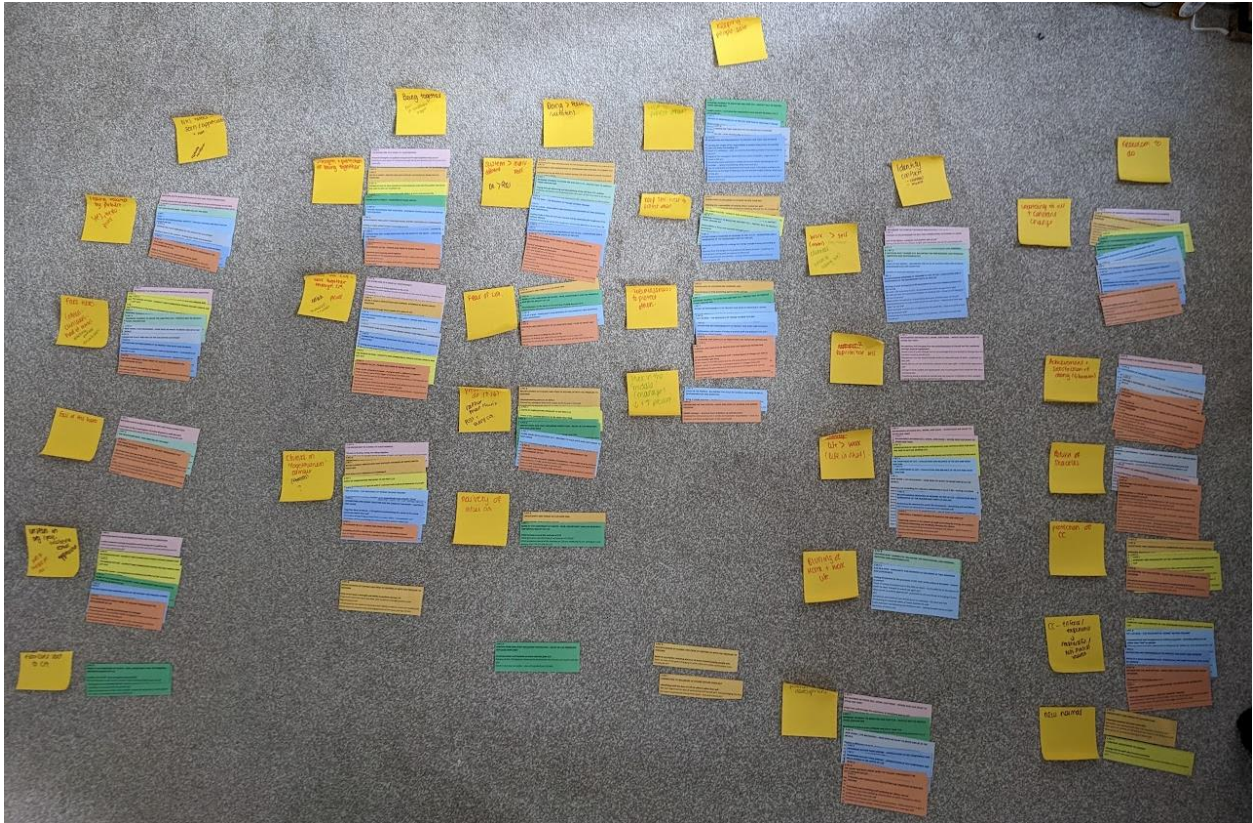| Transcript	Exploratory Notes (step 2 of analysis process) Descriptive noting; *Linguistic noting*; Conceptual noting; other reflections / notes on process	Experiential Statements (step 3 of analysis process)
J: Yeah. And very quickly umm, my seniors, it was it, it was just this overwhelming feeling of sink or swim. Either you are gonna sink or you're gonna swim type thing; because my managers, both of them, so my manager and then my manager's manager both either left or went off sick kind of a month into the pandemic. And they've gone off sick kind of when the pandemic hit it, and it was that feeling of people kind of dropping from beside you of Ohh, gosh!	*Sink or swim* - "fail or succeed entirely by one's own efforts", surviving in a story of C19, in a threat? Anxiety? Overwhelmingly alone at work? Managers above her on sick Early on – a month into pandemic *Repetition re leading (gone off)* - Feeling by herself – ALONE *Dropping from beside you* – their support not there, ALONE in terms of management structure *Oh gosh* – worry? Just observing this happening to her? Helplessness of seeing people 'drop off'?	Sink or swim – her managers going off sick - feeling alone in the depths of C19
the normal people that I would go to for escalation or for help or whatever aren't here, aren't able to be accessed. And not saying that they'd sunk because I'm not saying that that's the case at all but for whatever reason, they weren't able to continue fulfilling the role that they were in in those pressured times.	Escalation – people that would normally help NOT THERE HELP, not accessible ?worried I think she is criticizing her colleagues for going off sick? Trying to show me she UNDERSTANDS (people have many reasons for being off sick at work) – not JUDGING or guessing	
Because Ops are manager roles are pressured enough anyway, but then with that, with people that have comorbidities with family members that you worried about, with everything, it was a lot for a lot of people. So in those first couple of weeks I was immediately asked to then act up into the general manager role that I had no experience of doing. No senior to go to because I still didn't have a boss and it was that, that's what I mean by that sink or swim, fight or flight type thing.	C19 = pressured times – pressure in the doing? Uncertainty like she talks about later? Normal ops is PRESSURED enough *WITH that* = additional pressure in C19 to 'normal' work, C19 exacerbated the already tough for others? What about for her? *Immediately* – with little consideration for her fit to role? Just needed to get someone in? NO EXPERIENCE – thrown in the deep end? (like another one of her placements?), you just had to work it out, not sink in the UNCERTAINTY of role No senior – NO EXPERTISE, guidance = Fight/ flight – anxiety, THREAT (?does she mean it this way?)	Acting up into a more senior role – thrown into the deep end of the unknown
And I very much remember having to say to myself, OK, you've got a fight and you've got a swim! because if you don't, there's gonna be no one else to be able to do that. Umm, and obviously there is and all of that kind of thing, but that's, that's kind of like a memorable feeling that I felt right at the start. And it was very much, well, I don't know if I should say that, but making it up as you go along, no one had any experience of it before. No one knew really what they were doing. We didn't know how bad it was going to be. I just remember the we, we basically within a couple of days flipped an entire outpatient.	Say to self – needing to do the job ALONE, motivate and rely on self? *FIGHT* – defend self, MOVE, ATTACK, SURVIVE C19? *swim* – move, not drowned in C19 = SURVIVE No one else – WEIGHT, she HAD to perform, little CHOICE *Shouldn't say* - worried I will see has as incompetent? (this interpretation captured later in interview) *Make it up* – NOT KNOW, UNCERTAINTY, JUST DO IT 'We' pronoun, no one knew – SHARED exp – repetition of 'we' did not know (emphasize togetherness in the ANXIETY AND UNCERTAINTY?) Couple of days *FLIPPED* – transformed, IMMEDIACY of action that needed to be taken	Weight of acting up and less management structure – little choice but to swim Shared experience of the unknown – you immediately had to do / react even if you did not know

Appendix I
Illustration of Individual Analysis for Jess

Appendix J
Illustration of Jess' Personal Experiential Theme (PET) Table

PET	Sub-theme	Experiential Statement	Quote
7 PET A **SURREALNESS OF C19 – SHOCK AND FEAR OF THE NEWNESS IT BOUGHT**		Stopping normal outpatient service to make a C19 centre – immediacy of action to keep safe p10	"we basically within a couple of days flipped an entire outpatient...umm, unit into like a COVID assessment unit"
		Lack of normality a constant reminder of the real and potential death and loss that C19 can bring p14	"it was a really sombre time and it just felt really sombre for so long. And it wasn't like you were then on the train being able to chat to somebody and it feels normal. It felt so abnormal because of the circumstances and everything just made you think of that."
		C19 shook and disrupted the ingrained socialisation to meet service targets – cancel services instead p23	"it felt like going against everything, you know, to then cancel all these clinics and theatre lists. And I'm talking like months worth that you've, that you've worked so hard and so meticulously to make sure everybody is in, in the right amount of time, on the right day"
		Following firm orders to stop hospital care – surrealness of cancelling normality p11	"just the shock and everybody's, are we really doing this?"
		Unparalleled experience of leading in C19 – a tough and unprecedented challenge p27	"hopefully touch every wood, I'm never going to have to manage or lead through a tougher time than that"
7 PET B **NAVIGATING HER RESPONSIBILITY TO PROTECT HER STAFF AND PATIENTS**	**Pride of feeling needed to her job during C19**	Connected to the power to influence of those people (such as her) that reliably showed up during C19 p21	"if there was, I don't know, 1000 people on the train before. And now there's one, those 999 people are not influencing what's gonna happen in that hospital right now"
		Pride of being relied upon to keep the healthcare service running during C19 p21	"there wouldn't be anybody doing this"

Appendix K
Illustration of the Group Analysis Process

Appendix L
Extract of Group Experiential Theme (GET) Table

GET A: REACTING TO THE POWER OF A GLOBAL PANDEMIC				
Sub-theme	P	Experiential Statement	Quote	Comments
1. The power of C19 to harm	1	Collective sense of fear and uncertainty around what C19 was and what harm it could bring p22	"*even* our clinicians were worried about it. And there was all the media going on about this, that and the other"	DEATH, LOSS, FEAR SUSPENSE
	2	The sense of initial distance of C19 was quickly replaced with the power and realness of C19 in the UK p17	"there's this bit of a virus over in China somewhere. To oh my God! And we, and that had been drip fed and then just suddenly it was like drip, drip, drip of a tap. And then the tap was just turned on full and that was it."	DEATH, FEAR SUSPENSE
		Unease and anticipation around who may be unwell with C19 next p25	"People were losing family members through Covid once it started to hit. *Well* people were very ill. And you started to wonder, you know, who'd be next?"	
	3	Initial fear of contracting C19 meant rigidity around rule following p23	I think at the beginning I, for one, was personally scared about getting COVID"	FEAR
	4	Russian roulette - fear, powerlessness and the possible lethal consequences of contracting C19 p31	"*it* was like if I catch COVID, what's *gonna* happen? Am I going to end up *on* ICU. Will there be enough respiratory equipment for me? Will there be *a space* for me? You know, *is my need gonna* be judged, greater than somebody else's because of *my, my* age and my ability to, to survive. It, you know it was, it was that level of Russian roulette, really"	FEAR, POWERLESSNES S, DEATH SUSPENSE
	5	Shocked at having to call on the 'roughness' of his army identity to survive the C19 war in his civilian life p10	" *it* felt like a war zone. I mean, it was literally people 24 year old on the ventilator, probably going to their end game. And that was *a real*... And I remember that time is a bit fuzzy, but that's how you felt about it and feeling big rough-ty tufty army soldier, nothing could faze me in the civilian life, I'll never have to be worried about that again. And it did. And it really shocked me"	WAR – FEAR, DEATH ?NO SUSPENSE?
	7	Lack of normality a constant reminder of the real and potential death and loss that C19 can bring p14	"*it* was a really sombre time and it just felt really sombre for so long. And it wasn't like you were then on the train being able to chat to somebody and it feels normal. It felt so abnormal because of the circumstances and everything just made you think of that."	FEAR of C19 bringing death SUSPENSE
	8	Unfamiliarity of new job and C19 – foreboding threat of C19 nearing his work life p5	"I was very nervous, actually, very nervous about what was coming"	
		Bracing himself for the stressful hit of urgent care *and* C19 – is he strong enough? P11	"[job was] kind as a test for *myself*. And you know what, what would it be like to, to be in that job you know at one of the busiest A&Es in the country in [city]. Er, but then to see then the pandemic coming over the horizon"	SUSPENSE

Appendix M
Reflexive Log Entry Extract for Jess Prior and Post the Research Interview.

Note: Reflections questions were created using prompts from (Corrall, n.d.).

"Before the interview : What emotional texture am I likely to be bringing to the interview today? (How do I feel?) - anxious but trying to hold onto some of the excitement and I know once I meet the person, it is okay and I get involved in having a conversation with them which helps my anxiety and being curious

What do I believe / expect / predict? What do I hope with happen? What assumptions might be making already? - unsure about assumptions, I know little about the person. I hope they are reflective and can pause and just think about things with me! It is possible that that might not be the case and that is okay. I will aim to work with the person in the room.

After the interview: What is the emotional texture I am left with? (emotional process): I feel grateful and excited about having met [Jess]. it felt like an interesting interview. There were moments where things felt a little emotional (and she said it too) when she was talking about two colleagues dying from C19 early on and she even noted that she is not an emotional person but suggested that she was feeling some emotion talking about. I did not feel I wanted to press more in that moment. I bought up the idea of her not being 'emotional' again in the interview in the wellbeing section to see if she may expand / talk more about it (without trying to lead her too much). I wonder if I will have to be a little more interpretative with the wellbeing section of the questions?

What is my overview of the interview and sense of it as a whole? How might I interpret this? What did I conclude from this? How have I perceived my participant? And how do they perceive me? How do I know this? (cognitive process) - I heard a story of someone who did a really hard job during C19 and just ploughed on, did what she needed to at that time. She described herself as resilient and she has gone from one demanding job to another demanding job [deleted for confidentiality] - she is a person that 'swam' is continuing to 'swim' (in strong currents I would say) whereas she noted that others did not (e.g., her bosses) and she just managed it. My research will only cover those that are still in the job which is bias in some way but also homogeneous in this sense too. I think when we first started talking, it felt like she had SO much to say and that it was just all spilling out of her, all the things that just happened. I tried to keep a note of some of those themes as she went along and go back to some of them (bias on my part in what I chose to go back to and explore) but it felt like I did not want to INTERRUPT her in that initial flow – I think this is maybe also reflected in the length of the interview (1 hour 25 minutes). Not having opportunity to talk? I think she was reflective and often answered questions that I was going to ask of her (e.g., offering up how she felt in a situation without me asking).

How have my personal experiences and characteristic (gender, age, culture, etc) may have interacted with the participants story and what I did / said or what they did / said? (biases, fears, hopes) - I felt we had some connections (location of where we both previously lives, age, gender, Whiteness) from when we first met, which I think built rapport. I initially thought that she was relatively young versus other participants and wondered if that will make a difference to her experience (e.g., have less experience?) but for me was not the case. She even talked about being thrown in the deep end because it is a start of her career in some ways and how C19 almost accelerated that. I think having met older operational managers since then, having met someone my own age basically in such a position made realise how many skills and experiences she had. Thinking about the term 'resilience' in all this.

Appendix N
Reflection of the Naming of Group Experiential Theme (GET) One

I initially called the GET One 'ADJUSTING TO C19'. I used the word 'adjusting' because I wanted to show how people's thoughts and worries around their normal day-to-day work were shifted or 'adjusted' to include the worries around C19 (e.g., what it will mean for them, what it will mean for the world). However, I did not think the word 'adjusting' captured some of the suddenness or the newness of C19 in their work life and how powerful this change was. There is perhaps a gentleness to the word 'adjusting' that I did not think was appropriate. I also considered using the word 'discovering' the unprecedented nature of C19 given that many of the participants were trying to discover what an unparalleled pandemic will mean for them as they are encountering it for the first time and emotional experiences in relation to this. However, this again did not capture the suddenness or the power with which C19 entered their lives. I chose to use the word 'react' to illustrate some of the power that C19 had in people's cognitive experiences (such as worry) and ways that operational leaders 'reacted' to the powerful C19 (by emotionally distancing from worries and experiences and prioritising work over parts of themselves). As such, the GET refers to the intrapersonal processes of 'reacting' to the powerful C19 and is called 'Reacting to the Power of a Global Pandemic'.

Appendix O
Reflection of the Naming of Group Experiential Theme (GET) Three

Initially, the GET was called 'Surviving C19 by Being Together as One' however, this did not encompass some of the leader's experience of feeling it was their responsibility to protect others. Leaders were joined and contributed to the full effort of C19 but at the same time, their responsibility to protect patients and clinicians meant they experienced a level of separateness from the direct patient care, which sometimes gave rise to that sense of helplessness. For me, this GET is about the relationship between the 'whole' (everyone being united together via C19) and the 'part' in the whole (such as the more unique and specific responsibilities as a leader). The 'whole' protected them, and for some, their unique 'part' in this whole was to perhaps protect others.