

A multiple-case study evaluation of the RCN Clinical Leadership Programme in England

*Final Report to the Royal College
of Nursing and the NHS
Leadership Centre, England*

Dr Shirley Large – Research
Manager, NHS Direct Online;
formerly Senior Research Fellow,
RCN Clinical Leadership Programme

Annie Macleod – Hull and East
Yorkshire Service Design Team;
formerly Research Fellow, RCN
Clinical Leadership Programme

Geraldine Cunningham – Acting
Director RCN Institute, formerly
Director of the RCN Clinical
Leadership Team

Professor Alison Kitson – Executive
Director Nursing, Royal College of
Nursing

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Executive summary

Aim

The RCN Clinical Leadership Programme (CLP) was funded by the NHS Leadership Centre, as part of its National Nursing Leadership Project. The purpose of the multiple-case study evaluation was to establish how key stakeholders perceive the effectiveness and acceptability of the CLP.

Effectiveness will be determined by assessing if there has been any development in the leadership capabilities of programme participants (clinical leaders) and if there is any attributed impact on patient care, clinical practice, the team and the trust. The acceptability of the programme, and its interventions, will be explored in interviews with clinical leaders and service users across a broad range of clinical environments.

Objectives

- ◆ To explore the effectiveness and acceptability of the CLP from the perspectives of patients (clients/service users), clinical leaders and other stakeholders from clinically diverse environments.
- ◆ To measure the development of leadership behaviour of clinical leaders, utilising the Leadership Practices Inventory (Posner and Kouzes 1988, 1993).
- ◆ To undertake a cost evaluation to establish the trust staff and time costs attributable to implementing the CLP.

Design

A multiple-case study approach was used for the evaluation, incorporating a range of methods. Primarily, these were undertaking qualitative interviews with key stakeholders and an assessment of documentary data. In addition, a 360-degree leadership inventory was used at the start and close of the programme with a randomly selected sample of clinical leaders, to measure change in leadership capability.

Sample

A total of 16 case study sites (two from each region) were identified from the 80 English trusts taking part in the CLP. This ensured a varied sample, utilising four variables of interest; trust type, location, number of directorates and annual patient turnover.

A clinical leader from each site was selected for the case studies. These were identified on the basis of ensuring a diverse sample of clinical environments, grade, gender and experience. This sampling strategy allows the research questions concerning impact and acceptability to be explored from a broad range of clinical perspectives.

A total of 143 key stakeholder interviews were undertaken at the 16 case study sites. Some stakeholders were interviewed more than once at different stages of the study. Interviews were undertaken with:

- ◆ 16 clinical leaders(who were the focus of the case study)
- ◆ 36 clients from the clinical areas of the clinical leaders
- ◆ 30 colleagues of the clinical leaders
- ◆ 15 local trust facilitators
- ◆ 14 heads or directors of nursing

Following a sample size calculation, a random sample of 154 clinical leaders (154/267 – 58% response rate) returned a baseline and post-programme questionnaire outlining their Leadership Practices Inventory results. The sample population did not include clinical leaders from the case study sites. In addition, 91 of the 215 clinical leaders (42%) from the case study sites completed the same baseline and post-programme questionnaire.

Findings

Clinical leaders from 16 different clinical environments reported the CLP to be a highly effective and acceptable programme of clinical leadership development.

The pre-eminent finding of this study is the positive change in leadership capability of clinical leaders. Leadership change is confirmed in the triangulated data of the qualitative interviews of the key stakeholders

from the 16 case study sites and from the findings of the more broadly applied baseline and post 360-degree Leadership Practices Inventory.

Clinical leaders describe a commitment to improving service user care and developing team effectiveness and this is shown in the team goal setting and action planning described. These strategies promote a greater alignment of the team, and thus greater team effectiveness. Clinical leaders are more confident in their leadership approach and have a greater sense of value and optimism about their clinical roles. The findings show a greater sense of appreciation of the contribution of individuals within the teams, with an increased intent to share knowledge and facilitate the development of other members of the team. Clinical leaders provided examples of how they were developing ways to constructively confront and resolve difficulties in their clinical environments.

The experiential nature of the CLP together with programme interventions which link directly to client care, clinical practice and team development, were highly evaluated by the clinical leaders, colleagues, local facilitators and directors of nursing informants from the 16 case study sites.

The CLP clearly offers one way of delivering the leadership development crucial to translating the national and trust-level policy agenda to provide more patient-centred care. The conceptual framework of the programme — learning to manage self, patient-focus, developing effective relationships, networking and political awareness — provides a clear structure for clinical leaders to develop, conceptualise and describe their leadership development.

The varying amounts of time that clinical leaders participated in programme activities resulted in the equivocal findings of the cost analysis aspect of the study. Further research will be required to undertake a more illuminating cost analysis.

Recommendations

The recommendations that arise from this study are presented in relation to some of the key stakeholders. However, a number of the issues these recommendations address are clearly not restricted to one key group and therefore should not be considered to be the sole responsibility of the identified stakeholder.

Recommendations are outlined that require consideration or action from the CLP, trusts and local facilitators. Recommendations focus on issues related to the provision of information, individual and trust support, time management, closer collaboration and communication with patients, and the development of outcome indicators to measure the impact of leadership development within trusts.

RCN CLP recommendations

- ◆ Provide more pre-programme information to local facilitators and clinical leaders about the experiential learning principles underpinning the CLP.
- ◆ Prior to implementation in a trust, there should be discussion about how to manage any absence of a local facilitator, if that should become necessary.
- ◆ Explore further what recommendation should be made to trusts regarding how much time clinical leaders should allocate to leadership development, in order to achieve full personal and professional impact.
- ◆ Further explore the implications for the role and outcomes of the programme of a part-time local facilitator, as opposed to a full-time facilitator.
- ◆ Explore the requirement for the number and timing of the patient stories and observations of care.
- ◆ Provide more support and guidance with implementing patient stories and other programme interventions in clinical areas, where the immediate transferability appears less obvious in the early stages of programme implementation.
- ◆ Further explore how to meaningfully engage very vulnerable patients in patient stories.
- ◆ The readability, sensitivity and findings of the 360-degree Leadership Practices Inventory should be explored further.
- ◆ Explore the feasibility of monitoring patient complaints, staff retention and recruitment in programme implementation areas, as outcome indicators of the impact of the CLP.
- ◆ Further research is required to more accurately undertake a cost analysis of the CLP.

Trust recommendations

- ◆ It should be considered a minimum standard to have a Leadership Steering Group (LSG) that has formal links with clinical governance and patients advocacy liaison services, in those trusts with staff undertaking the CLP.
- ◆ There should be patient representation on trust LSGs, in order to raise patient awareness about clinical leadership and help staff reflect and further learn from the experiences of patients.
- ◆ Ensure that there are processes in place for shared learning across the organisation to promote continuously improving patient care environments.

Local facilitator recommendations

- ◆ Give a clearer indication of the purpose and development opportunity of one-to-one sessions, to ensure that this programme intervention meets the needs of clinical leaders.
- ◆ Explore ways to provide patients with feedback from action plans and action taking that result from patient stories and observations of care, without compromising the anonymity and confidentiality of the patients involved.
- ◆ Raise awareness within trusts that many clinical leaders feel unable to take the full amount of negotiated study time, which may have a consequent impact on the programme outcomes.

Glossary of Terms

Reproduced from the RCN Clinical Leadership Toolkit (Royal College of Nursing 2001)

RCN Clinical Leadership Programme

An 18-month leadership development programme which aims to provide local facilitators and clinical leaders with practical strategies to use within their teams, in order to enhance the care received by patients.

Clinical leader

An individual who leads a clinical service.

Clinical area

The term clinical area refers to the location of the clinical leader's responsibility. This could be a ward, a community caseload, a department or it could be a nurse working as a nurse specialist, practitioner or manager.

Facilitation

Facilitation means to make things simpler. For the CLP, this means working with a group of individuals to enable them to achieve their potential and become skilled at how to learn again. Facilitation is seen as an integral part of leadership development. On the programme, each of the local facilitators has a considerable amount of experiential learning opportunities to develop their role as facilitators, and in turn become very strong role models to the clinical leaders participating in the programme.

Lead facilitator

The lead facilitator is director of CLP.

Regional facilitator

The facilitator appointed by the RCN to directly support local facilitators and the overall delivery of the programme within trusts.

Local facilitator

A facilitator appointed by the organisation to support the clinical leaders undertaking the programme.

Personal development

An integral part of the CLP, personal development is seen as crucial to the development of leaders. The

programme provides a number of opportunities for participants to develop personally. They start the programme by undertaking a 360-degree Leadership Practices Inventory; each participant produces a personal development plan and identifies areas of strength and areas for development. A number of interventions also contribute to the participant's personal development, including one-to-ones, action learning, mentoring and shadowing.

360-degree Leadership Practices Inventory

A 30-item measure of leadership action and behaviour, scored on a 10-point scale. Designed for use in a variety of settings, including health care, it facilitates a 360-degree evaluation of leadership incorporating an evaluation for self, the manager, co-workers and people who directly report to the clinical leader.

One-to-ones

Each participant on the programme has a one-hour one-to-one meeting every four to six weeks. The clinical leader undertakes the one-to-one with their local facilitator; the local facilitator has a one-to-one with a RCN facilitator. One-to-one sessions help to ensure that programme participants are developing on the programme and getting the time to participate in programme activities. One-to-ones also provide an opportunity for further challenge and support, which contributes to the clinical leader's personal development.

Action learning

Action learning is a method of personal, leadership, management and organisational development. For the duration of the programme, clinical leaders and local facilitators belong to an action learning set and meet every four to six weeks for a whole working day. Each action learning set has a facilitator. Participants of the action learning set explore important issues and then agree an action plan; they then reflect on what they have learnt from the action taken.

Mentoring

Each programme participant is encouraged to find a mentor, once they have received their feedback from the 360-degree Leadership Practices Inventory. The role of the mentor is to assist the clinical leader and local facilitator, providing a strong leadership role model to work closely with throughout the programme. Mentors provide valuable networking and political

opportunities. Participants are encouraged to select their mentors carefully; in the past participants have found trust board members and individuals external to their organisations to be extremely valuable in this role.

Shadowing

Clinical leaders and facilitators are encouraged to consider who they could shadow, in assisting the development of their leadership potential. Usually the participants select an individual they admire for their leadership qualities, or somebody they want to learn more about in order to understand their way of working. Ultimately, participants need to consider how the shadowing experience will contribute to their leadership development.

Team building

Clinical leaders and facilitators on the programme are enabled to cultivate creative methods to support team development. A number of team building techniques are introduced to help establish how a group of individuals work together, how their strengths and areas for development contribute to joint working, and how groups can be helped to work more effectively as a team to achieve their primary tasks.

Observation of care and practice

Observation of care and practice is a simple quality improvement and personal development tool; it contains an important message: that 'seeing' and 'observing' are not the same. The approach to observation of care on the programme was created from the original piece of action research on the programme (Royal College of Nursing 1997). This involves two observers; an insider and an outsider. The clinical leader (insider) and an outsider (either the local facilitator or another clinical leader) observe and record the insider's clinical area for 30 minutes. Always starting with the insider, observers then share what they have observed and recorded and engage in a critical dialogue about what they have observed. Observers then share their observations with the other clinical staff present at the time of the observation. Areas for improvement are identified, actions agreed and good practice celebrated.

Patient, client or carer stories

Patient stories, also known as patient narratives, are audio-taped interviews with clients about their experience of being in hospital or receiving care in other settings. This is a powerful way of getting patients to

help identify areas for quality improvement and to ascertain which aspects of their service user experience they value. Clinical leaders pair-up, to ensure that they do not undertake patient stories within their area of work. Able service users are randomly selected and invited to tell their story about their experience of receiving patient care. The stories are taped, mind mapped and then given to the other paired clinical leader to verify. When six stories have been collected from a single clinical area, the clinical leaders identify common themes that service users did and did not value. These themes are fed back to the multi-disciplinary team, so that areas for improvement can be identified. Finally, action plans are agreed and implemented.

Networking

Networking is encouraged; clinical leaders are encouraged to network, both internally and externally to their organisations. This provides opportunities for clinical leaders to develop their confidence and to compare and learn new creative ways of working. Networking helps to strengthen the core value of working in the health service.

Political awareness

The development of the political awareness capacity and capability of programme participants is crucial to developing their ability to influence key stakeholders within their trusts and ultimately ensure that resources, structures and systems can be introduced to promote patient-centred care.

Workshops

Intervention and needs-led workshops in the CLP are responsive to the needs of the participants. Therefore, in addition to the core workshops specified in the toolkit, there is flexibility and negotiation about the content of additional workshops. Expert facilitation will be available from the RCN on a range of topics.

1. Introduction

This report presents the findings of the multiple-case study evaluation of Phase 3 of the RCN Clinical Leadership Programme (CLP) in England. The evaluation builds on two previous action research projects, which were concerned with developing the programme interventions and methods of implementation. The present study utilises a multiple-case study approach to evaluate the programme and its interventions, and to further define and understand the outcomes perceived to be attributable to the CLP. The data collection period of the study spans April 2001 to December 2002.

In 2001 and 2002 (Phase 3) the CLP was jointly funded by the NHS Leadership Centre and the RCN, extending the programme to encompass a total of 96 programmes within 80 NHS trusts in England. During this phase of the programme 1,052 clinical leaders and their teams undertook the CLP and the multiple-case study evaluation was conducted during this period of time.

1.1 Context of the research

Government recommendations, such as those contained in Department of Health (1999) *Making a Difference*, support the creation of learning opportunities for nurse education in clinical practice. *Making a Difference* identified the development of leadership in nursing as a crucial component in forging the new framework for nursing in the modern NHS. It identified the importance of self-aware leaders, motivated to produce real improvements in clinical practice and to establish direction and purpose, to inspire and motivate their teams. In addition, it identifies the need for leaders who have the ability to work with others across professional and organisational boundaries. The Department of Health (2000) *NHS Plan* signalled the importance of leadership and the need to redesign the NHS around the needs of patients. Therefore, nurses are required to respond to the plan by focusing on the essential elements of care, providing strong leadership which will enable innovative ways of working and the active involvement of patients in their care.

There are a number of leadership development initiatives that support the national and local professional and policy agenda for leadership development in the NHS. In addition to academic leadership courses, there are practice-based programmes developed specifically for health care professionals.

The CLP differs from other practice-based programmes; the length of supported leadership development is designed to utilise experiential processes to focus on improving service users' experience of health care. An interested NHS trust is asked to second a local facilitator to lead the programme within their organisations, for up to 100% of their work time, over a period of 18 months. The CLP team recommends that each local trust facilitator support the leadership development of up to 12 clinical leaders, at any one time. Clinical leader participants are recommended to take 20% of their work time, over a 12 month period, to undertake the programme.

During this time, learning is driven by participant-identified work needs and is characterised by a dynamic and emergent personal learning plan with explicit goals, protected time for reflection and action learning. The observations of care and patient story telling techniques used in the CLP offer direct feedback on patient experience, relevant to the clinical context and clinical team (Cunningham and Kitson 2000a). Cunningham and Kitson (2000b) showed that the focus on specific patient issues, rather than general issues, enabled contextually appropriate action plans to be developed and implemented in practice. This ensures the real needs of service users are addressed in a diversity of

clinical settings. In addition to the local support for programme implementation in trusts, regional facilitators provide support for the leadership and facilitator development of local facilitators, and for overall programme delivery within trusts.

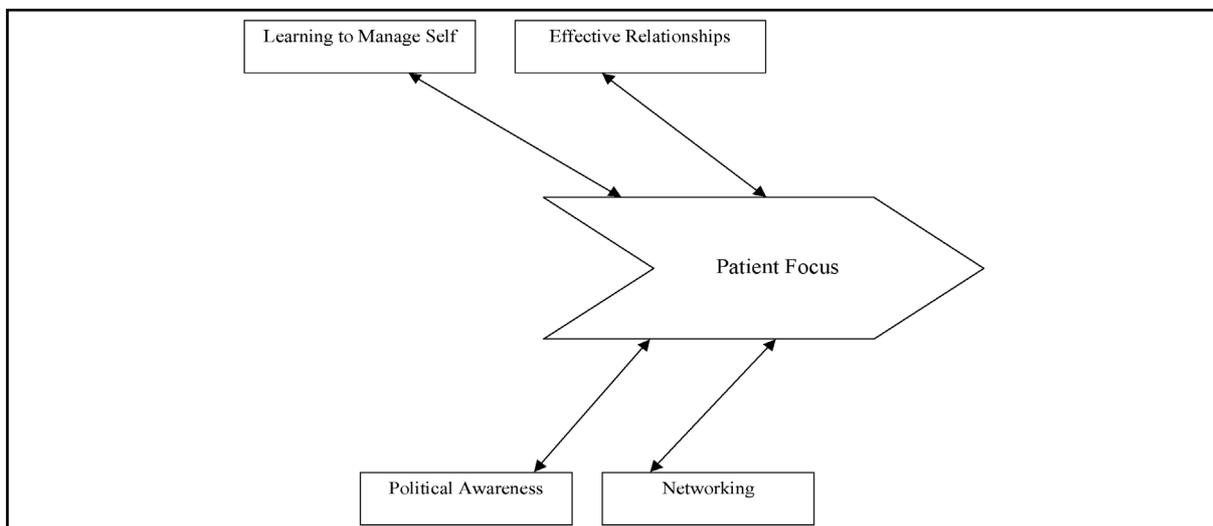
Key stakeholders in the organisation are enlisted to support the leadership development initiative. This ensures the programme is integrated and responsive to the organisation's strategic objectives and can achieve maximum impact in enhancing patient care locally.

In Phase 3 of the programme, the 1,052 participants are predominantly nurses and midwives, although up to 10% are allied health professionals (e.g. occupational therapists and physiotherapists). The aim of the CLP is to develop the transformational leadership capabilities of clinical staff, by supporting staff through a process of experiential learning and underpinned by five key principles, which are described in section 1.2.

1.2 Review of related literature

Recognition that the ward sister is key in determining the provision of quality patient care was the catalyst for developing the CLP in 1994. To understand how to best facilitate staff in providing leadership that would enable the best care possible, the CLP engaged in a collaborative action research study with ward leaders (Cunningham and Kitson, 2000a, Cunningham and Kitson, 2000b and Kitson, 2001). The outcome of this three year study was the development of a framework to underpin the CLP, as illustrated in Figure 1.

Figure 1 — CLP development framework



The five themes within the development framework represent areas that nurses need to develop, in order to enhance their leadership capabilities and become more patient-centred clinical leaders. The study described ‘learning to manage self’ as fundamental to the incremental development of more effective relationships within teams, developing a patient-focus, networking, and developing political awareness. A brief summary of the emergence of the principles is given below:

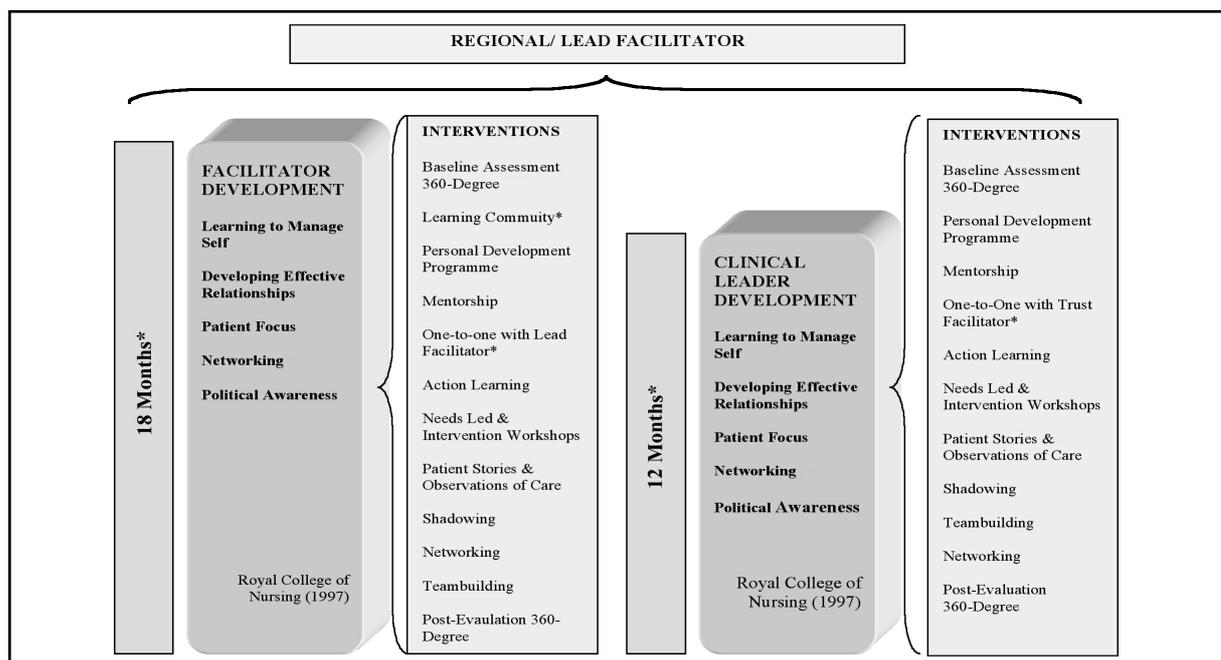
- ◆ Learning to manage self – during the project, ward leaders reported that they became more self-aware, less defensive, and more open to criticism and therefore, were able to be more focused on delivering and improving the quality of patient care.
- ◆ Effective relationships within teams – ward leaders developed greater understanding of how to influence teams and build relationships with other disciplines.
- ◆ Developing a consistent patient focus on care – two of the main ways that emerged in supporting ward leaders to become more patient-focused was direct observation of practice and patient story-telling. This insight led to the development of two major interventions of the programme; ‘Observations of Care’ and ‘Patient Stories’.

- ◆ Networking and developing political awareness – nurses in the study recognised the importance of talking to each other, as well as linking to other stakeholders and policy outside their own clinical area. (Cunningham and Kitson 2000b)

From this original study, a toolkit was developed to guide the process of implementing the CLP within organisations. The implementation is supported by a model of external-internal facilitation. Regional facilitators employed by the RCN, act as external facilitators, supporting and enabling internal local facilitators to develop their facilitator and leadership capability. In turn, internal local facilitators support and enable the clinical leaders in the development of their leadership capability and change management within their clinical areas.

In a concept analysis describing the role of the facilitator, Harvey et al (2002) concluded the role is about supporting people to change their practice. However, there is some evidence to suggest that facilitators move from being initially directly supportive, towards developing a more enabling role as their skills develop (Harvey, 1993). In many of the current practice development initiatives within health care organisations, the facilitator’s role is concerned with enabling cultural change through facilitating

Figure 2 – RCN Clinical Leadership Programme



*Identifies differences in the interventions between the Facilitator and Clinical Leader Programmes

individuals and teams to analyse and challenge current ways of working, through methods of reflection that use action learning and mentoring (Garbett and McCormack, 2001). Models of external-internal facilitation, where facilitators from outside the organisation work with identified internal facilitators, are described by Binnie et al. (1999).

The toolkit of interventions used in the 15-month local facilitator development programme and 12-month CLP is summarised in Figure 2.

The toolkit is not designed as a rigid set of interventions; the intention is to have a cache of interventions to guide the process of enabling the local facilitator to run the programme.

Most practice-based programmes that support change in practice have been developed around the concept of adult-centred learning (Knowles, 1990), providing opportunities for people to build on their knowledge and previous experience. Strategies focus on the learning process rather than the teaching process, thereby encouraging independent and self-directed learning. Through mentorship, reflective learning and support, people are placed at the centre of their learning. This allows individuals to take responsibility for their learning and enhances their ability to develop skills in lifelong learning (Peters, 2001). This approach to learning offers a way in which the links between personal development, work and education can be strengthened and explored (Kolb, 1984). Day-to-day experiences are valued as learning experiences and the process by which learning takes place has been described in various ways by theorists as experiential learning. Put simply, experiential learning is learning through reflecting on the 'doing' (Morrison and Burnard, 1991).

An experiential approach to developing practice has its roots in the field of experiential learning and is strongly influenced by underlying theories of humanistic psychology and human inquiry. Kolb (1984) presented an influential four-stage model of experiential learning. The first stage is the concrete experience or event that has taken place. In the second stage (reflective observation) the individual thinks about, or reflects upon, the event that has taken place. During the third stage (abstract conceptualisation) connections and ideas are made which might change and evolve, to assimilate the new experience. Finally, Kolb proposed that the fourth stage of active experimentation is when a

new understanding of the experience is tested in practice.

Henry (1989) rejected the concept of sequential experiential learning in favour of proposing that all learning is experiential. In addition, Blacker (2003) highlights that learning does not necessarily take place in distinct steps, but may happen simultaneously. While expert opinion in the field appears to differ on an exact process of experiential learning, theorists do agree this type of learning is not the more formal instructive approach to education, such as attending lectures or reading set course materials.

The personal development aspect of experiential learning is founded on the original insight of Socrates, the ancient Greek philosopher, who suggests that to 'know thyself' is the basis for wisdom and right action. A number of leadership development approaches adopt the principle that improving self-knowledge is a basis for leadership development (Cacioppe, 1998). The adoption of experiential learning strategies as being the most appropriate for promoting self-awareness for pre-registration and post-registration nurses, is well established (Cook, 1999). However, experiential learning strategies often challenge taken-for-granted processes and understandings with a view to changing them. It is therefore not uncommon for such experiences to generate conflict and anxiety within participants, especially when focused on the self (Cook, 1999). Cook urges caution in relation to claims that the pursuit of self-awareness produces nurses with a greater depth of theoretical understanding, enabling them to have more therapeutic relationships with patients/clients, as there is currently little empirical evidence to support this notion.

Argyris and Schon (1976) explored experiential approaches to leadership development and proposed that many leaders were able to articulate their espoused values (i.e. those they said underpinned their actions) but noted that those values could be different from the implicit actions or values observed in practice. Argyris and colleagues termed this style of leadership 'Model I' and claimed that when espoused values were not implicit in the leaders' behaviour, subsequent leadership behaviour was autocratic, minimised one's own exposure to challenge and in the event of emotional issues arising, led to minimal confrontation. Argyris and Schon facilitated a programme of experiential leadership development that aimed to enable leaders to

develop a more effective, collaborative, challenging and open style of leadership in a group environment, which they termed 'Model II'.

Following an action research project, Manley (2000) highlighted that approaches which enable leaders to distinguish between the culture in practice and their espoused culture, were more likely to be successful in developing transformational leaders. In an overview of the work undertaken by Argyris and Schon, Schein (1980) highlighted that organisations would benefit from better leaders if leaders learned how to learn themselves and understood the underlying assumptions and emotions associated with their behaviour.

Downton (1973) first distinguished transformational leadership from transactional leadership. However, the concept of transformational leadership really became eminent with the work of Burns (1978) who described it as the process whereby an individual engages with others, creating a connection that raises the level of motivation and potential of the leader and others within the team (described as 'followers'). By contrast, in transactional leadership approaches, staff are driven in an authoritarian way rather than led, so that 'followers' are worked on rather than worked with.

This model places priority on the achievement of tasks, whereas, transformational leadership changes and transforms individuals in a way that instils faith and respect (charisma), treats each employee as an individual (individualised consideration), promotes innovative ways of problem solving (intellectual stimulation), transmit values and ethical principles (idealised influence), provides challenging goals and communicates a vision of the future (inspirational role).

Transformational leadership is concerned with values, ethics, standards and long-term goals. Although the transformational leader plays a pivotal role in hastening change, leaders and their colleagues are bound together in the transformation process (Northouse, 2001). A key factor in successful leadership of change is enabling those in their organisations to lead themselves.

According to Kotter (1990), leadership involves the creation of a vision and strategic direction for the organisation, the communication of that vision to the users of the organisation as well as inspiring, motivating and aligning organisation and people to achieve this vision. Bass (1985) considered transformational leadership and transactional leadership to be distinct,

but not mutually exclusive processes, stating that both types of leadership may be used at different times, depending on the requirements of the situation.

It is widely believed that workplaces with transformational leaders are likely to be more productive, flexible and strategically aware than workplaces with more conventional (transactional) leaders (Bass and Avolio, 1994). It is a leadership style that is reported to better suit the need to adapt to increasingly complex health care organisations (De Geest et al., 2003) and has its focus on people and problem-solving in a changing environment (Lafferty, 1998).

It's suggested that transformational leaders recognise that in order for an organisation to thrive, there needs to be constant challenge about the way things are traditionally done, what is done and who does it (Alimo-Metcalfe, 1996). Therefore, proficiency in managing change and motivating others in a changing environment becomes increasingly necessary. If leadership is to focus on transforming cultures and ensuring a shared vision, this will need to be accompanied by transparent personal values and beliefs that inform self-behaviours and the behaviour of others. Thus, clinical leaders need to attend to their personal development needs and these can be identified in number of ways, including personal reflection and mentorship (Rippon and Monaghan, 2001).

Clear leadership has been recognised as essential to effective team working; effective teams enhance the ability to deliver high quality health care and support innovation in practice (Borrill et al., 2002). Borrill et al provide a definition of clear leadership which encompasses all the elements of transformational leadership:

"Clear leadership involves creating alignment amongst team members around shared objectives, and strategies to attain them; increasing enthusiasm and excitement about the work, and maintaining a sense of optimism and confidence; helping those within the team appreciate each others' contribution and helping them to learn how to confront and resolve differences constructively; helping people to co-ordinate activities; and continuously improve; helping them to develop their capabilities and encouraging flexibility; and offering objective

analysis of processes and encouraging collective learning about better ways to work together.” (p.9)

The leader’s role, in a health care context, emphasises creating a strong and unified culture that focuses upon innovation and improving patient/client care (Clarke and Wilcockson, 2001). At a more strategic level, recent health care policy is shaped around the needs of patients, promoting the involvement of both service users and the public in the evaluation and development of health care services. The influences for this policy development are essentially twofold; firstly, involving service users and the public is believed to improve the quality of health care and secondly, involving service users and the public is considered a democratic or ethical requirement because service users pay for the health service, giving them a right to influence how the services are managed.

Conversely, and more cynically, it has been argued that through a process of consulting with users of health services, support for decisions that would otherwise be unpopular can be obtained (Crawford et al., 2002). A recent systematic review, exploring patient involvement in the planning and development of health care, reported that although user involvement has been undertaken by a variety of methods, including surveys, quality-of-life measures and action research, the effect of that involvement is not really known. The authors however, caution against believing that the absence of evidence means the absence of effect (Crawford et al., 2002).

Bass (1985) was the first researcher to advance the concept of measuring transformational leadership. Posner and Kouzes (1993) state that an accurate assessment of leadership is essential, when developing individuals’ capabilities to lead people more effectively and developed the Leadership Practices Inventory (LPI) for this purpose. The Leadership Practices Inventory provides a 360-degree assessment of leadership behaviour and is an empirically based measure of the ‘five practices of exemplary leadership’ model of transformational leadership. The authors claim the ‘five practices of exemplary leadership’ can be tested, learned and taught.

The leadership behaviours, which make up the five practices, were empirically derived from case studies of over 1,100 managers and their personal best experiences as a leader. The written cases were

enhanced with in-depth interviews, which identified critical leadership actions and behaviours (Posner and Kouzes, 1993). The five practices of exemplary leadership, which make up the measure, were developed from extensive psychometric validation of the properties of the measure. The authors claim sound validity and reliability of the measure (Posner and Kouzes, 1988).

Leadership measures may be used on leadership programmes to facilitate leadership development and to explore changes and the individual’s leadership capability over the course of a programme. The Leadership Practices Inventory (Posner and Kouzes, 1988 and Posner and Kouzes, 1993) has recently been described as “one of the most attractive, clearly articulated and rigorously tested contributions to the literature” (Bowles and Bowles, 2000). The five practices of exemplary leadership, each of which consists of two basic strategies are outlined below:

1. Challenging the process
 - ◆ Search for opportunities
 - ◆ Experiment and take risks
2. Inspiring a shared vision
 - ◆ Envision the future
 - ◆ Enlist the support of others
3. Enabling others to act
 - ◆ Foster collaboration
 - ◆ Strengthen others
4. Modelling the way
 - ◆ Set the example
 - ◆ Plan small wins
5. Encouraging the heart
 - ◆ Recognise contributions
 - ◆ Celebrate accomplishments

(Posner and Kouzes, 1988; Posner and Kouzes, 1993)

Bowles and Bowles (2000) evaluated transformational leadership in nursing development units and non-nursing development units within England. The study was also concerned with evaluating the utility of the 360-degree Leadership Practices Inventory. They describe the scale as attractive, cogent and well described, but raised some concerns around terminology, stating that the language used within the questionnaire occasionally confused interviewees.

Bowles and Bowles conclude that the questionnaire may require 'Anglicisation'.

The development of transformational leadership within a framework of experiential learning is considered the most appropriate leadership model to underpin the CLP. It values personal development alongside the more conventional leadership traits, such as acknowledging power, authority, influence and charisma (Cunningham and Kitson, 2000b). At the start of the Phase 3 CLP implementation, the Leadership Practices Inventory was considered by the RCN Clinical Leadership Team to be the most suitable measure of leadership development and change for participants undertaking the programme. This decision was based on the experience of using different measures of leadership development, a review of the literature and on the successful use of Leadership Practices Inventory in Phase 2 of the programme. The transformational concepts that make up the Leadership Practices Inventory were perceived to match well the underpinning values of the CLP.

1.3 Research aim and objectives

The aim of the multiple-case study evaluation is to establish how key stakeholders perceive the effectiveness and acceptability of the CLP.

Effectiveness will be determined by whether or not there has been development in leadership capability of the programme participants (clinical leaders) and if there is an attributed impact on patient care, clinical practice, the team and the trust. The acceptability of the programme, and programme interventions, are explored in interviews with clinical leaders and service users across a broad range of clinical environments.

There were three primary objectives:

- ◆ To explore the effectiveness and acceptability of the CLP from the perspectives of clients, clinical leaders and other stakeholders across clinically diverse environments.
- ◆ To measure the development of leadership behaviour of clinical leaders utilising the Leadership Practices Inventory (Posner and Kouzes 1988, 1993).
- ◆ To undertake a cost evaluation to establish the trust staff and time costs attributable to implementing the CLP.

2. Research design and methods

A number of different approaches to evaluation have been described by Øvretveit (1998), of which formative evaluation and outcome, or impact evaluation, are of relevance to the current study. Formative evaluation is described as a type of 'developmental' evaluation that enables findings to feed back into the programme or intervention, with the aim of improving it. Outcome or impact evaluation concentrates on discovering the outcomes of an intervention or programme and may be part of a formative evaluation. These two evaluation approaches describe the dual endeavour of the RCN clinical leadership evaluation; firstly in contributing to the developmental aspect of the CLP and secondly, in exploring the impacts which are attributed to the CLP at a number of levels (clinical leader, patient, team and trust).

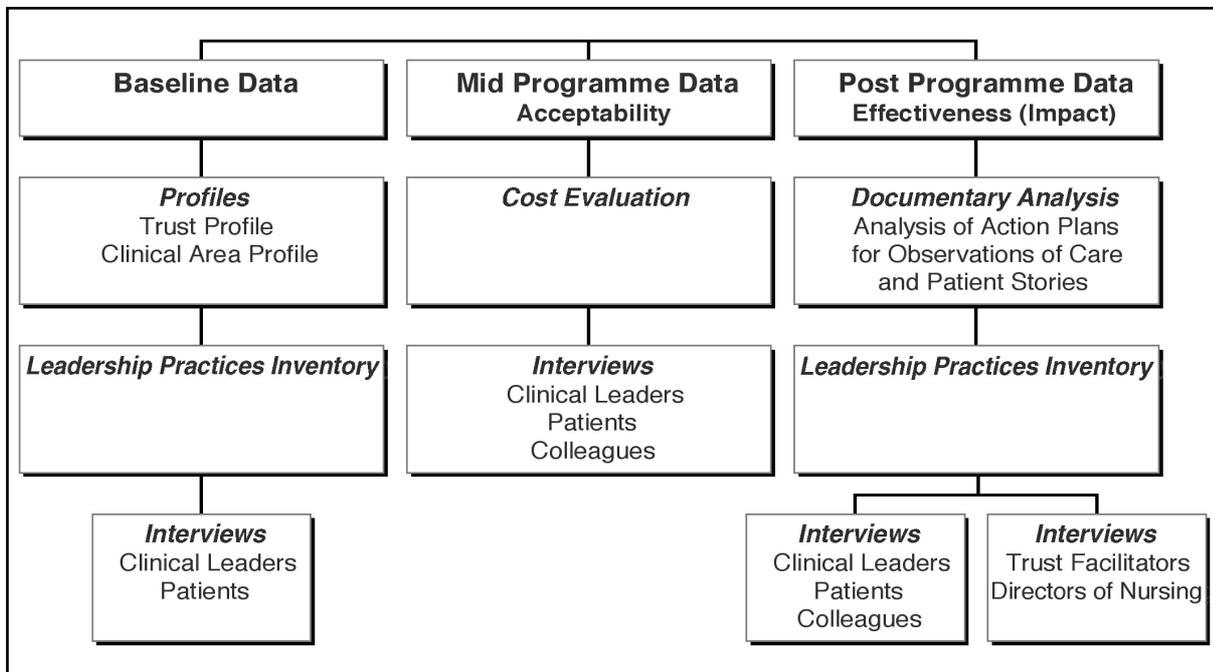
Most evaluation designs follow a chronology that includes the collection of baseline information, structured inputs, process information, immediate and intermediate outputs and impacts and longer-term outcomes and impact (Lazenbatt, 2002). As the present evaluation research runs concurrently with the programme implementation, the collection of longer-term outcomes is not incorporated within the design. However, the remaining data collection points are included to enable an exploration of the programme processes, indicate the acceptability of the programme, and identify the immediate and intermediate impacts attributed to the CLP.

The broad evaluation approach adopted is a formative evaluation, incorporating an impact (outcomes) analysis. The formative evaluation design, the data collection points and the research methods used are outlined in Figure 3.

Figure 3 outlines the data collection points and research methods used for each phase of the research evaluation. Each phase of data collection had a primary goal:

- ◆ The baseline interviews and profiles are concerned with eliciting descriptions and information about the case study sites. Baseline patient interviews explore patients' perceptions of clinical leadership.

Figure 3 – Data collection points and research methods



- ◆ The mid-phase data collection and interviews are concerned with acceptability, therefore, evaluation of the processes and interventions of the programme.
- ◆ The final interviews and data collection explore the impact (outcomes) of the programme from the perspectives of the clinical leaders, a client from the clinical area of each clinical leader, a colleague of each clinical leader, the local facilitator from each case study site and the head of nursing or director of nursing from each case study site. The baseline and post analysis of the Leadership Practices Inventory explores the change in leadership capability of clinical leaders.

In evaluation research, a case study design may be considered appropriate when it is necessary to explain the links in real-life interventions that are too complex for survey or experimental strategies, particularly in circumstances where there are no clear explanations of what the links are between the programme implementation and the programme effects (Yin, 1994). Yin defines case study as an empirical study that:

1. Investigates a contemporary phenomenon (in this study, the CLP).
2. Within its real life context (i.e. within the context of the clinical environment).

3. Where the boundaries between the phenomenon and context are not clearly defined.

Therefore, a case study approach will be relevant when the contextual conditions are pertinent to the understanding of the phenomenon studied (Yin, 1994).

Case studies may describe, explore or explain the phenomenon under investigation. Descriptive case study research describes the phenomenon, exploratory research debates the value of further research and suggests various hypotheses or propositions and explanatory research seeks to explain various aspects and causal arguments highlighted by descriptive research (Yin 1994). Within this framework, the current study is an explanatory study seeking to explain the effect of leadership development on the individual, patient, team and the trust.

Multiple sources of evidence, allowing converging methods of inquiry, are considered integral to case study approaches. The philosophical distinctions between qualitative and quantitative research are not regarded as incompatible in this method; instead they are valued for their ability to explore more broadly the phenomenon under investigation. The findings of a case study are described as more likely to be convincing and accurate if they are based on several different sources of corroborative information (Yin, 1994).

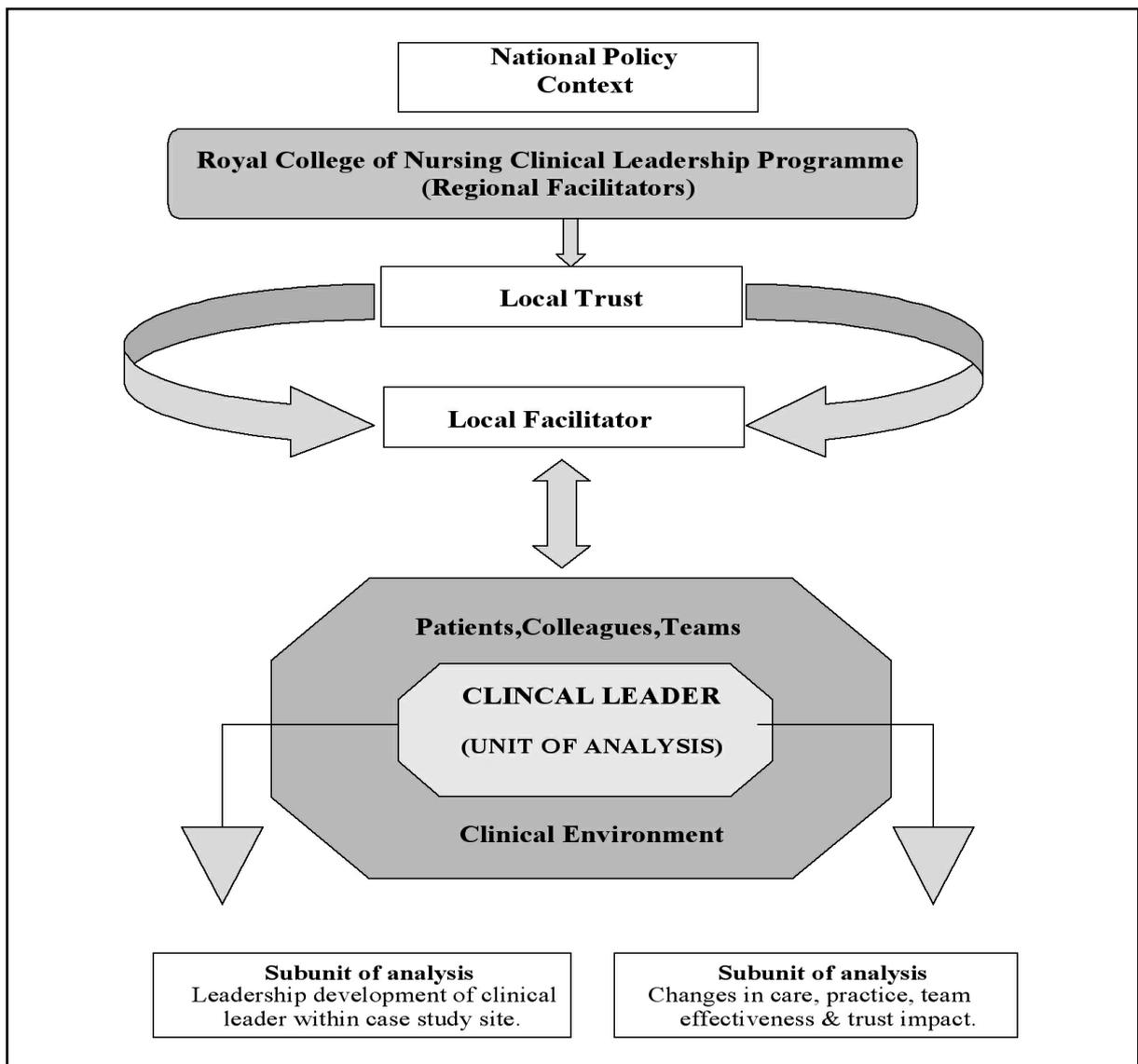
The prior development of theoretical propositions, which guide the data collection and analysis, is also a distinguishing feature of this approach. A proposition directs attention to something that should be examined within the scope of the study (Yin, 1994). In the current evaluation, the theoretical propositions guiding the research design are the RCN Clinical Leadership Development Framework (Royal College of Nursing, 1997) and the Leadership Practices Inventory (Posner and Kouzes, 1988).

It is important when using a case study approach to define clearly the 'case' or unit of analysis, so that the propositions can both guide the collection of relevant

data and ultimately enable the linking of data to the propositions, to aid analysis and interpret the findings (Yin, 1994). In addition, sub units of analysis (embedded areas of interest or impact to the case) may also be identified.

In this design, the clinical leader is the case, and the leadership development of the clinical leader is central to the case. The sub units of analysis explored will be how the clinical leader's leadership development impacts on patient care, the clinical environment, team effectiveness and the trust. The contextual issues and units of analysis of the case study sites are shown in Figure 4.

Figure 4 – Flow diagram of the contextual issues, units of analysis and sub units of analysis



When sub units of analysis are defined in the design of a case study, it is termed an embedded case study

design. Yin (1994) describes four types of case study design:

Table 1 — Basic designs for case studies (Yin, 1994)

	Single-case design	Multiple-case design
Holistic (single unit of analysis)	TYPE 1	TYPE 3
Embedded (multiple units of analysis)	TYPE 2	TYPE 4

The evaluation of the CLP is a Type 4 case study since it incorporates an embedded multiple-case study design. Type 4 case studies have high explanatory potential and are invaluable where “broad complex questions have to be addressed in complex circumstances” (Keen and Packwood, 1995). Yin (1994) acknowledges, however, that complex, multiple case studies are difficult to undertake, especially with regard to analysing a combination of data from different sources. In the current evaluation, 16 simultaneous case studies, undertaken in diverse clinical environments, are incorporated in the design. Multiple sources of evidence are used to illuminate different aspects of the research aim and objectives. The research methods incorporated interviews with a range of key informants, documentary evidence, informal observation, questionnaires and trust profiles.

One of the criticisms of case study method is that the results cannot be generalised, because they relate to specific situations and localities. In response, Yin (1994) and Woods (1997) argue that multiple-case studies are not concerned with statistical generalisations but with analytical generalisations. Yin described analytical generalisation as a two-stage process. In stage one, data from the same case may be related to some theoretical proposition about what is going on and this strengthens the internal validity of the research. Stage two consists of replication logic, whereby the results of one case are compared with those from other cases and the theoretical propositions. In the context of the current study, because participants have a range of experience and are from diverse clinical environments, confidence will be increased in the findings being transferable to a broad range of clinical settings.

2.1 Timeframe of the evaluation

The multiple-case study evaluation ran concurrently with the planning and implementation of the CLP.

Clinical leaders were recruited for the evaluation as they commenced the CLP in July and August 2001. They completed the programme between June and July 2002. The timeframe for the multiple-case study evaluation was January 2001 to October 2003, which allowed time for preparation of the design and evaluation methodology, and analysis of the data, in addition to the production of the final report.

2.2 Ethical considerations

The research proposal and report has been through a process of peer review, both within the RCN, and with members of the steering and advisory groups. Multi-centre Research Ethics Committee approval was granted for the project in May 2001, while local ethical approval and permission from directors of nursing was granted by all trusts involved in the in-depth research. An amended Multi-centre Ethics Committee application was submitted and approved in December 2001. The amendment proposed to omit a measure of organisational characteristics that had proved to be unacceptable to some participants.

Written and verbal consent was obtained from all participants. In addition, patients were assured that their care or treatment would not be affected in any way, whether they did or did not consent to take part in the study. A confidential introductory letter invited the clinical leaders to take part in the study; they were assured that if they did not wish to take part, this would remain confidential and it would not affect their progress on the CLP. All participants were advised that if they objected to any question, they were not obliged to answer and that they could, without prejudice, withdraw from the study at any time.

All participants were given an information sheet (see Appendix 2). Patients were given a period of 24 hours to consider if they wished to take part in the study; the

clinical leader made the initial approach to patients on the case study sites.

Audio-taped interviews were erased following transcription of the interview. Participants were informed that quotations from the interview may be used in the evaluation report, in the event that these illustrated an aspect of importance that emerged from the data. However, participants were assured that all transcripts and questionnaires would be given a numerical identifier, in order to make them anonymous, and that all other identifying information about the participant would be removed from the transcript. Transcripts were stored securely in locked filing cabinets.

2.3 Sample selections

2.3.1 Case study site selection

All RCN local facilitators enrolled in the programme in July 2001 were sent a trust sampling questionnaire. Of those trusts that returned the questionnaires, two in each of the eight English regions were purposively selected to ensure a maximum variety sample. This was done using a matrix which detailed the four variables of trust type, location, number of directorates and annual patient turnover. The selected sites varied by size and location (for example, city, inner-city, town, seaside and rural) and by trust type. Consequently there are eight acute trusts, of which two are also teaching trusts; two primary care trusts; two mental health trusts; one NHS Direct trust; and three combined trusts (for case study data collection procedure, see Section 2.4). The 16 selected trusts were coded and each researcher was allocated one trust in each region: 1 to 8 (Researcher 1) and 11 to 18 (Researcher 2). Figure 5 shows the approximate location, region and type of trust selected for the study.

2.3.2 Case selection

A screening questionnaire was sent to clinical leaders at the case study sites enrolled on the programme between July and August 2001. One clinical leader from each site was purposively selected to be the focus of the case study, to ensure as varied a sample as possible.

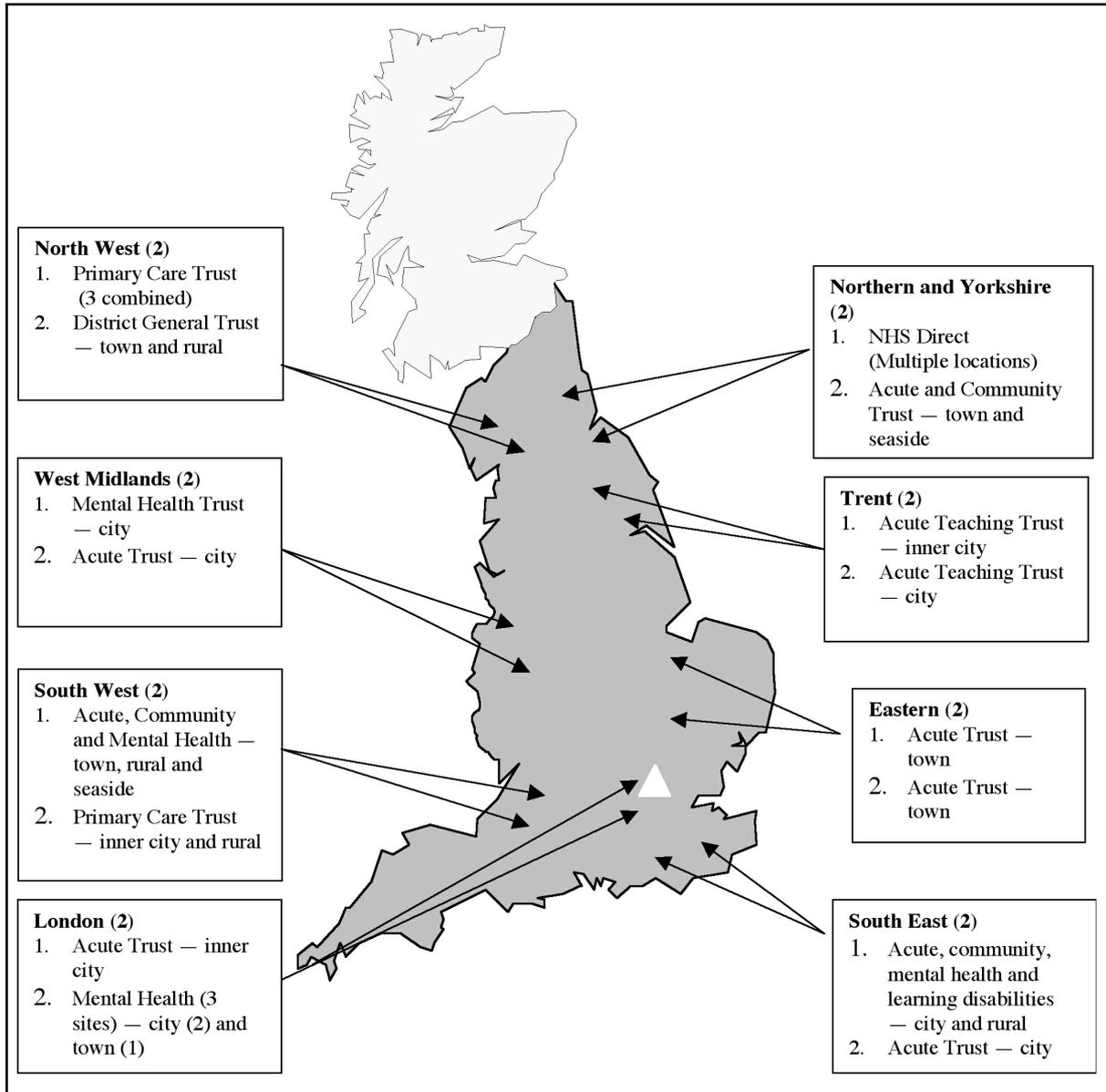
The variables of interest for selection were clinical area, grade, gender and years of nursing experience. The purpose of this two-stage sampling frame was to ensure the maximum variety of clinical areas possible within the 16 trusts selected (Appendix 1). Of the 16 participants initially approached, 15 agreed to participate in the study. At one of the case study sites, where a clinical leader declined to participate, a clinical leader in the same trust with similar characteristics was approached and agreed to participate in the study. One of the clinical leader participants was promoted after the first interview and felt she was unable to continue participating in the research. A clinical leader at the same case study site volunteered, and was recruited for the mid-phase and final phase of the study.

2.3.3 Patient sample

Patient interviews were undertaken at the beginning, middle and end of the programme. The clinical leader participant at each of the 16 research sites initially approached a number of patients, identified by the staff in the clinical area. Staff identified patients who were most physically and cognitively capable of participating in the study; patients were told that they may or may not be approached by a researcher on the following day. Patients were provided with information letters about the research (Appendix 2) and given at least 24 hours to consider taking part. The researcher then selected, at random, one of the patients identified by staff. All patients approached during the course of the study consented to interview, except for one who declined in the mid-interview phase. Informed written and verbal consent was obtained from all patient participants.

Patients were interviewed in each of the selected clinical leaders' wards or clinical areas. For community staff who visited patients at home, interviews were carried out in the home environment. At the NHS Direct site, specialist equipment for telephone interviewing was not obtained until after the baseline interviews were complete. One telephone interview was undertaken with an NHS Direct patient for the final interview. Mid-programme interviews were only undertaken if the patient had taken part in a 'Patient Story' when the researcher was on a case study site. Mid-programme interviews with the clinical leader and a colleague of the clinical leader were undertaken at the same time.

Figure 5 — Location of case study sites, by region (arrows provide a broad approximation of site location)



The patient sample comprised of 26 patients over the three interview phases:

- ✦ First interviews — 15 patients
- ✦ Mid-programme interviews — 8 patients
- ✦ Final interviews — 3 patients

2.3.4 Colleague sample

Colleagues of the clinical leaders from the 16 case study sites were interviewed at the mid-phase data collection point and at the end of the programme. Clinical leaders were asked to identify a colleague, not previously interviewed, with some knowledge of the programme and programme interventions.

The colleague sample comprised of 30 colleagues over two interview phases:

- ✦ Mid-programme interviews — 16 colleagues
- ✦ Final interviews – 14 colleagues

2.3.5 Local facilitator sample

For the final phase interview, 15 local facilitators from 15 research sites consented to participate. The local facilitator at Site 7 was also the facilitator for Site 17; therefore all facilitators from the research sites were interviewed.

2.3.6 Director or head of nursing sample

Fourteen directors of nursing or heads of nursing from the research sites consented to a final-phase interview. On one of the research sites, the director of nursing post was vacant and on another site the director of nursing had only recently taken up post and, therefore, declined to be interviewed.

2.3.7 360-degree Leadership Practices Inventory sample

In order to obtain a sample size that fulfilled this aspect of the study the method outlined by Streiner and Norman (2000, pp.124-125) was utilised. Specifying a likely minimum, Cronbach's alpha of 0.81 with alpha =

0.05 and 95% confidence limits of no more than alpha 0.05 gives a sample size of 200 clinical leaders. Specification of a minimum alpha was based on the psychometric validation papers of the 360-degree Leadership Practices Inventory (Posner and Kouzes, 1988) where the Cronbach's alpha ranged from 0.81 to 0.91. This gives the clinical leader sample size and there is also data gathered from the manager, co-workers and people who report directly to the clinical leader, to provide a full leadership profile of the clinical leader.

The number of 360-degree Leadership Practices Inventory responses will vary according to team size. The 360-degree Leadership Practices Inventory (Appendix 3) was distributed to 267 clinical leaders; distribution was stratified by region (it was calculated that if 267 were distributed, a 75% response rate would enable us to achieve the 200 respondents identified in the sample size calculation). In addition, the Leadership Practices Inventory data from all clinical leaders, their managers, co-workers and people who directly reported to them were requested, at all the case study sites.

The response rate for the baseline 360-degree Leadership Practices Inventory data was 58% (154/267) from the randomly selected clinical leaders across the whole programme. In addition, 91 of the 215 clinical leaders submitted their Leadership Practices Inventories from the case study sites (42%). The total response for the 360-degree Leadership Practices Inventory was 245 participants (only 244 clinical leader responses were used for the baseline analysis, because the responses on one self-assessment were not decipherable).

2.4 Procedures

2.4.1 Case study data collection

Two short questionnaires were distributed to trusts running Phase 3 of the CLP. The trust sampling questionnaire was used, to enable purposive sampling of 16 research sites. This questionnaire requested data on four trust variables:

- ✦ Type of trust
- ✦ Location of trust (inner city, city, town, rural, seaside location, other)
- ✦ Number of clinical directorates in the trust
- ✦ Annual patient turnover in the trust

The trust profile, which was sent to the RCN local facilitators within the selected trusts, requested the following data:

- ◆ Number of staff undertaking formal leadership development
- ◆ Number of staff undertaking the CLP
- ◆ Brief description of the professional development strategy of the trust
- ◆ Brief description of the staff retention policy of the trust.

2.4.2 Baseline CLP data collection

- ◆ Interviews were undertaken with clinical leaders and patients (see Appendices 4 and 5 for interview schedules). The purpose of these interviews was to understand the baseline characteristics of the clinical areas and to understand the patients' view of clinical leadership.
- ◆ Baseline programme 360-degree Leadership Practices Inventory.

2.4.3 Mid-stage data collection

The mid-stage data collection comprised of:

- ◆ Interviews with clinical leaders and colleagues of the clinical leaders, to ascertain their perceptions of the value of the interventions and processes of the CLP (see Appendices 6 and 8 respectively for interview schedules).
- ◆ Patient interviews explored patient perceptions and experience of being involved in 'Patient Stories' (see Appendix 7 for interview schedule).
- ◆ A cost evaluation to establish the trust staff and time costs attributable to implementing the CLP.

2.4.4 Post programme data collection

The post CLP data collection comprised of:

- ◆ A document analysis of the action plans from the

'Patient Stories' and 'Observations of Care' from the clinical leader at each of the 16 research sites and explored patient and clinical practice impact.

- ◆ Interviews with the clinical leaders, a client/patient and a colleague of the clinical leader were undertaken to explore impact (see Appendices 9, 10 and 11 respectively for interview schedules).
- ◆ Semi-structured interviews were undertaken with local facilitators at each research site, to gain a broader understanding of programme impact on each research site (see Appendix 12 for interview schedule).
- ◆ Semi-structured interviews were undertaken with directors of nursing, to gain a broader understanding of programme impact across the trust (see Appendix 13, for interview schedule).
- ◆ Post 360-degree Leadership Practices Inventory data was requested from the clinical leader to enable a change analysis of the leadership capability.

2.5 Data analysis

2.5.1 Qualitative data analysis

All interview data were analysed from full transcripts. A categorisation system was developed from the theoretical propositions and the sub units of analysis identified in the evaluation design. Categories therefore reflected the major interventions of the RCN Ward Leadership Project (Royal College of Nursing, 1997) and the impact of leadership development on patient care, the clinical environment, team effectiveness and the trust.

In addition, a process of openly coding identified further categories that arose from the data. The qualitative data analysis software QRS Nud.ist v5 (non-numerical unstructured data indexing, searching and theorising) was used to assist in the data management, coding and analysis. The qualitative case study data was thematically analysed, seeking patterns and contradictions in the data from across the 16 diverse case study sites. Stake (1995) called this process "categorical aggregation of instances".

A thematic approach to data analysis allows cross-site comparisons, using the accounts of different

participants to show a multi-dimensional picture of the impact of the programme. In addition thematic data, as opposed to presenting individual cases, protects the anonymity of the clinical leaders involved.

Ensuring the anonymity of clinical leaders in this study was a concern, because colleagues and the directors of nursing on each research site were aware of the identity of clinical leader participants involved. Extracts from interviews are included in the write-up of the study, so that the readers of the evaluation can discern the patterns identified in the analysis (Yardley, 2000).

The triangulation of methods in this study was concerned with examining data relating to similar concepts, from the different perspectives of the key stakeholders and from the different qualitative and quantitative research paradigms. Triangulation of the methods and analysing data in a way that evidence is actively sought that either confirms or rejects the findings, increases the validity of the study (Mays and Pope, 1995).

To ensure agreement of coding systems and consistency of data analysis between the two researchers, three transcripts from each interview group were read independently by each researcher. Each researcher developed coding frameworks for the baseline, acceptability and impact analysis of the data. The two researchers discussed discrepancies and inconsistencies in the coding frameworks until agreement was reached. This process enabled a high level of researcher agreement in the coding of the remaining transcripts.

Coding systems were then developed into codebooks, with clear definitions of all codes. Although codebooks had been established, the researchers were attentive to the possibility of further categories arising from the data. The codes were analysed to develop themes, by identifying relevant patterns and contradictions in the interview data.

2.5.2 Analysis of baseline data and 360-degree Leadership Practices Inventory

For baseline data, descriptive statistics are given.

To measure change in the leadership domains (termed 'practices') of the 360-degree Leadership Practices Inventory (Posner and Kouzes 1988, 1993), data were

collected at the beginning and again at the end of the 12 month programme for each clinical leader. At the same times, the inventory was completed by managers, co-workers and the staff who report directly to the clinical leader to obtain a 360-degree evaluation of leadership capability. The Leadership Practices Inventory measures leadership behaviour in five practices of exemplary leadership:

- ◆ Challenging the process
- ◆ Inspiring a shared vision
- ◆ Enabling others to act
- ◆ Modelling the way
- ◆ Encouraging the heart

Each leadership domain incorporates six behaviours, and each behaviour is scored from 1 (almost never) to 10 (almost always). Thus, each practice ranges from 6 to 60, with higher scores denoting better leadership skills. The 360-degree Leadership Practices Inventory feedback is given as total scores for each practice, as scored by the participant and as average total scores of each practice as scored by the managers, colleagues and direct reports. To inform the clinical leaders' leadership development, all behaviours are ranked in descending order of observer average rating, with a line to separate the lowest 10 scores and a '*' to mark those where the difference between self-rating and average observer rating is greater than/equal to 1.5. This allows easy identification of areas of development opportunity.

The analysis of the 360-degree Leadership Practices Inventory in this report comprises of two data sets:

- ◆ A stratified random sample of clinical leaders from the whole programme cohort; 154 out of the total of 267 (58%). Case study sites were not included in this sample.
- ◆ The 360-degree Leadership Practices Inventory data from the clinical leaders from the 16 case study sites relating to 42% (91/215) of clinical leaders taking part in the programme at these sites.

Thus, the analysis in this report concerns 245 clinical leaders and their 360-degree assessments of leadership capability.

It is acceptable in statistical practice, if the data are not severely skewed, to treat rating scale data as if it were interval data without introducing severe bias (Streiner

and Norman, 2000). Therefore, the two sample groups were examined for differences between the means, using an independent samples t-test. Statistical analysis did not reveal sufficient evidence to suggest a difference and therefore the results of the two sample groups were aggregated for the analysis.

For those leaders included in the analysis, some had missing components of the information (for example some clinical leaders in the baseline data did not submit questionnaires for their post data change score analysis). Therefore, the number of leaders included in each part of the analysis will vary from variable to variable, because of occasional missing data.

3. Findings

This chapter presents findings from the evaluation study in three sections, which correspond with the three main phases of the evaluation study; the collection of baseline data, the mid programme evaluation of the programme's acceptability, and evaluation of the programme's impact. At the end of each section, a summary of the findings will highlight important issues to take forward to Chapter 4 for further discussion.

3.1 Baseline findings

Findings in the first section relate to the baseline data collected from the clinical leaders' questionnaire and the interviews undertaken with the clinical leaders and service users across the 16 case study sites at the beginning of the programme.

3.1.1 Clinical leader questionnaire findings

Of the 16 selected clinical leaders from the case study sites, four (25%) were male and 12 (75%) were female. This compares reasonably well to the gender of all the clinical leaders enrolled for Phase 3 of the CLP: 16% male, 73% female (no record of gender for 11% of clinical leaders).

The age range of the selected clinical leaders was from 25 to 52 years. The clinical grading of participants ranged from F grade (31%), G grade (50%), H grade (13%) and G/H-grade (6%). The range of nursing experience varied between 3.5 years to 30 years (data from 1 participant missing).

3.1.2 First interviews with clinical leaders

The purpose of the first interviews with the 16 case study clinical leaders was to gain an understanding of the diversity of the working environments of the participants in the study. The clinical leaders were asked to briefly describe the clinical areas in which they work. The descriptions that follow précis how the clinical

leaders chose to describe their roles and clinical areas. The job titles of the clinical leaders are presented as portrayed in the interviews.

3.1.2.1 Clinical areas described

Clinical leader 1 is a health visitor and at the time of the first interview had just moved to a different location to take up a new, demographically varied caseload of approximately 250 families. Clients might be professionals or unemployed, but the majority of this health visitor's work concerns families with children under four and half years old and focuses on health promotion, child development, and child protection.

Clinical leader 2 is a ward sister for a 42 bedded unit that specialises in care for patients with diabetes; however, some patients with a general medical condition are also cared for on the ward. There are three consultants for the unit; one consultant team had strong academic links. The size and layout of the unit required that five qualified and five support staff were on the

early shift, four qualified and three support workers on an evening shift and four qualified and three support workers on a night shift. Staff also provide care for any patients staying overnight on the Planned Investigations Unit.

Clinical leader 3 is a ward manager for a 28 bedded general medicine and gastroenterology ward. There are six beds allocated for patients requiring dermatology care, and two beds for patients requiring ophthalmology care. However, the clinical leader said to her knowledge there had not been patients requiring ophthalmology inpatient care on the ward. Over the previous five years they had received patients earlier from the Intensive Care Unit and therefore, the staff at times cared for patients who required a ventilator to support their breathing.

Clinical leader 4 is a team leader for a dual theatre suite, covering orthopaedics and trauma surgery. The theatre suite consists of nine individual theatres. The theatre team includes nurses, anaesthetic room and operating room personnel. Although part of the

Table 2 – Clinical leader characteristics

Clinical Area	Gender	Grade	Number of Years Nursing Experience
Health visiting	Female	G	3.5
Medical diabetology ward	Female	F	22
Medical ward	Female	G	15
Theatres	Male	G	19
Mother and baby psychiatry unit	Female	F	10
A&E	Male	H	19
Gastroenterology ward	Female	G	8
NHS Direct*	Female	G	
Orthopaedics ward	Female	G	23
Cardiac care	Male	H	11
Acute psychiatric ward	Female	F	27
Surgical ward	Female	G/H	21
District nursing	Female	G	10
Learning disabilities day centre	Male	G	17
Elderly rehabilitation	Female	F	30
Special care baby unit	Female	F	27

*Second clinical leader recruited

orthopaedic team, staff could be allocated to other theatres for some shifts.

Clinical leader 5 is a deputy manager for a day service within a mother and baby psychiatric unit. The day service offers support to vulnerable new mothers, by providing therapies such as supportive counselling individually or in groups, bonding work with mothers and their babies and play work with the children. The day service opens between 9am to 5pm and has approximately 35 new referrals a year.

Clinical leader 6 is a senior clinical nurse for an accident and emergency department in an acute trust. There are four clinical areas within the accident and emergency department; minor treatment, major treatment, resuscitation and a four-bedded observation ward.

Clinical leader 7 is a ward manager for a medical ward providing gastroenterology and nutrition care in a district general hospital.

Clinical leader 8 is a practice development manager for NHS Direct. NHS Direct is described as providing a service to assess patient symptoms and queries over the telephone, assisted by a software support system. People ring in but may not necessarily speak to a nurse immediately; clinical risk is initially assessed and then a nurse or other appropriate centre worker will ring back according to the assigned priority of the situation.

Clinical leader 11 is a ward manager of a 32 bed orthopaedic unit, specialising in trauma and elective surgery. The unit closed a number of beds four to five years earlier and therefore, occasionally has the capacity to undertake waiting list initiative work. The orthopaedic unit has 65 staff of varying grades.

Clinical leader 12 is a cardiac nurse specialist for a cardiac unit. The unit has a 6-bedded area for patients with acute cardiac problems, three side rooms, a 6-bed day case area for angiography, and a rapid access chest pain clinic. The unit cares for patients with acute cardiac symptoms, unstable angina and myocardial infarctions. The rapid access chest pain clinic, in which 10 patients a week are seen, was part of a National Framework Initiative. Referrals are received from general practitioners for patients with new onset on-exertion chest pain. There are five clinics each week.

Clinical leader 13 is a charge nurse for a 23-bed acute psychiatric ward. Patients on the ward receive care for a variety of mental health problems, from acute

psychiatric illness to being ready for discharge. There is a system of cascade supervision of staff, for example, the F grade personnel each supervise two or three E grade personnel and the E grades have responsibility for supervision of more junior grades.

Clinical leader 14 is a ward manager for a 27-bed general surgical ward. The ward primarily specialises in breast and bowel surgery. There is also a high dependency unit, comprising one bay and one side room. There are plans for the high dependency unit to move to a purpose built unit, which will accommodate an intensive therapy unit, a high dependency unit and a cardiac care unit.

Clinical leader 15 is a district nursing sister, working mainly with older and often housebound patients. Referrals are received from a variety of sources including general practitioners, hospitals and relatives. The caseload incorporates the patients of seven single-handed general practitioners.

Clinical leader 16 is a ward manager of a purpose-built day service for people with challenging behaviour. The day service is part of a trust providing various services; mental health, learning disabilities, community services and NHS Direct. The day service accepts referrals from across the trust, social services or from members of the public. The unit provides 12 day places each day for people with mental health problems, learning disabilities, a history of criminal offences, or a combination of these.

Clinical leader 17 is a ward manager for a 28-bed rehabilitation ward for the elderly in a primary care trust. Patients, ranging in age from 60 to 100 years, are usually transferred from the general hospital or referred from the community following surgery or medical problems. Patients experience a range of mobility problems, therefore rehabilitation focuses on enabling people to regain their mobility or to cook and clean at home.

Clinical leader 18 is a deputy ward manager for a 14-bed special baby care unit. Babies of less than 36 weeks gestation, babies less than two kilograms in weight or any sick baby, regardless of weight or gestation may be admitted for care. The unit undertakes some high dependency care, although the unit is not funded for this provision. Babies requiring a ventilator to support their breathing are transferred to the regional centre. However, for the time they are in the unit, care may be provided by the staff for up to 10 hours.

3.1.2.2 Summary of clinical leader baseline findings

The baseline data show the clinical context of the clinical leaders and highlight the diversity of practice, clinical areas and experience of the clinical leaders. The richness and range of clinical environments enables an extensive exploration of the acceptability and impact of the CLP across a broad range of clinical practice and clinical areas.

3.1.3 First interviews with patients

The purpose of the first interviews with service users was to understand how clients perceive clinical leadership. The 16 patients were from each of the clinical areas of the case study clinical leaders. They were asked the following question:

“Who would you say provides the leadership in the ward/clinical area?”

The two themes to emerge from the data are concerned with how service users identify leaders in the clinical area and how they describe the characteristics of a clinical leader.

3.1.3.1 Identifying clinical leadership

This theme depicts how patients identify who provides leadership in the clinical area. The construction of this theme is based on two sub-themes; identifying leaders and teamwork.

Identifying clinical leaders

The ward sister/manager was cited most frequently as providing leadership in ward settings; the following quotation from a patient on a ward providing care for patients with medical and gastrointestinal problems illustrates this viewpoint:

“I think that the ward manager should be as it said, ward-manager. As in, the respect of full control of her staff.”

(7P1, lines 270 to 273)

A patient receiving care in an elderly care rehabilitation unit gives another example of this view:

“Oh, no doubt, the lady in blue. Yes. She certainly does.”

(17P1, lines 134 to 136)

Some patients describe particular strategies for identifying who provides leadership in clinical areas, these included identification by task or by uniform. The following extract of an interview illustrates the response of a service user receiving psychiatric care when asked who provides leadership on the ward:

“Well I’d been a patient there before, and I could tell by who did the drug round who was the qualified nurse and who’s the nursing assistant.”

(13P1, lines 104 to 106)

A service user on a ward providing care for patients with diabetes identified the person providing leadership by role and uniform. However, he did find the number and variety of uniforms a little confusing:

“Yeah, yeah. I know there’s that many uniforms but there’s no way of telling.”

Later, discussing the same issue, the service user said:

“I saw her in a dark dress. Is she a sister?”

(2P1, lines 161 to 162)

A few patients believed that staff nurses who tend to give more direct patient care on the ward were providing the leadership in the clinical area. A service user from a surgical ward explained this perspective:

“Who would I say provides the leadership? Do you mean nurses, consultants? I would say nurses, staff nurses. They’re the ones that are looking after the patients, they’re the ones that are doing ward rounds with the doctors, they’re the ones that everything falls back to them”.

(14P1, lines 119 to 123)

Teamwork

Some clients identified the person they perceived as providing the leadership. However they also emphasised the value of teamwork, as the following quotation exemplifies:

“It’s obvious, it’s the senior person who you met [ward manager]. But again, they work as a team.

At times when something needs doing and one of them says could you do so and so they just do it. There are no arguments or anything. That's leadership. They are very light-hearted."

(12P1, lines 52 to 55)

One patient from an A&E department did not link leadership to a role or person, but stated all staff worked together to provide leadership:

"Well no, no they seem to work together."

(6P1, line 92)

In contrast to the ward setting, a service user in a community setting is less likely to observe how teams work and interact together. Consequently, a client who was receiving care from a district nurse made the following observation about leadership in community settings:

"I think they organise it between themselves because they all meet, as I understand it, they all meet at a certain time during the day, and they, they discuss it."

(15P1, lines 218 to 221)

Some patients mentioned medical staff as part of the team in the clinical area. However, the medical role tended to be described in this context in relation to specific professional responsibilities, such as drug therapy and discharging patients. The following excerpt from a patient receiving care in a psychiatric mother and baby day centre explains this perspective:

"Really, I think the doctors again, this is from my own experience, tend to only get involved in the drug therapy."

(5P1, lines 405 to 406)

Another service user gave a further illustration of this perspective, describing the role medical staff play in hospital discharge:

"And I don't know what time he'll be coming. I know he's got other parts of the hospital. I don't know, I think the doctors on the ward have a bit more thing to say you can go home."

(2P1, lines 222 to 224)

However, one client described uncertainty about how team dynamics and training influence leadership in the clinical area, particularly with respect to the relationship

between nurses and medical staff:

"Oh dear I really don't know. I'm not sure how its supposed to work, I'm well aware of the fact that there's ranks among the nursing staff, nurses are different ranks etc., but I don't know how much of what goes on in the wards is because of the nurses responsibility or training or how much is just being followed by consultants orders, that's something I don't know about you know"

(11P1, lines 135 to 140)

3.1.3.2 Defining characteristics of clinical leaders

When patients described the characteristics of clinical leaders, sharing information with the team was frequently highlighted. The following quote from a client on a medical ward illustrates this view:

"Well there's, they sort of let everyone know what they're doing, if you know what I mean. So everybody knows so if they get a problem they go straight to them, if they're free they will go over to help her. They seem to cope together, like a team"

(3P1, lines 183 to 191)

Other salient characteristics of the leadership role identified by some patients are, being observant, listening and following through actions, giving feedback and following up outstanding issues. The following quote illustrates all of these characteristics:

"They are observant, they listened, they did what they said they were going to do they followed through on what they said and feedback and follow up"

(5P1, lines 418 to 420)

A service user from an A&E department identified being friendly and confident as defining characteristics of clinical leaders.

"That is it, friendly and confident"

(6P1 lines, 102 to 107)

One participant, who was receiving care from a health visitor, also described confidence as an important characteristic of leadership:

I don't know, it was just their confidence and the

way that they seem to sort of know what they were talking about, you know, and they were really helpful just their general manner I think.

(1P1, lines 164 to 166)

One client from a ward providing care for patients with diabetes said that a characteristic of leadership was dealing with a complaint quietly and without everyone knowing about it, suggesting that it is done effectively and in a confidential way.

“Yeah, if you’ve got a complaint or about somebody you can perhaps deal with it quietly without, you know, everybody knowing about it. But you might tell somebody and they might want to tell somebody else and somebody else. If you just told one person they can deal with it.”

(2P1, lines 197 to 206)

3.1.3.3 Summary of first interviews with patients

Most participants identified the person leading care in the clinical area as the person occupying the formal leadership role; the ward manager or sister. Some service users said that because staff nurses provided most clinical care, they were most likely to provide clinical leadership. Others were less certain about who provided clinical leadership and cited instead the tasks undertaken by staff or the uniforms that nurses wear as a way of identifying clinical leaders. Teamwork was recognised as an important element of leadership. Service users described the benefit of clinical leaders sharing information with their team, particularly as it promotes a common understanding of how care should be delivered.

Confidence was perceived as an important characteristic of leadership and was frequently mentioned by patient participants in conjunction with less tangible traits such as friendliness, helpfulness and the general manner of the clinical leader. Other salient characteristics identified by patients are; being observant, listening, following through actions and dealing with outstanding issues, giving feedback and the ability to deal with a concern or complaint in a confidential and effective way.

3.2 Acceptability findings

The findings in this section report the acceptability of the programme and the programme interventions, from the differing perspectives of the clinical leaders, patients and colleagues who had been involved in programme interventions. Interviews were undertaken with the case study clinical leaders, patients (involved in patient stories) from the clinical area of the clinical leaders and colleagues of the clinical leaders who had been involved in any of the interventions of the programme. In addition, clinical leaders were asked to identify their key learning attributable to the programme to date. An independent health economist undertook a cost evaluation.

3.2.1 Mid-programme clinical leader interviews

A total of 16 clinical leaders took part, one from each of the case study sites. However, due to promotion, the clinical leader at Case Study Site 8 did not feel she could continue with the research. Another clinical leader from that site volunteered to be involved in the remainder of the research evaluation study. Interviews were undertaken between November 2001 and May 2002 and were approximately 1 hour in duration.

The findings from these interviews are reported in two parts, which relate to the dual aims of the mid-interviews with clinical leaders. The first part reports on the clinical leader’s perceptions of learning that can be attributed to the programme under two sub-sections; increasing self-awareness of clinical leaders and increasing team effectiveness. The second part of this section provides the findings of the evaluation of the individual learning interventions of the CLP.

3.2.1.1 Increasing self-awareness of clinical leaders

The programme utilises a number of approaches to the ‘management of self’ including; developing self-awareness facilitated through feedback from the 360-degree Leadership Practices Inventory, action learning sets, personal development planning, workshops, one-to-ones, mentoring and shadowing. The mid-interviews with the clinical leaders show the initial focus of the

programme on ‘management of self’ as valuable and effective.

The majority of participants identified self-awareness as an important area of their leadership development. The following quotation describes how the increasing self-awareness of one clinical leader, from a mental health trust, gave her confidence in her knowledge and experience to take on a more senior leadership role:

“Gave me back my confidence, that made me realise all these years of experience and knowledge that I haven’t been using and I’ve been sitting on it and why shouldn’t I have my own ward where I can bring the changes, rather than say to someone else, I think we should do this, oh no I don’t think so, either they lacked the knowledge and experience or I’m the boss how dare you sort of thing, and this is why the leadership course it made me, it brought me to this point without it I would not have moved.”

(13CL2, lines 64 to 79)

Most clinical leaders describe the benefit of having time to reflect on and identify areas for personal development and having structures in place to help initiate change. The following extract from an interview with a health visitor illustrates this perspective.

“I’ve learnt a lot, I feel like it’s the best course I’ve ever been on, I have really enjoyed the self-awareness aspect of the course as I think a lot of the time when you’re working you don’t have that important think time so your development doesn’t really progress, whereas with the course it gets you thinking about issues that you mean to develop, it’s constantly looking at ways of how you can action that and give yourself time scales so the overall things from the course have been that I’ve become a lot more self-aware of where my strengths and weaknesses lay and we’ve also been given a sort of a method of how to action what we’ve learnt.”

(1CL2, lines 23 to 42)

3.2.1.2 Increasing team effectiveness

Some clinical leaders described how they felt their growing self-awareness had helped them to work more effectively in their teams. One clinical leader, for

instance, describes how the single most important thing gained from the course has been the opportunities it provided for looking at ways of managing work and time. The programme led to an increased ability to delegate to other staff and to adopt new ways of problem solving that helped to develop other members of the team. She describes her changed approach to problem solving in the team:

“You can’t take it all on yourself, it’s about sharing and giving other people ownership and if they bring a problem to you or an issue to you, it’s better to be able to give them the information to go off and sort it for themselves than actually take it off them and actually sort it yourself.”

(15CL2, lines 30 to 36)

A number of clinical leaders said that their increased understanding of the beneficial effect of sharing knowledge with team members helped to increase team effectiveness. The following extract from an interview describes one clinical leader’s realisation that sharing knowledge resulted in communication that was more effective, and contributed to the development of other team members:

“I am more aware that knowledge can sometimes be termed as power, and I recognise in some people and in myself I think that was important for me to hang onto, but in leadership I am now more keen, I don’t want to hang on to my knowledge, I want to pass it on. I’ve gone from one extreme I think to the other.”

(8CL2, lines 41 to 50)

The participant goes on to say how she derives great pleasure from seeing how others develop as a result of this knowledge transfer.

3.2.1.3 Evaluation of programme interventions

Clinical leaders were asked about the individual interventions of the programme. The questions were open ended, to enable participants to describe the contribution of the programme interventions from their perspective. Therefore, some programme interventions may not be represented in this section. Interventions discussed include; action learning, 360-degree Leadership Practices Inventory, patient stories,

observations of care, intervention and needs-led workshops, one-to-ones with the local facilitator, personal development planning, networking and political awareness development.

Action Learning

All clinical leaders highly and positively evaluated action learning. One element of action learning, described by a number of clinical leaders, is the opportunity to learn from other clinically based colleagues. As one participant said:

“Action learning group, brilliant, brilliant, any problems that I had at work I went to the action learning group and met with colleagues and I realised we all had similar problems.”

(13CL2, lines 93 to 95)

The groups brought together members of staff with greater and lesser management experience, as well as those from different clinical areas. Having access to this diversity of knowledge and experience was clearly valued. One participant, for example, spoke of how much this was appreciated:

“Sharing different experiences and being able to talk freely and trust somebody out of your clinical area and then being able to come back and have a structure to how you do things.”

(13CL2, lines 100 to 104)

The supportive open questioning style adopted in action learning was positively commented on, for example:

“Yeah I’ve learnt an awful lot from different people’s problems, with problem staff and how they dealt with it because what we tend to do is we have the problem, and we all discuss it, we don’t say I would do this I would do that, it’s a case of offering perhaps this might work or this might work.”

(2CL2, lines 139 to 146)

A number of clinical leaders also talked positively about the way the group worked towards a way of providing ‘supportive challenge’ for members and how this support was carried through to ensure the translation and review of any action plans into practice. As one participant said:

“What is so brilliant about action learning, which is quantifiable is the fact that you have to do

something about it, so you take a problem and you say this is what you are going to do with it and now we have got to the stage where we are challenging each other.”

(7CL2 lines, 191 to 196)

As an example, this participant talked about her need to discuss the management of a member of staff who was under-performing, and how she had to develop an action plan, implement this and then report and reflect on the outcomes with the group at the next session.

The majority of clinical leaders hoped to continue action learning after they had completed the programme, as they felt it was a useful intervention:

“I think it’s a really useful tool and I think if there’s anything I take from this course it would be to try and keep those going.”

(5CL2, lines 248 to 252)

360-Degree Leadership Practices Inventory

The Leadership Practices Inventory aims to provide a 360-degree assessment of the clinical leader’s leadership behaviour at the beginning of the programme, to establish areas for leadership development, and at the end of the programme, to identify change in leadership behaviour over the course of the programme. The assessment is undertaken by the clinical leader (self-assessment), the manager, colleagues and people who directly report to the clinical leader.

The findings of this measure relate to 15 of the 16 case study clinical leaders because one clinical leader had not had her feedback from the 360-degree Leadership Practices Inventory at the time of the mid-programme interviews.

The 360-degree Leadership Practices Inventory was highly evaluated by most clinical leaders, with comments such as “excellent” or “totally enlightening”. One clinical leader for example, identified that it showed differences in the way that she saw herself and the way her team saw her. She explained:

“I saw myself as going one way and my colleagues saw me as something totally different. I thought I had a very clear vision for the future and they just didn’t see me as I had been promoting a clear vision.”

(8CL2, lines 202 to 211)

Some clinical leader participants found the 360-degree Leadership Practices Inventory a valuable basis for their professional development plan, although they did not identify many areas for leadership development. Others described the Inventory positively because of the opportunity it provided for the clinical leader's team to give feedback about their leadership capability and areas for development. This could help boost morale, with participants stating, for example, that they were "chuffed" or that it was "quite fun". On the other hand, there was some indication that those involved might have found it difficult to be frank in their feedback, as the following quote implies:

"It was all very, very positive so there wasn't really a lot (laugh) I had to improve on I know that sounds really big headed but there wasn't that many things identified that were below the mark, it was useful to see how people saw you and what you could change but I don't know whether it was the best tool I suppose I still think people give nice comments."

(12CL2, lines 122 to 128)

This participant also commented "I still think people give nice comments", implying perhaps that staff found it difficult to provide anything other than positive feedback.

One area of initial anxiety for the clinical leaders was if they should undergo leadership appraisal before they were fully established in their current post. One participant, for example, thought that the exercise was of limited benefit in this circumstance:

"I found it very accurate because I hadn't been in the job for very long. You know when my colleagues were having to write about me and it was a bit scary at how much they knew me, you know, and how well, how obvious it was the type of person I was."

(14CL2, lines 90 to 95)

Yet she also implied, perhaps because the feedback had held no surprises but also perhaps because she had other priorities as a new member of staff, that she had not as yet paid much attention to the outcome of the leadership appraisal.

Some clinical leaders suggested some flexibility about the timing of the 360-degree leadership assessment. However, this would pose some difficulty in terms of providing a facilitated baseline and post 360-degree

leadership assessment. The first leadership assessment also contributes to the personal development plan at the beginning of the programme.

Patient stories

Patient stories provide an opportunity for service users to tell their story about their experience of being in hospital, or receiving care in other settings. It is a way of collaborating with patients to help identify areas for quality improvement.

Two clinical leaders had not undertaken the patient story intervention of the programme at the time of the interviews (mid-way through the programme implementation).

Of the rest, all clinical leaders valued the opportunity to undertake patient stories and saw these as a means of accessing very different information to that obtained by other more traditional methods, such as taking a history. One participant, for example said:

"It has been nice to actually sit down with the patients and listen to what they've got to say, rather than perhaps sit with them, with a sheet with questions and a tick box."

(3CL2, lines 130 to 134)

Not only was the process different to other approaches participants had been familiar with, but also the aim behind it was seen to be different; patient stories allowed patients to determine what was significant and to "talk about whatever they wanted".

Participants spoke of how using patient stories allowed them new insights into how patients experienced care. A clinical leader from a psychiatric clinical area, for example, spoke of how through listening to a patient's story, she gained new insight into what it must be like to be constantly referred between different health care professionals — a perspective that she could apply to the care of other patients. Other staff found that patient stories prompted them to think, for instance, about the length of time it took staff to respond to patient bells, or how difficult it was for patients to identify different professionals or to understand the nature of their role.

Giving feedback on clinical issues to the participant's Trust Board was an integral part of the programme and patient stories appeared to provide an important source of information. Participants reported on issues such as patients' experiences of problems with food, noise and dirty lavatories.

The collection and mapping of the aggregated patient stories in each clinical area is the first stage of the method, followed by feedback to the clinical team and the development of an action plan as a team activity. A number of participants commented on the constructive effects that feedback could have on the team. As the district nurse in the study sample said, for example, it was unusual for staff to receive direct positive comments from patients, but when they mapped out the messages from patients' stories they found "a lot of positives there to feed back to the team". These messages had helped to improve morale.

A few clinical leaders, however, did not appear to adopt the part of the patient story process that required the team to develop the action plan. In the following quote a clinical leader indicates that, she did not involve the team in developing an action plan, discussing the patient story process she said:

"I've got an action plan from the patient stories which I am devising and I'm hoping to do like a little mini session with staff, get them in [to] explain what I've done - that we're in mid point - this is the action plan, this is what we are going to be doing".

(2CL2, lines 646 to 650)

Although she went on to say that she would be asking team members to contribute to the action plan and take ownership of this process, it does not completely reflect the programme approach advocating action planning as a completely participative team activity, which involves the team from the beginning of the action planning activity.

In addition, a small number of clinical leaders described a concern about identifying an action in the action plan, which they considered beyond their sphere of influence or the solution appeared to run counter to trust priorities. The CLP advocate that issues of concern like this are highlighted at a trust-wide forum, where there can be discussion and potential action taken more widely across the trust. Therefore, in a few circumstances there appears to be a discrepancy between the operational processes and what happens in practice.

Observations of care

During an observation of care, the clinical leader and an outside observer (usually another clinical leader or the local facilitator) observe and record activity in a clinical area for 30 minutes. Following a discussion, the

observations are fed back to the team for collaborative action planning.

Most clinical leaders gave extremely positive responses for the observations of care, seeing them as helpful in identifying, for example, how practitioners' practice could impact on patient care and where change was necessary. Some participants spoke of how valuable this exercise had been. For example:

"It's been nice to actually stand back. It was a benefit to me [to] actually stop and listen and actually see what's going on, which you just don't get the opportunity to do."

(2CL2, lines 456 to 460)

Participants were able to identify numerous examples of the benefits that this approach had led to. The clinical leader from theatres, for example, said:

"One of our observations of care actually centred around the front entrance it's an area that patients and anybody coming into the theatres has immediate impact upon them. So it was a very cluttered area, and one of the things that we actually came out with was not only did we decide that we had to get an action plan to get it cleared but we actually created a post for a storeman who would be responsible for that area."

(4CL2, lines 45 to 57)

Participants spoke of observing and then taking action to rectify a range of issues such as unnecessary noise, clutter and lack of privacy. Infection control issues were particularly highlighted through the observations of care. As one participant said:

"The biggest thing and the biggest shock I got was the [lack of] hand washing and everybody was the same, you know. And yet outside every bay there is a sink and there's staff aprons there."

(14CL2, lines 305 to 307)

Observations of care were not only good as a stimulus for addressing areas of practice requiring improvement, but also as a way of becoming aware of and disseminating good practice. One participant said of observations of care, for example:

"They have opened my eyes to a lot of good nursing practice on my ward. And practice that I was very pleased to be a part of."

(17CL2, lines 285 to 288)

Moreover, as this last quote implies, benefits arose not only from the spread of good practice, but also from the impact that recognition of good practice had on staff. One clinical leader spoke of this in the following terms:

“The value to the staff is that I’ve been able to increase morale amongst the staff. Because a lot an awful lot of the care is excellent and it’s stuff that they do every day, day in day out without thinking. It’s being able to share that with the staff and say, “What you did this morning for that lady was brilliant, that’s excellent, but keep it up.”

(2CL2, lines 460 to 465)

She went on to describe the everyday practices she became aware of, “little tiny things”, such as lowering the bed so a relative can see the service user properly, or making sure drinks are in patients’ reach.

Some participants talked about how observations of care raised issues about how to feed back information, both positive and negative, to the rest of the team. The clinical leader mentioned above, for example, spoke of how important it was to let the domestic worker know how patients’ faces lit up when she exchanged a few words with them, as she was being instructed by her supervisor not to interact with patients. In a rather different example, one participant spoke of how s/he tended to provide positive feedback publicly, while more negative insights were offered on a one-to-one basis.

One of the most positive endorsements of the observations of care method was that some participants were keen to make this an integral part of practice, to be conducted by all staff within a unit.

Intervention and needs-led workshops

Intervention workshops are specified in the toolkit and form the basis of the fundamental interventions of the RCN programme. The needs-led workshops are flexible and negotiable depending on the needs identified by the participants.

Examples of topics dealt with in needs-led workshops include managing confrontation and how to conduct patient stories where there may be difficulties either in communication or mental health issues.

All clinical leaders positively evaluated the workshops, saying, for example:

“The workshops are absolutely brilliant - the information that they share with us really,

really helped.”

(1CL2, lines 261 to 262)

However, despite the very good evaluations of the workshops, a small number of clinical leaders expressed concern about the experience and knowledge level of the local facilitator. For example, one participant who found the workshops particularly good when there was a guest speaker seemed to gain less when workshops were more focused on the development of self-awareness, or the development of skills in observations of care. This was because these depended on a facilitator who was undertaking the programme shortly before the clinical leaders and therefore, had no practical experience of these activities. Therefore, she said:

“Couldn’t really help us out and it felt like the blind leading the blind a bit sometimes.”

(1CL2, line 310)

Similarly, problems were identified in maintaining the workshop programme if the facilitator was absent for a while, highlighting the dependency of the programme on this central figure. As one clinical leader noted:

“We’re catching up at the moment because we had quite a few months when we didn’t have anything because [Local facilitator] was off, so we’ve just started back on the workshops again. And what we’ve done so far has been excellent, very good. Very well presented and, you know, very good information in them. We’ve got a few more to catch up on and they’ve been sort of crammed in to a month you know”.

(14CL2, lines 124 to 130)

One-to-one sessions with local facilitators

The one-to-ones are regular, individual sessions that the clinical leaders have with the local facilitator during the course of the programme, which give an opportunity for the clinical leader to focus on their own leadership journey. The relationship is based on a model of challenge and support and the sessions provide opportunities for the clinical leaders to reflect on and gain greater insight into leadership, personal development and how they are progressing through the programme.

Most clinical leaders described the one-to-ones with the local facilitator in a positive way, a good opportunity, for example, to review progress. The kinds of issues

discussed included ways of developing confidence or of ensuring that the clinical leader's team feels that they have gained from the programme.

For a small number of clinical leaders the purpose, frequency and expectations of the one-to-ones did not appear to be clearly defined and attention to this aspect may be useful for future programme planning. The following excerpt, for example, highlights that the clinical leader felt more regular one-to-ones would be beneficial:

“Well, perhaps a little more regularly. I mean, perhaps even not once a month - perhaps once every six weeks or something, just to check progress, what are we supposed to be doing, what's expected.”

(5CL2, lines 338 to 340)

Personal development planning

Personal development involves increasing self-awareness and self-management, seeking feedback, building on strengths and setting realistic goals. The programme provides the opportunity for clinical leaders to develop personal development plans using the feedback from the Leadership Practices Inventory.

Clinical leaders who had initiated a personal development plan tended to find it beneficial, particularly when they identified very specific goals about leadership or interpersonal skills development.

For example, one participant explained how she had drawn up a personal development plan prior to the programme but this had become much more focused on gaining leadership skills as a result of her engagement in the programme. For some, the goals related to career planning. For others, the goals might be more about the attainment of interpersonal skills. One participant said, for example:

“I have focused on why I haven't got any confidence and I have spoken to my manager about it as well, and we have had various discussions about me as a ward sister and what she thinks of me, because that means a lot to me.”

(7CL2, lines 97 to 101)

Alternatively, a number of clinical leaders spoke of their focus on team-oriented goals. As one clinical leader said:

“It was useful to me because my personal

development plan was to look at ways in which I could develop team building. Because I recognised, I recognised in my workplace that there was a desperate need to develop harmony and pulling together of the staff because I felt that there was a lot of problems with retention, with recruitment and retention.”

(8CL2, lines 164 to 170)

Networking and political awareness

The networking interventions of the programme provide the opportunity for clinical leaders to recognise the influence they already have, and the potential for using this influence to improve patient care, which is the political awareness aspect of the programme. Networking is explored from a number of perspectives in the programme, the opportunity to network with other programme participants, the opportunity to network within the trust and the opportunity to network outside the trust.

Clinical leaders frequently referred to the way that the programme presented them with opportunities for networking across their trust. As one participant said:

“Certainly I mean the programme gives you that just for the simple reason that you've got such a wide diversity of people from different clinical backgrounds. That alone gives you plenty of opportunity to network. Also I mean part of my PDP [personal development plan] is for networking [with] senior managers so it gives me the opportunity to use the programme to sort of say “Well, can I spend an afternoon with you?” or whatever.”

(4CL2, lines 334 to 340)

Clinical leaders in more isolated clinical areas particularly appreciated trust-wide networking as the following quotation illustrates:

“I think from my personal point of view working [in] Theatres the RCN programme has given me a chance to network with similar grades across [the] Trust and that's not just on the ward level - that is those that work out in community, and in other departments.”

(4CL2, lines 10 to 13)

Some clinical leaders described using networking opportunities to learn more about the work of other departments in the trust:

“This course has given me a brilliant opportunity to network because I’ve been able to utilise my study days and one of the things I’ve wanted to do is learn more about the social work department, social workers so I’ve been able to book a day and I’m going to go and spend some time with them, get to know the social work department, find out how the full needs process goes through.”

(2CL2, lines 426 to 432)

3.2.1.4 Summary of mid-programme interviews with clinical leaders

The majority of clinical leaders identified their developing self-awareness during the course of the programme as an important aspect of their learning. Self-awareness was described as beneficial to developing the confidence of clinical leaders and this consequently helped them to interact more positively with their teams.

Examples of more effective team working were described as better management of work and time, delegation, problem solving and sharing knowledge with the team. One of the principles of the CLP, ‘Learning to Manage Self’ encompasses self-awareness as a central component of the development of this attribute. Within the framework of the principles of the programme ‘Learning to Manage Self’ is regarded as a precursor to ‘Developing Effective Relationships’. In the current study, clinical leaders also considered that their growing self-awareness had enabled them to develop greater understanding about how to work more effectively with their team and this reinforces the value placed on ‘Learning to Manage Self’ in the programme design.

All programme components were highly evaluated by clinical leaders. Patient stories and observations of care were perceived to enable change in practice and action learning was identified as helping to support the process of change in practice. Clinical leaders stated that they hoped to incorporate patient stories, observations of care and action learning into their future practice, which showed a very high positive endorsement of these particular interventions. Action learning was experienced as an opportunity to learn from other

colleagues from different clinical areas and with greater or lesser management experience.

Although the baseline 360-degree Leadership Practices Inventory was highly evaluated by most clinical leaders at the mid-stage interviews, some clinical leaders expressed concern about the accuracy of the measure if they had not been leading the team for very long and others wondered if there might be a positive response bias. Of course, at this stage, clinical leaders would not be in a position to evaluate if there had been any discriminating change identified between their baseline and post evaluation 360-degree Leadership Practices Inventory. A further concern was about the quality of the workshops if a local facilitator is absent for any length of time and being able to have regular one-to-one sessions with the local facilitator.

There was also anxiety expressed about having a 360-degree leadership appraisal before being established in post. However, it will be difficult to resolve this issue as the necessity of a baseline and post assessment does not allow for flexibility in the timing of this intervention.

Some clinical leaders did not fully involve team members in the action planning stage of the patient story interventions; others were concerned about actions identified in the action plan that they considered outside their sphere of influence. The process of a patient story intervention is designed to involve team members in action planning and to take action-planning issues to a trust wide forum, usually the clinical leadership steering group, therefore, if local facilitators work closely with their steering groups, these forums might address more general trust-wide quality improvement issues.

As these comments are made at the mid-point of the programme, it might be that by the end of the programme a greater understanding about the process of the intervention is developed. However, local facilitators will need to consider how and when the processes of these patient-focussed interventions are communicated to the clinical leaders undertaking the programme so that all involved — the patients, clinical leaders and their colleagues — may gain the most from undertaking this activity.

3.2.2 Mid-programme interviews with patients

The two foremost CLP patient involvement interventions are patient stories and observations of care. As patient stories require more active direct engagement with an individual service user than the observations of care, it was decided to carry out the mid-interviews with patients who had been involved in a patient story. Therefore, acceptability of this programme intervention was explored, in terms of how clients who had participated in a patient story perceived the purpose and benefit of their involvement.

Interviews with patients, following a patient story, were undertaken opportunistically at least 24 hours after the patient story, when the researcher was on the case study site for other interviews or observations. Therefore, eight interviews with service users were undertaken; six patients participated from acute trust sites and two from primary care sites. There were six females (one accompanied by her partner) and two males. Interviews took place between November 2001 and May 2002, and lasted for approximately 30 minutes.

The main themes to emerge from the mid-programme patient interviews are concerned with improving the quality of care, expectations of change and the experience of participating.

3.2.2.1 Improving patient care

Overall, the patient participants believed the purpose of patient stories to be about improving patient care. One service user expressed his anticipation for this outcome in the following way:

“Hopefully to improve things, where things can be of a better standard or improve one way or another.”

(6P2, lines 8 to 9)

Some service users believed improving care initiatives such as patient stories, which engage clients in openly talking about their experiences of care, are a good approach to making improvements as the following quote illustrates:

“There can’t be a better way than talking to people about it.”

(12P2, line 155)

Whilst patients generally described an expectation that their contribution would be beneficial for improving the quality of care, some also expressed the supportive benefit in terms of being able to tell someone about issues of concern in their general experience of health care.

“Yes, it was good I hope I’ve been of some help and it’s also helped me get a lot of things off my chest, I didn’t tell somebody about that hospital for instance I’m not that happy with the GP service.”

(1P2, lines 4 to 6)

Two service users also indicated that they valued the more informal conversations that they had with staff caring for them as a way in which to express their views.

One participant however, indicated that he believed that there would be no benefit because the person conducting the patient story was not involved in his direct care. It was not clear if the participant had been given a clear explanation that the interview data would be presented to the clinical team, aggregated with the information from the other patient stories in an anonymous form for discussion and action planning issues of quality. If this were the case it would suggest that the purpose and process of the patient story was not adequately explained. The excerpt below shows the participants concern in this regard:

“Can’t have any direct benefit because this nurse I haven’t seen before and she doesn’t appear to be part of the team that’s looking after me at the moment.”

(12P2, lines 82 to 84)

3.2.2.2 Expectations of change

Participants generally expected the care improvements to be more long-term, and as such did not expect to see an immediate outcome of the patient stories. The following excerpt illustrates the expressed hope that participation would be helpful in the long-term:

“I don’t think direct but I hope eventually along the line there will be changes, I don’t expect them to change overnight nobody can change overnight but if it’s brought in slowly maybe over a year or two something.”

(1P2, lines 11 to 14)

However, a smaller number of participants stated that the patient stories did have some immediate benefit as described in an example given by the following patient participant:

“When I first came in everyone had this plastic cutlery, white like kids have you know and it was bending and you just could not eat very well with it, but since the last two days we’ve had nice cutlery.”

(11P2, lines 71 to 74)

3.2.2.3 The experience of participating

Most participants found participating in patient stories to be enjoyable. The following excerpt from a patient from an acute trust indicates that she enjoyed the process and was pleased that her contribution might be helpful:

“I really did enjoy, honestly, and it’s nice to know that it might be helpful to others.”

(11P2, lines 6 to 7)

A small number of patients described how the anticipation of being involved in a patient story had caused them some initial anxiety. However, having information and an opportunity for discussion about the process appeared to alleviate the initial anxiety experienced. The following excerpt from an interview illustrates well this perspective:

“I was very, very nervous at first... I think it was yesterday that she came, yeah, but yes she was very informative and helpful and she put my mind, she put me at rest.”

(11P2, lines 7, 46-47)

However, one participant stated that while patient stories were worthwhile, they were not necessarily enjoyable.

“No, not enjoyable (laugh) wouldn’t say not like going to get my hair highlighted is enjoyable, no not enjoyable I think it’s worth doing.”

(13P2 lines 8 to 10)

Some participants highlighted how the interpersonal skills required for active listening such as paraphrasing were used successfully in the process of the patient stories:

“She kept summarising actually didn’t she quite nicely? She was picking out the quotes from, you know reconfirming them.”

(1P2, lines 36 to 39)

3.2.2.4 Summary of mid-programme interviews with patients

Most participants described their involvement in patient stories to be about improving the quality of care, particularly in the long term, but some also identified short-term benefit. Where long-term or short-term benefit was not described, it appears that the process of how the aggregated information from patient stories would be used with the clinical teams had not been well communicated to the patient.

It is salutary that not all service users found the experience of being involved in a patient story enjoyable. This finding reiterates the requirement outlined in the patient story guidelines; ensuring informed consent is obtained in an ongoing way, throughout the process of the patient story.

None of the service users indicated that they had an expectation of feedback, from their individual or the aggregated findings of the patient stories from their clinical areas. The interviews were undertaken immediately after the patient story interview; therefore, patient feedback was not fully explored. Clearly service users had immediate feedback during the interview; one patient described the interpersonal skills of summarising and paraphrasing. However, it is possible that a much greater benefit would be derived from formally giving feedback to clients by describing the action plans and the resulting changes as a consequence of the patient stories and action planning.

3.2.3 Mid-programme interviews with colleagues

Colleagues of the case-study clinical leaders were interviewed, at approximately the mid-point of programme implementation, to explore their perception and knowledge of the CLP. In addition, the acceptability of participating in the programme interventions, such as observations of care and feedback sessions, was investigated.

The case study clinical leaders identified colleagues, who had some knowledge of the programme and its component interventions, and who agreed to being interviewed. In total, 16 'colleague participants' took part: four health care assistants, five staff nurses, three junior ward sisters, one nursery nurse and three G grade staff. The face-to-face interviews were conducted between November 2001 and May 2002.

The majority of interviews took place following an observation of care and/or feedback session. Colleagues are more likely to be involved in the process of an observation of care (they may be working in the clinical area during an observation of care), whereas it is usually the clinical leaders who undertake the patient interview aspect of a patient story.

However, colleagues are involved in the feedback and action planning of both patient stories and observations of care interventions. The majority of colleagues indicated that they had been present at feedback sessions. However, despite a request from the interviewers that some involvement in the programme interventions was necessary, not all colleagues had participated in either a feedback session or an observation of care.

The main theme emerging from the data is concerned with the interconnected relationship between increasing leadership capability and improving patient care and increasing team effectiveness. The acceptability of the programme interventions from a colleague perspective is also portrayed.

3.2.3.1 The relationship between developing clinical leadership capability, improving patient care and increasing team effectiveness

When asked to define the purpose of the CLP, most colleagues responded by indicating an expectation that leadership development would lead to improvements in patient care and an increase in team effectiveness. The quotations that follow illustrate the relationship between these concepts.

“First to give [clinical leader] and people like [clinical leader] an insight into the role of being a leader of either a team or a ward, and just see how

things can be improved, with leadership styles and team work and different things like that, well and well the aim ultimately is to provide better patient care or more effective patient care, to identify how that can be done.”

(15C02, lines 8 to 15)

Several of the colleague participants described the potential of the clinical leaders to be a role model. The following quote from a colleague of a health visitor clinical leader shows how she perceives the enhanced leadership capability enables the clinical leaders to be a role model for practice development in the wider team:

“Well I suppose it’s a way of hopefully identifying individuals that will progress and pass on their skills to others and, and hopefully as the name suggests they lead and set examples to others of good practice and maybe organisational skills that others can learn from.”

(1C02, lines 312 to 316)

A small number of colleague participants assumed that improvements in leadership capability and patient care would also have a beneficial impact on staff morale and recruitment and retention. The following quote illustrates this perspective:

“...improving patient care ultimately and hopefully staff morale, in the recruitment and retaining of staff if they’re working where they can see benefits for patients and it’s a nice area to work in then hopefully people stay.”

(15C02, lines 119 to 122)

3.2.3.2 Acceptability of programme interventions

Most colleagues who had participated in the observations of care indicated they found the initial process of being observed uncomfortable, but that these uncomfortable feelings were not sustained. The following quotation from a health care assistant illustrates the initial concern felt:

“Well at first I thought oh my God, they’ve come to pick up on everything we do wrong but I thought we shouldn’t really be doing anything wrong for them to pick on anyway. So when they actually came round and were watching me I thought just do what you should normally do, so I wasn’t

particularly bothered about it, but I was nervous before.”

(2CO2, lines 64 to 69)

Many of the colleague participants described the feedback after the interventions as beneficial, both in terms of highlighting where care could be improved, and also to identify and celebrate the high standards of pre-existing nursing practice. The following excerpt is illustrative:

“It’s been quite nice actually, yeah it’s been nice to have feedback and just have some points highlighted so that we can improve.”

(7CO2, lines 59 to 60)

Many colleague participants indicated that it would be beneficial to have wider participation in leadership development. The following quotation describes the potential benefit of providing leadership development all staff:

“I think probably everybody because when you do something nobody knows what exactly can be brought out of each person so, each person might bring out something individual.”

(8CO2, lines 42 to 44)

In addition, some colleagues specifically mentioned the applicability of leadership development for other grades of staff. The following quotation from a staff nurse working in an acute psychiatric ward illustrates this perspective:

“I think it should be beneficial for the E Grades as well. You cannot get more clinical than an E Grade and they are the ones who institute and, to a certain extent can manage the decisions that are handed down to us from the Fs and the Gs. So I think for that reason it should be extended because you have E Grades like myself, who are qualified for nearly eight years who could become G Grades.”

(13CO2, lines 92 to 98)

3.2.3.3 Summary of mid-programme interviews with colleagues

The colleagues of the clinical leaders from the case study sites described an expectation that there would be a relationship between the development of leadership

capability, and improvements in patient care and increased team effectiveness. In particular, the clinical leader as a role model and the impact this has on improving care and practice was highlighted. A small number of colleague participants identified the possibility that improved leadership capability and improving care environments may lead to increased staff morale that in turn may have a beneficial effect on recruitment and retention of staff.

Most colleagues described feeling initially uncomfortable with the sense of ‘being observed’ during observations of care. However, all of the colleague participants said that these feelings dissipated when they had fully been through the whole process of the intervention. The feedback and action planning aspects of observations of care and patient stories were highlighted as beneficial for indicating where care could be improved and to identify and celebrate high standards of pre-existing practice.

The acceptability of the programme is reinforced by an appeal by many of the colleagues for wider access to leadership development.

3.2.4 Cost analysis of the programme

An independent health economist undertook a cost analysis of the CLP. Therefore, the cost analysis is presented a little differently from the remainder of the report. The procedure, analysis and findings are presented together in this section for greater clarity and to maintain the independence of this aspect of the evaluation.

3.2.4.1 Procedure

In each of the 16 case study sites the clinical leaders were asked to keep a diary and record the time spent (in hours) on a set of defined activities associated with the clinical leadership programme over a three month period. Of the 16 sites involved with the research evaluation, 10 responded with diary information from the clinical leaders. The set of defined activities (an explanation of terms can be found at the Glossary of Terms) for clinical leaders were as follows:

- ◆ Personal development plan (PDP)
- ◆ Workshops

- ✦ Action learning
- ✦ Mentorship
- ✦ Patient stories
- ✦ Observations of care
- ✦ 1:1 (One-to-ones)
- ✦ Shadowing
- ✦ Self-directed time for leadership development activity.

Actual salary costs (including National Insurance and superannuation) from the 10 trusts in the cost analysis

aspect of the study were used to estimate the cost per activity. Where this was unavailable, costs from Netten et al. (2002) were used. Costs of the licence fee for the CLP were also included (although for Phase 3 of the programme the cost of the licence fee for the trusts taking part was met by the NHS Leadership Centre). It was assumed that each trust recruited the recommended number of staff for the CLP. This would equate to one local facilitator at grade H full-time (although some trusts facilitators are 0.5 FTE) and 12 clinical leaders at 0.2 FTE (2.4 FTE) of varying grades (F to G, salary range £21,617 to £31,176) for each trust.

Table 3 – Percentage of clinical leaders time spent on identified activities

Clinical Leader Activity	Average % of Time Spent on Activity (over 3 months)
PDP	2%
Workshops	21%
Action Learning	15%
Mentorship	3%
Patient stories	4%
Observations of care	2%
One-to-one	8%
Shadowing	1%
Self-directed leadership development	4%
Allocated programme time unaccounted for*	40%
Total	100%

* This figure is calculated by working out the maximum number of hours allocated to the Clinical Leadership Programme over the 3 months, minus the actual number of hours spent on defined activities (900 hours allocated to the clinical leadership programme over 10 Trusts minus 542 hours identified tasks from the diaries 358 hours of allocated programme time not accounted for).

3.2.4.2 Limitations

There were a number of limitations that emerged as the cost analysis progressed. Firstly, as clinical leaders started the programme at different times during the year, the three month period they were asked to keep activity diaries varies from trust to trust and is not homogenous.

Secondly, although the facilitator and clinical leaders were in theory seconded to the programme at 1.0 and 0.2 full-time equivalents respectively, in reality they did not spend the full compliment of this time on the programme. In particular, clinical leaders seemed to

spend less time than was allocated on the programme, due to a number of factors which included pressure of workload or staff shortages. To take account of this, calculations in this section of the report are based on the clinical leaders using *all* their time allocated to the programme but included in the analysis is a category called 'allocated programme time unaccounted for'. This category covers time that was allocated to the CLP, but which was not used for programme activities.

3.2.4.3 Data Analysis

Data from the clinical leaders' diaries from 10 of the 16

Table 4 – Costs to the trust of the CLP

	% Time Spent on Activity	Average Cost per Trust
Licence Fee		£12,500
Local facilitator (1x 1FTE @ £31,720)		£31,720
Clinical leaders* (12x 0.2 FTE @ £27,079)		
PDP	2%	£1,191
Workshop	21%	£13,828
Action learning	15%	£10,001
Mentorship	3%	£1,733
Patient stories	4%	£2,527
Observations of care	2%	£1,444
On-to-one	8%	£4,874
Shadowing	1%	£686
Private study	4%	£2,852
Allocated programme time unaccounted for	40%	£25,852
Total		£64,990
Total		£109,210

* To estimate costs associated with clinical leader activity, the percentage of time spent on an activity was calculated as a percent of the salary costs

case study sites were analysed to assess percentage of time spent in the three month period on the defined activities. The results are shown in Table 3.

Ignoring the ‘allocated programme time unaccounted for’ category for the reason given above, the majority of the clinical leaders activity was spent on attending workshops (21%) and action learning sets (15%). This may not be typical of the complete programme as this represents a three month snapshot of activities during the programme. It also seems apparent that where there is a specified task or activity such as a workshop these were well attended. However, for other tasks which relied upon the clinical leaders taking time away from work (self-directed time for leadership development activities and PDP) the percentage of time taken was not as high. This may be expected where there is pressure of work and the need to prioritise time spent on activities.

3.2.4.4 Cost Analysis

The annual average staff costs for the local facilitator and clinical leaders from each trust were calculated and

were averaged out at £31,720 and £27,079 respectively. The licence fee for the CLP is £12,500 and is usually paid for by each trust (in this cohort of clinical leaders this amount was calculated but was actually paid for by the NHS Leadership Centre). Table 4 shows the estimated average annual cost per trust.

From Table 4 it can be seen that the average cost to a trust is £109,210, assuming that staff allocated to the programme is in line with programme recommendations of one full-time local facilitator and 12 clinical leaders. This is based on the salary rate supplied by the trusts and has been adjusted to take into account National Insurance and superannuation costs. This then represents the true costs to a trust of the CLP.

3.2.4.5 Summary of the cost analysis findings

It is interesting to note that of the total average cost per trust of £109,210, 40% of this (£25,852) is due to the ‘allocated programme time unaccounted for’ category. This may be misleading, as it is not clear either why clinical leaders did not use this time or what activities

might have gone into this category. If it is assumed the clinical leaders are under pressure to fulfil their normal workload, it may be that there is not enough time for the clinical leaders to be able to participate fully in the programme.

The final qualitative interviews with clinical leaders and directors of nursing also highlight the difficulty of clinical leaders not taking the initially negotiated time of 0.2FTE of their work time. Conversely, it may be that the clinical leaders need fewer than the negotiated hours to participate effectively in the programme. Without further research, this is unclear. It may be worthwhile to revisit those clinical leaders participating in the programme, to explore this issue further.

In addition, discussions with local facilitators indicated that the pressure of work restricted clinical leaders from totally participating in the CLP. They perceive the clinical leaders prioritising their work and focusing on the workshops and the action learning, whilst not fully taking advantage of the other aspects of the programme. This perception is reflected in Table 3 showing 21% and 15% of time spent on these activities respectively.

It is noteworthy that many of the initiatives benefiting patients, highlighted in the qualitative analysis, have been initiated as a result of the observations of care and patient stories. However, both of these programme activities appear to be relatively low in cost both in terms of time spent and thus financial cost to the trusts. However, from the same discussions it is indicated that other aspects of the programme (personal development, action learning, mentorship etc.) are also essential in being able to achieve the aims of the programme.

It could be surmised that many of the benefits highlighted in the findings of the multiple-case study evaluation were at very little cost to trusts. For example, introducing coloured aprons to enhance infection control was reported to be at no additional cost. In addition, the enhanced communication skills of the clinical leaders, which in turn led to positive change in patient care and team effectiveness, had little apparent cost implication. However the cost of initiatives, such as reorganising care through the introduction of new clinics, or adjusting existing services, is unknown and is an area for further, more detailed, cost evaluation.

It is not clear if any of the trusts needed to employ extra staff to cover for the local facilitator or clinical leaders. If this were the case, this would be an additional cost. It is unclear if there are any other additional costs that have

not been identified. These might include the hire of rooms and equipment that were needed to hold workshops for the clinical leaders. Conversations with local facilitators have identified that these costs do occur, but they are moved onto other budgets. As an example, one local facilitator managed to obtain drug company sponsorship for holding a teambuilding exercise for the clinical leaders.

In conclusion, it appears that the identified average cost of the CLP programme of £109,210 per trust does not reflect the true actual cost. The diaries of the clinical leaders showed that they did not take 0.2FTE of their work-time, with 40% of their allocated time not being accounted for in terms of programme activity. In addition, the cost reflects a hypothetical situation of one full-time local facilitator and 12 clinical leaders, and not all trusts had full-time facilitators or 12 clinical leaders.

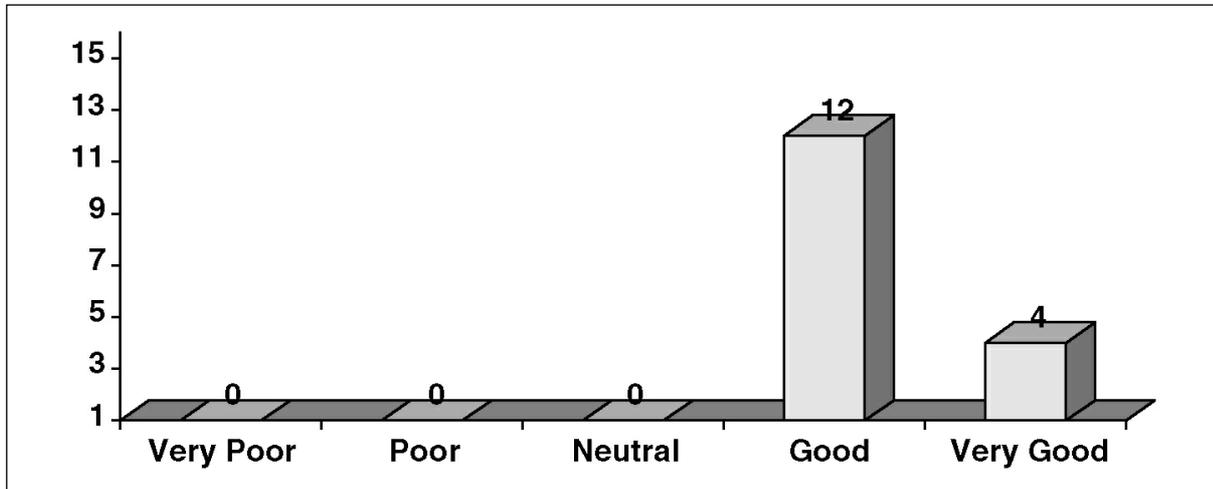
The financial outlay related to the cost of the CLP should be considered simultaneously with findings of the evaluation, more generally in terms of enhancing the quality of patient care, developing the leadership potential of clinical leaders and the leadership development and facilitation skills of the facilitators. An important question however, that has not been addressed by this research, is whether the benefits of the CLP could have been achieved in some other way and with less resource, or would the achievements have been greater if the clinical leaders had taken 0.2FTE of their time as initially negotiated?

3.3 Effectiveness (impact) findings

This section of the report presents the effectiveness (impact) findings. Effectiveness was defined as whether or not there has been development in leadership capability of the programme participants (clinical leaders), and the perceived impact this has on patient care, clinical practice, the team and the trust.

To explore the effectiveness of the programme, the case study clinical leaders, a patient from their clinical area and one of their colleagues were interviewed. To obtain a broader more trust-wide view of effectiveness, the local facilitators and the directors of nursing were interviewed on the case study sites. An analysis of the actions described in the action plans from the patient stories and observations of care further elucidates the transfer of programme activity into practice. In

Figure 6 – Clinical leaders’ overall assessment of the CLP



addition, an analysis of the Leadership Practice Inventories from clinical leaders from across the whole Phase 3 programme, as well as from the case study sites, indicates if there has been a change in the leadership capability of the clinical leaders.

Figure 6 shows that 12 clinical leaders rated the CLP as good and the remaining four rated the programme as very good. Three clinical leaders stated that they would rate the programme as excellent, if excellent had appeared on the rating scale.

3.3.1 Final interviews with clinical leaders

The purpose of the interviews was to obtain an overall assessment of the CLP. The leadership development and the impact of clinical leadership development perceived to be attributable to the CLP was also explored in the interviews.

All 16 clinical leaders were interviewed between July and November 2002. The interviews lasted approximately one hour.

The main themes that emerged from the data concerned developing clinical leadership and areas of programme improvement. First however, the overall assessment of the CLP will be described.

3.3.1.1 Overall assessment of the CLP

The 16 clinical leaders were asked how they would rate the CLP on a single item five point scale ranging from ‘very poor’ to ‘very good’. The responses are outlined in Figure 6.

3.3.1.2 Developing clinical leadership

All 16 clinical leaders identified substantial areas of their own leadership development. During the analysis, it was discovered that all of the categories developed to code leadership development and impact, described by clinical leaders, nested within a higher order analytical framework comprised of the five principles underpinning clinical leadership development, empirically developed by Cunningham and Kitson (2000b). The areas of leadership development and the subsequent impact will be described, therefore, within the principles framework.

Learning to manage self

Clinical leaders described utilising change models and strategies for understanding, developing and enhancing attributes that would underpin the development of leadership capability. The following quotation highlights a clinical leader’s awareness of her own leadership capability. It suggests that the clinical leader’s espoused values are also implicit in her leadership behaviour, a finding which possibly reflects the more transformational leadership style, termed as Model II (Argyris and Schon, 1976).

“I am more flexible and adapt it according to who I’m talking to and, and you, instead of thinking leadership is this separate entity to me and I must do it, leadership has become part of what I do from going to a client’s house and talking about weaning maybe or anything like that and empowering and trying to influence to, being a team co-ordinator here and getting the staff to do team building work.”

(1CL3, lines 91 to 97)

Being more self-aware enabled clinical leaders to develop confidence in their leadership capability. The following quotation describes well this perspective:

“You start, you start to believe in yourself and you think yeah I am a good leader, yeah I can do that.”

(2CL3, lines 113 to 115)

For some clinical leaders, an important outcome of their self-awareness was a reaffirmation in the value of their own contribution to the care of patients. This was expressed by some as being more settled in their current role, or alternatively as a commitment to stay clinically focused in their career aspirations. One clinical leader described the experience of deciding to stay in clinical practice in the following way:

“I was disillusioned, not that I was going to give up the job. I was just looking at maybe other ways I could, direction of my career in the future and clinical facilitation or practice development or something like that in the future. In fact you’ll remember at the beginning of the course we had to write down and stuff in an envelope which I presume we will open soon, and I remember saying at the end of this 12 months I want to have moved from the job but it’s actually stopped me doing that. It’s made me happier with probably the issues of being a ward manager.”

(11CL3 lines 877 to 887)

Developing more effective relationships

Most clinical leaders generally described valuing the team more, sharing knowledge and facilitating greater autonomy in team members. One clinical leader described how her developing leadership skills enabled her to interact differently with the team and value them more:

“The way I work within the team on the ward has changed. My skills as a team leader has, or as a

team person has changed as well. I think appreciating what I’ve got in the team and who’s there and what they can do and who they are.”

(14CL3, lines 124 to 127)

Sharing knowledge is essential to effective teamwork. Some clinical leaders acknowledged that knowledge supported professional power but described developing a greater willingness to share knowledge. One clinical leader said:

“I am more aware that knowledge can sometimes be termed as power, and I recognise in some people and in myself I think that was important for me to hang onto, but in leadership I am now more keen, I don’t want to hang on to my knowledge, I want to pass it on.”

(8CL2, lines 41 to 56)

The following excerpt describes how one clinical leader’s own developing self-awareness enabled him to facilitate the development of other people in the team as well:

“I sometimes used to look at probably conflict within the workplace, in quite a negative way; I often didn’t look at myself. I knew what had to be done and I was very happy to tell someone to go and do it, I’ve since learnt that that’s not always the best way forward, we have to look at ways in which we are encouraging others to learn and inspiring them to make a change. If you don’t have an empowered happy workforce, how are we going to have happy patients?”

(8CL3, lines 92 to 102)

Some of the clinical leaders described transferring skills and strategies they attributed to participating in the CLP, into their clinical area. One clinical leader said:

“I’ve actually used the Action Learning Set style on a one-to-one basis with someone that had a problem which was a communication problem between themselves as a manager and a consultant who, they had to work with closely, she went away with a plan and I probably wouldn’t have done that, I would have listened and said ‘that’s terrible, what are you going to do about it?’ ‘Don’t know.’ ‘Oh, good luck.’ Or I would have said ‘what you need to do is this.’”

(6CL3, lines 193 to 202)

Developing patient focus

All the clinical leaders cited an impressive range of patient-centred care delivery initiatives. In the following quotation, a clinical leader from the special care baby unit describes how an observation of care revealed the impact that a sudden noise had on the babies in the unit:

“It seems so simple, the rubbish bins, and they are foot operated rubbish bins, and we wash our hands a lot, the nappies, clean the babies and when you put your foot on the bin, you put the rubbish in, and you take your foot off. The lid goes bang and the babies jump and yes we knew there’d been related noise but I wouldn’t have said that we realised how much of a noise, so we made some enquiries, wrote away and yes we could have these silent lids fitted but we’d had our bins too long so we had to actually buy whole new bins and we bought four initially to see what happened. Unbelievable how quiet these silent lids are.”

(18CL3, lines 406 to 423)

The introduction of coloured aprons as an infection control measure is described by another clinical leader as a change in practice attributable to observations of care. The clinical leader described this measure as not incurring any additional costs because the aprons would have been purchased anyway:

“Things like going into a MRSA room or infected rooms, coming out in that apron that they’re wearing. Have they then gone to a clean area and done some direct care with the patients? So I’ve now got the yellow aprons for infected rooms. They have the white aprons for direct care within clean, clinical area, and I’ve also now got green aprons for dressings so again I know it’s somebody that’s had a white apron on for direct care, say toileting somebody, and then not doing the dressing of that same patient in the same apron. Immediately if I see somebody in a yellow apron walking into a big area that’s clean, I pull them out.”

(11CL3, lines 483 to 495)

In another example of change, a clinical leader describes how service users are now consulted about whether they would like any distraction techniques during surgical procedures when they have spinal anaesthesia. In this particular example, the clinical leader attributes the change in practice to the patient stories.

“Our patients undergoing spinal anaesthesia and regional anaesthesia are especially concerned that they were lying flat on their back, aware that somebody was performing surgery upon them but it was very difficult for them to distract their minds from, to get away from that so we now offer them music to listen to through headphones, stories, tapes, tape books, etc. Yes, these are quite long procedures. Some patients just like the opportunity for somebody to sit next to them and talk to them during the procedure and that is available. I think that is attributable to the Patient Stories.”

(4CL3, lines 267 to 284)

The programme interventions of observations of care and patient stories were also described as having the potential to highlight and deal with patient complaints more rapidly.

Networking and political awareness

Clinical leaders described being more able and confident to approach and raise concerns and generally communicate more with senior staff in the trust. The benefit of wider networking within the trust was described by the following clinical leader:

“I enjoy working across directorates, I really think it’s incredibly important and I go out of my way to meet people from other areas, out of my way to do that because I think that’s really important and I will, and I encourage the staff if we get medical patients on the ward to actually go to the ward and say to somebody; “Look, I’ve got this patient on the ward, I’ve not looked after this before, tell me what shall I look for, what shall I do?”

(14CL3, lines 856 to 862)

One example was cited where the ‘within programme networking’ had resulted in staff from across the trust working together on a patient focused quality initiative:

“At the end of, we were finishing the programme, and we decided because we had such a good cross-section of senior nurses, both the head of nursing for surgery and medicine felt that it would be an excellent idea for us to, for us to take that on [audit] for the trust and we invited community staff obviously in on it as well. We looked at the personal hygiene and oral hygiene.”

(14CL3, lines 535 to 542)

3.3.1.3 Areas for programme improvement

Clinical leaders identified several areas for programme improvement or consideration.

Most clinical leaders highlighted the difficulties of taking the negotiated 20% of work-time to undertake the programme. Most clinical leaders focused on the difficulty of undertaking some of the programme interventions, particularly the patient stories and observations of care, outside the workshop days as contributing to this difficulty.

During the programme implementation there are two separate occasions when observations of care and patient stories are undertaken; the number and timing of these interventions was described as difficult by a number of the clinical leaders. A number of clinical leaders felt that only one set of interventions should be undertaken. A clinical leader described this perspective in the following way:

“I think it’s probably much better if you’d done one set of observations of care and patients’ stories at the beginning and I think the idea was to do one set at the end but in actual fact that hasn’t happened.”

(18CL3, lines 435 to 446)

Similarly, another clinical leader highlights the value of undertaking patient stories but describes the need to undertake so many as too time consuming:

“I think if you wanted to do two lots there’s probably too many to do six patient stories, it is a lot. Because they do take up a long time, so I think the information you get from them is very good, but we, no way would we have fitted twelve in.”

(12CL3, lines 318 to 321)

An alternative solution to the number and timing of the observations of care and patient stories, made by a number of clinical leaders, was to incorporate them into the planning of the organised days:

“It was hard to find time to actually do it; we had study time one day a week. In reality that wasn’t achievable and, you know, if you had one of the study days with [local facilitator], to find other time that week very often you were catching up on the sort of the work we had planned for that day and not done. Possibly if you could incorporate the

observations of care or the interviews in a study day so that the afternoons were spent as a group but mid morning you would all go out, do your interview or your observation, then come back so it was part of the study day.”

(6CL3, lines 15 to 32)

Some clinical leaders mentioned the difficulties of a local facilitator being absent for any length of time and the impact this had on programme interventions. The following quotation describes the impact on the action learning set of a local facilitator being absent:

“We ended up more of a clinical supervision group because we lost the [name of local facilitator] half way through the course.”

(11CL3, lines 121 to 124)

Several clinical leaders highlighted that more programme information would have been beneficial before the start of the programme, particularly as there seemed to be some uncertainty about the nature of experiential learning as the following quotation identifies:

“More information on how the programme was going to be, how it was going to be planned out over the year, and how much of our time we’re actually going to have to commit to this, and because we were told at the very beginning there was no real writing or, on the studying and that we had to do in our own time, which I found to be quite an untruth.”

(8CL3, lines 15 to 19)

3.3.1.4 Summary of findings of clinical leader final interviews

All of the case study clinical leaders highly evaluated the CLP, conferring a rating of good or very good.

The five principles of the CLP that underpin the approach to clinical leadership development are evident in the final interviews of the clinical leaders. Therefore, the principles provided a conceptual framework for analysing and describing the development of the leadership capability of the clinical leaders. Within the principle of ‘learning to manage self’ the clinical leaders describe an increase in self-awareness and confidence in their current and developing clinical leadership

capability. Some clinical leaders described how they valued more their contribution to patient care, which for some acted as an incentive to remain in a clinical career.

In 'developing effective relationships' the clinical leaders describe valuing the team more, they understood more the value of sharing knowledge and facilitating greater autonomy in team members. In 'developing patient focus', an impressive range of care improvements were described; some examples include initiatives in infection control, noise level reduction and patient comfort during spinal anaesthesia.

In 'networking' and 'political awareness' a number of trust level initiatives were described, including communicating more effectively with senior managers and collaborating with colleagues across the trust in quality improvement initiatives. Clinical leaders attribute these different levels of impact in respect of their individual, patient, team and trust impact to their developing leadership capability.

One area identified by the clinical leaders for programme improvement relates to identifying ways that clinical leaders could be supported to take the full negotiated 20% of work-time for leadership development. Some clinical leaders found the number and timing of the patient stories and observations of care contributed to the difficulty of taking the allocated programme time. One obvious suggestion was to reduce the number of interventions during the programme implementation. However, an alternative suggestion was to timetable the patient stories and observations of care into the current intervention workshop days. This suggestion is worthy of consideration, given the impact on the quality of patient care attributed to this intervention.

A contingency plan for the possibility of local facilitator being absent during the implementation of the programme should be considered by the trust, before the programme starts. The detrimental impact on leadership development of the clinical leaders is apparent in one interview. However, the expansion over time of facilitator capacity within trusts may ameliorate this experience in the future.

Some clinical leaders identified the need for more pre-programme information. This would be particularly relevant, because there seemed to be some uncertainty about the nature of the workload required for an experiential programme of development.

3.3.2 Final interviews with patients

The purpose of the final interviews with patients was to identify if there were any changes in how service users perceived clinical leadership since the first interviews and to explore patients' satisfaction with their care.

In total, 14 patients were interviewed from the clinical areas of 14 of the 16 clinical leaders involved in the multiple-case study. The clinical leaders from Site 5 and Site 6 had moved from their clinical areas by the time the programme had been completed, therefore interviews with patients in those areas were not carried out. Between July and October 2002, 13 face-to-face interviews and one telephone interview were conducted; the interviews lasted approximately 30 minutes. Ten male and four female patients were interviewed.

The findings therefore, concern patients' evaluations of the care they received and their perception of clinical leadership.

3.3.2.1 Patient satisfaction with care

Patient satisfaction with the care was explored using a 10 point visual analogue scale, where 1 represents poor care and 10 is excellent care.

Approximately two-thirds (9) of the patients rated the care they were receiving as excellent (assigning a score of 10 on the scale). Two of those patients stated they had no doubts about rating their care as excellent. A further three patients rated the care towards the top end of the scale between 8 to 10, suggesting that they were also satisfied with the care they were receiving. One patient from an acute trust, rated his care at 6, slightly above the midpoint of the scale, and one patient from a mental health trust, indicated that he was less satisfied, rating his care at 3 on the scale.

The majority of patients therefore, were highly satisfied with the care they received. The following quotation describes how one patient felt confident in the care he was receiving:

"You know I'm really confident in everything they do, and they do it with a smile. Can't wish for nothing better. I don't think you get a level of care like this on the private medicine. Honestly, I really

honestly believe that.”

(2P3, lines 188 to 191)

Similarly, the following excerpt indicated that the client perceived care to be excellent and she could not think what else the staff could have done for her:

“Well, it’s really hard not to say almost the excellent, I mean I can’t honestly think of anything else your people could have done for me.”

(7P3, lines 28 to 30)

The reasons why patients assigned a score of less than 10 on the rating scale are described below.

One service user who scored 8 on the satisfaction rating scale indicated that, even though she generally felt that the nurses were overworked and understaffed, she believed that some were better than others, indicating that she could not expect the same level of care from all staff:

“Well, it isn’t the nurses’ fault. They’re understaffed. They’re overworked and, you know, some of them are very, very good and some not quite so good.”

(11P3, lines 53 to 55)

Similarly, the patient who scored 3 on the rating scale identified differences in his evaluation of staff. In this instance it appears that there may have been a problem in the way the team worked together:

“The manager is trying her best, often her very best to make the ward work, but they’ve got some nurses that been on the ward too long, they think they own the ward.”

(13P3, lines 5 to 8)

The service user who scored 6 on the rating scale described staff not communicating well about who was responsible for his care; consequently he was less satisfied with his care:

“I think is that it’s hard to determine sometimes exactly what nurse, which nurse is dealing with whom as it were. Sometimes you don’t know, you’ve no idea who is dealing with you or somebody is dealing with you, then they disappear, so you don’t know whether they’re still dealing with you or not.”

(3P3, lines 12 to 16)

3.3.2.2 Clinical leadership

In terms of clinical leadership, patients highlighted all the same issues identified in the findings of the first interviews with patients. Again, patients mostly identify the ward manager or sister as the leader of care in the clinical area. In some situations, the clinical leader participant is the ward manager or sister however, the response from patients appear to be concerned with identifying the traditional role of the ward manager or sister. It does not encompass leadership development to enable the transformation of care be more patient-centred.

This finding reveals a limitation in evaluating change in the clinical areas from a patient perspective and in the research design; for service users the concept of clinical leadership is different to the way clinical leaders and researchers conceptualise clinical leadership. A more participatory style of research may have ensured that patients were more informed about the purpose and aims of undertaking a programme of transformational leadership development. However, what does remain clear is that there is a difference in the way leadership is perceived. Until that is addressed, it will be difficult to engage service users in evaluating the effectiveness of transformational leadership approaches.

3.3.2.3 Summary of findings of final interviews with patients

Patient satisfaction with care could be viewed as a proxy for good leadership in clinical areas. However, there is clearly not a direct relationship between satisfaction with care and clinical leadership. Further, it is not possible in this study to consider how satisfaction with care relates to the leadership development of the clinical leader because the clinical leader is only one of many people influencing care. However, recognising this limitation, it is possible to say that most service users were satisfied with the care they received. For the three patients who were less satisfied with care, the factors influencing their evaluations were concerned with three issues. Firstly, one client indicated that some staff gave better care than other staff in the clinical area. Another identified that the team in the clinical area did not appear to work well together and lastly one service user highlighted difficulty with not being able to identify which member of staff was responsible for his care.

The issues highlighted by patients, where they were less satisfied with care, are issues central to clinical leadership. Therefore, the development of the leadership capability of staff in the clinical area and how this relates to team working is clearly of importance to patients. However, currently the way patients and staff conceptualise and discuss clinical leadership is different.

Patients could have been more informed about clinical leadership if clinical leaders had adopted a more participatory style to leadership change in the clinical area, and involved patients more in the planning and implementation of change. In addition, if service users are to be involved in the evaluations of effectiveness of these strategies, they will require much more information about the purpose and aims of clinical leadership development. Equally, if the multiple-case study evaluation had been designed in a more participatory way, patients may have developed more understanding of the aspects of clinical leadership that were being evaluated.

3.3.3 Final interviews with colleagues

The purpose of the final interviews with colleagues of the case study clinical leaders was to explore whether colleagues had observed any changes in the clinical leader's leadership capability and if so, what the impacts of those changes are on patient care, clinical practice and team effectiveness.

In total, 14 colleagues of case study clinical leaders were interviewed. The clinical leaders were asked to identify a colleague who had knowledge of the CLP through being involved in an observation of care, a patient story or a feedback session. Of those participants identified by the clinical leaders, 10 out of 14 had worked with the clinical leader for a year or more, during which time the clinical leaders had undertaken the programme. The clinical leaders of Trust 6 and Trust 7 had moved to different posts, so an interview with a colleague was not undertaken in these areas. All the colleague participants who consented to interview were trained members of staff consisting of six D and E grade staff nurses, three F grade junior managers, four G grade ward managers (including a G grade job-share partner of the clinical leader) and one participant who was a clinical leader's line manager.

The theme that emerged from the interview data is concerned with the impact of leadership development on the clinical leader and the subsequent impact this had on patient care, clinical practice, and the team.

3.3.3.1 Clinical leadership development and attributed impact

Clinical leadership development was described by colleagues in the context of having impact on the individual clinical leader and the subsequent impact this had on patient care, clinical practice and team effectiveness.

Impact on the individual clinical leader

Generally, where colleagues described the impact on the individual clinical leader it tended to be in terms of increased confidence and enhanced communication skills. A colleague described positive changes in one clinical leader with respect to an increase in the individual interaction and increased acknowledgement of staff contribution to care:

“I think maybe it just seems more apparent now that you know kind of he often talks to people individually and will say kind of thanks for doing that shift.”

(12C03, lines 59 to 63)

Most colleagues interviewed also indicated that they believed leadership development would be beneficial for other grades of staff, not just senior clinical staff.

Some colleagues found it difficult to distinguish the development of leadership capability attributable to the programme from the existing leadership capability of the clinical leader prior to undertaking the programme. This may have been because the colleagues were unaware of the nature of experiential learning whereby new ideas or new practices are assimilated into practice. Therefore, they would have been unaware of what may have stimulated a change or development of practice.

Impact on patient care and clinical practice

Colleagues identified the programme interventions such as patient stories, observations of care and the related feedback as initiating improvements in patient care and clinical practice. Improvements in patient comfort, information and cleanliness were highlighted as being

initiated by these interventions. These interventions were not only perceived to facilitate change but also to engage the staff in the process of that change. One example of change is how a simple colour coding of aprons allowed differentiation of staff doing 'dirty' and 'clean' clinical procedures:

"It's like, yes, if you've got a green apron on now, you're doing a dressing, you know, whereas if you've got your yellow apron on you're in a barrier side room so if you've got a yellow apron and you were up and down the corridor, or even the store room, what are you doing here? You stand out like a sore thumb really."

(11CO3, lines 302 to 306)

Impact on developing team working

Most colleagues commented positively on the increased feedback that clinical leaders gave to the rest of the team. The feedback did not just surround the patient stories and observations of care but was described as a greater awareness of the positive benefit of giving feedback when working generally. As one colleague said:

"I think she's very aware of feedback nowadays and very aware of giving positive feedback to staff all the time and even if it's not positive, just to be out there giving feedback."

(11CO3 lines 110 to 113)

A more inclusive decision-making process was described by several of the colleagues, as the following quotation typifies:

"I think [communication] has developed more since [clinical leader] has been on the course, so I think the whole communication process on, on the ward, has actually developed tremendously so that involvement of everyone in the decision making... I think it works really, really well."

(17CO3, lines 766 to 768)

3.3.3.2 Summary of the findings of the final interviews with colleagues

Colleagues described multiple levels of impact attributable to the CLP. These impacts encompassed patients, practice and team level changes. Impact relating to clinical leaders was described in respect of

increased confidence and enhanced communication skills. The interventions of patient stories, observations of care and the related feedback were described as initiating changes in patient comfort, information cleanliness and infection control. Positive comments on feedback were not just related to the patient stories and observations of care, but were described as an increased awareness of the use of positive feedback when working generally. Colleagues reported being more involved in decision-making within the clinical areas.

Some colleagues found it difficult to distinguish the leadership development attributable to the programme from the pre-existing leadership capability of the clinical leaders. It is suggested that this may be the nature of general understanding about experiential learning, whereby new ideas or new practices are assimilated into practice and therefore colleagues may have been unaware of what may have stimulated an innovative development in practice. In addition, colleagues' awareness of the content of the CLP was varied, possibly because some of the participants had not taken part in any of the programme activities. It was intended that clinical leaders would identify colleagues for interview who had taken part in one or more of the programme activities, but it was evident from the interviews that this was not always the case.

3.3.4 Final interviews with local facilitators

The purpose of the interviews with local facilitators was to elicit a broad overview of the effectiveness and acceptability of the programme within the case study sites, after clinical leaders had completed the programme. Therefore, the findings report on the issues relating to all of the clinical leaders within each of the sites concerned not just the case study clinical leaders. In total, 15 local facilitators consented to interview. The local facilitator for Site 7 was also the facilitator for Site 17; therefore, all case study sites were represented. The face-to-face semi-structured interviews were carried out between July and October 2002 and lasted approximately one hour.

The themes to emerge from the final interviews with the local facilitators concerned the impact on clinical leaders of clinical leadership development, and how

clinical leadership was integrated more generally into the trust. There was also some discussion about the preparation of the local facilitator for the role of facilitating the CLP within the trust.

3.3.4.1 Clinical leadership development and attributed impact

Impact on clinical leaders

The general consensus of the local facilitators was that clinical leaders became more confident, assertive and had increased problem-solving skills after undertaking the CLP. One local facilitator described how increased confidence in the clinical leaders had enhanced team working and patient care.

“Most of them have reported that their confidence has increased in terms of the way they do their work, the bounds that they place on their role and the value they place on themselves in terms of leading their team and it actually is shaping the care that’s delivered.”

(7TF3, lines 194 to 197)

Impact on patient care and clinical practice

The facilitators said they had observed patient care benefits as a result of the clinical leaders undertaking the programme. Many examples were given of improvements including improvements in patient care, cleanliness and in the clinical environment. One local facilitator describes the general improvements in the following way:

“I think yeah, a lot of, a lot of de-cluttering, a lot of just looking at the environment from a patient’s point of view. Trying to think about noise levels, trying to look at the cleanliness.”

(15TF3, lines 260 to 262)

Local facilitators described the patient stories and observations of care as powerful tools for enabling change in clinical settings. Although there were a number of very positive changes in mental health trusts attributed to the patient stories and observations of care, the difficulties of working in partnership with some patients with limited communication or mental health problems was highlighted by some of the local

facilitators. One local facilitator described translating the programme information and consent documentation into British Sign Language, which indicates that programme information can be adapted to suit particular settings. Another local facilitator highlighted how working with patients to identify areas of concern was a particular challenge in a high security mental health trust:

“I can think of couple of people, again in high security who said they were very happy with everything and all the staff were marvellous; their rooms were lovely, their wards were fabulous and the food was, everything was wonderful. And we sort of said it can’t be wonderful.”

(13TF3, lines 232 to 238)

The facilitator believed that in the circumstances of high security care, the patients would not have evaluated their care and environments so highly and therefore was sceptical about how open and honest the patients felt they could be.

Organisational integration of clinical leadership

Most local facilitators gave examples of the increased networking across the organisation particularly networking with senior staff within the trust. Several clinical leaders gave examples of working across trusts on local or national policy initiatives. One local facilitator described how clinical leaders were using the outcome of the patient stories and observations of care to inform the ‘Essence of Care’ initiative within the trust.

“We’ve tried to link ‘Essence of Care’ with the users’ views and patient stories and observations of care and we’re trying to use the evidence that we’ve gathered in that to actually inform the ‘Essence of Care’.

(7TF3, lines 679 to 682)

However, although links with other trust initiatives were successful in some trusts other trusts described making the links more explicit as areas for continued development as the following quotation shows:

“And one of the things that you know as a facilitator you try and get them to do is to make the link to, you know things like the ‘Essence of Care’ and the clinical governance. But I think that’s something that they don’t, that they’re not particularly, their thinking doesn’t always link that well.”

(15TF3, lines 304 to 308)

Although most trusts had a clinical leadership steering group or other forum which made links with other trust initiatives (as recommended by the CLP) a small number of local facilitators said that there was not a forum in place to make links from the programme activities to the wider agendas of clinical governance, benchmarking and other user involvement initiatives. The facilitators were aware that this was an area for improvement. The following quotation illustrates this response:

“Now the other thing we didn’t do very well is the patient stories and the observations of care. Although they got fed back quite well within the clinical team, the key things and key issues, there wasn’t a forum at the time to be able to share them across the Trust.”

(12TF3, lines 648 to 651)

3.3.4.2 Preparation for the role of local facilitator

In preparing for the role of facilitator, the findings indicated that most facilitators appreciated the support of the regional facilitator, particularly in the early stages of programme implementation. But this support was not as intense for some trusts in more remote geographical locations.

Some facilitators would like more information, before undertaking the programme of facilitation, about the purpose of the programme and the residential week (learning community). Some facilitators stated they would have liked more focus on the processes of facilitation and giving feedback during the residential week.

It could be surmised that some did not fully understand the theoretical principles of experiential learning underpinning the programme and, therefore, initially felt a little uncomfortable with the experiential nature of the residential week and the programme. Two facilitators described facilitating the programme as an experiential process. Therefore, generalisations about what would be required to prepare facilitators, both in terms of the residential week’s content and experiential learning principles of the programme are difficult to make. Further discussion of this issue by the participants and providers of the programme will be necessary to explore this issue.

The perceptions about the local facilitator’s role as a full or part-time post are too varied to conclude how the nature of the post impacts on the clinical leaders, or the more general outcomes of the programme. To explore this question further, more research would be required. Some facilitators stated that their other roles in the trust helped to inform clinical leaders and vice versa, while others perceived that the clinical leaders had not had the full benefit of a full-time local facilitator, when doing programme activities such as feedback or one-to-ones. The following excerpt from a local facilitator describes the perceived benefits of having a dual role:

“I think that if I’d purely been focusing on the RCN Leadership Programme and the facilitation role for that, what I think is it may have been difficult to keep the contact across the organisations that I have as a result in my wider role. So I can see that being involved in different parts of the organisation, having a variety of roles, is actually quite useful in being able to create, institute organisationally my role as facilitator of the programme and I think that that’s helped me to help them [the clinical leaders] to access what’s going on in the organisation as well.”

(3TF3, lines 19 to 27)

In contrast, the following local facilitator highlights that facilitating the programme, as recommended by the RCN, requires a full time facilitator:

“The recommendation would be that if you want the programme to be delivered in the way that it is delivered - in terms of the components, stuff that goes on in the workplace and stuff that goes on outside the workplace in terms of workshops and action learning and it was giving 12 people one-to-one individual support for their clinical development and you’re also looking at their team, in terms of their clinical development, not just doing patient stories and observations of care, you’re trying to look at the other issues, feedback, trying to bring the team on, it’s impossible to deliver all of the physical elements in the programme in two and a half days as well as do preparatory work if you need longer you need ideally to be full time.”

(7TF3, lines 103 to 120)

3.3.4.3 Summary of the interviews with local facilitators

Local facilitators gave a broad overview of the impact of the programme in terms of the observed leadership development of the clinical leaders, the impact on patient care and clinical practice and the organisational integration of clinical leadership into the trust.

All local facilitators described clinical leaders as being more confident, more assertive and having increased problem-solving skills. Many examples of change to patient care and clinical practice were given including improvements to patient care, cleanliness and the clinical environment. Patient stories and observations of care were described as interventions that are powerful enablers of change in practice. Some local facilitators described ongoing work to improve the effectiveness of these interventions with patients with limited communication and patients with mental health problems.

The increased networking of the clinical leaders, particularly with more senior staff, was one way that clinical leadership was organisationally integrated into the trust. Having local trust forums, such as a clinical leadership steering group, which enabled the co-ordination of patient improvement initiatives across the trust, also facilitated integration.

Most local facilitators appreciated the support of the regional facilitators although some of the more remote locations appeared to experience less support.

The findings regarding programme information and the part-time versus full-time nature of the local facilitator post were equivocal and will therefore, require further investigation.

3.3.5 Final interviews with head/directors of nursing

The purpose of the interviews with the directors of nursing was to gain a broader understanding of the impact of clinical leadership development across trusts. There are up to 12 clinical leaders undertaking the programme within each trust, therefore, the issues raised will relate to the cohort of clinical leaders on the case-study sites not just to the case study clinical leader.

In total, 14 interviews were undertaken with the head or director of nursing at 14 of the 16 case study sites, after the completion of the programme. In the remaining two sites, one director of nursing post was vacant and in the other site the director of nursing had only recently taken up post and therefore declined to be interviewed. The interviews took place between July and November 2002; there were 10 female and three male head/director of nursing participants.

The themes that emerged from the interviews with directors of nursing concerned the clinical leadership development of the clinical leaders and the subsequent attributed impact to patient care, clinical practice and the trust.

3.3.5.1 Clinical leadership development and attributed impact

Impact on clinical leaders

All of the directors of nursing described a noticeable change in the confidence of the clinical leaders after they had undertaken the programme. The following quotation is illustrative:

“One of the striking features has been confidence, of individuals, and that’s in quite a few ways, I mean just the way they actually conduct themselves in one-to-one’s with me, that you know, that they’ll come in and they’ve usually you know half way through until the end of the programme, they’ve actually prepared, they’ve, they’ve given some thought to you know the meeting and they’re actually prepared for that, whereas you know initially they might sort of just come in and feel a little bit in awe of you know I’m, you know I’m meeting the director of nursing, and whatever and they come in very confident, they’ve actually given some thought to what they want to say to me.”

(7DNS3, lines 205 of 214)

Most directors of nursing commented that the problem-solving skills of the clinical leaders had developed during the course of the programme:

“I feel they are a group of staff more willing to problem solve, they see the problems and they’re now willing to come up with proposals to try and

solve those sorts of problems, they're taking control of the issues, rather than, just throwing them at their manager and saying this is the problem, we can't cope with it."

(3DNS3, lines 116 to 121)

A number of directors of nursing described the programme as being able to re-energise or refresh staff to motivate them to maintain an environment that is appropriate for patient care. One director of nursing described the phenomenon in the following way:

"So it's acted, I think, as a refresher and a challenge to the establishment to be thinking right, we invest in people, we employ them, we do individual personal appraisal, we do all the things that theoretically you should be doing to support staff to develop and to maintain an environment which is appropriate for patient care, but over time those individuals may become, I don't know that burnt out is the right word, but maybe it becomes routinised. The patient care process becomes routinised and this programme has most definitely taken them out of that spiral."

(18DNS3 lines, 107 to 117)

Impact on patient care and clinical practice

The majority of directors of nursing described the most successful aspects of the CLP as being patient-centred, experiential and rooted in clinical practice. A number of directors of nursing described the programme's relevancy to the patients' experience and the continued leadership development of clinical leaders over a relatively long period of time as beneficial:

"I think it is relevant to the patient experience, because it's rooted in practice. And for me that was very important and it's obviously a much longer and more developmental process rather than a specific input that people may or may not be able to do much with."

(2DNS3, lines 72 to 78)

Some directors of nursing linked the sustainability of leadership capability with the relevance and length of the programme. One director of nursing said:

"I think its patient centeredness, so I think for many clinical leaders and indeed managers, I think people easily engage with it, because of that, there's a real relevance of it, I think the length of the

programme and the opportunity to get some real sustainability is, is a real plus for the programme, so it's, it doesn't in any sense seem like a quick fix."

(17DNS3, lines 226 to 232)

Patient stories and observations of care were mentioned by a number of directors of nursing, because of their direct impact on patient care and clinical practice:

"But the thing that seemed to have kind of really captured the imagination have been the patient stories, have been the observations of care, where they've had the opportunity to sit back and actually look at what's happening in their own areas and in other people's."

(2DNS3, lines 135 to 139)

Integration of clinical leadership into the trust

Most directors of nursing expressed strong organisational support towards the development of clinical leaders. This was expressed in terms of establishing a Leadership Steering Group and ensuring there was trust board commitment. The clinical leaders were perceived by some directors of nursing to be in a position to contribute substantially to trust-wide policy initiatives such as the 'Essence of Care' and 'Clinical Governance' agendas. The following quotation highlights this perspective:

"They [clinical leaders] are in a much better position now to see the bigger political picture and very clearly a lot of emphasis has gone on in the programme to enable them to do that and what they are able to do is, when they are thinking about Clinical Governance and continuous quality improvement, they are able to link that with other sorts of policy initiatives so they're able to look at it in relation to the access targets."

(12DNS3, lines 130 to 138)

Similarly, the following quote shows the contribution that clinical leaders can make to the policy demands experienced by trusts:

"A lot of trust business now is already predetermined through Government policy and targets so, you know, there are givens that we have to deliver. What is important is that the clinical leaders' experience informs that policy, and that they can drive it to an extent by having their voices

heard and having an input to the policy, into policy development.”

(4DNS3, lines 262 to 271)

One director of nursing suggested that the development of clinical leaders had resulted in a positive benefit for retention and recruitment of staff and a reduction in patient complaints. It would be interesting to explore this aspect further in future research:

“Most of the clinical leaders who have been through the programme have very few vacancies on their ward, and you know I believe there’s a really strong correlation between retention, vacancy rate and ward leadership, so I think because junior staff see a strong leader who’s passionate about the patient care, who will facilitate, they’re actually more likely to stay in that clinical environment, so I think recruitment and retention, I think early days and it’ll be interesting to see after the second cohort, but I get a feel that in most of the areas, there have been a reduction in complaints but I don’t have the figures to hand.”

(3DNS3, lines 231 to 240)

Some directors of nursing identified the ambiguity of staff undertaking leadership development, whilst still being expected to sustain the full responsibilities of their clinical posts. This expectation would most probably impact on the clinical leaders’ ability to make full use of the development opportunity:

“Although we say we are willing to support it, they always have to fit in their day job as well”.

(3DNS3, lines 132 to 134)

3.3.5.2 Summary of the final interviews with the head/director of nursing

Most heads or directors of nursing describe a beneficial change in the confidence and problem-solving skills of the clinical leaders after they had undertaken the CLP. Some directors of nursing consider that leadership development re-energises staff to motivate them to sustain appropriate patient care environments.

Directors of nursing described the most successful aspects of the CLP as being patient-centred, experiential and rooted in clinical practice. The patient-centred nature and length of the programme was considered to sustain the leadership capability of the clinical leaders. Patient stories and observations of care were described as “really capturing the imagination” because of their impact on patient care and clinical practice.

The organisational support for clinical leadership development was strongly reinforced in the interviews and ways of integrating leadership into the trust were identified such as the establishment of steering groups or other forums which would link all other patient-centred trust-wide policy initiatives.

One director of nursing suggested that the development of leadership capability had a positive impact on retention and recruitment of staff and on reduction in patient complaints. It would be interesting to explore this perception further in future research.

Some directors of nursing acknowledged the ambiguity of supporting clinical leadership development without enabling clinical leaders to take time away from their clinical roles.

3.3.6 Analysis of action plans from observation of care and patient stories

The action plans of the clinical leader participants in the case study sites were analysed, to gain an understanding of any impact on patient care and clinical practice attributable to the patient stories and observations of care.

Following observations of care and patient stories, clinical leaders worked together in pairs to agree and map out their findings. Common themes arising were identified and discussed in their clinical areas for development into action plans. The following section is a synopsis of the action plans from the clinical leaders in the case study sites; it is illustrated with examples, to demonstrate some of the recorded action taken to benefit patients, the clinical environment, and teams.

3.3.6.1 Patient Issues

Patient Information

Improving information for patients and their relatives was an action described in the action plans. An example of an action identifying that a booklet about types of investigations carried out in the department and how long they might take would prove useful was from a clinical leader in an accident and emergency unit. A further example was from a health visitor; when she discovered that some patients were unsure about the health visiting role, she described in the action plan the development of a leaflet clarifying the health-visiting role. In addition, she described the need for more up to date leaflets about the different primary care services.

Patient access to services

A common issue in the action plans was the different ways that appointments could be organised to suit patients better. One example is an action plan to address the issue of patients in a psychiatric unit having to wait a long time to see the doctors on the ward round, which prevented patients from being able to do other things outside the unit.

The clinical leader described setting up an appointment system, which allowed each patient 10 to 15 minutes discussion of their care with the doctors. Another action plan described distributing questionnaires to clients to get ideas for the establishment of a new child development clinic, which would alleviate pressure on existing clinics. In addition the same clinical leader, following a patient story, described arranging to meet general practitioner colleagues to develop a team approach to tackle postnatal depression.

Privacy and dignity

Issues relating to the privacy of service users were frequently recorded in the action plans. The following examples will show the range of issues highlighted. A clinical leader in an A&E department noted inconsistency regarding leaving cubicle screens open or closed when patients were waiting for treatment. The subsequent action plan described highlighting the issue for discussion at a meeting of the accident and emergency sisters. The clinical leader described including this initiative as part of the privacy and dignity work in the Essence of Care (Department of Health, 2001), after which sisters would disseminate information to other staff in individual interviews.

Similarly another clinical leader intended to raise the issue of staff opening the bed-screening curtains without warning to the patient, at team meetings, in ward handovers and in the ward communication book.

Another clinical leader described an action to communicate the need to keep curtains drawn when there was discussion around the patient's bed about a patient's condition. A clinical leader from theatres described reintroducing modesty knickers/pants and ensuring theatre doors were kept shut when patients were exposed. The clinical leader described in the action plan that the part of the body to be operated on would only be exposed when the entire team was ready to begin the procedure.

3.3.6.2 Clinical environment issues

Clinical Areas

Some clinical leaders noted in their action plans that the clinical areas were clean and tidy following the observations of care. Other clinical leaders however described clinical areas as more cluttered. One clinical leader for example had noted that time was being wasted looking for equipment, therefore reorganising the storage area and appointing a porter to act as store man, was described in the action plan. The clinical leader indicated that the initiative would be evaluated.

Another clinical leader noted that unused vomit bowls were being used as fruit bowls for patients, therefore proper fruit bowls were ordered. A clinical leader from a primary care trust recorded that the clinic room was cramped for both clients and professionals. Therefore, the action plan described exploring the use of the room next door where there was more space.

Noise

High noise levels were frequently reported in the action plans, following the observations of care and patient stories. The clinical leaders concerned responded in a number of ways. One clinical leader from an acute trust, for example, acknowledged that noise from other patients was a difficult problem to solve, but earplugs could be made available for patients.

Two clinical leaders mentioned restriction in the use of mobile phones in clinical areas and another clinical leader mentioned purchasing telephone equipment

where the volume could be lowered. One action plan identified that quieter bins were replacing noisy bin lids, and one clinical leader was investigating bin 'silencers'. A clinical leader from an NHS Direct call centre noted that staff at the call centre were, at times, noisy. The action plan described ensuring that all personnel were made aware of the need to communicate appropriately, when in the call centre.

Infection Control

Several clinical leaders identified in the action plans infection control issues highlighted from the observations of care. A clinical leader in an acute trust described infection control issues around MRSA side rooms; subsequently, teaching sessions were to be given by the link nurse regarding correct procedures when dealing with MRSA patients. The clinical leader also described raising staff awareness of MRSA by introducing a coloured apron system, so that staff entering the MRSA side rooms wore a coloured apron which was different from the colour of the aprons worn when working in other clinical areas.

Hand washing was indicated as an area for action by another clinical leader, who described re-educating staff with regard to the infection control policy. Similarly another clinical leader identified infection control issues affecting all staff including ward staff, physiotherapists and ECG technicians. The action plan described discussing the issues at all meetings and handovers, giving feedback to physiotherapists, to wear white aprons when attending to patients. Cross infection between patients of all wards was highlighted as an issue for discussion with ECG technicians who would be advised about hand washing and wearing aprons.

Health and safety issues

Some clinical leaders described the disposal of rubbish and soiled linen as an area of concern in their action plans. One clinical leader stated that bin containers would be purchased as well as ensuring an adequate supply of rubbish bags. Another clinical leader stated that the importance of emptying of linen skips would be communicated to the staff. Inadequate room for the storage of wheelchairs was an issue identified for action by another clinical leader.

Another issue mentioned by a clinical leader was the need to ensure that commodes were being used appropriately, when transporting patients. Additionally, following an observation of care, the same clinical

leader had noticed that intravenous infusion bags were being hung on the toilet cistern when patients were using the toilet facilities. The clinical leader acted to order hooks from estates to install in the toilet area at an appropriate height. An observation of care by another clinical leader had led to the ordering of more steps, as some patients were seen to be struggling to get onto to hospital trolleys which were too high. Two clinical leaders had observed that the drug administration policy was not being followed correctly and both described instigating new systems to ensure that the policies were adhered to.

3.3.6.3 Team issues

Most clinical leaders noted in the action plans that interaction between patients and staff was friendly and professional. Some clinical leaders identified in the action plan the intention to celebrate with the team the high standards of interpersonal skills identified by the observations of care and patient stories. For example, one action plan, from a clinical leader from theatres described taking action to reduce the number of unnecessary staff in theatre during procedures. Another example from a clinical leader in a primary care trust described introducing a clinic assistant and discussing with her how she envisaged her role developing in the team.

3.3.6.4 Summary of the findings from the analysis of the action plans

Many of the actions and intentions identified in the analysis of the action plans are responses to commonly recognised problems in the NHS. Issues identified here, such as improving patient information, patient access to services, privacy and dignity issues, clean clinical environments, noise, infection control and health and safety issues, are commonly reported in evaluations of other quality improvement initiatives. However, what is novel in this instance is that the actions are not taken in response to national or local calls for improvements in these areas.

These issues are identified by patient-centred interventions designed to be used by clinical leaders within their own clinical areas. The patient stories give

service users an opportunity to engage in the process of change and improvement by describing the experience of care from their own perspective. In the observations

of care, change is stimulated from the professional perspective of clinical leaders actively observing the care within their own clinical environments.

Table 5 – Baseline levels for five leadership characteristics

Characteristic	Number of clinical leaders included	Mean (s.d)	95% Confidence interval
Self challenge	244	37.9 (7.9)	(36.9,38.9)
Self inspiring	244	38.0 (9.2)	(36.8,39.1)
Self enabling	244	47.8 (5.7)	(39.1,46.1)
Self modelling	244	43.8 (7.1)	(42.9,44.7)
Self encouraging	244	41.3 (8.2)	(40.3,42.3)
Manager challenge	226	40.1 (8.4)	(39.0,41.3)
Manager inspiring	225	39.7 (9.4)	(38.7,41.2)
Manager enabling	220	46.5 (6.4)	(45.5,47.3)
Manager modelling	227	45.9 (7.3)	(44.8,46.8)
Manager encouraging	221	43.7 (7.3)	(42.8,44.8)
Co-workers challenge	228	41.7 (6.9)	(40.8,42.7)
Co-workers inspiring	227	40.7 (8.2)	(39.7,41.9)
Co-workers enabling	223	46.9 (6.6)	(46.0,47.8)
Co-workers modelling	228	46.6 (6.8)	(45.8,47.6)
Co-workers encouraging	227	43.4 (8.0)	(42.3,44.5)
Direct reports challenge	225	42.8 (6.7)	(41.9,43.7)
Direct reports inspiring	225	42.5 (7.5)	(41.5,43.5)
Direct reports enabling	225	48.0 (6.8)	(47.2,49.0)
Direct reports modelling	225	47.7 (6.5)	(46.9,48.6)
Direct reports encouraging	223	43.8 (7.8)	(42.7,44.8)

3.3.7 360-degree Leadership Practices Inventory findings

The baseline Leadership Practices Inventory mean scores are presented in this section, so that the mean change scores can be considered in relation to the baseline mean scores.

3.3.7.1 Analysis of baseline data

The Leadership Practices Inventory aims to provide a 360-degree assessment of the clinical leader's leadership behaviour at the start of the programme (to establish areas for leadership development) and at the end of the

programme (to identify change in leadership behaviour over the course of the programme). The assessment is undertaken by the clinical leader (self-assessment), the manager, colleagues and people who directly report to the clinical leader. Each leadership domain incorporates six behaviours; each behaviour is scored from 1 (almost never) to 10 (almost always). Thus, each practice ranges from 6 to 60, with higher scores denoting better leadership skills.

The baseline level across all the leaders of the five leadership domains as assessed by self, manager, co-workers and people that report directly to the clinical leader (direct reports) was analysed. The number of baseline and post analysis entered for the change analysis ranges from 220 to 244. This is less than the

number entered for a baseline analysis, due to post programme data not being returned or being incomplete.

Table 5 shows the mean, standard deviation (sd) and confidence interval of the 360-degree Leadership Practices Inventory score across all the clinical leaders. The table also indicates how many clinical leaders are contributing to the descriptive statistics for each characteristic.

Table 5 shows that the mean scores for the direct reports are consistently higher than the mean scores for clinical leaders' self-assessment. Similarly, the scores for the manager and co-worker are higher than the clinical leaders' self-assessment in scores in all domains except for enabling where the scores are; self 47.8, manager 46.5, co-worker 46.9. Conversely, the direct report scores with a mean of 48.0 are higher than the self-score for the clinical leaders.

This is in contrast to the validation studies of the authors of the measure, Posner and Kouzes (1988, 1993), where higher baseline self-scores were found, although the difference was not statistically significant. The mean scores for the clinical leaders in all domains and as assessed by all respondents showed above-average scores; as the clinical leaders occupied F, G, H and I roles, it could be assumed that they already are showing some leadership capability.

3.3.7.3 Change in 360-degree Leadership Practices Inventory scores

The mean change in score can be tested for clinical leaders who have baseline and post Leadership Practices Inventory assessment data. This can be done

Table 6 – Change analysis for 360-degree Leadership Practices Inventory from before to after completion of the CLP

Characteristic	Number of clinical leaders included	Mean (s.d)	95% Confidence interval	p-value
Self challenge	162	8.2 (7.9)	(6.9,9.3)	<.001
Self inspiring	161	8.4 (8.8)	(7.1,9.8)	<.001
Self enabling	161	4.6 (6.6)	(3.5,5.6)	<.001
Self modelling	160	6.0 (7.6)	(4.8,7.2)	<.001
Self encouraging	158	6.9 (8.3)	(5.6,8.1)	<.001
Manager challenge	141	5.9 (8.7)	(4.4,7.3)	<.001
Manager inspiring	140	5.9 (9.7)	(4.2,7.3)	<.001
Manager enabling	134	4.0 (6.7)	(2.8,5.2)	<.001
Manager modelling	140	4.5 (7.6)	(3.2,5.8)	<.001
Manager encouraging	135	5.2 (8.5)	(3.8,6.7)	<.001
Co-workers challenge	151	3.6 (6.9)	(2.5,4.7)	<.001
Co-workers inspiring	149	4.5 (7.5)	(3.2,5.7)	<.001
Co-workers enabling	145	3.2 (6.8)	(2.1,4.3)	<.001
Co-workers modelling	149	3.4 (6.1)	(2.4,4.4)	<.001
Co-workers encouraging	147	3.7 (7.6)	(2.5,4.9)	<.001
Direct reports challenge	144	2.6 (6.1)	(1.6,3.6)	<.001
Direct reports inspiring	143	3.0 (6.6)	(1.9,4.1)	<.001
Direct reports enabling	143	1.4 (6.4)	(0.4,2.5)	0.006
Direct reports modelling	142	1.6 (6.0)	(0.6,2.6)	0.001
Direct reports encouraging	139	2.4 (6.5)	(1.3,3.5)	<.001

for each characteristic using a t-test. For all five characteristics for self and manager, co-workers and direct reports the mean change in score is significantly different to zero, showing that in all domains, the mean score has significantly increased after the CLP leadership intervention.

Table 6 shows the mean difference, the p-value and the 95% confidence interval for the mean difference. The mean change scores for self-assessment range from 4.6 to 8.4. For manager assessment the mean change scores vary from 4.0 to 5.9. For co-worker assessment the mean change scores vary from 3.2 to 4.5. For the direct report assessments, the mean change scores vary from 1.6 to 3.0.

The assessment of changes in leadership domains was analysed to see if the scores vary for self, manager, co-worker or direct reports (Table 7).

For each leadership domain we explore whether the mean difference for the domain is the same, or not, for each of the four 360-degree respondent groups by using a one-way analysis of variance (ANOVA) technique. The results are summarised in Table 7.

The difference in change scores between the 360-degree Leadership Practices Inventory for all respondent groups is statistically significant at the 5% level. The ordering of the results show that the change score reduces in descending order from the self, manager, co-worker and direct reports. It may be hypothesised that this pattern of analysis could be explained in a number of ways:

1. The manager, co-worker and direct reports were higher at baseline, except for the enabling domain for manager and co-worker. Therefore, it could also be surmised that the higher change scores of the clinical leaders are related to their increasing

confidence in their leadership capability. The finding that the self-score was generally lower at baseline contrasts with the original validation studies of the measure, which show a higher baseline self-score. This raises a question about whether it is only nurses, in contrast to leaders from other disciplines and professions, who rate a lower self-score at baseline.

2. Finally, it may be that clinical leaders become more aware of their increased knowledge and intention to utilise new leadership behaviours, before changes in leadership behaviour become apparent to others. This would echo the second stage of Kolb's (1984) four stages of experiential learning, whereby clinical leaders are aware of changes but have not yet assimilated them into new behaviours yet.
3. Conversely it may show that the clinical leaders rated more highly their leadership capabilities. However, statistically significant change scores are reported from the other respondents assessing the leadership behaviour of the clinical leader.

3.3.7.4 Clinical leader evaluation of the 360-degree Leadership Practices Inventory

In total, 66 clinical leaders from the case study site respondent group contributed to the evaluation questions about the 360-degree Leadership Practices Inventory (72% response rate).

Figure 7 shows that of the 66 participants, 62 (94%) agreed or strongly agreed that the 360-degree Leadership Practices Inventory was useful for understanding leadership development needs.

Table 7 — Change analysis for 360-degree Leadership Practices Inventory from before to after completion of the CLP

Characteristic	Change score				p-value
	Self	Manager	Co-worker	Direct Report	
Challenging	8.2	5.9	3.6	2.6	<.001
Inspiring	8.4	5.9	4.5	3.0	<.001
Enabling	4.6	4.0	3.2	1.4	<.001
Modelling	6.0	4.5	3.4	1.6	<.001
Encouraging	6.9	5.2	3.7	2.4	<.001

Figure 7 — Responses to the statement “I found the 360-degree Leadership Practices Inventory a useful tool for understanding my leadership development needs”

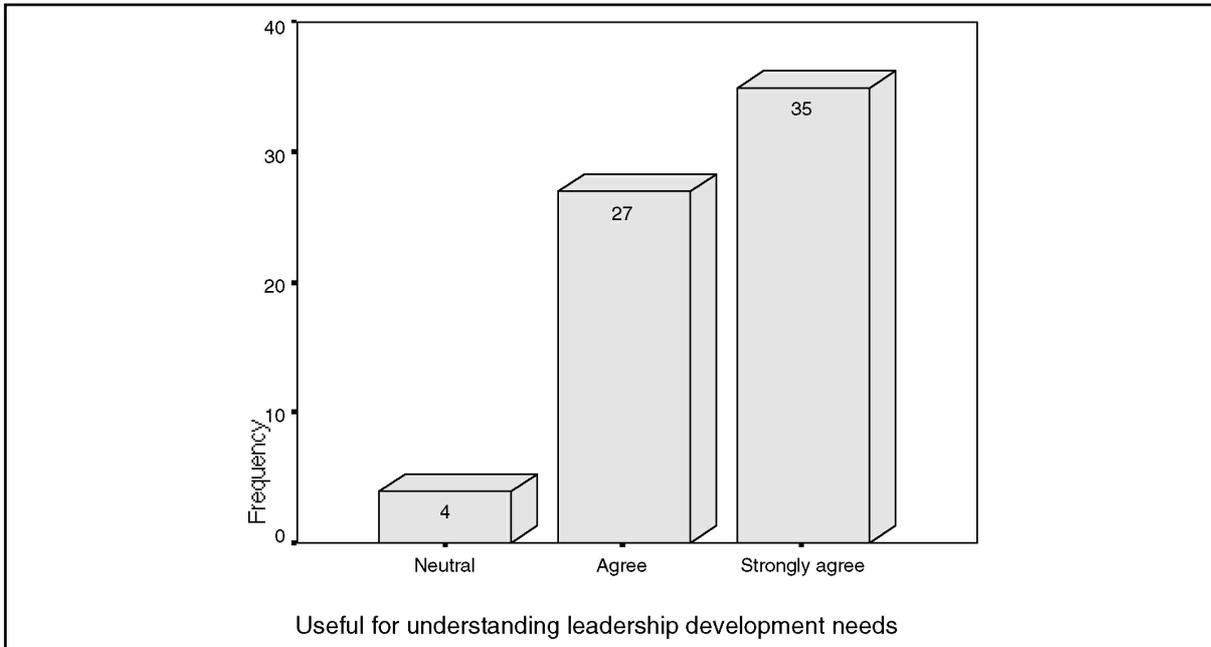


Figure 7 shows that of the 66 participants, 62 (94%) agreed or strongly agreed that the 360-degree Leadership Practices Inventory was useful for understanding leadership development needs.

Figure 8 — Responses to the statement “I found the 360-degree Leadership Practices Inventory useful for developing my professional development plan”

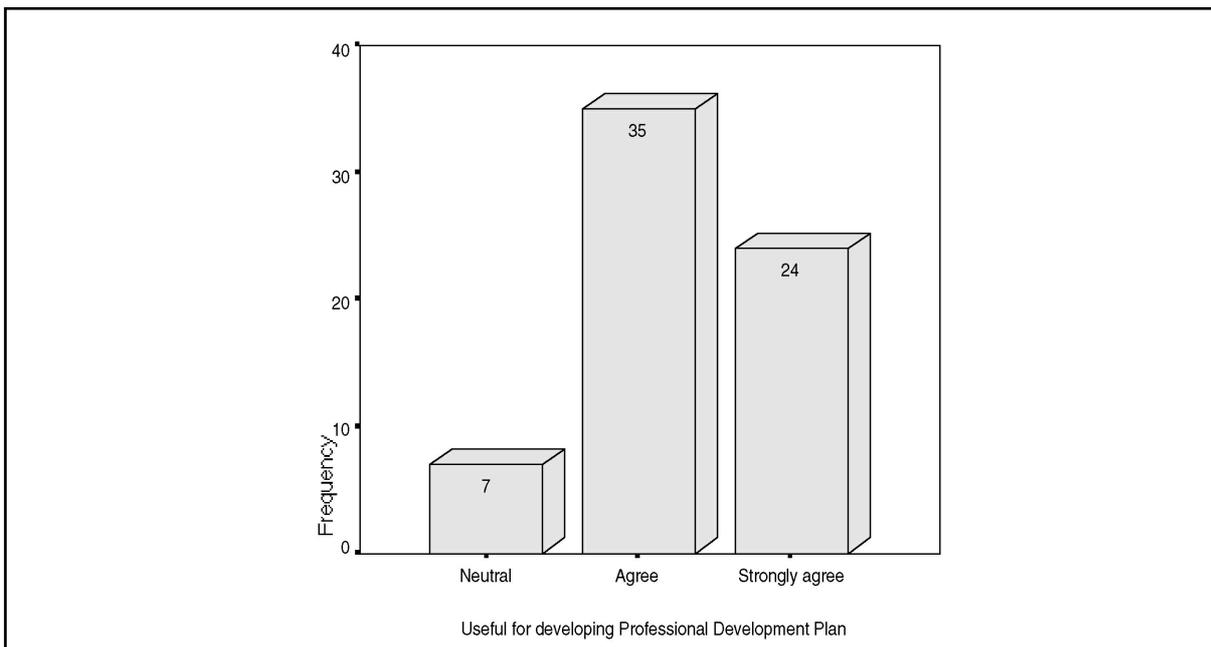


Figure 8 shows that 59 (89%) of the 66 participants found the 360-degree Leadership Practices Inventory useful for developing their personal development plan.

Figure 9 — Responses to the statement “It was useful to have a measure of how others perceive my leadership capabilities”

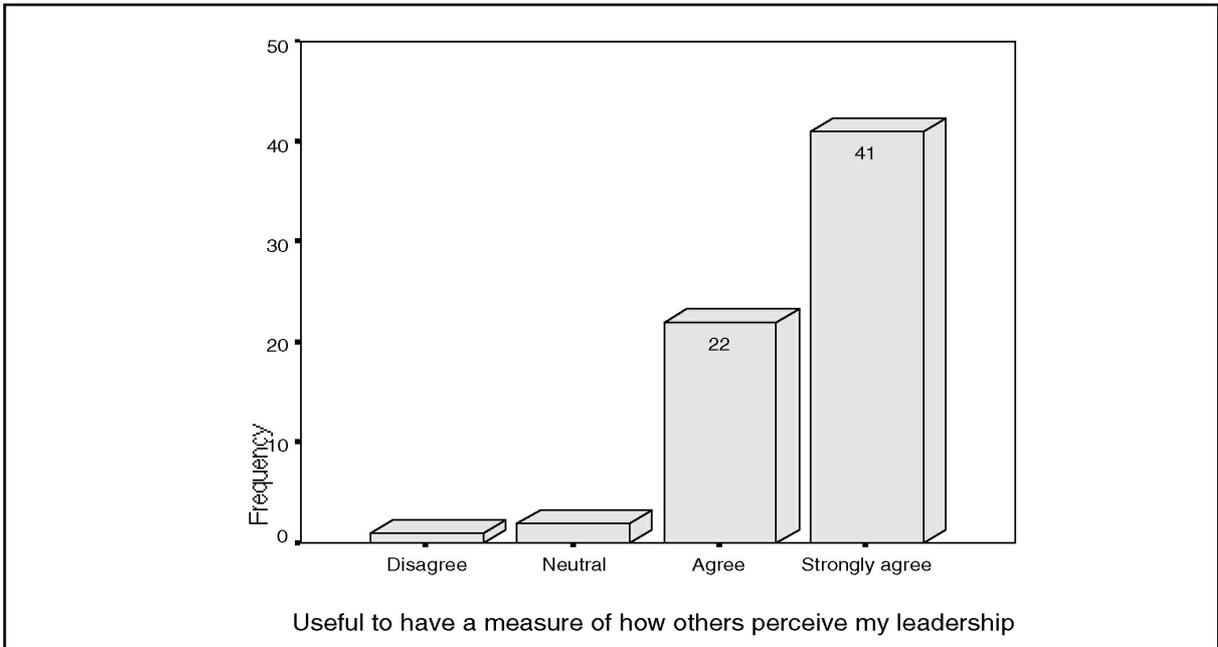


Figure 9 shows 63 (95%) of the 66 participants agreed or strongly agreed that it was useful to have a measure of how other perceive their leadership capability.

Figure 10: Responses to the statement “The 360-degree Leadership Practices Inventory was able to show changes in my leadership capability over time”

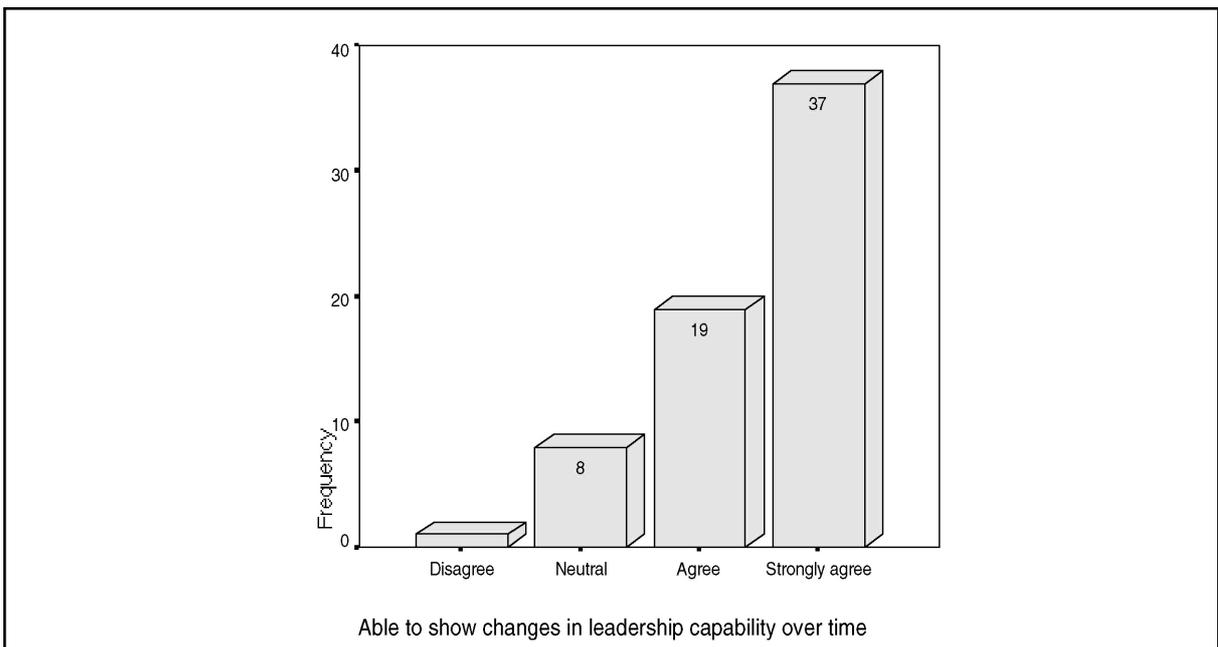


Figure 10 shows that 56 (85%) of the 66 participants agreed or strongly agreed with the statement that the 360-degree Leadership Practices Inventory was able show changes in leadership capability.

Figure 11 — Responses to the statement “The terminology used in the 360-degree Leadership Practices Inventory was easy to understand”

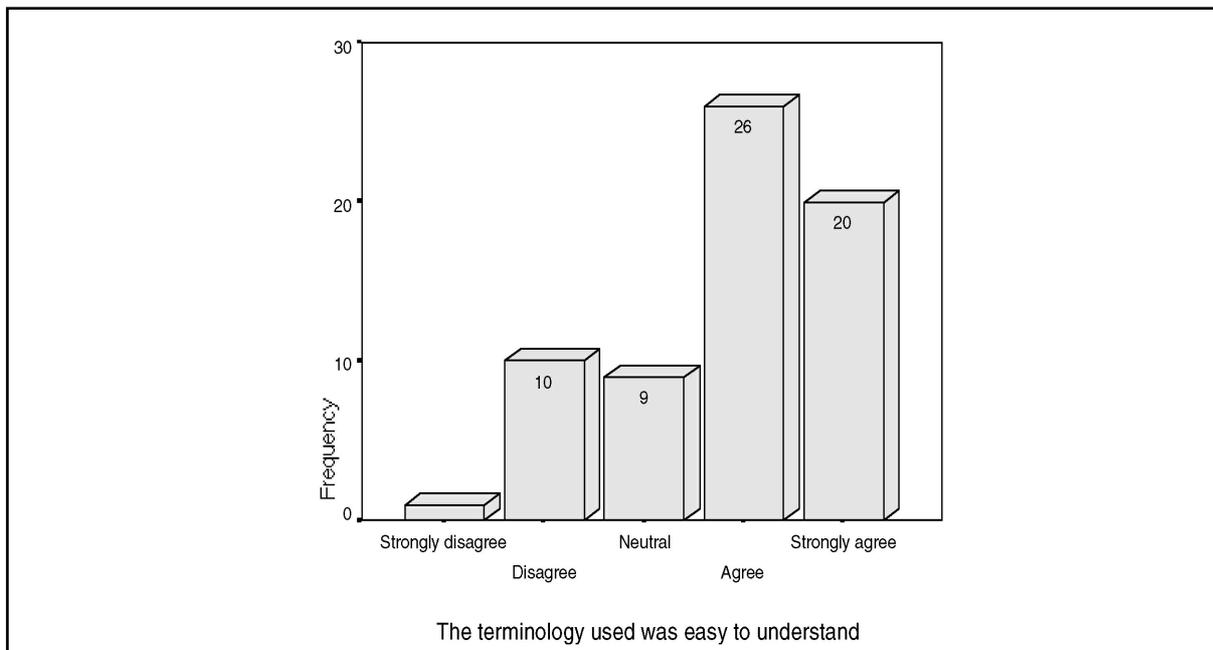


Figure 11 shows that 46 (69%) of the 66 participants agreed or strongly agreed that the terminology in the 360-degree Leadership Practices Inventory was easy to understand. However, 10 (15%) disagreed with this statement and one respondent strongly disagreed. This result suggests that the readability of the measure may require further investigation.

3.3.7.5 Summary of the 360-degree Leadership Practices Inventory findings

The Leadership Practices Inventory has been subjected to extensive reliability and validity testing by its authors (Posner and Kouzes 1988; 1993). The number of people contributing to the change analysis of the 360-degree Leadership Practices Inventory varied between 134 and 162 people. The mean difference for all leadership domains measured by the 360-degree Leadership Practices Inventory showed a statistically significant increase by the end of the programme, when measured against the scores at the beginning of the programme.

This indicates a positive change in leadership behaviours, as measured by the self, managers, co-workers and people who directly report to the clinical leaders (the 360-degree Leadership Practices Inventory respondent groups). The difference between the change scores of the 360-degree Leadership Practices Inventory respondent groups was significantly different at the 5%

level. The clinical leaders’ self-score had the largest change in mean scores at the end of the programme, followed by manager, co-workers and direct reports. This result may be explained in the following ways:

1. The manager, co-worker and direct reports were higher than the clinical leader assessment at baseline, except for the enabling domain for manager and co-worker. Therefore, it could also be surmised that the higher change scores of the clinical leaders are related to their increasing confidence in their leadership capability. The finding that the self-score was generally lower at baseline contrasts with the original validation studies of the measure, which show a higher baseline self-score. This raises a question about whether it is only nurses, in contrast to leaders from other disciplines and professions, who show a lower self-score at baseline.
2. It may be that clinical leaders become more aware of their increased knowledge and intention to utilise new leadership behaviours before changes in leadership behaviour becomes apparent to others.

3. Conversely it may show that the clinical leaders rated more highly their leadership capabilities, however, statistically significant change scores are reported from the other respondents assessing the leadership behaviour of the clinical leader.

The contribution of the 360-degree Leadership Practices Inventory was evaluated as follows:

- ◆ 62 (94%) of the 66 participants agreed or strongly agreed that the 360-degree Leadership Practices Inventory was useful for understanding leadership development needs.
- ◆ 59 (89%) of the 66 participants found the 360-degree Leadership Practices Inventory useful for developing their personal development plan.
- ◆ 63 (95%) of the 66 participants agreed or strongly agreed that it was useful to have a measure of how other staff perceive their leadership capability.
- ◆ 56 (85%) of the 66 participants agreed or strongly agreed with the statement that the 360-degree Leadership Practices Inventory was able show changes in leadership capability.
- ◆ 46 (69%) of the 66 participants agreed or strongly agreed that the terminology in the 360-degree Leadership Practices Inventory was easy to understand. However, 10 disagreed with this statement and one participant strongly disagreed. This result suggests that the readability of the measure may require further investigation.

4. Discussion

The pre-eminent finding of this study is the positive change in leadership capability of clinical leader participants. The Leadership Practices Inventory (Posner and Kouzes 1988; 1993) data were collected from a random selection of the 1,052 clinical leaders undertaking Phase 3 of the CLP, and from clinical leader participants from the 16 case study sites at the beginning and end of the 12 month CLP. In addition, a Leadership Practices Inventory assessment relating to the clinical leaders in the sample was collected from managers, co-workers and staff who report directly to the clinical leaders enabling a 360-degree assessment of change in leadership capability of the clinical leaders. The analysis of baseline and post leadership assessment data shows statistically significant change in all the leadership domains.

Thus, self-challenging, self-inspiring, self-enabling, self-modelling and self-encouraging domains showed statistically significant positive change in a self-assessment, manager assessment, co-worker assessment and assessment from people who directly report to the clinical leader. The qualitative findings, from 16 clinically diverse case study sites, shows how clinical leaders, patients, local facilitators and the heads or directors of nursing within each trust described changes in the leadership capability of the clinical leaders and the attributed impact on patient care, clinical practice, team effectiveness and the organisation.

The clinical leaders' self-score had the largest change in mean scores for the Leadership Practices Inventory (Posner and Kouzes 1988; 1993) at the end of the programme, followed by manager, co-workers and direct reports. A number of hypotheses were suggested to explain why clinical leaders have the largest change score. At the baseline assessment, managers, co-workers and direct reports were higher than the clinical leader assessment, except for the enabling domain for manager and co-worker. It could also be surmised that the higher change scores of the clinical leaders are related to their increasing confidence in their leadership capability. Increasing confidence of clinical leaders was also shown in the interview findings from all staff on all case-study sites.

The finding that the self-score was generally lower at baseline contrasts with the validation studies of the

Leadership Practices Inventory (Posner and Kouzes 1988; 1993), which show a higher baseline self-score. This raises a question about whether it is only nurses, in contrast to leaders from other disciplines and professions, who show a lower self-score at baseline. Secondly, it may be that clinical leaders become more aware of their increased knowledge and intention to utilise new leadership behaviours before changes in leadership behaviour becomes apparent to others. Conversely, it may show that the clinical leaders rated more highly their leadership capabilities.

However, statistically significant change scores are reported from the other respondents assessing the leadership behaviour of the clinical leaders, which would appear to counter this argument. A total of 62 (94%) of the 66 Leadership Practices Inventory evaluation participants agreed or strongly agreed with the statement that the measure was useful for understanding leadership development needs. In addition, 63 (95%) of the 66 participants agreed or strongly agreed that it was useful to have a leadership measure of how other staff perceive their leadership capability. Also, 56 (85%) of the 66 participants agreed or strongly agreed with the statement that the measure was able to show change changes in leadership capability. A lower number (46 or 69%) of participants agreed or strongly agreed that the terminology of the measure was easy to understand. However, 10 participants disagreed and one participant strongly disagreed with this statement. This suggests that the readability of the measure may require further investigation.

The experiential nature of the CLP and programme interventions, which link directly to patient care, clinical practice and team development, were highly evaluated by the clinical leaders, colleagues, local facilitators and directors of nursing informants from the 16 case study sites.

4.1 Clinical leadership development

Directors of nursing highlighted the length and relevancy of the programme as a factor that will potentially contribute to the sustainability of the leadership development of the clinical leaders involved.

Most patients identified the ward manager or sister as the person leading care in the clinical area. This finding suggests that most patients appeared to assume that the person occupying the formal hierarchical role would also be the person providing clinical leadership in the clinical area. Some patients said, however, that because staff nurses provided most clinical care they were most likely to provide clinical leadership. This description appears to support the view that different grades of staff are required to, and do, show leadership behaviour within their own sphere of clinical practice.

Some service users recognised that team working was an important element of leadership and described the benefit of clinical leaders sharing information with their team, particularly as it promotes a common understanding of how care should be delivered. Some patients were less certain about who provided clinical leadership and cited instead the tasks undertaken by staff or the uniforms that nurses wear as a way of identifying clinical leaders. Service users identified the leadership characteristics required by clinical leaders as: confidence, being observant, listening, following through with actions, dealing with outstanding issues, being friendly, helpful, giving feedback and dealing with a concern or complaint in a confidential and effective way.

Clinical leaders reported developing confidence as an important area of their increasing leadership capability; colleagues, local facilitators and heads/directors of nursing also confirmed this viewpoint. Clinical leaders mostly attributed their developing confidence to the initial programme focus on the self-development. Clinical leaders clearly had found beneficial what Cacioppe (1998) described as improving self-knowledge as a basis for leadership development.

The development of assertiveness skills, particularly the ability to challenge organisational and patient care issues, was perceived to be a noticeable change in clinical leaders by the end of the programme and was reported by all staff respondent groups. The clinical leaders' enhanced leadership capability at the end of the programme was described by all staff respondent groups and was confirmed by the highly statistically significant changes in the baseline and post analysis of the 360-degree Leadership Practices Inventory.

4.2 Improving patient care and clinical practice

The consensus of all the staff respondent groups interviewed is that patient stories and observation of care are central for linking with and achieving improvement in patient care and clinical practice. Local facilitators described patient stories and observations of care as powerful enablers of change. Heads/directors of nursing described them as really capturing the imagination because of the impact on care and clinical practice. The other programme interventions, particularly action learning and one-to-ones, were described as having a role in patient stories and observations of care, by providing opportunities for reflection and rehearsal of necessary change strategies.

In the early stages of programme implementation, the clinical leaders from theatres and health visiting described some difficulty in implementing patient stories in their clinical environments. This was described in respect of feeling powerless to take action about the issues identified by patients which clinical leaders believed were outside their sphere of influence. However, by the end of the programme these clinical leaders cited areas of substantial change related to undertaking patient stories

Most clinical leaders and local facilitators identified the necessity of having organisational opportunities for addressing some of the complex issues identified in patient stories and observations of care. Successful strategies to create the organisational opportunities were identified as the Leadership Steering Group and working with clinical governance, Essence of Care, and patient advocacy and liaison services. Patient and staff informants viewed patient stories as a positive way to elicit patients' views about the care and service they had received; ensuring patients were having an input into improving the quality of care and practice within clinical environments.

4.3 Increasing team effectiveness

Clinical leaders, colleagues and local facilitators gave examples of clinical leaders transferring skills and strategies into their clinical environments. A number of examples were given. For example, clinical leaders

described valuing team members more, involving colleagues more in decision-making, sharing knowledge more with the team, giving more feedback and facilitating greater autonomy in team members

The colleagues described an expectation that clinical leaders would become more of a role model in the clinical area. The patient stories and observations of care and the subsequent related action planning were evaluated as successful activities in respect of involving teams in the programme processes and thus increasing team effectiveness. Patient stories and observations of care were described as a way of celebrating good practice as well as highlighting areas for improving care and developing practice.

4.4 Organisational integration of clinical leadership

Most directors of nursing expressed strong organisational support for the development of clinical leaders. Most heads/directors of nursing described establishing a Leadership Steering Group, to ensure there was trust board commitment and integration of patient-centred initiatives more widely across trusts. The clinical leaders were perceived by some directors of nursing to be in a position to substantially contribute to trust-wide policy initiatives such as the Essence of Care and clinical governance agendas.

All the directors of nursing described noticeable changes in the clinical leaders, after they had undertaken the programme, such as increased confidence, having a more patient-centred approach and having a broader trust perspective. These changes were attributed to the clinical leaders undertaking the CLP. Clinical leaders described communicating more effectively with managers and collaborating with colleagues across the trust in quality improvement initiatives.

One outcome described by different participant groups is the perception that the clinical leaders participating in the CLP are re-energised in their approach to their role and this enables them to develop and maintain continuously improving patient care environments. Some clinical leaders described how they increasingly valued their contribution to patient care, which for some acted as an incentive to remain in a clinical career.

The leadership development of participants in this

study clearly resonates with the aim of leadership described by Borrill et al. (2002) as being “to create a strong and unified culture with an emphasis upon innovation and patient care”.

4.5 Concerns identified

A number of concerns were identified during the interviews: clinical leaders, local facilitators and head/directors of nursing identified their concern about staff taking their full negotiated time to undertake the programme activities. The cost evaluation and the clinical leader interviews identified that a number of the clinical leaders spent less than the initially agreed and negotiated 20% of their time on programme related activities.

However, even with the less than negotiated time described there remains strong evidence of positive change at the individual, patient, team and trust level. It is difficult to unravel whether the clinical leaders should negotiate fewer hours for the programme or whether taking the full allocated time would result in more profound impact. The varying times that clinical leaders participated in programme activities resulted in equivocal findings of the cost analysis aspect of the study. Further research will be required to undertake a more illuminating cost analysis.

A further staffing issue concerned the quality of some of the programme components if a local facilitator was absent for a period of time. In addition, the nature of the local facilitator role, in respect of whether it should be a full-time or part-time post, emerged during the local facilitator interviews in the final stage of interviews. Some local facilitators were part-time and believed there were benefits to the role being part-time; other facilitators who were full-time described the benefits of having a full-time local facilitator.

This finding did not emerge until the final interviews and therefore, was not really resolved in the current study. It will require further investigation to explore and subsequently understand the implications of a full or part-time facilitator for future programme development.

Some clinical leaders felt a little unprepared for an experientially based programme of development and suggested more pre-programme information.

4.6 Limitations of the research design

It has been argued that case study research is a poor basis for generalisation (Stake, 1995). This criticism is based on traditional sampling theory, which in turn is based on how representative the sample selection is and the consequent ability to make inferences about a population. However, the multiple-case study approach adopted in this research ensured that a maximum range of participants from differing clinical environments were involved in the evaluation; increasing the case diversity and number in this way has been described as a way to increase the generalisability (Bryar, 1999). Therefore, the research generalises to the theoretical propositions (analytic generalisation to the propositions) rather than statistical generalisation. Evidence from multiple-case studies is described as more robust than that from single case studies, because it incorporates 'replication logic'. This is where the results of one case study are compared or matched with the results of subsequent ones (Yin, 1994).

As the researchers evaluating the impact of the CLP were part of the CLP team, the researcher 'insider-outsider' debate will need to be addressed. The major disadvantage of an inside evaluator is that objectivity may be compromised, and there may be a vested interest to evaluate the programme in a favourable light.

However, to limit the potential of this occurring, there were external members on the steering and advisory groups and the evaluators, and clinical leadership team remained aware of the potential of biased reporting. There were, however, a number of advantages of being insider evaluators. Firstly, the researchers were able to clarify and more quickly understand the complex processes of the programme and the various levels of impact. Secondly, the findings of the research are more likely to be assimilated into the further development of the programme. Finally, because of the relationships they had developed within the trusts, the programme facilitators assisted the researchers to access the research sites which reduced the potential difficulties in gaining access to research sites.

Because this evaluation ran concurrently with Phase 3 of the CLP, the issue of how to sustain the clinical leadership development within trusts was not fully explored within this research design. However, some participants talked about the length and clinical focus

of the programme sustaining leadership development. Further research will be required to understand if and how clinical leadership is sustained, and what happens to the careers of the participants of the CLP.

5. Conclusions and recommendations

5.1 Conclusion

Supporting clinical staff to develop leadership capability, that in turn transforms care to be more centred on the expressed needs of patients and simultaneously develop the effectiveness of teams, is extremely challenging. The findings of the multiple-case study evaluation of the CLP and the baseline and post Leadership Practices Inventory provides powerful evidence, showing both the development of leadership capability for individuals in the study and also how the programme interventions support staff to translate their personal development and learning into activities that impact on improving patient care, clinical practice, team effectiveness and more widely across the trust.

The multiple case study evaluation has shown that clinical leaders from a wide range of clinical practice areas developed a more patient-centred approach to their work, which they attribute to the CLP. Leadership change is confirmed in the triangulated data of the qualitative interviews of the key stakeholders and in the findings of the more broadly applied baseline and post 360-degree Leadership Practices Inventory.

The clinical leaders describe a commitment to improving patient care and developing team effectiveness, shown in the team goal setting and action planning described. These strategies promote a greater alignment of the team and thus promote greater team effectiveness. The clinical leaders are more confident in their leadership approach and have a greater sense of value and optimism about their clinical roles. The findings show a greater sense of appreciation of the contribution of individuals within the teams, with a greater intention to share knowledge and facilitate the

development of other members of the team. The clinical leaders gave examples of how they were developing ways to constructively confront and resolve difficulties in their clinical environments.

The CLP clearly offers one way of delivering the leadership development crucial to translating the national and trust-level policy agenda in providing more patient-centred care. The conceptual framework of the programme (learning to manage self, patient focus, developing effective relationships, networking and political awareness) provided a clear structure for clinical leaders to develop, conceptualise and describe their leadership development.

5.2 Recommendations

The 16 recommendations that arise from this study are presented in relation to some of the key stakeholders. However, some of the issues are clearly not located within one key group and should not be considered to be the sole responsibility of the stakeholder identified. Recommendations are outlined that require consideration or action from the CLP, trusts and local facilitators. The recommendations focus on issues related to the provision of information, individual and trust support, time management, closer collaboration and communication with patients and the development of outcome indicators to measure the impact of leadership development within trusts.

5.2.1 CLP recommendations

1. Provide more pre-programme information to local facilitators and clinical leaders about the experiential learning principles underpinning the CLP.
2. Before implementing the programme in a trust, there should be discussion with trusts about managing the absence of a local facilitator, if that should become necessary.
3. Explore further what recommendation should be made to trusts about how much time clinical leaders should allocate to leadership development, in order to achieve full personal and professional impact.
4. Further explore the implications for the role and outcomes of the programme of a part-time local

facilitator as opposed to a full-time facilitator.

5. Explore the requirement for the number and timing of the patient stories and observations of care.
6. Provide more support and guidance with implementing patient stories and other programme interventions in clinical areas, where the immediate transferability appears less obvious in the early stages of programme implementation.
7. Further explore how to meaningfully engage very vulnerable patients in patient stories.
8. The readability, sensitivity and findings of the 360-degree Leadership Practices Inventory should be explored further.
9. Explore the feasibility of monitoring patient complaints and staff retention and recruitment in programme implementation areas as outcome indicators of the impact of the CLP.
10. Further research is required to undertake a more accurate cost analysis of the CLP.

5.2.2 Trust recommendations

1. It should be considered a minimum standard to have a Leadership Steering Group, with formal links with clinical governance and patients advocacy liaison services, in all trusts where staff undertake the CLP.
2. There should be patient representation on trust Leadership Steering Groups, in order to raise patient awareness about clinical leadership and help staff reflect and further learn from the experiences of patients.
3. Ensure that there are processes in place for shared learning across the organisation to promote continuously improving patient care environments.

5.2.3 Local facilitator recommendations

1. Give a clearer indication of the purpose and development opportunity of the one-to-ones, to ensure that this intervention of the programme meets the needs of clinical leaders.

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Appendix 1

Clinical area characteristics

Of the 16 clinical area profiles distributed, 15 (94%) were returned. These participants were from eight acute clinical areas (53%), two from mental health clinical

areas (13%), three from settings within the community or primary care (20%), one from a learning disabilities site (7%) and one from A&E (7%). The average number of new patients in a six-month period ranged from three to 20,500, which highlights the different nature of these clinical areas. Likewise, the length of stay of patients varied substantially, with the minimum length of stay 30 minutes (A&E) and the longest length of stay 4.5 years (health visiting).

Table 8 – Clinical area characteristics

Clinical Area*	Average number of new patients in a six-month period	Average length of stay of patients
Health visiting	120	Up to 4.5 years if staying with same GP
Medical diabetology ward	44	14 to 20 days
Medical Ward	300	1 week to 1 month
Theatres	700	2.5 hours
Mother and baby psychiatry unit	60	3 to 6 months
A&E	20,500	30 minutes to 48 hours
Gastroenterology ward	300	5 days
Orthopaedics ward	1250	5.2 days
Cardiac care	500	48 hours
Acute psychiatric ward	100	69 nights
Surgical ward	630	4.27 days
District nursing	240	
Learning disabilities	3	4 years
Elderly rehabilitation	90	6 weeks
Special care baby unit	102	14 to 21 days

Table 9 – Average number of new patients in a 6-month period in the clinical area

	Number of trusts*	Number (range) of new patients in a 6-month period	Average length of patient stay
Acute	8	44 to 1,250	2.5 hours, to 1 week, to 1 month
Mental Health	2	60 to 100	69 nights, to 3 to 6 months
Community/PCT	3	90 to 240	6 weeks to 4.5 years, if stay with same GP
Learning Disabilities	1	3	4 years

*Clinical area profiles from Trust 6 (A&E) and Trust 8 (NHS Direct) are outstanding.

Appendix 2

Patient letter



Dr Shirley Large
Senior Research Fellow

Royal College of Nursing
20 Cavendish Square
London
W1G 0RN
Telephone 0207 647 3951
Mobile 07810 525213

Email shirley.large@rcn.org.uk

Dear

Re: A research evaluation of the Royal College of Nursing Clinical Leadership Programme

I would like to ask you for your help in an evaluation research project currently being undertaken by the Royal College of Nursing. The evaluation research is jointly funded and supported by the Department of Health and the Royal College of Nursing.

The purpose of the research is to collect information about the Royal College of Nursing Clinical Leadership Programme and how this may influence the quality of patient care. The RCN Clinical Leadership Programme is being funded in 96 health trusts in England to help develop the leadership skills of nurses. It is believed that developing and strengthening nursing leadership will result in a better quality care for patients. Your involvement in the research may not have direct benefit on your care but it may influence the care given to future patients.

I would be most interested to talk to you about your opinions and beliefs about leadership in the NHS and how this may affect your experience of being a patient. Nursing staff from 16 trusts across England will identify lists of patients who they believe would be suitable and able to take part in the research. If you agree to contribute to the research an appointment would be made with you at your convenience and I would ask you to sign a consent form. The interview would take approximately 30 minutes and we would talk in quiet place where we cannot be overheard. With your permission the interview will be tape-recorded. A secretary at the Royal College of Nursing will, in confidence, type up the tapes in full. However, all tapes will be erased after the interview has been typed up and the transcripts of the interview would be stored in a locked filing cabinet. Only common themes from the transcripts and anonymous quotes will be used in reporting the findings of the research. Therefore, no individual person will be identified and all of your answers would be treated confidentially.

You are under no obligation to take part in the research and you are free to withdraw from the research at any time without needing to give an explanation. A number of patients are being approached to take part in this research, if you decide not take part your health-care would not be affected in any way.

I will speak to you again tomorrow to find out if you agree to being involved in this research.

If you have any questions at all please telephone the local Royal College of Nursing Clinical Leadership Facilitator, <insert name and telephone number>. The RCN Clinical Leadership Facilitator will be able to answer your questions or contact me immediately to get in touch with you.

Thank you for taking the time to read this letter.

Yours sincerely,

Dr Shirley Large
Senior Research Fellow

Appendix 3

360-degree Leadership Practices Inventory

1 <i>Almost Never</i>	2 <i>Rarely</i>	3 <i>Seldom</i>	4 <i>Once In a While</i>	5 <i>Occasionally</i>	6 <i>Sometimes</i>	7 <i>Fairly Often</i>	8 <i>Usually</i>	9 <i>Very Frequently</i>	10 <i>Almost Always</i>
1. I seek out challenging opportunities that test my own skills and abilities.									<input type="checkbox"/>
2. I talk about future trends that will influence how our work gets done.									<input type="checkbox"/>
3. I develop co-operative relationships among the people I work with.									<input type="checkbox"/>
4. I set a personal example of what I expect from others.									<input type="checkbox"/>
5. I praise people for a job well done.									<input type="checkbox"/>
6. I challenge people to try out new and innovative approaches to their work.									<input type="checkbox"/>
7. I describe a compelling image of what our future could be like.									<input type="checkbox"/>
8. I actively listen to diverse points of view.									<input type="checkbox"/>
9. I spend time and energy on making certain that the people I work with adhere to the principles and standards that we have agreed on.									<input type="checkbox"/>
10. I make it a point to let people know about my confidence in their abilities.									<input type="checkbox"/>
11. I search outside the formal boundaries of my organisation for innovative ways to improve what we do.									<input type="checkbox"/>
12. I appeal to others to share an exciting dream of the future.									<input type="checkbox"/>
13. I treat others with dignity and respect.									<input type="checkbox"/>
14. I follow through on the promises and commitments that I make.									<input type="checkbox"/>
15. I make sure that people are creatively rewarded for their contributions to the success of our projects.									<input type="checkbox"/>
16. I ask, "What can we learn" when things do not go as expected.									<input type="checkbox"/>
17. I show others how their long-term interests can be realised by enlisting in a common vision.									<input type="checkbox"/>
18. I support the decisions that people make on their own.									<input type="checkbox"/>
19. I am clear about my philosophy of leadership.									<input type="checkbox"/>
20. I publicly recognise people who exemplify commitment to shared values.									<input type="checkbox"/>
21. I experiment and take risks even when there is a chance of failure.									<input type="checkbox"/>
22. I am contagiously enthusiastic and positive about future possibilities.									<input type="checkbox"/>
23. I give people a great deal of freedom and choice in deciding how to do their work.									<input type="checkbox"/>
24. I make certain that we set achievable goals, make concrete plans and establish measurable milestones for the projects and programs that we work on.									<input type="checkbox"/>
25. I find ways to celebrate accomplishments.									<input type="checkbox"/>
26. I take the initiative to overcome obstacles even when outcomes are uncertain.									<input type="checkbox"/>
27. I speak with genuine conviction about the higher meaning and purpose of our work.									<input type="checkbox"/>
28. I ensure that people grow in their jobs by learning new skills and developing themselves.									<input type="checkbox"/>
29. I make progress toward goals one step at a time.									<input type="checkbox"/>
30. I give the members of the team lots of appreciation and support for their contributions.									<input type="checkbox"/>

Appendix 4

First interview schedule for clinical leaders

Semi-structured interview schedule. Additional follow-up questions to clarify or describe particular points will be asked as necessary.

1 Biographical details

- i May I record your age?
- ii What are your qualifications?
- iii Describe your clinical area (i.e. type of clinical area and type of patients)
- iv Describe your Trust

2 Values, patient care and professional development

- i How is the nursing care in your clinical area organised?
- ii Do you have a written philosophy of patient care? Please elaborate.
- iii Do staff work to a philosophy of patient care?
- iv Do staff understand the philosophy of patient care?
- v How would you describe the quality of care in your clinical area?
- vi Have you identified any ways in which the quality of care could be raised?
- vii What sort of clinical governance initiatives are there currently in place in your clinical area?
- viii Have you identified any particular problems in the clinical area in the way that care is organised or delivered that may have a detrimental effect on patient care? Please describe.
- ix Do you believe you have good teamwork in your clinical area- give examples of teamwork?
- x Do you work well with all the other non-clinical area based health care staff that are involved with care? Give examples.
- xi Are there any current research initiatives/projects underway in your clinical area?

- xii What professional development programmes are there for staff from your clinical area?

3. RCN CLP expectations

- i How would you define leadership?
- ii How would you describe your current leadership attributes?
- iii What do you believe are your current strengths as a leader and what does this mean in practice?
- iv Name three specific skills you hope to develop or build on over the course of the RCN Clinical Leadership Programme.
- v Can you explain why you would like to develop the leadership skills identified?
- vi How would the leadership skills identified benefit a) patient care, b) the clinical area and c) the Trust?
- vii Do you believe clinical area is open to change and keeping pace with developments in clinical practice — if so how?
- viii Are there any particular barriers to change that you can identify?

4. Job satisfaction

- i Do you feel satisfied with your job — if not why?
- ii Do you feel satisfied with your ability to influence the organisation of patient care — if not why?
- iii Do other staff in your clinical area of work feel satisfied with their job — if not why?

5 Follow-up interview

- i Will you agree to an interview during and at the end of the RCN Leadership Programme?

6 Opportunity to comment generally

Would you like to add anything that you think I may have missed? Would you like the opportunity to say anything in relation to the RCN Clinical Leadership Programme?

Thank you very much for your time.

Appendix 5

First interview schedule for patients

Thank you for agreeing to take part in this interview. I am now going to ask you some questions about the care you receive and what your beliefs are about leadership in the ward/clinical area. There are no right or wrong answers — we are just interested in your views. All of your comments are treated confidentially. With your permission I would like to tape record the interview.

- 1 Which service provides the care you receive?
- 2 Are you satisfied with this service?
- 3 From your point of view, what is good about the care you receive?
- 4 From your point of view, what is not so good about the care you receive?
- 5 Have you experienced any problems as a result of the care you receive?
- 6 What is your opinion about being involved in telling staff about your experience?
- 7 What is your experience of staff taking time to observe care in the ward/clinical area?
- 8 Do you feel that you are involved in planning your care?
- 9 Have you received enough information about:
 - ◆ The ward/clinical area?
 - ◆ The care you receive?
- 10 Have your relatives had opportunity to:
 - ◆ Talk to staff?
 - ◆ Be involved in discussions about your care?
- 11 Who would you say provides the leadership in the ward/clinical area?
- 12 Do you think there is good teamwork in the ward/clinical area?
- 13 If you had the chance to make some comments to the people who run the service, what would you say?

Thank you for your time. Have you any more you wish to say that you think is important?

Appendix 6

Mid-programme interview schedule for clinical leaders

- 1 What have you learned so far from the RCN CLP?
- 2 How has the programme contributed to the areas of learning you have identified?
- 3 What has not been beneficial to you with regards to your involvement with the RCN CLP? (Please explain).
- 4 How could these areas be addressed for future programmes?
- 5 What about the contribution of key programme interventions:
 - Personal development plans
 - Learning Practices Inventory
 - Action learning sets
 - Workshops
 - One-to-ones
 - Peer supported learning
 - Networking
 - Interview skills
 - Observations of care
 - Patient stories
- 6 What has been the contribution of:
 - Local facilitators
 - Regional facilitators
 - Mentor
 - Director of nursing
- 7 What has been the reaction of:
 - Teams
 - Colleagues
- 8 What has been the impact in terms of:
 - Patient care
 - Personal leadership development
 - Clinical governance
 - Clinical environment
 - Development of policy
- 9 Do you think the care in your clinical area has or is changing in any way, as a result of your participation on the RCN CLP?
- 10 If so, is that a result of your participation on the RCN CLP?
(If yes, how?)
- 11 Has your development plan started to address the goals you identified at the beginning of the programme?
- 12 What is your actual total time commitment to the RCN CLP?
- 13 Would you like to make any further comments?

Appendix 7

Mid-programme interview schedule for patients

Thank you for agreeing to take part in this interview. I am now going to ask you some questions about the observation of care or patient interview you were involved in. There are no right or wrong answers — we are just interested in your views. All of your comments are treated confidentially. With your permission I would like to tape-record the interview.

1. Did you enjoy being involved in a patient story/observation of care?
2. What do you think the purpose of it is?
3. Was the process of being involved explained to you?
4. Did you understand what was going to happen?
5. What did the staff gain from this experience?
6. Did you gain anything from being involved?
7. Do you think it will have a direct benefit for patient care?
8. Do you think it will have a benefit for staff training/understanding?
9. Did the staff find anything of importance while they were undertaking the patient story/observation of care?
10. If so, what did they find?
11. Do you think is it important that staff observe or listen to patients about care in this way?
12. If not, do you think there are any ways that staff can better understand how patients experience care in this clinical area?
13. Who would you say provides the leadership in the ward/clinical area?
14. Do you think there is good teamwork in the ward/clinical area?
15. If you had the chance to make some comments to the people who run the service, what would you say?

Thank you for your time. Have you any more you wish to say that you think is important?

Appendix 8

Mid-programme interview schedule for colleagues

Thank you for agreeing to take part in this interview. I am now going to ask you some questions about your impressions of the RCN Clinical Leadership Programme. There are no right or wrong answers — we are just interested in your views. All of your comments are treated confidentially. With your permission I would like to tape-record the interview.

1. What is your professional relationship with?
2. What is your understanding of the purpose of the RCN Clinical Leadership Programme?
3. Does the RCN Clinical Leadership Programme, in your opinion, achieve the purpose you stated?
4. Does it have any benefits for the clinical leader? Give examples.
5. From a colleague perspective do you think there have been any benefits or negative aspects for the staff team/colleagues? Give examples.
6. Have there been any benefits for patient care? If so, please give examples.
7. Have there been any staff or patient initiatives as a result of your colleague being on the RCN Clinical Leadership Programme?
8. Have there been any clinical governance initiatives as a result of your colleague being on the RCN Clinical Leadership Programme?
9. What do you think the purpose is generally of staff improving their leadership skills?
10. Have you heard of other leadership programmes? What are the main differences in the other programmes?
11. What is the general benefit to the NHS of improving the leadership skills of clinical staff?
12. It is now your opportunity to comment. Would you like to make any general comments about leadership? Would you like to make any comments at all?

Thank you very much for your help with this research evaluation.

Appendix 9

Final interview schedule for clinical leaders

Thank you for agreeing to take part in this interview. I am now going to ask you some questions about the observation of care or patient interview you were involved in. There are no right or wrong answers — we are just interested in your views. All of your comments are treated confidentially. With your permission I would like to tape-record the interview.

1. How would you describe your overall experience of the RCN Clinical Leadership programme?
2. How would you rate the RCN Clinical Leadership Programme on the scale below:

Very Poor	Poor	Neutral	Good	Very Good

3. Has your leadership capability changed? Please describe:
 - ◆ are the leadership attributes you identified highlighted in your PDP?
 - ◆ was the Learning Practices Inventory useful in identifying areas of subsequent change?
4. How would you now describe yourself as a leader?
5. Did undertaking the programme fulfil your expectations?
6. Were there any aspects of the programme that could be improved?
7. Are there changes directly attributable to you being involved in the RCN Clinical Leadership programme:
 - ◆ patient care
 - ◆ changes in organising the way care is delivered
 - ◆ clinical environment
 - ◆ staff development
 - ◆ staff support
 - ◆ clinical governance
 - ◆ benchmarking activity/clinical governance
 - ◆ communication — patient, team or wider team
 - ◆ policy development
8. Are there any changes in the way the team works together in your clinical environment? If so, are these changes in any way connected to your involvement in the RCN Clinical Leadership Programme?
9. Have you changed your post whilst being on the RCN Clinical Leadership Programme? Has this change altered your perceptions of the appropriateness of the programme for your development need? Has being on the programme helped or hindered?

10. Has being on the programme altered your career focus or direction? If so, how?

11. How satisfied are you with your current job? Please indicate on the scale below:

Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied

Has satisfaction with your current job changed over the course of the programme? If so, please explain.

12. Have you observed any change in the job satisfaction of staff in your clinical area?

13. Has being on the programme affected your relationship with your line manager?

◆ Other managers in the trust? If so, please explain.

14. We have so far been exploring impact on your personal development, the patient, the team and the clinical environment. Do you think there is any trust level benefit?

15. Would you like to add anything you think I may have missed? Would you like the opportunity to say anything in relation to the RCN Clinical Leadership Programme?

Thank you very much for your time and support in undertaking this project.

Appendix 10

Final interview schedule for patients

Thank you for agreeing to take part in this interview. I am now going to ask you some questions about your impressions about leadership in the NHS and also about the care you have received in this ward/clinical area. There are no right or wrong answers — we are just interested in your views. All of your comments are treated confidentially. With your permission, I would like to tape-record the interview.

1. From your point of view what is good about the care you have received in this ward/clinical area?
2. From your point of view what is not so good about the care you have received?
3. How satisfied are you with the care you have received? Please indicate a satisfaction score between 1 and 10 on the table below. 1= poor care, and 10=excellent:

Poor									Excellent

4. Who do you think leads the staff in providing care for the patients/clients in this ward/clinical area?
5. What is the relationship between the person you have identified and the other professionals that give care (ask related to groups outlined below as applicable):
 - ◆ other nurses on the ward/clinical area
 - ◆ other staff on the ward
 - ◆ ward manager/sister
 - ◆ matron
 - ◆ doctors
 - ◆ physiotherapists/OTs
6. How is the care you received co-ordinated between the various carers i.e. sister/ward staff/doctors/physios etc.?
7. What are the particular skills required by the people who lead care in wards or clinical areas i.e. what do they need to do to lead care effectively?
8. Do you think there is good teamwork on the ward/clinical area?
 - ◆ If yes, what makes the staff work well together?
 - ◆ If no, what prevents the staff from working well together?
9. If you had a problem related to your care in this ward/clinical area, who would you talk to?
10. Do you feel you have been involved in planning your care?

11. Have you been given enough information about:

- ◆ the ward
- ◆ your illness
- ◆ concerns that you have had?

12. Do you feel that staff have listened to your concerns?

13. If you had the opportunity to make some comments about your care to the people who run the service, what would you say?

Thank you for your time. Have you any more you wish to say on something that I have may have missed or that you think is important?

Appendix 11

Final interview schedule for colleagues

Thank you for agreeing to take part in this interview. I am now going to ask you some questions about your impressions about leadership in the NHS and also about your understandings of the purpose and impact of the RCN Clinical Leadership programme. There are no right or wrong answers — we are just interested in your views. All of your comments are treated confidentially. With your permission, I would like to tape-record the interview.

1. What is your professional relationship with.....?
2. Are you aware that your colleague has been involved in the RCN Clinical Leadership Programme?
3. What are the leadership strengths of your colleague?
4. What are the areas of leadership that still need development?
5. Can clinical leadership be learned by undertaking a programme of development and study?
6. Do you believe that you have seen any changes in the leadership skills of your colleague? If so, do you believe they are attributable to undertaking the leadership programme, and are they beneficial changes?
7. Did you fill in the Leadership Practices Inventory? If so, did you think the questionnaire adequately allowed you to describe the leadership capability of your colleague?
8. Have you been involved in any of the key interventions of the RCN Clinical Leadership programme, such as the patient stories and observations of care/practice? If so, what is your experience of these activities?
9. Have you seen any changes in the following areas over the past year:
 - ◆ Patient care — if so, is it related to RCN programme?
 - ◆ Changes in organising care — if so, is it related to RCN programme?
 - ◆ Clinical environment — if so, is it related to RCN programme?
 - ◆ Staff development — if so, is it related to RCN programme?
 - ◆ Staff support — if so, is it related to RCN programme?
 - ◆ Clinical governance — if so, is it related to RCN programme?
 - ◆ Benchmarking activity — if so, is it related to RCN programme?
 - ◆ Communication — patient, team or wider team? If so, is it related to RCN programme?
10. Would you like to make any comments generally about leadership? Do you think I have missed anything?

Thank you for your help in this evaluation.

Appendix 12

Final interview schedule for local facilitators

Thank you for agreeing to take part in this interview. I am now going to ask you some questions about your role and your perceptions of the impact of the RCN Clinical Leadership programme for clinical leaders, patients, the clinical environment and the trust.

1. Would you describe your role please?
2. What has been the impact of the programme for clinical leaders?
3. What sort of development strategies have you used with the clinical leaders?
 - ◆ What are the most successful strategies?
 - ◆ What are the least successful strategies?
4. How were you prepared for your role in the leadership programme?
 - ◆ Was the preparation sufficient for the role?
 - ◆ What is the role of the regional facilitator?
5. Are there any leadership changes to the participants of the RCN Clinical Leadership Programme in this trust? If so, please describe.
6. Are there any changes to patient care that you believe are directly attributable to the RCN Clinical Leadership programme? If so, please describe.
7. Are there any changes to the clinical environment that you believe are directly attributable to the RCN Clinical Leadership Programme? If so, please describe.
8. Are there any clinical governance initiatives that are attributable to the RCN Clinical Leadership Programme? If so, please describe.
9. Are there any policy initiatives that are attributable to the RCN Clinical Leadership Programme? If so, please describe.
10. Are other staff in the trust aware of the programme? How is the programme perceived in the trust?
11. What is the future for clinical leadership in this trust?
12. Are staff able to make changes to care or environment in practice?
 - ◆ Are there any barriers to making changes?
 - ◆ What are the facilitators to change in practice?
13. Do you think that clinical leader participants are more or less satisfied in their jobs on completion of the RCN Clinical Leadership Programme?
14. Do you think I have missed asking anything important about the impact of leadership in the trust?
15. Would you like to make any comments generally about the RCN Clinical Leadership Programme?

Thank you so much for your help with this research study.

Appendix 13

Final interview schedule for directors of nursing

Thank you for agreeing to take part in this interview. I am now going to ask you some questions about your perceptions of the impact of the RCN Clinical Leadership Programme for clinical leaders, patients, the clinical environment and the trust.

1. Would you please describe the leadership strategy for the trust?
2. What function does the RCN Clinical Leadership Programme have in the strategy?
3. Is the RCN Clinical Leadership Programme successful in developing leaders in the trust?
4. What are the most successful aspects?
5. What are the least successful aspects?
6. Are there any leadership changes to the participants of the RCN Clinical Leadership Programme in this trust? If so, please describe.
7. Are there any changes to patient care that you believe are directly attributable to the RCN Clinical Leadership Programme? If so, please describe.
8. Are there any changes to the clinical environment that you believe are directly attributable to the RCN Clinical Leadership Programme? If so, please describe.
9. Are there any clinical governance initiatives that are attributable to the RCN Clinical Leadership Programme? If so, please describe.
10. Are there any policy initiatives that are attributable to the RCN Clinical Leadership Programme? If so, please describe.
11. Are other staff in the trust aware of the programme? How is the programme perceived in the trust?
12. What is the future for clinical leadership in this trust?
13. Are staff able to make changes to care or environment in practice?
14. Are there any barriers to making changes?
15. What are the facilitators to change in practice?
16. Do you think that clinical leader participants are more or less satisfied in their jobs on completion of the RCN Clinical Leadership Programme?
17. Do you think I have missed asking anything important about the impact of leadership in the trust?
18. Would you like to make any comments generally about the RCN Clinical Leadership Programme?

Thank you so much for your help with this research study.

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