An evaluation of the RCN Clinical Leadership Development Programme: part 1


Abstract

Aim The RCN Clinical Leadership Development Programme was set up in 1995 and sought to identify how clinical nurses in recognised leadership positions could improve the quality of patient care.

Method The programme was tested on four senior nurses and 24 ward sisters in four acute hospital trusts in England over an 18-month period. The primary research question was whether the intervention improved the clinical leadership skills of participants. A pre-test/post-test design incorporating action research was deployed.

Results On a number of leadership dimensions, ward sisters’ and senior nurses’ performance had significantly improved. Five key themes emerged from the process data documenting the journey towards more effective clinical leadership: managing self; managing the team; patient-centred care; networking; and becoming more politically aware. There was evidence to show that patient care had also improved as measured by the way nursing care was organised; by patients’ accounts of care they received and by documented improvements nurses carried out as a result of direct observation of care.

Conclusion From the results of the study, it appears that there is a need for more effective clinical leadership development programmes for nurses to achieve better patient-centred care.

Introduction

Leadership, and particularly the need for clinical leadership, has become a central policy for health reforms across the world (Nuffield Trust 1999) and for the most recent UK health reforms (DoH 1997a, 1997b, Goodwin 2000, RCN 2000). Quality improvement, organisation theory and change management literature all identify the importance of strong leadership (Berwick 1989, Dawson 1996). Most recently, debates about the effectiveness of strategies to get research evidence into practice also focus on the persuasive powers of the local opinion leader (Bero et al 1998).

Trends in leadership style reflect a move from ‘command and control’ type leadership (often called ‘great man theory’) to more transformational or facilitative styles (Bass 1990). Such a trend recognises that leadership styles are contingent on cultural determinants and value systems of organisations (Bate 1994), yet promotes a more participatory, emancipatory style of leadership that emphasises creative problem solving, flexibility and speed of response. Effective transformational leaders are those who know how to enable everyone to become a leader of something (Barker and Young 1994).

In nursing, the role of the ward sister had long been recognised as a key in determining the provision of quality patient care and the efficiency of the ward as a learning environment (King’s Fund 1988, Kitson 1991, Ogier 1982, Pembrey 1980, Redfern 1981). Common themes that emerged from early studies of the ward sister are the ‘power of the role’ and the extent to which it is underestimated by the ward leaders themselves. Effective ward leaders also tended to practise in a more patient-centred way – role-modelled behaviour that positively influenced the behaviours and attitudes of team members – and were able to describe their caring role in therapeutic, positive ways (Binnie and Titchen 1998).

In addition to such positive findings, several studies in the early 1990s reported the difficulty many ward leaders were experiencing, particularly regarding role overload, role conflict and lack of time (Binnie and Titchen 1998, Menzies 1960). Thus, while it was recognised as a pivotal role, the organisational pressure on the individual was often perceived to be overwhelming and ward leaders themselves reported they had little support or mentoring into the role (Manley 1997).

The RCN Clinical Leadership Development Programme was established to address some of...
these problems. From the start its focus was to be on the development of work-based, problem-focused ways of helping ward sisters and senior nurses become effective clinical leaders and thereby have a positive influence on the quality of patient care. It was also expected to generate a practical tool that, once tested, could be used by other ward leaders and clinical staff.

This article describes the evaluation of the first phase of this programme. Phase One began with a three-year investigation into the role of the ward leader – the sister or charge nurse – and the senior nurse. The purpose of the project was to identify how clinical nurses in recognised leadership positions (ward sister, senior nurse level) could provide high-quality patient-centred care.

Phase One ran from early 1995 to early 1998 and involved four acute trusts in England. It tested the main intervention – a clinical leadership development programme, produced a teaching pack (RCN 1999) and evaluated its effectiveness on the leadership capacity of the participants.

Phase Two began in 1999 with the first of three cohorts of 12 trusts per cohort entering an 18-month programme to evaluate the content of the teaching pack (the Toolkit). This phase is due to be completed by the end of 2001.

The intervention: elements and process

The intervention being tested was a menu of activities that had been identified in the research literature as contributing to improvements in personal development and professional performance. However, they had not been integrated with supportive facilitation over a sustained time period (18 months).

Elements

The intervention consisted of the following elements:

- Personal development plans (PDPs) specify an individual’s learning and development needs and identify targets for improving job performance. Essential elements include clear objectives, actions and mechanisms to achieve actions. The first step is to undertake a rigorous personal assessment, such as 360 degree feedback (Alimo-Metcalfe 1998).

- Action learning (AL) is a method of personal management and organisational development (Revans 1994). It is a structured way of tackling everyday problems in a supportive yet challenging and informed way. It requires volunteers who come together on a regular basis to share their experiences. Pre-requisites to successful action learning groups are non-judgemental attitudes, not imposing one’s views or attitudes, asking questions rather than giving advice, and respecting the views of others.

- Workshops on common issues were organised for participants.

- Mentorship and developing networking skills have long been features of leadership programmes (Neubauer 1995a, 1995b). Both techniques were used in the programme.

- Observation of care involves an ‘insider’ – someone from the clinical area – and an ‘outsider’ – someone from another ward or in an external role, for example a researcher. Together they select an area on the ward/unit to be observed for a 30-minute period (conditional on obtaining patient and staff consent). They make a note of everything they see and hear and then compare notes. Feedback is given to staff, issues are clarified and discussed and any action for improvement is identified.

- Using patient narratives is a way of involving participants in directly obtaining patients’ experiences of being nursed in hospital. Each interview is recorded and patients are encouraged to tell their own story. Patients’ accounts are then analysed, focusing on common areas for quality improvement and indicators for good practice.

Process

Not only was the content important, but the way it was introduced by the expert facilitator was seen to be central to its success.

Expert facilitation

The intervention was introduced by the lead researcher, who was also the expert facilitator. In this role the expert facilitator helped all participants to construct their personal development plans and coached them personally. In addition, the four senior nurses were mentored and facilitated in their own action learning set by the expert facilitator. This preparation subsequently helped each senior nurse to set up and run one action learning set with the clinical leaders from their hospital. This created a cascade effect from the expert facilitator to each senior nurse whose role was to support the leadership development of the six clinical leaders in their group.

During this time, the expert facilitator also co-ordinated the workshops, developed participants’ skills in observation of care and patients’ story telling, and set up mechanisms for the identification of mentors and developed networks. In her researcher role, the expert facilitator co-ordinated the collection of pre- and post-test data and process data.

Study aims, design and methods

The primary aim of the project was to test whether the intervention improved the clinical leadership capability of participants recruited onto the 18-month programme. Capability
incorporates dimensions such as skills, style, values, attitudes and behaviours.

Specific hypotheses being tested were:

**Hypothesis 1:** Senior nurses will significantly improve their leadership capability as measured by the multifactor leadership questionnaire (Bass 1990), following participation in the programme.

**Hypothesis 2:** Ward leaders will significantly improve their leadership capability as measured by the multifactor leadership questionnaire following participation in the programme.

**Hypothesis 3:** Quality of patient care will significantly improve following ward leaders’ participation in the programme as measured by the organisation of care tool (Bass and Thompson 1995) and qualitative data from patient narratives and observation of care.

### Project design

A pre-test/post-test design was selected that incorporated a process evaluation of the intervention. The primary focus of the pre-test/post-test design was on detecting any changes in the leadership capability of participants (as measured by the multifactor leadership questionnaire). The process evaluation, which incorporated an action research approach, focused on documenting the participants’ experiences of the leadership programme.

The project was divided into five stages:

**Stage 1: Exploration of issues and selection of study sample (seven months)** During this preparatory phase, work was done to review possible measures to be used in the study, prepare the expert facilitator for her role, refine the elements of the intervention and to select the hospitals (and thereby have access to one senior nurse and six clinical leaders per hospital).

Four hospital trusts within commuting distance of the research centre were randomly selected according to pre-determined criteria that covered physical, organisational and cultural aspects of the trusts. Six ward sisters (clinical leaders) were randomly selected from each of the four hospital trusts. In addition, one senior nurse per hospital was also selected.

A range of leadership tools were evaluated and two were piloted during this stage: the multifactor leadership questionnaire (MLQ) developed by Bass (1990), and Kouzes and Posner’s (1995) leadership practice inventory. Both questionnaires had also been tested during this stage: the multi-factor leadership questionnaire (MLQ) developed by Bass (1990), and Kouzes and Posner’s (1995) leadership practice inventory. Both questionnaires had been designed to look at transformational leadership characteristics and, therefore, were appropriate for this study. They had also been tested for validity and reliability. The MLQ had been used in one previously reported UK study within the healthcare sector (Alimo-Metcalfe 1995). Following piloting, both measures were found to be acceptable. It was decided to use the MLQ because of the more detailed breakdown of elements into transformational and transactional styles.

The MLQ is completed by a leader and any person reporting to that leader. It consists of 87 questions divided into 12 main themes. The measure is used as a self-assessment and evaluative tool. The MLQ measures transformational and transactional leadership characteristics. Five of the 12 leadership characteristics describe transformation leadership qualities:

- **Attributed charisma (AC).**
- **Idealised influence (II).**
- **Inspiration (INS).**
- **Intellectual stimulation (IS).**
- **Individual consideration (IC).**

Individual leaders improving scores on these dimensions would demonstrate the acquisition of more transformational leadership qualities.

Four characteristics in the MLQ relate to transactional leadership (transactional leadership describes a more process-oriented, procedural type of leadership style, which tends to be less empowering and motivational). They are:

- **Contingent reward (CR).**
- **Active management by exception (MBEA).**
- **Passive management by exception (MBEP).**
- **Laissez-faire (LF).**

The other characteristics, which are not directly related to either style, are:

- **Extra effort (EE).**
- **Effectiveness (EFF).**
- **Satisfaction (SAT).**

Other tools selected at this stage were the Organisation of Care Tool (Bass and Thompson 1995), which was used to provide a measure of how care was organised in the ward and whether it changed (from task to team or primary nursing) after the intervention. A key assumption in the measure is that quality patient care improves with the move from task to team or primary nursing. The Newcastle Satisfaction with Nursing Scale (McCull et al 1996) was selected to obtain patients’ views of the quality of nursing care before and after the intervention. The final pre-test/post-test measure was the Team Roles Effectiveness Tool (Poulton and West 1993). This was selected to identify the extent to which ward leaders felt themselves to be part of an interdisciplinary team. Ethical approval was sought from each site during this time.

**Stage 2: Establishing baseline measures (two months)** Pre-test data using each of the tools (MLQ, Organisation of Care Tool, Newcastle Satisfaction with Nursing Scale and Team Roles Effectiveness Tool) were collected by the researcher. Data from every leader and senior...
Nurse were collected for the MLQ and, in addition, ‘followers’ or colleagues who worked with the clinical leaders were asked to complete an MLQ giving their view on the leadership qualities of their ward sister. A minimum of six nursing staff per ward were approached.

Clinical leaders were also asked to complete the Team Roles Effectiveness Tool and help with the Organisation of Care Tool. The Newcastle Tool was sent to a random selection of patients on discharge from medical and surgical wards in the study (patient group appropriate for the tool). This process was co-ordinated by the ward clerks in the appropriate wards and supervised by the researcher.

The originators had tested all of the above measures for validity and reliability.

**Stage 3: Intervention (18 months)**

The intervention period ran for 18 months from mid-1995 to the beginning of 1997, during which time the expert facilitator concentrated on outlining the programme and then started to work on participants’ personal development plans (which included training on the use of 360 degree feedback). Participants also became familiar with working in action learning sets that were mandatory for a minimum of one day a month.

Once these were established, participants were then taught how to undertake observation of care and patient narratives. Each clinical leader experienced observing care on the ward and having their own area observed by the expert facilitator. They also had to record at least six patient narratives from their clinical area over the 18-month period.

Interspersed with this clinically focused work were networking and mentoring opportunities, as well as attendance at workshops where all participants would have the opportunity to meet each other and share experiences.

Three methods or process measures were used during the intervention period. These were data collection on the action learning sets, patient narratives and observation of care.

Action learning set data were collated from researcher case notes and observations and self-reports from senior nurses and ward sisters of their impact on their performance. The aim of the patient narratives was to hear the experience of hospitalisation as recalled by the patient. These were used for the retrospective analysis of all participant activities. A complete ‘file set’ was collated for each participant, recording key events that had happened to them during the project. The expert facilitator, together with the four senior nurses, then undertook a thematic analysis (Titchen and McIntyre 1993) of a sub-set of the data to identify any emerging themes or patterns.

Each senior nurse was asked to identify one ward leader (participant) from his or her trust whom they thought had demonstrated the most change in leadership behaviour (n=4). One participant file and one senior nurse file were selected randomly by the expert facilitator and these eight files were analysed in detail by the expert facilitator. Each senior nurse was given a participant file from another trust to analyse and together, through a process of triangulation (Titchen 1993) and refinement, the senior nurses and expert facilitator identified a number of first and second order themes (Titchen and McIntyre 1993).