An evaluation of the RCN Clinical Leadership Development Programme: part 2


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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

Part 1 of this article, which was published in last week’s Nursing Standard, provides the background and method of this study.

Results

Characteristics of participants Twenty eight participants were recruited to the project. One participant withdrew in the first six months and another changed jobs but continued to attend the workshops and action learning sets. The majority of participants were between 30 and 39 years of age (n=14) and female (n=22). Half of the participants had been in their current post for 18 months or less; almost two-thirds of the participants (n=17) had not had any previous leadership training.

The clinical leaders worked in a variety of clinical specialties. Both acute and community services were represented, as well as mental health and children’s services. Hospital size ranged from 350 to 1,000 beds. The ratio of qualified to unqualified staff ranged from 6.3:4.7 to 7.5:2.5.

From the trust characteristics and demographic data, there appeared to be no outstanding differences between sites or between participants.

Multifactor Leadership Questionnaire (MLQ) (Bass 1990) The questionnaire was completed by leaders themselves and also by colleagues on the wards who worked with the leaders (termed followers). A total of 176 MLQ questionnaires were distributed at the pre-test stage, of which 131 were returned. In the post-test stage, 231 were distributed and 150 returned. Some problems were encountered with the length of the questionnaire and clarity of some of the questions. Some concern was voiced by nurses on the ward who sought reassurance that there would be no negative repercussions for them from their leader if they completed the questionnaire truthfully.

MLQs were distributed to all senior nurses and clinical leaders in the programme and, to show the effect of the intervention, trends in individual responses were expected to improve significantly for the transformational characteristics and decrease for the transactional characteristics.

Summary scores of leaders’ assessment of themselves and of followers’ assessment of their leadership behaviour were produced for each of the 12 dimensions: attributed charisma (AC), idealised influence (II), inspiration (INS), intellectual stimulation (IS), idealised contribution (IC), contingent reward (CR), active management by
exception (MBEA), passive management by exception (MBEP), laissez-faire (LF), extra effort (EE), effectiveness (EFF) and satisfaction (SAT).

Tables 1 and 2 show that the majority of self and follower scores improved following the intervention.

**Leaders’ assessment of themselves** Table 1 shows the number of leaders for which it is possible to calculate both a pre-test and post-test score. The column pre-test mean (s.d.) gives the mean across the leaders of their pre-test scores for the identified leadership variable. Similarly, post-test mean (s.d.) gives the mean across the leaders’ post-test scores for that leadership variable.

For each leadership variable the difference between the post-test value and pre-test value was calculated. The mean of this difference, across leaders, is reported in Table 1. Since for each leadership variable the pre-test and post-test scores form a pair for each leader, a paired t-test has been used to test whether the difference is significantly different from zero.

There is a mean increase in AC, II, INSP, IS, IC, EE, EFF and SAT and there is a mean decrease in CR, MBEA, MBEP and LF (Fig. 1).

A paired t-test was used to test the changes in each score. There are statistically significant changes (since p-value < 0.05) for INSP, MBEA, EFF and SAT. All other changes are not statistically significant.

Analysis of variance (ANOVA) was used to check for any site differences in the change for each variable. There were no significant site differences. All differences are in the ideal direction and there is a mean increase in those attributes

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**Table 1. MLQ test results for leaders’ assessment of themselves**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pre-test mean (s.d.)</th>
<th>Post-test mean (s.d.)</th>
<th>Number of leaders</th>
<th>*Difference mean (s.d.)</th>
<th>p-value from paired t-test</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transformational</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AC</td>
<td>2.58 (0.42)</td>
<td>2.71 (0.43)</td>
<td>25</td>
<td>0.13 (0.48)</td>
<td>0.194</td>
</tr>
<tr>
<td>II</td>
<td>3.07 (0.47)</td>
<td>3.17 (0.41)</td>
<td>24</td>
<td>0.11 (0.50)</td>
<td>0.299</td>
</tr>
<tr>
<td>INSP **</td>
<td>2.90 (0.51)</td>
<td>3.14 (0.47)</td>
<td>25</td>
<td>0.24 (0.49)</td>
<td>0.024</td>
</tr>
<tr>
<td>IS</td>
<td>2.95 (0.55)</td>
<td>3.12 (0.48)</td>
<td>24</td>
<td>0.17 (0.46)</td>
<td>0.052</td>
</tr>
<tr>
<td>IC</td>
<td>3.19 (0.49)</td>
<td>3.32 (0.40)</td>
<td>25</td>
<td>0.13 (0.47)</td>
<td>0.183</td>
</tr>
<tr>
<td><strong>Transactional</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CR</td>
<td>2.18 (0.64)</td>
<td>2.15 (0.84)</td>
<td>17</td>
<td>-0.03 (0.87)</td>
<td>0.897</td>
</tr>
<tr>
<td>MBEA **</td>
<td>1.87 (0.61)</td>
<td>1.23 (0.64)</td>
<td>25</td>
<td>-0.64 (0.63)</td>
<td>0.000</td>
</tr>
<tr>
<td>MBEP</td>
<td>0.79 (0.58)</td>
<td>0.67 (0.40)</td>
<td>25</td>
<td>-0.12 (0.51)</td>
<td>0.252</td>
</tr>
<tr>
<td>LF</td>
<td>0.60 (0.44)</td>
<td>0.53 (0.41)</td>
<td>25</td>
<td>-0.08 (0.36)</td>
<td>0.311</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EE</td>
<td>2.72 (0.54)</td>
<td>2.93 (0.57)</td>
<td>25</td>
<td>0.21 (0.59)</td>
<td>0.094</td>
</tr>
<tr>
<td>EFF **</td>
<td>2.54 (0.57)</td>
<td>2.76 (0.49)</td>
<td>25</td>
<td>0.22 (0.49)</td>
<td>0.033</td>
</tr>
<tr>
<td>SAT **</td>
<td>2.38 (0.76)</td>
<td>3.06 (0.70)</td>
<td>25</td>
<td>0.68 (0.75)</td>
<td>0.000</td>
</tr>
</tbody>
</table>

* Difference is calculated as post-test value minus pre-test value for each leader for each leadership variable

** There were statistically significant differences (p<0.05) between leaders’ pre- and post-test assessment
Table 2. MLQ test results for followers’ assessment of their leaders

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pre-test mean (s.d.)</th>
<th>Post-test mean (s.d.)</th>
<th>Number of leaders</th>
<th>*Difference mean (s.d.)</th>
<th>p-value from paired t-test</th>
</tr>
</thead>
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<tr>
<td>Transformational</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AC **</td>
<td>2.76 (0.72)</td>
<td>3.07 (0.42)</td>
<td>24</td>
<td>0.30 (0.70)</td>
<td>0.043</td>
</tr>
<tr>
<td>II</td>
<td>2.69 (0.78)</td>
<td>3.01 (0.51)</td>
<td>23</td>
<td>0.32 (0.81)</td>
<td>0.068</td>
</tr>
<tr>
<td>INSP **</td>
<td>2.71 (0.81)</td>
<td>3.04 (0.53)</td>
<td>24</td>
<td>0.33 (0.77)</td>
<td>0.049</td>
</tr>
<tr>
<td>IS</td>
<td>2.62 (0.77)</td>
<td>2.89 (0.50)</td>
<td>24</td>
<td>0.27 (0.65)</td>
<td>0.050</td>
</tr>
<tr>
<td>IC **</td>
<td>2.62 (0.75)</td>
<td>2.92 (0.63)</td>
<td>23</td>
<td>0.31 (0.68)</td>
<td>0.039</td>
</tr>
<tr>
<td>Transactional</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CR</td>
<td>1.75 (0.70)</td>
<td>1.85 (0.76)</td>
<td>22</td>
<td>0.05 (0.82)</td>
<td>0.767</td>
</tr>
<tr>
<td>MBEA</td>
<td>1.46 (0.57)</td>
<td>1.53 (0.48)</td>
<td>22</td>
<td>0.07 (0.44)</td>
<td>0.452</td>
</tr>
<tr>
<td>MBEP</td>
<td>0.81 (0.52)</td>
<td>0.62 (0.55)</td>
<td>24</td>
<td>-0.19 (0.53)</td>
<td>0.089</td>
</tr>
<tr>
<td>LF</td>
<td>0.73 (0.46)</td>
<td>0.60 (0.47)</td>
<td>24</td>
<td>-0.13 (0.35)</td>
<td>0.081</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EE **</td>
<td>2.10 (0.86)</td>
<td>2.59 (0.70)</td>
<td>23</td>
<td>0.49 (0.67)</td>
<td>0.002</td>
</tr>
<tr>
<td>EFF **</td>
<td>2.63 (0.57)</td>
<td>2.83 (0.53)</td>
<td>24</td>
<td>0.19 (0.44)</td>
<td>0.042</td>
</tr>
<tr>
<td>SAT</td>
<td>2.86 (0.87)</td>
<td>3.15 (0.64)</td>
<td>24</td>
<td>0.29 (0.72)</td>
<td>0.059</td>
</tr>
</tbody>
</table>

* Difference is calculated as post-test value minus pre-test value for each leader for each leadership variable
** There were statistically significant differences (p<0.05) between followers’ pre- and post-test assessment of their leaders

associated with transformational leadership (AC, II, INSP, IS, IC, EE, EFF and SAT), with a mean decrease in CR, MBEA, MBEP and LF (dimensions of transactional leadership behaviour).

Followers’ assessment of their leaders The same analysis was carried out for the followers’ assessment of their leaders (Table 2).

For variables AC, II, INSP, IS, IC, EE, EFF and SAT there has been a mean increase (Fig. 2). For AC, INSP, IC, EE and EFF there is a statistically significant increase. For variables MBEP and LF there has been a mean decrease, but neither are statistically significant. For CR and MBEA there has been a very small increase in mean. However, in both cases the change is not statistically significant.

A paired t-test was used to test the changes in each score. There are statistically significant changes (since p-value <0.05) for AC, INSP, IC, EE and EFF. All other changes are not statistically significant.

Analysis of variance (ANOVA) showed no significant site differences in the change for each variable.

In summary, 76 per cent of the leaders rated themselves as being more effective overall; 63 per cent of the followers rated their leaders as being more effective overall; 60 per cent of the leaders were more satisfied with their own leadership style; 63 per cent of the followers were more satisfied with the leadership style of the ward leaders; 56 per cent of the leaders felt their followers had exerted effort beyond the ordinary as a consequence of improvements in their leadership skills, and 78 per cent of followers felt they had exerted effort beyond the ordinary as a
consequence of improvement in the leadership skills of the ward leaders.

Organisation of care (Bowman and Thompson 1995) Leaders and followers were asked to complete this tool as pre- and post-tests. The tool measures the way nursing is organised and detects movement towards a more patient-centred approach. However, only ten leaders completed this tool post-test and, of these, only eight completed the pre-test. There were also ten leaders for whom their followers completed the organisation of care tool before pre-test and post-test.

Pre- and post-test information was analysed on the organisation of care for eight leaders (1 in site 1, 3 in site 2, 1 in site 3 and 3 in site 4). For these eight leaders the mean (s.d.) pre-test score was 29.25 (3.88) and the mean (s.d.) post-test score was 32.00 (4.21). The mean difference is an increase of 2.75 (2.12). This is a small but statistically significant increase (p=0.008 for the paired t-test).

Pre- and post-test information was obtained on the organisation of care from the followers of ten leaders (3 in site 1, 3 in site 2, 2 in site 3 and 2 in site 4). For each leader who has follower information, the mean score for their followers has been calculated. For these ten leaders who have a follower score, the mean (s.d.) pre-test score is 27.14 (3.73) and the mean (s.d.) post-test score is 31.13 (3.21). The mean difference is an increase of 3.98 (1.98). This is a statistically significant increase (p < 0.001 for the paired t-test).

Whereas these results show a significant improvement in the organisation of care in eight out of 24 wards as judged by the ward leaders, and ten wards as judged by the ward staff, it is difficult to make generalisations about the results because of the relatively poor response rate. Leaders and ward staff reported that they found the measure to be time-consuming to use and this might in some way explain the lower response rate. However, given the limited data, the trend towards a more patient-centred approach to organisation of care in the light of MLQ results would seem to suggest that the way nursing care was being managed was altering. Additionally, the fact that leaders and followers report similar trends is encouraging.

Newcastle Satisfaction with Nursing Scale (McColl et al 1996) The response rate was set at 80 questionnaires per clinical site pre- and post-test and all the medical and surgical wards were asked to respond. Ward clerks were asked to co-ordinate the distribution of questionnaires on discharge. The research team found it was unable to collect this quantity of data during the time period before the introduction of the intervention. Data sets were incomplete and it was therefore not possible to analyse any data collected in a meaningful way.

Interdisciplinary team questionnaire (Poulton and West 1993) The majority of participants felt they were not in a position to identify an interdisciplinary team of which they were members. However, five participants agreed to use this tool in the pre-test. Of these participants, team member responses (n=4 per team) were returned by four of the five groups identified. From the data returned, it was not possible to analyse trends in interdisciplinary teamwork. However, two observations can be made: ward leaders do not naturally see themselves as members of an interdisciplinary team and there is little consistency in what team members see as their team colleagues within their team.

Results from process data To provide a qualitative dimension to the changes recorded above, a rigorous analysis of the process experienced by the clinical leaders was conducted. Five major themes emerged from these data: learning to manage self; building,
Box 2. Common areas for improving patient care

Observation of care
Privacy and dignity
Communication
Ward environment
Nursing care
Attitudes of staff

Patient story telling
Attitudes of staff
Noise levels
Rest and sleep
Communication
Business of nurses
Quality of food
Ward environment
Visiting times
Boredom

developing and managing effective relationships with team members; patient focus; networking (internal and external); and political awareness. Each theme identified a number of sub-themes or styles that participants went through to become proficient in each of these skills (Box 1).

The ability of ward leaders to learn the skills of self-management was crucial for all nurses. Ward leaders reported that they became self-aware, less defensive, more open to criticism and more focused on delivering and improving the quality of care for patients. The need to influence the nursing team and build relationships with other disciplines was also a common theme. These skills enabled the ward leaders to develop staff in the way that directly influenced delivery of care.

New techniques were developed by the ward leaders to enable them to monitor the development of their team, and to ensure that the team was focused on the needs of the patients. Observation of care and patient stories enabled nurses to explore how they delivered care to patients in ways that other approaches, such as clinical or nursing audit, had failed to do. These processes helped many nurses to recognise the shortcomings and, more importantly, have the confidence to do something about improving the situation. Common problems across all clinical areas are identified in Box 2.

Networking was also key to the ward leaders’ development. The networks they developed, internally and externally to their organisation, were essential in providing them with additional support and introducing them to new ideas. Political awareness skills developed as ward leaders recognised the importance of being able to influence key stakeholders within their trusts, so that resources could be used to promote improvements to patient care.

Taken together, the pre- and post-test data and the thematic analysis of the process data during the intervention, indicate that the intervention does lead to improvements in the clinical leadership capacity of senior nurses and ward sisters. Also there was evidence from patient interviews to suggest that patient care was also improving because nurses were more capable of responding to the problems.

Discussion

The primary aim of the project was to test whether the RCN Clinical Leadership Development Programme enabled ward leaders and senior nurses to become more effective clinical leaders. The focus of the programme was practical, experiential and work-based, with an emphasis not just on skills acquisition but on an exploration of the attitudes, values and behaviours needed to produce leaders. Transformational leadership was selected as the most appropriate leadership model for clinical nursing as it accommodates personal development with more conventional leadership traits, such as power, authority, influence and charisma.

Leadership capability was the generic term used to describe the mix of skills, techniques and personal attributes that clinical leaders displayed during the programme. Leadership capability was measured in a number of ways: primarily by the use of the MLQ questionnaire and by participants’ (and others’) accounts of changes in their leadership behaviour, skills, attitudes and values. Changes in the leadership behaviour of senior nurses and ward sisters (clinical leaders) were detected after the introduction of the programme. From the data from ten wards, there was also some evidence to suggest that the way nursing care was organised was changing towards a more patient-centred approach. Coupled with accounts from patients’ narratives and direct observation of care, this would suggest that patient care was indeed improving as a result of the leadership programme.

The methods and approach involved in introducing and conducting the development programme were as important as the actual elements of the programme itself. The elements (personal development planning, action learning, workshops, networking and mentoring, direct observation of care and patient story telling) are dependent on the methods and approach used to introduce them, particularly the influence of the expert facilitator in managing a complex set of activities such as self-directed learning, reflection and the development of evaluative skills. This intimate relationship between ‘content’ and ‘process’ meant that the principal researcher played an active part in the intervention or facilitation and that participants were research subjects and research evaluators in their own right.

This is best illustrated in the way the (qualitative) process data were analysed by the principal researcher and the four senior nurses. By being involved in the thematic analysis, the senior nurses were also able to get a stronger sense of the main changes that had taken place in themselves and their colleagues.

The interpretative data are substantiated by the results of the MLQ, demonstrating that as a result of the RCN Clinical Leadership Development Programme, the senior nurses and ward leaders had significantly improved their leadership capability. Equally important, the MLQ results showed that ward staff also detected changes in the leadership styles of the ward sisters; in fact, more improvements were recorded by followers than by leaders themselves.
However, what might be the most important observation from the study is the description of the processes involved in transforming nurses from under-confident ward leaders to clinical leaders who felt in control and were excited by their work. From the research it was clear that ward sisters had not been prepared for their role; few had experienced good role models and the majority felt out of control (often describing themselves as victims of the system). They did not see professional colleagues as supportive and rarely viewed the nursing management structure as anything other than primitive.

By initiating a needs-led development programme that concentrated on helping clinical leaders learn to manage themselves, a whole process of personal development began to unfold. Personal accounts demonstrate that it was not easy and many difficult personal behaviour and relationship issues had to be addressed. Whole areas of skill deficits were also acknowledged but, instead of reacting defensively as they had done previously, clinical leaders were able to act on the information and do something to help themselves – for example, inviting an expert on clinical audit to run a workshop after having identified a skill deficiency in this area.

Poor coping mechanisms had to be replaced by more effective ways of managing the workload. For example, at the beginning of the project, one ward sister reported working 60 hours per week on average, as well as taking work home with her in the evening. She raised this in her action learning set as the problem she wished to solve; how she could get through the work and still find time to ‘have a life’. What she had to confront (with the help of her clinical leader colleagues) was the fact that she did not know how to delegate effectively to her ward team and that she did not trust her colleagues to provide the same quality of care. Despite the fact that she was an experienced ward sister, she had never helped to develop effective team management skills. By the end of the project she was going home on time, had a much more effective ward team, was getting through the work and had reformed her life.

While it is evident that the RCN Clinical Leadership Development Programme does improve leadership capability, the intervention is intense, relying on expert facilitation over a period of 18 months. It is work-based and experiential, with the actual contents determined by the participants. Although the methods such as personal development planning, action learning and observation of care are relatively straightforward, it is customising them to the individual, the group and indeed the organisation that make it such a unique intervention.

The second stage of the project is to cascade the programme out across more organisations. This will involve further field testing and evaluation of the development of the teaching pack (toolkit) and expert facilitators. In this second stage, 36 trusts are to be involved. This stage will be completed by the end of next year.

From a nursing perspective, the study has reinforced the research literature on the importance of the ward sister’s role, and has teased out the complex interaction between personal development needs and effective clinical performance. In the light of current UK government thinking about continuing professional development, leadership development and creating more flexible multiskilled clinical teams, findings from this study strongly point the way forward. Equally, given the global interest in quality improvement through empowering and enabling clinicians at local level to become more effective problem solvers and team players, leadership capacity development has a major role to play.

A considerable proportion of the nursing workforce is likely to be performing sub-optimally without such personal development or appropriate training, as training generally focuses on skills acquisition rather than personal development. This suggests that new, more flexible approaches to ongoing professional and personal development need to be considered and investment in the development of the facilitation role of senior nurses is a strong candidate in this respect.

Two further related issues that require more research should be noted. First, one cannot ignore the finding that clinical leaders did not see themselves as part of an interdisciplinary team. Whether they literally considered this to mean less involvement in providing direct clinical care needs to be explored. More worryingly, it could be that, rather than seeing themselves as integrated members of a team, they consider that care is provided to patients by a series of individuals, who use the patient as the point of continuity rather than relying on and supporting other team members.

Second, in terms of receptiveness to patient care issues, it took at least nine months of an 18-month project before clinical leaders were able to see and hear what patients were telling them. As one participant noted: ‘After being so long in nursing, I tended to forget what the patient wanted, what the patient needed. I have become more patient-focused, which is quite a sad thing to say really isn’t it; that I wasn’t before?’

That it required a process of personal and team development before patient issues were tackled effectively strongly suggests that many developments are required to achieve the involvement of...
The RCN Clinical Leadership Development Programme was an ambitious and complex project. Its strengths lay in the skills and experience of the expert facilitator who was able to work effectively with nurses from four hospital trusts. This could also be seen as its major weakness (from a traditional evaluation research perspective) in that the primary change agent was also the principal data collector. How much of the effect in terms of improvement in leadership style was due to the leadership and facilitative skills of the expert facilitator and how much was due to the experience of being on the programme?

We can begin to answer this question in part because of the cascade approach that was used. The expert facilitator concentrated her efforts on the senior nurses who were in turn responsible for facilitating the action learning sets of the clinical leaders. That neither the MLQ nor the Organisation of Care tools detected any differences between hospitals suggests that senior nurses were all able to undertake their facilitation role successfully.

One unexpected consequence of the design was the lack of time the expert facilitator had to devote to aspects of her other role, that is, co-ordinator of pre- and post-test data. In particular, it is acknowledged that the failure to collect sufficient patient data on the Patient Satisfaction with Nursing Scale was related to a breakdown in communication between the local ward clerks and the principal researcher. The consequence of this was that it was not possible to demonstrate whether patients detected any improvements, other than the reports collected from patient narratives and nurses’ views that the organisation of care had become more patient-centred. These lessons have influenced the subsequent use of pre- and post-test tools in phases two and three of the project.

As far as the overall study design is concerned, there continues to be debate as to whether a stronger experimental design should be used, introducing matched control groups in hospitals involved in the project. Another view is that there should be greater concentration on the process, with a much more overt action research approach and concentration on the experiences of the main stakeholders involved in the programme. Discussions are continuing on building up stronger nursing satisfaction data as well as focusing on a few discrete nursing-sensitive patient outcomes. Colleagues in Belgium and Switzerland (De Geest 2000) who are replicating the study in four hospitals, are testing a range of nurse outcomes such as job satisfaction (Whitley and Putzier 1994); perceived unit effectiveness (Shortell et al 1991); ethical reasoning (Dierck de Casterlé 1998), as well as patient outcomes.

A final weakness of the study might be that the success as experienced by the participant has not been sufficiently acknowledged through the objective data. This could be more of a function of poor selection of measures than a weakness of the effect of the intervention. Although the MLQ was piloted and selected on the basis of its specificity, it was found to be lengthy to use, particularly as a repeat measure. Feedback from participants indicated that they wanted something simpler and shorter next time.

Despite these limitations, the overall results do indicate that the RCN Clinical Leadership Development Programme improves senior nurses’ and ward sisters’ leadership capacity (hypotheses 1 and 2) and that there is some evidence to suggest that patient care has also improved (hypothesis 3).

**Implications for practice**
- There is a need to establish more effective clinical leadership development programmes for nurses
- All new ward sisters need to be properly supported, developed and mentored
- The role of senior nurses should be re-evaluated in terms of their meeting/facilitation role with clinical leaders

**Conclusion**

The study demonstrates how clinical leaders benefited from a personal development programme and how it was necessary to focus on such issues as learning to manage uncertainty, gaining insight into self, learning to manage negative feelings, staff motivation, and developing and managing others, before leaders could concentrate on quality patient care issues.

The programme’s strength was seen to lie in its experiential work-based approach where the content and the process of engaging were equally important to its success. The role of the expert facilitator was seen as pivotal to successful implementation of the programme, a fact that complicated the study design even that the expert facilitator was also the principal investigator. However, the limitations of this design were addressed by using a mixed methodology – pre- and post-test together with action research.

From this first phase a toolkit has been developed and is now being tested in 36 further sites. The programme content and processes have been refined as have the pre- and post-test measures.

**Acknowledgements**

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