Evaluation of the National Clinical Leadership Development Project Pilot

Final Report

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January 2012
Acknowledgements

The UCD Research Team gratefully acknowledges the support and guidance provided by the Office of the Nursing and Midwifery Services Director (ONMSD), HSE. In particular, the Research Team acknowledges Michael Shannon, Director, ONMSD and Joan Phelan, Area Director NMPD, HSE South, Project Lead and Chair of the Steering Group of the National Clinical Leadership Development Project (NCLDP).

The Research Team also gratefully acknowledges the guidance and support of the members of the NCLDP Project Steering Committee and the members of the Project Team, in particular Project Manager Catherine Killilea (Director, Nursing & Midwifery Planning and Development Unit (NMPDU), Cork & Kerry) and the two Project officers Miriam Bell and Bernadette Toolan for their support and guidance during the study scoping and data collection phases. The team also acknowledges Mary Sexton, secretary to the Director, NMPDU, Cork & Kerry, for her ongoing support to the data collection.

The Research Team gratefully acknowledges the support and co-operation of the NCLDP Project sites, Cork University Hospital, Cork University Maternity Hospital, South Infirmary Victoria University Hospital, Mercy University Hospital, North Lee Mental Health Services, North Lee Public Health Nursing Services and St Finbarr’s Hospital (Care of the Older Adult).

The support given by Cork University Hospital (CUH) in providing facilities for the conduct of data collection activities is gratefully acknowledged, and in this connection, the Research Team is particularly grateful to Aoife Lane, NCLDP site co-ordinator at CUH, Rose Hayes, Documentation Officer, CUH, and Aoife Crowley, Secretary to the Director of Nursing, CUH. The contribution of all the site co-ordinators in supporting data collection is also gratefully acknowledged. The site co-ordinators were: Aoife Lane, Cork University Hospital, Ruth Lernihan, South Infirmary Victoria University Hospital, Margaret McKiernan, Mercy University Hospital, and James O’Mahony, North Lee Mental Health Services, Cork. The Research Team is grateful to members of the National Leadership & Innovation Centre for Nursing and Midwifery, for their helpful comments on the penultimate draft of the Final Report of this evaluation study.
The Research Team is also indebted to all the directors and assistant directors of nursing and the directors and assistant directors of midwifery and their respective staff at the pilot sites who so generously and enthusiastically facilitated the recruitment of research participants and who offered additional support as and when it was required. The Research Team is grateful to Mary Duff and Sinead Brennan for facilitating the process of cognitive interviewing for instrument development at St Vincent’s University Hospital (SVUH), Dublin, and to all the staff at SVUH who participated in the cognitive interviews.

The Research Team is indebted to all of the study participants who provided the data for this evaluation study, including all those who participated in focus groups, group interviews, one-to-one interviews, and telephone interviews and to all of those who responded to the various questionnaires. Without their time and contribution, the study would not have been possible.

The Research Team gratefully acknowledges the advice of Professor David Coghlan, Trinity College Dublin, in relation to aspects of the research design. The Research Team also acknowledges the assistance and expertise of Caroline McKeown for her contribution to the statistical analysis of study data and to Cyril Connolly and Ruth Geraghty for providing additional advice and assistance on aspects of statistical analysis. The Team is indebted to Isabel Hidalgo and Enda Fitzsimons for providing administrative support to the study.
GLOSSARY OF TERMS

**Action learning:** An intervention provided to the participants on the Clinical Leader Development Pathway

**Action learning set facilitator:** An individual who facilitated an action learning set

**Coach:** An individual who provided the coaching intervention for Pathway participants

**Coaching:** An intervention provided to participants on the Clinical Leader Development Pathway

**Competence:** A complex and multidimensional phenomenon and is defined as the ability of the Registered Nurse to practise safely and effectively, fulfilling his/her professional responsibility within his/her scope of practice (ABA 2005)

**The Framework:** The Clinical Leadership Development Framework

**Internal coach:** A coach recruited from within the HSE to provide the coaching intervention

**Line manager:** The line manager of the individual participant on the Clinical Leader Development Pathway

**Mentor:** An individual who provided an intervention to participants on the Clinical Leader Development Pathway

**Mentoring:** An intervention provided to participants on the Clinical Leader Development Pathway

**Participant:** An individual participating on the Clinical Leader Development Pathway. In particular contexts it also refers to all those participating in the pilot

**Pilot:** The roll out of the national Clinical Leadership Development Project on a pilot basis at seven health service areas during a six-month period
**Pilot site:** The seven hospitals participating in the pilot

**Project Steering Committee:** The Committee with responsibility for the governance and oversight of the pilot

**Project Team:** The Team with responsibility for the day-to-day operation of the pilot

**Site co-ordinator:** A named individual who coordinated activities associated with the pilot at each pilot site

**The Pathway:** The Clinical Leader Development Pathway for clinical leadership development

**Competencies:** The seven competencies for clinical leadership. These are: self-awareness, advocacy and empowerment, decision-making, communication, quality and safety, teamwork and clinical excellence.

**Workshop:** An intervention provided to participants on the Clinical Leader Development Pathway

**Workshop facilitator:** An individual who facilitated the workshop intervention

**Abbreviations**

AL  Action learning
ALSFT  Action Learning Set Facilitator Toolkit
CLB-Q  Clinical Leadership Behaviours Questionnaire
CLDP  Clinical Leadership Development Project
CLFT  Clinical Leadership Facilitator Toolkit
CLP  Clinical Leadership Project
CLRP  Clinical Leader Resource Pack
DARI  Documentary Analysis Rating Instrument
LDP  Learning and Development Portfolio
LPI  Leadership Practices Inventory
LPI-O  Leadership Practices Inventory-Observer
LPI-S  Leadership Practices Inventory-Self
NCLDP  National Clinical Leadership Development Project
ONMSD  Office of the Nursing and Midwifery Services Director
PEQ  Participant Experiences Questionnaire
The National Clinical Leadership Development Project Pilot
Evaluation Study

EXECUTIVE SUMMARY

Introduction and background

A key priority of the Office of the Nursing and Midwifery Services Director (ONMSD) is to provide leadership, support excellence and build capacity in nursing and midwifery. This priority is aimed at enhancing patient care and service delivery within the HSE, and in line with this priority, the ONMSD instituted a National Clinical Leadership Development Project (NCLDP) in 2009. Following a national needs analysis (HSE 2009), an expansive review of the literature and consultation with key stakeholders, an Interim National Clinical Leadership Competency Framework was published (HSE 2010). The competencies, behavioural indicators and concepts outlined in the 2010 publication underpinned the development of a suite of resources that now collectively constitute the National Clinical Leadership Development Framework. The pilot of the Framework and its component parts is the subject of this evaluation. While the overall aim of the Project is to implement a national approach to the development of clinical leaders in nursing and midwifery in Ireland, the pilot set out to test the components of the Framework in order to inform a national approach. The National Clinical Leadership Development Framework for Nursing and Midwifery comprises the following:

A Clinical Leader Development Pathway
A Clinical Leader Resource Pack
A Clinical Leadership Facilitator Toolkit
An Action Learning Toolkit
A Coaching Reference Manual
A Mentor Guide
A Mentor ‘Train the Trainer’ Guide

The purpose of the Framework is to assist and support nurses and midwives to identify and develop the competencies needed to perform as a clinical leader and to provide a national
approach and structure for competency achievement for clinical leaders and their development.

The Clinical Leader Development Pathway (the Pathway) element enables individual nurses and midwives to gain access to the Framework at the appropriate level that meets their individual, self-identified clinical leadership development needs. The process is closely linked to patient and service need in that it assists nurses and midwives to clarify their roles in advancing, championing and protecting clinical care, in order to ensure patient safety and quality care. Specifically, the National Clinical Leadership Development Framework aims to assist all grades of nurses and midwives to develop clinical leadership competencies. Seven competencies have been identified, as follows: self-awareness, advocacy and empowerment, decision making, communication, quality and safety, team work, and clinical excellence.

The pilot of the National Clinical Leadership Development Framework commenced at seven pilot sites in the Cork city area in June 2011. The pilot involved the roll out of the components of the Clinical Leadership Development Framework among an initial group of fifty nurses and midwives from all grades. The pilot participants were provided with a range of resources contained in the National Clinical Leadership Development Framework in addition to a range of interventions to assist them in developing a minimum of two of the clinical leadership competencies within a six-month timeframe. The chosen competencies were selected on the basis of an assessment of leadership development need, conducted by each pilot participant in consultation with his/her line manager, using an Assessment and Development Tool, designed for the purpose. Interventions available to the participants included mentoring, coaching, action learning and workshops. Facilitators providing interventions were drawn from among the ranks of senior and experienced nurses and midwives involved in clinical practice, service management, policy, practice development and continuing education.

At the time of the commencement of the pilot, a team of researchers from the UCD School of Nursing, Midwifery & Health Systems, University College Dublin, was commissioned to conduct an evaluation of the pilot. The team was charged with examining three key areas, as follows:
o Each step of the Clinical Leader Development Pathway, in order to capture information on the approach to clinical leader development

o All the resources that support the participants on the Clinical Leader Development Pathway

o Short-term outcomes of the NCLDP pilot.

The Project Steering Committee was responsible for the governance and oversight of the pilot and its evaluation. The Project Team was responsible for the operational elements of the pilot. The UCD Research Team reported to the Project Steering Committee and worked closely with the Project Team in developing and implementing the pilot evaluation design. The evaluation study was conducted over the period of the pilot and its timing therefore coincided closely with that of the pilot. This report presents the findings of the evaluation of the pilot of the National Clinical Leadership Development Framework in seven sites in Cork city.
Evaluation design

The evaluation design was influenced by current thinking on evaluation theory, including the recommendation for an eclectic approach to evaluation, involving case study action research, which advocates multiple data sources and multiple methods of data collection. The evaluation process involved close collaboration with the National Clinical Leadership Development Project (NCLDP) Project Team in the development and iteration of the discrete elements of the evaluation design. This ensured that the design was rigorous, context relevant and consistent with the evaluation strategy, and that the design was responsive to the particular exigencies and circumstances of the pilot participants.

The Pathway was examined with reference to participant experiences and to the Pathway as an approach to clinical leader development. A Participant Experiences Questionnaire (PEQ) was developed for this purpose and administered by telephone interview to generate self-report information on experiences from all those involved in the pilot, including those who withdrew. This survey was complemented by a range of qualitative data collection methods, including focus groups, group interviews, individual interviews and written submissions received, all of which provided rich narrative data on the participants’ experiences of the Pathway, including each step in the process and the interventions used.

Evaluation data on all pilot participants’ experiences of resources and supports were generated from the various qualitative data collection methods and from data provided in responses to the PEQ. Analysis of individual constituent resource documents within the Framework was conducted using a standardised, purposely designed Documentary Analysis Rating Instrument (DARI), complemented by a conference of analysts. Documentary analysis focused on quality and presentation, language and representation of the key constructs and concepts, and the level of inter-documentary relatedness regarding use of language.

The short-term outcomes were examined with reference to the changes in the participants’ clinical leadership behaviours over the period of the pilot and at the end of the pilot, and with reference to service outcomes, such as practice innovations undertaken by participants as a result of their participation on the Clinical Leader Development Pathway.
Participants’ generic leadership practices were measured at two points in time over the course of the evaluation using the Leadership Practices Inventory-Self (LPI-S) and the Leadership Practices Inventory-Other (LPI-O) instruments. Participants’ clinical leadership behaviours at completion of the pilot were measured using a Clinical Leadership Behaviours Questionnaire (CLB-Q), which was developed for the study.

Data on short-term outcomes were also generated from the focus group discussions, individual interviews and group interviews and in responses provided in the PEQ. In these various qualitative data collection methods, two areas related to short-term outcomes were discussed, namely the participants’ own sense of having attained clinical leadership competencies and the reported service and/or organisational impact.
Findings: Participant experiences of the pilot

The total number of individuals associated with the pilot was 119. For the purpose of the study, five categories of pilot participants were identified, as follows: Category A: Pathway participants (36); Category B: Line managers (21); Category C: Mentors, coaches and action learning set facilitators (21); Category D: Workshop facilitators, pilot site coordinators and members of the Project team (23); Category E: Pathway participants who withdrew (18). However, a number of participants had more than one role in the pilot and these individuals belonged in more than one category of participant; hence the net number of participants was smaller. Participants who withdrew from the pilot were included in the survey of participants, using the Participant Experiences Questionnaire (PEQ).

The PEQ was administered by telephone interview to all pilot participants. The overall number of participants involved in the pilot was 119 and a total of 86 individuals completed the relevant section of the PEQ, representing an overall response rate of 72 per cent. Overall, respondents rated their experiences of the pilot very positively.

While participants reported that they did not have a good idea of what was expected of them when they first entered the Clinical Leader Development Pathway, they reported a positive experience of the process related to the assessment of their leadership development need. They found that aspects of the process, such as agreeing a score with their line manager, deciding their development priorities and deciding how development priorities would be linked to the service/organisation were easy to follow. They also found it easy to complete the Assessment and Development Plan and to maintain their Learning and Development Portfolio and they found the Clinical Leader Resource Pack to be an effective intervention and a document that accurately reflected their everyday experiences.

Participants reported that they were developing clinical leadership with reference to individual competencies and that their participation in the pilot had a positive impact on their service/organisation. The majority reported that they experienced support from their line manager, from the pilot site co-ordinator and from the Project Team, but fewer experienced support from their work colleagues, departmental team or their organisation. Many of the
participants experienced time constraints in meeting with their line manager to complete the Assessment and Development Tool.

Line managers also reported a very positive experience overall. However, fewer than half agreed that they had a good understanding of what was expected of them at the outset. Line managers found the processes of deciding priorities for the individual participant’s development and how those priorities would be linked to the service/organisation easy to understand. They reported that they were able to accurately rate the participant’s assessment and development needs against the behavioural indicators, agree interventions to meet the needs of service and decide on the most appropriate intervention(s) to meet the participant’s needs. The majority of line managers reported that participation in the Clinical Leader Development Pathway had resulted in a practice innovation and had resulted in a positive impact on the service/organisation. While they provided support to their participant on the Pathway, they experienced time as a constraint in relation to meeting their participant.

The majority of mentors, coaches and action learning set facilitators reported that they had a good understanding of their role at the outset and that they had adequate and effective preparation for their role. While just half of the respondents reported that they had enabled the participant(s) to develop competencies, the majority agreed that their particular intervention method was effective for clinical leader competence development. While the majority of mentors, coaches and action learning set facilitators experienced support from their organisation and from the HSE Project team, just half experienced support from their line manager. Like other participants in the pilot, they experienced the constraint of limited time when meeting their respective participant(s) on the Pathway.

Workshop facilitators, site co-ordinators and HSE Project Team members reported a positive experience overall. The majority had a good understanding of their role at the outset and reported that they had adequate and effective preparation for their role. Most did not encounter unforeseen problems while acting in the role and were able to effectively overcome any unforeseen problems. A large proportion reported that the demands of their role on the pilot competed with the other work demands; however, the vast majority experienced support from their line manager and organisation.
The most common reason cited for withdrawing from the pilot by participants who withdrew was that their work situation prevented their participation. The majority reported having little control over the circumstances that led to their withdrawal and they reported experiencing disappointment at having to withdraw. Most agreed that they would participate on the Clinical Leader Development Pathway or would seek another course to develop their clinical leadership competencies, if given another opportunity.
Findings: Experiencing the Clinical Leader Development Pathway

The various qualitative data collection methods yielded a body of very rich narrative data concerning the Clinical Leader Development Pathway, including participants’ experiences at various stages in the process, interventions used, service impact and operational and logistical arrangements involved in rolling out the pilot.

Participants had overall positive experiences of using the Assessment and Development Tool. While many referred to divergence between themselves and their line manager in relation to self rating, they also referred to arriving at a consensus with them in relation to the meaning of behavioural indicators and the scores. Participants experienced the process of maintaining their Learning and Development Portfolio as helpful in stimulating their thinking and reflection. Some participants experienced initial difficulty in selecting an intervention. The emphasis on self-monitoring in the development of competencies was a novel experience for some. However, the process of self-monitoring itself represents leadership behaviour.

The various interventions were experienced positively. Workshops were seen as beneficial in enabling the sharing of experiences of practice problems and finding possible solutions to them through group interactions. The action learning set intervention was also viewed as a very valuable experience in facilitating the sharing of ideas and concerns about practice. The focus on finding solutions to real everyday problems was seen as the particular benefit of the intervention.

The mentoring intervention was positively evaluated, with many referring to the value of the one-to-one arrangement that mentoring provided. Both mentees and their mentors referred to the importance of a good mentor-mentee relationship to the success of the intervention and many commented on how well this worked for them.

The coaching intervention was also experienced positively. Participants valued coaching as an intervention in their clinical leadership development and many spoke of how the coaching style had contributed to their development. Some coaches referred to the challenge to effective coaching when personal and emotional issues emerged in the process. Despite this
challenge, coaches were overall positive about the intervention and its contribution to clinical leadership development.

For many, the Clinical Leader Development Pathway was a very positive experience, as attested to in comments offered from across the entire range of data collection methods. Many comments referred to the Project itself, in terms of its merits and the professional way that it was conducted, while others referred to the Project with reference to their own very positive personal experience of it.

Quality and safety and clinical excellence were the clinical leadership competencies selected most often by participants. In the process of selecting a competence, service development could take precedence over leader development, with some line managers focusing on competencies that appeared to result in a more direct and tangible impact on service. Participants and their line managers referred to evidence of the development of particular competencies. Frequent reference was made to the competencies self-awareness, communication and team work and examples were offered of how these were manifest in the behaviours and dispositions of participants and in changes in the culture and atmosphere of the working environment. Many believed that self-awareness was so important that it underpinned all other competencies.
Findings: Supports and resources

While participants experienced support, time was a factor. This was experienced with reference to the timing of the pilot itself – the pilot commenced in the summer time during the school holidays – and with reference to the time required to commit to the Clinical Leader Development Pathway. Limited time was seen as a barrier to full engagement in the various elements of the Pathway. A barrier to completing chosen leadership interventions was seen to reside in the competing demands of work.

Many participants spoke in very positive terms about the support received from their line manager or service manager. While line managers were supportive, this support was moderated by two factors, firstly, their line manager’s limited formal input into the Pathway after the initial assessment of clinical leadership development need, and secondly, their line manager’s ability to engage due to competing work demands and commitments. Some participants on the Pathway considered that the line manager should have a greater input beyond the initial assessment process and some considered that their line manager was not fully prepared for their role in the process. While participants experienced support from their team and organisation, it appears that for some, their team was either not aware of their involvement or disinterested.

Documentary analysis indicated that Project documents were of a very good quality, in terms of their production, evidence base and content and in terms of their usefulness in supporting interventions in the Pathway. Accordingly, the various supporting documents were evaluated as being fit for purpose. Positive aspects of their design included distinct branding, good inter-documentary relatedness and ease of navigation.

The documentary materials were considered to be appropriate to the different grades participating in the Pathway and they provided a wide variety of evidence-based resources and supports for participants and those providing interventions. The range of documents for mentors, coaches and others were developed with reference to relevant and appropriate current evidence. The presentation and packaging of the Learning and Development Portfolio as four distinct documents, with separate content to reflect the distinct service development needs and leader development needs of each grade, was seen as a positive feature. The
Action Learning Set Facilitator Toolkit and the Clinical Leadership Facilitator Toolkit and Mentor Guide were found to be particularly well constructed. It was decided at the commencement of the project that the Coaching Reference Manual would be a ‘work in progress’ during the pilot, allowing for the inclusion of learning and any required revision of content, when published as planned after the evaluation.

While the materials were considered to be of the highest quality, some minor issues were highlighted. The wording of some behavioural indicators was such that interpretation was difficult. The availability of an overall index of the various documents would substantially aid navigation. The actual physical bulk of the documents was such that they might be deemed to be cumbersome to transport and this could be a deterrent to their regular use.
Findings: Short-term outcomes

The findings from Leadership Practices Inventory-Self (LPI-S) and Leadership Practices Inventory-Observer (LPI-O) ratings of leadership behaviours indicated that both participants and their line managers rated the participants as frequently engaging in behaviours associated with five generic leadership practices. Additionally, participants rated increases in their behaviours in three of the five generic practices and their line managers rated increases in participant behaviours in two of the five practices across the time of the pilot. Observed differences in self and observer ratings of generic leadership practices between time 1 and time 2 were not statistically significant. This finding must be viewed in the light of the short timeline between time 1 and time 2 and the low response rate, of just thirteen observer respondents, at time 2. The small number of participants in the pilot and the consequent low numbers overall that participated in the evaluation study should also be borne in mind.

Observed differences in self and observer ratings of generic leadership practices between time 1 and time 2 were not, as stated, statistically significant. However, it was noteworthy that the overall self-reported leadership behaviours scores across the five constructs showed a net increase in the summated difference between time 1 and time 2, indicating a belief among participants that their leadership practices had improved in the short timeframe of the pilot. Line managers also observed some changes in participants’ leadership practices although they rated the participants higher in fewer constructs over the same time period. Changes in self-rating scores are likely to be incremental and gradual over periods of time and therefore it may be unrealistic to expect to observe radical redirections in the short period of the pilot. A key consideration therefore in the interpretation of the results from the assessment of leadership practices using the LPI is the short timeframe of the pilot.

The self-ratings of clinical leadership behaviours associated with the seven clinical leadership competencies showed that participants overall rated themselves as frequently engaging in the leadership behaviours. Behaviours related to competencies for ‘decision making’ were most highly rated by participants. There were minor differences in self-ratings between senior (managerial) and junior (non-managerial) grades, although the observed differences in CLB-Q scores by grade were not statistically significant.
The data from focus groups, group interviews and individual interviews illustrate a positive view of the Clinical Leader Development Pathway and demonstrates the worth placed on it by participants. There was also a view given of the positive developments that had taken place as a result of the process for the participants, the service and, indirectly, the service users.

Analysis of the narrative data obtained in the various qualitative data gathering activities indicated that individual participants and their line managers could provide clear accounts of how they had developed aspects of clinical leadership competencies over the course of the pilot and how they had initiated service improvements as a result. These accounts spoke of new or improved capabilities that had resulted from their experiences of the Pathway interventions and improvements in participants’ own professional and personal development. There were mixed views on the issue of academic accreditation of the Framework and Clinical Leader Development Pathway, with positions varying from full support to scepticism and opposition.

Participants on the Pathway and those acting in supporting roles also gave numerous examples of how the pilot had led to service initiatives and/or improvements in the culture of the working environment. Service initiatives ranged in their focus from improvements in particular clinical practices and procedures to more general service developments aimed at improving safety, service quality or the patient experience at the service-user interface. Some participants on the pilot believed that it was too early in the process of leadership development to see a tangible service impact and saw leadership competencies and their associated individual and service impacts as requiring time to emerge.
Conclusions

The Clinical Leader Development Pathway is targeted at professional nurses and midwives from across all clinical and managerial grades and is designed with reference to the roles that individuals occupy in their respective grades. The study findings indicate that the Clinical Leader Development Pathway interventions and supports that are provided are designed with reference to this broad spectrum of grade-specific clinical leadership development need.

Overall, participants on the pilot, including those on the Clinical Leader Development Pathway and all those providing supports and interventions, evaluated their experiences of the pilot as very positive. This finding provides affirmation of the decisions and actions taken by the Project Team and Steering Committee in rolling out the Project and constitutes a positive finding at the level of process evaluation.

Participants had overall positive experiences of the various interventions for clinical leadership development, including workshops, action learning, mentoring and coaching. While the study did not measure particular participant outcomes against particular interventions, the value of the various interventions used in the Clinical Leader Development Pathway was attested to in the evidence provided.

There was evidence of good organisational support for the Project and there was also evidence of ongoing monitoring and refinement. However, participants cited time and competing work and family commitments as constraints on their ability to engage in elements of the Clinical Leader Development Pathway. This is a challenge in any project involving multiple individuals in their work settings.

Overall the documentary materials supporting the Project were of a very high quality and provided a wide variety of evidence-based resources and supports for participants and those providing interventions. This points to the Project having a major strength at the level of material supports and means that the Clinical Leader Development Pathway can be readily applied across multiple sites and settings, and with other resources and supports in place, can proceed with little extra planning and preparation.
Participants frequently engaged in the behaviours associated with the seven clinical leadership competencies, and evaluation data pointed to particular instances of nurses and midwives displaying evidence of clinical leadership development through their behaviours and/or through specific service or organisational initiatives that they undertook. The findings demonstrate that the focus on organisational development, particularly at the level of the individual clinical unit, was an important element of clinical leadership development in the Clinical Leader Development Pathway. Participant and service-level outcomes were linked to participation on the Clinical Leader Development Pathway and these outcomes suggest that the Clinical Leadership Development Framework is a viable method of developing clinical leadership competencies in nurses and midwives of all grades.

The Clinical Leader Development Pathway is focused on developing individual clinical leader competencies and developing the service or organisation through the expression of these competencies in context, i.e. in the everyday performance of the individual’s professional role. The Clinical Leader Development Pathway is consistent with the principles that leader development and organisational development go hand in hand and that leadership and organisational change go hand in hand. The introduction of the Clinical Leader Development Pathway is a positive development in encouraging clinicians’ commitment to change through professional development.

This evaluation study contributes evidence of the enabling and constraining factors at work in a planned programme of clinical leadership development. Enabling factors include the range and quality of human and material supports, the quality of interventions like coaching, mentoring, action learning and workshops, and the level of organisational support for individuals who are participating on the Clinical Leader Development Pathway. Factors that constrain a clinical leadership development programme include work-related constraints, such as competing demands on professionals’ time, which can, in turn, impact on the support experienced for particular development activities.

The model of clinical leadership development around which the Clinical Leader Development Pathway is built has a number of major strengths. A key strength of the Clinical Leader Development Pathway is its application across all nursing and midwifery grades, which is consistent with the idea that clinical leaders are to be found among all staff levels.
Another major strength of the Pathway is its use of andragogical approaches and interventions that are based on meeting the needs of individuals that are, in much part, self-identified. Unlike most short attendance taught courses, the Pathway takes place over a period of weeks and months and focuses on the development of individual self-identified competencies through targeted and bespoke interventions. The Pathway contains interventions, such as mentoring, coaching and action learning, which focus on participants’ development within their own practice setting.

The HSE is well placed to grow its nursing and midwifery leaders for the following reasons. It has a well developed and clearly articulated strategy for clinical leadership development, a distinct national clinical leadership development framework, a competency development pathway and a range of supports and practice-focused interventions that can be readily deployed in multiple settings. The Clinical Leader Development Pathway is designed on the assumption that clinical leadership can be demonstrated at all grades of nurses and midwives and the various supports and interventions for the Pathway are designed on that basis. This fact represents a major strength of the National Clinical Leadership Development Framework.

The Clinical Leader Development Pathway also supports the idea of lifelong learning, since an individual can access the Pathway at the appropriate level and at different points across the individual’s professional career trajectory. This is strength of the National Clinical Leadership Development Framework.

When the individual outcomes in relation to clinical leadership development and the service developments are considered, it is clear that a considerable amount has been achieved in the relatively short timeline of the pilot.

Through the pilot, the components of the Clinical Leader Development Framework have been tested in the real world of busy health care settings and among all grades of nurses and midwives and has been shown to be workable, focused on both individual and service/organisational development and capable of developing the participant’s competencies for which it is designed. The National Clinical Leadership Development Framework and Clinical Leader Development Pathway are therefore evaluated as being fit for purpose.
Recommendations

Recommendations on policy and strategy

- At the time of completing the evaluation study, clinical leadership development was an ongoing and open-ended process for the pilot participants, inasmuch as they were continuing to take interventions and had only focused on two clinical leadership competencies. The need to facilitate individuals in the pilot to complete their self-identified clinical leadership development needs should be considered.

- Accreditation of the National Clinical Leadership Development Framework should be considered at two levels. For example, academic accreditation at the level of a professional certificate could be considered. Establishing professional accreditation of the Framework should also be considered.

- The Nurses and Midwives Act 2011 requires nurses and midwives to maintain their professional competence on an ongoing basis and the Act provides An Bord Altranais with the authority to establish one or more schemes to monitor the competence of all nurses and midwives. In line with these provisions in the new legislation, consideration should be given to the possibility of the Framework being utilised in the development and recognition of continued competency schemes by the statutory regulator.

- Given the close interdisciplinary working and the high degree of interdisciplinary interdependence that characterise work in modern health care organisations, the possibility of engaging other disciplines in clinical leadership development alongside nurses and midwives should be considered. The National Clinical Leadership Development Framework and Clinical Leader Development Pathway should be considered as the suitable model for such multidisciplinary clinical leadership development.

- Since the evidence indicates that the National Clinical Leadership Development Framework and Clinical Leader Development Pathway can be applied across multiple
sites and settings and among all staff grades, consideration should be given to the further roll out of the Project either at targeted regional sites or on a national basis.

Recommendations on structures, supports and interventions

- The Clinical Leader Development Pathway algorithm needs to be revised and should appropriately describe the timeframe involved in clinical leadership competency development as experienced on the pilot.

- Based on a frequency rating scale, the scoring mechanism in the Assessment and Development Tool caused some confusion for participants and their line managers, and no scores were entered into the 1 (‘never’) category. The scoring mechanism could be reviewed in order to ensure that it is sufficiently discriminatory and easy to use.

- Since a common observation made by many who contributed data was that self-awareness underpinned all other competencies, consideration should be given as to whether self-awareness should be the starting point in the Clinical Leader Development Pathway for all participants.

- Since a major strength of the Framework were the material supports that supported the participants on the Pathway, consideration should be given to preparing these supports in electronic and online formats for ease of use and cost containment.

- Periodic checks of cited URL links in the documents should be undertaken to ensure that the links to cited resources can be established.

- The behavioural indicators used to describe the clinical leadership competencies should be reviewed. Ambiguity regarding the language and interpretation of behavioural indicators could be reduced if more concise and direct statements of behaviours were used. Additionally, learning outcomes for the workshop interventions should be reviewed to ensure that they are stated in terms that are clear and observable.
Consideration should be given to the development of a structure and process to validate the individual participant’s Learning and Development Portfolio. Linked to this is the need for a structure for ongoing monitoring and feedback for participants, in order to ensure that they receive objective feedback in relation to their progress and that their progress is not wholly reliant on self-monitoring. However, participants should be encouraged to self-monitor and to see the process of self-monitoring as representing leader behaviour.

The use of interventions that are action oriented and focused on service development, such as mentoring, coaching and action learning should be supported. In using these interventions, the focus should be on each participant’s current role and everyday practice and on helping the participant to develop and demonstrate clinical leadership skills in these contexts.

**Recommendations on procedures**

In the roll out of the National Clinical Leadership Development Project at sites in the future, close attention should be paid to the initial information provision and dissemination of the Project in the service area. All those involved directly or indirectly on the Clinical Leader Development Pathway, including line managers and work colleagues, should be clear as to its purpose and their respective roles in it. This should ensure better buy in and support for roll out at the levels of the local clinical department and the wider organisation. Participants on the Pathway should be provided with information to ensure that expectations for clinical leadership development are realistic.

As the line manager is central to facilitating the participant’s progress on the Pathway, the role of the line manager needs to be more clearly set out and the line manager needs more deliberate and better preparation for the role. Ongoing monitoring of the Pathway should include a focus on the line manager’s role in the process.
In the assessment and development process, particular emphasis should be paid to the aspect of assessment of service need, so that the development of the individual’s leadership skills is with reference to the particular practice role that they occupy and the services in which they operate.

In selecting appropriate interventions for the development of individual competencies, participants on the Pathway need clear guidance as to the precise function of each intervention and should receive guidance on the selection of the most appropriate intervention.

Since the development of competence in clinical leadership is a lifelong journey and learning associated with clinical leadership is developmental, there is a need to recognise that the ‘sign off’ of development in a chosen competence does not necessarily imply that further development in that competence is not possible. This fact should be communicated through the Project.

The mentorship intervention should be considered with reference to the way that it is conducted in practice. For example, the establishment of a mentoring contract and tri-party meetings between the participant on the Pathway, the mentor and the line manager should be considered, similar to the model in place for coaching.

An exit interview or survey should be conducted with participants on the Pathway who withdraw and the patterns and reasons for withdrawal should be monitored.

Recommendations for future research

Further testing and development of the CLB-Q instrument with a larger sample is warranted and with further refinement the instrument should be considered as a means of conducting the standardised degree-of-change questionnaire or a 360-assessment instrument.

The effectiveness of individual interventions should be established statistically within an Irish setting, using research approaches that involve hypothesis testing for causal
relationships and the application of higher-level multivariate statistical procedures like structural equation modelling.

- The interventions that have been used in the National Clinical Leadership Development Framework, such as mentoring, coaching and action learning, have been shown elsewhere to be effective in skills development and in relating development to real-world practice. As they were very positively evaluated in the present study, these interventions should be further developed for nursing and midwifery clinical leadership development and their effectiveness evaluated again at a later point.

- A unique element of the Framework is the development of the clinical leader’s competencies to enable the development of the clinical leader’s services/practices area. The impact of the outcomes of leaders and services development on the leaders themselves, on the service outcomes and on patient experiences warrant investigations to give tangible credibility to clinical leadership development in the Irish context.

- Developing and building relationships are fundamental as the clinical leader travels through the pathway. Influencing and enabling those relationships are skills the clinical leader must acquire to progress. This aspect of clinical leadership development has rarely been captured and an examination of ‘leadership development’ focusing on relationship development in the clinical area would add considerably to building our services and practices.
Chapter 1

INTRODUCTION

1.1 Introduction and background

In order to enhance patient care and service delivery within the HSE, a key priority of the Office of the Nursing and Midwifery Services Director (ONMSD) is to provide leadership, support excellence and build capacity in nursing and midwifery. In line with this priority, the ONMSD instituted a National Clinical Leadership Development Project (NCLDP) in 2009. The overall aim of the NCLDP is to implement a national approach to the development of clinical leaders in nursing and midwifery in Ireland. The Project comprises a National Clinical Leadership Development Framework and its associated Clinical Leader Development Pathway. The purpose of the Framework is to assist and support nurses and midwives to identify and develop the competencies needed to perform as a clinical leader and to provide a national approach and structure for competency achievement for clinical leaders and their development. The Framework and Clinical Leader Development Pathway are underpinned by the Interim National Clinical Leadership Competency Framework for Nursing and Midwifery (HSE 2010). Based on an extensive review of literature, the Framework aims to develop seven core clinical leadership competencies for all grades of nurses and midwives.

A pilot of the NCLDP commenced on 14 June 2011 at seven pilot sites in Cork city, namely: Cork University Hospital, Cork University Maternity Hospital, South Infirmary Victoria University Hospital, Mercy University Hospital, North Lee Mental Health Services, North Lee Public Health Nursing Services and St Finbarr’s Hospital (Care of the Older Adult). An initial group of fifty nurses and midwives of all grades was recruited onto the pilot and the pilot was supported by a range of human and material resources aimed at facilitating the Clinical Leader Development Pathway and providing appropriate interventions to enable the development of pre-specified clinical leadership competencies, as identified by the participants in consultation with their line managers. A Project Steering Committee was responsible for the overall governance of the pilot and a Project Team was responsible for the day-to-day operation of the pilot. The pilot ended in mid December 2011.
In June 2011, a team of researchers from the UCD School of Nursing, Midwifery & Health Systems, University College Dublin, was commissioned to conduct an evaluation of the pilot. The team was required to examine three key areas of the pilot, as follows:

- Each step of the National Clinical Leader Development Pathway, in order to capture information on the approach to clinical leader development
- All the resources that support the participants on the Clinical Leader Development Pathway
- Short-term outcomes of the NCLDP pilot

In commissioning the evaluation study, it was anticipated that the findings of the study would inform the development of a National Clinical Leadership Development Framework for Nursing and Midwifery, which will be published in 2012.
1.2 The National Clinical Leadership Development Project

The journey towards becoming a clinical leader in nursing and midwifery involves leading change, influencing others and being able to demonstrate the skills to adapt to changing circumstances and to facilitate team development and personal and professional accountability in the process of planning, delivering and measuring outcomes of clinical care. These capabilities are within the scope of every professional grade in nursing and midwifery to achieve and are achievable through a variety of interventions, both self-directed and directed.

The National Clinical Leadership Development Project aims to support nurses and midwives to attain competence in up to seven core clinical leadership competencies, which are listed below. The two key elements of the Project are the National Clinical Leadership Framework and the Clinical Leader Development Pathway. The purpose of the Framework is to assist and support nurses and midwives in planning and carrying out their responsibilities for directing and shaping clinical care in their respective services and organisations, through the development of leadership competencies that enable them to perform as effective clinical leaders. It is also intended that the Framework will provide a national approach and structure for leadership competency achievement. In summary, the aims of the National Clinical Leadership Framework are:

- To assist and support nurses and midwives to identify and develop the competencies needed to perform as a clinical leader
- To provide a national approach and structure for competency achievement for clinical leaders and their development

The Clinical Leader Development Pathway element aims to enable an individual nurse or midwife to gain access to the Framework at the appropriate level that meets their individual clinical leadership development needs. The Clinical Leader Development Pathway also assists nurses and midwives to clarify their roles in advancing, championing and protecting clinical care, thereby promoting patient safety and quality care. The Pathway is akin to a decision-tree algorithm, in that it enables each individual nurse or midwife to engage in a self-assessment of development need (Figure 1.1). The Framework and Clinical Leader
Development Pathway are supported by a range of human and material resources and supports.
1.3 The Framework and Clinical Leader Development Pathway

Once the individual nurse or midwife enters the Clinical Leader Development Pathway, s/he is invited to attend an introductory workshop and is then supported by his/her line manager in assessing clinical leadership development need, with reference to each of the seven competencies. With the assistance and support of the line manager, the individual nurse or midwife determines her/his individual development need in relation to the seven core clinical leadership competencies. The needs assessment is conducted using the Assessment and Development Tool, which is contained within the *Learning and Development Portfolio*. The assessment is based on a self-assessment against a set of behavioural indicators for each competence and the process yields a score ranging from 1 to 4 for each behavioural indicator. Each score, in turn, corresponds to the frequency with which an associated behaviour is performed by the participant (Figure 1.1).

<table>
<thead>
<tr>
<th>Behavioural indicator</th>
<th>1 Never</th>
<th>2 Sometimes</th>
<th>3 Frequently</th>
<th>4 Always</th>
<th>Agreed score following discussion with LM</th>
<th>Evidence</th>
</tr>
</thead>
</table>

**Figure 1.1. Scoring system for determining competency development need**

The total overall score for each competence provides the basis for the intervention(s). In addition, the individual and line manager discuss and agree priority areas for development within the service area or organisation and agree the actions to be taken in addressing the service development need.

Once development need in relation to each of the competencies is determined, a range of bespoke interventions is identified and agreed with the individual’s line manager. The various interventions are provided through human and material supports and range from self-directed activities to more directed activities, such as mentoring, coaching, action learning and/or attendance at one or more workshops. A key documentary support is the *Clinical Leader Resource Pack* (CLRP), which contains seven distinct units of learning, one for each of the seven clinical leadership competencies. The CLRP is a core resource to support all participants on their clinical leadership pathway and constitutes part of the suite of interventions. Interventions also consist of mentoring, coaching and action learning arrangements and these are conducted according to the methods and procedures offered in the relevant supporting documents.
As well as the individual participant’s line manager, other human resources and supports consist of mentors, coaches, action learning set facilitators and workshop facilitators. Each support person has a precise role in providing an intervention. The human supports, including coaches and mentors are, in turn, supported by a range of material supports, particular to their respective roles in the Clinical Leader Development Pathway. These supports include: the Action Learning Facilitator Toolkit, the Clinical Leadership Facilitator Toolkit, the Mentor Train the Trainer’s Programme, the Mentor Guide and the Coaching Reference Manual.

For the purpose of the pilot, the overall Clinical Leader Development Pathway was managed by key individuals. These included a Project coordinator for each of the pilot sites, a Project Team, which managed the day-to-day operational elements of the pilot, and a Project Steering Committee, which maintained strategic oversight and governance of the pilot.

The competencies for clinical leadership are: self-awareness, advocacy and empowerment, decision-making, communication, quality and safety, teamwork and clinical excellence. Leadership development concerns all four nursing and midwifery promotional grades, from the staff grade to service director. The Framework is built on nine overarching core values:

- Promotion of individualism/person centredness
- Promotion of health
- Personal accountability and responsibility
- Advancement of collaborative teamwork
- Prevention of illness
- Practice of political acumen
- Practice of evidenced based care
- Lifelong professional, personal and clinical competence
- Strengthening the organization

The Clinical Leader Development Pathway indicates the decision algorithm for identifying an individual’s indicative competence deficit and indicative development pathway towards addressing an identified deficit and is part of the Framework (Figure 1.2).
Participants invited to participate in NCLD process

Week 1

Attend introductory workshop

Week 2

Line manager assesses the participant using the assessment and development tool for all competencies

Participants complete the assessment and development tool for all competencies

Participant and line manager meet and agree:
- Participant LDP priorities
- Conduct service assessment
- Intervention(s) to be undertaken

All scores of 4
- No further action

Mostly scores of 3
- Choose one intervention
- Workshop optional

Mostly scores of 1 & 2
- Workshop & one other intervention

Intervention plan sent to Site Coordinator

Week 4

Site Coordinator sends intervention plan to NMPDU, for analysis and requirements

Collated intervention plan returned to Site Coordinator

Timetable of individual interventions sent to each participant from NMPDU

Week 5

Figure 1.2 Clinical Leader Development Pathway (HSE 2011)
1.4 Report structure

This report presents the findings of the National Clinical Leadership Development Project Pilot evaluation study. The report includes a review of literature on areas pertinent to the evaluation study, notably: leadership and clinical development and approaches to clinical leadership development, models and methods of leadership and clinical leadership development evaluation and reported evaluation studies of clinical leadership development initiatives.

The study findings are presented in four distinct chapters, each addressing a key aspect of the pilot evaluation, as follows: the Clinical Leader Development Pathway, the resources and supports and the short-term outcomes of the pilot. The Clinical Leader Development Pathway was examined with reference to participant experiences and the Pathway as an approach to clinical leader development. The resources that supported the Clinical Leader Development Pathway were examined with reference to material resources and supports and human resources and supports, including individual and organisational-level supports. The short-term outcomes were examined with reference to the self-reported changes in clinical leadership competencies over the period of the pilot and at the end of the pilot, and with reference to organisational outcomes, such as innovations undertaken by participants as a result of their participation on the Clinical Leader Development Pathway.

The study findings are discussed in the light of existing literature in the areas of leadership development, and policy regarding the development of the nursing and midwifery resource. The overall evaluation strategy and aspects of the research design are also discussed. The effectiveness of the Clinical Leader Development Pathway as a model for clinical leadership development is also discussed. The report concludes with some recommendations that may inform the further development of the National Clinical Leadership Development Framework and the operation of the Clinical Leader Development Pathway element of the Framework.
Chapter 2

LITERATURE REVIEW

2.1 Introduction

Clinical leader development, or leader development in a clinical context, are distinctly different from more generic leader development. Clinical leadership development is the development of the nurses’ and midwives’ leadership skills with the mutual purpose of developing their clinical skills, practices and the services in which they operate. It is concerned with collective development of leaders linked together in a context of practice relationship. The focus of leadership development is on developing social capital, social awareness and social skills, such as collaboration, co-operation and conflict management (Fealy et al. 2009); it focuses on developing the organisation’s capacity ‘to enact the basic leadership tasks needed for collective work’ (McCauley & Van Velsor 2004: 18).

The following review of literature examines a number of areas of literature pertinent to the present evaluation study, as follows: leader and clinical leadership development; approaches to leadership and clinical development; interventions used in leadership and clinical leadership development; models and methods of leadership and clinical leadership development evaluation and outcomes of evaluation studies of leadership and clinical leadership development initiatives.
2.2 Clinical leadership development in Ireland

While the clinical leader role in nursing and midwifery is exercised at the departmental level, including the clinician-patient interface, it is also expressed in interdisciplinary working and at the level of organisational policy and planning (Fealy et al. 2011). Hence, clinical leadership development in nursing and midwifery involves developing both ‘intrapersonal and interpersonal competencies and dispositions that are expressed in context’ (Fealy et al. 2009: 16). The National Clinical Leadership Needs Analysis study demonstrated that dimensions of clinical leadership development that give rise to particular types of clinical leadership development need included managing the clinical area, managing patient care, developing the individual, developing the profession and skills for leadership (Fealy et al. 2009, Casey et al. 2011). The study also showed that clinical leadership development needs differed by grade, with the staff grade reporting a greater development need than all manager grades in relation to ‘managing the clinical area’, ‘managing patient care’ and ‘skills for clinical leadership’ (Casey et al. 2011). Additionally, grade differences in relation to perceived barriers to clinical leadership development were a function of the relative influence that each grade perceived it had in effecting quality care and wider organisational policy (Fealy et al. 2011).

The greatest barriers to clinical leadership development were those that related to nurses’ and midwives’ spheres of influence in interdisciplinary working and in the wider departmental and organisational sphere (Fealy et al. 2011). To be effective leaders in both clinical and policy arenas, nurses and midwives need to acquire and articulate a disciplinary discourse that outlines the scope, content and future of nursing and midwifery as professional clinical disciplines (McNamara & Fealy 2010). In summary, clinical leadership development needs in nursing and midwifery relate to the intrapersonal and the interpersonal, the grade at which the nurse or midwife operates and the different practice contexts in which leadership is expressed.

In a review of the factors that contribute to nursing leadership, Cummings and colleagues categorised leadership factors into four groups as follows: behaviours and practices of individual leaders, traits and characteristics of individual leaders, influences of context and practice settings, and leader participation in educational activities (Cummings et al. 2008). The authors reported evidence from the literature that individual leaders who take on practice
leadership styles, skills and roles can significantly influence leadership. They also found that the traits and characteristics of individual leaders with previous leadership experience and the leader’s level of education had positive effects on observed leadership. Cummings *et al.* (2008) also reported that the practice setting had a moderate influence on leadership effectiveness and that participation in leadership development initiatives can have a significant positive influence on observed leadership.
2.3 Approaches to leadership and clinical leadership development

The target of leader development is the individual and the focus is on intrapersonal capacities like self-awareness, self-regulation and self-motivation, whereas leadership development is relational and focuses on interpersonal capacities like social awareness and social skills (Day 2001). These capacities are appropriate to clinical leadership development and leadership development can operate at both individual and relational levels (Day 2001). Leadership development is concerned with developing collective capacity for effective engagement in leadership roles and processes (Day 2001, McCauley et al. 1998). Among the goals of leadership development are the following: expanding the capacity of individuals to be effective in leadership roles; developing the pipeline of leaders within an organization; identifying and giving voice to emerging and/or invisible leadership; strengthening the capacity of teams to improve organizational outcomes and creating a critical mass of leaders who can accelerate change in communities to address key issues and problems (Hannum et al. 2007). These goals are especially relevant to clinical leadership development in nursing and midwifery.

To achieve these and associated goals, numerous approaches to leadership development have been advanced. One approach is to support greater organizational effectiveness and use leadership development to support specific individuals to develop their capacities to make them and their organizations more effective (Grantcraft 2003). Another approach is to work to strengthen communities and fields of practice by developing leadership as a mechanism for bringing about change through increasing skills, providing role models, resources and opportunities for people who work in the community or field and by bringing them into contact with new perspectives or approaches to social change (Grantcraft 2003). Given the interprofessional and organisational-level barriers to clinical leadership development experienced by nurses and midwives in Ireland, clinical leadership development projects should encourage both boundary-building and boundary-spanning by nurses and midwives, by providing experiences that help nurses and midwives to articulate a distinctive disciplinary perspective and to engage with the perspectives of diverse professional and client groups (McNamara et al. 2011).
The attainment of these goals gives rise to types of leadership and clinical leadership
development programmes and initiatives and provides the basis for planning project
evaluation. Leadership and clinical leadership development initiatives can have an impact
beyond the individual participant and his/her immediate work organisation; training can foster
changes in systems policies and organisations through the agency of wider informal networks
and coalitions of like-minded leaders, who are capable of leading the development and
diffusion of innovations (Umble et al. 2007). Hence, leadership development projects should
foster collaborative leadership through ‘engaging leaders in systems thinking, team
leadership, dialogue, conflict resolution, and negotiation’ and through the use of networks for
sustained personal and system development (Umble et al. 2007).

The number of occupational leadership development programmes is increasing worldwide,
but the majority are aimed at those who occupy or are preparing to occupy managerial
positions (Duygulu & Kublay 2010). However, in nursing there is evidence that organizations
are investing in leadership development training for nurses who do not occupy management
positions (Wessel-Krejci & Malin 1997). These initiatives are related to organisations’ altered
expectations of front-line nurses in relation to the management of change (Wessel-Krejci &
Malin 1997) and are therefore more focused on developing clinical leadership.

A number of leadership development projects in nursing have been reported in the literature.
The Leading an Empowered Organisation (LEO) programme is a professional development
programme aimed at promoting the development of leadership skills and empowerment
among staff working within the health services. The programme has been widely used in
leadership development for nurses and midwives Ireland, the United Kingdom and the United
States. Tourangeau (2003) reported the development of a five-day residency program for
aspiring nursing leaders with a booster educational weekend held three months following the
programme. The programme focused on four domains of leadership, as follows: nursing
practice, the business of healthcare, leadership practices and the use of self. Andragogical
methods used included didactic sessions, self-reflection, small group discussion and problem-
solving, coaching, and networking opportunities. A feature of this and similar programmes is
their focus on nurses in established leadership roles or aspiring to develop leadership
positions. More recently, leadership development projects have been developed for nurses in
the front-line of clinical service and have as their focus the development of clinical leadership skills.

Duygulu and Kublay (2011) developed a transformational leadership training initiative for unit charge nurses at a large children’s hospital in Turkey. The aim of the short 28-hour initiative was to develop unit charge nurses’ leadership practices and it focused on a range of topics, including power, motivation, exemplary leadership practices and becoming an effective leader. Wessel-Krejci and Malin (1997) reported the development of a three-day clinical leadership development initiative based on training workshops aimed at developing a range of competencies in front-line nurses with a focus on planned change, communication, conflict, group dynamics, systems theory, and oppressed group behaviour. The RCN clinical leadership programme is a twelve-month training programme based on developing transformational leadership behaviours and self-development in participants and it incorporates experiential learning through workshops as the main pedagogical approach (Large et al. 2005). Roberts and Coghlan (2011) offer a model of leadership, facilitated by action learning, which can provide a way for individuals to develop both intrapersonal and interpersonal skills as it strengthens social networks, facilitates shared learning and meaning-making and acts as a catalyst for organisational change.

Interventions
Day (2001) identified six interventions that can be used to facilitate leadership development, as follows: 360-degree feedback, executive coaching, mentoring, networking, job assignments and action learning. Experiential approaches to leadership development, such as 360 degree feedback, mentoring and coaching, have been widely supported in the literature on leadership development (Proctor-Thompson 2008) According to Day (2001), mentoring is an especially effective component of leadership development in context. In a review of school leadership development, Bush et al. (2007) concluded that mentoring was an effective method of leadership development and that mentoring requires considerable training in its proper use. As an intervention, informal mentoring has demonstrated more positive benefits than formal mentoring (Day 2001).

Leonard and Lang (2010) reported on the use of action learning as a competence-based intervention for leader development in a range of settings, including US government
departments, industry and at an institute of the US National Institutes of Health. In these various settings, participants in action learning experienced the intervention as significantly contributing to their development as leaders, and in one study the intervention had contributed to the development of specific critical competencies, including communication, team building and decisiveness. Leonard and Lang (2010) concluded that action learning was effective due to its efficiency, its focus on particular individually-relevant leadership skills and its focus on real-world practice problems and actionable solutions.

According to Day (2001) coaching is aimed at improving specific leadership skills or solving specific problems, and is viewed as an ongoing process rather than a discrete event. Byrne (2007) advocates coaching as a way of developing clinical leadership skills in context. Coaching places individuals into real situations in which they see and experience at first hand the unique problems that occur in particular clinical settings. As a strategy for developing clinical leaders, coaching is both action and learning oriented, focusing on the individual’s personal and professional goals and on developing intrapersonal and interpersonal skills, such as personal and professional self-management and interpersonal communication (Byrne 2007). Reid-Ponty (2006) reported that nurses who experienced coaching found it effective in helping them to identify and correct behaviours that hampered their performance, thereby improving their individual and organisational effectiveness.

Leonard and Lang (2010) assessed and compared a range of leadership development interventions against criteria for effectiveness, including participant insight, motivation, skill development and real-world practice. They concluded that action learning and individual coaching were more strongly effective on participant outcomes like insight, skill development and real-world practice than the more traditional leadership development approaches, such as attendance at taught programmes.
2.4 Models and methods of leadership and clinical leadership development evaluation

Leadership development evaluation models must be flexible in order to fit the particular development project being evaluated. Evaluation should be a form of systematic inquiry about a project or initiative that seeks information on its logic, resources, activities, outputs and outcomes and should distinguish real outcomes from vague programme aspirations (Leviton 2007). Evaluation can function to demonstrate a wider range of outcomes. These include: demonstrate the benefits of a programme to participants and their organization; assist with fine-tuning a leadership-development intervention to better meet its goals; demonstrate how leadership development experiences relate to wider goals, such as improving organizational performance; promote learning-centred reflection as a central evaluation activity; pinpoint which leadership competencies are most appropriate in particular settings, and encourage more comprehensive discussion about what works and why (Hannum et al. 2007).

Key points to be considered when evaluating leader development projects include leader development and leader impact, and where appropriate, leader network development and network activities (Umble et al. 2007). Grove et al. (2007) advocate an open-systems approach to evaluation on the basis that the outcomes of leadership development occur at the individual, organisational and community (social or professional networks) domains (Grove et al. 2007). Hannum et al. (2007) write that while evaluation does not generally follow a linear process, a number of basic steps must be completed, as follows:

- Identify stakeholders for the initiative and the evaluation
- Articulate the initiative and evaluation process
- Specify at what level (e.g. organisational or individual) impact is expected to occur
- Specify the type and timing of impact (e.g. a change in a specific behaviour after six months)
- Determine and prioritise critical evaluation questions
- Identify or create measures or processes for gathering information about the initiative and its impact
- Gather and communicate information
- Share and interpret information from the evaluation
Grove et al.’s (2007) evaluLEAD evaluation framework proposes two principal forms of inquiry, namely evidential and evocative. The former gathers descriptive and measurable objective evidence from individual stakeholders. The latter seeks the perspective and sentiments of those who are influenced by the programme and gathers information of feelings, insights, values, self-awareness and personal stories. Both forms of inquiry can be applied in an evaluation study design and the relative value of each in informing data gathering is a function of the relative emphasis placed on either outcome.

Methods of leadership development evaluation
A review of the literature on methods of leadership and clinical leadership development evaluation revealed a number of studies, all of which deployed multiple methods for generating evaluative data. Umble and colleagues evaluated the work of the National Public Health Leadership Institute (PHLI) in the United States, to determine the Institute’s influence on key domains of leadership in the area of public health over a fifteen-year period (Umble et al. 2007, 2011a, 2011b). The evaluation focused on key domains, such as individual leader development, leader actions, leadership network development and network actions, systems and infrastructure. The authors used a combination of quantitative and qualitative data collection methods, including an online survey and participant interviews. The online survey yielded self-report data on key areas of interest to all stakeholders, including leader-related attributes and leader practices. A key focus in the evaluation was on evidence of the ‘contribution’ of the Center for Health Leadership & Practice to individuals, teams, networks, and infrastructure that were already in place. This ‘open-systems’ view of program evaluation was adopted because it gave a purchase on ‘the complexity and interconnectedness’ of programme results at individual and wider levels.

Stol et al. (2010) evaluated the UK National Health Service (NHS) London Darzi Fellowships in Clinical Leadership Programme with reference to its impact at the levels of the programme participants, their work organisations, other stakeholders and the ‘wider systems’. Evaluative data were generated using interviews with participants and other stakeholders, interviews with the programme originators and designers and case studies of individual participants. Large et al. (2002) reported a multiple-case study evaluation of the RCN Clinical
Leadership Programme (CLP). Foci of the evaluation were the development of clinical leadership capabilities in programme participants, the impact on patient care, clinical practice, team and organisation, and key stakeholder perceptions of the effectiveness and acceptability of the programme. Data collection included qualitative interviews with key stakeholders, measurement of the development of participants’ leadership behaviours using the Leadership Practices Inventory (LPI) (Kouzes and Posner 2003) and assessment of documentary data supporting the programme. Data were collected at baseline, midpoint and programme completion stages.

In the course of leadership development evaluation studies, a range of instruments have been deployed to measure outcomes related to the development of participants’ leadership capacities and behaviours. Conway (2009) evaluated the Clinical Excellence Commission Clinical Leadership Program (CEC CLP) in New South Wales, with reference to its capacity to facilitate leadership of improved clinical practice and its cost effectiveness. Evaluative data were drawn from a variety of sources, including development and training documents, interviews with key informants, surveys of participants and other stakeholders, submissions, portfolios of learning and reflections of stakeholders. Duygulu and Kublay (2011) evaluated a transformational leadership training initiative for unit charge nurses in Turkey. With a focus on participants’ leadership practices, the evaluation team used modified versions of the Leadership Practices Inventory: Self (LPI-S) and the Leadership Practices Inventory: Observer (LPI-O). The LPI-S and LPI-O were administered at four sequential points in the process, namely at base line, at training programme end, at three months and at nine months. The LPI-S and LPI-O are based on the work of Kouzes and Posner (2003) and permit the assessment of leadership practices within five categories: model the way; create a common vision; challenge the process by looking at ways to improve organisational effectiveness and capacity; encouraging others to act, and encouraging the heart. The original instrument is presented as a series of statements concerned with leadership practices on a ten-point Likert frequency scale from ‘almost never’ to ‘almost always’. Duygulu and Kublay (2011) modified the instruments to achieve a five-point frequency scale.

Aside from the use of the Leadership Practices Inventory to measure leadership behaviours in programme participants, other tools have been deployed in evaluation studies to measure leader behaviours and capacities. Young (1992) used the Leadership Behaviour Questionnaire
to measure the leadership behaviours of nurse leaders and Mansen (1993) used the Leader Behaviour Descriptive Questionnaire to measure the leadership behaviours of nursing faculty and faculty administrators. Black and Earnest (2009) reported the development of the Leadership Program Outcomes Measure (LPOM), a degree-of-change questionnaire with three subscales corresponding to the individual, organisational and community outcomes identified in Grove et al.’s (2007) evaluLEAD framework. The instrument was developed as a summative evaluation tool to establish individual participant outcomes after they had exited a leadership training programme. Martineau and Hannum (2004) advocate the use of ‘degree-of-change’ measures, from ‘no change’ to ‘great change’, to assess change across rater groups, such as peers and supervisors, in preference to pre and post test measures. This is in order to counter the limitations of self-report surveys in determining a programme’s effects.
2.5 Outcomes of leadership and clinical leadership development

At the levels of the individual, organisation and professional community, leadership development outcomes may occur at episodic, developmental or transformative levels and these changes take place concurrently and not sequentially or chronologically (Grove et al. 2007). Episodic outcomes are the well-defined and time-bound actions of participant. Developmental outcomes occur over time and may be represented as steps taken by participant in a particular challenging situation. Transformative outcomes represent the fundamental shifts in participant behaviour, or ‘radical redirections of effort ... and [are] the prize to which programmes aspire’ (Grove et al. 2007: 79).

Particular instructional methods can result in particular leader outcomes. Hence, teaching-learning methods, such as self-assessment tools, developmental assignments, action learning and case discussions, can result in particular participant outcomes, such as changed understanding, new knowledge and skills for leadership, increased confidence and self-awareness and changes to clinical leadership practice (Miller et al. 2007). However, while particular instructional methods are related to specific participant outcomes, participants in leadership development often integrate information and skills from multiple methods to achieve particular outcomes (Miller et al. 2007).

Leadership and clinical leadership development initiatives have been shown to have a positive impact on participants’ leadership effectiveness at the personal, organizational and community levels and in their particular disciplinary field (Woltring et al. 2003). Participation in leadership and clinical leadership development training in nursing has also been shown to be the most significant factor contributing to increased leadership practices (Cummings et al. 2008). For example, Tourangeau (2003) reported that nurses who participated in a leadership development training initiative used clinical leadership behaviours more often and concluded that participation can promote significant improvements in leadership practices of both established and aspiring leaders. With a focus on self-perceived competencies in leadership understanding and ability, Wessel-Krejci and Malin (1997) reported significant increases in both understanding and ability to perform stated competencies immediately following and three months after completing a three-day leadership training programme.
The findings from studies reporting the effectiveness of leadership development programmes show evidence of changes in leadership behaviours following interventions. A number of researchers have reported statistically significant self-reported and other-reported increases in leadership practices using the LPI following educational interventions for clinical leadership development in nursing. Duygulu and Kublay (2011), Krugman & Smith (2003) and George et al. (2002) all demonstrated statistically significant self-reported and other-reported increases in leadership practices using LPI following educational interventions for leadership development in nursing. Wessel-Krejci and Malin (1997) observed significant increases in programme participants’ understanding and ability to perform leader competencies immediately following and at three months after completion of a three-day workshop-based training initiative. Examining the effects of transformational leadership training on unit charge nurses’ leadership practices, Duygulu and Kublay (2011) reported that their clinical leadership practices had increased significantly with the implementation of the training. These authors found that both self and observer ratings of unit charge nurses’ leadership practices had increased following a leadership development programme and that the self-ratings of leadership behaviours were significantly higher than those of their observers. Similarly, Krugman & Smith (2003) found that programme participants’ self-rated leadership practices were higher than those of their observers.

Using self and observer ratings of leadership practices before and following a three-day leadership training programme, Tourangeau (2003) reported that while participants did not rate increases in their own leadership practices, their peers did observe improvements in participants’ leadership behaviours in all five leadership practices measured by the LPI, and their supervisors observed improvements in two of the five leadership practice areas on the LPI. George et al. (2002) similarly found that leadership practices were rated lower by leadership programme participants than by their observers.

Large et al. (2005) reported that the RCN clinical leadership programme resulted in an empowering of clinical leaders to deliver more effective care through such outcomes as increased self-confidence in their leadership approach, improved value and optimism about their leadership role, increased commitment to improving care and developing team effectiveness. Lunn et al. (2008) evaluated the RCN clinical leadership programme, which they implemented on a pilot basis in the West of Ireland using participant self-report data.
Reported participant benefits included improved job satisfaction and morale and enhanced leadership skills and capabilities in the areas of communications, conflict management and problem-solving. Other participant benefits included improved confidence among team members in dealing with managers and in finding novel ways of delivering care. Factors that have been shown to influence the impact of a clinical leadership development project include a supportive organisational culture, high quality mentoring, targeting transformational change in the project and ongoing project monitoring and refinement (Stol et al. 2010).

**Key points**

A range of leadership and clinical leadership development projects have been developed and implemented in nursing and to a lesser extent in midwifery, with the aim of developing new capacities and behaviours in individuals and also developing the organisations in which those individuals operate. Some projects focus on the development of generic leadership skills, while others are targeted at developing clinical leadership competencies in front-line staff.

In clinical leadership development project evaluation, outcomes are generally examined with reference to leadership practices and new or improved leader behaviours over time, using self-reports and observer reports. The service impact of a clinical leadership development project may also be examined with reference to changes in organisational mission and culture. Evaluation can also focus on participant experiences and the acceptability of a project to the project participants and other stakeholders. Cost-benefit measures are not generally reported.

The evidence points to positive benefits of leadership and clinical leadership projects and initiatives, in terms of participants’ enhanced clinical leadership behaviours and practices.
2.6 Conclusions

A range of leadership and clinical leadership development projects have been developed and implemented in nursing and to a lesser extent in midwifery, with the aim of developing new capacities and behaviours in individuals and of developing the organisations and communities in which those individuals operate. These approaches seem to place greater emphasis on leader development and effectiveness than on organisational development. Some projects focus on the development of generic leadership skills, while others are targeted at developing clinical leadership competencies in front-line staff.

The literature points to a range of models and methods of leadership and clinical leadership development project evaluation. These can vary in terms of their focus and/or their methods of inquiry, but common among the various approaches are efforts to determine training outcomes with reference to participants. These outcomes are generally examined with reference to new or improved leadership capacities and leader behaviours, as measured with the use of scales. These same key outcomes are relevant for clinical leadership development project evaluation in nursing and midwifery.

Beyond measures of participant and organisational outcomes, attention can also be directed towards other aspects of a development project such as participant experiences and the acceptability of the project from the perspectives of clients, clinical leaders and other stakeholders. The service impact of clinical leadership development may also be examined with reference to changes in practices and changes in organisational mission and culture. Cost-benefit measures are not generally reported.

A common way of establishing leadership and clinical leadership development effectiveness is to measure leader behaviours and practices over time, using self-reports and observer reports. The evidence points to the benefits of projects and initiatives in developing and enhancing clinical leadership behaviours and practices. Few studies reviewed have reported organisational-level development in any great detail.
2.7 References


Dublin: Nursing and Midwifery Planning and Development Unit, Health Services Executive.


Proctor-Thomson SB (2008) *Constellations or stars?: What is being developed in leadership development?* Lancaster University Management School, Centre for Excellence in Leadership (CEL).


Chapter 3

RESEARCH DESIGN

3.1 Introduction

As providers of front-line clinical care, nurses and midwives are ideally placed to offer the clinical leadership required to ensure safe and effective care (McNamara et al. 2011). The development of leadership competence must be a key outcome of clinical leadership development initiatives for nursing and midwifery (Casey et al. 2011). Leadership is context dependent and so leadership development initiatives must also focus on the context in which the leadership occurs. Accordingly, evaluation of such initiatives must also take place in context.

This chapter describes the evaluation strategy, including the theoretical foundations that gave rise to the particular research design, and the materials and methods of data collection and data handling that were used to conduct the evaluation of the National Clinical Leadership Development Project (NCLDP) pilot. The evaluation design was influenced by current thinking on evaluation theory, including the recommendation for an eclectic approach to evaluation, involving case study action research, which advocates multiple data sources and multiple methods of data collection. The strategy was also informed by the principles of partnership (Casey 2008, Ford et al. 2008) and illuminative programme evaluation (Fealy et al. 2000).

In setting out the requirements for the evaluation of the NCLDP Pilot, the HSE identified three ‘key areas’ that should be the focus of the evaluation. The evaluation should examine:

- Each step of the Clinical Leader Development Pathway, in order to capture information on the *approach* to clinical leader development
- All resources to support the pilot, including material resources, such as toolkits and portfolios, resources for learning and development, such as workshops and action learning sets, and organisational resources, such as service time and commitment
Short-term outcomes of the pilot, including the impact on participant clinical leadership behaviours, impact on the service and service users and supports required

These three areas gave rise to three key research questions as follows:

1. Is the NCLD Pathway approach and Clinical Leader Development Pathway a sustainable model for clinical leadership development in nursing and midwifery?
2. How effective were the resources in supporting the Pathway approach and process?
3. What were the short-term outcomes of the Pathway approach and process from individual and service perspectives?

The National Clinical Leadership Development Project (NCLDP) Project Team required the following tasks to be completed by the Research Team:

- The development of a mixed methods evaluation strategy to evaluate the National Clinical Leadership Development Pilot, in consultation with the Project Team
- The conduct of an evaluation of the National Clinical Leadership Development Project Pilot
- Analysis and presentation of evaluation findings within one month of the end of the pilot

A specific task was to evaluate each step of the Clinical Leader Development Pathway, in order to ‘capture information on the approach to clinical leader development, [and] in the final analysis ... to determine if [the whole approach] is a sustainable model for clinical leadership development in nursing and midwifery’.
3.2 Pilot evaluation strategy

While evaluation methods and procedures should ideally be designed in tandem with project design and in advance of the project start up, this was not be possible in the present evaluation study, given the closeness of the timelines for pilot commencement and Research Team commissioning. However, the evaluation strategy and design were based on a number of key operating principles, as follows: consultation with all key stakeholders at all stages; clarification of outcomes of the evaluation with the stakeholders; discussion of the purpose of the evaluation and how the information would be used and the use of multiple methods to generate evaluative data (Hannum et al. 2007). In addition, the strategy aimed to capture relevant data on the three key areas of the evaluation project requirements, namely: evaluation of the Clinical Leader Development Pathway, evaluation of the resources supporting the process and assessment of the short-term outcomes of the pilot.

A key feature of the pilot evaluation process was the collaborative approach adopted in the ongoing development and iteration of the evaluation and its discrete elements. This was characterised by regular and open communication between the Research Team and the Project Team. The function of this communication was to ensure that the perspectives and needs of the Project Team were addressed on an ongoing basis and to ensure that the methods of data collection were rigorous, context relevant and consistent with the evaluation strategy. The open communication also ensured that the Research Team was alert to the exigencies of the particular situations and circumstances of all the pilot participants, while at the same time ensuring that the key deliverables were achieved.

The evaluation strategy did not hold evaluation to be an end product to be achieved; rather, evaluation was seen as a key aspect of ongoing project development and change in the way that it could provide value-free and constructive information (Leviton 2007). Since the NCLDP is ultimately concerned with bringing about changes in practitioners and related changes in clinical practice and service, the evaluation strategy was appropriately informed by the Donabedian action-research model in which structure, process and outcomes data were generated (Figure 3.1). Developed within the case study action research approach, the strategy was based on the principles of a partnership approach.
The Donabedian elements of structure, process and outcome specify the contextual programmatic areas which require evaluation, while the steps in the action research cycle identify the mechanism for undertaking the evaluation. The four steps in the action research cycle are: constructing, planning action, taking action and evaluating action (Coghlan & Brannick 2010). These steps offered both a mechanism with which to evaluate the pilot itself and a means of addressing any issues in the structure, process or outcomes elements that might have warranted corrective action.

According to the framework, action could be co-constructed with the pilot providers, the Project Team, the evaluation Project Team, mentors and others, as appropriate. Focusing on the three contextual domain elements of structure, process and outcomes also facilitated a comprehensive, unified and holistic evaluation of both participant and service components.

In addition to the evaluation framework, the Research Team took the major steps suggested by Hannum et al. (2007) as a broad guide in developing the evaluation strategy, namely that
the evaluation should be conducted with reference to: the Project aims and objectives; participant experiences; participant (short-term) outcomes, including specific skills and competencies; stakeholder requirements and wider contribution. The evaluation design addressed two key requirements of the tender: (i) the development of a mixed methods evaluation strategy, in consultation with the Project Team and (ii) the conduct of the required evaluation of the pilot. Accordingly, a mixed methods approach to data collection was developed as the main strategy for generating evaluative data. This data triangulation approach aimed to ensure that all those experiencing the pilot were represented in the data that were collected. Data triangulation also aimed to provide additional evidence of the impact of the initiative and to generate rich and comprehensive information from diverse sources and, in so doing, addressed all the stakeholder needs (Craig & Hannun 2007).
3.3 Pilot evaluation design: Data sources

The main elements of the pilot evaluation, including the scoping, development and data collection elements were conducted over the six-month period of the pilot and involved data collection at points in time across this period. In developing the evaluation strategy in consultation with the Project Team, the Research Team focused the data collection approach on three key areas: the experiences of participants on each step of the Clinical Leader Development Pathway, the resources to support the pilot and the short-term outcomes of the pilot. This required the identification of the main sources of evaluation data and the approaches and methods that would be developed and deployed to gather the data from each of these sources. Sources of data were categorised according to six major categories, as follows: Category 1: Participant on the Pathway; Category 2: Line manager; Category 3: Provider of the intervention; Category 4: Project Team; Category 5: Participants who withdrew; Category 6: Material resources and supports. The major data collection approaches are summarised in Figure 3.2.
Table 3.1 summarises the main data sources (by category) and the main methods of data collection from each source. The table indicates the *relative* weighting of each evaluation element and demonstrates that the substantial proportion of the evaluation activity was aimed at generating data that addressed the first and second key areas, namely the Clinical Leader Development Pathway and the supports.
Table 3.1 Data sources and data collection methods by pilot participants

<table>
<thead>
<tr>
<th>Evaluation element</th>
<th>Sources of data</th>
<th>Focus of evaluation</th>
<th>Evaluative data collection by...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category 1: Participant on the Pathway</strong></td>
<td>Nurse and midwife participants</td>
<td>Experiences of participating in the Pathway approach and process</td>
<td>Focus group (x5); PEQ Individual interview (x1); PEQ Focus group (x1); PEQ</td>
</tr>
<tr>
<td></td>
<td>DoN &amp; DoM participants</td>
<td></td>
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<tr>
<td><strong>Category 2: Line manager</strong></td>
<td>Line managers</td>
<td>Experiences of participating as line manager in the Pathway approach and process; Relationship of individual development and service development</td>
<td>Focus group (x 2) PEQ</td>
</tr>
<tr>
<td><strong>Category 3: Provider of intervention</strong></td>
<td>Mentors, action learning set facilitators</td>
<td>Experiences of participating as provider of an intervention in the Pathway approach and process</td>
<td>Focus group (x1); PEQ Group interview (x1); PEQ Focus group (x1); PEQ</td>
</tr>
<tr>
<td></td>
<td>Internal coaches</td>
<td></td>
<td></td>
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<td></td>
<td>Workshop facilitators</td>
<td></td>
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<tr>
<td><strong>Category 4: Project Team</strong></td>
<td>Project Steering Committee</td>
<td>Experiences of developing implementing and overseeing the pilot</td>
<td>Group interview (x1); PEQ Individual interview (x2); PEQ</td>
</tr>
<tr>
<td></td>
<td>Project Team: Strategic</td>
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<tr>
<td></td>
<td>Project Team: Operational and site co-ordinators</td>
<td>Experiences of supporting the Clinical Leader Development Pathway</td>
<td>Group interview (x1); PEQ</td>
</tr>
<tr>
<td><strong>Category 5: Participants who withdrew</strong></td>
<td>Participants who withdraw from the pilot</td>
<td>Experiences of participating in the pathway approach and process</td>
<td>PEQ</td>
</tr>
<tr>
<td><strong>Category 6: Material resources</strong></td>
<td>Learning &amp; Development Portfolio; Clinical Leader Resource Pack; Action Learning Facilitator Toolkit; Clinical Leadership Facilitator Toolkit; Mentor Train the Trainers Programme; Mentor Guide; Coaching Reference Manual</td>
<td>Effectiveness of the material resources in supporting the Pathway approach and process</td>
<td>Documentary analysis Focus group (as above) PEQ (as above) Interview (as above)</td>
</tr>
<tr>
<td><strong>(Key area 1)</strong> Each step in the Clinical Leader Development Pathway</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>(Key area 2)</strong> Resources to support the pilot</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(Key area 3)</strong> Short-term outcomes of the pilot</td>
<td>Nurse &amp; Midwife Pathway participants</td>
<td>Short-term individual and service outcomes</td>
<td>LPI: Self; CLB-Q (self-report)</td>
</tr>
<tr>
<td></td>
<td>Line managers</td>
<td></td>
<td>LPI: Observer (Observer report)</td>
</tr>
</tbody>
</table>

**Key**: LPI-S: Leadership Practices Inventory-Self; LPI-O: Leadership Practices Inventory-Observer; CLB-Q: Clinical Leadership Behaviours Questionnaire; PEQ: Participant Experiences Questionnaire
3.4 Data collection for key area 1: Clinical Leader Development Pathway

The Clinical Leader Development Pathway was examined with reference to participant experiences and the Pathway as an approach to clinical leader development. The overall aim of data collection in relation to the Clinical Leader Development Pathway was to establish the suitability of the process as a sustainable model for addressing clinical leadership development in nursing and midwifery. In order to generate evaluative data in relation to each step of the Clinical Leader Development Pathway, a number of complementary data collection methods were deployed. These included focus groups, group interviews, individual interviews and the administration of a Participant Experiences Questionnaire (PEQ) (Table 3.1).

A total of ten focus group discussions were conducted, as follows: five focus groups with participants on the Clinical Leader Development Pathway, two focus groups with line managers and a single focus group each with directors of nursing and directors of midwifery, mentors (including action learning set facilitators) and workshop facilitators. In addition three group interviews were conducted, one each with internal coaches, the Project Team members responsible for operational aspects of the pilot and the Project Steering Committee. Two individual interviews were conducted with the members of the Project Team with responsibility for the strategic development and oversight of the pilot. A single interview was conducted with one participant.

The focus groups with the pilot participants were organised on the basis of the clinical leadership competencies. The purpose of the focus groups, group interviews and individual interviews was to generate rich qualitative data on the experience of the various participants involved in the pilot. One action learning set was observed with reference to the effectiveness of the intervention at the level of process evaluation. In addition, four internal coaches provided written reflections on their experiences of coaching and mentors provided written comments to inform the study.

The focus groups, group interviews and individual interviews were conducted over the final six weeks of the pilot. The comprehensive plan for the roll-out of the qualitative data collection was developed in consultation with the Project Team and participant recruitment
and data collection was supported at pilot sites by the local site co-ordinators. In order to avoid any undue disruption to services, focus groups were scheduled on not more than one day per week.

**Focus groups, group interviews and individual interviews**

The conduct of focus groups was informed by best practice in the field of social research (Krueger & Casey 2009, Barbour 2007). Each focus group discussion was facilitated by a moderator, with the assistance of an observer, acting as a support to the moderator. Each focus group was conducted according to a topic guide, which was standardised with reference to categories for discussion, but with modifications with reference to focus group membership (Appendix 1). In that way, discussion in each focus group was directed toward the particular role and experiences of each individual group within the Clinical Leader Development Pathway. The broad category areas were: experiences of entering the Clinical Leader Development Pathway, leadership capacity, the Assessment and Development Tool, experiences of interventions, practice or organisational innovations, supports and outcomes. The topic guide was subjected to initial testing at the level of the Research Team and the guide was modified as necessary following the first two focus groups and preliminary analysis of data.

In conducting each focus group, the group moderator provided the circumstances for open and frank discussion, through careful planning and judicious moderation to promote the engagement of all participants. The moderator introduced the discussion, briefed the group on the purpose of the discussion, stated the ground rules to be observed, facilitated discussion and closed the discussion. Particular strategies employed to promote candid discussion included the use of varied questioning styles, including targeted, follow-up and open-ended questions, paraphrasing and summarising, exploration of divergence of views and active listening (Puchta & Potter 2004). The observer administered demographic questionnaires, recorded field notes, observed group dynamics and managed the environment, including the digital recording equipment.

Focus group participants were selected by purposive sampling, with the aim of recruiting informants who were best placed to provide valid and reliable information on the experiences of the Clinical Leader Development Pathway. Each participant signed a consent form and all
participants were assured of anonymity and advised that the names of individuals or healthcare organisations would not be included in any reports of the findings. At the close of each focus group, participants were thanked for their contribution. Focus group discussions lasted from between one hour to one hour and thirty minutes.

**Group interviews and individual interviews**

Group interviews differed from focus group discussions only with reference to their size and degree of group homogeneity. Group interviews were conducted with the internal coaches, the Project Team, including site co-ordinators, and the Project Steering Committee. The participants in each group interview were homogenous with reference to their role in the pilot. The same degree of careful planning, judicious moderation, careful monitoring and ethical probity was applied to the group interviews. Each group interview was conducted according to a predetermined topic guide (Appendix 2) and each was completed over a period of less than one hour. Individual interviews were conducted according to an interview schedule (Appendix 2). The focus of the schedule was on the particular role and experiences of the individual in the role that s/he performed in the pilot. Each interview was conducted at a time and location suitable to the participant.

**Observation of an action learning set**

A Research Team member observed one action learning set intervention, in order to examine and document the degree of facilitation and interaction among action learning set participants and to gauge the overall effectiveness of the intervention at the process level of evaluation. The observation was conducted with the prior consent of the action learning set facilitator and the participants. Data from the observation were recorded as field notes and compiled as a short qualitative report. The data were incorporated into the total qualitative data set.

**Participant Experiences Questionnaire (PEQ)**

The Participant Experiences Questionnaire (PEQ) was a major element of the data collection in relation to the evaluation of the Clinical Leader Development Pathway and the supports for the process (Appendix 3). The PEQ was developed specifically for the study and was designed to elicit evaluative data on the experiences of all pilot participants, including the participants on the Pathway, line managers, mentors, internal coaches, workshop and action-learning set facilitators, members of the Project Team and the Project Steering Committee.
and withdrawn participants. The aim of the questionnaire was to generate data that would inform the evaluation of the Clinical Leader Development Pathway experience and the Pathway structures and supports. The PEQ instrument also provided specific data on the pilot participants’ experiences, with reference to their particular role in the pilot.

The questionnaire was designed as a self-report instrument, with five separate rating scales, one for each category of pilot participant. Each scale was presented as a list of declarative statements about the Clinical Leader Development Pathway and related aspects, and respondents were asked to indicate the extent to which they agreed or disagreed with each statement, using a simple five-point Likert scale from: 1 = strongly disagree; 2 = disagree; 3 = uncertain; 4 = agree; 5 = strongly agree. The declarative statements described aspects of the experience of participating in the pilot.

The PEQ was constructed as five distinct scale-type questionnaires within a single instrument and each questionnaire was presented as a rating scale, with subcategories, as follows:

Section A: Pathway participant. This scale contained a total of thirty-eight items constructed under five category headings, as follows: (i) Getting on the Pathway, (ii) Using the Assessment and Development Tool, (iii) Interventions to support my development, (iv) Supports and (v) Outcomes of the Clinical Leader Development Pathway.

Section B: Line manager. This scale contained sixteen items constructed under four category headings, as follows: (i) Participating in the pilot, (ii) Determining the participant’s assessment and development needs, (iii) Interventions and supports and (iv) Service impact.

Section C: Mentor or coach or action learning facilitator. This scale contained fourteen items constructed under four category headings, as follows: (i) Participating in the pilot, (ii) Training for my role, (iii) Acting in my role and (iv) Supports.

Section D: Workshop facilitator or Site coordinator or member of the HSE Project Team. This scale contained fourteen items constructed under four category headings, as follows: (i) My role in supporting the pilot, (ii) Preparation for my role, (iii) My experiences in supporting the pilot and (iv) Supports.
Section E: Withdrawn pilot participant. This section of the PEQ contained a list of ten reasons for withdrawing from the pilot and respondents were asked to select a single item from the list which best represented their reason for withdrawing. The Section also contained a small five-item scale that incorporated statements relating to the experiences of participants who withdrew from the pilot and their intention to pursue clinical leadership development in the future. The scale required respondents to indicate their level of agreement with the statements.

A single open-ended item invited respondents to provide additional comments if they wished. The instrument was developed through several iterations by the Research Team and in consultation with the Project Team. The PEQ was administered by telephone survey method.
3.5 Procedures: data collection for key area 1: Clinical Leader Development Pathway

Ethical approval
An application was made to the Research Team’s institutional Human Research Ethics Committee (HREC) for exemption from full ethical review. This was in accordance with the standard procedure required in the conduct of evaluation studies of this kind. The application to the HREC contained the detailed procedures for participant recruitment, the conduct of data collection, including the online survey, focus groups and the individual interviews, and details of the data handling and storage. This included the procedures for obtaining written informed consent and assuring confidentiality and anonymity in the reporting and dissemination of the study findings. The application to the Committee also included a letter of indemnification from the University’s insurers. Approval of exemption from full ethical review was granted on 8 August 2011 (Ref No: LS-E-11-112-Fealy).

Participant recruitment
An initial individualised e-mail invitation to participate in the evaluation study was issued by the Research Team to all pilot participants, including Clinical Leader Development Pathway participants, line managers, coaches, mentors, workshop facilitators and action learning facilitators in August 2011. This was followed up by individualised and targeted e-mail invitations to members of the various categories of pilot participants, inviting them to contribute to their respective elements of the data collection (Appendix 4). In the process of issuing participant invitations, the precise reasons for seeking the data were indicated. Invitations to participate were later issued to the Project Team and the Project Steering Committee.

All focus group participants and participants in group and individual interviews were asked to give written informed consent prior to participating in their respective focus groups, group interview or individual interview (Appendix 5). All participants were informed that the names of individuals or their organisations would not be recorded or identified in the report or subsequent publications, and that all data would be stored securely at the Research Unit of the Research Team.
The PEQ was administered over the final two weeks of the pilot or in the week immediately following completion of the pilot. The questionnaire was administered by telephone interview with the prior agreement of respondents. Prior agreement to receive a telephone call and participate in the telephone interview were taken to indicate consent to participate in the survey element of the evaluation study. Pilot participants who had more than one role in the pilot completed all those elements of the PEQ that applied to them.

3.6 Data analysis for key area 1: Clinical Leader Development Pathway

Data obtained from the Participant Experiences Questionnaire (PEQ) were analysed using SPSS Version 18.0 (SPSS Inc. Chicago IL) software. Calculations of frequency distributions, measures of central tendency and measures of variability were conducted to summarise data, including means of group responses to each separate section of the instrument. For the purpose of analysis and reporting, each section was treated as a separate and distinct instrument and accordingly a separate mean score was calculated for each of the category scale in the questionnaire. However, the various sub-elements within each of the five instrument sections were not treated as distinct subscales. Descriptive data were displayed visually through the appropriate use of charts and graphs and frequency distribution tables.

Data handling for the qualitative data was facilitated by the use of NVivo software. Data obtained from the focus groups, group interviews and individual interviews were analysed using thematic content analysis in order to permit the extraction of emergent themes in the data. Content analysis involved a modified multi-stage approach to analysis, involving the identification of preliminary categories, reaching consensus on categories, allocating category and detail codes, merging and re-allocating details (Fealy et al. 2009). The overall outcome of this analytical process provided for the development and narration of emergent themes supported with exemplary participant narratives.
3.7 Data collection for key area 2: Resources

Sources of data on resources to support the Clinical Leader Development Pathway

The study design required the evaluation of all the resources that supported the pilot. These were examined with reference to material and human resources, including individual and organisational-level supports. Evaluation data on human supports had as their focus the pilot participants’ self-reported experiences of supports. These data were collected in the course of the focus groups, group interviews and individual interviews; each topic guide typically began with the broad question: ‘can you discuss your experiences of supports’ and included targeted questions about supports at the levels of the team, line manager and organisation.

Other data on supports were generated through the use of individual items in the Participant Experiences Questionnaire (PEQ); for each distinct category of participant in the pilot, a number of rating scale items were included, as follows: Clinical Leader Development Pathway participants (6 items), line managers (1 item), coaches, mentors and AL facilitators (3 items), and workshop facilitators, site co-ordinators and Project Team members (3 items).

Documentary analysis

Data on the material supports were collected using a documentary analysis method designed specifically for the pilot evaluation study. The aim of the documentary analysis design was to generate information on the quality, layout and internal structure of each document and on specific aspects of the content of the documents, such as their use of language to convey constructs and concepts, and the relation of these constructs and concepts within and among the various supporting documents.

In designing the documentary analysis method, the aim was to construct a standardised tool, with which each member of the Research Team could independently and objectively analyse the documentary materials. Specifically, the design involved the development of a bespoke rating instrument, which required each analyst to rate elements of each document according to their appearance, structure, content, use of language and intra-documentary and inter-documentary relation of concepts and constructs (Appendix 6).
Designated as the Documentary Analysis Rating Instrument (DARI), the instrument contained seventy eight statements about the documents, presented within seven major categories, as follows: (i) all documents (10 items), (ii) the Learning and Development Portfolio (13 items), (iii) the Clinical Leader Resource Pack (29 items), (iv) the Action Learning Toolkit (8 items), (v) the Clinical Leadership Facilitator Toolkit (Parts 1 and 2) (8 items), (vi) the Mentoring document (5 items) and (vii) the Coaching Reference Manual (5 items). Each statement was presented on a rating scale with which analysts were required to indicate their level of agreement, from ‘strongly disagree’ (1) to ‘strongly agree’ (5). Each category incorporated an open-ended item with which analysts could insert additional comments. A final open-ended item was included, which enabled analysts to provide additional comments on any aspect of the documents. A sample of items contained in the instrument is presented in Figure 3.2 below.

<table>
<thead>
<tr>
<th>Please indicate the extent to which you agree with the following statements concerning the content of the Learning and Development Portfolio (LDP) document for all four grades. Please rate the document in general.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regarding the Learning &amp; Development Portfolio, in general…</strong></td>
</tr>
<tr>
<td><strong>tick ONE number only</strong></td>
</tr>
<tr>
<td><strong>1</strong> The five major sections (i.e. Sections 1 to 5) are set out in a logical order</td>
</tr>
<tr>
<td><strong>2</strong> The ‘instructions for use’ (page 3) are clear and unambiguous to the user</td>
</tr>
<tr>
<td><strong>3</strong> The rating scores for each competence are sufficiently discriminatory</td>
</tr>
<tr>
<td><strong>4</strong> The guide for determining the most appropriate mechanism for developing each competence, based on each score, is clear</td>
</tr>
<tr>
<td><strong>5</strong> The behavioural indicators for each of the seven competencies are stated in clear language</td>
</tr>
</tbody>
</table>

**Figure 3.2 Sample of items in the documentary analysis instrument**

The rating instrument permitted analysis of the documents at three levels, as follows:
(i) The quality of documents, in terms of their presentation and layout;
(ii) The content of each document, with reference to the language and the representation of the key constructs and concepts;
(iii) The relationship among the documents, with particular emphasis on the relationship between the constructs in the assessment and development tool and the documents supporting the various interventions.

The DARI was developed after a number of iterations and refinements. All key documents that informed and supported the range of activities associated with individual participant development and the interventions on the Clinical Leader Development Pathway were analysed using the instrument. Four members of the Project Team were involved in this element of the evaluation design.

Simple descriptive statistics were employed in the analysis of the DARI responses; measures of dispersion and central tendency were calculated for the responses to statements in the seven DARI scales, in order to yield an overall group rating for each document. Once each analyst completed the documentary analysis independently using the rating scales in the DARI tool, a conference of analysts was convened among the four analysts. This conference was moderated by a fifth member of the Research Team who did not conduct the documentary analysis using the DARI. The discussion was digitally recorded with the verbal consent of all present. The key themes to emerge from the conference of analysts constituted complementary qualitative data for the documentary analysis.
3.8 Data collection for key area 3: Short-term outcomes

The short-term outcomes were examined with reference to the changes in participant behaviours over the period of the pilot and at the end of the pilot, and with reference to organisational outcomes, such as innovations undertaken by participants as a result of their participation on the Clinical Leader Development Pathway.

In order to establish short-term outcomes, three behavioural rating questionnaires were administered. The Leadership Practices Inventory-Self (LPI-S) and the Leadership Practices Inventory-Other (LPI-O) were administered at the commencement of the pilot (time 1) and at completion the pilot (time 2) to the individual participants and their line manager, respectively. In addition a Clinical Leadership Behaviours Questionnaire (CLB-Q) was developed for the study and administered to individual participants at completion the pilot (Appendix 7). The overall aim of data collection using these questionnaires was to measure the short-term outcomes of the Clinical Leader Development Pathway and its associated interventions, with particular reference to the attainment of leader and clinical leadership behaviours.

Leadership Practices Inventory: Self (LPI-S)

The Leadership Practice Inventory: Self (LPI-S) (Kouzes & Posner 2003) is a short self-report questionnaire that asks respondents to rate themselves against thirty general leadership behaviours. The LPI-S contains thirty statements of behaviour, with six statements each measuring one of five basic leadership behaviours or practices, as follows: ‘model the way’, ‘inspire a common vision’, ‘challenge the process’, ‘enable others to act’, and ‘encourage the heart’ (Kouzes & Posner 2003). The five basic leadership behaviours and their corresponding scale items are summarised in Table 3.2.

<table>
<thead>
<tr>
<th>Basic leadership behaviour</th>
<th>Corresponding items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model the way</td>
<td>1, 6, 11, 16, 21, 26</td>
</tr>
<tr>
<td>Inspire a common vision</td>
<td>2, 7, 12, 17, 22, 27</td>
</tr>
<tr>
<td>Encourage others to act</td>
<td>3, 8, 13, 18, 23, 28</td>
</tr>
<tr>
<td>Challenge the process</td>
<td>4, 9, 14, 19, 24, 29</td>
</tr>
<tr>
<td>Encourage the heart</td>
<td>5, 10, 15, 20, 25, 30</td>
</tr>
</tbody>
</table>
The list of thirty behaviours is presented on a ten-point rating scale, with respondents required to rate their leadership behaviours from 1 (‘Almost never’) to 10 (‘Almost always’). Respondents are requested to answer with reference to how they typically behave ‘on most days, on most projects, and with most people’.

The instrument has been deployed in a number of leadership development evaluation studies among nurses (Duygulu & Kublay 2010, Krugman & Smith 2003, Tourangeau 2003, George et al. 2002). Cronbach’s Alpha coefficient of the Leadership Practices Inventory has been reported as varying between $\alpha =0.75$ and $\alpha =0.87$ (Duygulu & Kublay 2010), indicating a high reliability coefficient.

The Leadership Practice Inventory: Other (LPI-O)
The Leadership Practice Inventory: Other (LPI-O) is a short questionnaire that asks respondents to rate another individual against the same thirty general leadership behaviours that are contained in the LPI-Self. The Cronbach’s Alpha coefficient of the Leadership Practices Inventory Observer (LPI-O) varies between $\alpha =0.88$ and $\alpha =0.92$ (Duygulu & Kublay 2010). Kouzes & Posner (2002) have reported an overall test-retest reliability coefficient of more than $\alpha =0.90$ for the instruments and Duygulu (cited by Duygulu & Kublay 2010) later reported a Cronbach’s alpha internal consistency coefficient of $\alpha =0.92$ for the leader scale and $\alpha =0.97$ for the observer scale.

Clinical Leadership Behaviours Questionnaire (CLB-Q)
In consultation with the Project Team, an instrument was developed to measure clinical leadership behaviours particular to the seven core clinical leadership competencies that are set out in the National Clinical Leadership Development Framework. Based on the lists of behavioural indicators for each of the seven competencies and for each of the four nursing and midwifery grades, a list of generic clinical leadership behaviours was developed. Applicable to all four grades, these behaviours were presented as short self-report statements describing practitioner actions and behaviours in everyday professional practice.

The statements were grouped into seven categories, with each category corresponding to one of the seven Framework competencies. Each statement was presented on a simple five-point Likert scale and respondents were asked to rate the frequency with which they engaged in
each behaviour. The frequency ratings ranged from 1 (‘Never’) to 5 (‘Always’). Respondents were asked to rate themselves with reference to their current professional role and, when responding, to reflect ‘your typical behaviours in everyday practice and not how you think you should act’.

In order to assure a good degree of validity and reliability, the Clinical Leadership Behaviours (CLB) instrument was pretested using six cognitive interviews. The cognitive interview is a method of pretesting questionnaires prior to their distribution to the sample of interest. It especially useful in establishing how respondents comprehend, interpret and respond to questions and so provides the perspective of the respondent rather than that of the researcher in questionnaire design (Drennan 2003). The cognitive interview is informed by a combination of cognitive psychology and survey research methodology to locate and identify sources of response error in questionnaires (Drennan 2003).

The six cognitive interviews took place at a large urban university teaching hospital in early October. The hospital was not participating in the pilot. Participants in the cognitive interviews included representatives from all four nursing grades and two members of the HSE Project Team. Each interview was digitally recorded and the interview transcripts were examined for participants’ ‘thinking-aloud’ responses to the questionnaire, including individual items.

The cognitive interviews were especially useful in establishing the face validity of the CLB-Q items and the data generated from the interviews resulted in refinements to the draft instrument, including the deletion of a number of items and modifications to the language used in some of the behavioural statements. This refinement resulted in a forty-eight item self-rating questionnaire presented as seven subscales, as follows: self-awareness (6 items), advocacy and empowerment (6 items), decision making (7 items), communication (6 items), quality and safety (7 items), team work (8 items) and clinical excellence (8 items).

A sample of instrument items for the subscale ‘Advocacy and empowerment’ is presented in Figure 3.3.
Please read each statement and rate your own clinical leadership behaviours using the scale, as follows:

1 = Never; 2 = Infrequently; 3 = Sometimes; 4 = Frequently; 5 = Always

<table>
<thead>
<tr>
<th>COMPETENCE: ADVOCACY AND EMPOWERMENT</th>
<th>Never</th>
<th>Infrequently</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>In my current professional role...</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 I am generally able to recognise when patients or colleagues need my support</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>8 I advocate for others when they are unable or unwilling to speak or act themselves</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>9 I create an environment in which others are empowered to speak or act in meeting their own needs and the needs of others</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>10 I actively support patients or colleagues when they are acting to meet their own needs and the needs of others</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>11 I actively support colleagues to achieve the highest standards in their work</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>12 I encourage others to act according to best available evidence and best-practice standards</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Figure 3.3 Sample of items in the CLB instrument

The CLB-Q questionnaire had a high index of reliability, as evidenced in the range of Cronbach’s alpha scores for each instrument subscale. The Cronbach’s Alpha coefficient ranged from between $\alpha = .677$ (advocacy and empowerment) and $\alpha = .842$ (team work).

**Qualitative sources on short-term outcomes**

In addition to the three leadership behaviours rating questionnaires, data on short-term outcomes were also generated from the focus group discussions, individual interviews and group interviews and in responses to the PEQ. In the various qualitative data collection methods two areas related to short-term outcomes were examined, namely the participants’ own sense of having attained clinical leadership competencies and the reported service and/or organisational impact.

**3.9 Procedures: Data collection for short-term outcomes**

Following the issuing of the initial individualised e-mail invitation to participate in the evaluation study to all pilot participants, the Leadership Practices Inventory-Self (LPI-S) questionnaire was administered to all participants on the Pathway using Survey Monkey.
online software. The invitation to complete the LPI-S questionnaire was issued via e-mail; the link to the instrument in Survey Monkey was incorporated into the body of the e-mail. For the purpose of determining any change over the time of the pilot, the timing of the administration of the LPI-S was designated as ‘time 1’. The questionnaire was administered in August 2011, and following a period of four weeks, a reminder e-mail was issued to all non-respondents.

The Leadership Practices Inventory-Other (LPI-O) questionnaire was administered to all line managers who conducted a leadership development assessment with one or more participants on the Pathway. Since a number of the line manager respondents were assigned to two or more participants, it was not possible to administer the LPI-O instrument using Survey Monkey, which permitted a single online observer rating only. Accordingly, the LPI-O instrument was administered by post. Those line managers who had conducted a leadership development assessment with more than one participant received the required number of LPI-O questionnaires and were requested to complete a separate questionnaire for each participant with whom they had conducted an assessment.

For the purpose of determining any observed change over the time of the pilot, from the perspective of line managers, the timing of the administration of the LPI-O was designated as ‘time 1’. A reminder e-mail was issued to non-respondents following a period of four weeks.

The LPI-S and LPI-O were again administered to all participants and their line managers, respectively, at a time towards the completion of the pilot or in the week immediately after completion of the pilot; this time was designated ‘time 2’. In order to assure a standardised approach, the same method of data collection was deployed as at ‘time 1’.

The Clinical Leadership Behaviours questionnaire (CLB-Q) was administered to all participants at the same time as the focus group discussions were facilitated, in order to reduce the overall burden on participants and to optimise response rates. Those participants not attending a focus group were invited to complete the CLB-Q using a telephone interview.
3.10 Data analysis for short-term outcomes instruments

Data obtained from the LPI-S, LPI-O and CLB-Q were analysed using SPSS Version 18.0 (SPSS Inc. Chicago IL). Calculations of frequency distributions, measures of central tendency and measures of variability were conducted to summarise data, including means of group responses. Items that were grouped into categories were treated collectively as subscales. Accordingly, mean scores were calculated for each of the five categories of leadership behaviours that were measured using the LPI-S and LPI-O instruments. Similarly, mean scores were calculated for each of the seven subscales representing the seven clinical leadership competencies in the CLB-Q. For ease of interpretation, data were displayed visually through the appropriate use of charts, graphs and frequency distribution tables.

Appropriate parametric tests were used to identify group differences in responses associated with pre-determined sample characteristics, such as staff grade, which were treated as independent variables. The t-test was used to assess whether the means of two groups were statistically different from each other. In addition a non-paired two-tailed t-test was used to test for significance in LPI-S and LPI-O mean scores at time 1 and time 2.
3.11 Summary of evaluation strategy and design

The aim of the pilot evaluation design was to evaluate the following three elements of the Clinical Leader Development Pathway:

- Each step of the Clinical Leader Development Pathway, in order to capture information on the approach to clinical leader development
- All resources to support the pilot, including material resources, human resources and organisational resources, such as service time and commitment
- Short-term outcomes of the pilot, including the impact on participant leadership behaviours, impact on the service and service users and supports required

The pilot evaluation design was influenced by current thinking on evaluation theory, including the recommendation for an eclectic approach to evaluation, involving case study action research, which advocates multiple data sources and multiple methods of data collection. The evaluation process involved close collaboration with the Project Team in the development and iteration of the discrete elements of the evaluation design. Regular and open communication between the Research Team and the Project Team ensured that the Project Team’s needs were addressed, that the design was rigorous, context relevant and consistent with the evaluation strategy, and that the design was responsive to particular exigencies and circumstances of the pilot participants.

The Clinical Leader Development Pathway was examined with reference to participant experiences and the Pathway as an approach to clinical leader development. A Participant Experiences Questionnaire (PEQ) was developed for this purpose and administered by telephone interview to generate self-report information on experiences from all those involved in the pilot. This included information on experiences of the steps in Clinical Leader Development Pathway, as reported by the participants themselves, their line managers, and all those providing interventions and supports to the Clinical Leader Development Pathway, including mentors, coaches, action learning set facilitators, workshop facilitators, site coordinators and the HSE Project Team. This survey was complemented by a range of qualitative data collection methods, including focus groups, group interviews, individual interviews and written submissions provided by pilot participants, all of which provided rich
narrative data on the participants’ experiences of the Clinical Leader Development Pathway, including each step in the process and the interventions used.

Evaluation data on pilot resources and supports were also generated from the aforementioned qualitative data collection methods and these provided information on all pilot participants’ experiences of supports from others, including colleagues, line managers, the organisation and the Project Team. Data provided in responses to the PEQ provided additional data on experiences of supports.

Data on the material supports were collected using a Documentary Analysis Rating Instrument (DARI), a bespoke rating questionnaire designed to provide a standardised method for analysing the range of supporting documents. A three-level analysis of the documents was conducted with reference to the quality of presentation and layout, the language and representation of the key constructs and concepts, and the level of inter-documentary relatedness regarding use of language.

The short-term outcomes were examined with reference to the changes in participant clinical leadership behaviours over the period of the pilot and at the end of the pilot, and with reference to organisational outcomes, such as innovations undertaken by participants as a result of their participation on the Clinical Leader Development Pathway.

Participants’ leadership practices were measured at two points in time using the Leadership Practices Inventory-Self (LPI-S) and the Leadership Practices Inventory-Other (LPI-O) instruments. Participants’ clinical leadership behaviours at completion of the pilot were measured using a Clinical Leadership Behaviours Questionnaire (CLB-Q), which was developed for the study. The questionnaire had a high index of reliability, as evidenced in the range of Cronbach’s alpha scores for each instrument subscale.

In addition to the three instruments for measuring leader behaviours, data on short-term outcomes were also generated from the focus group discussions, individual interviews and group interviews and in responses provided in the PEQ. In these various qualitative data collection methods, two areas related to short-term outcomes were discussed, namely the
Participants’ own sense of having attained clinical leadership competencies and the reported service and/or organisational impact.
3.12 References


Chapter 4

FINDINGS: PARTICIPANT EXPERIENCES, PART 1

4.1 Introduction

In order to capture information on the approach to clinical leadership development, the evaluation study examined the Clinical Leader Development Pathway, as experienced by all pilot participants, including those providing interventions and supports. The overall aim of data collection in relation to the Clinical Leader Development Pathway was to establish the suitability of the process as a sustainable model for addressing clinical leadership development in nursing and midwifery. In order to generate evaluative data to inform each step of the Clinical Leader Development Pathway, a number of complementary data collection methods were used, including focus groups, group interviews and individual interviews.

A major element of the data collection was a survey of all pilot participants using a Participant Experiences Questionnaire (PEQ) administered by telephone interview. The PEQ gathered self-report information on numerous aspects of the pilot Clinical Leader Development Pathway. This included information on experiences of the steps in Clinical Leader Development Pathway, as reported by the participants themselves, their line managers, and all those providing interventions and supports to the Clinical Leader Development Pathway, including mentors, coaches, action learning set facilitators, workshop facilitators, site co-ordinators and the HSE Project Team. Data included information on experiences of structures activities and supports associated with the Clinical Leader Development Pathway.

The experiences of all participants in the pilot, as reported in their responses to the telephone interview using the PEQ are presented here.
4.2 Participant experiences: Participant Experiences Questionnaire (PEQ)

The Participant Experiences Questionnaire (PEQ) was a self-report instrument, with five separate rating scales, one for each category of pilot participant. The aim of the questionnaire was to generate data that would inform the evaluation of the Clinical Leader Development Pathway experience and the Pathway structures and supports. The PEQ instrument also provided specific data on the pilot participants’ experiences, with reference to their particular role in the pilot. The PEQ was administered by telephone interview over a two-week period, in the final week of the pilot and in the week immediately following completion of the pilot.

Response rate
The total number of individuals associated with the pilot was 119. This included all participants on the Pathway, their line managers, mentors, coaches, action learning (AL) set facilitators, workshop facilitators, site co-ordinators and members of the Project Team and the Project Steering Committee. However, it should be noted that a number of participants had more than one role in the pilot and these individuals belong in more than one category of participant; hence the net number of participants was smaller. Participants who withdrew from the pilot were also included in the PEQ sample. It should be noted that of the participants that withdrew, many withdrew before the commencement of the pilot and not during the pilot. For example, many had completed the application form, but were not in a position to commence the pilot. The overall number of participants involved in the pilot was 119 and a total of 86 individuals completed the relevant section of the PEQ, representing an overall response rate of 72 per cent (Table 4.1). This was achieved, in part, through a 72 per cent response rate for participants on the Pathway.
### Table 4.1 Pilot participants completing Participant Experiences Questionnaire

<table>
<thead>
<tr>
<th>Category of pilot participant</th>
<th>Number of pilot participants</th>
<th>Number completing PEQ</th>
<th>Response rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category A</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Leader Development Pathway participants</td>
<td>36</td>
<td>26</td>
<td>72</td>
</tr>
<tr>
<td><strong>Category B</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Line managers</td>
<td>21</td>
<td>11</td>
<td>52.4</td>
</tr>
<tr>
<td><strong>Category C</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mentors, coaches, action learning set facilitators</td>
<td>21</td>
<td>21</td>
<td>100</td>
</tr>
<tr>
<td><strong>Category D</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workshop facilitators, Site co-ordinators Project Team</td>
<td>23</td>
<td>20</td>
<td>95.2</td>
</tr>
<tr>
<td><strong>Category E</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawn Pathway participants</td>
<td>18</td>
<td>8</td>
<td>44.4</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>119</strong></td>
<td><strong>86</strong></td>
<td><strong>72.2</strong></td>
</tr>
</tbody>
</table>

N = 106

**Participant Experience Questionnaire (PEQ) responses**

A total of 86 participants in the pilot completed the Participant Experiences Questionnaire over the five distinct sections. Frequency distributions were calculated for responses to each of the five major subsections of questionnaire. The frequency of responses to the PEQ are summarised in Table 4.2.

### Table 4.2 Frequency distribution of responses to Participant Experiences Questionnaire (PEQ)

<table>
<thead>
<tr>
<th>Section</th>
<th>No of items</th>
<th>Number of respondents</th>
<th>Mean score</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section A</td>
<td>38</td>
<td>26</td>
<td>2.97</td>
<td>.39517</td>
<td>1.61</td>
</tr>
<tr>
<td>Section B</td>
<td>16</td>
<td>11</td>
<td>3.66</td>
<td>.52162</td>
<td>1.75</td>
</tr>
<tr>
<td>Section C</td>
<td>14</td>
<td>21</td>
<td>3.10</td>
<td>.90310</td>
<td>3.29</td>
</tr>
<tr>
<td>Section D</td>
<td>12</td>
<td>20</td>
<td>3.35</td>
<td>.71475</td>
<td>2.75</td>
</tr>
<tr>
<td>Section E</td>
<td>6</td>
<td>8</td>
<td>3.60</td>
<td>.84853</td>
<td>2.60</td>
</tr>
</tbody>
</table>

N = 86

Analysis of the frequency distribution of mean scores by scale indicates that respondents overall rated their experiences of the pilot very positively. The highest mean score was yielded for line managers (M =3.66), while the lowest mean score was yielded for participants on the Pathway (M =2.97). However, this mean score for participants must be considered with reference to the construction of the Section A subscale of the PEQ. Within Section A, the maximum score available to the participants was 190, while the minimum possible score was 38. However, items 18–29 were optional for this section and respondents
completed only those items that applied to them, based on the interventions that they had undertaken. Hence not all items in Section A were completed by all respondents. This fact accounts for the relatively low mean score for the Section A subscale and does not equate with a negative experience for participants of the pilot, as will be seen from the presentation of findings for Section A below.

Selected responses to individual items in subscales A to E are presented here. For the purpose of the report, the rating choices ‘agree’ and ‘strongly agree’ and the choices ‘disagree’ and ‘strongly disagree’ are reported as a single percentage value of agreement (‘agreed’) or disagreement (‘disagreed’).

Pathway participants’ experiences
Twenty six participants on the Pathway rated their experiences of the Clinical Leader Development Pathway using the relevant thirty-eight item subscale in the PEQ, representing a response rate 72 per cent. Of this number, twenty three were female and three were male. The mean age of the respondents to Section A was 41.61 years and the age range was 28 to 58 years. Over half of respondents (53.8%) were currently working in the general division of the Register of Nurses and over one fifth (21.1%) were currently working in the psychiatric division (Figure 4.1). The majority (88.5%) worked in a public HSE hospital.

Respondents reported that they did not have a good idea of what was expected of them when they first entered the Clinical Leader Development Pathway, with over two thirds (69.2%)
disagreeing with the statement: ‘I had a good understanding of what I was expected to do as a participant’ (M = 2.31, SD = .928). Very few respondents (23.1%) experienced anxiety about their participation (M = 2.15, SD = 1.15). In relation to the assessment of leadership development need, respondents reported a positive experience of the process. The majority of respondents (73%) agreed that it was easy to agree a score with their line manager (M = 3.54, SD = 1.17) and the vast majority (88.5%) agreed that the process of deciding their development priorities with the line manager was easy to understand (M = 3.92, SD = 796). The majority (80.7%) also agreed that deciding how development priorities would be linked to the service/organisation was easy to follow (M = 3.42, SD = 896) and the same proportion (80.7%) agreed that they were able to accurately rate their assessment and development needs against the behavioural indicators (M = 3.81, SD = 801). Overall the majority of respondents (73%) agreed that the Personal Development Plan was easy to complete (M = 3.54, SD = .989) and the majority (80.8%) also agreed that the Service Assessment Tool was easy to complete (M = 3.69, SD = .928). Approximately two thirds (73%) agreed that the Learning and Development Portfolio enabled them to accurately document their journey on the Clinical Leader Development Pathway (M = 3.54, SD = 1.20).

Regarding elements of the material supports, the vast majority of respondents (84.6%) agreed that the Clinical Leader Resource Pack was an effective intervention to enable them to develop competencies (M = 4.08, SD = .845) and most (76.9%) also agreed that the Clinical Leader Resource Pack contained information that accurately reflected their everyday experiences (M = 3.77, SD = .951).

Regarding self-reported outcomes of the Clinical Leader Development Pathway, the majority (80.8%) of respondents agreed that they had attained clinical leadership competencies as a result of their participation in the Clinical Leader Development Pathway (M = 3.85, SD = 1.34) and the same proportion (80.8%) agreed that their participation in the Clinical Leader Development Pathway had a positive impact on the service/organisation (M = 40.4, SD = .958).

In relation to their experiences of support, the majority of respondents (73%) agreed that they experienced support from their line manager (M = 3.65, SD = 1.19), the site-coordinator (80.8%, M = 3.81, SD = 1.02) and from the HSE Project Team (76.9%, M = 3.85, SD = .881).
However, less than half (46.1%) of respondents agreed that they experienced support from their work colleagues ($M = 3.08, SD = 1.35$) and just a quarter (25%) agreed that they experienced support from their departmental team ($M = 2.76, SD = 1.45$). Just half (50%) agreed that they experienced support from their organisation ($M = 3.12, SD = 1.36$). A little over half (57.7%) of the respondents agreed that they had sufficient time to meet with their line manager to discuss development needs using the Assessment and Development Tool ($M = 3.23, SD = 1.36$) and approximately one third (34.6%) indicated that they did not have sufficient time for this activity.

**Line managers’ experiences**

Eleven line managers completed the relevant sixteen-item subscale in the PEQ to rate their experiences. This represented a response rate of 52.4 per cent. The mean age of line manager respondents was 46.45 years and the age range was 32 to 56 years. Over half (54.5%) of the respondents were working in a public HSE hospital and the same proportion (54.5%) was currently working in the general division of Register (Figure 4.2).

![Figure 4.2 Branch of nursing in which currently employed: Line managers (n = 11)](image)

Fewer than half (45.5%) of the line managers agreed that they had a good understanding of what was expected of them ($M = 3.60, SD = 1.09$). However, the majority had a positive experience of the assessment and development process; almost two thirds (63.7%) agreed that the process of deciding priorities for the participant’s development was easy to understand ($M = 3.64, SD = 1.28$) and the vast majority (81.8%) agreed that the process of deciding how priorities for the participant’s development would be linked to the service/organisation was
easy to understand (M =3.91, SD =1.13). The vast majority (90.9%) also agreed that they were able to accurately rate the participant’s assessment and development needs against the behavioural indicators (M =4.27, SD =.647).

Most line managers agreed with the following two statements concerning the participants’ selected interventions: ‘the interventions, which I agreed with the participant, were tailored to meet the needs of service’ (81.8%, M =4.09, SD =.701) and ‘it was easy to decide on the most appropriate intervention(s) to meet the participant’s needs’ (90.9%, M =4.09, SD =.539). While just over half (54.6%) of line manager respondents agreed that the participant had introduced a change/innovation in the organisation as a result of her/his participation in the Clinical Leader Development Pathway (M =3.55, SD =1.03), the majority (72.8%) agreed that the participant’s participation in the Clinical Leader Development Pathway has resulted in a positive impact on the service/organisation (M =4.0, SD =1.00). The vast majority of line managers (90.9%) also agreed that they provided continuous support to the participant while s/he was participating on the Clinical Leader Development Pathway (M =4.09, SD =.539). Just over half (54.6%) reported that they had sufficient time to meet with the participant to discuss her/his development needs (M =3, SD =1).

**Mentors, coaches and action learning set facilitators**

Twenty one mentors, coaches and action learning set (ALS) facilitators completed the relevant fourteen-item subscale (Section C) in the PEQ to rate their experiences. The mean age of the respondents was 48.95 years and the age range was 35 to 60 years. Over half (60%) of the respondents were currently working in the education or ‘other’ division of the Register of Nurses (Figure 4.3).
The majority of mentors, coaches and AL facilitators (61.9%) agreed that they entered the pilot with a good understanding of what they were expected to do in their role (M =3.48, SD =1.32). Regarding their experiences of preparation for their respective roles in the Clinical Leader Development Pathway, the majority reported that, overall, the training that they received was effective in preparing them for their role in the pilot (76.4%, M =3.62, SD =1.32), overall, the training methods were effective in enabling them to act in their role (80.9%, M =3.67, SD =1.16) and, overall, the training materials were effective in enabling them to act in their role (81%, M =3.90, SD =1.39). Reporting on their own effectiveness in the role, just over half (51.4%) of mentors, coaches and ALS facilitator respondents agreed that they enabled the participant(s) to develop competence (M =2.71, SD =.927), although two thirds (66.7%) reported that they tailored interventions to the participant’s individual competence development needs (M =2.95, SD =1.96). In addition, two thirds (66.7%) of respondents agreed that the role of mentor/coach/action learning facilitator is an effective intervention for enabling nurses and midwives to develop clinical leadership competencies (M =3.33, SD =2.00).

Mentors, coaches and ALS facilitator respondents reported on their experiences of support during the pilot. Just over half (52.4%) reported experiencing support from their line manager (M =3.10, SD =1.70). However, upwards on two-thirds (61.9%) experienced support from their organisation (M =3.19, SD =1.63) and the vast majority (85.7%) agreed that they experienced support from the HSE Project Team (M =3.95, SD =1.43). Fewer than half
(47.6%) agreed that they had sufficient time to meet with their participant(s) (M = 2.62, SD = 1.85).

**Workshop facilitators, site co-ordinators and HSE Project Team**

Twenty workshop facilitators, site co-ordinators and HSE Project Team members completed the relevant twelve-item subscale in the PEQ to rate their experiences. The mean age of the sample of respondents to Section D was 47.2 years and the age range was 32 to 57 years. While just 40% worked in a public HSE hospital, upwards on half (45%) worked in ‘other’ settings, which including nurse practice development units and education centres (Figure 4.4).

![Figure 4.4](image)

*Figure 4.4 Branch of nursing in which currently employed: Workshop facilitators, site co-ordinators and Project Team (n = 20)*

Almost two-thirds (65%) of this subset of respondents agreed that they understood what they were expected to do in their respective roles in the pilot (M = 3.60, SD = 1.09). Very few respondents (10%) experienced anxiety about their participation (M = 1.80, SD = 1.00). Reporting on their experiences of preparation for the role, the vast majority (85%) agreed that they were adequately prepared (M = 3.85, SD = 1.22) and the same large proportion (85%) also agreed that the materials that were supplied were effective in enabling them to act in the role (M = 3.90, SD = 1.51).

Just over one third (35%) of workshop facilitators, site co-ordinators and Project Team members reported that while acting in their role, they encountered unforeseen problems that adversely affected the implementation of the pilot (M = 2.25, SD = 1.61) and over half of the respondents (55%) agreed that they able to effectively overcome unforeseen problems that
they encountered in the role (M = 2.50, SD = 2.01). Upwards on two thirds (60%) reported that the demands of the role in the pilot competed with the other work demands (M = 3.50), SD = 1.37). Reporting on their experiences of support, the majority (80%) of workshop facilitators, site co-ordinators and the Project Team members who responded to the PEQ agreed that they were supported by their line manager (M = 3.95, SD = 1.39) and a large majority (85%) also agreed that they were supported by their organisation (M = 4.05, SD = 1.31).

Participants who withdrew

Participants who withdrew were invited to complete the relevant subscale and question in Section E of the PEQ. Eight participants who withdrew completed the relevant section and ten did not respond (Figure 4.5). The mean age of respondents was 45.6 years and the age range was 34 to 58 years. Of this number, almost two thirds (62.5%) were currently working in midwifery and the remainder (37.5%) were currently working in general nursing.

Section E of the PEQ contained a list of ten possible reasons for withdrawing from the pilot. While the majority of participants who withdrew in advance of the pilot commencing, a number withdrew in the early stage of the Clinical Leader Development Pathway. Of the eight withdrawn respondents who completed the PEQ, four (50%) withdrew because their work situation prevented it, two withdrew due to personal circumstances, one withdrew due to lack of sufficient support from their line manager and one withdrew for private personal reasons (Figure 4.6). Two thirds (75%) of withdrawn respondents agreed that they had little control over the circumstances that led to their withdrawal from the pilot (M = 4.29, SD = 1.49).
Three quarters (75%) of participants who withdrew agreed that they would participate on the clinical leadership Clinical Leader Development Pathway, if given another opportunity (M = 4.0, SD = .756), and upwards on two thirds (62.5%) agreed that if given another opportunity, they would seek another course to develop their clinical leadership competencies (M = 3.86, SD = .690). The majority (75%) agreed that they were disappointed at the time when they withdrew (M = 4.14, SD = 1.46) from the pilot.

![Figure 4.6 Participants who withdrew’ reasons for withdrawing (n = 8)](image)

**Key points**

A Participant Experiences Questionnaire (PEQ) provided self-report information on the experiences of all those involved in the pilot, including Clinical Leader Development Pathway experience and the Pathway structures and supports. The PEQ was administered by telephone interview to all pilot participants and a response rate of 72 per cent (N = 86) was achieved.

Overall, participants on the pilot, including participants on the Pathway and all those providing supports and interventions, evaluated their experiences of the Project as very positive. The majority of participants on the Pathway agreed that they had attained clinical leadership competencies as a result of their participation in the Clinical Leader Development Pathway and agreed that their participation in the Pathway process had a positive impact on the service/organisation.
Both participants and line managers reported that the various aspects of the process, such as completing the Assessment and Development Plan, were easy to follow and the participants found the Clinical Leader Resource Pack to be an effective intervention and a document that accurately reflected their everyday experiences. The various interventions for developing clinical leadership competencies, including workshops, coaching, mentoring and action learning were also evaluated positively in terms of their effectiveness by both participants experiencing the interventions on the Pathway and those providing the interventions.

Process-level experiences were also positive. Pilot participants and those providing interventions experienced support from their line managers and organisation. However, some participants and line managers experienced time as a constraint in relation to completing the Assessment and Development Plan.

The most common reason cited by participants for withdrawing from the pilot was that their work situation prevented their participation and the majority who withdrew reported having little control over the circumstances that led to their withdrawal.
4.3 Summary of findings from the survey of pilot participants

A Participant Experiences Questionnaire (PEQ) was administered by telephone interview to all pilot participants. The overall number of pilot participants including those providing interventions and supports involved in the pilot was 119 and a total of 86 individuals completed the relevant section of the PEQ, representing an overall response rate of 72 per cent. Overall, respondents rated their experiences of the pilot very positively.

While participants reported that they did not have a good idea of what was expected of them when they first entered the Clinical Leader Development Pathway, they reported a positive experience of the process related to the assessment of their leadership development need. They found that aspects of the process, such as agreeing a score with their line manager, deciding their development priorities and deciding how development priorities would be linked to the service/organisation were easy to follow. They also found it easy to complete the Assessment and Development Plan and to maintain their Learning and Development Portfolio and they found the Clinical Leader Resource Pack to be an effective intervention and a document that accurately reflected their everyday experiences.

Participants reported that they were developing clinical leadership with reference to individual competencies and that their participation in the Clinical Leader Development Pathway had a positive impact on their service/organisation. The majority reported that they experienced support from their line manager, site co-ordinator and the Project Team, but fewer experienced support from their work colleagues, departmental team or their organisation. They also experienced time constraints in meeting with their line manager to complete the Assessment and Development Tool.

Line managers also reported a very positive experience overall. However, fewer than half agreed that they had a good understanding of what was expected of them at the outset. Line managers found the processes of deciding priorities for the participant’s development and how those priorities would be linked to the service/organisation easy to understand. They reported that they were able to accurately rate the participant’s assessment and development needs against the behavioural indicators, agree interventions to meet the needs of service and decide on the most appropriate intervention(s) to meet the participant’s needs. The majority
of line managers reported that the Clinical Leader Development Pathway had resulted in a practice innovation and had resulted in a positive impact on the service/organisation. While they provided support to their participant on the Pathway, they experienced the constraint of time in relation to meeting their participant.

The majority of mentors, coaches and action learning set facilitators reported that they had a good understanding of their role at the outset and that they had adequate and effective preparation for their role. While just half of the respondents reported that they had enabled the participant(s) to develop competencies, the majority agreed that their particular intervention method was effective for clinical leader competence development. While the majority of mentors, coaches and action learning set facilitators experienced support from their organisation and from the HSE Project Team, just half experienced support from their line manager. Like others in the pilot, mentors, coaches and action learning set facilitators experienced the constraint of limited time to meet their respective participant(s) on the Pathway.

Workshop facilitators, site co-ordinators and HSE Project Team members reported a positive experience overall. The majority had a good understanding of their role at the outset and reported that they had adequate and effective preparation for their role. Most did not encounter unforeseen problems while acting in the role and were able to effectively overcome unforeseen problems. A large proportion reported that the demands of their role on the pilot competed with the other work demands; however, the vast majority experienced support from their line manager and organisation.

The most common reason cited for withdrawing from the pilot by participants who withdrew was that their work situation prevented their participation. The majority reported having little control over the circumstances that led to their withdrawal and they reported experiencing disappointment at having to withdraw. Most agreed that they would participate on the clinical leadership Clinical Leader Development Pathway or would seek another course to develop their clinical leadership competencies, if given another opportunity.
Chapter 5

FINDINGS: PARTICIPANT EXPERIENCES, PART 2

5.1 Introduction

The evaluation study examined the Clinical Leader Development Pathway, as experienced by all participants on the pilot, including those providing interventions and supports, in order to establish the suitability of the process as a sustainable model for addressing clinical leadership development in nursing and midwifery. Evaluative data were generated to inform each step of the Clinical Leader Development Pathway and this involved a number of complementary qualitative data collection methods and a survey of all participants using the Participant Experiences Questionnaire (PEQ).

The focus groups, group interviews and individual interviews generated a large body of narrative data on the participants’ experiences of the Clinical Leader Development Pathway, including the steps in the process and the interventions. These data provided detailed information on participants’ experiences of entering the Pathway, using the Assessment and Development Tool and maintaining the Learning and Development Portfolio and their experiences of the various interventions. They also provided information on service developments and practice innovations, material and human supports, including supports at the level of the line manager, mentor, coach, team, organisation and so forth. Participants also provided rich data on their own sense of developing clinical leadership competencies. The experiences of all participants in the pilot, as reported in the focus groups, group interviews and individual interviews, and in written submissions are presented here.

5.2 Participant experiences: Qualitative data

A total of 66 pilot participants were recruited to eighteen separate qualitative data collection events (Table 5.1). In addition, four internal coaches provided written reflections on their experiences of coaching and a group of mentors provided written comments and suggestions, following one of their scheduled mutual support meetings. Ten focus group discussions were conducted in total. Of this number, six were conducted with participants on the Clinical Leader Development Pathway, one of which included directors of nursing and directors of
midwifery; two were conducted with line managers and one each with mentors (including action learning set facilitators) and workshop facilitators. In addition three group interviews were conducted, one each with internal coaches, the Project Team members with responsibility for operational aspects of the pilot and the Project Steering Committee. Two individual interviews were conducted with the members of the Project Team with responsibility for the strategic development and oversight of the pilot. A single interview was conducted with one participant on the Pathway. One action learning set was observed.

Table 5.1 Data collection by participant and focus

<table>
<thead>
<tr>
<th>Method</th>
<th>Focus of data collection</th>
<th>Participant</th>
<th>Number of participants</th>
</tr>
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<tbody>
<tr>
<td>Focus group</td>
<td>Pathway experience</td>
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</tr>
<tr>
<td>Focus group</td>
<td>Pathway experience</td>
<td>Pathway participant</td>
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<tr>
<td>Focus group</td>
<td>Pathway experience</td>
<td>Pathway participant</td>
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<tr>
<td>Focus group</td>
<td>Pathway experience</td>
<td>Pathway participant</td>
<td>3</td>
</tr>
<tr>
<td>Focus group</td>
<td>Pathway experience and service impact</td>
<td>ADoN/ADoM, DoN/DoM</td>
<td>4</td>
</tr>
<tr>
<td>Focus group</td>
<td>Conducting assessment and development plan and service impact</td>
<td>Line managers</td>
<td>3</td>
</tr>
<tr>
<td>Focus group</td>
<td>Conducting assessment and development plan and service impact</td>
<td>Line managers</td>
<td>3</td>
</tr>
<tr>
<td>Focus group</td>
<td>Providing an intervention</td>
<td>Mentors, AL facilitators</td>
<td>6</td>
</tr>
<tr>
<td>Focus group</td>
<td>Providing an intervention</td>
<td>Workshop facilitators</td>
<td>7</td>
</tr>
<tr>
<td>Group interview</td>
<td>Providing an intervention</td>
<td>Internal coaches</td>
<td>4</td>
</tr>
<tr>
<td>Group interview</td>
<td>Operational management of the Project</td>
<td>Project Team (operational)</td>
<td>3</td>
</tr>
<tr>
<td>Group interview</td>
<td>Project oversight</td>
<td>Steering Committee</td>
<td>6</td>
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<tr>
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<td>Managing the pilot</td>
<td>Project Team (strategic)</td>
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<tr>
<td>Individual interview</td>
<td>Managing the pilot</td>
<td>Project Team (strategic)</td>
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<td>Individual interview</td>
<td>Pathway experience</td>
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<td>Action learning set processes</td>
<td>AL participants</td>
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<tr>
<td>Written reflections</td>
<td>Providing coaching intervention</td>
<td>Internal coaches</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>70</strong></td>
</tr>
</tbody>
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In addition, many respondents to the Participant Experiences Questionnaire provided comments in the free text box that was incorporated into the instrument. These comments were also included in the qualitative data set.

The various qualitative data collection methods yielded a body of very rich narrative data concerning the Clinical Leader Development Pathway, including participant experiences at various stages in the process, interventions used, service impact and operational and logistical arrangements involved in rolling out the pilot. Participants were facilitated to speak openly.
about their individual and collective experiences and to offer views and comments on the Clinical Leader Development Pathway and its associated interventions. Participants also provided data on the practical arrangements associated with the Clinical Leader Development Pathway and offered suggestions as to how the Clinical Leader Development Pathway might be enhanced. These data informed the question as to the suitability of the process as a sustainable model for addressing clinical leadership development in nursing and midwifery.

Analysis of the qualitative data yielded five major themes, which reflected the experiences of all the pilot participants, as follows (Figure 5.1):

Beginning the process
1. Experiencing the process
2. Developing competence for clinical leadership
3. Experiencing supports
4. Developing the service

The findings associated with Theme 4 ‘experiencing supports’ are presented in Chapter 6. The findings associated with Theme 5 ‘developing the service’ are presented in Chapter 7.

Figure 5.1 Participant experiences, themes and subthemes
5.2.1 Theme 1: Beginning the process

This theme describes the experiences of participants on the Pathway and those providing interventions and supports in starting on the Clinical Leadership Development Pathway. The theme contains two sub themes, ‘making the decision’ and ‘assessing leadership development need’ (Figure 5.2). The data were derived from the focus group interviews in the main, but also from group interviews and individual interviews.

Figure 5.2 Theme: beginning the process

Making the decision

Many participants spoke of how they first learned of the pilot and about how they could become involved. Participants spoke of seeing the notices on the ward, the information leaflet up on the board, the e-mail circular or of learning about the Project at one of the two open days. For some their involvement was as a result of their own initiative in seeking to become involved and for others involvement was the result of a request from another, often their line manager, to become involved. Some participants became involved through the opportunity that the pilot presented to them, in terms of improving their own practice situation. On learning about the clinical leadership project from her practice development coordinator, one participant saw the immediate relevance to her own work situation. Mindful of
‘recommendations’ about leadership in maternity services in Ireland and recognising that there was ‘a huge gap in leadership in the service’, the participant in question was ‘very interested in taking this course.’ For her, the project offered a challenge and she decided to ‘take the step and see what effective leadership is about or what do I know or where I am or where [do] I need to go to’. Another participant similarly saw the Project as offering her an opportunity to develop her skills as a clinical unit manager:

I ended up in the role [of unit coordinator] without any previous experience in management or leadership. And I knew that, well I wanted to see how you could actually improve your skills, so I jumped on the opportunity (Pathway participant).

Reflecting on her role as the coordinator of services and staff in her unit, the same participant reasoned that up to that point her focus was on leading tasks and not people:

And I suppose I was more into putting things into boxes and making sure everything was neat and everyone was doing their job rather than actually looking at the people themselves, [at] leading people. I suppose I didn’t get the most out of the people that I could have had (Pathway participant).

On receiving the information via e-mail a clinical nurse specialist considered that the development Pathway would be ‘a good way to maybe consolidate [my] experiences.’ For another participant, getting on the Pathway was the result of her interest being stimulated, having read the Project materials which she downloaded from an e-mail: ‘[I] was reading it and thought it was very interesting, [and] so I contacted the practice development officer ... [and] ... I decided to go.’

For other participants, getting on the Clinical Leader Development Pathway was less as a result of their own initiative and more the result of their respective line manager’s decision or request. A PEQ respondent stated: ‘I had little choice in my name going forward.’ A focus group participant recalled how her departmental manager had ‘asked three of us on the ward if we would be interested and would we like to do it.’ Another put it more directly, stating that her line manager had presented her with little option at the outset: ‘here is the form, sign your name, good bye!’ Nevertheless the same participant reasoned that while her line
manager had seemed to present her participation as a fait accompli, she (her line manager) was more deliberate in her decision:

I was volunteered to a point, but I think she knew it was going to be good for me, [in the] long term. And I think the people she picked, she had reasoning behind it, and the people she approached, she knew what she was doing (Pathway participant).

Some participants spoke about how their practice development coordinator had encouraged them to participate; one observed: ‘[she] was very encouraging and I suppose she sold it well.’ Entering the Clinical Leader Development Pathway was the result of happenstance for one participant, who explained that while attending a meeting, his director of nursing ‘just happened to get the email [about the Project] there and then and he turned to me and goes: “you wouldn’t mind doing that would you?” So I said: “okay I would go.” This situation was described as being ‘[in] the right place at the right time or the wrong place at the wrong time.’

Despite the apparent lack of locus of control regarding their participation, when questioned directly about their decision, the majority of participants agreed that ultimately the decision to participate was their own, as the following short extracts illustrate: ‘I made the decision myself’; ‘I made the decision to go on it myself”; ‘I made the decision.’

Many participants spoke of their initial lack of knowledge and confusion about what was involved and about their role in the process. One spoke of feeling ‘daunted by the whole thing’ and remarked:

It took me a little while to get to the bottom of it and fully understand it ... it took me a while to actually fully grasp what role I had to play in all of this [process] (Pathway participant).

This lack of any real sense of what was involved was a common experience for a number of participants. One said: ‘I didn’t really know much about it other than the fact that it was to do with leadership and it was a development of competencies [and] that’s it.’ Another remarked that ‘until I came on the first day ... I really didn’t know what was in store for me’ and another commented: ‘I couldn’t figure out where my role was in the process ... and I did not
fully understand what was expected of me.’ One PEQ respondent observed that ‘the project was much more of a mammoth task than I anticipated when I started out.’

**Assessing leadership development need**

Participants were asked to discuss their experiences of using the Assessment and Development Tool, a process which represented the first major step on the Clinical Leader Development Pathway. They were also asked to comment on how useful they found the tool in assisting them to determine their current leadership skills and their particular leadership development needs. Participants discussed their experiences of rating themselves against the behavioural indicators in the Assessment and Development Tool and they also discussed their experiences with their line managers in the process.

Many participants spoke about the content and structure of the Assessment and Development Tool and issues with the Tool were highlighted, such as the use of language. One participant observed that ‘the language was a bit alien ... it was difficult to know what it actually meant.’ Another observed that ‘the wording of it ... you could take several meanings to it’ and another commented:

> I did feel the language was quite broad and I would have liked a concrete example in each section to make you think what they mean in that sense (Pathway participant).

A line manager commented: ‘[the language was] too complicated, I found, and I was saying: “God what did they mean by that?”’ Another line manager referred to the language as being ‘too wordy’, while another spoke of having ‘to read it a couple of times’ and another commented that ‘a lot of the language was kind of, it wasn’t, I felt, out there.’ However a number of line managers, when questioned directly, replied that they did not have a problem with the language, as these three sample extracts show: ‘I don’t recall any problems’; ‘I thought it was okay’; ‘I had no problems’.

Many participants referred to their experiences of interpreting the behavioural indicators and at arriving at different scores due to divergence between themselves and their line manager:
When I was doing it with my service manager, my scoring and her scoring were different, because my interpretation and her interpretation were different as to meaning (Pathway participant).

This experience was similar for other participants, as the following extracts illustrate:

I just found that when you were reading it you really had to dissect each ... assessment lines under each competence to figure out what they meant. Some of them were clear but some of them were like statements and they were a bit vague. You could interpret them in lots of different ways (Pathway participant).

Some of the questions, I thought, were a bit woolly; you wouldn’t necessarily know what they actually meant, like you could interpret them differently (Pathway participant).

So we went separately to decide on the tool and the numbers and she came back to me and said her interpretation of the language, or the wording, was totally different (Pathway participant).

I left a lot of blanks in mine until I met up with my service manager because my interpretation and her interpretation were completely different (Pathway participant).

[My line manager] felt it was completely different and she said, “no that is not what that means”, and I was sitting there going, “oh jeepers” (Pathway participant).

I found that we were very different in what we came up with ... I just found there were some things she had a different comprehension of or she thought it differently to me (Pathway participant).

One participant interpreted the scoring system with reference to her grade, suggesting that her grade level was the factor in how she should conduct her own self rating:
So in view of where I am in my role, I suppose and my current position, my marks were quite low, but if I was at a lower grade I could have said that the marks were higher. So you had to look at it in relation to your grade (Pathway participant).

A line manager admitted to having great difficulty with the scoring system in the Assessment and Development Tool: ‘the scoring system wrecked my head ... because I couldn’t understand it [at first].’

Some participants concluded that, in retrospect, they might not have used the scoring tool in the correct way: ‘We scored it slightly wrong, we didn’t score it right, myself and my line manager, looking back on it, and what I have seen from other people, I think we didn’t score it totally right.’ Another admitted: ‘we filled it out slightly wrong first and then we had to go back and fill it out again’. Participants spoke about their efforts to arrive at a consensus with their line manager in relation to the meaning of behavioural indicators and the scores, as the following extracts show:

We sat down and spoke about it, we kind of agreed and said, “oh yes, that is what that means, we think” (Pathway participant).

Now we did come to an agreement in the end, but it did take a while to go through them (Pathway participant).

In fairness to her she did correct, she changed some of the stuff. We discussed some of the stuff and she changed some of the ratings on it (Pathway participant).

When we actually sat down and worked through it, it worked out fine. But it was good in [that] it made me decide which competencies I needed to focus on (Pathway participant).

Line managers also confirmed this process of arriving at a consensus:
I was assessing him and he was assessing himself, and ... what we did afterwards was we discussed the tool together and if he gave himself a ‘3’, I might have said: “no I thought you were a ‘4’ there.” (Line manager)

The staff nurse went off and she looked at it and she did her own work on it. Then I did my work on it and we got together. And we both came to the same conclusion actually, but again we had a discussion and the same person would have undermined herself in relation to it. I would have felt she was quite a capable person (Line manager)

Some participants found the language less problematic. One said: ‘I think it is just a language and a format that you have to get used to before you can use it comfortably.’ Another commented: ‘I was very comfortable with the lingo in it, I was comfortable in myself, but then ... [the line manager] had different interpretations.’ A number of participants attributed their level of relative comfort with the language and format to the fact that they had recently completed studies at university, where similar language was commonly used. One participant spoke about her experience of trying to go beyond the words to arrive at an understanding of the standard that was to be achieved:

I think for some of them (the behavioural indicators) you were kind of working at, not just interpreting what your response was, but interpreting what was the meaning of the actual standard.

One internal coach remarked that ‘because of the range of the behavioural indicators within each competence, the reality is that some people will score themselves maybe higher or lower on aspects of the behavioural competencies.’

While some participants experienced challenges in using the Tool, the process of completing the Assessment and Development Tool with the line manager was seen as valuable, in terms of the opportunity it afforded for an objective assessment of the individual:

It wasn’t personal, it wasn’t based on personality; it was more based on your competencies and abilities. So it was a really good tool to say “look are you good at
decision making or do you need to work on it or maybe would you like to go to a study day?” (Pathway participant).

This same participant, who was a manager, saw the Tool’s potential as a mechanism for conducting performance appraisal more generally:

It was like an appraisal ... I think it is a tool that could be used in the future, not just leadership but for managers in general. I thought it was a really good tool [and] for the future as a manager I have something I would like to use, that you could look at it as a key performance indicator to see how people are getting on or areas they need to develop on a broader scale than leadership (Pathway participant).

The experience of completing the Assessment and Development Tool was also positive in that it provided a pretext with which line managers could provide positive feedback on performance, as the following two extracts show:

It was nice to think that even if you scored yourself so low that your manager would say: “Well I don’t know if you are actually a ‘2’, I would say you are a ‘3’ and you have loads of things you bring to the table, and you did this and you did that” ... When your line manager is somebody you work very closely with, and obviously if you have a good relationship, that there is constructive criticism there to develop you further and to work with your mentor (Pathway participant).

It was very good to actually sit down with her and get feedback. That part was very good to be honest, but it should be done more often (Pathway participant).

The process of completing the Assessment and Development Tool with the line manager was also viewed as a positive learning experience by participants. One participant commented:

I thought sitting down with the line manager was very good because sometimes you could be very hard on yourself, you can be very critical, and it was good to get the perspective then of my line manager ... So I think the input from your line manager is absolutely a must (Pathway participant).
Key points

There was evidence of good organisational support for the Project and there was also evidence of ongoing monitoring and refinement. However, pilot participants cited time and competing work and family commitments as constraints on their ability to engage in elements of the Clinical Leader Development Pathway.

Although Pathway participants reported that they did not have a good idea of what was expected of them when they first entered the Clinical Leader Development Pathway, they reported a positive experience of the process related to the assessment of their leadership development need.

While there was divergence between participants and their line manager in relation to self rating, they were able to achieve consensus in relation to the meaning of behavioural indicators and the scores. Some found the language in the behavioural indicators difficult to interpret.
5.2.2 Theme 2: Experiencing the process

This theme refers to the Participants’ experiences of engagement in the Clinical Leader Development Pathway. The data reflected the experiences of all the participants, including those providing interventions and supports. The theme contains the following six sub-themes: ‘maintaining the Portfolio’, ‘experiencing workshops’, ‘experiencing action learning’, experiencing mentoring’, ‘experiencing coaching’ and ‘a very positive experience’ (Figure 5.3).

![Major themes diagram]

**Figure 5.3 Theme: ‘experiencing the process’**

*Maintaining the Portfolio*

Part of the Clinical Leader Development Pathway experience was maintaining the Learning and Development Portfolio and participants were asked to discuss their experiences of using the Portfolio. Many spoke of how they found the process to be helpful in stimulating their thinking and further reading, as the following three extracts illustrate: ‘I found it, when you had to actually write it down, you had to think a lot deeper’; ‘I found the writing ... it was like my brainstorming’; ‘Like it does make you think and you had to go off and look up stuff just
to see.’ Writing in the Portfolio was also of value in promoting reflection, as a number of participants observed:

I find it makes you reflect. Having to write it you have to sit and reflect and you have to think about it (Pathway participant).

I found it quite useful because when you have to go home and reflect on what you have done you actually have to think about it and write it down, put it into words; it is a very good tool (Pathway participant).

Reflection in the Clinical Leader Development Pathway was seen as valuable in that it aided recall of actions taken, as the following two extracts indicate: ‘I found it good to reflect as much as I could because otherwise I would have forgotten what I had done; ‘If you don’t write it on the day or maybe the day after or when you go home it has gone out of your mind ... you do need to write it down pretty sharply.’ One participant used the Portfolio in this reflective way to gauge progress in her own competence development:

I used to keep a record of it; that was actually quite good because you could see what you were working on previously and you could see the changes that you are making. I was reading back through them this morning and you could actually see a little pattern in them ... you could see it was coming along (Pathway participant).

This writing and reflection also seemed to benefit participants in recording actions associated with service development, as two participants indicated: ‘I find when I read over things I can think, “oh yeah”, so for certain situations within the team or within ward meetings’; ‘It really motivates you to keep trying to see how it works out and then writing about it again and saying “Oh I will try again”.

The benefit of recording one’s experience in relation to self-awareness was illustrated by one participant who admitted: ‘I was in denial that there was an issue [on my ward], but when you actually have to write it and you have to think and you have to say how you really felt.’ One line manager spoke about the value of maintaining her Portfolio as she embarked on a practice innovation in her ward:
I think writing it down and writing down the positive reactions versus the negative. The positive kept me going to get through this and to come out the other side of it ... So on both counts I can tick my boxes and it has worked (Pathway participant).

There was the view that the effort required in working through the Portfolio was a matter for individuals and the effort that they put into it:

It depends on how much you want to put in to it. You could just fill it out and say “that is done, move onto the next page” if you wanted to and nobody is ever going to say otherwise. But then I know it is up to you and what you want learned. I suppose I just wanted to do this so I was reading stuff around it to make sure I was filling it in right (Pathway participant).

As a learning and development experience, the Clinical Leader Development Pathway was something that none of the participants had experienced previously. Some referred to the uniqueness of the experience and the fact that it required so much self direction:

I think the whole experience is so new because normally you are in a classroom and you are given assignments ... you get your mark at the end ... [and] you know you have achieved a certain standard. With this, you can do as much as you like or little as you like. But then I feel I am starting from my own level as well (Pathway participant).

Other participants similarly remarked on the apparent absence of any external monitoring of progress in the Pathway while developing a single competence. One stated: ‘I am working through the competence myself and I don’t know who will judge it competent’ and another stated:

You work on it but there is nothing to state that you completed the project, where you are, where you are going, what problems you are encountering. There is nobody to give anything to ... there is no measuring, monitoring or whatever’ (Pathway participant).
Some participants spoke of their experiences of completing the Portfolio in a sporadic and intermitted manner. One participant admitted: ‘I am getting it done but I am not doing it on a regular basis, I am doing it in bursts.’ Another similarly admitted: ‘I wouldn’t consistently use it, I would occasionally have my mentor saying “we need to meet” and I would have to do a little blast of work before we’d meet as opposed to using it on a regular basis.’ This same participant added: ‘But I just think that is probably everybody’s life, just different calls and there are just some weeks you couldn’t even contemplate doing it.’

Some participants had difficulty in selecting an intervention, as one PEQ respondent remarked: ‘it took some time to decide how my development priorities would be linked to my organisation.’ In selecting an intervention, personal preference was important to some:

I preferred mentorship to be honest with you. I suppose I liked the interaction, the talking, somebody showing me sometimes what to do (Pathway participant).

However, in choosing an intervention, some participants might not have made the right choice, as one PEQ respondent observed:

The right choice by the participant for the right support wasn’t always made. The right method for the participant is important. I felt some of the participants on the workshops would have been better off in action learning, but someone told them workshops or mentoring would be better. Some participants didn’t come prepared, having read the section in the folder, and weren’t quite tuned in to the session ... Participants may need more support and more time over the process.

Many participants spoke about the various interventions that they had taken and how they experienced them. Data on the experiences of interventions included discussion of workshops, action learning sets, mentoring and coaching.

*Experiencing workshops*

Most participants spoke in very positive terms about their experiences of the workshop intervention. For them, the sharing of experiences and possible solutions to problems seemed
to be a key benefit from the workshops and many spoke of the value of group interactions and the group process that enabled them to share experiences, as the following selection of short extracts indicate: ‘Because everybody has just different perspectives on everything [and] it is nice to hear other people’s experiences because you learn a lot from listening to them as well’; ‘[it] is nice as well to hear how everybody else is getting on or what their issues are’; ‘I found it good listening to other people’s issues and how other people approach things’; ‘it was always interesting to see what other people who were in similar situations in different hospitals and different settings and how they dealt with the situations.’ One participant summarised the benefits of workshop group processes in the following terms:

Well you are meeting people from different backgrounds, [and] they are not all just within [your own hospital]. It is very useful from that point of view, you are getting feedback from other people and how they deal with it. Like if you have an issue you bring it to the group and you have confidentiality there and you know whatever you say is kept within that group. The rapport has definitely developed over time.

One spoke of the role of the facilitator in promoting thinking and discussion: ‘her open questions are excellent, they really get you thinking.’ A number spoke about how both the workshop facilitator and the group processes within the workshops had assisted them in developing their competence. One participant experienced the ‘small groups’ as liberating:

You were able to speak about your experiences. I felt they were amazing. I went petrified and I got more out of them than I would ever in my wildest dreams. I got so much out of it and I wouldn’t have thought that I would get anything. I was actually shocked and I felt enlightened even in my work place after doing the two [workshops] (Pathway participant).

Participants also spoke positively about the value of certain learning activities in the workshops, including process mapping and group discussions. The value of discussions over reading essays and articles was seen by one participant as especially helpful in a workshop on teambuilding.
You were always getting essays and articles on how to deal with this situation or that situation, but it was actually dealing or talking to your work colleagues in other institutions who might have come across similar problems and how they would have dealt with it.

One participant spoke of the need for skilled facilitation in workshops, in order to ensure that participants received the correct messages about good leadership:

When people who are facilitating those workshops [they] should actually say “this was the good, this was the bad, this is what we need to do.” And put out that leadership, and to be able to do that, there is a gift in it, but to be able to do it without rocking anyone’s boat.

Another saw the relationship of the workshop processes to the Clinical Leader Resource Pack:

We did little exercises that made you think and prepared you then to do the book, the resource pack ... it got you thinking down that line for the resource pack then.

Experiencing action learning

Non-participant observation of one action learning set provided the Research Team with the opportunity to observe the intervention first hand. This observation was undertaken with the informed consent of the action learning set facilitator and the set members, obtained in advance of the set meeting. This observation provided the following narrative description of the process element of an action learning set intervention:

The action learning set comprised five members drawn from a variety of grades and a variety of practice settings. The room was prepared in advance with flip charts and pens and materials posted on the walls of the room. The meeting lasted for four hours. At the start, the action learning set facilitator welcomed the members and restated the ground rules of the meeting.
During the action learning set, each participant was afforded an opportunity to reconnect with the goals that they had set for themselves from the previous action learning set meeting. Each participant spoke for approximately 30 to 40 minutes about their individual goals and the practice context of these goals. The action learning set facilitator assisted each participant by asking reflective and challenging questions and by inviting other members to listen effectively to verbal and non-verbal language in use and to share insights. While presenting to the group, each participant used different techniques with which to frame their goals, such as the circle of concern, circle of influence and the Johari window. The listeners used reflective questioning, which were available from a series of questions that had been posted on the walls of the room prior to the commencement of the action learning set. Each participant optimised the time available to speak and to get the most from the questions posed by other participants.

It was evident that a good trusting relationship had been established between each set member and the action learning set facilitator. Some members spoke of how much they had ‘grown’ within themselves through reflecting on their particular practice issue and how they had experienced a ‘feel good’ factor in attempting to achieve their practice goals. One participant reflected on how participation in the action learning set had contributed to her professional development by enabling her to take personal responsibility for her professional actions. This was publicly manifest in his/her deliberate use of the first person – ‘what I will do’ – in place of the second person – ‘what you should do’. The practice issues identified by the participants appeared to be challenging and included issues such as the locus of responsibility for risk management in multidisciplinary care and the delivery of a quality service in the face of reduced clerical support and restricted space.

Each participant participated fully in the action learning set processes, actively listening to each other’s case story and asking appropriate, insightful and reflective questions. They afforded each other the space for discussion and appeared to value the contribution of each other. All members affirmed personal goals and openly shared them with the group. Each member gave a commitment to taking action and to giving feedback on the outcomes of this action to the next action learning set meeting (End).
After the action learning set had ended, the non-participant observer asked the members to volunteer comments on their experience of the action learning set as an intervention in their development of clinical leadership competence. All participants spoke of their positive experience of the intervention and commented on the importance of having time and space away from the work setting to frame and reframe their particular practice and work-related issues and their own personal and service development goals. While the time away from the work setting was important, some also saw this as a practical limitation of the intervention due to time and cost. The possibility of facilitating action learning sets locally in the work setting was considered by some, but all members agreed that this was not an alternative, since it could stifle open and confidential discussion with work colleagues and could impact on trust. This dynamic would, in turn, impact on the effectiveness of the intervention. The members of the group also reflected on the wider issue of clinical leadership development; some participants cautioned that the development of competence should not be seen as a once-off process and spoke of the need for ongoing support.

Like the workshop, the action learning set intervention was also seen as valuable in facilitating the sharing of ideas by focus group participants. The fact that the intervention was action oriented was seen as the particular benefit of the intervention. Participants spoke of the action learning set as a way of finding ‘some way forward towards resolution in relation to the programme’ and of being able to ‘work on that [issue] and you can bring it back to the next meeting and discuss how you have got on with it.’ Others also spoke about this extrinsic value of the action learning set in suggesting possible solutions to practice problems. One PEQ respondent wrote: ‘Action learning was a fantastic way of teasing out problems [that] you might have.’ A focus group participant stated:

I thought the action learning was brilliant. You got to know people, [and] you knew that other people had issues just like yourself. And I know you weren’t given solutions and nobody was judgemental or whatever, but you felt by discussing things out you were going to get some kind of plan or you might be able to form some kind of plan yourself. That is why ... I think I will have no problem making up some template for it. So I did find it very good (Pathway participant).
Similar to the workshops, action learning sets required good group facilitation in order to develop the group dynamics, as one senior nurse put it: ‘The actual group dynamic itself is incredibly powerful, especially when somebody is kind of squirming away in the corner trying to sneak away and avoid confronting something.’ This same participant elaborated further on the action learning set and how good facilitation functioned to promote good participant engagement in learning and problem solving:

There is nowhere to hide. The idea here is that you actually learn something and get something out of it. And getting feedback from everybody else when they are in the same boat as you, I think for me, that is the beauty about it. And I think a lot of learning takes place in that situation and under that kind of structure ... When you have the group going you start talking and I think it is in the action of the exchange, I think that is where the learning takes place (Pathway participant).

**Experiencing mentoring**

Overall, participants spoke in positive terms about the mentoring intervention. A typical positive comment was offered by one participant: ‘My mentoring was great, I was very happy with it.’ One PEQ respondent wrote: ‘I had a great experience with my mentor.’ Some spoke about the contribution of the mentor in the process and of how the mentor acted as a motivator. One stated: ‘my mentor pushed me and she evaluated me and she challenged me, so I feel I have something achieved’ and another said: ‘she hasn’t given me the answers, [but] she has really made me think and she has dangled the carrot for me to bite, but yet guided and supported me all the way.’ Others spoke of the qualities of their respective mentors, as the following selected extracts show: ‘she is so motivated, I think, which really helps’; ‘my mentor is ... all about what to do for me’; ‘I have a very good mentor, so I can discuss anything with her, [and] she is always there and I can contact her whenever I want anything.’

A number of participants talked about how their mentor seemed to be tuned into their leadership development needs: ‘I just think that mentors have a good insight into where you progress to’; ‘I have a mentor ... and even though we don’t work together, [she] just has much more insight into what all this [is] about’; ‘my mentor ... has been very supportive ... very much focusing on the need to develop myself and the service being developed as a by product of that.’
Mentoring was seen by mentors and mentees as an intervention suitable for enabling individuals to clarify their clinical leadership development needs and to examine their leadership development needs in the context of their professional role. Mentors played a role in the participant’s self-rating and selection of service initiatives, as two participants on the Pathway indicated. One instanced the role of her mentor in assisting her to work through her self-assessment of clinical leadership development need: ‘it is the mentor who has worked through it with you, or in my case, it is my mentor’ and another explained how her mentor assisted her in selecting the service initiative which she would develop: ‘well I have got to pick a project to do ... [and] so my mentor then was very much involved.’ Another spoke about how her mentor was more familiar with the Clinical Leader Development Pathway and with her clinical leadership development needs than her line manager:

I just feel [that] I can depend a bit more on my mentor to have a better understanding of the whole thing and she seems to be able to spend more time at it than my line manager. And I understand why my line manager can’t, because she is just extremely busy but I just feel that the mentor bit is better for me (Pathway participant).

Some participants spoke of the value of the one-to-one arrangement that mentoring involved: ‘I like to sit down and discuss one to one and that works very well.’ The mentoring process was described by one participant, as follows:

It is a very personal intervention because you meet one to one. I had never met my mentor before ... we just went through the indicators and discussed areas that I could help to develop me in that area in those indicators. And we have had our meetings and I find her good and very supportive (Pathway participant).

A number of participants spoke about the importance of having ‘the right person’ as a mentor and about the importance of a good mentor-mentee relationship to the success of the intervention. One participant stated that ‘it worked extremely well for the both of us and she said that she got quite a bit out of it as well’ and another similarly remarked how ‘we worked very well together.’ Another stated that ‘it is really a personal thing that you get on well with your mentor and that they have the same vision as you, which we did, so that is very helpful.’
A participant saw greater merit in having a mentoring relationship with a colleague than with an assigned mentor:

The mentor I was assigned, she is very good, but ... I find that my skills are developed more with the people I am working more closely with and that I admire so much, I suppose, that they are my role models ... It would have been great [to be mentored by someone with whom I work] (Pathway participant).

One participant remarked on her experience of feeling like a ‘puppet on a string’ in the mentoring relationship and commented: ‘I suppose the mentoring is good, but I felt it reined me in a little bit.’ Another expressed the view that the mentoring arrangement was somewhat open-ended, in terms of time commitment: ‘They had nothing to say that my mentor should give me 10 hours between now and Christmas ... There is nothing set to say you need this amount of time at least to achieve a competence.’ Another concluded that mentoring was concerned mainly with ‘your personal development rather than actually looking at service needs.’ One participant spoke of how the mentoring arrangement was constrained by her very busy work situation and how this had delayed her progress: ‘My mentor is very good ... and very positive and I think would like me to be further than I am.’ One PEQ respondent observed that ‘mentoring must occur in association with other interventions’ and suggested that the mentor could have a role to play in assessing whether competencies had been attained.

Mentors themselves spoke about their experiences of mentoring. Mentors spoke in positive terms about their mentoring experience and about how they developed from it and assisted their mentee to develop: ‘I think the mentorship has been hugely beneficial to the mentees and I think it gives them the opportunity in a safe environment to think out a lot of solutions themselves.’ A number of mentors stressed the importance of the safe environment as constituting part of the mentoring process: ‘I think that is the thing, it is a safe environment ... it is a safe area for them, very much so.’ Mentors also spoke about their understanding of the role. One mentor spoke of her understanding of the role as ‘giving the tools, showing the way, signposting what was available for them to do.’ Another described the importance of the mentee leading the process:
You are there to mentor, to give guidance and to sign post, if the mentee wishes to or not maintain their portfolio at the rate that maybe the guidance suggest then again it is up to the mentee. It should be very mentee driven because that is their responsibility, certainly not the mentors, from my understanding.

Mentors also spoke about their experience of preparation for the mentoring role. One spoke about how she already engaged in mentoring-type activities ‘informally’ in her role as a clinical manager. One suggested the need for more initial preparation: ‘give clear guidelines to those that are going to set out as mentors what is expected, maybe a tightening up of the process and of the meetings and the dos and the don’ts maybe, that is probably what is not in it at the moment.’

Some mentors mentioned that they were unaware that their mentee was required to maintain a Learning and Development Portfolio, as these two extracts show: ‘I was aware she was keeping notes and she didn’t mention the portfolio’; ‘I wasn’t clear that there was a portfolio in the first place.’ However, others used the Portfolio in a deliberate way to support the mentoring process, as one mentor stated: [we] focused very much on the portfolio as well and she kept it very well up to date and ... this was a very good way of getting to know [her].’ Another spoke about how the Portfolio was the basis for guiding the mentoring activities:

We used the portfolio from the very beginning and we used it through most of our meetings, we went back through any of them that she had worked on, we went back through it and we looked to see if there were any points that needed clarification or a bit more mentoring on. We discussed things ... [and] we used that as a basis most of the time and it was really, really helpful because it gave us something to focus on because especially when you are busy as well and you’re dashing in for the meeting, you kind of want something to focus on and forget about what is going on in the wards and that as well; so we found it very, very helpful and have used it all along and it was really good (Mentor).

Commenting on the Portfolio, one mentor remarked: ‘as our relationship developed as mentor and mentee it became her property and I had nothing to do with it.’
A mentor spoke of role confusion in the tri-party meetings, where it was ‘kind of difficult then to see what the line manager’s expectation was of the project and of the mentoring sessions as well.’ A mentor spoke about the need for an earlier tri-part meeting in the Clinical Leader Development Pathway:

I just felt that I was mentoring a staff nurse and her CNM wasn’t aware of where she was at and was putting pressure on her from her side, but yet wasn’t giving her the support she needed. And I think there could have been a lot more achieved in the initial stages if there had been that three way meeting and everyone got to say, “okay, this is where we are at and this is the amount you can go off and do by yourself and I don’t need to be in that loop.” I think that would have definitely benefited from the start (Mentor).

Mentors spoke about the sense of the limited time to achieve the required two competencies:

So some things have been achieved, other things will take longer to achieve for competence and for, I suppose, to the indicators within the competence to be achieved (Mentor)

Others saw the time constraint as relating to the development of the service initiative, as the following two extracts illustrate:

She was very focused and knew exactly where she was. But like that, what she is doing is going to take a lot longer than December to actually implement it and carry it out. She has everything set and the ground work done but it will take a lot longer to actually carry out (Mentor).

My mentee had the impression I suppose that the project had to be done by December, and when we were talking through it we realised that you might have started the process by December, but inevitably these projects would take longer, particularly if it is around practice changing (Mentor).
A meeting of the assigned mentors took place in the latter part of the pilot. This meeting was a normal part of the schedule of activities for mentors on the pilot and was concerned with self-monitoring and mutual support and was not convened at the behest of the Research Team. In the course of the meeting, mentors reflected on their experiences and provided a number of observations and suggestions that would add to the evaluation data. These comments and suggestions therefore constituted a small element of the data set. In reflecting on their experiences, mentors commented that the process of mentoring had worked well for many of them and their mentees and that the chemistry between mentor and mentee also worked well. The mentors’ reflections on their experiences included a number of observations and suggestions for good mentoring. These included the following points, which they referred to as ‘top tips for mentoring’:

- The mentor, mentee and line manager must be committed to the process of mentoring
- The mentor should be well prepared for both the individual mentoring sessions and for the process as a whole
- Mentor-mentee meeting dates and times should be pre-arranged at the outset; however, mentoring sessions may be structured as required by the mentor and mentee, i.e. flexibility in the process is required
- In advance of a formal mentoring session, the mentor should ‘relax’ and spend a few moments catching up before the formal session begins so that both mentor and mentee can ‘settle in’ to the session
- Clarity is essential in relation to all aspects of mentoring and both the mentor and the mentee are required to maintain confidentiality and be honest in the process
- Both the mentor and the mentee need to be very familiar with the clinical leadership competencies
- The mentor needs to be self-aware and to listen effectively in the mentoring session, in order to ensure that what is being said is heard, and the mentee also needs to listen effectively
- The mentor needs to accept where the mentee ‘is at’ and proceed at the mentee’s pace
- The mentor should aim to balance the levels of challenge and support in the mentoring process
- The ongoing communication between the mentee, mentor and line manager should be led by the mentee
Additional suggestions from the mentor group included the need for tripartite meeting(s) between mentor, mentee and line managers and the need for flexibility in the choice of competencies to reflect both individual and service needs. Mentors also suggested that the mentor should have the option to attend clinical leader competence workshops, have competence workshop information available to them and also have access to the Learning and Development Portfolio.

Experiencing coaching
Data from coaches and their coachees provided copious narrative evidence of experiences of the coaching intervention. Pathway participants provided data on their experience of coaching in the course of focus group interviews and this was augmented by data provided by coaches in the course of a single group interview. In addition, four internal coaches provided written reflections that informed and further complemented the evaluation data concerning the intervention.

Some participants spoke about the coaching intervention and how they experienced it. For one participant, choosing the coaching intervention was based on her sense of needing 'to have someone who is outside [my work]'. The coaching process was described by one internal coach, who presented written reflections on her experience:

Progress in competence development was enabled by exploring the coachee’s current position in relation to a competence and the position they would have attained if more clinical indicators of competence had been achieved and to map out a route between these two points. The route involved addressing many levels of learning to include finding new information, brainstorming actions, deconstruction beliefs, values, attitudes, ways of working and engagement that prevent action and competence growth, and replace them with processes and ways of being as a professional that enhance competence and its application in the clinical field. The process involved ... the coachee in bringing these issues to awareness, challenging them to growth in a way that builds resourcefulness in the coachee and engages them actively in overcoming any obstacles to improving their competencies and in taking action based on these improvements in the clinical field (Internal coach).
During the internal coaches’ group interview, a coach explained how coaching was linked to the participant’s assessment and development and how the coaching contract also figured in the process:

The contract ... almost takes up where the assessment and development tool finishes ... part of the role during the contracting meeting [with the coachee and line manager] is to actually work through what that means so you do continue to some degree part of that assessment and it is really, really important obviously that the contracting meeting is very comprehensive ... And part of the contract is about finding out, making all of that explicit and also maybe doing a complete reality check with the line manager about what is possible as well (Internal coach).

Participants described their experiences of the coaching process. One spoke about the respective roles of the coach and coachee as she understood them:

So far I found it very good and the coach is very nice ... and so everything is explained before you start. It is very much your own agenda and you set the tone for the meeting and she is very challenging as well, which I find absolutely brilliant ... so far I have benefited an awful lot from her, but again she won’t give you any answers, it is very much up to you to find solutions (Pathway participant).

A senior nurse similarly recognised the role of the coachee in the relationship:

It is not always like “oh the coach is fabulous and she is going to sort everything out” and coaching isn’t about that either. Coaching is about you deciding what you are doing and they working along with you. Like a mentor, they’ll tell you what to do, but the coaching is you, but they are working along with what you are doing (Pathway participant).

Participants spoke of the how the coaching style contributed to their development: ‘I’d say the coaching is challenging enough, she (my coach) is making you think about it a different way, so I found that good.’ Another said that ‘[the coach] makes you focus more [on] the one
thing.’ The fact that coaching arrangements were ‘far more structured’ than those for mentoring was also seen as a benefit for one participant: ‘You are going off site because there is (sic) interruptions ... and at least when you leave the hospital you cannot worry about anything.’ Referring to feedback to her coach, a coachee expressed ‘amazement of having a sacred space to actually discuss real issues that [she] just didn’t seem to have the time for her normally to discuss.’ One coachee remarked on a how ‘very lucky [I feel] to have been given this opportunity.’

One senior nurse spoke about how the coaching intervention had helped her with communication:

> We have looked at the whole communication thing and ... I am just more aware of how I am communicating and who I am communicating to and from; that aspect of it has been good ... because I am very conscious of, I suppose we get a lot of problems in the door every day and how do you respond to those.’

Some coachees spoke about the constraints and limitations of coaching. One spoke about the relative inexperience of her coach: ‘it was her first time to coach, so she is very by the book and I know she is trying to use the skills she has learned because I can see her in the way she approaches the coaching sessions.’ Another recognised that coaching required ‘a while initially to build up that relationship, for them to get to know where you are and where you are going.’ Another remarked that ‘maybe my expectations of her were that she was going to be something much more.’

A coach remarked how coaching was helping her coachee: ‘just working through the coaching process, she is gaining clarity obviously about her goals and what is realistic and what is not.’ Another wrote of the direct benefits of coaching for her coachee:

> Coaching was a new approach for my coachee but she quickly learned that the focus was on personal resourcefulness and determining her own actions to competence growth (Internal coach).
An internal coach summarised the particular function of the coaching process in the development of leadership competencies that differentiated it from other interventions:

I think coaching is very apt for the development of competencies because it is asking questions that are not obvious and questions that are not anywhere in the literature. And it is challenging for the client and asking some very powerful questions that don’t get asked in normal circumstances (Internal coach).

Another coach saw the benefit of integrating coaching with clinical leadership training and within the HSE more generally, since it gave individuals ‘an opportunity to pause and look at how we do our work.’ This coach considered that this was particularly important since ‘our request for additional resources is often only part of the answer to our challenging times; in many instances it is about doing things differently with the resources we have.’ Another coach also wrote of the potential that resided in coaching, a potential which, in her view, had not yet been realised in her coaching experience:

The nature of the personal awareness work achieved in developing the competency involves shifts in personal beliefs and attitudes that enable information to be put into action. This learning can be applied in all aspects of the coachee’s professional and personal life. An example which did not occur within my ... coaching: An individual can learn many techniques and approaches about building a team and resolving conflict in a team but unless they have personal courage, creativity and are authentic in their approach, limited outcomes can be achieved. This is the kind of personal resources that coaching develops. It is about marrying the information with the capability of the individual (Internal coach).

In reflections, one coach wrote about how the newness of coaching had impacted on the process:

Coaching is a new intervention within the HSE [and] hence ... there is certainly lack of clarity as to what coaching is and what it can offer. This misunderstanding is evident from both the line manager and the coachee (Internal coach).
Coaches in the group interview also spoke about the newness of the intervention and discussed the rationale for selecting coaching as an intervention in the pilot, as one coach explained:

> We were looking for methodologies and interventions that would support the adult learner outside of a classroom setting ... we explored it and that was it really and [we] offered it to the workforce ... in terms of their wish to be involved. If you look at learning and development literature outside of the health services, coaching and mentorship are talked about quite a bit. So it was looking at what could we bring to a new model of clinical leadership, and really that was it (Internal coach)

This coach also spoke about how, in selecting coaching, there was the wish to explore how interventions ‘might help managers and nurses and midwives in the health service.’ Another coach spoke about ‘testing a new way of supporting nurses and midwives on this development pathway’ in addition to other facilitative interventions like mentoring and action learning.

Coaches reflected on best-practice principles in the coaching process. One coach wrote that ‘one of the key principles of coaching is that the focus is on the client’s agenda.’ In the course of the group interview another coach spoke of the importance of the disposition of the coach when coaching: ‘I have to go in more neutral into the sessions as a coach because I am responding to the client’s needs and what they want to focus on.’ Another wrote about the importance of establishing an awareness of boundaries in the tri party coaching situation, ‘so as to offset the potential or perceived potential for collusion between the coach and line manager.’ One coach spoke about how she experienced the reality of coaching as quite different to her training experience:

> My experience of it, I suppose while we would have done a lot of practice when we were doing the course with each other, I think the real life thing is quite different when you are with a real person with real issues ... and being faced with that, that was a difficult experience for me personally and hoping that I was managing it appropriately and doing the right thing, I suppose (Internal coach).
Coaches reflected on problems and challenges that they had encountered in the coaching process, which included cancelled appointments, geographical distance between the coach and coachee, and lack of time to conduct meetings as planned. One wrote that coachees ‘were particularly slow in general in making contact with their coach’ and another wrote of her disappointment that ‘the relationship between myself and the coachee never really materialised.’ Reflecting on the practical difficulty of coachees failing to initiate contact with their coaches, one internal coach wondered whether such resistance was ‘based on fear [or] lack of understanding’ on the part of the coachee. Another coach wrote of the ‘ongoing challenge ... to ensure that coaching sessions were not used to fire fight challenges encountered in day-to-day clinical experience’ and a fourth coach wrote of her ‘frustration with the coaching process, as it was not following the course of what was agreed in the framework.’ Speaking in the group interview, one coach referred to the challenge of having to address ‘lots of other things like personal issues, conflict issues that are going on for the coachee.’

This particular challenge was echoed in coaches’ written reflections. Two coaches referred to the challenge to effective coaching when personal and emotional issues emerged in their respective coachee. Encountering such challenges raised issues that were not within the contractual remit or professional competence of the coach. One coach observed that ‘the personal issues of the individual coachee have to be addressed in the first instance ... a separate personal development piece in advance of commencing the coaching relationship.’ A third coach also suggested that personal issues could emerge in coaching sessions: ‘I learned much in the process and in particular the balance between the personal and subjective work often addressed in coaching sessions and the measurable outcomes contracted for.’

Despite these challenges, internal coaches were overall positive about the coaching intervention, as one coach wrote: ‘The opportunity afforded by coaching to unlocking a person’s capacity to grow, develop and maximise their own performance is significant.’ For this coach the experience was also ‘both a personal and professional journey of introspection, learning, discovery and growth.’ Another coach was similarly positive, writing: ‘Personally the coaching experience for me was very positive and my coachee feedback also reflected this.’ Internal coaches also spoke positively about their experience in the course of the group interview. One experienced coaching as ‘quite different [and] refreshing.’
Two coaches offered suggestions as to how coaching might be more effectively established within the HSE for nurses and midwives. One suggested that since coaching was ‘a very new concept for many ... a demonstration of what it is and how it works would have been very useful to participants and managers during the induction session for the course.’ Another coach proposed a more deliberate and structured introduction to coaching:

I believe there is a need to address this deficit in understanding [of coaching] so as to make the coaching process more effective for all parties ... possibly by providing more and clearer written information for line manager and coachee, by providing a sample coaching session at introductory workshops, by direct telephone contact with the potential line manager explaining what coaching is and indeed what it is not (Internal coach).

A very positive experience
This sub theme refers to participants’ accounts of their participation in the pilot. Experiencing the Clinical Leader Development Pathway was for many a very positive experience, as attested to in several comments offered from across the entire range of data collection methods. Many comments referred to the Project, its merits and the way that it was conducted, while others referred to the Project with reference to their own personal experience of it. Many respondents to the PEQ provided positive comments about the Project. The following selection of short extracts illustrates the range of comments about the Project itself:

Overall I think it is an excellent project

It is a very worthwhile project and I really enjoyed it and I had a brilliant coach. I thought it was great. It can be hard to find the time ... It was a great experience overall and I was really grateful to be a part of it.

I think it’s a very valuable programme, I hope that it is supported going ahead. Competencies are excellent. I think that it would be great if the HSE could adapt it to the rest of the country.
One PEQ respondent saw a ‘huge opportunity for coaching in the HSE’ as a result of the pilot. Another wrote: ‘I felt it was an excellent process. I would do some mentoring in my current role, the training formalised it for me. The trainers were very passionate and easy to contact.’ One commented on the immediate relevance of the project to their work: ‘It (the Pathway) feeds into other work that I do’

Participants commented on their own experiences on the project:

The project was very enjoyable and the Project Team were great to work with and very helpful, always (Pathway participant).

Another observed: ‘An amazing experience, it’s been learning from start to finish. There was good learning in the obstacles [and] in the work of overcoming them (Pathway participant).

A number of managers spoke of the benefits of the Project to them or their staff. For one manager, the experience had a particular personal relevance and impact:

It was a positive experience [and] it’s the first time in my life that there was an investment in me as a manager. It was a golden opportunity, a learning curve, reflective and very positive and it required a degree of honesty from myself (Pathway participant).

This same respondent expressed the hope that that ‘we could have more nursing and midwifery people involved, engaging in the process.’ Another manager commented: ‘I would say what I have done to date has added to my confidence as a manager.’ A line manager remarked that ‘four staff members participated and they benefitted enormously, and they encouraged other staff members to get involved.’
Key points

The various interventions were experienced positively. The benefits of workshops and action learning were seen in terms of group interactions and in sharing experiences and finding solutions to real everyday practice problems. Mentoring and coaching were also positively evaluated by participants on the Pathway and those providing the interventions, in terms of their contribution to clinical leadership development. A good mentor-mentee relationship was seen as important to the success of mentoring and the coaching style was seen as contributing to the participant’s clinical leadership development.

Both mentors and coaches experienced challenges in finding time to meet their respective mentees and coachees. Coaches also referred to the challenge to effective coaching when personal and emotional issues emerged in the process.

For many, the Clinical Leader Development Pathway was a very positive experience and many remarked on the merits of the Project and the very professional way that it was conducted.
5.2.3 Theme 3: Developing competence for clinical practice

This theme refers to participants’ accounts of how they experienced developing their competencies for clinical leadership. These accounts were offered by both participants on the Pathway and others, notably line managers and service directors. The theme is presented as two sub-themes, ‘choosing the competencies’ and ‘developing the competencies’ (Figure 5.4).

Choosing the competencies

Data provided by the Project Team indicated that most participants selected the competence ‘quality and safety’, from among the seven competencies and that the competence ‘advocacy and empowerment’ was selected by fewest participants (Table 5.2). The decision in each individual case was based on the outcomes of assessment and development meetings with line managers.
Participants spoke of arriving at the decision on which competencies needed development and it appears from the data that some line managers were more focused on competencies that appeared to result in a more direct service impact. For example, one line manager remarked:

We concentrated on clinical excellence and quality and safety in improving a practice on the ward ... I felt that was best. I wanted to improve something clinically that would impact to everybody rather than just one individual (Line manager).

Respondents to the PEQ also spoke of the pre-eminence of service development over leader development in the assessment and development process. One respondent stated: ‘[the participant] did not choose the competencies, the line manager did’ and another stated: ‘the interventions agreed were more about the service than about me.’ In reflections on coaching, one internal coach also admitted that ‘the manager chose the competencies for the coachee to work on based on what she felt the organisation would benefit from most.’ The coach also observed how, at the end of her tri party meeting with her coachee and line manager, she was ‘struck by how unrelated the outcomes were to the chosen competencies.’

A line manager, herself a participant on the Pathway, saw the importance of clinical excellence and quality and safety to her own practice situation:

The reason I chose the clinical excellence and the quality and safety, which were my two, was because I felt there was room for improvement there because there is always room for improvement there ... On reflection, I needed to put more time into thinking

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### Table 5.2

<table>
<thead>
<tr>
<th>Competence</th>
<th>No. Pathway participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self awareness</td>
<td>7</td>
</tr>
<tr>
<td>Advocacy and empowerment</td>
<td>3</td>
</tr>
<tr>
<td>Decision-making</td>
<td>7</td>
</tr>
<tr>
<td>Communication</td>
<td>7</td>
</tr>
<tr>
<td>Quality and safety</td>
<td>12</td>
</tr>
<tr>
<td>Teamwork</td>
<td>5</td>
</tr>
<tr>
<td>Clinical excellence</td>
<td>9</td>
</tr>
<tr>
<td><strong>N = 36</strong></td>
<td></td>
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</tbody>
</table>
of my own practice, my own service and where the areas are for development there (Pathway participant).

Developing the competencies
This theme refers to participants’ accounts of developing competencies as a result of their participation in the pilot and as a result of the interventions which they experienced. Many spoke of how their sense of developing new insights or new skills in their work and of having a different perspective on themselves and others. Others spoke of specific competencies and the attributes and capacities associated with them that they had developed or were in the process of developing. Many linked competence development to their sense of professional and personal development. Participants and their line managers referred to evidence of the development of particular competencies. Self-awareness, communication and team working were frequently referred to.

The sense that the development of one clinical leadership competence depended on the concurrent or prior development of other competencies was expressed by one participant in the following terms:

We chose to do particular competencies, but you can’t really do one competency without taking from each of the other competencies ... because you can’t go into your team and say: “I want to do this, I want to do this policy that we have” without using your team building and your communication and all of those things (Pathway participant).

A common observation made by many who contributed data in the study was the notion that self-awareness was important and that it underpinned all other competencies. Contributors to the study spoke of self-awareness as a pre-requisite competence for all other competencies. The following extract, provided by an internal coach, typified this view:

The competence of self awareness underpins all the other six competencies and should perhaps be an essential mandatory competence. If you are not self aware and self managing it will be difficult to progress along the development pathway for all the remaining competencies (Internal coach).
One participant offered the view that self-awareness ‘will shape how you will engage with everything else’ and stated:

I suppose my self-awareness would have certainly been weakened by [my relationship] with a colleague ... [and] when I did the self awareness group ... lines of communication have opened where there would have been little or nothing for years, literally little or nothing.

Another spoke of the importance of self-awareness combined with communication as pre-requisites for all other competencies:

I think to start too with communication and self awareness, to work on yourself first rather than going head long into clinical excellence, which I did [and] which was very intense. And you are jumping, like you said that is good for everybody to go through and start then developing yourself before you can go into developing a programme for work.

Many participants referred to the way that their interpersonal relationships with colleagues had changed as a result of their participation in the Clinical Leader Development Pathway. Some spoke about this as being related to a greater awareness of the other’s perspective and others referred to it as simply improved communication in the work setting. One participant spoke of experiencing a new perspective in relation to communication with colleagues:

So I suppose in my own practice now I am very, very aware of everyone I am working with whether it be people on the ward, my own line managers and stuff like that. They might actually have a lot more going on, and like I was misinterpreting a lot of stuff that might have been coming to as “they are just cranky” or something like that. But I have become a lot more aware of it.

A clinical nurse specialist spoke about her sense of improved communication skills:

I think I would be better able to express myself in terms of where I want to take those skills and bring them into the team situation and informing our practice going forward.
in the team rather than say one dimensionally changing how I think about things. It probably just gives you the language, the formalisation to bring it more to the team rather than keep it on an individual basis.

A line manager commented on the improved communication skills of her colleague as a result of the CLRP intervention:

I give her time to read and go over the book as much as I can, but she is coming back with little snippets all the time in relation to other things in the department. Her communication skills have improved (Line manager).

For some, improved competence in communication had improved the way that practice was conducted, as the following two extracts illustrate:

Well we are having a lot more staff meetings now and getting staff input as well. Before we would kind of let it drift and if there was an issue then we would call a meeting, whereas now it is more common, we are doing it more often (Pathway participant).

I would be more prone to, say, not dismiss people or I am more open or I will be more accepting of very different viewpoints. Or if I don’t agree with somebody I wouldn’t go headlong and say “oh no, that is wrong”. I will just let it go now, whereas before ... And if you were asking for ideas for the particular project I am doing, I wouldn’t say no to any idea. I will write it all down and say that is a great idea we will look into that. Whereas before I might say “ah no, that wouldn’t work”, whereas now I wouldn’t do that (Pathway participant).

Developing competence for team working was referred to by a number of participants. One stated:

I suppose it has made me very conscious of the fact of how to work in a team and it is all about the team vision as opposed to individuals in a team. I am very conscious of that. If there are disagreements, it should be about the team vision rather than getting
bogged down in personal issues ... You can see that more clearly now, that it is not all about the individuals on the team, it should be about what you are doing [as a team] (Pathway participant).

Another spoke about how her perspective had changed as a result of her developing competence in team working:

And you understand why they react in a different way to the next person because they are a certain type of person. That was introduced at the beginning and it was really interesting (Pathway participant).

Another spoke about their sense of improved skills in managing conflict within the team: ‘I would say more around dealing with conflicts in the team, dealing with that better.’ A line manager referred to her new disposition to colleagues as a result of action learning. ‘As a manager I was thinking that [empathy], that was something I needed to be aware of, but definitely after the action learning sets it was amazing to see what other people go through.

Key points

The clinical leadership competencies selected most often by participants were ‘quality and safety’ and ‘clinical excellence’. Evidence of the development of particular competencies was provided, such as self-awareness, communication and team work. Evidence was also provided of new clinical leadership behaviours and dispositions in participants and of changes in the culture and atmosphere of the working environment. Many believed that self-awareness was so important that it underpinned all other competencies.
5.3 Summary of findings: Experiencing the Clinical Leader Development Pathway

The various qualitative data collection methods yielded a body of very rich narrative data concerning the Clinical Leader Development Pathway, including participants’ experiences at various stages in the process, interventions used, service impact and operational and logistical arrangements involved in rolling out the pilot.

Participants on the Clinical Leader Development Pathway had overall positive experiences of using the Assessment and Development Tool. While many referred to divergence between themselves and their line manager in relation to self rating, they also referred to arriving at a consensus in relation to the meaning of behavioural indicators and the scores. Participants experienced the process of maintaining their Portfolio as helpful in stimulating their thinking and reflection. Some participants experienced initial difficulty in selecting an intervention. The emphasis on self-monitoring in the development of competencies was a novel experience for some. However, the process of self-monitoring itself represents leadership behaviour.

The various interventions were experienced positively. Workshops were seen as beneficial in enabling the sharing of experiences of practice problems and finding possible solutions to them through group interactions. The action learning set intervention was also viewed as a very valuable experience in facilitating the sharing of ideas and concerns about practice. The focus on finding solutions to real everyday problems was seen as the particular benefit of the intervention.

The mentoring intervention was positively evaluated, with many referring to the value of the one-to-one arrangement that mentoring provided. Both mentees and their mentors referred to the importance of a good mentor-mentee relationship to the success of the intervention and many commented on how well this worked for them.

The coaching intervention was also experienced positively. Pathway participants valued coaching as an intervention in their clinical leadership development and many spoke of how the coaching style had contributed to their development. A new intervention, coaching was experienced by some coaches with reference to challenges that were encountered in the coaching process, including cancelled appointments, geographical distance between the
coach and coachee, and lack of time to conduct planned meetings. Coaches also referred to the challenge to effective coaching when personal and emotional issues emerged in the process. Despite these challenges, coaches were overall positive about the intervention and its contribution to clinical leadership development.

For many, the Clinical Leader Development Pathway was a very positive experience, as attested to in comments offered from across the entire range of data collection methods. Many comments referred to the Project itself, in terms of its merits and the professional way that it was conducted, while others referred to the Project with reference to their own very positive personal experience of it.

Quality and safety and clinical excellence were the core clinical leadership competencies selected most often by participants. In the process of selecting a competence, service development could take precedence over leader development, with some line managers focusing on competencies that appeared to result in a more direct and tangible impact on service. Participants and their line managers referred to evidence of the development of particular competencies. Frequent reference was made to the competencies self-awareness, communication and team work and examples were offered of how these were manifest in the behaviours and dispositions of participants and in changes in the culture and atmosphere of the working environment. Many believed that self-awareness was so important and that it underpinned all other competencies.
Chapter 6

FINDINGS: SUPPORTS AND RESOURCES

6.1 Introduction

The Framework and Clinical Leader Development Pathway were supported by a range of human and material resources and supports. The human supports included the individual participant’s line manager who conducted the Assessment and Development Tool with the participant, mentors, coaches, action learning set facilitators and workshop facilitators, each of whom had a distinct role in providing an intervention. For the pilot, other designated human supports included site co-ordinators, the Project Team and the Project Steering Committee. In addition, individual participants relied on supports from their work colleagues and their wider organisation to enable them to engage in the Clinical Leader Development Pathway.

A range of documents both informed and supported the various activities associated with individual participant development and the range of Pathway interventions. These included the Learning and Development Portfolio, the Clinical Leader Resource Pack, the Action Learning Facilitator Toolkit, the Clinical Leadership Facilitator Toolkit, the Mentor Train the Trainer’s Programme, the Mentor Guide and the Coaching Reference Manual.

This chapter reports on the findings from the evaluation of the human and material resources that supported the pilot. Evaluation data on human supports had as their focus the Pilot participants’ experiences of supports and were collected in the course of the focus groups, group interviews and individual interviews and through the use of a free text ‘additional comments’ item in the Participant Experiences Questionnaire (PEQ). The findings from the documentary analysis included numeric scores yielded from analysis of the documents, conducted independently by four analysts using the Documentary Analysis Rating Instrument (DARI), and the consensus evaluative data generated in the conference of analysts.
6.2 Findings: Experiencing support

The qualitative data provided detailed information on pilot participants’ experiences of support. These experiences were conveyed in accounts given in focus group discussions, group interviews and individual interviews and in comments provided in the PEQ. These data suggested one main theme, named ‘experiencing support’, which contained two sub-themes, namely ‘getting the time’ and ‘getting the support’. The two sub-themes describe participants’ accounts of their experiences of support while undertaking the Clinical Leader Development Pathway and other pilot participants’ experiences of support.

Figure 6.1 Major theme: Experiencing support

Getting the time

The time required to commit to the Clinical Leader Development Pathway was seen by many as a barrier to their full engagement in the process. Many respondents to the PEQ commented on the timing of the pilot, observing that ‘the timing wasn’t great’ and there was ‘too little time’ as it was ‘peak holiday time’. One respondent commented: ‘the timeframe was very short, [with] a lot of urgency, especially during the peak holiday period.’ The following two extracts typified this concern with the Project timing:
The time of the year this programme was run was an issue, all these study days throughout peak holiday time throughout the summer. And even for your own motivation, having to sit down and do this type of work in an evening in the middle of the summer is extremely difficult (Pathway participant).

July, August is horrendous. [For] anybody who has children that is not a practical time of the year to be ... Normally most people down tools for the summer (Pathway participant).

A line manager spoke about how the timing of the Project had meant that the process was slow to get started:

I would say the short timeframe since June; that has been a difficulty. I mean it took quite a long time for people, and it was summer holidays and all of that, to engage or link up with their coach or their mentor and the months were passing by, so there was a time pressure there (Line manager).

Many participants experienced the time constraint not with reference to the time of year, but to the amount of time required to complete elements of the Clinical Leader Development Pathway. This was reflected in comments provided by PEQ respondents. One respondent stated: ‘When there is a high amount of paperwork, I felt a bit disheartened that there wasn’t a bigger time out.’ Another respondent commented on the value of the documentary supports, but saw the need for a ‘lead-in’ time to better prepare:

The documents were good, the resources were good. I was able to augment them if I needed to and there needs to be a good amount of lead-in time for a project such as this, so that participants and the services can prepare (Pathway participant).

A line manager also remarked on the time required to complete the Learning and Development Tool: ‘I would say it was time consuming, the participant and myself worked through it and it took a considerable amount of time.’ Another line manager was ‘apprehensive about it because we don’t have the time at ward level to give to people.’
Participants and those providing interventions commented on how work demands had impacted on participants’ ability to fully engage in the Clinical Leader Development Pathway, as one PEQ respondent remarked: ‘the competing demands of work meant I was unable to get to all the meetings, which was frustrating.’ Another similarly commented:

My other work demands had to come first. I would like to be able to commit more time to it and would like to be continuously involved in it (PEQ respondent).

The challenge to the successful roll out of particular leadership interventions was seen to reside in these competing demands of work, and many participants spoke about the time challenges in taking their chosen interventions, such as workshops, as the following two extracts convey:

The participants are finding it very difficult to attend because they find it difficult to get away from work, to be released from their duties. This then has an impact on numbers attending the workshops and low attendances at the workshops impact on the group dynamic in the workshops and consequently on the learning experience in the workshop (PEQ respondent).

The only issue we would have felt, well I had personally, was just facilitating time off because we weren’t, was it eight hours, I don’t know how many hours study, you know we got the time for the day but just trying to fit it in around (Pathway participant).

A participant wrote of the ‘personal time constraints at the time of meeting my mentor’ which resulted in ‘slower progress’ on the Clinical Leader Development Pathway and another commented that ‘we need more time to absorb all the material.’ The time constraint also impacted on participants’ ability to participate in the coaching intervention. One coach remarked that ‘the timeframe is too pressurised due to the nature of coaching ... coaching can be a slower process.’ Another coach spoke sympathetically about the time constraints experienced by her coachees:
I would just like to talk about just how busy the coachees are in their working life, that they just get a moment to catch their breath and so reflection for them is quite difficult unless they take it home to reflect and then a lot of the time they are young people with young families, so it doesn’t seem to translate for them (Internal coach).

One participant spoke of how she experienced difficulties in managing the coaching arrangements with her coach and line manager:

I am finding it hugely difficult as it is to get the coaching in, you know. You have your chemistry meeting over the phone; we did that. That was fine but then to actually pin my line manager down to get a tri party meeting was difficult. And I came in on my annual leave to do it (Pathway participant).

Some line managers tended to focus less on the participants’ ability to complete intervention tasks and more on the time required to attain competencies. One line manager observed that participants ‘move at different paces and achieve things at different rates’ and another stated: ‘I think it is difficult in a short time to show tangible outcomes ... it is a journey, isn’t it?’

One pilot participant who withdrew cited the reason for withdrawing as the result of demands for service changes and reconfiguration that s/he was required to implement at the time of the pilot. Another participant who withdrew cited ‘cost containment and short staffing’ as the ‘main reason’ for withdrawing. Another speculated that those who ‘dropped out’ of the programme did so because ‘they got nothing from it.’

Getting the support

Many participants spoke about the support that they experienced from their line manager or service manager. Many spoke in very positive terms about the support experienced, as the following short extracts show: ‘my line manager was very helpful’; ‘my line manager totally supported me’; [my] nursing manager ... had no problem in supporting me to do it’; ‘[I] was one hundred percent supported [by my service manager]’. Others spoke of similar experiences:
I approached my service manager about doing it and she was very supportive of me doing it, so it just went from there (Pathway participant).

My line manager knows the two areas that I am focusing in on and she has always offered support as well if she can help me in any way or whatever (Pathway participant).

My line manager ... she is very pro education and always developing and that you always have to learn something new. So I was very, very lucky, and when it comes to a course like this and the fact that she has a particular interest in it everything ... in relation to discussing it and working it through (Pathway participant).

While line managers were generally supportive, two constraints appeared to be associated with the level of support proffered by line managers. One was related to the line manager’s limited formal input into the Clinical Leader Development Pathway after the initial assessment of the participant’s leadership development need and the other was related to the participant’s accessibility to the line manager due to the latter’s other commitments. Hence, some participants commented that while their line manager was supportive, this level of support tended to be moderated by the exigencies of the work situation, as the following three extracts illustrate:

My line manager was very helpful and very good ... And actually getting her to sit down, actually grabbing her, a lot of it was done if she had a spare minute, that kind of way. But I know that is kind of the way we work, grab someone while you can. But I have to say she was very good to sit down mostly and do it. And she was interested in doing it, definitely, she was very positive that way (Pathway participant).

My line manager supported me in spirit but not in practice. I suppose that very point that you can be ‘in voice’ supported, but not in any other way, because people are just too busy. I feel I cannot have been any more supported or any better prepared because the project is so new. Some line managers were very supportive, [but] you’re not able to overcome all the problems, if you are not supported by a line manager (PEQ respondent).
My line manager was very supportive of the things I wanted to do with the service ... but she is also very busy, so I wouldn’t think she gave this a huge amount of attention, just one more thing she had to do ... just trying to pin her down for meetings and things was difficult because of all the stuff that is going on here and because it is such a busy hospital (Pathway participant)

Some participants spoke of the importance of the line manager in the process and suggested that the line manager should have considerably more input into the process. One suggested that ‘it would have helped if she had actually done the [Clinical Leader Development Pathway]’ and another stated:

If she had more of an input it would have, I think, helped me hugely in the fact that she could intervene and work with my mentor, saying that she really needs to work more on this bit and that bit and that angle. I think if the line manager had a little bit more input into planning, whatever subject you decide to work on at the time, that it probably would be more beneficial (Pathway participant).

Some participants commented on the role of the line manager in the process. One suggested that the line manager was somewhat redundant following the initial assessment of the participant’s learning and development:

I do think they didn’t really focus on drawing in your line manager, which I think is a huge fault in this programme, is that they detach your line manager from you (Pathway participant).

Another also spoke of the line manager’s limited involvement after the initial assessment:

I did my own filling out first and then we came together, but I hadn’t anything more to do with her after that then because her role in it was finished. I went onto the workshops and stuff then (Pathway participant).
Some participants also spoke of their sense of their respective line manager’s limited preparation for the role in the Clinical Leader Development Pathway. One remarked that it seemed to her that her line manager had not been fully briefed in advance of the first meeting: ‘my line manager, the first time she looked at the folder was when she was sitting down to do mine.’ Another had a similar experience, stating: ‘I just felt mine (line manager) didn’t know enough about the actual whole thing and she admitted that, she didn’t know.’ One participant considered that her mentor would ‘have done a more accurate assessment’ than her line manager, as she ‘had much more insight into the programme’. A similar view was also expressed by another participant, who stated:

Because maybe the person that you get mightn’t know you at all, so you are getting somebody who doesn’t know anything about you and they are meeting you and the person who does know you, that there is a big gap there.

Participants discussed their experiences of support from their own team. One said:

They will ask the odd question about how you are getting on and what is involved but I suppose some of them are studying themselves so they are tending to not get too interested in it but they are fine about it, they haven’t passed any comments (Pathway participant).

Others also commented on the level of interest from their team. One stated that ‘there wasn’t that much interest [from my team]’ and a PEQ respondent provided a similar comment regarding the support experienced from her/his team: ‘[there was] no interest rather than a lack of support ... from my departmental team.’

Participants also spoke of their experiences of support at the level of the organisation. One PEQ respondent stated that there was ‘no input from [my] organisation’. In contrast, another spoke of unfettered support: ‘I was always allowed go even if I was working I was allowed go, there was never a question ... I was able to go to all my action learning, I didn’t miss anything (Pathway participant).
Many participants spoke in very positive terms about the level of support proffered by the Project Team. One remarked that ‘[they were] brilliant I have to say, you can ring them up and talk to them’ and another stated ‘I thought they were excellent.’ A PEQ respondent wrote that ‘the Project Team were great to work with and very helpful, always.’

Some participants in the evaluation study made reference to the documents that support the Clinical Leader Development Pathway. Many of the comments submitted by the PEQ respondents typify how the supporting documents were experienced. One PEQ respondent referred to the quality of the supporting documents:

   The competencies were very clearly laid out in a wonderful document for leadership for nursing and midwifery. It is more up to date for all the competencies, articulating all the elements and focussing the participants (PEQ respondent).

While one PEQ respondent admitted to being unsure as to the ‘usefulness’ of the CLRP, s/he commented that ‘the folder was a brilliant resource, something I will always refer back to ... [and] the LDP was useful and good.’ Another PEQ respondent similarly admitted: ‘I didn’t know the relevance of the folder for each competence; what am I supposed to do with it?’, but declared that it was ‘still a fantastic document.’ This same respondent also commented that other participants had experienced the sense of not knowing the relevance of the ‘folder for each competence.’

**Key points**

Participants spoke in very positive terms about the support received from their line or service manager. However, line managers’ support was moderated by two factors, firstly, the line manager’s limited formal input into the Clinical Leader Development Pathway after the initial assessment of clinical leadership development need, and secondly, the line manager’s ability to engage due to competing work demands and commitments. Some participants considered that the line manager should have a greater input beyond the initial assessment process and some considered that their line manager was not fully prepared for their role in the process.
While participants experienced support, time was a factor. This was experienced with reference to the timing of the pilot itself and with reference to the time required to commit to the Clinical Leader Development Pathway. Hence, limited time was seen as a barrier to full engagement in the various elements of the Clinical Leader Development Pathway.
6.3 Findings: Material supports (documentary analysis)

Data on the material supports were collected using a documentary analysis method designed specifically for the pilot evaluation study. The method involved the use of the Documentary Analysis Rating Instrument (DARI) tool, a bespoke rating instrument that permitted analysis of the documents at three levels, as follows:

- Level 1: the quality presentation and layout of the documents
- Level 2: the language and representation of the key constructs and concepts within each document
- Level 3: the relationship between the constructs and concepts in the assessment and development tool and the documents supporting the various interventions

Generated independently by four analysts, the DARI scores were discussed in a conference of analysts, which generated additional qualitative evaluative data. The findings presented here include the DARI scores and the consensus evaluation of the documents arrived at in the conference of analysts.

The method of documentary analysis provided rich information on the quality, presentation, layout, content and internal structure of each document and on specific aspects of their content, such as their use of language to convey constructs and concepts and the relation of constructs and concepts within and across the documents. A focus of the analysis was the extent to which each documents appeared fit for purpose.

Table 6.1 summarises the frequency distributions of the scores yielded from the documentary analysis procedure using the DARI rating scales. The scores were generated from the four analysts, rating each document independently using the appropriate rating scale. Scores are presented as aggregate and scale scores. In addition, the mean score for each rating subscale for each document is also presented. Since the total aggregate score for each rating subscale for each document is a function of the number of items in that rating scale, each score needs to be viewed independently of the other scores and with reference to the possible highest aggregate score for the subscale in question. For example, when interpreting the scores, it is evident that the total aggregate score of 23 out of a possible total score of 25 for the
Mentoring document indicates that the document was rated very highly by the four analysts overall. The mean score of 4.6 on a scale from 1 to 5 is also very high.

### Table 6.1: Frequency distribution of analysts’ DARI scores

<table>
<thead>
<tr>
<th>Scale category (document)</th>
<th>Aggregate raw score</th>
<th>Aggregate scale score</th>
<th>Mean*</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentation of all documents (Level 1 analysis)</td>
<td>189/200</td>
<td>47.25/50</td>
<td>4.72</td>
<td>0.99</td>
</tr>
<tr>
<td>Learning and Development Portfolio</td>
<td>236/260</td>
<td>59/65</td>
<td>4.53</td>
<td>1.4</td>
</tr>
<tr>
<td>Clinical Leader Resource Pack</td>
<td>132/145</td>
<td>33/36.25</td>
<td>4.55</td>
<td>0.46</td>
</tr>
<tr>
<td>Action Learning Toolkit</td>
<td>151/160</td>
<td>37.75/40</td>
<td>4.71</td>
<td>0.8</td>
</tr>
<tr>
<td>Clinical Leadership Facilitator Toolkit (Part 1)</td>
<td>72/80</td>
<td>18/20</td>
<td>4.5</td>
<td>1.4</td>
</tr>
<tr>
<td>Clinical Leadership Facilitator Toolkit (Part 2)</td>
<td>71/80</td>
<td>13.25/20</td>
<td>4.43</td>
<td>2.2</td>
</tr>
<tr>
<td>Mentor Guide</td>
<td>92/100</td>
<td>23/25</td>
<td>4.6</td>
<td>0.89</td>
</tr>
<tr>
<td>Coaching Reference Manual</td>
<td>87/100</td>
<td>17.4/25</td>
<td>4.35</td>
<td>1.3</td>
</tr>
</tbody>
</table>

* The rating scale was 1–5

#### 6.3.1 Level 1 analysis: Overall presentation of the documents

Using the DARI instrument to rate the overall quality of the support documents, in terms of their presentation and layout, the range of possible DARI scores for the ten-item scale relating to the ‘presentation of all documents’ was from 10 to 50. The analysts’ aggregated total score for this aspect of the documentary analysis was 189/200, the subscale aggregate score was 47.25/50 and the mean overall score was 4.72 (SD =0.99). This score indicated the analysts assigned a very high rating to the documents at Level 1 analysis. This indicated that overall the documentary supports were assessed as being of a very high standard and quality of presentation.

Analysis of data from the conference of analysts confirmed this high rating with reference to the overall presentation of all the supporting documents. The analysts agreed that the documents were of a very good quality in relation to the printed paper and document binding. A key feature was the use of a distinct branding for all the documents; the use of a jigsaw motif in the graphic design and the predominance of a single branding colour, orange, contributed to the distinctive look of the documents. The predominant colour was repeated in each document, both in the page margins and in major text headings and ribbons. The predominant colour was also used in many diagrams, with the exception of the Clinical Leader Resource Pack (CLRP), where distinct shades of blue were introduced for some diagrams. In the CLRP, activities for managers were highlighted in green rather than orange.
and this was seen as being useful for user signposting and navigation. The analysts considered that the consistent use of a distinct branding was important, as it gave the documents a degree of substance, formality and identity.

The formatting of the Coaching Manual was found to be inconsistent with the formatting of the other supporting documents and of a somewhat lesser standard in terms of its production and finish. However, the analysts acknowledged that this document was in a state of ongoing development. It was also noted that as coaching was a new intervention in nursing and midwifery, the full and proper development of the coaching manual warranted considerable attention and time and several iterations before it could be committed to final printing. The analysts agreed that, in time, the Coaching Manual document should be brought up to the same standard as the rest of the documentation.

In terms of being 'user-friendly', the analysts agreed that all of the documents were easy to navigate, with clearly-signposted distinct sections and the use of section tabs and tables of content to direct the user to the various sections within documents. On overall reading of the documents, the analysts agreed that the documents were replete with helpful content and that overall the documents provided participants with a wide range of resource materials that were generally of a high quality. This positive aspect could be somewhat negated by the physical size of the documents, particularly the CLRP, which appeared to be rather weighty and bulky. This was seen as a possible source of discouragement for some participants. Nevertheless, the analysts agreed that any reduction in the physical size of the CLRP or of the total number of documents could be seen to dilute what they otherwise saw as a coherent set of material resources and a well-resourced approach to clinical leadership development.

Many sections in the CLRP and the LDP made very good use of bullet points and lists. These functioned well to aid comprehension and also to break up long passages of narrative text. Also noted was the good use of colourful diagrams to support the text. In addition, the slides used in the CLRP were generally well presented, although overall they were deemed to be somewhat over-reliant on text, where diagrams and charts would perhaps have been more andragogically effective.
The question of the inclusion of short summaries of key points at intervals in each of the documents was discussed as a possible useful addition to aid learning. The analysts recognised that the ring-binding used for the documents was also helpful, in that it allowed for the addition of materials and the removal of sections for ease of transport. This was confirmed by many participants who reported that, when using the CLRP, they tended to remove a single section at a time rather than carry the entire document with them. For example, one focus group participant remarked that there was ‘a lot of bulk coming in and out and you wouldn’t bring them in every day because of the weight.’ Referring to the Clinical Leader Resource Pack as her ‘white friend’, another participant remarked on how she experienced the materials as ‘frightening and daunting’ because of ‘the whole thing about the quantity, the size [of the document].’

All of the URL links were tested using the electronic versions of the documents. While the majority of links were successfully retrieved online, the analysts reported that a number of the URL links could not be accessed.

The analysts concluded that overall the supporting documentary materials constituted a distinct, well designed and physically robust set of resources to support the Clinical Leader Development Pathway and its various activities and interventions for all users. The documents were easy to navigate and appeared to be replete with a range of resources and references to additional supporting materials. While their physical bulk might be a deterrent to regular use, this was countered by the use of ring binding, which permitted sections to be removed for ease of transport when in use. The analysts recommended that all of the resources should be made available as an online resource, and through a range of applications for smart phones and android devices, such as the I-pad. Additionally, to reduce cost, each document could be provided in CD-ROM format.

6.3.2 Level 2 analysis: Language and representation of key concepts and constructs

A key focus of the documentary analysis was the content of the individual documents, and in particular, the use of language and the representation of the key concepts and constructs. For the purpose of the analysis, a concept was defined as a mental representation of what is experienced that is generally given a label, such as health, leadership and competence.
Constructs are higher-level concepts that incorporate a number of concepts; examples include self-awareness, clinical excellence and software. The analysts considered that overall the language in the documents was clear and consistent with the concepts and constructs that were contained in the documents. Concepts and constructs were clearly defined and numerous examples were provided. In addition, a range of andragogical tools, such as the use of learning activities, were incorporated into the documents to assist the user to understand ideas.

**Learning and Development Portfolio (LDP)**

The purpose of the Learning and Development Portfolio (LDP) is to provide a means with which participants can undertake and document their clinical leadership assessment and development needs and their assessment of their service area needs. Using this document, participants can prioritize their learning and development needs in conjunction with their service needs. They may present evidence of their learning and development and may create structured reflections on their learning and their clinical leadership practices. Four distinct LDPs are available, one for each of the four nursing and midwifery grades, as follows: staff grade, the clinical manager grades 1 and 2, the clinical manager grade 3 and the director of nursing/midwifery grade. The LDP contains the following sub sections:

- An assessment and development tool to record the participant’s grade and summary sheet
- A service assessment tool
- A personal development planning log
- The seven clinical leadership competencies and their behavioural indicators for the relevant Pathway participant grade
- Information on reflection, models of reflection and sample reflection logs
- Coaching, mentoring and action learning record sheets
- Additional blank logs and record sheets.

Using the DARI instrument, the range of possible DARI scores for the thirteen-item scale relating to the the LDP was from 13 to 65. The analysts’ aggregate raw score was 236/260, the subscale aggregate score was 59/65 and the mean score was 4.53 (SD =1.44). These
scores indicated that the analysts assigned a very high rating to the LDP documents for all grades and the consensus view was that the document was fit for purpose.

Based on these scores, the analysts agreed that overall the behavioural indicators for each of the seven competencies were stated in language that was generally clear, stated in a way that generally reflected the real world of everyday practice and accurately reflected the name of the competence. However, the analysts considered that in the case of a small number of the behavioural indicators, the language was somewhat over wordy, and as a consequence, difficult to interpret. For example, some behavioural indicators contained two or more behaviours, as was evident in the following two examples: ‘models accountability and supports others’ and ‘acts to ensure that the voice, needs and views of the patient are heard in a meaningful way’. This was viewed as being a threat to the reliability of the individual behavioural indicators in question and a source of possible confusion for both the participant on the Pathway and her/his line manager.

In addition, some of the behavioural indicators were found to be expressed with the use of phrases and clauses that were somewhat vague, for example: ‘embraces positive change as a way of life’, ‘participates in and uses clinical governance processes’ and ‘translates key messages relevant to their agendas’. The analysts considered that these indicators could be open to several interpretations, either by the participant, the line manager, or both. The analysts also considered that there was a risk that the participants or their line manager might interpret the competencies differently, depending on the degree to which the participant engaged in different activities in their everyday practice, for example: ‘writes reports/papers to suit a variety of audiences’.

The analysts agreed that there was enormous value in presenting the LDP documents as four distinct versions, one for each of the four grades. This allowed for a clear differentiation between the different grades, in terms of the particular role that each performed and the particular clinical leadership development needs that were appropriate for the performance of that role. In this connection, the analysts drew attention to the competencies ‘clinical excellence’ and ‘quality and safety’ as exemplifying this distinction.
A noteworthy feature of the LDP was the clear guidelines that are set out for the achievement of competencies and in particular the use of the scoring system, which incorporates a rating scale of 1 to 4 for each behavioural indicator and each competence overall. The analysts considered this to be a strong feature of the Assessment and Development Tool component of the LDP, since it offered a simple, yet discriminatory, rating system that could be easily understood by both the participants and their line managers.

The analysts observed that the structure of the LDP required participants to engage in a considerable amount of reflection and a lot of documentation of these reflections. In addition, with the long list of behavioural indicators contained in the LDP, there was a risk of some repetition of behaviours. However, the analysts agreed that the sources of evidence in the LDP provided a good range of items and useful suggestions to help participants attend to the assessment of their clinical leadership development needs.

The analysts made a number of suggestions for improvements to the LDP. They suggested that instructions be provided for the Assessment and Development Tool, in order to assist participants to complete the second rating box. The spare sample sheets provided in the LDP to assist participants with record keeping, for example, for coaching and/or mentoring interventions, seemed to be largely redundant and might constitute an unnecessary additional cost in the production of the document. The analysts also noted that the list of references for the LDP are positioned on the final page of the document and they observed that their positioning at that point in the document might result in the references being overlooked by the document user.

*The Clinical Leader Resource Pack (CLRP)*

The Clinical Leader Resource Pack (CLRP) is a major component of the National Clinical Leadership Development Framework for Nursing and Midwifery and is a core documentary resource for supporting participants on the Clinical Leader Development Pathway. The CLRP contains seven distinct units of learning, each dedicated to one of the seven core clinical leadership competencies. The CLRP is a resource provided to support all participants on the clinical leadership pathway. It constitutes part of the suite of interventions. Other interventions include mentoring and coaching and these are conducted according to the methods and procedures offered in the relevant supporting documents.
The CLRP is structured around the seven competencies identified in the Framework. Each section relates to a specific competence and each contains a range of materials which:

- Provide insights into a core aspect of clinical leadership
- Suggest activities that participants should complete in order to relate what they are learning to their own clinical leadership journey and to their specific work role
- Signposts where participants can find out more about particular aspects of clinical leadership
- Offers suggestions as to how participants might use the supports that are available to them, for example, colleagues, managers, mentors or coaches
- Prompts participants to consider how to apply their learning in other contexts, for example, in action learning
- Aids participants in completing their personal portfolio of learning, which in turn, enables them to demonstrate how they have put into action what they have learned, in order to improve the quality of care provided in their own work setting

The DARI instrument contained twenty eight items, with four items each to measure aspects of the language and content of the seven competencies in the CLRP. An additional item was used to rate the introductory section of the CLRP. The range of possible DARI scores for the twenty-eight item scale relating to the CLRP was 28–140. Using the DARI instrument, the analysts assigned an aggregate raw score of 132/140, an aggregate scale score of 33/36.25 and the mean score was 4.55 (SD =0.46). This score indicates that the analysts assigned a very high rating overall to the CLRP document.

The analysts agreed that the CLRP was a substantial, comprehensive and well structured document that provided a key resource for participants on the Pathway and others, including those providing interventions. The document contained copious information on aspects of each competence and also numerous links and references to additional resources. The analysts agreed that the material contained in the CLRP and the resources cited were of great relevance to the seven competencies.

Analysts sampled some of the cited additional resources, using URL links, and agreed that these resources were relevant to the competencies and helpful to the user. References were
generally up to date and while some of the cited references were considered somewhat dated, a great many of the dated references were seminal texts.

The analysts also remarked that the various activities presented to the user of the CLRP had the potential to engage participants in learning and personal development and in the Clinical Leader Development Pathway. The learning activities also generally reflected the learning outcomes for the competence for which they were designed. However, some analysts observed that the learning outcomes that were presented in the CLRP were not stated in behavioural terms, for example the phrase ‘demonstrate an understanding of’ was used on several occasions. Phrasing learning outcomes in this way means that the outcomes in question were neither observable nor measurable in the participant. While cognitive outcomes are measurable, this was not the expressed focus of the Project.

While much of the content in relation to the seven competencies was deemed to be generic and applicable across all four grades, there was some effort to target the particular needs of different grades. In this connection, the CLRP addressed the competencies ‘decision making’ and ‘communication’ particularly well. The analysts observed that relative to all the other sections, the section on ‘quality and safety’ was treated most comprehensively.

The analysts agreed that there was a good effort to relate the activities and related resources in the CLRP to the Irish context, since many of the resources cited included key policy documents and guidelines published by An Bord Altranais and the HSE, for example the HSE Quality & Risk Management Standards, the HIQA National Standards for Healthcare, and so forth.

The ‘teamwork’ section appeared to draw to a considerable degree on the participant’s own experiences and reflections, which enhanced the overall content validity of this section of the CLRP document. One possible draw-back associated with this reliance on personal experience and reflection is the risk that participants might only get out of the activity section what they put into it; hence the learning activity depended on each individual’s level of motivation and ability to reflect. The CLRP might also benefit from the inclusion of additional content on ‘team work’ related to effective team working in multi-disciplinary
teams. Activities that enabled participants to share their experiences could complement personal and private reflection.

Overall, the analysts concluded that the CLRP was a very comprehensive document, containing a range of materials and resources suitable for supporting participants as they develop their clinical leadership competencies. As the major documentary intervention of the Pathway, the CLRP was a resource of considerable quality, in terms of its content and structure, and was fit for purpose.

**Action Learning Set Facilitator Toolkit**

The Action Learning Set Facilitator Toolkit (ALSFT) is a resource for individuals who are acting as action learning set facilitators. The toolkit assists in the planning and conduct of an action learning set, one of the major interventions of the Clinical Leader Development Pathway. The toolkit document is divided into three sections, as follows. Section 1 describes and discusses action learning with reference to: the philosophy and principles that underpin action learning; action learning in the context of the National Clinical Leadership Development Pathway; how action learning works; what makes an effective action learning set and planning an action learning programme or set. Section 2 describes the role of Action learning set facilitator, with a particular focus on what the individual facilitator brings to the role and the work of managing the process of action learning. Section 3 presents the action learning set facilitator with a range of tools and techniques that can be used to enhance learning in an action learning set, suggestions for evaluating the action learning set and references to further reading and resources.

The DARI instrument contained eight items concerned with aspects of the structure and content of the ALSFT. The range of possible DARI scores for the rating scale was from 8 to 40. Using the DARI instrument, the analysts assigned an aggregate raw score of 151/160, an aggregate scale score of 37.75/40 and a mean score of 4.71 (SD =0.8). This score indicates that the analysts assigned a very high rating overall to the ALSFT document.

The analysts agreed that the ALSFT was well-designed, with clear and distinct sections that followed a logical order. The analysts observed that the steps to be followed by the ALS facilitator were clearly outlined in the document and that the range of resources and activities
contained in the document appeared relevant and useful in assisting the ALS facilitator to plan and conduct an action learning set. The use of activities such as ice-breakers, questions and particular facilitation techniques for use with an action learning set were noteworthy features of the document. The analysts concluded that the ALSFT represented a comprehensive documentary resource for ALS facilitators, one which can assist in the major elements of planning and preparing an action learning set.

The analysts agreed that the document was strongly oriented to the practical activities for which it was designed and that it contained clear language to guide the ALS facilitator. The role of the practice-orientated exercises in breaking up the content of the document was also seen as helpful to the user; this structure could function to punctuate otherwise dense information and was seen as a good andragogical device in the document. Overall, the document was found to be easy to navigate.

The ALSFT was found to contain well-supported evidence-based research for the inclusion of particular resources, teaching tools and teaching-learning strategies. Ten techniques for the facilitation of action learning were described in very good detail and the document had a good focus on ways of managing group processes within an action learning set. The document also included an action learning review sheet and a facilitator reflective practice and feedback sheet.

The analysts concluded that the ALSFT was an excellent and comprehensive resource that seemed to function very well in achieving what it was designed to achieve, and accordingly, was fit for purpose. The analysts agreed that a number of aspects of the document warranted consideration as a way of improving the toolkit. They suggested the following. The action learning review sheet provides a mechanism for identifying the learning that has taken place and has a focus on encouraging further learning. The analysts proposed a minor revision of the wording of the sheet in the section on application; rather than focusing on ‘how the ALS worked today’, the focus might be more future oriented and couched in terms of ‘my identified actions’ for future action learning sets. Regarding the facilitator reflective practice review, this was thought to be very useful as a focus for double-loop learning. It was suggested that the inclusion of an inbuilt debriefing activity for the ALS facilitator might be
useful in aiding reflection and future planning. The possible inclusion of a reflective journal in the toolkit might also aid learning.

**Clinical Leadership Facilitator Toolkit, Parts 1 and 2**

A major intervention in the National Clinical Leadership Development Clinical Leader Development Pathway is the use of workshops, which are aimed at augmenting the content of the Clinical Leader Resource Pack and assisting participants to identify and develop their knowledge and understanding of each competence. The Clinical Leadership Facilitator Toolkit (CLFT) Parts 1 and 2 are designed to provide the clinical leadership workshop facilitator with guidance about the role of the facilitator and information about the structure and content of each workshop so that there is a consistency of approach in the conduct of workshops. The Toolkit contains the following information and resources: strategies for effective facilitation of learning and development and detailed information for each of the seven competence workshops, including suggested timing of activities, facilitator notes, tools and activities, PowerPoint presentations and handouts.

The DARI instrument contained eight items for scoring the CLFT Parts 1 and 2. Using the DARI instrument, the range of possible DARI scores for the eight item scale was from 8 to 40. The analysts’ aggregate raw score for Part 1 was 72/80, the aggregate scale score was 18/20 and the mean score was 4.5 (SD =1.4). This score indicates that the analysts assigned a very high rating overall to the CLFT Part 1 document.

The analysts agreed that the CLFT Part 1 was well designed to enable an individual to plan and conduct a workshop. The opening part clearly set out the purpose of the Toolkit and the notion of facilitation was promoted over training and instruction. The toolkit provided a good range of examples and numerous facilitation strategies that could be readily deployed in a workshop. A very positive feature of the CLFT Part 1 was the comprehensive information that was provided to direct the facilitation of a range of andragogical strategies, such as group work. Content on aspects of group facilitation, such as promoting and managing discussions, managing difficult situations and having a presence, was also considered to be very comprehensively addressed. These aspects were well supported with examples and useful tips. The structure of Part 1 appeared to be user friendly, with liberal use of short paragraphs and bullet points. It was noted that some of the references appeared dated and the analysts
questioned whether newer editions of some of the cited textbooks were available for consultation. The analysts considered CLFT Part 1 fit for purpose.

The aggregate raw score for CLFT Part 2 was 71/80, the aggregate scale score was 13.28/20 and the mean score was 4.43 (SD =1.4). This mean score indicates that the analysts assigned a very high rating overall to the CLFT Part 2 document. The CLFT Part 2 was evaluated to be a well structured and well written document that functioned to enable a workshop facilitator to conduct a workshop in a planned and structured way. Each section contained a clear set of workshop learning outcomes, handouts, Power Point presentations and exercises and activities. The analysts agreed that the material for each individual workshop was presented in a logical and systematic way. Of particular value were the detailed lesson plans that were offered to the workshop facilitator, which contained activities, intended outcomes for each activity and facilitator notes suggesting the timing of activities. The analysts considered that this ensured that a workshop could be facilitated in a fairly standardised way, regardless of the experience of the facilitator.

It was noted that there was something of a mismatch between the learning outcomes for each individual workshop and the range of learning activities that were included in the workshop. This was particularly evident in the fact that the majority of the learning outcomes were written with reference to the cognitive domain of learning and, accordingly, few of the outcomes reflected learning in the skills and/or affective domains, outcomes which appeared to be implicit in many of the workshop activities. With the exception of outcomes like ‘carried out a problem solving exercise’ and ‘develop skills in enabling others’, there were no outcomes in the skills domain and no outcomes for the affective domain. In addition, many of the learning outcomes for each workshop were written in terms that were not observable or measurable in the workshop participant; the use of verbs like ‘[will] understand’, ‘[will have] learned about’ and ‘[will have] considered’ exemplified this minor content-level shortcoming.

The accompanying Power Point slides were considered to be well designed, but appeared to be over reliant on textual content, at the expense of diagrams and charts that might be more effective as visual cues to aid learning. In addition the workshop facilitator is informed that each accompanying Power Point slide presentation aims to ‘stimulate discussion, debate and
shared learning within the group’. This suggests that the workshop facilitator might be given the view that slides have andragogical functions and effects for which they are not designed. The analysts observed an apparent copy-and-paste error in each of the ‘please note’ text boxes concerning the slides. The text erroneously reads ‘the principles underpinning quality and safety’ in each of the seven text boxes.

The analysts concluded that the CLFT Part 2 document is a comprehensive and well designed document to guide a workshop facilitator in planning and running a workshop and is fit for purpose. The analysts recommend that in future revisions of the toolkit the following should be considered. The learning outcomes should be written in measurable and observable behavioural terms and learning outcomes in the skills and affective domains should be included to more accurately reflect those learning activities that have skills, attitudes and values as their focus. The aforementioned copy-and-paste error in the seven text boxes should be corrected. The use of pagination and page tabs would assist the user to better navigate the document.

**The Mentor guide**

The purpose of the Mentor Guide is to act as a guide that builds on and supports the initial mentor training and to provide support for the mentoring relationship in the initial months of mentoring. The Mentor guide is a large comprehensive document that contains detailed information on the function of mentoring, the procedures for instituting mentoring and ways to develop the mentor-mentee relationship. The document also contains a range of handouts, which focus on key mentoring skills and other resources, including a sample mentoring contract, a sample personal development plan and progress review sheets.

The range of possible DARI scores for the five-item scale relating to the Mentor Guide was from 5 to 25. Using the DARI instrument, the analysts’ assigned aggregate raw score of 92/100, an aggregate scale score of 23/25 and the mean score was 4.6 (SD =0.89). This mean score indicates that the analysts assigned a very high rating overall to the Mentor Guide.

The analysts agreed that the Mentor Guide was an excellent resource for mentors. It was viewed as a comprehensive, focused, and a very well constructed document that appeared to address all of the major aspects of the mentoring process. The Mentor guide was fit for
purpose. The first mentoring session appeared to be very well written and presented. The analysts agreed that the tools and resources included in the guide should provide a prospective mentor with a range of helpful resources with which to engage meaningfully in a mentoring relationship. The inclusion of the short FAQ section was seen as especially helpful in assisting the mentor with problems that might emerge in the mentoring relationship.

The Coaching Reference Manual
The Coaching Reference Manual is designed as a guide for internal coaches. It aims to provide the internal coach with relevant information and resources with which to engage with the coachee and it outlines the processes of engagement. The manual contains guidance on how to schedule and conduct coaching sessions, including tripartite meetings between coach, coachee and line manager, and it includes detailed guidance on the coaching sessions and on providing feedback to the coachee. The manual also contains guidance for the coach on continuing professional development and supervision and it contains a code of ethics. The manual is supported with references, including sample coachee and line manager assessment forms and a coaching contract.

The range of possible DARI scores for the five-item scale relating to the Coaching Reference Manual was from 5 to 25. Using the DARI instrument, the analysts’ assigned an overall aggregate score of 87/100, an aggregate scale score of 17.4/25 and a mean score of 4.35. (SD =1.3) to the Coaching Reference Manual. This mean score indicates that the analysts assigned a very high rating overall to the manual. The manual was considered fit for purpose.

The analysts agreed that the Coaching Reference Manual was a well constructed document that provided sufficient information and resources necessary in order to permit a prospective coach to engage in coaching for the clinical leadership development process. The document provided sufficient information to illustrate the complexity of coaching, yet attempted to demonstrate the practical aspects of coaching, such as establishing the coaching relationship, conducting meetings effectively and so forth. The analysts noted that the engagement of two coaching experts as advisors in the development of the manual enhanced the validity and quality of the manual. This was considered important, as coaching is a new intervention in nursing and midwifery clinical leadership development.
The manual did not include information on additional supports, such as peer supports, or practical guidance for related processes, such as coach de-briefing. In advance of the pilot, the Project Team decided not to publish the Coaching Reference Manual until the conclusion of the pilot. Accordingly, it was noted that the formatting of the manual was inconsistent with the formatting of the other supporting documents. The analysts recommended that in due course the document should be brought up to the same standard of finish and production as the other NCLDP documents.

6.3.3 Level 3 analysis: Relationship between constructs and concepts across documents

The focus of the documentary analysis at level 3 was to examine the relationship between the constructs and concepts in the assessment and development tool and the documents supporting the various interventions, most especially the CLRP document. The analysts reviewed the documents with reference to the degree of consistency in the use of language within and across the documents. This intra-documentary and inter-documentary review involved each analyst tracking the use of words and phrases to convey the meaning of ideas within each competence section in the CLRP to its corresponding section in the LDP. For the purpose of the level-3 analysis, just two competencies, decision making and team work, were sampled and the findings associated with level-3 analysis are summarised here.

The analysts agreed that overall the language in the section of the LDP related to ‘decision making’ was consistent with that used in the CLRP and this consistency also held for the range of materials and resources that were cited. The analysts concluded that in relation to decision making, the materials across the two documents related very well in the following ways:

- In the CLRP, the ‘clinical judgment’ section describes using tools to assist in decision-making and the use of decision-making tools is also referred to in the LDP related to behavioural indicators for the staff grade
- The language of the concept decision-making and associated with leadership in relation to encouraging others to take risks appears consistently in the CLRP and in the LDP
Material on systematic clinical decision-making is contained within the CLRP and in elements of behavioural indicators in the LDP and the language in the two documents is used consistently.

Material on developing decision-making capability in others and developing problem-solving skills is represented in the competencies for all grades in the LDP and is also represented in a consistent way in the corresponding section of the CLRP.

Risk assessment and risk management appears in the CLRP and at each level of the framework.

In two areas of decision making, there appeared to be a lack of relation across documents, as follows:

- In the CLRP, the development of the competence decision-making focuses on processes of decision-making and problem solving. The behavioural indicators for decision-making in the LDP also include material on accountability and taking responsibility for decisions, whether they are made by the participant or by the participant’s team. However, this aspect of decision-making does not seem to be included in the CLRP.

- Clinical governance processes and structures are referred to in the behavioural indicators within the LDP, but they do not appear to be mentioned in the corresponding section of the CLRP.

The analysts agreed that overall the language in the section of the LDP related to ‘team work’ was consistent with that used in the CLRP and this held for the range of materials and resources that were cited. The analysts concluded that in relation to team work, the content across the two documents related very well in the following ways:

- When referring to team work, both the CLRP and its corresponding section in the LDP used language consistently across both documents.

- Both the CLRP and its corresponding sections of the LDP included concepts of team and team roles, team development and team effectiveness.
Multi-disciplinary team working was referred to in the ‘team work’ section and in the learning outcomes in both documents. This was dealt with for the most part under the heading of ‘diversity within teams’ through some activities and exercises.

The section on ‘team work’ contained in the CLRP was considered to be of greater use and relevance to a participant who was managing a team than to participant who was a team member. While the activities presented in the CLRP were considered to be useful in promoting the development of the competence for team working, it was considered that they were less relevant to those individuals on the Clinical Leader Development Pathway who did not operate in a distinct or discrete team.

The analysts concluded that overall the language in the documents was clear and consistent when discussing concepts and constructs. Concepts and constructs were generally well defined and the use of words and phrases to convey meaning of ideas was generally consistent within and across the various supporting documents.

### Key points

Overall the documentary materials supporting the Project were of a very high quality and provided a wide variety of evidence-based resources and supports for participants and those providing interventions. This points to the Project having a major strength at the level of material supports and means that the Clinical Leader Development Pathway can be readily applied across multiple sites and settings, and with other resources and supports in place, can proceed with little extra planning and preparation.

Positive aspects of the design of the documentary materials included distinct branding, good inter-documentary relatedness and ease of navigation. The range of documents for mentors, coaches and others were developed with reference to relevant and appropriate current evidence.

The presentation and packaging of the Learning and Development Portfolio as four distinct documents, with separate content to reflect the distinct service development needs and leader development needs of each grade, was a positive feature. The Action Learning Set Facilitator
Toolkit and the Clinical Leadership Facilitator Toolkit and Mentor Guide were found to be particularly well constructed. It was decided at the commencement of the project that the Coaching Reference Manual would be a ‘work in progress’ during the pilot, allowing for the inclusion of learning and any required revision of content, when published as planned after the evaluation.

Some minor issues were highlighted. The wording of some behavioural indicators was such that interpretation could be difficult. The availability of an overall index of the various documents would substantially aid navigation. The physical bulk of the documents was such that they might be cumbersome to transport and this could be a deterrent to their regular use.
6.4 Summary of findings: Supports and resources

While participants experienced support, time was a factor. This was experienced with reference to the timing of the pilot itself and with reference to the time required to commit to the Clinical Leader Development Pathway. Limited time was seen as a barrier to full engagement in the various elements of the Clinical Leader Development Pathway. A barrier to completing chosen leadership interventions was seen to reside in the competing demands of work.

Many participants spoke in very positive terms about the support received from their line manager or service manager. While line managers were supportive, this support was moderated by two factors, firstly, the limited formal input from line managers into the Clinical Leader Development Pathway after the initial assessment of clinical leadership development need, and secondly, the constraints on line managers in terms of their ability to engage due to competing work demands and commitments. Some considered that the line manager should have a greater input beyond the initial assessment process and some considered that their line manager was not fully prepared for their role in the process. While participants experienced support from their team and organisation, it appears that for some, their team was either not aware of their involvement or were disinterested.

Documentary analysis indicated that Project documents were of a very good quality, in terms of their production, evidence base and content and their usefulness in supporting interventions in the Clinical Leader Development Pathway. Accordingly, the various supporting documents were evaluated as being fit for purpose. Positive aspects of their design included distinct branding, good inter-documentary relatedness and ease of navigation.

The documentary materials were considered to be appropriate to the different grades participating in the Clinical Leader Development Pathway and they provided a wide variety of evidence-based resources and supports for participants on the Pathway and those providing interventions. The range of documents for mentors, coaches and others were developed with reference to relevant and appropriate current evidence. The presentation and packaging of the Learning and Development Portfolio as four distinct documents, with separate content to reflect the distinct service development needs and leader development needs of each grade,
was seen as a positive feature. The Action Learning Set Facilitator Toolkit and the Clinical Leadership Facilitator Toolkit and Mentor Guide were particularly well constructed. It was decided at the commencement of the project that the Coaching Reference Manual would be a ‘work in progress’ during the pilot, allowing for the inclusion of learning and any required revision of content, when published as planned after the evaluation.

While the materials were considered to be of the highest quality, some minor issues were highlighted. The wording of some behavioural indicators was such that it rendered their interpretation difficult. The availability of an overall index of the various documents would substantially aid navigation. The actual physical bulk of the documents was such that it might render them as cumbersome to transport and therefore a deterrent to their regular use.
Chapter 7

SHORT-TERM OUTCOMES

7.1 Introduction

This chapter reports on the findings relating to the short-term outcomes of the pilot. The short-term outcomes of the pilot were examined with reference to the changes in participant behaviours over the period of the pilot and at the end of the pilot, and with reference to service and organisational outcomes, such as innovations undertaken by participants as a result of their participation on the Clinical Leader Development Pathway. The evaluation of short-term outcomes involved the administration of a number of standardised instruments, designed to collect data on three key areas, as follows:

- Participants’ generic leadership behaviours, as reported by participants themselves and by their line manager. These data were collected using the Leadership Practice Inventory Self (LPI-S) and the Leadership Practice Inventory Observer (LPI-O), respectively.
- Participant’s self-reported clinical leadership behaviours related to the seven leadership competencies incorporated in the National Clinical Leadership Development Framework. These data was collected using the Clinical Leadership Behaviours Questionnaire (CLB-Q), designed for the study.
- Accounts of changes and impact of the pilot on both participants and service. These data were gathered in the course of the focus group interviews, individual interviews and group interviews and from the Participant Experiences Questionnaire.

Results from each of these areas are presented here.
7.2 Pathway participants’ self-reported generic leadership practices

The Leadership Practices Inventory Self (LPI-S) instrument was administered to participants at two time intervals, in the early weeks of the pilot (Time 1) and in the final two weeks of the pilot (Time 2). Data from the LPI-S instrument were analysed using SPSS Version 18 software (SPSS Inc., Chicago, IL, USA). Frequency distributions were calculated on responses to questionnaire demographic and scale items.

Demographic profile of respondents to LPI-S

The demographic profile of respondents completing the LPI-S is presented for Time 2 (T2), as a greater number of LPI-S respondents were represented at T2, and differences for Time 1 (T1) are highlighted. The demographic profile of the respondents at T2 was broadly similar to that of the respondents at T1. A total of twenty-seven respondents completed the Leadership Practices Inventory-Self (LPI-S) instrument at T2. Of this number, twenty-four respondents were female and three were male. The mean age of respondents was 42.23 years (SD = 9.07) and the respondent’s ages ranged from 28 to 58 years. Of the sample, the majority (76.9%, n=20) were aged 30–49 years. Of this number, ten were aged between 30–39 years and a further ten were aged 40–49. Five respondents were in the age range 50–59 and just one respondent was in the age range 20–29 years.

The demographic profile of respondents at T1 was marginally different than at T2, since just eighteen respondents completed the LPI-S at T1. At T1 the mean age of the sample was 38.44 years (SD = 7.44) and a greater proportion of respondents were in the age range 40–49 years. Due to the small sample size, comparisons between the study sample and the national sample of nurses and midwives were not calculated.

Registration status

The profile of the respondents in relation to registrations held was broadly similar for T1 and T2. The majority of respondents at T2 (85.2%, n=23) indicated that they held a registration in the General division of the Register of Nurses maintained by An Bord Altranais. This was comparable to the 83.3% (n=15) of respondents at T1. Four respondents were registered in the psychiatric division, four in the division for children’s nursing, two in the division for
public health nurses and one respondent was registered in the Nurse Prescriber division. The sample at T2 also contained six registered midwives (Figure 7.1).

![Figure 7.1 Registration(s) held](N=18 at T1, N=27 at T2)

**Division in which currently employed**

Figure 7.2 illustrates that the current division of the Register in which currently employed matched closely the frequency distribution for registrations held. Just over half of the respondents (51.9%, n=14) at T2 were currently employed in general nursing, four were employed in children’s nursing and a further four were employed in psychiatric nursing. Two respondents were currently employed in midwifery and just one respondent was employed in public health nursing. Two respondents were employed in ‘other’ settings.
Figure 7.2 Division of Register in which currently employed (N=18 at T1, N=27 at T2)

Health setting in which currently employed
All of the respondents at T2 reported that they were currently employed in the public health services, with the majority (81.5%, n=22) employed in a public HSE hospital. Three respondents were employed in a public voluntary hospital and two were employed in a public health or community setting. The proportion of the sample employed in a public hospital at T1 was marginally smaller at 72.2 per cent (n=13).

Grade
The distribution of respondents by grade indicates a heterogeneous sample of pilot participants. At T2, just over one third of respondents (37%, n=10) were at the clinical nurse manager grade 1 and grade 2, six were at the nursing staff grade, two at the clinical nurse specialist grade and three at the assistant director of nursing grade. A further two respondents were at the assistant director of midwifery and director of midwifery grades. The sample of respondents by grade at T2 was broadly comparable to the profile of respondents completing the survey at T1.

Years of experience since first registration
At T2 the respondents’ number of years’ experience working in nursing or midwifery since first registration ranged from 7 to 39 years (M =19.7, SD =9.17). Ten respondents reported having between 11–20 years’ experience, and a further ten respondents had between 21–30 years’ experience. Five respondents had 10 years’ experience or less, while four respondents had 31 years’ experience or greater
**Years working in current area of practice**

The number of years working in current area of practice in nursing or midwifery at T2 ranged from less than 1 year to 31 years. The mean number of years working in the current area was 9.2 years (SD =8.52). Approximately half of the respondents (48.1%, n =13) reported working in their current area of practice for 4 years or less, seven reported working (25.9%) for between 7–13 years and a further seven (25.9%) were employed for 15 years and over.

**Highest educational level attained**

Figure 7.3 illustrates the highest educational level attained, as reported by the sample at T1 and T2. Over one third (37%, n =10) of respondents at T2 held a master’s degree and a further one third (37%, n =10) held either a higher diploma or a bachelor’s degree. While the number of respondents holding a master’s degree at T1 was smaller than at T2, proportionally the same number (33%, n=6) held a master’s degree and the same proportion (33%, n=6) held a higher diploma. Hence, despite the variations at T1 and T2, the two samples were largely similar with reference to highest educational level attained (Figure 7.3).

![Highest Educational Level Attained](image)

**Figure 7.3 Highest level of education attained** (N=18 at T1, N=27 at T2)

**Pathway participants’ self-ratings for leadership behaviours**

The demographic section of the Leadership Practices Inventory-Self (LPI-S) instrument contained a single item that required respondents to indicate the rating agreed with their line manager in relation to each of the seven core clinical leadership competencies. Figure 7.4
illustrates the respondents’ self-reported rating scores for the seven competencies provided at T2. Respondents reported that their scores for each of the seven competencies were principally in the ‘3’ (frequently) and ‘4’ (always) rating categories for leadership behaviours on the Assessment and Development Tool. No respondents reported a ‘1’ (never) rating on any of the competencies and a small number of respondents reported a ‘2’ (sometimes) rating for behaviours in the following competencies: self-awareness, communication, quality and safety, team work and clinical excellence. The competence that received the highest reported number of ‘4’ ratings was team work and this was closely followed by self-awareness, advocacy and empowerment and communication.

Across all seven clinical leadership competencies, between 37 and 41 per cent of respondents could not recall the rating scores agreed with their line manager at T2. Many respondents reported an average score across the competencies, but did not have their ratings to hand when completing the questionnaire.

![Rating score 1-4 agreed with line manager](chart)

**Figure 7.4 Respondents’ competence rating scores, as agreed with line manager (N=18 at T1, N=27 at T2)**

*Self-reported leadership practices*

The Leadership Practices Inventory-Self (LPI-S) contained thirty statements of leadership behaviour, with six statements each measuring one of five basic constructs which represent
leadership practices, as follows: ‘model the way’, ‘inspire a common vision’, ‘challenge the process’, ‘enable others to act’, and ‘encourage the heart’ (Kouzes & Posner 2003). Using the LPI-S, participants on the Pathway rated the frequency with which they engaged in the thirty leadership behaviours on a frequency scale in the range from 1 (‘almost never’) to 10 (‘almost always’). For each construct, the range of possible scores is 6 to 60. The LPI-S was administered to participants at T1 and T2.

In general, the majority of respondents rated themselves on the higher end of the range of ten numeric ratings of the LPI-S scale, with most self-rated scores in the range 6 to 10. Table 7.1 summarises the self-reported leadership practices mean score distribution for the respondents at T1 and the corresponding score for T2. Overall, the participants’ most frequently-rated scores were 8 (‘usually’) and 7 (‘very frequently’) in relation to the frequency with which they engaged in the thirty leadership behaviours.

When self-rating scores were compared for T1 and T2, the pattern of change observed indicated a minor rise in mean scores from T1 to T2 for three out of the five leadership practices constructs. The most marked increase in self-rating scores was observed for the construct ‘inspire a shared vision’ and increases in mean scores were also observed in the mean scores for the constructs ‘model the way’ and ‘encourage the heart’. The mean score for the construct ‘challenge the process’ indicate no change between T1 and T2, while the self-reported mean score for the construct ‘enabling others to act’ was marginally lower at T2.

Table 7.1 shows the frequencies of LPI-S mean scores at T1 and T2, and the un-paired two-tailed t-test results. The critical value for the test statistic is approximately ±2 based on a significance level of 2.5% or 0.025. All p-values were greater than .05 and therefore not significant. However, the mean difference of 4.2 for the construct ‘inspire a shared vision’ was the highest difference recorded and reported the lowest p-value at 0.04, i.e. the greatest observed change over time. However, it was not significant using the 0.025 significance threshold applied. The 0.00 p-value for the construct ‘challenge the process’ arises because both of the means were equal at T1 and T2 for this construct.
### Table 7.1 Pathway participants’ self-reported leadership practices at T1 and T2

<table>
<thead>
<tr>
<th>Model the way</th>
<th>Self-rating at Time 1</th>
<th>Self-rating at Time 2</th>
<th>t-test results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>s1</td>
<td>n1</td>
</tr>
<tr>
<td>Model the way</td>
<td>42.7</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Inspire a shared vision</td>
<td>38.1</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>Challenge the process</td>
<td>41.2</td>
<td>7.2</td>
<td>18</td>
</tr>
<tr>
<td>Enabling others to act</td>
<td>48</td>
<td>4.7</td>
<td>18</td>
</tr>
<tr>
<td>Encourage the heart</td>
<td>42.8</td>
<td>6.7</td>
<td>18</td>
</tr>
</tbody>
</table>

(n=18 at T1, n=27 at T2)

Legend: s = the square root of the pooled variance; s² = s (square) = the pooled variance (the combined variance using both sample standard deviations); t = the result, i.e. the t test statistic, or the difference of two means divided by the standard error of the difference.

* = significant; ** = not significant

While statistically significant results were not observed on each of the five generic leadership practices constructs, an increase in the frequency with which respondents engaged in the leadership behaviours was evident in three out of the five constructs contained in the LPI-S, following participation on the Clinical Leader Development Pathway.
7.3 Pathway participants’ generic leadership practices as reported by line managers

Using the Leadership Practices Inventory-Other (LPI-O), line managers rated the frequency with which the participants on the Pathway engaged in the same thirty leadership behaviours listed on the LPI-S. For each construct, the range of possible scores was 6 to 60. The LPI-O instrument was administered to line managers at T1 and T2. Frequency distributions were calculated on responses to questionnaire demographic and scale items using SPSS Version 18 software (SPSS Inc., Chicago, IL, USA).

Demographic profile of respondents to LPI-O

In total, twenty two line managers completed and returned the LPI-O questionnaire at T1 and thirteen at T2. A number of line managers rated more than one participant. The demographic profile of line managers is reported for T1.

The majority of line manager respondents were female (91%, n =20) and just two were male. The mean age of the respondents was 45.5 years (SD =7.2). The respondents’ ages ranged from 32 to 56 years, with half (50%, n=11) in the age range 40–49 years. Seven respondents were in the age range 50–59, and four were in the range 32–39. All of the respondents were Irish.

Registration status of line managers

The majority of respondents (86.4%, n=19) held a registration in the General division of the Register of Nurses maintained by An Bord Altranais (Figure 7.5). Twelve of the respondents held two registrations; eight of these were in midwifery and four were in children’s nursing. Two respondents held three registrations each; two of these third registrations were in public health nursing. The line manager respondents included just one registered midwife, one registered psychiatric nurse and one registered children’s nurse.
Health setting in which currently employed

All of the respondents were currently employed in the public health services, with the majority (68.2%, n=15) employed in a public hospital. Five respondents (22.7%) were employed in a public voluntary hospital, one was employed in a nursing and midwifery planning and development unit (NMPDU) and one was employed as a manager of residential and community care settings.

Grade

The distribution of line manager respondents by grade was as follows: two were at the staff grade, seven (31.8%) were at the CNM2 grade, five (22.7%) at the CNM3 grade, four (18.2%) at the assistant director of nursing grade, two at the director of midwifery grade, one at the director of nursing grade and one at NMPDU director grade.

Years of experience since first registration

The mean number of years since first registration was 23 (SD = 7.0). The number of years since first registration ranged from 10 years to 35 years. Approximately three quarters of the respondents (72.6%, n = 16) reported having 20 years experience or greater.

Years working in current area of practice

The number of years working in current area of practice ranged from less than 1 year to 29 years and the mean number of years spent working in the current area was 12.0455 (SD = 
Over half (54.4%, n=12) of the line manager respondents reported working in their current area of practice for ten years or more.

**Highest educational level attained**

The highest educational levels reported by the majority of the respondents was a bachelor’s degree (54.5%, n=12) (Figure 7.6). Six respondents (31.8%) had attained a master’s degree, n=6), one a diploma, one a hospital certificate, post-registration, and one a hospital certificate, pre-registration.

![Figure 7.6 Respondents’ highest educational level attained, T1 (N=22)](image)

**Observer reported leadership practices**

Overall, the line managers, acting as observers, rated their participant(s) on the higher end of the LPI-O scale, with most leadership practice scores in the range 5 to 10 on the scale. Table 7.2 summarises the leadership practices mean score distribution for the observer respondents at T1 and T2. Overall, the observers’ most frequently-rated scores were 8 (‘usually’) and 7 (‘very frequently’) in relation to the frequency with which the participant engaged in the thirty leadership behaviours.

When observers’ rating scores were compared for T1 and T2, the pattern of change observed indicated a very marginal decrease in mean scores from T1 to T2 for three out of the five of the leadership practices constructs. The most marked decrease in observer scores was for the construct ‘model the way’ and ‘enabling others to act’. The mean scores for the constructs ‘challenge the process’ and ‘encourage the heart’ indicated minor increases from T1 to T2.
Table 7.2 shows the frequencies of LPI-O mean scores at T1 and T2, and the non-paired two-tailed t-test results. All p-values were greater than .05; therefore observed changes in means scores over time were not significant.

Table 7.2 - Pathway participants’ other-reported leadership practices at T1 and T2

<table>
<thead>
<tr>
<th>Model the way</th>
<th>Self-rating at Time 1</th>
<th>Self-rating at Time 2</th>
<th>t-test results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>s1</td>
<td>n1</td>
</tr>
<tr>
<td>Model the way</td>
<td>44</td>
<td>12.2</td>
<td>22</td>
</tr>
<tr>
<td>Inspire a shared vision</td>
<td>39</td>
<td>13.9</td>
<td>22</td>
</tr>
<tr>
<td>Challenge the process</td>
<td>39.4</td>
<td>12.7</td>
<td>22</td>
</tr>
<tr>
<td>Enabling others to act</td>
<td>46.5</td>
<td>10.8</td>
<td>22</td>
</tr>
<tr>
<td>Encourage the heart</td>
<td>42</td>
<td>13</td>
<td>18</td>
</tr>
</tbody>
</table>

(=22 at T1, n=13 at T2)

Legend: s = the square root of the pooled variance; s2 = s (square) = the pooled variance (the combined variance using both sample standard deviations); t = the result, i.e. the t test statistic, or the difference of two means divided by the standard error of the difference. * = significant; ** = not significant

Table 7.3 summarises all of the mean scores for both the participants on the Pathway and their line managers. While the mean scores for both the participants and their line managers were not statistically significant from T1 to T2, for all five constructs of leadership practices, overall the self and observer mean scores were remarkably similar at both data collection points. This indicated that both line managers and the participants themselves rated the participants on the Pathway as frequently engaging in behaviours associated with the five generic leadership practices at both time points. The results also indicate that participants rated increases in their behaviours in three of the five generic practices and their line managers rated increases in behaviours in two of the five practices across the time of the pilot.
Table 7.3 Ratings of leadership practices at T1 and T2

<table>
<thead>
<tr>
<th></th>
<th>Ratings at Time 1</th>
<th>Ratings at Time 2</th>
<th>Numeric difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self (±SD)</td>
<td>Observer (±SD)</td>
<td>Self (±SD)</td>
</tr>
<tr>
<td>Model the way</td>
<td>42.7 (7)</td>
<td>44 (12.2)</td>
<td>45.1 (6.5)</td>
</tr>
<tr>
<td>Inspire a shared vision</td>
<td>38.1 (9)</td>
<td>39 (13.9)</td>
<td>42.3 (6.7)</td>
</tr>
<tr>
<td>Challenge the process</td>
<td>41.2 (7.2)</td>
<td>39.4 (12.7)</td>
<td>41.2 (6.5)</td>
</tr>
<tr>
<td>Enabling others to act</td>
<td>48.0 (4.7)</td>
<td>46.5 (10.8)</td>
<td>47.2 (5.8)</td>
</tr>
<tr>
<td>Encourage the heart</td>
<td>42.8 (6.7)</td>
<td>42 (13)</td>
<td>44.9 (6.2)</td>
</tr>
</tbody>
</table>

Self: n=18 at T1, n=27 at T2; Observer: n=22 at T1, n=13 at T2

Key points

The short-term outcomes of the pilot were examined with reference to the changes in participant behaviours over the period of the pilot and at the end of the pilot, and with reference to service and organisational outcomes, such as innovations undertaken by participants as a result of their participation on the Clinical Leader Development Pathway.

Participants on the Pathway and their line managers rated the participants as frequently engaging in behaviours associated with five generic leadership practices. Additionally, participants rated increases in their behaviours in three of the five generic practices and their line managers rated increases in participant behaviours in two of the five practices across the time of the pilot. Observed differences in self and observer ratings of generic leadership practices between time 1 and time 2 were not statistically significant.
7.4 Self-reported clinical leadership behaviours

In order to assess participants’ clinical leadership behaviours with reference to the seven clinical leadership competencies that are set out in the National Clinical Leadership Development Framework, a Clinical Leadership Behaviours Questionnaire (CLB-Q) was developed. The CLB-Q required participants to report the frequency with which they engaged in clinical leadership behaviours using a list of forty-eight behaviours derived from the seven clinical leadership competencies. The forty-eight behaviours were grouped into seven subscales, each corresponding to one of the seven clinical leadership competencies. The CLB-Q yields a range of possible scores from 48 to 240. The CLB-Q was administered to all participants on the Pathway in the final weeks of the pilot. The findings from the participants’ self-reported clinical leadership behaviours are presented here.

Reliability of the CLB-Q

The statistical reliability of the seven subscales was examined by calculating a Cronbach’s Alpha coefficient for each. This provided a measure of the internal consistency of each subscale, indicating how well the items functioned in measuring the same underlying factor. The optimal level for Cronbach’s Alpha was set at 0.7 or above. As illustrated in Table 7.4, the Cronbach’s Alpha coefficient of the Clinical Leadership Behaviours Questionnaire (CLB-Q) varied between $\alpha = .677$ (advocacy and empowerment) and $\alpha = .842$ (team work).

Table 7.4 Cronbach’s alphas ($\alpha$) for clinical leadership competence subscales

<table>
<thead>
<tr>
<th>Clinical leadership competence</th>
<th>Alpha ($\alpha$) level</th>
<th>Number of items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-awareness</td>
<td>.829</td>
<td>6</td>
</tr>
<tr>
<td>Advocacy and empowerment</td>
<td>.677</td>
<td>4</td>
</tr>
<tr>
<td>Decision making</td>
<td>.758</td>
<td>7</td>
</tr>
<tr>
<td>Communication</td>
<td>.745</td>
<td>5</td>
</tr>
<tr>
<td>Quality and safety</td>
<td>.815</td>
<td>7</td>
</tr>
<tr>
<td>Team work</td>
<td>.842</td>
<td>6</td>
</tr>
<tr>
<td>Clinical excellence</td>
<td>.810</td>
<td>6</td>
</tr>
</tbody>
</table>

The initial reported alpha level for the ‘advocacy and empowerment’ subscale was .637 when all six items were included in the scale. This was below the optimum alpha level of 0.7. Based on the item-total correlations, it was found that two inter-item correlation scores with the total for the other items on the subscale were below the 0.3 level and therefore should not
be included on the subscale. The deletion of the item ‘I am generally able to recognise when patients or colleagues need my support’ from the subscale increased the alpha level to .655; however the alpha level remained below the optimal alpha level of 0.7. A further deletion of the item ‘I encourage others to act according to best available evidence and best-practice standards’ increased the alpha level for the ‘advocacy and empowerment’ subscale to .677 and the alpha level remained under the optimum level of 0.7.

The initial reported alpha level for the ‘communication’ subscale was .728 when all six items were included in the scale. While the alpha level for this subscale was above the optimum level of 0.7, the inter-item correlation for ‘I use the language most appropriate to the individual or group with whom I am communicating’ was .242, which was too low for inclusion in the subscale. When this item was deleted from the subscale the alpha level for the five items raised the subscale index of reliability to .745.

The initial reported alpha level for the clinical excellence subscale was .780, also above the optimum alpha level of 0.7. However the item ‘I take responsibility for developing clinical practice’ inter-item correlation was below the 0.3 level at .218 and therefore should not be included in the subscale. When this item was removed from the subscale, the alpha for a seven-item subscale was .796. Another item ‘I participate in continuing professional development opportunities’ was also below the 0.3 inter-item correlation threshold at .271, and was deleted from the subscale. The alpha level of the six-item ‘clinical excellence subscale’ was .810.

**CLB-Q self-ratings by grade**

Thirty participants completed the CLB-Q. For the purpose of comparisons, participants were grouped into one of two grade types, as follows: assistant director grade and upwards were designated as ‘senior grades’, indicating a senior managerial grade, and all other grades were designated as ‘junior grades’, indicating a clinical, non-managerial grade, which included all grades up to and including CNM/CMM 3. Of the sample of thirty respondents, 29 per cent (n=9) were ‘senior’ grade and 71 per cent (n=21) were ‘junior’ grade.

The mean score yielded for the respondents who completed the CLB-Q was 183.97 (SD =15.67) and the range of scores was 151 to 216. When the respondents were ranked by grade,
the following differences were observed: the mean score for ‘senior’ grades was 185.44 (SD=18.45) and the mean score for ‘junior’ grades was 183.33 (SD=14.78). This finding indicates that both senior and junior grades of staff rated themselves highly overall on the frequency with which they engaged in the forty eight clinical leadership behaviours. Figure 7.7 illustrates the respondents’ mean ratings by the seven competence subscales and indicates that overall the respondents rated themselves as engaging in the clinical leadership behaviours with a high degree of frequency.

Table 7.4 presents the frequency distribution of participants’ mean scores for the seven CLB-Q subscales by ‘senior’ and ‘junior’ grades and by all respondents. The table indicates that the subscale ‘decision making’ yielded the highest mean score from among all seven of the clinical leadership competence subscales (M =4.18, SD =0.44). The second-highest mean score was for the subscale ‘advocacy and empowerment’ (M =4.14, SD =0.40). The same overall mean scores were yielded for the subscales ‘self-awareness’ (M =4.06, SD =0.54) and ‘team work’ (M=4.06, SD=0.53) followed by ‘communication’ (M =4.00, SD =0.44).
Respondents rated themselves lowest on the subscales ‘quality and safety’ (M =3.83, SD =0.58) and ‘clinical excellence’ (M =3.81, SD =0.52).

When self-rated scores were presented by the ‘senior’ (managerial) and ‘junior’ (non-managerial) grade subsets, very minor numeric differences were observed in the mean scores, as follows: senior managerial grades rated themselves higher in the subscales ‘self-awareness’ (M =4.06, SD =.61), ‘decision-making’ (M =4.13, DS =.42), ‘communication’ (M =3.98, SD =.48), ‘team work’ (M =4.03, SD = .56) and ‘clinical excellence’ (M =3.78, SD =.53) than their junior non-managerial grade counterparts. The junior non-managerial grades subset rated themselves higher for the subscales ‘advocacy and empowerment’ (M =4.18, SD =.38) and ‘quality and safety’ (M =3.84, SD =.58).

T-tests were performed to test for differences between senior and junior grades’ responses to each of the seven subscales. Differences in self-ratings of clinical leadership behaviours between the junior and senior grade subsets were found to be not statistically significant for all seven subscales (Table 7.4), as follows. For the self-awareness subscale there was no statistically significant difference between the groups [t (29) = .062, p = .951]. Within the subscale of ‘advocacy and empowerment’ there was no statistically significant difference between the senior and junior grade subsets [t (29)= -.903, p = .374]. For the ‘decision-making’ subscale there was no statistically significant difference between the grades [t(28) = .882, p = .385]. There was no statistically significant difference on the ‘communication’ subscale between the groups [t(28) = .451, p = .655]. On the ‘quality and safety’ subscale, there no statistically significant difference was observed between the junior and senior grades [t(28) = -.146, p = .855]. In relation to ‘team work’, there was no statistically significant

<table>
<thead>
<tr>
<th>Subscale</th>
<th>All grades</th>
<th>Senior grades (Managerial)</th>
<th>Junior grades (Non-managerial)</th>
<th>Difference p*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
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<tr>
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<td>.54</td>
<td>4.07</td>
<td>.35</td>
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<tr>
<td>Advocacy &amp; empowerment</td>
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<td>.40</td>
<td>4.03</td>
<td>.45</td>
</tr>
<tr>
<td>Decision making</td>
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<td>.44</td>
<td>4.29</td>
<td>.49</td>
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<tr>
<td>Communication</td>
<td>4.00</td>
<td>.44</td>
<td>4.06</td>
<td>.32</td>
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<tr>
<td>Quality &amp; safety</td>
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<td>Team work</td>
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<td>.53</td>
<td>4.13</td>
<td>.51</td>
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<tr>
<td>Clinical excellence</td>
<td>3.81</td>
<td>.52</td>
<td>3.86</td>
<td>.50</td>
</tr>
</tbody>
</table>

N = 30
difference between the grade subsets \[t(29) = .463, \, p = .647\]. Within the subscale of ‘clinical excellence’ there was no statistically significant difference observed between the junior and senior sub-groups \[t(29) = .440, \, p = .663\].

**Key points**

Using the CLB-Q, participants on the Pathway reported the frequency with which they engaged in clinical leadership behaviours using a list of forty-eight behaviours derived from the seven clinical leadership competencies.

The self-ratings of clinical leadership behaviours associated with the seven clinical leadership competencies showed that participants overall rated themselves as frequently engaging in the leadership behaviours. Behaviours related to competencies for ‘decision making’ were most highly rated by the participants.

There were minor differences in self-ratings between senior (managerial) and junior (non-managerial) grades, although the observed differences CLB-Q scores by grade were not statistically significant.
7.5 Narrative accounts of participant and service-level short-term outcomes (Theme 4)

Along with the three leadership behaviours rating questionnaires, the other source of data for examining short-term outcomes was the focus group discussions, individual interviews and group interviews. The topic guide for the various data qualitative data collection methods addressed two areas for discussion related to short-term outcomes. One area addressed the participants’ own sense of having attained the clinical leadership competencies for which they had received an intervention. The second area for discussion addressed service and/or organisational outcomes, in which focus group participants discussed priorities for service development using the Service Assessment Tool, service and/or organisational-innovations made in the course of the pilot and the impact of these innovations.

The qualitative data provided rich additional evidence of pilot short-term outcomes, from which the theme ‘developing the service’ emerged. This theme was made up of two subthemes, namely: ‘developing the clinical leader’ and ‘developing the service’ (Figure 7.8).

![Figure 7.8 Major theme: Developing the service](image-url)
Developing the clinical leader

This sub theme describes the focus group participants’ sense of how the participants developed their clinical leadership competencies in the course of the pilot. The sub theme is closely related to the sub theme ‘developing the competencies’ described in Chapter 5, in that it concerns participants’ clinical leadership development as a result of their participation on Clinical Leader Development Pathway. The theme emerged from data provided primarily by participants themselves, their line managers and directors of nursing and midwifery. Focus group participants spoke of how the Clinical Leader Development Pathway and the interventions associated with it had contributed to the professional and personal development of the participants. Focus group participants, including those acting in the various supporting roles, gave examples of how participation in the pilot had a direct and immediate impact at the level of the individual participant. The theme also relates to the issue of whether the National Clinical Leadership Framework and the Clinical Leader Development Pathway should receive academic and/or professional accreditation.

Participants spoke of the value that they had derived from the pilot initiative, both in relation to the particular competencies that they were developing and in relation to what their participation meant to them, in terms of their own development. Drawing on their experiences of having undertaken interventions for one or more of the competencies, participants spoke of the value of the knowledge and skills gained from the interventions, which had contributed to their own role as practitioners. Participants spoke of how the interventions had impacted on their performance in the work setting. Focus group participants frequently cited self-awareness and communication as competencies, which had immediate application and translation in their own practices. They spoke of how, having completed the relevant interventions for the competencies, their learning had translated immediately and effectively into their clinical leadership practices:

[The intervention] was a bit about counselling in many ways and about self-development. I think it is huge in how you manage people, like how you react, how they react, how not to react. I love it, I think it should be incorporated into every subject ... it is all about how people interpret what you say (Pathway participant, self-awareness).
Another spoke of the experience of developing communication and of how her perspective on others had changed as a result:

[By] developing or reading into, say, communication, I would be more prone to not dismissing people or I am more open or I will be more accepting of very different viewpoints. Or if I don’t agree with somebody, I wouldn’t go headlong and say, ‘oh no, that is wrong’. I will just let it go now, whereas before (Pathway participant, communication).

The same participant spoke about her openness to other’s ideas, having developed her own competence in communicating:

And if you were asking for ideas for the particular project I am doing, I wouldn’t say “no” to any idea. I will write it all down and say that is a great idea we will look into that, whereas before I might say, “ah no, that wouldn’t work” [and] whereas now I wouldn’t do that (Pathway participant, communication).

While participants spoke of how the interventions had a direct and immediate effect on their own leadership practices, some mentioned the value of what they had learned on the Clinical Leader Development Pathway to their personal lives. One participant spoke of how her experience of the Clinical Leader Development Pathway had helped her to ‘see myself different, maybe to challenge myself’. Another spoke of the deeper learning that had taken place through self-awareness interventions, which elevated what had been learned beyond the immediate practice context:

I have a friend who is going through a bit of a problem in her [personal life] ... and I said “well what would you do and what would you like?” And the answers were totally different; I didn’t tell her what she should be doing ... and she sat there and she was all bewildered and she was working it out for herself and I thought: “God that should be done more often!” So there is something in it definitely (Pathway participant, self-awareness).
Participation in the Clinical Leader Development Pathway was a transformative experience for some, in the way that it impacted on them in a deep way personally and professionally. One spoke of the value of the action learning set in helping her to develop her competence in communication:

And you don’t realise you need it going in there [to the action learning set], and that was me, when I came out I actually felt taller, I felt like a new woman (Pathway participant, communication).

Along with the knowledge and skills gained in the various interventions, participants also recognised the value of the learning skills acquired during the Clinical Leader Development Pathway interventions and how these skills had an immediate effect on how they approached their clinical leadership role. Chief among these were the skills of self-analysis and self-reflection. The andragogical strategies used within the Clinical Leader Development Pathway interventions for self-awareness had particular relevance for one participant, who considered such skills to be essential for everyday practice:

I think we should all be doing it (self-assessment) not just clinical nurse managers. I think staff nurses, everybody, I feel, could do with self assessment on a regular basis. Because you do reflect and there are some things you learn; I learned about myself, what I should be doing or should not be doing (Pathway participant, self-awareness).

Another spoke of the immediate practical relevance of self-reflection:

I found it quite useful because when you have to go home and reflect on what you have done you actually have to think about it and write it down, put it into words (Pathway participant, self-awareness).

Participants spoke of how they were able to combine the skills and the knowledge attained through interventions on the Clinical Leader Development Pathway into their own behaviours and leadership practices and they offered examples of instances in which they had actually changed their own practices or altered their approach to certain situations. One participant offered the following example:
A typical [example] was delegation. Obviously when you are in charge of a ward there are sometimes when you have to delegate work and maybe before all of this (the pilot), while I thought I was delegating to help, maybe I was delegating more task-related things to help myself, and since that now I would be ... using delegation more as a form of empowerment for the person that I delegate it to. And now I kind of weigh up which thing would benefit which person more, rather than just giving someone something to do. And it is not that I am off loading tasks now, it is more like I think they will benefit for this, and I am there just to support them while they are doing it, but it is more an empowerment for them while it is also a delegation for me (Pathway participant, advocacy & empowerment).

Line managers and others who contributed to the participants’ competency development also referred to the changes that they had observed in the participants. Some line managers spoke of their satisfaction at seeing their colleagues develop as a result of the Clinical Leader Development Pathway. One line manager remarked on the ‘marked improvement’ in one colleague and ‘gradual improvements in another’. Line managers did recognise that the Clinical Leader Development Pathway was in its early stages of development and observed that it was difficult to discern what the longer-term impact of the process would be for the development of clinical leadership skills in their staff. However they were clear that the Clinical Leader Development Pathway had been successful to date in developing certain individuals, as one observed:

I just find with the person herself, she would have had a lot of good qualities anyway, but she would be a quieter person and it is definitely bringing her out, she would be a very capable person. She would be a quiet person but it is definitely bringing her leadership skills out (Line manager).

The matter of whether the National Clinical Leadership Framework and the Clinical Leader Development Pathway should receive academic and/or professional accreditation was discussed in focus groups. Many participants considered that the Framework and Process should receive academic accreditation, although there was no real consensus as to what was the appropriate award level. Many participants considered a professional certificate to be the most appropriate award type.
Those who advocated academic accreditation did so on the grounds that the work involved in developing clinical leadership competencies was ‘quite challenging, time consuming’ or they saw the need for some recognition that ‘you have completed the national leadership programme.’

Others were sceptical of academic accreditation. One remarked: ‘I don’t know about going the college route’ and another said: ‘I personally wouldn’t want to see it in the academic route’. Another said: ‘I think that adds extra pressure to people to achieve academically ... [and] it may deter people from taking it up or moving it forward’ and another observed: ‘how you accredit it or how you acknowledge [it], I don’t know.’

Some considered that the Clinical Leader Development Pathway would be ‘very hard to assess’, as one pilot participant remarked:

A staff nurse maybe, she has maybe done a huge amount in the six months because she has grown hugely in that six months through the [Pathway] process. And how do you define that, how do you clarify that in terms of academia? ... These things are very practical things that actually feed your practice on a day to day basis and your clinical decision making, your communication, your team building skills. So I don’t know what you would gain from writing an academic essay on team building. It doesn’t necessarily mean you are any good at it (Pilot participant).

Another proposed that a way of assessing the participant for the purpose of academic accreditation would be to audit a service initiative undertaken: ‘the auditing of the service development initiative might be the completion of the diploma requirements.’

Some considered that the issue should not be about accreditation per se, but about the need to have a sign-off mechanism built in, as one participant commented: ‘maybe the mentor is the idea rather than going down the college route.’ Another commented that to place the Framework and Pathway within an academic framework would be to take away from the enjoyment of it: ‘I enjoyed it so I would hate to take the enjoyment out of it to make it competitive maybe.’
One participant proposed linking the Portfolio with registration evidence. Another suggested that the Clinical Leader Development Pathway could be a mandatory requirement for promotion to a clinical manager position:

I know we were talking about bringing it back onto ground level for staff nurses and stuff, but it wouldn't be any harm for everybody that takes on a CNM role to do this. Maybe that is how you could accredit this. In order to be a [clinical] manager you have to have a management course done, maybe now in order to be a manager you have to do a leadership [course]. Maybe that is how you accredit it, so you are not actually getting an award or you are not getting a cert or you are not getting points but you just can’t do the job unless you have it done (Pathway participant).

One pilot participant commented that since the clinical leadership competencies were about good practice, these should be developed in undergraduate training:

The fundamental thing is it is about being safe in your practice and making sure that the service delivery that you are providing to the patient is based in proper practice and evidence. So this should come from the [nursing] school (Pilot participant).

Another pilot participant proposed incorporating the Clinical Leader Development Pathway as a module in postgraduate diploma courses, such as intensive care or the care of older people.

*Developing the service*

Pilot participants, including participants on the Clinical Leader Development Pathway, line managers and those acting in the various supporting roles spoke of how the pilot was having immediate benefits for service and service users. This theme describes accounts of service initiatives that were provided by participants in the various evaluation study data collection activities. Due to the fact that the pilot had only been in operation for less than six months, some participants believed that it was too early in the process to see a tangible service impact. Nevertheless, numerous examples of service innovations were provided and discussed in the focus group discussions. Examples of service initiatives and developments and the reported benefits to the service are provided here.
In the course of the focus groups a number of participants offered examples of how the pilot had impacted positively and directly on service and service users. The most immediate impacts were those related to the interventions and projects undertaken by the participants as an explicit element of their clinical leadership development on the Clinical Leader Development Pathway. The interventions cited in the focus groups related to a range of service interventions and a number of projects were discussed. These included the following examples:

- A new patient handover list arrangement
- An initiative to improve children’s safety and security during transport to the operating theatre
- The development of an accurate and useable patient census on an extended care ward
- A project for auditing and improving hand hygiene in a clinical department
- A care pathway for patients with diabetes types 1 and 2
- An initiative to improve practice in recognising and treating hypoglycaemia in patients with diabetes
- A patient education initiative for patients with diabetes
- An initiative to teach patients how to self-instil eye drops
- A patient consultation and feedback initiative to improve care planning
- An audit and review of clinical guidelines in the paediatric setting
- An initiative to improve patient safety and reduce anxiety in children being transported to theatre
- A project aimed at improving multidisciplinary documentation
- A discharge planning initiative involving direct communication between the discharging nurse and the public health nurse

Participants in the focus groups and group interviews provided details of these projects, including the reasons for their institution, the steps taken by the participant in instituting the project and the stage of development at the time of the focus group discussion. Participants instanced these as tangible evidence of a direct impact of the Project on service users and the quality of service. Some spoke about the potential for sustainability in the various initiatives and expressed optimism that the changes in the service would be sustained after the pilot was concluded. Some focus group participants remarked on the fact that the service initiatives that
they had selected were associated with long-standing problems that were the subject of previous unsuccessful attempts to address them. They welcomed the opportunity that their participation in the Project had afforded them in finally addressing the problem, as one participant remarked: ‘[I] wouldn’t have done it if [I] hadn’t been on the Clinical Leader Development Pathway.’

In the course of focus groups participants made direct and explicit links with the clinical leadership competencies that they were developing and the service initiatives that they had introduced while on the Clinical Leader Development Pathway. Many provided details of the service initiatives, their reasons for introducing them and some reported on the progress of the initiative. Their accounts spoke of individual and team efforts to change practices where practices were previously seen as deficient.

Three separate initiatives in the care of patients with diabetes were reported by participants. One participant who was developing ‘team work’ spoke of introducing a care pathway for patients with diabetes types 1 and 2 for her identified need to ‘standardise the care of someone who is newly diagnosed with diabetes coming into us’:

[I am] looking at policies for pathways for someone who has been diagnosed with type 1 and type 2 diabetes and pathways of how to get into our service. So I have started working on that so ... [it] will hopefully streamline things for our patients (Pathway participants).

One spoke about an initiative to improve staff practice in the recognition and treatment of hypoglycaemia in patients with diabetes:

I looked at the knowledge of staff on wards and how they treat hypos because it was very variable and ... so we developed a hypo policy for the whole hospital and that was launched. And then it was to raise staffs’ awareness about how to treat a hypo for patients appropriately. So it was trying to figure out how to do that because various measures had been tried in the past about educating staff which didn’t really work or somewhat worked. So it was just to talk to some people about how to do it and I had to set up education sessions that would suit staff (Pathway participant).
Another instituted a patient education initiative for patients with diabetes:

I decided education for ... diabetic patients ... on how to protect themselves at home, because when they cut their toes wearing the wrong shoes, blisters, knock-on effect, long term is amputation and the effect on the HSE is very costly and to their family and to their own personal lives. So I decided to hone in on that area ... So it is a slow process, but it has already started and I am actually giving information to patients on where to get the shoes and they are specifically for people with leg ulcers and diabetes. So already I have been giving [information] and so have the other nurses been giving information in relation on where to get the shoes ... Even though it sounds very small, but it has a knock-on effect to them, their lives, their family and the HSE (Pathway participant).

Another spoke of an initiative to teach patients how to instil their own [eye] drops, in order to prevent diurnal fluctuations in intraocular pressures:

So we are doing that at ward level ... [and] we’re incorporating other members of staff and teaching them how to do it because if the patient knows how to do it, you are half way there and less risk of infection and pressure going up [in the evenings] (Pathway participant).

One participant developed a new patient handover list arrangement, stating: ‘[I] decided this is what I really have concerns about, what really needs to improve on the ward.’ Having agreed on a service initiative with her line manager, another developed a system for auditing intravenous cannula care:

Myself and my manager, we agreed on a service initiative and I interlinked both of my competencies and ‘clinical excellence’ and ‘quality and safety’, and I suppose it came about from feedback from staff and discussions with the IV nurse as well. [It] was an idea that the IV nurse had brought to the emergency department previously and she hadn’t brought it into the wards. So that is what I am actually doing at the moment, like auditing that on a weekly, two-weekly basis and reporting back to the staff then the results in order to be able to show optimum IV cannula care in the ward.
So that was my project or initiative (Pathway participant).

The same participant also referred to the direct impact on patient outcomes from the initiative:

From the first audit we did and the last audit I did last week ... there is a huge improvement already in the space of that length of time. The aim is to get to 100 per cent ... [and] it is at 77 [per cent] at the moment, which is good. So I see there has been an improvement in every audit I have done, which is good. So at least that is showing an improvement (Pathway participant).

A participant who was developing the competence ‘quality and safety’ referred to a collaborative project with a colleague in which they initiated ward-level ‘community meetings’ involving deliberate consultation with patients in order to obtain feedback from them in relation to their care planning:

And we are getting as much feedback as we can ... So everything we are actually implementing now and everything we are using we can actually turn around and say, “well it actually has been service user reviewed and we are changing it accordingly” (Pathway participant).

Another participant in children’s nursing spoke of instituting an audit and review of clinical guidelines in the paediatric setting, in order to bring the guidelines ‘up to scratch or indeed put some in place’. She stated: ‘Basically, what I kind of did was an assessment of need.’

Another reported on the imminent introduction of a system of admitting elective surgical cases directly to theatre to prevent prolonged waiting in the pre-operative clinical department: ‘they are being checked in with the A&U secretary as of from next Monday, and it will speed up the process and they will be in and out within an hour and a half.’

A participant developing ‘team work’ as one of her competencies reported on how she collaborated with the clinical nurse specialist (CNS) in infection control to improve hand hygiene practices:
We are focusing on ... hand hygiene with the team and ... we are still in the middle of that, but it is going quite well. Infection Control are working with us ... so it is going well [and] there is a big improvement in the ward because we have been quite poor. It was the CNS for the hygiene infection control who came to our ward and said she wanted to work with somebody to improve the standards, so I took the opportunity then (Pathway participant).

A clinical nurse manager in a children’s ward described an initiative to improve patient safety and reduce anxiety in children being transported to theatre. The initiative involved walking or carrying children to theatre, in order to avoid having to wait for a trolley and to reduce pre-operative anxiety in the children:

[We are now] walking patients to theatre or getting guardians or parents to carry them to theatre instead of the current practice of waiting for a trolley to come. So that had [an effect] for patient safety and reduced patient anxiety, and also because there is documentation out there, that any well-patient, to walk to theatre, to make them more independent as well, creates a sense of well being. So we are working on that, [and] there are a lot of stakeholders involved (Pathway participant).

The participant explained her rationale for introducing the new practice, which was directed at children undergoing simple elective procedures: ‘I could identify there was a delay in getting patients to theatre. So that had a knock on effect on other patients on the ward because they were delayed in going to theatre and their fasting times [were longer].’ She also explained that many children can get upset or feel nauseated when travelling on a trolley, and [she] referred to the impact on children and their parents:

Parents and guardians are happy with the new arrangement and they are quite pleased with it and impressed because it empowers them ... [and] the child is happy; it is about the care of the child (Pathway participant).

The impact was also evident to her work colleagues, as she explained: ‘nursing staff have commented on it as well that there isn’t, “oh we need to get a trolley or need to get a
wheelchair, need to get this, need to get that” [and there is] less drama, less phone calls, less people giving out, less fighting (Pathway participant).

Patient safety was also the rationale for an initiative to improve documentation in a clinical department by coordinating the recording of medical and nursing notes, as one participant explained:

I chose documentation. I decided to implement a plan where one particular person on the medical team would document every day somewhere, which we worked through, and then transcribe that into the medical notes, which is what we did. So it was just a matter of picking the person, speaking to the consultant, speaking to the team and then formulating how we would do it and then putting it into place and auditing it afterwards. So that is what we did (Pathway participant).

The participant explained how the initiative required interdisciplinary collaboration and how once instituted, it led to greatly improved communication of patients’ progress:

So the new intern came to the ward and from the first day, after I discussed it with the consultants, who left it up to me, what way I wanted to run it, but they (the medical team) had agreed that part of the job description of the intern would be to document. ... So [we] decided between us what we were going to do, how she would do it, how often she would do it and she started that from her first day on the ward ... And just for the other teams, I mean, it is a multi disciplinary service, and then if the patient got sick and needed to be moved elsewhere or needed something done there was nothing documented from the last few days as to whether they had been disimproving. So all that has changed now since, so it is 100 per cent better than it ever was.

A discharge planning initiative involving direct communication between the discharging nurse and the public health nurse was reported by another participant, who explained that the initiative was instituted to ensure that specific information on each patient’s nursing needs was included:
So the nurse will ring the public health nurse themselves. Because what was happening [before] was our case manager was ringing ... them (the public health nurse) on a fact finding mission often to say: “what supports have they and what will they need going home?” That was their focus. While now it is patient-centred and it is the holistic care of the patient from hospital to home.

One line manager referred to an innovation that she had instituted in her ward as a direct result of her doing the Clinical Leader Development Pathway. She referred to an aspect of patient safety and how, ‘after a lot of discussion’ with colleagues, they agreed to institute a new simple patient record system for handover reports. She concluded: ‘So it is a big safety thing and it is up and it is running. We had teething problems with it, but it has finally been passed. So it is a big achievement in the ward. It is a huge step, and a big safe step forward.’ Another line manager spoke of her colleague’s initiative in developing a ward-level audit system having participated in the pilot:

She keeps a folder, she tells me every time she does the audit, I ask her about the audit, I ask her about the results, [and] we put it up on the notice board. We make a note if it has disimproved or improved and we work in conjunction with the CNS as well, she is aware of what is happening with it. So it is improving practice and where it slips back then and it hasn’t improved practice, we look at the situation (Line manager).

Less tangible and more subtle benefits to services were also identified by the focus group participants as a result of their participation in the Clinical Leader Development Pathway. For some, involvement in the Process and their service initiative in particular had resulted in changed and improved working relationships at the departmental level and had given rise to a culture that was more receptive of change. One participant spoke of lines of communication being ‘opened where there would have been little or nothing for years’ and remarked on the cultural shift that had resulted from the aforementioned project to improve hand hygiene:

Everyone is actually correcting one another now and you can see some of the nurses correcting the doctors, which is fabulous because it is something that is so important.
So yes, there are changes, people are more aware of the importance of it and making it more aware to the public as well (Pathway participant).

Another participant similarly experienced the service impact as an improvement in the atmosphere within the work setting: ‘There appears to be a better atmosphere on the ward now, I inherited a lot of issues but we are getting to them.’

Line managers also recognised the less tangible changes; however one line manager cautioned against being overly confident at what the Clinical Leader Development Pathway could achieve in terms of service improvement and how misplaced expectations might be placed on the shoulders of participants at this early stage:

The idea that you can transform somebody from their leadership awareness, their leadership competencies ... that within twenty-one months you can transform them, I think that is unrealistic. I think they will certainly develop an awareness of it. They will certainly glean something from it, and in some respects, I think their performance will improve. The amount of time they are spending at it, the amount of effort that is going into it, I think there will be a moderate return from it (Line manager).

A participant similarly spoke of the idea of the impact of her development being seen in the long term rather than the short term:

So in terms of my actual change, I haven’t actually changed anything yet in my practice as a result of this, I feel it is going to be an ongoing process, it is not something I will have finished by the end of the six months of the pilot programme. It is going to be something that will impact more long term (Pathway participant).

Nevertheless, there was a sense that having staff participating in the process was positive for the wider working environment and that the benefits extended beyond the individual participants and their specific projects. In this regard, one line manager, referring to the aforementioned patient census project, spoke of the way the initiative had changed others’ practices:
[One participant] has actually changed the way she works and her working relationship has been pivotal ... She came up with this idea, ran it by her staff, and because she had the backing of the clinical leadership project, it was something that we wanted to try [and] they all bought into it. And it is now ingrained in their everyday practice ... and it just makes for a much safer environment (Line manager).

Coaches also offered comments on the service impact of the pilot. One coach pointed to the constraints of introducing a practice innovation:

I think my coachee is working towards changes and innovation in practice, but that is all very dependent on, what would I say, on reducing conflict within a work place and gaining acceptance within a work place. So it is moving towards achieving something positive from the service perspective but it is not there yet (Internal coach).

Another coach commented on her coachee’s readiness to introduce practice innovation:

From my experience, my coachee is busy working [on] her self-awareness right now and I don’t think there are going to be any developments there until she has come to a place where she has the confidence she needs and so that is the area from the perspective of an individual.

The narrative data from the focus groups indicated that individual participants had developed new skills that enabled them to assume a clinical leadership role and most of them had initiated specific practice changes as a result.

**Key points**

Participants and those acting in the various supporting roles reported evidence of clinical leadership development in the participants. This evidence was provided in numerous examples of service or organisational initiatives that participants undertook.

Examples of service initiatives ranged from improvements in particular clinical practices and
procedures to more general service developments aimed at improving safety, service quality or the patient experience at the service-user interface. Evidence of improvements in the culture of the working environment was also provided.

Participants spoke of the value that they had derived from the pilot initiative, both in relation to the particular competencies that they were developing and in relation to what their participation meant to them, in terms of their own development.

The findings demonstrate that the focus on organisational development, particularly at the level of the individual clinical unit, was an important element of clinical leadership development in the Clinical Leader Development Pathway.

Participant and service-level outcomes were linked to participation on the Clinical Leader Development Pathway and suggest that the Clinical Leader Development Pathway is a viable method of developing clinical leadership competencies in nurses and midwives of all grades.
7.6 Summary of findings: Short-term outcomes

The findings from LPI-S and LPI-O ratings of leadership behaviours indicated that both Participants on the Pathway and their line managers rated the participants as frequently engaging in behaviours associated with five generic leadership practices. Additionally, Participants rated increases in their behaviours in three of the five generic practices and their line managers rated increases in participant behaviours in two of the five practices across the time of the pilot. Observed differences in self and observer ratings of generic leadership practices between time 1 and time 2 were not statistically significant.

The self-ratings of clinical leadership behaviours associated with the seven clinical leadership competencies showed that participants overall rated themselves as frequently engaging in the leadership behaviours. Behaviours related to competencies for ‘decision making’ were most highly rated by participants. There were minor differences in self-ratings between senior (managerial) and junior (non-managerial) grades, although the observed differences CLB-Q scores by grade were not statistically significant.

The data from focus groups, group interviews and individual interviews illustrate a positive view of the Clinical Leader Development Pathway and demonstrates the worth placed on it by participants. There was also a view given of the positive developments that had taken place as a result of the process for the participants, the service and, indirectly, the service users.

Analysis of the narrative data obtained in the various qualitative data gathering activities indicated that individual participants and others could provide clear accounts of how they had developed aspects of clinical leadership competencies over the course of the pilot and how they had initiated service improvements as a result. These accounts spoke of new or improved capabilities that had resulted from their experiences of the Pathway and interventions and improvements in their own professional and personal development. There were mixed views on the issue of academic accreditation of the Framework and Clinical Leader Development Pathway, with positions varying from full support to scepticism and opposition.
Participants and those acting in the various supporting roles also gave numerous examples of how the pilot had led to service initiatives and/or improvements in the culture of the working environment. Service initiatives ranged in their focus from improvements in particular clinical practices and procedures to more general service developments aimed at improving safety, service quality or the patient experience at the service-user interface. Some participants believed that it was too early in the process of leadership development to see a tangible service impact and saw leadership competencies and their associated individual and service impacts as requiring time to emerge.
Chapter 8

DISCUSSION

8.1 Introduction

The National Clinical Leadership Development Project (NCLDP) was established by the HSE’s Office of the Nursing and Midwifery Services Director in 2009. Consisting of the National Clinical Leadership Development Framework and the Clinical Leader Development Pathway, the aim of the Project is to implement a national approach to the development of clinical leadership in nursing and midwifery in Ireland. The Clinical Leader Development Pathway element of the Project enables individual nurses and midwives to gain access to the Framework at the level appropriate to meet their individual, self-assessed clinical leadership development needs. The development of seven core clinical leadership competencies is a focus of the Framework and Clinical Leader Development Pathway.

In June 2011, a pilot of the NCLDP commenced at seven pilot sites in the Cork city area and involved the implementation of the Clinical Leader Development Pathway among a group of nurses and midwives from all grades. The nurses and midwives entered the Clinical Leader Development Pathway at a point based on an assessment of their clinical leadership development needs and they experienced a range of interventions and supports to enable them to attain a minimum of two core clinical leadership competencies. A total of 119 individuals were either directly or indirectly involved in the pilot. Of this number, 36 completed the Clinical Leader Development Pathway and the remainder were involved in aspects of the Project, including assessing development need or acting as mentors, coaches, action learning facilitators and workshops facilitators. Additional supports included pilot site co-ordinators and a Project Team. The Clinical Leader Development Pathway, including interventions, was also supported by a range of documentary materials, presented in ring-bound folders.

The pilot involved the roll out of the Clinical Leader Development Pathway and associated interventions for a six-month period, in which participants focused on developing two of the seven competencies. This study evaluated the pilot. The study findings are discussed here.
8.2 Evaluation strategy and study design

The methods and materials that were used to gather data were informed by literature on participatory action research and the illuminative evaluation model and aimed to generate reliable data with which to evaluate each step of the Clinical Leader Development Pathway, all the resources that supported the pilot and the short-term individual and service outcomes. A key aim was to generate information on the approach to clinical leader development.

Strategy and design

The design for the evaluation study consisted of a range of data collection methods that generated data from a variety of sources. Surveys, observation, focus groups, interviews, assessment of leader behaviours and documentary analysis were deployed (Davidson & Martineau 2007). The evaluation strategy and its associated design and methods are well supported in the specialist literature on leadership development evaluation (Hannum et al. 2007).

The data triangulation approach adopted for the study ensured that all those experiencing the pilot were represented in the data that were collected. Data triangulation also provided additional evidence of the impact of the initiative and provided rich and comprehensive information from diverse sources, and in so doing, addressed all the stakeholder needs (Craig & Hannum 2007). Additionally, the design was based on collaborative inquiry principles and in this way, was responsive in facilitating a two-way dialogue between the Research Team and the Project Team.

A substantial part of the present design involved qualitative approaches that generated a body of narrative data that offered themes which not only informed the key study questions about clinical leadership development, but can also generate new questions for future studies (Cummings et al. 2008). Similar to other studies that have evaluated clinical leadership development programmes and initiatives (Large et al. 2002, Stol et al. 2010), this study measured and/or observed both participant and service/organisational outcomes and succeeded in generating a range of data on both types of outcomes. In so doing, it addressed the relevant key research question around pilot short-term outcomes and impact of the pilot.
Sampling and response rates
Since the pilot was conducted in a single urban setting and with a finite group of participants, purposive sampling was the sampling strategy indicated for the qualitative data collection elements. Accordingly, comparisons of the demographic profile of the participants with that of the national sample of nurses and midwives were not warranted. Given the relatively small size of the sampling frame for the study, every effort was made to reach all participants for all data gathering elements. These efforts resulted in a very high overall response rate of 72 per cent to the Participant Experiences Questionnaire (PEQ). When the participants who withdrew are excluded, the response rate for participants on the Pathway was 77 per cent.

The use of a telephone interview approach to administer the PEQ enhanced the response rate (Dillman et al. 2008). Reliability of data was further strengthened in the fact that a total of 70 individuals, or 60 per cent of the total pilot population, participated in at least one qualitative data collection activity. The very high level of participant involvement in both the quantitative and qualitative data collection elements enhanced the validity and reliability of the study findings. This was achieved through the collaborative approach adopted, in which there was ongoing dialogue and consultation between the Research Team and the Project Team.

The response rates to the online administration of the Leadership Practices Inventory-Self (LPI-S) and Leadership Practices Inventory-Other (LPI-O) using Survey monkey were lower than those achieved for either the CLB-Q or the PEQ, which was administered using the telephone interview method. This was especially evident at Time 1. Anecdotal evidence gleaned in the course of the data collection suggested that many of the participants were not regular users of their work-based e-mail accounts, which may explain the relatively lower response rate yielded using the online method. The literature indicates that the telephone survey method yields higher response rates than the online method and that it is social factors, such as age and gender, which are key variables in both internet use and in response rates to online surveys (Al-Subaihi 2008).

In an effort to improve response rates at Time 2 for the LPI-S and LPI-O, a combination of online and telephone administration was used. This approach is supported by Dillman and colleagues who reported that switching to a second mode of administration is an effective
means of improving response rates in surveys (Dillman et al. 2008). Online and telephone methods of administration may also account for differences in the type of answers that respondents provide to survey instruments, and these differences are a function of whether the instrument is viewed or heard by the respondent (Dillman et al. 2008). However, based on the small sample sizes that completed the LPI-S and LPI-O, it is not possible to infer differences in rating responses as the result of aural and visual methods of administration.

**Qualitative data collection methods**

The recruitment strategy for the multiple qualitative data collection activities was aimed at ensuring maximum participation from among all pilot participants. This ensured that data from across the whole spectrum of participant experiences could be generated, and thereby enhance the reliability of the qualitative findings. While recruitment to some focus groups was slow in the early weeks of data collection, this was counteracted by skilful negotiation and promotion of the study by site co-ordinators and the Project Team.

The decision to recruit focus group participants according to the competencies that participants were taking resulted in focus groups of varying size and composition. However, this did not compromise the integrity of the focus groups, either as fora for discussion or as a means of generating rich data that could be analysed, interpreted, reduced and re-constituted as coherent themes and sub themes.

**Documentary analysis**

In analysing the materials supporting the pilot, no standardised documentary analysis framework was available to the Research Team and this necessitated the development of a bespoke documentary analysis instrument, the Documentary Analysis Rating Instrument (DARI). Like Appleton and Cowley (1997) who developed a documentary analysis method for analysing clinical guidelines, the Research Team used a combination of quantitative and qualitative methods to analyse the documents, and in so doing, arrived at a cogent evaluative description of the documents, with reference to pre-determined criteria of quality.

**Instruments**

A focus of the evaluation was participant clinical leadership behaviours and practices following the Clinical Leader Development Pathway interventions, and this approach, usually
conducted through self-reports, is a common method in studies evaluating leadership development programmes (Cummings et al. 2008). The Leadership Practice Inventory has been used in a number of intervention studies involving nurses (Duygulu & Kublay 2010, Krugman & Smith 2003, Tourangeau 2003, George et al. 2002) and has been found to have a high index of reliability (Duygulu & Kublay 2010) and its use was therefore justified in the present study.

A particular strength of the study design was the use of a clinical leadership behaviours instrument, the Clinical Leadership Behaviours Questionnaire (CLB-Q), to self-reported behaviours associated with the seven clinical leadership competencies. Others have used a similar approach in measuring leader behaviours (Young 1992, Mansen 1993). In providing a measure of pre-specified clinical leadership competencies, the instrument complemented the more generic LPI-S and LPI-O leadership behaviours measuring scales. The CLB-Q was developed rigorously and the experience with its use in the field demonstrated its ease of administration. Importantly, the relatively high Cronbach’s alpha scores (.677 to .842) for all seven on the CLB-Q’s subscales demonstrated the justification for the use of cognitive interviewing as a procedure for establishing the content and face validity of the instrument. Hence the CLB-Q has been shown to have good validity and internal consistency and adds to the validity and reliability of the findings concerning participants’ short-term outcomes in relation to clinical leadership competency development. Further testing and development of the CLB-Q instrument with a larger sample is warranted.
8.3 Study findings

The factors that contribute to nursing leadership are the behaviours and practices of individual leaders, the traits and characteristics of individual leaders, influences of context and practice settings, and leader participation in educational activities (Cummings et al. 2008). By examining leader behaviours and practices as short-term Project outcomes and the influence of the supports, resources and local circumstances on the pilot, this evaluation study provided evidence of at least two of these key factors.

Participant experiences

Overall, participants on the pilot evaluated their experiences very positively and this evidence both affirms decisions and actions taken in rolling out the Project and constitutes a positive finding at the level of process evaluation. In evaluations of clinical leadership development projects and initiatives, the factors that have been shown to influence the impact of a leadership development project include a supportive organisational culture, high quality mentoring, targeting transformational change in the project and ongoing project monitoring and refinement (Stol et al. 2010). Some of these factors were evident in the data relating to the process element of this evaluation study. In particular, there was evidence of good organisational support for the participants and the Project itself and there was also evidence of ongoing monitoring and refinement.

In a systematic review of the factors contributing to leadership development in nursing, Cummings et al. (2008) concluded that the practice setting had a moderate influence on leadership effectiveness. While the present study did not examine leadership effectiveness, per se, the influence of the practice setting was somewhat evident in the Clinical Leader Development Pathways, with pilot participants citing time and competing work and family commitments as constraints on their ability to engage in elements of the Clinical Leader Development Pathway, notably in completing the assessment and development of clinical leadership development needs.

Supports and interventions

With different expectations for front-line nurses in the context of managed change, there is evidence that organizations are investing in leadership development training for nurses who
do not occupy management positions (Wessel-Krejci & Malin 1997). The Clinical Leader Development Pathway reflects this trend in that it is targeted at professional nurses and midwives from across all clinical and managerial grades and is designed with reference to the roles that individuals occupy in their respective grades. Accordingly, the Clinical Leader Development Pathway interventions and supports are designed with reference to a broad spectrum of grade-specific clinical leadership development need.

The documentary supports have particular sections for each grade and the documentary analysis indicated that overall the materials supporting the Project were appropriate to the different grades participating in the Clinical Leader Development Pathway and they provided a wide variety of evidence-based resources and supports for participants and those providing interventions on the Pathway. Documentary materials were of a very high quality, of a good standard of production, were user friendly and were fit for purpose. This points to the Project having a major strength at the level of material supports and means that the Clinical Leader Development Pathway can be readily applied across multiple sites and settings, and with other resources and supports in place, can proceed with little extra planning and preparation.

Participants had overall positive experiences of the various interventions for clinical leadership development, including workshops, action learning, mentoring and coaching. The benefits of workshops and action learning sets were in their capacity to provide opportunities for participants to share experiences of practice problems and find possible solutions to them through group processes. Day (2001) identified six interventions that can be used to facilitate leadership development, as follows: 360-degree feedback, executive coaching, mentoring, networking, job assignments and action learning. Of these, coaching, mentoring, action learning and job assignments, as represented in service initiatives, were used in the pilot.

Experiential approaches to leadership development, such as 360 degree feedback, mentoring and coaching, have been widely supported in the literature on leadership development (Proctor-Thompson 2008). As an intervention, mentoring has been supported by a number of authors (Day 2001, Bush et al. 2007). In the present study, mentoring was found to be successful at the process level of evaluation, with many participants experiencing the intervention as positive and supportive.
While mentoring has been shown to be strongly effective on motivation and moderately effective on insight, it may not be as effective as either coaching or action learning in the areas of skill development and real-world practice (Leonard & Lang 2010). Coaching places individuals into real situations in which they see and experience at first hand the unique problems that occur in their practice (Byrne 2007). Evidence from the present study attests to these action and learning-oriented functions of coaching in the Clinical Leader Development Pathway and to the efforts of coaches in helping coachees formulate practitioner-generated solutions. Many coaches and participants spoke of coaching as a way of developing the individual for the role that s/he performed.

A particular strength of the action learning in the present study was its focus on sharing of ideas and concerns about practice and the action orientation of group discussions, which were focused on finding solutions to real everyday problems. Leonard and Lang (2010) concluded that action learning and individual coaching were more strongly effective on participant outcomes like insight, skill development and real-world practice than the more traditional leadership development approaches. While the present study did not measure particular participant outcomes against particular interventions, the value of mentoring, action learning and coaching as interventions in the Clinical Leader Development Pathway was clearly attested to in the evidence provided by pilot participants.

Short-term outcomes

There is evidence that clinical leaders are present at all nursing grade levels and are to be found among staff grades with significant client interaction (Stanley 2006) and this fact was implicitly recognised by many who contributed to data for this evaluation study. Participants overall rated themselves as frequently engaging in the leadership behaviours associated with the seven clinical leadership competencies. Additionally, many contributors to the study data referred to particular instances in which nurses and midwives displayed evidence of clinical leadership development through their behaviours and dispositions and/or through service or organisational initiatives. The demonstration of clinical leadership skills and capabilities was also linked with participation on the Clinical Leader Development Pathway.

Leadership and clinical leadership development can operate at both individual and relational levels and is concerned with developing collective capacity for effective engagement in
leadership roles and processes (Day 2001, McCauley et al. 1998). The Clinical Leader Development Pathway reflects efforts to develop both clinical leader and clinical leadership competencies, as evidenced in the combination of intrapersonal and relational skills and capabilities implicit in the core clinical leadership competencies; hence self-awareness is more oriented toward leader development, whereas communication and team work are typically leadership oriented capacities.

Participation in leadership development has been shown to be the most significant factor contributing to increased leadership practices (Cummings et al. 2008). Participants use clinical leadership behaviours more often (Tourangeau 2003) and have improved understanding and ability to perform stated competencies (Wessel-Krejci and Malin 1997). Using the LPI-S and the LPI-O instruments, this study found that both line managers and the participants themselves rated the participants as frequently engaging in behaviours associated with five generic leadership practices. Participants rated minor increases in their behaviours in three of the five generic practices and their line managers rated minor increases in participant behaviours in two of the five practices across the time of the pilot.

Observed differences in self and observer ratings of generic leadership practices between time 1 and time 2 were not statistically significant. However, it is noteworthy that the overall self-reported leadership behaviours scores across the five constructs showed a net increase in the summated difference between time 1 and time 2, indicating a belief among participants that their leadership practices had improved in the short timeframe of the pilot. Line managers also observed some changes in participants’ leadership practices although they rated the participants higher in fewer constructs over the same time period. Changes in self-rating scores are likely to be incremental and gradual over periods of time and therefore it may be unrealistic to expect to observe ‘radical redirections’ (Grove et al 2007) in the short period of the pilot. A key consideration therefore in the interpretation of the results from the assessment of leadership practices using the LPI is the short timeframe of the pilot.

Nevertheless, the self-ratings of clinical leadership behaviours associated with the seven leadership competencies showed that participants overall rated themselves as frequently engaging in the clinical leadership behaviours. This finding suggests that participants were
engaging in the types of behaviours associated with the core clinical leadership competencies at the end of the pilot period.

Other researchers have demonstrated the effectiveness of leadership development training on nurses’ leadership practices and a number of researchers have reported statistically significant self-reported and other-reported increases in leadership practices using the LPI following educational interventions for leadership development in nursing (Duygulu and Kublay 2011, Krugman & Smith 2003, George et al. 2002). Participants rated themselves higher for three of the five leadership practices constructs in the LPI than their line managers/observers at Time 1 and higher in all five than their line managers/observers at Time 2. This finding is reflected in studies by Duygulu and Kublay (2011) and Krugman & Smith (2003), all of whom reported higher self ratings than observer ratings following leadership training interventions.

In the present study, participants generally rated themselves higher than their line managers in leadership behaviours. This was in contrast to the findings of studies reported by Tourangeau (2003) and George et al. (2002), which found that leadership practices were rated lower by leadership programme participants than by their observers following a leadership development initiative.

Service outcomes
A clinical leader’s effectiveness as a leader is often related to the particular role s/he performs and is thus, in part, a function of the particular knowledge and skills that are required for that role (Stanley 2006). The Clinical Leader Development Pathway is focused on developing individual leader competencies and developing the service and/or organisation through the expression of these competencies in context, i.e. in the everyday performance of the individual’s professional role. This is consistent with the principles that leader development and organisational development go hand in hand and that leadership and organisational change go hand in hand.

The findings of this study demonstrate that the focus on service and organisational development, particularly at the level of the individual clinical unit, was an important element of clinical leadership development in the Clinical Leader Development Pathway. The data
obtained in the various qualitative data gathering activities contained numerous accounts of service development activities initiated by participants over the course of the pilot. These accounts included examples of specific service initiatives and/or improvements in the culture of the work setting. These accounts were confirmed and augmented in participants’ self-reported clinical leadership behaviours that related specifically to their service-related activities, such as clinical excellence and quality and safety.
8.4 The approach to clinical leader development

An understanding of the factors that contribute to enhancing nursing leadership is important in assisting organizations to develop leadership development strategies that will enable them to grow the next generation of nursing leaders (Cummings et al. 2008). From an Irish perspective, this understanding is increased with evidence from previous studies into clinical leadership among nurses and midwives in Ireland, which indicate that the factors influencing clinical leadership capacity reside at individual, organisational and wider disciplinary levels (Casey et al. 2011, Fealy et al. 2011, McNamara et al. 2011). Evidence from this evaluation study also adds further to our understanding of the factors at work in a planned project of clinical leadership development. The factors that enhance clinical leadership development have been shown to include the range and quality of human and material supports, the quality of interventions like mentoring, coaching and action learning and the level of organisational support for individuals who are participating on the Clinical Leader Development Pathway. Factors that restrict clinical leadership development include work-related constraints, such as levels of support and competing demands on professionals’ time.

Ham (2003) argues that strategies that appeal to clinicians’ motivation to helping others through providing a high standard of service are more likely to result in their commitment to development and change, and the use of professional development programmes is more likely to attract commitment than tight controls that seek to direct clinicians to change what they do. On that basis, the introduction of the Clinical Leader Development Pathway is a positive development in encouraging clinicians’ commitment to change through professional development.

Ham (2003) further argues that any changes secured may be fragile if they fail to engage clinical teams and to grow the capacity for change and innovation from within. While Ham does not specify which clinical teams should be engaged, the value of engaging all disciplinary teams is self-evident, given the close interdisciplinary working and the high degree of interdisciplinary interdependence that characterise work in modern health care organisations. This implies that clinical leadership development ought to be developed on a multidisciplinary, as opposed to a uni-disciplinary basis.
Clinical leadership is context specific and not a generic concept (Jackson & Watson 2006) and therefore its development requires attention to the situation and circumstances of the individuals that are engaged in leadership development. The fact that the Clinical Leader Development Pathway involves interventions that focus on participants’ development within their own practice setting is therefore a key strength of the Clinical Leader Development Pathway. Mentoring, coaching and action learning are particularly suitable interventions in this connection, as evidence from this evaluation study has demonstrated.

The ability of leaders to ‘learn rapidly in real time’ is critical to the success of organisations and an effective leadership development initiative is one that meets criteria related to skill development and real-world practice (Leonard & Lang 2010). The Clinical Leader Development Pathway contains interventions that have been shown to be effective against these two effectiveness criteria. Leadership learning in whatever intervention is used must be transferable to real-world contexts and this is achieved through interventions that have the real world as their focus (Hicks & Paterson 1999). The strength of the Clinical Leader Development Pathway is its focus on such intervention types.

In the field of educational psychology, it is accepted that all learners learn at their own pace and that learning is influenced by the learning style of the learner. This means that learning and development initiatives that are tailored to an individual’s particular learning style and developmental needs are more likely to be effective in meeting those needs and this is especially true when those needs are self-identified. The Clinical Leader Development Pathway is consistent with these andragogical principles in the way that the Assessment and Development Tool and the Learning and Development Portfolio are incorporated into the process.

Following a review of leadership development interventions, Day (2001: 606) concluded that any intervention practice for leadership development could be either effective or ineffective and that ‘effective leadership development is less about which specific [leadership development] practices are endorsed than about consistent and intentional implementation.’ Accordingly, the requisite organizational discipline to introduce leadership development throughout the organization, rather than at specific levels or grades, is the key to success (Day 2001). In the pilot, the Clinical Leader Development Pathway has been introduced.
across all nursing and midwifery grades and the implementation of the various interventions has been largely consistent, with the Project Team and local site co-ordinators offering support and encouragement to all those involved in the pilot.

The HSE is well placed to grow its nursing and midwifery leaders in that it has a well developed and clearly articulated strategy for clinical leadership development, a distinct national clinical leadership development framework, a competency developmental pathway and a range of supports and action-oriented interventions that can be readily deployed. The Clinical Leader Development Pathway is designed on the assumption that clinical leadership can be demonstrated at all grades of nurses and midwives and the various supports and interventions for the Clinical Leader Development Pathway are designed on that basis. This fact represents one of the major strengths of the National Clinical Leadership Development Project. The Clinical Leader Development Pathway also supports the idea of lifelong learning, since an individual can access the Pathway at the appropriate level and at different points across a professional career trajectory.

Other strengths of the Clinical Leader Development Pathway include the fact that, unlike most short-term attendance taught programmes, the development Pathway takes place over a period of weeks and months and focuses on the development of individual self-identified competencies through targeted and bespoke interventions. Through the pilot, the Pathway has been tested in the real world of busy health care settings and among all grades of nurses and midwives and has been shown to be workable, focused on both individual and service/organisational development and capable of developing the participant’s competencies for which it is designed. The Clinical Leader Development Pathway is therefore evaluated as being fit for purpose.

**Key point**
The HSE is well placed to grow its nursing and midwifery leaders for the following reasons. It has a well developed and clearly articulated strategy for clinical leadership development, a distinct national clinical leadership development framework, a competency developmental pathway and a range of supports and practice-focused interventions that can be readily deployed in multiple settings.
8.5 Limitations

As an evaluation study, the focus of the design was on generating valid and reliable data with which to describe experiences, evaluate supports and measure short-term participant and service-level outcomes. Accordingly, the design did not permit the testing or modelling of causal relationships of the influence of Pathway interventions on either individual or service-level outcomes. To do so would have required the establishment of research hypotheses, the formal estimation of the required sample size using power analysis and the application of inferential statistics and possibly higher-level multivariate statistical procedures like structural equation modelling (Cummings et al. 2008).

The challenge experienced in the recruitment to focus groups meant that in a number of focus groups the numbers attending were not optimal, thereby reducing the opportunity for more extensive discussion and more data. However, this limitation was largely obviated by judicious and skilful moderation, including the use of a comprehensive topic guide.

While the telephone survey method proved useful in improving LPI responses at time 2 and at yielding a high response rate to the PEQ, its use has limitations in survey research, including the limited time available for completion of data collection and the fact that the participants hear but cannot read the questions.

While the differences in frequency of generic leadership practices across the time period of the pilot were examined statistically, the relatively short duration of the pilot and the relatively small sample sizes involved meant that any observed changes in behaviours must be treated with caution.

The examination of pilot participants’ clinical leadership development in the short-term relied, in part, on self-reports using the CLB-Q and the LPI-S. Self-reports are inherently limited in that they raise issues about the validity of causal conclusions. These issues include respondent cognitive bias, response distortions and issues of the psychometric properties of instrument scales, such as reliability and validity. The use of self-reports also meant that the construct of clinical leadership behaviour was measured indirectly rather than directly observed. The CLB-Q measured clinical leader behaviours in all seven core clinical
leadership competencies and did not particularise the measurement of the two competences being developed by individuals at the time of its administration.

The examination of the service factors in the implementation of the pilot and the impact of the pilot on service outcomes relied on the evidence provided by pilot participants, particularly participants in the Clinical Leader Development Pathway. The availability of complementary data from independent sources ‘on the ground’ might have strengthened the overall quality of evaluative data. For example, a focused survey of clinical managers and service directors might have added confirmatory evidence of the impact on service and might have also pointed to barriers and enablers to implementation of the Project.

No patient/service user data were collected to examine the service impact. Examining the impact of individual service innovations through patient data would better inform the evidence concerning impact.
8.6 References


Proctor-Thomson SB (2008) Constellations or stars?: What is being developed in leadership development? Lancaster University Management School, Centre for Excellence in Leadership (CEL).


Chapter 9

CONCLUSIONS AND RECOMMENDATIONS

9.1 Conclusions

This study evaluated the National Clinical Leadership Development Project pilot, which was conducted over a six-month period from June to December 2011 at seven pilot sites in the Cork city area. The pilot involved the implementation of the Clinical Leader Development Pathway among a group of thirty-six nurses and midwives from across all grades. The participants were provided with a range of interventions and supports, including material supports.

Evaluation data were collected using a range of methods and data were collected from a wide range of sources. The strategies for pilot participant recruitment resulted in a very high level of participant involvement in both the quantitative and qualitative data collection elements. This enhanced the validity and reliability of the findings of the study. Effective collaboration between the Research Team and the Project Team ensured that the needs of the stakeholders were addressed in the conduct of the pilot evaluation and contributed to the high level of participation in the data collection.

The Clinical Leader Development Pathway is targeted at professional nurses and midwives from across all clinical and managerial grades and is designed with reference to the roles that individuals occupy in their respective grades. The study findings indicate that the Clinical Leader Development Pathway interventions and supports that are provided are designed with reference to this broad spectrum of grade-specific clinical leadership development need.

Overall, participants on the pilot, including participants on the Pathway and all those providing supports and interventions, evaluated their experiences of the Project as very positive. This finding affirms the decisions and actions taken by the Project Team and Steering Committee in rolling out the Project and constitutes a positive finding at the level of process evaluation.
Participants had overall positive experiences of the various interventions for clinical leadership development, including workshops, action learning, mentoring and coaching. While the study did not measure particular participant outcomes against particular interventions, the value of the coaching intervention in the Clinical Leader Development Pathway was attested to in the evidence provided by coaches and coachees. Action learning was also very positively evaluated as a process for enabling individuals to share experiences and concerns, and through the action orientation of group discussions, to examine practical solutions to real-world and everyday practice problems. Mentoring was also positively experienced by mentors and mentees, as an intervention suitable for enabling individuals to clarify their clinical leadership development needs and to examine their leadership development needs in the context of their professional role.

Evaluation data indicated there was evidence of good organisational support for the participants and for the Project itself and there was also evidence of ongoing monitoring and refinement. However, pilot participants cited time and competing work and family commitments as constraints on their ability to engage in elements of the Clinical Leader Development Pathway, notably in completing the assessment and development tool when assessing their clinical leadership development needs.

Overall the materials supporting the Project were appropriate to the different grades participating in the Clinical Leader Development Pathway and they provided a wide variety of evidence-based resources and supports for participants and for those providing interventions on the Pathway. Documentary materials were of a very high quality, of a good standard of production, were user friendly and were fit for purpose. This points to the Project having a major strength at the level of material supports and means that the Clinical Leader Development Pathway can be readily applied across multiple sites and settings, and with other resources and supports in place, can proceed with little extra planning and preparation.

A focus of the evaluation was short-term outcomes at the level of both participants and the service. Participants overall rated themselves as frequently engaging in the behaviours associated with the seven core clinical leadership competencies and minor increases in some more generic leadership practices were also reported by participants. Evaluation data pointed to particular instances of nurses and midwives displaying evidence of clinical leadership
development through their behaviours and dispositions and/or through service or organisational initiatives.

The findings demonstrate that the focus on organisational development, particularly at the level of the individual clinical unit, was an important element of clinical leadership development in the Clinical Leader Development Pathway. Accounts of service development activities initiated by participants over the course of the pilot were provided and these accounts included examples of specific service initiatives and/or improvements in the culture of the work setting. These participant and service-level outcomes were linked to participation on the Clinical Leader Development Pathway and suggest that the Clinical Leader Development Pathway is a viable method of developing clinical leadership competencies in nurses and midwives of all grades.

The Clinical Leader Development Pathway reflects efforts to develop both leader and leadership competencies, as evidenced in the combination of intrapersonal and relational skills and capabilities implicit in the core clinical leadership competencies. The Clinical Leader Development Pathway is focused on developing individual leader competencies and developing the service and/or organisation through the expression of these competencies in context, i.e. in the everyday performance of the individual’s professional role. The Clinical Leader Development Pathway is consistent with the principles that leader development and organisational development go hand in hand and that leadership and organisational change go hand in hand. The introduction of the Clinical Leader Development Pathway is a positive development in encouraging clinicians’ commitment to change through professional development.

This evaluation study contributes evidence of the enabling and constraining factors at work in a planned programme of clinical leadership development. Enabling factors include the range and quality of human and material supports, the quality of interventions like coaching, mentoring, action learning and workshops and the level of organisational support for individuals who are participating on the clinical leadership development Clinical Leader Development Pathway. Factors that constrain a clinical leadership development programme include work-related constraints, such as competing demands on professionals’ time, which can, in turn, impact on the support experienced for particular development activities.
The model of clinical leadership development inherent within the Clinical Leader Development Pathway has a number of major strengths. A key strength of the Clinical Leader Development Pathway is its application across all four nursing and midwifery grades, which is consistent with the idea that clinical leaders are to be found among all staff levels. Another major strength of the Clinical Leader Development Pathway is its use of andragogical approaches and interventions that are based on meeting the needs of individuals that are, in much part, self-identified. Unlike most short attendance taught programmes, the development Pathway takes place over a period of weeks and months and focuses on the development of individual self-identified competencies through targeted and bespoke interventions. The Clinical Leader Development Pathway contains interventions, such as mentoring, coaching and action learning, which focus on participants’ development within their own practice setting.

The HSE is well placed to grow its nursing and midwifery leaders for the following reasons. It has a well developed and clearly articulated strategy for clinical leadership development, a distinct national clinical leadership development framework, a competency developmental pathway and a range of supports and action-oriented interventions that can be readily deployed in multiple settings. The Clinical Leader Development Pathway is designed on the assumption that clinical leadership can be demonstrated at all grades of nurses and midwives and the various supports and interventions for Clinical Leader Development Pathway are designed on that basis. This fact represents a major strength of the National Clinical Leadership Development Project.

The Clinical Leader Development Pathway also supports the idea of lifelong learning, since an individual can access the Pathway at the appropriate level and at different points across the individual’s professional career trajectory. This is strength of the National Clinical Leadership Development Project.

When the individual outcomes in relation to clinical leadership development and the service developments are considered, it is clear that a considerable amount has been achieved in the relatively short timeline of the pilot.
Through the pilot, the Pathway has been tested in the real world of busy health care settings and among all grades of nurses and midwives and has been shown to be workable, focused on both individual and service/organisational development and capable of developing the participant’s competencies for which it is designed. The Clinical Leader Development Pathway is therefore evaluated as being fit for purpose.
9.2 Recommendations

Recommendations on policy and strategy

- At the time of completing the evaluation study, clinical leadership development was an ongoing and open-ended process for the pilot participants, inasmuch as they were continuing to take interventions and had only focused on two clinical leadership competencies. The need to facilitate individuals in the pilot to complete their self-identified clinical leadership development needs should be considered.

- Accreditation of the National Clinical Leadership Development Framework should be considered at two levels. For example, academic accreditation at the level of a professional certificate could be considered. Establishing professional accreditation of the Framework should also be considered.

- The Nurses and Midwives Act 2011 requires nurses and midwives to maintain their professional competence on an ongoing basis and the Act provides An Bord Altranais with the authority to establish one or more schemes to monitor the competence of all nurses and midwives. In line with these provisions in the new legislation, consideration should be given to the possibility of the Framework being utilised in the development and recognition of continued competency schemes by the statutory regulator.

- Given the close interdisciplinary working and the high degree of interdisciplinary interdependence that characterise work in modern health care organisations, the possibility of engaging other disciplines in clinical leadership development alongside nurses and midwives should be considered. The National Clinical Leadership Development Framework and Clinical Leader Development Pathway should be considered as the suitable model for such multidisciplinary clinical leadership development.

- Since the evidence indicates that the National Clinical Leadership Development Framework and Clinical Leader Development Pathway can be applied across multiple
sites and settings and among all staff grades, consideration should be given to the further roll out of the Project either at targeted regional sites or on a national basis.

**Recommendations on structures, supports and interventions**

- The Clinical Leader Development Pathway algorithm needs to be revised and should appropriately describe the timeframe involved in clinical leadership competency development as experienced on the pilot.

- Based on a frequency rating scale, the scoring mechanism in the *Assessment and Development Tool* caused some confusion for participants and their line managers, and no scores were entered into the 1 (‘never’) category. The scoring mechanism could be reviewed in order to ensure that it is sufficiently discriminatory and easy to use.

- Since a common observation made by many who contributed data was that self-awareness underpinned all other competencies, consideration should be given as to whether self-awareness should be the starting point in the Clinical Leader Development Pathway for all participants.

- Since a major strength of the Framework were the material supports that supported the participants on the Pathway, consideration should be given to preparing these supports in electronic and online formats for ease of use and cost containment.

- Periodic checks of cited URL links in the documents should be undertaken to ensure that the links to cited resources can be established.

- The behavioural indicators used to describe the clinical leadership competencies should be reviewed. Ambiguity regarding the language and interpretation of behavioural indicators could be reduced if more concise and direct statements of behaviours were used. Additionally, learning outcomes for the workshop interventions should be reviewed to ensure that they are stated in terms that are clear and observable.
Consideration should be given to the development of a structure and process to validate the individual participant’s *Learning and Development Portfolio*. Linked to this is the need for a structure for ongoing monitoring and feedback for participants, in order to ensure that they receive objective feedback in relation to their progress and that their progress is not wholly reliant on self-monitoring. However, participants should be encouraged to self-monitor and to see the process of self-monitoring as representing leader behaviour.

The use of interventions that are action oriented and focused on service development, such as mentoring, coaching and action learning should be supported. In using these interventions, the focus should be on each participant’s current role and everyday practice and on helping the participant to develop and demonstrate clinical leadership skills in these contexts.

**Recommendations on procedures**

- In the roll out of the National Clinical Leadership Development Project at sites in the future, close attention should be paid to the initial information provision and dissemination of the Project in the service area. All those involved directly or indirectly on the Clinical Leader Development Pathway, including line managers and work colleagues, should be clear as to its purpose and their respective roles in it. This should ensure better buy in and support for roll out at the levels of the local clinical department and the wider organisation. Participants on the Pathway should be provided with information to ensure that expectations for clinical leadership development are realistic.

- As the line manager is central to facilitating the participant’s progress on the Pathway, the role of the line manager needs to be more clearly set out and the line manager needs more deliberate and better preparation for the role. Ongoing monitoring of the Pathway should include a focus on the line manager’s role in the process.

- In the assessment and development process, particular emphasis should be paid to the aspect of assessment of service need, so that the development of the individual’s
leadership skills is with reference to the particular practice role that they occupy and the services in which they operate.

- In selecting appropriate interventions for the development of individual competencies, participants on the Pathway need clear guidance as to the precise function of each intervention and should receive guidance on the selection of the most appropriate intervention.

- Since the development of competence in clinical leadership is a lifelong journey and learning associated with clinical leadership is developmental, there is a need to recognise that the ‘sign off’ of development in a chosen competence does not necessarily imply that further development in that competence is not possible. This fact should be communicated through the Project.

- The mentorship intervention should be considered with reference to the way that it is conducted in practice. For example, the establishment of a mentoring contract and tri-party meetings between the participant on the Pathway, the mentor and the line manager should be considered, similar to the model in place for coaching.

- An exit interview or survey should be conducted with participants on the Pathway who withdraw and the patterns and reasons for withdrawal should be monitored.

**Recommendations for future research**

- Further testing and development of the CLB-Q instrument with a larger sample is warranted and with further refinement the instrument should be considered as a means of conducting the standardised degree-of-change questionnaire or a 360-assessment instrument.

- The effectiveness of individual interventions should be established statistically within an Irish setting, using research approaches that involve hypothesis testing for causal relationships and the application of higher-level multivariate statistical procedures like structural equation modelling.
The interventions that have been used in the National Clinical Leadership Development Framework, such as mentoring, coaching and action learning, have been shown elsewhere to be effective in skills development and in relating development to real-world practice. As they were very positively evaluated in the present study, these interventions should be further developed for nursing and midwifery clinical leadership development and their effectiveness evaluated again at a later point.

A unique element of the Framework is the development of the clinical leader’s competencies to enable the development of the clinical leader’s services/practices area. The impact of the outcomes of leaders and services development on the leaders themselves, on the service outcomes and on patient experiences warrant investigations to give tangible credibility to clinical leadership development in the Irish context.

Developing and building relationships are fundamental as the clinical leader travels through the pathway. Influencing and enabling those relationships are skills the clinical leader must acquire to progress. This aspect of clinical leadership development has rarely been captured and an examination of ‘leadership development’ focusing on relationship development in the clinical area would add considerably to building our services and practices.
Appendix 1

NATIONAL CLINICAL LEADERSHIP DEVELOPMENT PROJECT PILOT EVALUATION

Focus group Discussion: Pathway participant, line managers, etc.

TOPIC GUIDE

Introduction
Welcome to you all. Thank you for agreeing to take part in this focus group discussion. We are part of a team of researchers from the UCD School of Nursing, Midwifery & Health Systems and we are conducting this study on behalf of the Office of the Nursing and Midwifery Services Director (ONMSD), HSE. This is one of a total of 11 focus groups that will be taking place. These focus groups are one element of the mixed methods research approach that the UCD researchers are taking to the evaluation of the National Clinical Leadership Development Project Pilot.

The main purpose of the focus groups is to gather information from the participants in the Project pilot about their experiences of undertaking the Process. The information or data gathered in the focus groups will be analyzed and the analysis will form part of the report of the evaluation of the National Clinical Leadership Development Project pilot. The final report will be used to help develop the National Clinical Leadership Development Project and will, consequently, shape clinical leadership training for nurses and midwives in Ireland.

At the start, I would like to clarify with you what we will discuss in the focus group.

We are interested in documenting your experiences of undertaking the National Clinical Leadership Development Framework Project pilot. We will begin with a focus on your experiences of getting on the Pathway; we will then focus on your experiences of using the assessment and development plan; we are interested in your experiences with your line managers or facilitators; we are interested in your thoughts about and experiences of the interventions that you used in the Clinical Leader Development Pathway; we are interested in any innovations or changes in your practice as a result of you undertaking the Pathway, we want to discuss with you your thoughts and ideas about the supports provided to you in the work of undertaking the Pathway and, finally, we would like you to discuss any thoughts, ideas or experiences you have in relation to outcomes of the Clinical Leader Development Pathway.

Ground rules
All of you have been asked to sign a consent form –thank you. In accordance with standard practice we will record the focus group, so that we capture all of the ideas and views of the group members. A written transcript of the recording will be prepared and this will be analyzed along with the transcripts from the other focus groups and will be used in preparing the final report. No individuals or health care organisations will be identified in reporting the findings from the focus groups. We would like all members of the focus group to contribute.

Content of discussion
Throughout our discussion, I will suggest some particular topic areas for discussion. These topic areas will be concerned either directly or indirectly with your experience of
undertaking the Clinical Leader Development Pathway. For this discussion, I would like you to discuss seven particular areas:

1. Discuss your experiences of getting on the Clinical Leader Development Pathway;
2. Discuss your experiences of the Assessment and Development plan;
3. Discuss your experiences with your line manger or facilitator;
4. Discuss your thoughts about and experiences of the interventions;
5. Discuss any innovations or changes in your work practice that demonstrate new leadership skills;
6. Discuss your thoughts and ideas about the supports provided.
7. Discuss any thoughts, ideas or experiences you have in relation to outcomes of the Process.

Begin by asking each member to state their first name and the clinical department in which they work.

**Part 1: Your experiences of getting on the Pathway**

I would like us to begin by discussing your own particular experiences in relation to actually getting on the Pathway.

**Questions**
Can you talk about when you first heard of the Clinical Leader Development Pathway?
Talk about how you got on the Pathway?
Talk about how you decided to go on the Pathway?

**Part 2: Clinical Leadership Skills**

Now I would like us to discuss your sense of your own clinical leadership skills before you embarked on the Clinical Leader Development Pathway and your sense of your developing leadership skills as you undertake the Clinical Leader Development Pathway.

**Questions**
Did you think about your own clinical leadership skills before you were introduced to the Pathway or before you heard about the Pathway?
What would you say about your sense of your own clinical leadership skills before you came on the Pathway?
What would you say about your sense of your own developing leadership skills now that you are on the Pathway?

**Part 3.1: The Assessment and Development Tool**

In this third area, I would like you to discuss your experiences of the Assessment and Development Tool.

**Questions**
When you completed the tool for the leadership competence:

How useful was the tool, in assisting you to determine your current leadership skills and your particular leadership needs?
Can you talk about the actual tool itself? (For example: how well is it laid out?; how clear is the language?; was the scoring system clear?)
Can you talk about your line manager and the role they took as your facilitator in the Process?
Can you talk about the extent to which your line manager facilitated you in the Process? Was it, for example, easy to get agreement with your line manager on the score and on what needed to be done, in terms of interventions?
Think about the experience of sitting down with your line manager and discussing the documentation with them. Talk about this experience?
In relation to the competence that we are focus on here, do you think is it apt? Is it appropriate? As you engaged with it, did you think that there was anything missing from it?
Discuss the language in the competence (name the competence): how does the language used in the competence seem to you?
Discuss your experience of the Assessment and Development Plan, with particular reference to your experience of working on this competence, (name of competence).
Can you talk about the overall model of self assessment used in the project?
Do you think it is an effective model of self assessment? Why do you think this?

Part 3.2: Maintaining the Learning and Development Portfolio
Aside from using the Learning and Development Portfolio to conduct your individual assessment, service assessment and using it to plan interventions to help you develop this competence (name the competence); you will each have maintained your Learning and Portfolio. For example, you will have written in the reflection part and in the record sheets of interventions, your record of coaching and mentoring and your action learning review sheet.

Questions
Did you maintain the portfolio? Were there any issues generally with that?
Can you talk about your experiences of maintaining the portfolio?
Were the sections that needed to be filled in clear?
Can you discuss whether writing in the portfolio helped you in your professional development towards attaining this competence (name the competence)? Can you discuss how it did this and the extent to which it did this?

Part 4: Interventions
Now, I would like you to talk about the interventions that you used in working towards developing this competence (name the competence), your thoughts and ideas in relation to these interventions, as well as your experiences of them.

To begin with, can you each say which intervention or interventions you used for this competence (name the competence)?

Questions
Can you discuss the extent to which the intervention(s) helped develop your leadership skills overall?
How effective are the interventions? Why do you think that?
Can you discuss the service commitment and time commitment involved in participating in the Process?
How well did the interventions assist you in developing this competence (name the competence)?
Part 5: Innovations and changes in your practice
As part of the Learning and Development Portfolio, you were required to complete and maintain the Service Assessment Tool element. I would like us to discuss the various priority areas for service development that you agreed with your line manager, and how these were implemented in practice.

Questions
Can you discuss the priority areas for service development and your role in these, your role in identifying these and your role in working to bring about change and development in relation to these?
Did the intervention(s) you undertook, (e.g. mentoring, action learning set) help you to determine a priority area?
In what way(s) did the intervention(s) help?
Can you name any changes/innovations in service that you undertook as a result of your participation on the Pathway or specifically as a result of the interventions that you undertook to develop this competence (name the competence)?
Can you say what impact, if any, the changes/innovations in service had on service?
How do you know (i.e. what evidence do you have) that these changes/innovations in service had an effect on service?
Did anyone notice or comment on any of the changes/innovations? If yes, what kind of comments did they make?

Part 6: Supports
We are now coming to the final part of our discussion.

To begin with, in this section, I would like us to discuss the different supports that were in place on the Clinical Leader Development Pathway. I appreciate that we have already discussed some of the key supports in other contexts; along with other supports, we’ll explore these again in a little more detail here.

Questions
To begin with, you each used the Clinical Leader Resource Pack. Can you talk about your experiences of using the Pack, with particular reference to this competence (name the competence)?
Can you talk about your experiences of workshops and action learning sets?
Can you discuss your experiences of supports from your line manager (e.g. in assisting you to choose the particular interventions you did choose)?
Talk about the supports that you received at the level of your own team (e.g. ward team) as you worked through the Clinical Leader Development Pathway. Are your colleagues aware, for example that you are on the Clinical Leader Development Pathway? Do they provide you with any support in relation to your engagement with the Process?
Can you discuss the organisational supports that are available to you on the Process and your experiences of them (e.g. your DoN or DoM, the NCLDP site coordinator and any other supports that you are aware of)?
What about your experiences of support(s) beyond the organisation (e.g. at the level of the HSE Project Team). Are there any other supports that you would like to highlight?

Part 7: Outcomes
Finally, we would like you to briefly discuss any outcomes you have achieved or witnessed while on the pathway.
Questions
It would be helpful if you would discuss whether you think you are now competent in relation to this competence (name the competence).
Why do you say that?

Part 8 Accreditation
A final point now in relation to accreditation, should the HSE, do you think, consider accreditation of the Clinical Leader Development Pathway (i.e. academic accreditation with somebody like a university or HETAC)?

If yes, at what level do you think it should be accredited, Level 8: Higher Diploma, Level 9, Graduate Diploma?
Some smaller courses are accredited at Professional Certificate or Graduate Certificate level. Would this be appropriate for the Clinical Leader Development Pathway?

Close
Now, before we close, is there anything else that you would like to talk about and/or discuss and/or explain in relation to your experiences of the project?

Close by thanking all participants

-oOo-
Appendix 2

Topic Guide

NATIONAL CLINICAL LEADERSHIP DEVELOPMENT PROJECT PILOT EVALUATION

Group Interview and individual interview: Project Steering Committee

TOPIC GUIDE

Introduction
Welcome and thank you for agreeing to take part in this telephone focus group interview. We are part of the team of researchers from the UCD School of Nursing, Midwifery & Health Systems commissioned the Office of the Nursing and Midwifery Services Director (ONMSD), HSE, to conduct an evaluation study of the National Clinical Leadership Development Project Pilot. This interview is one element of the information gathering for the evaluation study.

The main purpose of the focus group interview is to gather information from you as the members of the NCLDP Pilot Steering Committee on your experiences of the Project Pilot. The information gathered in the interview will be analyzed and the analysis will form part of the report of the evaluation of the National Clinical Leadership Development Project pilot. The final report will be used to inform the development of the National Clinical Leadership Development Project and will inform national policy on clinical leadership development for nurses and midwives in Ireland.

At the start, I would like to clarify with you what we will discuss in the interview. We are interested in documenting your experiences of participating as strategic overseers of the National Clinical Leadership Development Project Pilot. We are particularly interested in your experiences of how the Project Pilot was conducted in the previous six months from your perspective, how you each contributed to the Project Pilot and how you experienced support in your role in the Project Pilot. We are also interested in hearing your views about the elements of the Clinical Leader Development Pathway, as you experienced them in the past six months.

Ground rules
You have been asked to sign a consent form, thank you. In accordance with standard practice we will record the focus group interview, so that we capture all of the ideas and views expressed. A written transcript of the recording will be prepared and this will be analyzed along with the transcripts from the other focus groups that we have conducted and will be used in preparing the final report.

No individuals or health care organisations will be identified in reporting the findings from this interview.

Content of discussion
Throughout our discussion, we will suggest some particular topic areas for discussion. These topic areas will be concerned either directly or indirectly with your experience of managing the Project Pilot as a member of the Steering Committee. For this discussion, we would like you to discuss four particular areas:
1: Your role in the Project Pilot
Can you say something about your role as members of the Steering Committee? For example, talk about how you came to be a member of the Committee, such as how your own particular background brought you to the Committee.

Can you talk about when you first heard of the Project Pilot?

Can you talk about your understanding of the Project Pilot?

Can you say what your precise role on the Steering Committee was? For example, did you have a particular function within the Committee?

2: Preparation for your role on the Steering Committee
I would like you each to discuss your level of preparation for your role as a member of the Steering Committee. Did you receive prior preparation in advance of the first meeting of the Steering Committee? For example, did you receive briefing documents, terms of reference for the Committee?

As members of the Steering Committee, how well prepared for your role did your feel? Did you understand the Clinical Leader Development Pathway at the start? Did you know about the various elements of the Clinical Leader Development Pathway, such as the Assessment & Development Tool, the CLRP and the various interventions? At the end of the Pilot period, do you feel you understand the Clinical Leader Development Pathway any better?

3. Acting in your role on the Project Pilot
I would like you to discuss your role as a member of the Steering Committee. What was your precise role?

Did you have any interactions with the pilot sites? What was the nature of those interactions?

How did you monitor progress over the Project Pilot period? For example, did you receive reports from the Project Team? Did you have any direct contact with Project Pilot participants, such as mentors, coaches, workshop facilitators? Were you able to monitor progress?

4. Experiencing support for your role
We would like you to talk about how you experienced support in your role as a member of the Steering Committee.

Can you say how you experienced support from your own team? For example, did other colleagues know of your role in the Project Pilot?

Can you say how you experienced support from your line manager?

Can you say how you experienced support from your own organisation?
5. Other aspects of the experience
We have come to the end of our discussion. Before we close I would like to ask two questions:

Having gone through the Project Pilot, would you in your role do anything different with the benefit of hindsight?

Are there any aspects of your experiences as members of the Project Pilot that you would like to comment on?

Thank you.

Close by thanking the participants

-oOo-
Appendix 3
Participant Experiences Questionnaire (PEQ)

Dear Colleague,

We invite you to complete this short participant experiences questionnaire. The questionnaire provides you with the opportunity to evaluate your experiences of participating in the National Clinical Leadership Development Project (NCLDP) Pilot. The questionnaire is being administered as part of the data collection for the evaluation of the NCLDP Pilot.

This is an anonymous questionnaire and therefore you should not include your name on the questionnaire. The information that you provide in this questionnaire is confidential and no individual’s name will be used in the study report.

Please take your time and ensure that you complete all questions. The questionnaire will take approximately 10 or fewer minutes to complete. Thank you for taking the time to complete the questionnaire.

Gerard Fealy RGN, PhD
Principal Investigator
gerald.fealy@ucd.ie
Telephone (01)7166461
**Private and confidential: Please do not include your name on this questionnaire**

Please place a tick ‘√’ in the space provided

**DEMOGRAPHIC INFORMATION** Please answer all questions

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HOW TO COMPLETE THIS QUESTIONNAIRE

You are only required to complete the section or sections of the questionnaire that apply to you. Below is a guide to the section(s) of the questionnaire that you should complete. If you had more than one role on the Project Pilot, complete all those sections that apply to you.

My role in the Pilot  You should complete...

Project Pilot participant  Complete Section A only and add additional comments in the last page if you wish

Line manager  Complete Section B only and add additional comments in the last page if you wish

Mentor or coach or action learning facilitator  Complete Section C only and add additional comments in the last page if you wish

Workshop facilitator or Site coordinator or member of the HSE Project Team  Complete Section D only and add additional comments in the last page if you wish

Withdrawn Project Pilot participant  Complete Section E only and add additional comments in the last page if you wish

Instructions for completing each question

The statements that follow describe aspects of the experience of participating in the National Clinical Leadership Development Project (NCLDP) Pilot.

- Please select the section or sections that apply to you
- Please read each statement and indicate the extent to which you agree with each statement using the scale, as follows: 1 = Strongly disagree; 2 = Disagree; 3 = Uncertain; 4 = Agree; 5 = Strongly agree
- Please be honest and accurate as you can be, i.e. try to remember how you actually experienced the NCLDP Pilot in your particular role(s)
- Rate what comes to mind
- After you have completed the questionnaire, go back through the questionnaire one more time to make sure you have responded to each statement. (Every statement in your section(s) must have a rating).

NB. Please take your time and be as accurate as possible when rating your experiences of actually participating in the NCLDP Pilot.
SECTION A (To be completed by Project Pilot participants only)

Please read each statement below and indicate the extent to which you agree with each statement using the scale, as follows: 1 = Strongly disagree; 2 = Disagree; 3 = Uncertain; 4 = Agree; 5 = Strongly agree

<table>
<thead>
<tr>
<th></th>
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<th>tick ONE number only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

### Getting on the Pathway

1. When I first learned that I was selected to participate in the Clinical Leader Development Pathway, I experienced anxiety   ○ ○ ○ ○ ○

2. The decision regarding my participation in the Clinical Leader Development Pathway was made for me by a senior colleague (e.g. ADoN/ADoM)   ○ ○ ○ ○ ○

3. I entered the Clinical Leader Development Pathway with a good understanding of what I was expected to do as a participant   ○ ○ ○ ○ ○

### Using the Assessment and Development Tool

4. In general, the process of deciding my development priorities with my line manager was easy to understand   ○ ○ ○ ○ ○

5. The process of deciding how my development priorities would be linked to my service/organisation was easy to follow   ○ ○ ○ ○ ○

6. In general, I was able to accurately rate my own assessment and development needs against the behavioural indicators   ○ ○ ○ ○ ○

7. In general, when discussing ratings with my line manager, we found it easy to agree a score   ○ ○ ○ ○ ○

8. In general, the agreed scores for each competence were an accurate reflection of my development needs   ○ ○ ○ ○ ○

9. In general, it was easy to identify sources of evidence to demonstrate my development needs   ○ ○ ○ ○ ○

10. I had sufficient time to meet with my line manager to discuss my development needs using the Assessment & Development Tool   ○ ○ ○ ○ ○

11. The Personal Development Plan (i.e. areas for development, actions, supports, etc.) was easy to complete   ○ ○ ○ ○ ○

12. The Service Assessment Tool (i.e. areas for development, actions, etc.) was easy to complete   ○ ○ ○ ○ ○

13. The Learning & Development Portfolio enabled me to accurately document my journey on the Clinical Leader Development Pathway   ○ ○ ○ ○ ○

14. In general, the major parts of Learning & Development Portfolio (e.g. Reflection, Review sheets) were easy to use   ○ ○ ○ ○ ○
**SECTION A (continued...)**

Please read each statement below and indicate the extent to which you agree with each statement using the scale, as follows: 1 = Strongly disagree; 2 = Disagree; 3 = Uncertain; 4 = Agree; 5 = Strongly agree

<table>
<thead>
<tr>
<th>Interventions to support my development</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>The interventions agreed (e.g. mentor, workshop) with my line manager were tailored to meet my development needs</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>The Clinical Leadership Resource Pack was an effective intervention to enable me to develop competencies</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>The Clinical Leadership Resource Pack contained information that accurately reflected my everyday experiences</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td><strong>Items 18 to 29 relate to interventions that were provided during the Pilot. Complete only those items that apply to you</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The action learning intervention was well structured to facilitate my active participation</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>I was supported by the action learning set facilitator in attaining the competencies for which the intervention was designed</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>In general, action learning sets were effective in enabling me to attain the competencies</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>I was able to meet with my mentor when I needed to</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>I was supported by my mentor in attaining the competencies</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>In general, the mentoring intervention was effective in enabling me to attain the competencies</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>I was able to meet with my coach when I needed to</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>I was supported by my coach in attaining the competencies</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>In general, the coaching intervention was effective in enabling me to attain the competencies</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>The workshop intervention was well structured to facilitate my active participation</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>I was supported by the workshop facilitator in attaining the competencies for which the intervention was designed</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>In general, the workshop intervention was effective in enabling me to attain the competencies</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
</tbody>
</table>
SECTION A (continued...)

Please read each statement below and indicate the extent to which you agree with each statement using the scale, as follows: 1 = Strongly disagree; 2 = Disagree; 3 = Uncertain; 4 = Agree; 5 = Strongly agree

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>30  While participating on the Clinical Leader Development Pathway, I was supported by my work colleagues</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>31  While participating on the Clinical Leader Development Pathway, I was supported by my line manager</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>32  While participating on the Clinical Leader Development Pathway, I was supported by my departmental team</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>33  While participating on the Clinical Leader Development Pathway, I was supported by my organisation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>34  While participating on the Clinical Leader Development Pathway, I was supported by my NCLDP Pilot Site Coordinator</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>35  While participating on the Clinical Leader Development Pathway, I was supported by the NCLDP Project Team members in the HSE</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>36  I have attained at least one clinical leadership competence as a result of my participation in the Clinical Leader Development Pathway</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>37  My participation in the Clinical Leader Development Pathway has had a positive impact on my service/organisation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>38  I have introduced a change/innovation in my organisation as a result of my participation in the Clinical Leader Development Pathway</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
</tbody>
</table>

If you wish to add any additional comments, go to the last page of the questionnaire
### SECTION B (To be completed by the Project Pilot participant’s line manager only)

Please read each statement below and indicate the extent to which you agree with each statement using the scale, as follows: 1 = Strongly disagree; 2 = Disagree; 3 = Uncertain; 4 = Agree; 5 = Strongly agree

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating in the Project pilot</td>
<td></td>
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<tr>
<td>When I first learned that I was selected to participate in the</td>
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</tr>
<tr>
<td>Project pilot, I experienced anxiety</td>
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<tr>
<td>The decision regarding my participation in the Project pilot was</td>
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<tr>
<td>made for me by a senior colleague (e.g. ADoN/ADoM)</td>
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<tr>
<td>I entered the Project pilot with a good understanding of what I</td>
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<tr>
<td>was expected to do as a line manager</td>
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<tr>
<td>Determining the participant’s assessment and development needs</td>
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<tr>
<td>In general, the process of deciding priorities for the participant’s</td>
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<tr>
<td>development was easy to understand</td>
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<tr>
<td>The process of deciding how priorities for the participant’s development</td>
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<tr>
<td>would be linked to the service/organisation was easy to understand</td>
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<tr>
<td>In general, I was able to accurately rate the participant’s assessment</td>
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<tr>
<td>and development needs against the behavioural indicators</td>
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<tr>
<td>In general, when discussing ratings with the participant, we found</td>
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<tr>
<td>it easy to agree a score</td>
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<tr>
<td>In general, the agreed overall score for each competence was an</td>
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<tr>
<td>accurate reflection of the participant’s development needs</td>
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<tr>
<td>In general, it was easy to identify sources of evidence to demonstrate</td>
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<tr>
<td>the participant’s development needs</td>
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<tr>
<td>I had sufficient time to meet with the participant to discuss her/his</td>
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<tr>
<td>development needs using her/his Assessment &amp; Development Tool</td>
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<tr>
<td>Interventions and supports</td>
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<tr>
<td>The interventions (e.g. mentor, workshop), which I agreed with the</td>
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<tr>
<td>participant were tailored to meet the participant’s needs</td>
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<tr>
<td>The interventions (e.g. mentor, workshop), which I agreed with the</td>
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<tr>
<td>participant were tailored to meet the needs of service</td>
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<tr>
<td>It was easy to decide on the most appropriate intervention(s) to meet</td>
<td></td>
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<tr>
<td>the participant’s needs</td>
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<tr>
<td>I provided continuous support to the participant while she/he was</td>
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<tr>
<td>participating on the Clinical Leader Development Pathway</td>
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<tr>
<td>Service impact</td>
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</tr>
<tr>
<td>The participant has introduced a change/innovation in the organisation</td>
<td></td>
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<tr>
<td>as a result of her/his participation in the Clinical Leader Development</td>
<td></td>
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</tr>
<tr>
<td>Pathway</td>
<td></td>
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</tr>
<tr>
<td>The participant’s participation in the Clinical Leader Development</td>
<td></td>
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</tr>
<tr>
<td>Pathway has resulted in a positive impact on the service/organisation</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
If you wish to add any additional comments, go to the last page of the questionnaire
SECTION C (To be completed by **mentors, coaches and action learning facilitators only**)

Please read each statement below and indicate the extent to which you agree with each statement using the scale, as follows: 1 = Strongly disagree; 2 = Disagree; 3 = Uncertain; 4 = Agree; 5 = Strongly agree

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>When I first learned that I was selected to participate in the Project pilot, I experienced anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The decision regarding my participation in the Project pilot was made for me by a senior colleague (e.g. ADoN/ADoM)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I entered the Project pilot with a good understanding of what I was expected to do in my role</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Overall, the training, which I received for my role was effective in preparing me for my role in the Project pilot</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Overall, the training methods (e.g. workshops) were effective in enabling me to act in my role in the Project pilot</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall, the training materials (e.g. training/reference manual, facilitator toolkit) were effective in enabling me to act in my role in the Project pilot</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>While acting as a mentor/coach/action learning facilitator, I enabled the participant(s) to develop competencies</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>While acting as a mentor/coach/action learning facilitator, I tailored interventions to the participant’s individual competency development needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>While acting as a mentor/coach/action learning facilitator, I had sufficient time to meet with the participant(s)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The process of mentoring/coaching/action learning facilitation was conducted according to the agreed procedures</td>
<td></td>
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</tr>
<tr>
<td>Overall, the role of mentor/coach/action learning facilitator is an effective intervention for enabling nurses and midwives to develop clinical leadership competencies</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>While acting as a mentor/coach/action learning facilitator, I was supported by my own line manager</td>
<td></td>
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</tr>
<tr>
<td>While acting as a mentor/coach/action learning facilitator, I was supported by my organisation</td>
<td></td>
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</tr>
<tr>
<td>While acting as a mentor/coach/action learning facilitator, I was supported by the HSE Project Team</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

If you wish to add any additional comments, go to the last page of the questionnaire
### SECTION D (To be completed by workshop facilitators, site co-ordinators and HSE Project Team members only)

Please read each statement below and indicate the extent to which you agree with each statement using the scale, as follows: 1 = Strongly disagree; 2 = Disagree; 3 = Uncertain; 4 = Agree; 5 = Strongly agree

<table>
<thead>
<tr>
<th>My role in supporting the Project pilot</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 When I first learned that I was selected to work with the Project pilot, I experienced anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 At the start of the Project pilot, I understood what I was expected to do in my role</td>
<td></td>
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</tr>
<tr>
<td>Preparation for my role</td>
<td></td>
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</tr>
<tr>
<td>3 Overall, the preparation (e.g. documents, briefing meetings) which I received adequately prepared me for my role</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>4 The materials that were supplied (e.g. briefing documents) were effective in enabling me to act in my role</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>My experiences in supporting the Project pilot</td>
<td></td>
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</tr>
<tr>
<td>5 While acting in my role on the Project pilot, I was able to complete the tasks for which I was responsible</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>6 While acting in my role on the Project pilot, I was effective in ensuring that the project was conducted according to plan</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>7 While acting in my role on the Project pilot, I encountered unforeseen problems that adversely affected the implementation of the Project pilot</td>
<td></td>
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</tr>
<tr>
<td>8 While acting in my role on the Project pilot, I was able to effectively overcome unforeseen problems</td>
<td></td>
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</tr>
<tr>
<td>9 The demands of my role on the Project pilot competed with the other demands of my work</td>
<td></td>
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</tr>
<tr>
<td>Supports</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 While acting in my role in supporting the Project pilot, I was supported by my own line manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 While acting in my role in supporting the Project pilot, I was supported by my organisation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 The role that I played in the Project pilot was essential to the successful implementation of the project</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you wish to add any additional comments, go to the last page of the questionnaire
SECTION E (To be completed by withdrawn Project Pilot participants only)

Please indicate the main reason why you withdrew from the Project Pilot

Tick ONE box only

1. My personal circumstances prevented my participation (e.g. maternity leave, sick leave)

2. My work situation prevented my participation (e.g. work area too busy)

3. I did not receive sufficient support from my line manager to participate

4. I did not receive sufficient support from my organisation to participate

5. I was not prepared to spend time on the Project in my off duty time

6. I found it difficult to understand the concepts contained in the Project documents

7. I found it difficult to understand what I was required to do on the Clinical Leader Development Pathway

8. I did not need to develop any of the clinical leadership competencies

9. I withdrew for private personal reasons

10. Other: Please specify _____________________________________________________

Please read each statement below and indicate the extent to which you agree with each statement using the scale, as follows: 1 = Strongly disagree; 2 = Disagree; 3 = Uncertain; 4 = Agree; 5 = Strongly agree

If you wish to add any additional comments, go to the last page of the questionnaire
### Additional comments

In the box provided you may write down any additional comments

---

Thank you for taking the time to complete the questionnaire
Dear Colleague,

The UCD School of Nursing, Midwifery & Health Systems has been commissioned by the Office of the Nursing & Midwifery Services Director to conduct an evaluation of the six-month *National Clinical Leadership Development Framework* (NCLDF) Pilot. The evaluation study will examine a number of key elements of the Pilot, including:

- The experiences of participants undertaking the National Clinical Leadership Clinical Leader Development Pathway
- The resources to support the process
- Short-term outcomes of the Pilot

Study data will include participant self-reports of their experiences (through questionnaires, focus groups and interviews) and some measures of leadership behaviours, through the use of standardised measuring scales. The findings of the evaluation study will provide important information to inform the ongoing development of the National Clinical Leadership Development Framework.

**As a participant in the NCLDF Pilot, I invite you to take part in this evaluation study. Your participation will involve completing a number of online questionnaires, attendance at one focus group, and possibly a single short interview.**

In the coming days you will receive the first of these questionnaires, which you will be invited to complete online. (If you do not have the facility to complete the questionnaire online, you will be provided with hard copies by post). Later in the year, you will be invited to complete the same questionnaire again and some additional questionnaires.

I take this opportunity to thank you in anticipation of your contribution to this important national evaluation study and to wish you every success as you complete the Clinical Leader Development Pathway.

Yours sincerely,

Professor Gerard Fealy RGN, PhD  
(Evaluation Study Lead Investigator)
Appendix 5

Qualitative data collection:
Informed Consent Form and Information Sheet

NATIONAL CLINICAL LEADERSHIP
DEVELOPMENT PROJECT PILOT
EVALUATION

School of Nursing, Midwifery & Health Systems,
UCD
on behalf of
the Office of the Nursing and Midwifery Services
Director (ONMSD), HSE

Focus group

CONSENT FORM

This is to state that I have read the Information Sheet, I understand the purpose of the focus group, and I hereby consent to participate in the focus group being conducted by the UCD Research Team on behalf of the HSE.

Conditions of participation
My participation in the focus group is entirely voluntary. I am free to withdraw my consent and discontinue my participation at anytime, either before the agreed time of the focus group or during the focus group, without prejudice.

The information that I provide during the course of the interview will be stored securely in the manner indicated in the accompanying information sheet and will be used solely for the purpose stated in the information sheet.

Name (please print) _________________________________
Signature _________________________________
Date: ____/____/______
Focus groups
INFORMATION SHEET (Sample)

(Given to Pathway participants, as part of obtaining informed consent)

Please read this information sheet carefully. If you are willing to take part in a focus group, please sign the Consent Form attached. However, please do not sign the Consent Form until you have read and are satisfied that you understand all that is contained in the information sheet.

Introduction

The aim of this study is to conduct an evaluation of the National Clinical Leadership Development Project (NCLDP) Pilot. The purpose of the focus group is to ascertain the views of nurses and midwives participating in the pilot regarding their experiences of participation and their experiences in terms of clinical leadership development as a result of their participation.

Who is conducting the research?

A team of researchers from the UCD School of Nursing, Midwifery & Health Systems is conducting the research on behalf of the Nursing & Midwifery Planning & Development Unit, HSE.

Why is this research important?

Effective care requires effective clinical leadership, and clinical leadership skills, like most skills, require development and appropriate training. This is the rationale for the development of the National Clinical Leadership Development Project. In order to evaluate this development project a pilot of the project is, as you are aware, being carried out. These focus groups are a part of the evaluation the researchers from UCD are conducting of that Project pilot.

Why have I been chosen?

You have been chosen because you are currently participating in the National Clinical Leadership Development Project Pilot. You are therefore considered to be an important source of information in researching this topic.

What do I have to do?

You will be invited to take part in one or two focus group(s), in which you will be given an opportunity to discuss your opinions and ideas on aspects of the National Clinical Leadership Development Project Pilot with other participants in the Project pilot. The focus groups will each last up to one hour and will take place in a private room in or near to your place of work.

Who will conduct the focus group?

Two members of the UCD Research Team will conduct the focus group. One of the UCD Research Team members will be a registered nurse and/or midwife and s/he will be supported in the work by a Research Assistant.

What will happen during the focus group?

The researcher conducting the focus group will ask the group members to discuss aspects of the National Clinical Leadership Development Project Pilot, with particular reference to their experiences of undertaking the project. With the group members’ permission, a digital recorder will be used in order to ensure that the views of the focus group are accurately recorded, and the transcript of the focus group will be treated confidentially and used only for the purpose stated.
What are the possible risks in taking part in the focus group?
There are no foreseeable risks to you in taking part in the focus group discussion.

What are the benefits in taking part in the focus group?
Your participation will provide important information on nurses’ and midwives’ views of the National Clinical Leadership Development Project Pilot. The information will assist in the preparation of a detailed report that will reflect the views of all stakeholders. In the longer term, the information contained in the report will assist in planning programmes to meet nurses’ and midwives’ clinical leadership development needs.

What will happen after the focus group is completed?
The researcher team will prepare written transcripts of the recorded focus group discussion.

How will the focus group information be stored and used?
The information recorded during the course of the focus group will be stored securely in digital form in a password-protected computer and as a written transcript in a locked filing cabinet in a locked office in the School of Nursing, Midwifery & Health Systems at UCD.

How will the focus group information be used?
The focus group written transcript will be analysed along with the transcripts from other focus groups and will be used in preparing the final report. No individuals or health care organisations will be identified in reporting the findings from the focus groups. In due course, some information from the focus group interviews may be used in preparing articles for publication in professional journals.

For further information, please contact:
Professor Gerard Fealy
UCD School of Nursing, Midwifery & Health Systems
University College Dublin, Belfield, Dublin 4
Tel: 353 1 7166461, E-mail: gerard.fealy@ucd.ie
Appendix 6

Documentary Analysis Rating Instrument

NATIONAL CLINICAL LEADERSHIP DEVELOPMENT FRAMEWORK
PILOT EVALUATION STUDY

DOCUMENTARY ANALYSIS

Please complete the following questionnaire, which asks you to rate the quality and content of the various documents supporting the National Clinical Leadership Development Framework Pilot. Rate the various aspects of the documents in general.

You may wish to make additional notes to support your scores.
Please indicate the extent to which you agree with the following statements concerning the overall presentation of the all the various documents supporting the National Clinical Leadership Development Framework Pilot. Please rate the documents in general.

<table>
<thead>
<tr>
<th>The documents are presented in distinct, easy-to-follow sections</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The binding is of a good quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The paper appears to be of a good quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The graphic design is of a good quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagrams/figures are effective in illustrating constructs and concepts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tables are clearly set out</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a distinct, easily-recognisable branding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The text (e.g. font style, size and formatting) is easy to read</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The presentation of text (e.g. portrait v. landscape) is helpful</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The lists of additional resources (e.g. reference lists) are helpful</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In the space below, please provide additional comments on any aspect of the National Clinical Leadership Development Framework Pilot documents.
Please indicate the extent to which you agree with the following statements concerning the content of the **Learning and Development Portfolio (LDP)** document for **all four grades**. Please rate the document in general.

<table>
<thead>
<tr>
<th>Regarding the Learning &amp; Development Portfolio, <strong>in general...</strong></th>
<th>tick ONE circle only</th>
</tr>
</thead>
<tbody>
<tr>
<td>The five major sections (i.e. Sections 1 to 5) are set out in a logical order</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The ‘instructions for use’ (page 3) are clear and unambiguous to the user</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The rating scores for each competence are sufficiently discriminatory</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The guide for determining the most appropriate mechanism for developing each competence, based on each score, is clear</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The behavioural indicators for each of the seven competencies are stated in clear language</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The behavioural indicators for each competence are stated in a way that reflect the real world of everyday practice</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The behavioural indicators demonstrate a clear distinction between and among each of the seven competencies</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The behavioural indicators for each competence accurately reflect the name of the competence</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The name of the competence and its associated behavioural indicators are related</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The behavioural indicators for each grade demonstrate a distinction between leadership competencies across grades</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The section on reflection (Section 3) supports the participant to actually engage in reflection</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The record sheets for interventions (Section 4) enable good record keeping of activities undertaken</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The additional record sheets for interventions (Section 5) enable good record keeping of activities undertaken</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
</tbody>
</table>

In the space below, please provide additional comments on *any* aspect of the **Learning and Development Portfolio** documents
Please indicate the extent to which you agree with the following statements concerning the content of the Clinical Leader Resource Pack (CLRP). Please rate the document in general.

<table>
<thead>
<tr>
<th>CLINICAL LEADER RESOURCE PACK (CLRP)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regarding the Clinical Leader Resource Pack (CLRP), in general...</td>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Uncertain</td>
<td>Agree</td>
<td>Strongly agree</td>
<td></td>
</tr>
<tr>
<td>The Introduction (pages 3–10) is effective in introducing the user to the content of the overall CLRP document</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>The language used in the section of the CLRP relating to Competence 1 (self-awareness) is consistent with the language used in the corresponding section of the LDP (all grades)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>The key constructs associated with Competence 1 (self-awareness) (e.g. values, vision, my behaviours) are reflected in the corresponding section of the LDP (all grades)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>The learning outcomes for Competence 1 (self-awareness) are reflected in the content of the CLRP document relating to that competence</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>The various activities associated with Competence 1 (self-awareness) appear relevant to the development of self-awareness in the CLRP user</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>The language used in the section of the CLRP relating to Competence 2 (advocacy &amp; empowerment) is consistent with the language used in the corresponding section of the LDP (all grades)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>The key constructs associated with Competence 2 (advocacy &amp; empowerment) (e.g. power, delegation) are reflected in the corresponding section of the LDP (all grades)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>The learning outcomes for Competence 2 (advocacy &amp; empowerment) are reflected in the content of the CLRP document relating to that competence</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>The various activities associated with Competence 2 (advocacy &amp; empowerment) appear relevant to the development of advocacy &amp; empowerment in the CLRP user</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>The language used in the section of the CLRP relating to Competence 3 (decision making) is consistent with the language used in the corresponding section of the LDP (all grades)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>The key constructs associated with Competence 3 (decision making) (e.g. clinical judgement, systematic approach) are reflected in the corresponding section of the LDP (all grades)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>The learning outcomes for Competence 3 (decision making) are reflected in the content of the CLRP document relating to that competence</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>The various activities associated with Competence 3 (decision making) appear relevant to the development of decision making in the CLRP user</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>
### National Clinical Leadership Development Project Pilot Evaluation
UCD/HSE January 2012

**The language** used in the section of the CLRP relating to Competence 4 (communication) is consistent with the language used in the corresponding section of the LDP (all grades)

**The key constructs** associated with Competence 4 (communication) (e.g. building trust, empathetic listening, influencing) are reflected in the corresponding section of the LDP (all grades)

**The learning outcomes** for Competence 4 (communication) are reflected in the content of the CLRP document relating to that competence

**The various activities** associated with Competence 4 (communication) appear relevant to the development of communication in the CLRP user

---

**The language** used in the section of the CLRP relating to Competence 5 (quality & safety) is consistent with the language used in the corresponding section of the LDP (all grades)

**The key constructs** associated with Competence 5 (quality & safety) (e.g. quality, audit, root cause analysis) are reflected in the corresponding section of the LDP (all grades)

**The learning outcomes** for Competence 5 (quality & safety) are reflected in the content of the CLRP document relating to that competence

**The various activities** associated with Competence 5 (quality & safety) appear relevant to the development of quality & safety in the CLRP user

---

**The language** used in the section of the CLRP relating to Competence 6 (team work) is consistent with the language used in the corresponding section of the LDP (all grades)

**The key constructs** associated with Competence 6 (team work) (e.g. team, effectiveness, roles) are reflected in the corresponding section of the LDP (all grades)

**The learning outcomes** for Competence 6 (team work) are reflected in the content of the CLRP document relating to that competence

**The various activities** associated with Competence 6 (team work) appear relevant to the development of team work in the CLRP user

---

**The language** used in the section of the CLRP relating to Competence 7 (clinical excellence) is consistent with the language used in the corresponding section of the LDP (all grades)

**The key constructs** associated with Competence 7 (clinical excellence) (e.g. team, effectiveness, roles) are reflected in the corresponding section of the LDP (all grades)

**The learning outcomes** for Competence 7 (clinical excellence) are reflected in the content of the CLRP document relating to that competency

**The various activities** associated with Competence 7 (clinical excellence) appear relevant to the development of clinical excellence in the CLRP user

---

In the space below, please provide additional comments on any aspect of the Action Learning Toolkit document.
Please indicate the extent to which you agree with the following statements concerning the content of the Action Learning Toolkit document. Please rate the document in general.

<table>
<thead>
<tr>
<th>Regarding the Action Learning toolkit, in general…</th>
<th><strong>tick ONE circle only</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The three major sections (i.e. Sections 1 to 3) are set out in a logical order</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>Section 1 clearly describes what action learning is</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The activities in Section 1 appear helpful in assisting the action learning set facilitator to get started on action learning</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>Section 2 clearly describes the role of the action learning set facilitator</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The activities in Section 2 appear helpful in assisting the action learning set facilitator to plan an action learning set</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>Section 3 clearly describes the available techniques for conducting an action learning set</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The action learning review sheet is well designed to enable group members to review what they have learned</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The action learning reflection &amp; feedback sheet is well designed to enable group members to reflect on learning</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
</tbody>
</table>

In the space below, please provide additional comments on any aspect of the Action Learning Toolkit document.
Please indicate the extent to which you agree with the following statements concerning the *Clinical Leadership Facilitator Toolkit Introduction* document and the *Clinical Leadership Facilitator Toolkit Part 2*. Please rate the document in general.

### Regarding the Clinical Leadership Facilitator Toolkit Introduction, in general…

| The various sections of the Toolkit Introduction document are set out in a logical order | ![ ] | ![ ] | ![ ] | ![ ] | ![ ] |
| The various strategies for effective facilitation of learning and development appear helpful in enabling effective facilitation | ![ ] | ![ ] | ![ ] | ![ ] | ![ ] |
| The information in the section entitled ‘An introduction to facilitation’ (pages 1–12) appears helpful in assisting the facilitator to *plan* a workshop | ![ ] | ![ ] | ![ ] | ![ ] | ![ ] |
| The information in the section entitled ‘An introduction to facilitation’ (pages 1–12) appears helpful in assisting the facilitator to *conduct* a workshop | ![ ] | ![ ] | ![ ] | ![ ] | ![ ] |

### Regarding the Clinical Leadership Facilitator Toolkit Part 2, in general…

| The various sections of the Toolkit Part 2 document are set out in a logical order | ![ ] | ![ ] | ![ ] | ![ ] | ![ ] |
| The learning outcomes for the seven competencies are clearly stated in behavioural terms | ![ ] | ![ ] | ![ ] | ![ ] | ![ ] |
| The detailed information for the facilitator as set out in tabular form (timing, activity, notes for facilitator) appear helpful in assisting the facilitator to conduct a competence workshop | ![ ] | ![ ] | ![ ] | ![ ] | ![ ] |
| The various workshop exercises associated with each competence appear helpful in assisting the facilitator to conduct structured workshop activities | ![ ] | ![ ] | ![ ] | ![ ] | ![ ] |

In the space below, please provide additional comments on any aspect of the *Clinical Leadership Toolkit Introduction* and/or *Clinical Leadership Toolkit Part 2* documents.
Please indicate the extent to which you agree with the following statements concerning the **content** of the **Mentoring** document. Please rate the document in general.

<table>
<thead>
<tr>
<th>Regarding the <strong>Mentoring document, in general</strong>…</th>
<th>tick ONE circle only</th>
</tr>
</thead>
<tbody>
<tr>
<td>The major sections (pages 2–21) are set out in a logical order</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The information on mentoring (Sections 1 to 8 inclusive) appears helpful in enabling a mentor to act in a mentor role</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The information on mentoring (Sections 1 to 8 inclusive) appears helpful in enabling a mentor to plan a mentoring session</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The various handouts appear helpful in assisting the mentor to engage in mentoring activities with the mentee</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>The supporting information (e.g. example of contract details sheet, example of personal development plan) appear helpful in assisting the mentor in the mentoring process</td>
<td>○ ○ ○ ○ ○ ○</td>
</tr>
</tbody>
</table>

In the space below, please provide additional comments on any aspect of the **Mentoring** document.
Please indicate the extent to which you agree with the following statements concerning the content of the Coaching Reference Manual document. Please rate the document in general.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The major sections (pages 4–10) are set out in a logical order</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>The manual contains sufficient information to provide the coach</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>with resources with which to engage in coaching</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The manual clearly sets out the processes by which the coach engages</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>with the coachee (e.g. contract process, tri-party meetings)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The manual clearly sets out the various coaching activities (e.g. number</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>of sessions, feedback process)</td>
<td></td>
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</tr>
<tr>
<td>The appendices provide information with which to support the coaching</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>process in practice</td>
<td></td>
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</tr>
</tbody>
</table>

In the space below, please provide additional comments on any aspect of the Coaching Reference Manual document.
In the space below, please provide any additional comments on any aspects of the quality and content of the various documents supporting the National Clinical leadership Development Framework Pilot. In particular, please provide justification for the rating scores that you gave.
Dear Colleague,

We invite you to complete this short self-assessment questionnaire. The questionnaire permits you to self-assess your clinical leadership behaviours. The questionnaire is being administered as part of the data collection for the evaluation of the National Clinical Leadership Development Framework Pilot.

The questionnaire contains some examples of clinical leadership behaviours that may be exhibited by you in the course of your work. However, the list of behaviours does not attempt to capture the full range of behaviours that are associated with clinical leadership competencies for your grade.

The questionnaire is presented as a series of statements describing clinical leadership behaviours. Each statement is presented with a self-assessment scale and you are required to assess your own clinical leadership behaviours using the scale, as follows: 1 = Almost Never; 2 = Infrequently; 3 = Sometimes; 4 = Frequently; 5 = Always

This is an anonymous questionnaire and therefore you should not include your name on the questionnaire. The information that you provide in this questionnaire is confidential and no individual’s names will be used in the study report.

Please take your time and ensure that you complete all questions. The questionnaire will take approximately 10 to 15 minutes to complete. Thank you for taking the time to complete the questionnaire.

Professor Gerard Fealy
Principal Investigator
gerald.fealy@ucd.ie
Telephone (01)7166461
Instructions

The items that follow describe clinical leadership behaviours, which are based on seven clinical leadership competencies.

- Please read each statement and assess your own clinical leadership behaviours using the scale, as follows: 1=Almost Never; 2=Infrequently; 3=Sometimes; 4=Frequently; 5=Always

- Please be honest and accurate as you can be, i.e. be as realistic as possible about the extent to which you actually engage in each of the behaviours listed

- Rate what comes to mind

- Your self-assessment should reflect your typical behaviours in your everyday practice and not how you think you should act

- When reading each statement, relate it to your current professional role

- After you have completed the questionnaire, go back through the questionnaire one more time to make sure you have responded to each statement. (Every statement must have a rating).
Please read each statement and rate your own clinical leadership behaviours using the scale, as follows: 1 = Never; 2 = Infrequently; 3 = Sometimes; 4 = Frequently; 5 = Always

### COMPETENCE: SELF-AWARENESS

In my current professional role...

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
</table>
| 1 | I reflect on my own effectiveness in my current professional role | O | O | O | 0
| 2 | I recognise my own abilities and limitations as a professional | O | O | O | 0
| 3 | I recognise my own emotional responses and reactions | O | O | O | 0
| 4 | I manage my emotional responses to situations | O | O | O | 0
| 5 | I am sensitive to others people’s emotions and responses | O | O | O | 0
| 6 | I act according to what I believe is right | O | O | O | 0

### COMPETENCE: ADVOCACY AND EMPOWERMENT

In my current professional role...

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
</table>
| 7 | I am generally able to recognise when patients or colleagues need my support | O | O | O | 0
| 8 | I advocate for others when they are unable or unwilling to speak or act themselves | O | O | O | 0
| 9 | I create an environment in which others are empowered to speak or act in meeting their own needs and the needs of others | O | O | O | 0
| 10 | I actively support patients or colleagues when they are acting to meet their own needs and the needs of others | O | O | O | 0
| 11 | I actively support colleagues to achieve the highest standards in their work | O | O | O | 0
| 12 | I encourage others to act according to best available evidence and best-practice standards | O | O | O | 0

### COMPETENCE: DECISION MAKING

In my current professional role...

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
</table>
| 13 | I am willing to make decisions that affect patients or colleagues | O | O | O | 0
| 14 | I take responsibility for making decisions that affect others | O | O | O | 0
| 15 | I act on decisions I have made which affect others | O | O | O | 0
| 16 | I am accountable for the outcomes of the decisions I have made that affect others | O | O | O | 0
| 17 | I weigh up the options before I respond to any problem or situation. | O | O | O | 0
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Never</th>
<th>Infrequently</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>When I take action I monitor the effects of that action on the problem or situation.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>19</td>
<td>In the context of decision-making, I take calculated risks within the parameters of quality and patient safety.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**COMPETENCE: COMMUNICATION**

In my current professional role...  
tick ONE number only

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>I actively listen when others are communicating with me</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>21</td>
<td>I give feedback to others when communicating with them</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>22</td>
<td>I use the <em>language</em> most appropriate to the individual or group with whom I am communicating</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>23</td>
<td>I use the means of communication (e.g. verbal, written, meetings, case conference, newsletters, public media) most appropriate for the message being conveyed</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>24</td>
<td>I intervene when necessary to manage conflict in the work setting</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>25</td>
<td>I use available networks (e.g. colleagues in my own and in other organisations) to share information and ideas</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**COMPETENCE: QUALITY & SAFETY**

In my current professional role...  
tick ONE number only

<table>
<thead>
<tr>
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<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>I reduce the risk of harm to patients by ensuring that my practice is of a high standard (i.e. evidence based)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>27</td>
<td>I ensure effective care by monitoring outcomes of care delivered (e.g. evaluate outcomes, review audit reports)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>28</td>
<td>I ask patient/service users for feedback on the quality of care that they receive</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>29</td>
<td>I actively monitor my own practice with regard to standards of quality and safety</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>30</td>
<td>I actively monitor the practice of others with regard to standards of quality and safety</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>31</td>
<td>I promote a culture of quality and safety by my actions (e.g. role modelling high standards in my own work, communicating evidence)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>32</td>
<td>I collaborate with others in the organisation to achieve high standards of quality and safety</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
### COMPETENCE: TEAMWORKING

**In my current professional role...**

<table>
<thead>
<tr>
<th></th>
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<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>33</td>
<td>I develop good working relationships with the people with whom I work</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>34</td>
<td>I assist in developing a common understanding of the objectives of the team</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>35</td>
<td>I contribute to the effective functioning of the team by playing my part as a team member and/or team leader</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>36</td>
<td>I draw on the particular strengths of individuals to ensure team effectiveness</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>37</td>
<td>I create a culture of team working through my actions (e.g. role modelling collaborative working)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>38</td>
<td>I celebrate team achievements (e.g. praising colleagues for their contribution)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

### COMPETENCE: CLINICAL EXCELLENCE

**In my current professional role...**

<table>
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<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>39</td>
<td>I take responsibility for developing clinical practice (e.g. developing clinical practice policies)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>40</td>
<td>I participate in continuing professional development opportunities (e.g. participation in journal clubs, in ward-based activities)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>41</td>
<td>I support other colleagues in participating in continuing professional development</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>42</td>
<td>I maximise the use of available resources (e.g. equipment, information technology, literature and library services) to ensure that clinical care is excellent</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>43</td>
<td>I work collaboratively with other professionals (e.g. physicians, social workers) to ensure that clinical care is excellent</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>44</td>
<td>I support efforts of others to examine the quality of clinical practice (e.g. clinical audit, clinical research, patient satisfaction surveys)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>45</td>
<td>I monitor the overall standards of clinical care in order to ensure that clinical care is excellent</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>46</td>
<td>I challenge practices that are not consistent with standards of clinical excellence</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
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</tbody>
</table>

Thank you for taking the time to complete the questionnaire.