# Nurses' and Midwives' clinical leadership development needs: A mixed methods study

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**Feedback Addressed on Journal Manuscript ID – JAN 2010-0185 R3**

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| Editor's & Reviewer's Feedback | Actions Taken |
|---|---|
| 1. Check the entire paper for grammar. For example, this sentence, The roles of clinical leaders have been specified (Cooke, 2001a and 2001b, Davidson et al. 2006), and its impact on care outlined, should be revised to read: … and their impact on care (you are referring to roles, not role). | The entire paper has been thoroughly review for grammar. |
| 2. The response rate is exceedingly low, which is a major limitation of the study. Moreover, the usable sample of surveys does not meet the required number, so sample size is not adequately justified. This issue is not yet adequately addressed in the text discussion section. | This section now includes a more complete explanation.<br><br>The low response rate to the national postal questionnaire is a limitation of this study. This can be account for in part in the fact that over five hundred returned questionnaires were from nurses and midwives who were ineligible to participate in the study as they were not employed to work in the public health service, a criterion stipulated by the funding body. Furthermore, the use of telephone or e-mail as a complementary method for enhancing the effectiveness of the Dillman method (Axford 1997) was not possible since the sample was anonymous to the researchers. Comparison of the study response rate with that of other large-scale national postal surveys among nurses and midwives in Ireland indicates that the response rates were very similar to those obtained in the *Experiences of Empowerment* study (Scott *et al*. 2003), which and reported a response rate 33.1% from a postal survey of 4,000 nurses and midwives and higher than the response of 20% from a survey of 10,000 nurses obtained in the *Report on the Continuing Professional Development of Staff Nurses and Staff Midwives* (National Council for the Professional Development of Nursing and Midwifery |

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| | (NCNM) 2004). A high response rate to questionnaires is considered desirable, particularly if the data are to be used for predictive purposes (Meehan *et al*. 2005).<br><br>The present study sought data on self-reported need and hence the burden of interpretation with reference to predicting need may be considered lower than that demanded in intervention and interrelationship studies. For the present study the response rate achieved must be considered with reference to sampling frame and the context in which the questionnaire was administered. The sampling frame was the Active Register of the Register of Nurses in Ireland, which does not permit targeted sampling of discrete subgroups such as nurses and midwives or those employed in either public or private sectors. In addition, the survey was administered at a time of uncertainty in Ireland when all public servants experienced large reductions in salaries and this mood may have impacted on data collection. |
| 3. Place the ethical considerations section after the survey instrument section and before the data analysis section. | Done |
| 4. Citations to the literature used for item generation are needed. | Done |
| 5. The survey questionnaire description remains insufficiently clear. What is Scale A and what is Scale B? | Done |
| 6. This sentence is unclear or grammatically incorrect: A scale score being an average of the scores on each item with a higher mean value indicated a higher self-reported development need. | This section now reads<br>Scale A measured the perceived importance of each item in the list of items in relation to effective performance of the clinical leader role in practice setting using a five-point scale from 1 ('not important') to 5 ('very important'). Scale B measured respondents' self-perceived clinical leadership development needs in relation to each item on the same list from 1 ('no need') to 5 ('very high |

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| | need’). |
| 7. The description of the factor analysis continues to read as if separate factor analyses were done for each subsection of the questionnaire. A factor analysis that includes all items will yield a certain number of factors from 1 to x. Each item of the questionnaire loads more or less better on a certain factor. Items are retained on the basis of preset criteria for loading and items that load on more than one factor are typically deleted. Thus, it is unclear why you wrote, for example, that a particular subsection of the questionnaire was made up of two components. | Included in this section is the following explanation<br><br>To further define the traits in each scale, factor analysis (Johnson & Wichern 2002) was conducted on each scale, and where appropriate new sub-scales defined. |
| 8. It is unclear why the factor analysis results mention the subsections when the data in Table 4 are only for the 5 subscales that also appear in the left column in Table 2. | Table 2 provides details of the results of factor analysis in terms of subscale titles and indicative content.<br><br>Table 4 indicates the dimensions of clinical leadership in terms of mean, standard deviation and skewness |
| 9. Citations are not consistent with JAN format (should be earliest date of publication first rather than alphabetical order | Done |
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# Nurses' and Midwives' clinical leadership development needs: A mixed methods study


## Aim

This paper is a report of a descriptive study of nurses' and midwives' clinical leadership development needs.

## Background

Nurses and midwives are expected to fulfill a leadership role at all levels, yet efforts to strategically support them are often unfocused. An analysis of clinical leadership development needs can provide the foundation for leadership initiatives to support staff.

## Method

A mixed methods design was used. A questionnaire was sent to 911 nurses and midwives and 22 focus groups comprising 184 participants were conducted. Data were collected between March and June 2009 across all promotional grades of nurses and midwives in Ireland. Repeated measures ANOVA with Greenhouse-Geisser adjustment was used for post-hoc pair wise comparisons of the subscale dimensions of clinical leadership. ANOVA with Tukey's post-hoc method was used for comparison between grades on each individual subscale. Thematic analysis was undertaken on the focus group data.

**Results**

Results reveal that needs related to development of the profession were highest for all grades. The staff grade expressed a higher need in relation to 'managing clinical area', 'managing the patient care' and 'skills for clinical leadership' than managers. Qualitative analysis yielded five themes; 'clinical leadership and leaders from a nursing and midwifery perspective'; 'quality service from a nursing and midwifery perspective'; 'clinical leaders' roles and functions'; 'capital and 'competences for clinical leaders and leadership and the context of clinical leadership'.

**Conclusion.**

Clinical leadership concerns quality, safety and effectiveness. Nurses and midwives are ideally placed to offer the clinical leadership that is required to ensure these patient care outcomes. Development initiatives must address the leader and leadership competencies to support staff.

**Keywords:** Clinical leaders, leadership development, Needs analysis, Mixed Methods.



## SUMMARY STATEMENT

**What is already known about this topic**

- Leadership is essential for organizational systems and processes to function effectively.
- Clinical leadership in nursing and midwifery is essential for optimizing the environment of care and for improving the effectiveness and outcomes of care.
- Clinical leadership development programmes enhance self confidence, improve care, job satisfaction and enhance leadership skills and capabilities in such areas

as team effectiveness, communications, change management and management of conflict.

**What this paper adds**

- The staff grade of nurses and midwives have higher clinical leadership development needs than managers in relation to managing the clinical area and patient care.
- Leadership development need was greater across all grades of nurses and midwives in relation to development of the profession which involves organizational and interdisciplinary interactions with other health care professionals, and influencing clinical decision making and health policy more generally.
- Clinical leadership in nursing and midwifery is about integrating the clinical leadership role and function into everyday practice to provide a quality service.

**Implications for Practice and/or Policy**

- Clinical leadership development must focus on individual and organizational competency development within each individual health care context.
- Leadership development initiatives are likely to be more successful if the various dimensions of clinical leadership development need and the promotional grade of the individual are taken into account.
- Clinical leadership development initiatives must take a partnership approach between clinical and academic input for the design and delivery of programmes.

## INTRODUCTION

From a global perspective, as providers of front-line clinical care, nurses and midwives are ideally placed to offer clinical leadership that is required to ensure quality and optimum patient care. The roles of clinical leaders have been specified (Cook, 2001a and 2001b, Davidson *et al.* 2006), and their impact on care outlined (Dierckx de Casterlé 2008, Hix *et al*. 2009). However, it is the way that these roles and skills are exercised within these roles that determines leadership effectiveness (Gopee & Galloway 2009).

## BACKGROUND

### Leadership in nursing and midwifery

Leadership in healthcare involves the creation of conditions for success and the achievement of professional and organizational goals (Milward & Bryan 2005). In nursing and midwifery, leadership involves taking responsibility for direct care and for monitoring service more generally (Davidson *et al*. 2006, Carryer *et al*. 2007,). Effective leadership empowers individuals and groups to engage in change (Casey 2006) and improve quality (Alleyne & Jumma 2007, Shaw 2007). Improving nurses' leadership skills enhances the provision of quality healthcare (Borrill *et al*. 2002, Large *et al*. 2005).

The American Association of Colleges of Nursing (AACN) defines a clinical nurse leader as someone who supports and leads innovations that improve outcomes of care, ensures quality and reduces costs, integrates research into practice, is recognised as a leader and an advocate for transforming the health system and implementing best practice (Smith & Dabbs 2007). Clinical leadership enables evidence-based care to improve patient outcomes (Milward & Bryan 2005) by integrating activities and

processes within disciplines and across-service (Tornabeni & Miller 2008). Hence, clinical leadership is essential in complex health systems, in which multiple professional groups, often with complex interdisciplinary social relationships and at times divergent disciplinary goals, work closely together. The challenge for contemporary leadership in healthcare is to maintain a perspective that combines the lofty goals of strategy formulation with the minutiae associated with the day-to-day management of direct care in the clinical context (Casey 2006).

Leadership development takes time (Hartley & Hinksman 2003) and involves sustained interaction between the clinical leader and coworkers (Dierckx de Casterlé *et al*. 2008). Leader development requires human capital, expressed as a range of intrapersonal competences, and social capital which underpins the interpersonal competences required for leadership development as seen in Table 1.

**Table 1 Key Aspects of leader and leadership development (Day 2001)**

| **Aspects of leader development (Human Capital)** | **Aspects of leadership development (Social Capital)** |
|---|---|
| Building intrapersonal competence | Building interpersonal competence |
| Developing individual knowledge, skills and abilities | Building network relationships through interpersonal exchange |
| Self awareness (emotional awareness, self confidence) | Social awareness (empathy, service orientation and enabling others) |
| Self regulation (self control, trustworthiness, ability to cope with change) | Social skills (collaboration, partnership, cooperation, conflict management) |
| Self motivation (commitment, take initiative, positive outlook) | Membership of influential social networks (Bourdieu 1997, Maton 2005) |

Both leader and leadership competency development must be addressed for the integration of the cognitive, affective and behavioural dimensions of the role required to enact leadership. Essentially, leadership development involves building individual and organizational capacity so that members' intrapersonal competences can be effectively

expressed, in the interpersonal domain, in the leadership roles and processes (McCauley *et al.* 1998).

## THE STUDY

### Aim

The aim of this study was to describe nurses' and midwives' clinical leadership development needs.

### Design

A concurrent triangulation mixed methods design involving a survey and focus group interviews was used.

### Sample

*Survey respondents*

The sampling frame was 68,000 nurses and midwives (An Bord Altranais 2008) and with a precision of ± 3% at a 95% confidence interval, it was considered that a sample size of 1,100 would be required. A simple random sample of 3,000 nurses and midwives employed within the Health Service Executive (HSE) in Ireland was selected from the Active file of the Register of Nurses. This ensured that all grades and in each of the five divisions of the Register, viz. general, children's, psychiatric, intellectual disability, and midwife, would be represented. At the closing date for return of questionnaires, a total of 802 (26.73%) replies were received, 534 (17.8%) of which were returned completed and 268 (8.9%) were incomplete. Using the Dillman (2000) procedure another circulation of

questionnaires were sent to the non-respondents which yielded 630 (27.91%) replies, of which 377 (16.7%) were completed and 253 (11.2%) incomplete. This procedure involves three contacts with the sample: a pre-notification A5 postcard, an initial administration of the questionnaire and a second administration to non-respondents of the first attempt. Accordingly, a total of 1,432 responses were received, of which 521 questionnaires were unusable. From the unusable questionnaires, 477 were categorised as not employed in the public sector (273) or provided no indication of the sector in which employed (194). An additional 29 questionnaires indicated that they were either no longer working in nursing or midwifery, were ill or living abroad. A further 25 questionnaires were returned as undeliverable. This resulted in a valid sample of 2,946 and a useable sample of 911 questionnaires, representing a response rate of 30.92%.

*Focus group participants*

A purposive sample of all grades of nurses and midwifes from each of the four HSE administrative regions was selected to elicit their view on clinical leadership and their perceived clinical leadership development needs. Twenty-two focus groups were conducted at fourteen different sites which included a mixture of national, regional and local tertiary care centres. The mean number of participants per group was 8 and the range was 3–12 members. Group homogeneity was achieved by grade and discipline in all but one focus group and a total of 184 participants representing all disciplines and clinical and promotional grades participated in the focus groups

Data collection

Data collection took place between March and June 2009. Data for the national postal survey were collected using the Clinical Leadership Analysis of Need Questionnaire (CLAN-Q©). Focus group data were collected over the same period. Each focus group was held in private, audio recorded and lasted approximately sixty minutes.

*Survey instrument*

A 'questionnaire' the Clinical Leadership Analysis of Need Questionnaire '(CLAN-Q©).' was developed to measure the clinical leadership development needs of nurses and midwives. An initial item pool (Bray *et al.* 2003) of over one hundred items that reflected critical tasks associated with effective performance as a clinical leader were generated from the literature (Christian and Norman 1998, Cook 2001a and 2001b, Williams 2004, Large *et al*. 2005, Davidson *et al.* 2006, Dopson and Fitzgerald 2006, Flood 2007, Lunn *et al.* 2008, Sorenson *et al.* 2008, Hix *et al.* 2009) and critically reviewed by the research team acting as content experts. The items were presented in two Likert scales. Scale A measured the perceived importance of each item in the list of items in relation to effective performance of the clinical leader role in practice setting using a five-point scale from 1 ('not important') to 5 ('very important'). Scale B measured respondents' self-perceived clinical leadership development needs in relation to each item on the same list from 1 ('no need') to 5 ('very high need').

A small pilot study was conducted among a convenience sample of one junior and three senior grades of nurses and midwives in different settings and this provided confirmation of the feasibility of the questionnaire (Hallberg 2008). Following pilot

testing it was observed that responses to Scale A in all categories elicited responses that were in the higher end of perceived importance (i.e. important and very important). This indicated a threat to the discriminating power of the items with respect to Scale A. However, given the absence of any extant list of leadership behaviours and capabilities with which to construct a needs analysis scale, the research team considered that it was necessary to retain Scale A as a self-report mechanism of perceived importance as this provided internal validation of each item with respect to Scale B. This consideration outweighed that limitation, and the fact that 80% of the respondents ranked these items as 'very important' lends support for claims of construct validity of the instrument items. The CLAN-Q incorporated a demographic questionnaire and took approximately twenty minutes to complete.

*Validity and reliability of survey instrument*

Instrument content validation involved domain identification, item generation, and instrument construction (Grant & Davis 1997). Each item was independently examined by four experts from the research team and items were excluded or retained on consensus. Finally, a list of 68 items was retained and compiled into three main category scales based on specific concepts based on their fit with emergent constructs, namely 'improving the environment for care delivery' (31 items), 'personal and professional development' (14 items) and 'skills for clinical leadership' (23 items). The multiple iterations of the instrument items and the use of cognitive interviewing principles (Drennan 2003) added rigor to the process of content validation.

To further define the traits in each scale, factor analysis (Johnson & Wichern 2002) was conducted on each scale, and where appropriate new sub-scales defined. It was determined that the scale 'skills for clinical leadership' consisted a single component. The scale relating to 'improving the environment for care delivery' (31 items) was determined to have two components based on Eigen value greater than 1 from a principal component extraction. Varimax rotation was used to identify which component each item contributed to based on a loading factor greater than 0.5. The two components or subscales were identified as 'managing clinical area' (6 items) and 'managing patient care' (25 items).

A similar analysis of scale 'personal and professional development' (contained 14 items) also identified two components or subscales; 'development of individual' (9 items) and 'development of the profession' (5 items). Based on scale reliability calculations it was noted that the third subscale relating to 'skills for clinical leadership' improved if one item was deleted. The item 'influencing key stakeholders within the profession' was omitted from the survey, leaving 22 items for this third subscale. The results of factor analysis and the indicative content of the final five subscales are listed in Table 2.



**Table 2 Results of factor analysis, subscale titles and indicative content of CLAN-Q instrument**

| **Subscales, factor analysis, number of items of category scale 'improving the environment for care delivery'** | |
|---|---|
| Subscale Title | Number of items and indicative content of subscale |
| Managing clinical area<br>Eigenvalue 20.53<br>% of Variance 66.24<br>Cumulative % 66.24 | Contained 6 items related to coordinating care in the work setting, ensuring adequate resources to provide optimum care, identifying priorities for service improvement, and ensuring that team members carry out duties appropriate to their grade. |
| Managing patient care<br>Eigenvalue 1.34 | Contained 25 items related to protecting dignity and confidentiality of patients, involving patients in their own care, contributing to the |

| | |
|---|---|
| % of Variance 4.36<br>Cumulative % 70.60 | development of clinical practice guidelines, and ensuring the outcomes of care and other interventions are documented |
| **Subscales, factor analysis, number of items of category scale 'personal and professional development** | |
| Development of individual<br>Eigenvalue 8.53<br>% of Variance 60.93<br>Cumulative % 60.93 | Contained 9 items related to demonstrating commitment to lifelong learning, recognising own strengths and weaknesses, coping effectively with pressure, and acting as a mentor to colleagues |
| Development of profession<br>Eigenvalue 1.63<br>% of Variance 11.61<br>Cumulative % 72.54 | Contained 5 items related to participating in nursing/midwifery forums, networking and understanding the impact of organisational politics on the work of the profession. |
| **Subscales, factor analysis, number of items of category scale 'skills for clinical leadership'** | |
| Skills for clinical leadership | Contained 22 items related to effective working relationships with the interdisciplinary team, motivating others, accepting accountability, and initiating change to ensure optimal care |

The reliability of each subscale was examined by calculating a Cronbach's Alpha coefficient. An acceptable Alpha level is 0.7 or above, and the properties of the five scales were: 'managing clinical area' contained 6 items, α=0.91, 'managing patient care' contained 25 items, α=0.98; 'development of individual' contained 9 items, α=0.96; 'development of profession' contained 5 items α=0.91 and 'skills for clinical leadership' contained 22 items, α=0.98.

## Ethical considerations

Permission for the study was received from the university. Return of the CLAN-Q was accepted as consent to participate in the survey and each participant in the focus group gave informed written consent on the basis of confidentiality.

Data analysis

Data analysis were undertaken using the Statistical Package for the Social Sciences© (SPSS Version 15.0) software. Descriptive variables related to respondents' demographic characteristics were summarised using frequency distributions to describe the sample. As the distribution of scores are centred near the middle of the range, and are essentially symmetric (skew near 0), the scores were assumed to be normally distributed. Based on repeated measures ANOVA with Greenhouse-Geisser adjustment for non spherical data to correct degrees of freedom, post hoc comparisons of subscales were performed using the Bonferroni method for controlling Type 1 error to 0.05. ANOVA with Tukey's post-hoc method was used for comparison between grades on each individual scale.

*Dependability and credibility of focus groups*

The focus group questions were prepared in advance and structured using the same categories that were developed for the national survey instrument, viz. 'the care environment', 'personal and professional development needs', 'professional skills for leadership'. Dependability was enhanced by the use of a topic guide (Holloway and Wheeler 2002), based on the three categories as the questionnaire and by judicious group moderation and by analysis of the data by two members of the research team which achieved complete agreement on the interpretation and analysis of themes. Data analysis involved data reduction, exploration and synthesis (Attride-Stirling 2001). Credibility of the analysis was enhanced by adherence to systematic analytical process which involved reading each transcript closely and breaking down significant segments into themes which were allocated to free nodes using *NVivo 7*©. As significant relationships between

the free nodes were identified and further explored in the existing and incoming data, a tree node structure was devised. This process allowed relationships between themes to be explored, revealing underlying patterns and relationships in the data, thus assisting dependability. Dependability was also enhanced using a coding framework based largely on the work of Day (2001). This framework was modified to refine the tree node structure until the maximum amount of data was accounted for, with minimal overlap and redundancy in order to identify and describe the clinical leadership development needs of nurses and midwives.



## RESULTS

The justification for combining quantitative and qualitative methods was to provide a more complete account of clinical leadership development needs and a more detailed explanation of these perceived needs (Bryman 2006). To this end, the results of the survey and focus group are presented separately and 'the mix' is in the interpretative treatment of the results manifest in the unifying discussion (Plano-Clarke and Creswell 2008).

### Survey sample characteristics

The majority of the sample was female 92% (n=836) and all promotional grades were represented. The mean age of the sample was 42 years (SD=10.14, range 22–70). Two-thirds (66.3%, n=584) worked in a public or public voluntary hospital setting, 21% (n=180) worked in the community or in nursing homes and other non acute care sector. The majority of respondents (61.5% (n=547) were employed as general nurses and

midwives accounted for just over 5% (n=46). Details of the grades of each participant are provided in Table 3.

**Table 3. Survey results in relation to grade at which currently employed**

| Grade | Percentage (number) |
|---|---|
| Staff Nurse | 66.6 (n=599) |
| Clinical Nurse Manager level 1 (CNM1) | 6.3 (n=57) |
| Clinical Nurse Manager level 2 (CNM2) | 10.6 (n=95) |
| Clinical Nurse Manager level 3 (CNM3) | 1.1 (n=10) |
| Clinical Nurse Specialist | 5.1 (n=46) |
| Advanced Nurse Practitioner | 0.4 (n=4) |
| Assistant Director of Nursing | 3.1 (n=28) |
| Director of Nursing | 0.8 (n=7) |
| Staff Midwife | 3.9 (n=35) |
| Clinical Midwife Manager level 1 (CMM1) | 0.2 (n=2) |
| Clinical Midwife Manager level 2 (CMM2) | 0.8 (n=7) |
| Clinical Midwife Manager level 3 (CMM3) | 0.4 (n=4) |
| Clinical Midwife Specialist | 0.2 (n=2) |
| Advanced Midwife Practitioner | 0.1 (n=1) |
| Assistant Director of Midwifery | 0.2 (n=2) |
| Director of Midwifery | 0 (n=0) |
| Missing | 1.3 (n=12) |
| Total | 100 (n=911) |



The sample was representative when compared with the national Register of Nurses statistics of just under 92,000 qualifications. In the study sample of registrations of 1,306, general nursing was underrepresented 58% (n=755) compared to 63% (n=57,474) in the national Register. Psychiatric Nursing was (9% n=112) approximately 2.1% less representative than the national Register (11% n=9796) and there was slight over representation of midwifery of 17% (n=222) compared to 14% (n=12,988) and, intellectual disability accounted for 7% (n=86) compared to 5% (n=4,233) and public health over representative at 4% (n=47) than the national Register of 3% (n= 2,378).

*Dimensions of clinical leadership development*

Based on repeated measures ANOVA with Greenhouse-Geisser adjustment for non spherical data, at least one scale was statistically significant from others, F (3, 2068.7) =32.2, p<0.001. The subscale 'development of profession' (M=3.22, SD=0.99) was significantly higher than 'managing clinical area' (M=3.07, SD=1.00, p<0.001), 'skills for clinical leadership' (M=3.07, SD=1.0, p<0.001), 'development of individual' (M=3.04, SD=1.00, p<0.001) and 'managing patient care' (M=2.92, SD=1.1, p<0.001).

Additionally, the subscale 'managing patient care' (M=2.92, SD=1.1) was significantly lower than 'managing clinical area' (M=3.07, SD=1.00, p<0.001), 'skills for clinical leadership' (M=3.07, SD=1.0, p<0.001) and 'development of individual' (M=3.04, SD=1.00, p<0.001). The five subscales of dimensions of clinical leadership development need are presented in Table 4.

**Table 4 Subscales of clinical leadership development need**

| Subscale of Clinical Leadership Development Need | Mean | SD | Skewness | n | Missing values* |
|---|---|---|---|---|---|
| Managing the clinical area | 3.07 | 1.0 | 0.19 | 880 | 31 |
| Managing patient care | 2.92 | 1.1 | 0.31 | 834 | 77 |
| Development of individual | 3.04 | 1.0 | 0.24 | 863 | 48 |
| Development of profession | 3.22 | 0.99 | 0.05 | 872 | 39 |
| Skills for clinical leadership | 3.07 | 1.0 | 0.15 | 834 | 77 |

*Non responses

*Clinical leadership development and promotional grades*

For the purpose of analysing differences by grade, nurses and midwives were grouped together and recoded into four categories; 1) staff (incorporating public health nurse), 2) clinical manager, 3) specialist and advanced practitioner and 4)senior manager and director of nursing/midwifery.

A significant difference among promotional grades was observed in the subscale 'managing the clinical area' (F (3,865) =2.906, p=0.034). Pair wise post hoc tests did not identify any significant differences. A pooled analysis combining staff and specialists views, based on their greater engagement and proximity to clinical care, with those of middle and senior management levels revealed a significant difference between frontline workers (M=3.12, SD=1.00) and those more distant from the bedside (M=2.89,SD=0.97, p=0.003), where frontline staff expressed a higher leadership development need.

A significant difference between grades in the subscale 'managing patient care' was also observed (F (3,819) =3.41, p=0.017). Pair wise comparison indicated a significant difference between staff (M=2.99, SD=1.14) and manager grades (M=2.67, SD=1.04, p=0.010), with staff reporting higher clinical leadership development need.

No significant differences between grades for the subscale 'development of the individual' (F(3,847)=2.43,p=0.064) was observed. While the scale comparisons indicated that the highest scale across all grades was in relation to' development of the profession', there were no significant differences between grades (F(3,856)=0.36,p=0.781).

There is at least one difference between grades for the 'kills for clinical leadership' (F (3,819) =3.232, p=0.022). Post-hoc comparisons identified that staff grade (M=3.14, 1.031) differed from manager grade (M=2.85, SD=.94, p=0.011), with staff expressing a higher clinical leadership development need.

Results: Focus groups

Just over half the participants in the twenty-two focus groups were employed in general nursing (52%, n=93), a quarter (24%, n= 44) in midwifery and the remainder in either children's nursing (7.7%, n=14), psychiatric nursing (6.6%, n=12) or intellectual disability nursing (4.9%, n=9). The majority (92%, n=169) were female and the average age was 40 years with a range age of 23-60 years.

*Clinical leadership and views on clinical leaders*

Focus group participants found it difficult to agree on a definition of clinical leadership, but agreed that it is founded on clinical expertise, experience and credibility. Being a clinical leader was seen as more challenging for clinical nurse managers and midwifery managers (CNM/CMM) due to their position in the organization (middle management) their multiple and conflicting responsibilities and poor role definition:

> We describe ourselves as the meat in the sandwich…we are like the filling. Stuck in the middle…we are the ones that are being pushed from the top down…. (CNMG1)

Clinical leaders were seen as the 'guardians' of patient care and expected to advance nursing and midwifery practice by advocating for patients' interests and by maintaining standards:

> I think at the core of it is patient advocacy, patient-centred care…emphasis is on quality and safety … maintenance of standards is at the core of what we're at. (DoN&M)

*Quality nursing and midwifery services*

Participants portrayed a very strong commitment to their role as clinical leaders, patient advocates and protectors of patient dignity and privacy and were uncompromising about the difficulties they encounter in so doing:

> …you are striving for best practice but the way things are with the patient numbers and the lack of staff it's very hard… to give them a small bit of privacy to see a doctor never mind anything else. (SNG G2)

*Roles and functions of clinical leaders*

Nurses and midwives emphasised their coordinating role as integrating diverse disciplinary inputs in the interests of patient care; indeed, they regarded themselves as the main group to whom this responsibility fell:

> …the whole thing is multi-disciplinary…call in this discipline or that discipline but as nurses we're the ones who seem to pull it all together. (CNM G4)

Nurses and midwives were seen as ideally placed to provide clinical leadership but this role potential was frequently underutilized and their contributions unrecognized:

> nurses are uniquely positioned…the difficulty is the level of understanding within other groups may not value that role or may not understand that role …we've been struggling for so many years as a profession, articulating what it is that we bring to the table. (DoN & M)

All grades were able to provide examples of specific initiatives that had made a difference to patient care. Directors, specialists and some managers emphasised the importance of challenging existing practices and initiating change at organizational level. Discussions around dealing with conflict arose mainly in response to concerns about

patient care. Where these result from the actions or omissions of nursing or midwifery colleagues, participants indicated that they would try to deal with concerns at the lowest appropriate level and refer upwards according to their professional judgment and established policies:

> the best way is to talk to the person privately…in a safe, professional way…I think being honest and professional is the right way to approach a colleague …it depends how serious it was…you try and solve it as local as possible. (SNGG4)

Dealing with concerns about medical colleagues was considered much more of a challenge:

> the majority of your battles when it comes to patients, and they are right royal battles sometimes, is about inappropriate discharging…there is huge social implications. (CNMG1)

*resources and competencies for clinical leaders and leadership*

A lack of personal and professional autonomy was a recurring theme in the data:

> 'we' can literally do absolutely nothing because 'we' don't have power …to do anything….there is a lack of support there…there's no support. (CMMG1)

Participants indicated a leadership development need at the interpersonal level associated with intrapersonal needs expressed through feelings of powerlessness and poor self and professional image:

> we're looked down on ... if you're down in the pecking order you end up hitting a brick wall…they don't listen to us. (SNID)

There were numerous examples of nurses' and midwives' motivation, personal initiative and commitment to initiating change and while there was consensus that managing

change was a vital ingredient of clinical leadership, participants believed that their initiative was not effectively harnessed. This again suggested a leadership need at the wider organizational level:

> one of the big problems in changing policy …they don't have the time…ward meetings are going out the window…there's nowhere to come together and say, how do we feel things are going, how can we improve? (SMG1)

*The context of clinical leadership*

Whether leaders' human capital, as manifest in their intrapersonal competences, translates into social capital and effective leadership depends on the context in which they operate. Overall, motivation, recognition of contribution, teamwork, mutual respect, organizational support and inclusiveness were identified as the key ingredients of a supportive work context:

> from the time a staff nurse comes to work in a unit… there's a development plan put in place…the hospital is very proactive in allowing staff to participate in these programmes. (CNM G5)

## DISCUSSION

### Study limitations

Leadership is culturally influenced and context-dependent, hence the outcomes of this study are most relevant to how nursing and midwifery is delivered in Ireland, and regulatory frameworks and clinical environments in other countries may elicit different leadership development needs.

The low response rate to the national postal questionnaire is a limitation of this study. This can be account for in part in the fact that over five hundred returned questionnaires were from nurses and midwives who were ineligible to participate in the

study as they were not employed to work in the public health service, a criterion stipulated by the funding body. Furthermore, the use of telephone or e-mail as a complementary method for enhancing the effectiveness of the Dillman method (Axford 1997) was not possible since the sample was anonymous to the researchers. Comparison of the study response rate with that of other large-scale national postal surveys among nurses and midwives in Ireland indicates that the response rates were very similar to those obtained in the *Experiences of Empowerment* study (Scott *et al*. 2003), which and reported a response rate 33.1% from a postal survey of 4,000 nurses and midwives and higher than the response of 20% from a survey of 10,000 nurses obtained in the *Report on the Continuing Professional Development of Staff Nurses and Staff Midwives* (National Council for the Professional Development of Nursing and Midwifery (NCNM) 2004). A high response rate to questionnaires is considered desirable, particularly if the data are to be used for predictive purposes (Meehan *et al*. 2005).

The present study sought data on self-reported need and hence the burden of interpretation with reference to predicting need may be considered lower than that demanded in intervention and interrelationship studies. For the present study the response rate achieved must be considered with reference to sampling frame and the context in which the questionnaire was administered. The sampling frame was the Active Register of the Register of Nurses in Ireland, which does not permit targeted sampling of discrete subgroups such as nurses and midwives or those employed in either public or private sectors. In addition, the survey was administered at a time of uncertainty in Ireland when all public servants experienced large reductions in salaries and this mood may have impacted on data collection.

Defining clinical leadership

There was consensus that clinical leadership is directed at ensuring quality patient services, and nurses and midwives closest to the patient consider themselves well-positioned to make a difference to patient and quality care. The staff grade expressed higher development needs in relation to 'managing the clinical area', 'managing patient care' and 'skills for clinical leadership' which involved activities such as coordinating care, developing effective working relationships with the interdisciplinary team, managing conflict, implementing change, coordinating care and ensuring adequate resources for care. The principal mechanisms through which nurses and midwives impacted on patient care were patient advocacy and safety, maintaining dignity and privacy through the co-ordination of the care. These mechanisms are well supported in the literature where a clinical leader is an expert clinician involved in providing direct clinical care and as a clinician can influence others to achieve optimal care (Cook 2001a, 2001b). While the management of relationships between patients, multidisciplinary team members and the wider organization is widely acknowledged to be a key function of clinical leaders (Milward & Bryan 2005), the ability to articulate concise definitions of clinical leadership and of needs related to its development at the individual, group and wider organizational level varied across the focus groups. It is not surprising therefore that although the subscale' development of the profession', which included items as networking and organizational politics, did not indicate any significant differences between the grades, it was the highest expressed leadership development need.

Describing and distinguishing need

The staff grade expressed higher needs in relation to 'managing the clinical area', 'managing patient care' and 'skills for clinical leadership' and than any manager grade. Focus group participants spoke of their commitment to motivating other s to improve care and while the acknowledged their responsibility and accountability in providing quality care, they also emphasized their lack of self confidence and autonomy and lack of control over local resources. Clinicians can exert influence in directing patient care by exemplary leadership and by excellence in their practice domain (Davidson *et al*. 2006), but their scope of leadership is influenced by their position, status and the everyday challenges of limited resources. In contrast, managers are somewhat removed from the patient interface but perceive their influence as being greater.

The subscale 'development of the profession' concerning leadership at team, interdepartmental and organizational levels of leadership was the highest reported need among all grades. Focus group data also confirmed that nurses and midwives struggle to get their voices heard at the policy table and feel increasingly excluded within their organizations, which is consistent with the evidence from other Irish studies (Tracey 2003, Hogan 2006, O'Shea 2008). Clinical leadership involves not only taking responsibility for direct care and its outcomes but also for monitoring and developing services in general (Davidson *et al*. 2006, Carryer *et al*. 2007). As the focus shifts away from the bedside and the micro-system in which the nurse or midwife is central (Hix *et al*. 2009) and outwards to the multidisciplinary team and wider organisation, the focus group data suggested that nurses and midwives are much less assured of their roles.

Further examination of these needs is warranted to determine what role the organisation and individual can contribute to meeting this leadership development need deficit.

Whether and to what extent nurses and midwives gain recognition and exert influence at the individual, team, department and organizational levels will ultimately impact on the quality of patient services. The need for nurses and midwives to be involved at strategic and operational levels of decision-making is essential to the development of more accountable and integrated health services (O'Shea 2008). That nurses and midwives in management positions should be so constrained in acting as leaders removes a source of role models and mentors for junior colleagues and an incentive to assume such roles. Hence, a distinct leadership development need for nurses and midwives is the ability to better represent their unique contributions to patient outcomes in a credible manner.

Clinical leaders in nursing and midwifery advocate for patients and for their professions (NCNM 2005) and shared decision-making among doctors, nurses and other health professionals is an important condition for such wider advocacy (Office for Health Management 2003). This need is linked to their ability to participate fully in multidisciplinary teams, work in partnership and to drive change. When this need is met it gives rise to effective leadership in the way that the leader is aware of the political nuances that impact on clinical practice and can effectively manage conflict and departmental turfism (Casey 2008). This requires better role differentiation for meaningful integration and highlights the importance of developing both individual leaders and collective leadership (Glatter 2008) thereby building individual and organizational capacity. These competences require capacity-building through

interpersonal competences such as communication and decision making, advocacy, empowerment, quality, partnership, and political awareness. This finding supports leadership development approaches that address the intrapersonal, such as self awareness and the interpersonal domains of competence associated with the individual, team, departmental and organizational levels (McAuliffe *et al*. 2002, Large *et al.* 2005, Sorensen *et al*. 2008, Stanley 2008, Tornabeni & Miller 2008)

Clinical leadership development

Needs in relation to the dimensions of clinical leadership development were successfully identified using the ©CLAN-Q. These needs are related to managing clinical area, managing patient care, development of the individual, development of the profession and skills for clinical leadership. On the evidence in this study *leader* development, in terms of self awareness, and *leadership* development (collective organizational context) must be considered as part of the spectrum of clinical leadership development. Moreover, there is a difference in the degree of need depending on the promotional grades as highlighted between staff and manager grades. Any strategy for clinical leadership development therefore must take cognisance of the promotional grade and particular context in which nurses and midwives operate as well as the overall development needs of nursing and midwifery as professional disciplines (Williams 2004, Large *et al.* 2005, Tornabeni & Miller 2008, Proctor-Thompson 2008, Sorensen *et al*. 2008, Stanley 2008).

CONCLUSION

Leader and leadership competency development must be key outcomes of clinical leadership development initiatives for nursing and midwifery. This requires a focus on the individual, the professions and the organizations in which they operate. Undertaking clinical leadership needs assessment and developing mechanisms to address leadership deficits at individual, team, department and organisational levels are necessary. Clinical leadership development is a shared responsibility and those in leadership positions must work together across professional boundaries to secure the recognition and influence that they need so that clinical leadership capacity can be harnessed, developed and deployed in the interests of patient care.



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