

# Leadership Development for Doctors in Postgraduate Medical Training



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A national framework for action on  
improvement and leadership development  
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# Leadership Development for Doctors in Postgraduate Medical Training

## Executive summary

This report for Health Education England examines the current state of leadership development for doctors in postgraduate training and offers a set of co-created principles and recommendations to guide future investment, design and delivery. The design principles include the need for clear, accessible, tiered programmes of development that normalise clinical leadership, support personal and skills development, are predominantly work-based, multiprofessional and future focussed, and accompanied by programmes of faculty development. A consistent, collaborative and coproduced approach is essential to ensure sustainability. The values of the NHS Constitution should underpin all activity with a particular emphasis on leading with compassion and for inclusivity.

## Recommendations and next steps

1. Postgraduate deans, working together with their local leadership academy, should ensure that a clear development offer is available, and accessible, to all doctors in postgraduate training built on the principles in this report. The workforce boards of sustainability and transformation partnerships should be engaged in this process. ACTION Postgraduate deans and local leadership academies.
2. Postgraduate deans and local leadership academies should engage in a three-way conversation with employers about how to create workplaces that support and invite leadership learning. This report should be used as the basis for those discussions. ACTION Postgraduate deans and local leadership academies.
3. Health Education England's national quality framework should be used to ensure leadership development opportunities are available as an integral part of all clinical placements. ACTION HEE Directorate of Education Quality, postgraduate deans.
4. A national implementation group of leads for postgraduate medical leadership development, representing all localities, should be established for the purpose of sharing best practice and resources, and developing a common approach. ACTION HEE Postgraduate Deans.
5. HEE should work with the Academy of Medical Royal Colleges and the Faculty of Medical Leadership and Management to ensure that local delivery, and curricula requirements and support are aligned. ACTION NHS Leadership Academy
6. Explicit measures of progress should be established, including a baseline assessment, and nationally coordinated monitoring and reporting. ACTION NHS Leadership Academy.
7. Implementation plans should be developed locally in line with this guidance and progress reported through HEE Postgraduate Deans (subject to governance review) and the Management Board of the NHS Leadership Academy. Overall accountability for clinical leadership development rests with Director of the Leadership Academy reporting to HEE Executive. ACTION HEE Postgraduate Deans and NHS Leadership Academy.

## Section 1: Setting the scene

### Introduction

The invitation for clinicians to participate in the management and leadership of health services and systems has been championed by successive governments with unfavourable international comparisons often drawn between the proportions of senior healthcare leaders from a clinical background at home, and internationally. Doctors in particular are perceived as a group that has 'ceded managerial authority to non-clinical leaders' and 'lost influence over, and responsibility for, quality at an organisational level'<sup>1</sup>. In response to these concerns, in 2016 – alongside a raft of other measures - the Secretary of State for Health asked the General Medical Council (GMC) and Health Education England (HEE) 'to examine how clinical leadership can be incorporated as a core component of all specialty training'.<sup>2</sup>

Health Education England has an avowedly multiprofessional remit - as does the NHS Leadership Academy - but also a specific set of responsibilities to 50 000 doctors in postgraduate training for whom it commissions and manages the quality of clinical placements and oversees professional progression from selection to certification. This report summarises the current context and the extent to which the doctors in training in England are exposed to appropriate leadership development opportunities. It makes a number of recommendations about how the current training offer may be improved cast in the form of a set of **principles to inform future design, delivery and investment**. These have been co-created with a range of stakeholders across the country, including trainees, patients and lay representatives, service leaders, learning and development leads from trusts and community education providers, representatives of local and national NHS leadership academies and Health Education England's local teams, and members of postgraduate medical education and training networks. See Annexe A for details. Although the context of this report is the NHS in England, the messages within it are generic and can be applied across the four nations of the UK.

The report is intended as a beginning, not an end, and postgraduate deans and leadership academy teams are now asked to work together at a local level together with employers and other key stakeholders to progress this vitally important agenda using the principles as a guide.

### Why clinical leadership?

Health systems across the developed world face a set of wickedly complex challenges; a rapidly aging population, the rise of long term conditions and comorbidity, a belated but wide-reaching response of health system redesign, a relentless drive for increased quality and productivity coupled with accelerating technological advance, against a background of severe financial constraint.

Given the operating context, health system leadership is no longer an option for clinicians, it is a responsibility. It is not enough in the 21<sup>st</sup> century to simply be a technical expert. Healthcare isn't delivered by individuals working in isolation, but by complex systems that cross disciplinary and organisational boundaries. Effective clinicians need to understand those systems, be able to work *within*, and *with* those systems for the benefit of patients and populations.

In addition to the socio-political imperative, there are both theoretical and empirical arguments to support the engagement of clinicians in the leadership task.

The theoretical arguments tend to revolve around the self-determining nature of professions and the inverted power structures of 'professional bureaucracies' where staff on the front line have greater influence over day-to-day decision making than those in formal positions of managerial authority. Dickinson and colleagues<sup>3</sup> suggest this has a number of significant implications for health care organisations; key leadership roles are played by professionals, leadership is dispersed or distributed, the system requires collective leadership by teams of leaders from different levels of the system.

There is also a growing empirical evidence base, well summarised elsewhere, that supports a strong relationship between the engagement of clinicians in the leadership task and a range of healthcare quality and outcomes.<sup>4</sup>

### **Why now?**

A focus on 'medical' leadership development is not new, and was pushed to the fore in 2008 through the development of the Medical Leadership Competency Framework<sup>5</sup> and with an impetus sustained since the establishment of the Faculty of Medical Leadership and Management in 2011. But there are a number of new contextual issues that drive us to pursue this agenda with renewed vigour.

December 2016 saw the publication of a multiagency strategic framework for leadership development and improvement, *Developing People - Improving Care*<sup>6</sup>. This evidence-based framework aims to 'guide action on improvement skill-building, leadership development and talent management for people in NHS-funded roles'. It reiterates the need for clinical leadership and argues for a focus on the development of compassion and inclusivity, systems leadership, improvement skills and talent management. The overall aim of the framework is to 'create continuous improvement in care for people population health and value for money'. A number of conditions are identified as necessary to achieve that aim supported by thirteen proposed actions including (#2) 'Develop and implement strategies for leadership and talent development' and (#8) 'Embed improvement and leadership development in curricula, revalidation and reward schemes'. Health Education England and its local and national leadership academies are key signatories to the Framework and one of a number of lead organisations in its implementation.

In May 2017 the General Medical Council published its Generic Professional Capabilities a set of 'broader human skills, such as communication and team working, needed by doctors to help provide safe and effective patient care...common to doctors across all medical specialties'.<sup>7</sup> The intention is to embed the Capabilities, which include both leadership (Domain 5) and quality improvement (Domain 6), in the curricula of all royal medical colleges. This is a huge opportunity to position leadership and management in the main stream of postgraduate training, but also creates risks around approaches to implementation.

To be successful, any leadership development initiative requires a healthy interaction between employee and a workplace that enables and encourages learning. The recent contractual dispute by junior doctors highlighted a dissatisfaction of doctors in training with their work and

workload. Health Education England is leading a concerted effort to improve the working lives of this important frontline staff group and significant progress has already been made<sup>8</sup>.

Finally there is an on-going issue of constrained funding and resources, issues that challenge HEE'S ability to implement new centrally-run educational initiatives. In combination with the other factors listed above, this makes it vital that HEE works in collaboration and partnership across system if it is to deliver on this important aspect of training.

### **What is clinical leadership?**

As currently framed within health, leadership is considered to reside throughout organisations – a process, not a position – with the core purpose of bringing about continuous improvement in health of populations within finite resources. This has been encapsulated in a number of 'competency frameworks' the most recent being the Healthcare Leadership Model (2013)<sup>9</sup>. The model is built around nine dimensions under three themes. In which leadership serves to

- Motivate teams and individuals to work effectively
- Provide and justify a clear sense of purpose
- Focus in improving system performance

*Developing People - Improving Care* builds on this common approach making a key link, in terms of how we think about leadership development, between leadership and quality improvement. Similar frameworks can be found around the world with a growing consensus on what needs to be learned. Less clear perhaps, is how that learning should be approached.

### **How do we learn to lead?**

Before proceeding to heart of this report, it is useful to briefly consider some current trends in leadership development<sup>10</sup>. These trends are borne predominantly out of 'best practice' as the evidence base for leadership development is still emerging<sup>1</sup> but nevertheless are reasonably stable and pervasive.

First is a shift in thinking about leadership learning that moves us away from exposure to isolated programmes of 'teaching' and 'training' to a **longitudinal process of personal development** in which 'rather than learning leadership as it is known by others, learners make sense of their own experiences, discover and nurture leadership in themselves and in each other, not in isolation but in community' <sup>11</sup>. Framed in this way, learning leadership becomes then a process of participation in increasingly complex and personally informative tasks, rather than purely as the acquisition of a predetermined set of knowledge and skills. The role of the 'trainer' becomes then primarily one of structuring and sequencing appropriate experiences and providing opportunities to promote insight.

Secondly, the location of learning is moving **from the classroom to the workplace**. This is usefully encapsulated in a 30 year, almost universal, acceptance of the 70:20:10 model of leadership development<sup>12</sup>. In this model, 70% of the learning comes from work-based tasks, challenges and problem solving; 20% from learning about self from others through coaching, mentoring, role-modelling and social networks and only 10% from formal education and training. The corollary of this kind of approach is a need to think much more carefully about how to make

the workplace invitational to leadership learning and allow time for developmental conversations.

Finally there is the question; **whose career is it anyway?** Increasing geographical mobility, part-time working, portfolio careers and generational shifts have all led to careers becoming more the property of the individual than the organisation that employs them. It cannot be assumed that individuals who are singled out for development will want to undertake it. Organisational control over who is developed for leadership and management is therefore diminished, as is control over how and when this occurs. This is a particular issue in relation to doctors in training where organisational allegiance and ownership are challenged by the nature of training rotations, and within this group of (predominantly) 'millennials' there may be specific orientations to learning and development relating to choice and flexibility.<sup>13</sup>



## Section 2: Current state

### Leadership development opportunities for doctors in training

Across the country there are some excellent examples of local leadership development initiatives, a few of which have been highlighted in Box 1 below. However, the picture is one of variability; by location, by specialty and by stage of training, with little evidence of a sustainable, joined up or system-wide approach.

#### **Learn to Lead**

Health Education England in East Midlands offer a tiered leadership and management programme targeted at all doctors in local training programmes. Benchmarked against Faculty of Medical Leadership and Management standards the programme provides a clear and explicit offer delivered by local trained faculty founded on six taught days delivered across the training programme. Supported practical leadership activities provide an intermediate tier, and the programme aims to develop a higher tier of opportunities that offer sustained exposure to leadership activity.

#### **Fellowships in Clinical Leadership**

London's 'Darzi' Fellow programme - now in its 8<sup>th</sup> year - is founded on a year-long attachment to a workplace sponsor under whose guidance the participant leads a service improvement project. Project work is supported by a multimodal, accredited programme delivered by a university partner to a multiprofessional cohort of early career health professionals. Doctors in training constitute around half of all participants and access the Fellowship by taking a year 'out of programme'. The programme is commissioned by the London Leadership Academy. Similar Fellowship models are available elsewhere e.g. Yorkshire & Humber, Kent Surrey & Sussex, and nationally through the Faculty of Medical Leadership and Management.

#### **Leadership schools**

In Manchester and Liverpool, trainees have established leadership 'night schools'. These monthly evening meetings are addressed by guest speakers, many from senior leadership roles.

#### **Lead And Be Led and Leadership Development Centre**

Health Education England in Wessex offers a suite of leadership and personal development courses to healthcare professionals including doctors in training and educators. For example, the two-day Learn and be Led explores personal impact and uses team exercises to illustrate how important leadership is to an effective team. The Leadership Development Centre provides a two-day individual assessment of leadership and management skills to help individuals identify their own development needs and understand their own influencing styles. These are supplemented by attendance on a range of masterclasses, and access to coaching and mentoring, including feedback on the Healthcare Leadership model.

#### **Chief Resident Programme**

Cambridge University Health Partners and the Judge Business School's Centre for Health Leadership and Enterprise offer this joint programme to specialist registrars and GPs in the East of England. The programme, initiated in 2010 at Cambridge University Hospitals NHS Foundation Trust, attracts 40-50 participants each year and is sponsored by Health Education England. A similar national Chief Resident programme has since been established by the Royal College of Physicians.

#### **Central and North West London Mental Health Trust**

This programme is an example of a single specialty (psychiatry), place-based programme operating over a six year timeframe across three participating trusts. The programme includes a 12 month project, supervised by a trust manager, culminating in a presentation to the trust Board. An analogous programmatic offer in psychiatry is provided in West Midlands, but through the Health Education England School of Psychiatry.

#### **Professional and Generic Skills programme**

A collaborative venture provided by Health Education South West (HESW) delivered jointly by local universities. The programme is designed to provide doctors in training a combination of practice skills, knowledge and thinking to develop their career path as a clinical leader within an evolving NHS. Similar university-provided courses have been commissioned by other HEE teams e.g. North West.

#### **Taunton and Somerset NHS Foundation Trust**

In common with a growing number of trusts, Taunton and Somerset has an organisation-wide improvement strategy led by an Improvement Team created to help the hospital deliver change and improvement more effectively. Using Institute for Healthcare Improvement (IHI) principles the team supports services, departments and directorates deliver better, quality, safety and value healthcare to patients. In addition, the LEAD development programme aims to equip all staff who undertake it with the skills to undertake leadership roles and develop the capacity of their services to change.

#### **Box 1: Examples of leadership development currently provided for doctors in postgraduate training**

The best people to ask about development opportunities are, of course, doctors in training themselves, and following a series of focus groups conducted in Jan-Feb 2017 and developed during a number of regional stakeholder events held during Mar-Apr 2017 (see Annexe A for details), the following themes emerged:

#### ***Formal learning***

Formal learning opportunities were reported by trainees as ranging from 'nothing' to dedicated local, regional or national training days. Most trainees interviewed were being encouraged to (just) attend a short management course towards the end of training. Some trust-based provision was reported but this was the exception rather than the rule, and appeared to be most effective when linked to an organisation-wide system approach to (say) quality improvement. Trainee-led initiatives were in evidence in some areas and tended to focus on talks or interviews with guest senior leaders. In some parts of the country, HEE has begun to develop a structured programmatic offer.

Simulation-based training opportunities tended to cover some similar territory, particularly in consideration of 'human factors', but appeared to be underutilised in relation to the exploration of personal influence, team working and interprofessional learning. E-learning was accessed but usually in order 'to tick a box' with the currently available online provision (e.g. Edward Jenner programme) found 'slow going'. There was some self-motivated sign up to a range of university postgraduate provision including NHS Leadership Academy programmes. Fellowships of various models exist in most areas, some with multiprofessional cohorts, but with considerable variability in relation to structure and cost. Funding for such programmes tended to be short term with no year-on-year commitment.

#### ***Informal learning***

*'we take trainees out of service organisations to teach them in a classroom about the very organisations we've just taken them out of'*

Most trainees reported observing 'good people at work' but with little facilitated reflection on what had been witnessed. Reflection was invited for the purposes of the e-portfolio but this was felt to be stylised and ritualistic rather than authentic and useful.



Learning from role models was felt to be important but access to the appropriate individuals or experiences was not always easy and depended on how 'expansive' each individual 'apprenticeship'<sup>14</sup> or attachment was found to be. In lieu of facilitated access, shadowing of senior figures was sought out by the highly motivated.

A significant amount of quality improvement activity is starting to take the place of audit, but this was mostly unsupported, not linked to larger programmes of work or designed to meet organisational objectives. To some extent this echoed feelings of distance from mainstream trust direction with trainees often feeling side-lined or peripheral

*'nobody ever talks to a junior doctor about what the organisation wants'*

Although there had been recent improvements in this area as new terms and conditions for the 2016 junior doctor contract include a requirement that all trainees in England must be able to access and participate in a junior doctor forum.

Coaching was available in most areas but rarely accessed. Indeed, developmental conversations focusing on potential and aspiration, rather than performance, appeared hard to come by. Mentoring was available for the lucky few, but was usually dependent on a single committed and enthusiastic individual such as a training programme director or educational supervisor.

### ***Challenges and issues***

Trainees identified a set of challenges, issues and opportunities:

Allegiance and ownership The rotational nature of postgraduate training programmes has tended to privilege clinical and specialty learning over organisational experience. Short stints in a succession of service providers weaken the employee/employer relationship, reduce engagement and compromise access to work-based learning. Longer placements and place-based development - a key workstream of Enhancing Junior Doctors Working Lives<sup>8</sup> - are a way of overcoming these issues. Get it right and there are tremendous opportunities for trusts to attract future employees. This appears to be particularly important at 'on boarding'.

Identifying as a leader Doctors in postgraduate training may need help to recognise that they *are* in a leadership role, whether they like it or not. Some lack confidence or have a fear of failure that inhibits them from stepping forward. For others, there is a fundamental lack of understanding of the structures, in which they work, or how to identify and engage with stakeholders in order to get things done. The language and discourse used is important in identifying and naming activities as leadership but once trainees can recognise leadership in the everyday, the development task becomes a lot easier.

Timing of development It is widely recognised that there is a need to start early, but there are some fundamental issues at the undergraduate level concerning 'teaching leadership' to a group that lack managerial responsibility or experience. In postgraduate training, trainees report a palpable difference to between how treated or viewed in foundation or core training as opposed to higher specialty training. And there is little identifiable connection through into the continuing professional development of established GPs and consultants.

Curricula flexibility Although most curricula already feature leadership and management, a great deal of energy is expended in getting a tick in the right box at the right time. Workplace-based assessments are generally viewed as not fit for purpose and annual reviews - currently the subject of a review by Health Education England - are 'to be endured rather than aid development'. Personal development and future aspirations tend to be ignored in favour of clinical targets, numbers of assessments or procedures undertaken and portfolios to be better structured to encourage more meaningful engagement.

Work-based learning Access to rich learning opportunities in workplace settings is difficult unless the workplace is deliberately 'invitational' to learning. There are a number of ways that organisations were reported to have done this ranging from buddying schemes with managers, to regular meetings with the Chief Executive. Making time and space for leadership learning is more challenging, particularly in the face of the high clinical workloads being experienced by doctors in training.

Faculty There appears to be a paucity of faculty who understand the territory and are sufficiently connected into the business of the organisation to provide access. Supervisors tend to place value on other activities e.g.

*'we're not training you to be a leader, we're training you to be a xxx doctor'*

There was also a suspicion that motivation to engage in leadership development was about hierarchical progression

*'I just want to be able to do my job better'*

And in the main, truly developmental conversations were in short supply

Inclusivity The competitive entry for many 'high end' programmes such as fellowships led to concerns of elitism. This was also a worry in relation to talent management or suggestions that a similar structured scheme to that in operation for academic training could be established. Leadership development opportunities were seen as needing to be offered to all.

Coordination and phasing In a distributed training system, there are issues about who holds the ring for leadership development. This is important in ensuring coverage, design, delivery and phasing of the offer. Should it be the employer, the profession (via the College), HEE or the individual?

Availability of resources Finally there is the challenge of ensuring 'the greatest good for the greatest number' but across the country ideas and resources are not shared, national resources not utilised and service-based development programmes tend not to be accessible for doctors in training. Financial constraint necessitates a much greater sharing of resources and where investment is required we must recognise the value, rather than the cost.

## Section 3: Looking into the future

Leadership development, for all the reasons outlined above, must become a routine, core component of medical education. A sea change in how leadership and management are valued within the medical profession will be required but doctors in training appear hungry for such development and the future of our health services is at stake. If we are to do this well, a concerted effort from education and service providers is required underpinned by an intelligent approach to how development opportunities are delivered and accessed.

### Principles to inform future investment design and delivery

The following principles have been distilled from a series of regional stakeholder events held during Mar-Apr 2017 (see Annexe A for details). The aim of these principles is to inform the future investment in, and design and delivery of leadership development for doctors in postgraduate training. The principles, although couched as recommendations, are intended not as a straight jacket, but as a touchstone, or guide, for commissioners and developers.

#### 1. Values-based

The values of the NHS Constitution<sup>15</sup> should underpin all development activity with a particular emphasis on leading with compassion and inclusivity, both key components of the national framework for improvement and leadership development, *Developing People-Improving Care*. Trainers, employers and those in training organisations need to 'own' these values and model their associated behaviours.

#### 2. Universal coverage

'Build a floor, not a ceiling'. Everyone gets something, but not everyone has to do everything. Leadership should be embedded within all curricula, not an add-on extra.

#### 3. Spiral curriculum

A curriculum for leadership should continually revisit leadership in the context of self, team, organisation and system at increasing levels of complexity, focusing on what's important to a trainee at a particular phase of professional development. Early on that might be predominantly (but not exclusively) around personal impact and influence, later in training about team leadership and followership, later still about organisation and system.

#### 4. Tiered

Create a tiered offer. A programme of 'leadership literacy' is useful early on (e.g. in Foundation training) providing a language with which to discuss leadership and management and developing an understanding of both the working context (e.g. the NHS) and one's influence relationship with others. This should be followed by flexible range of learner-driven options supporting the leadership of change and improvement within workplace settings. More sustained development opportunities should also be provided for those with a special interest through a leadership and management 'track' or out-of-programme 'Fellowship' experience. Care is required over the presentation of high end programmes as they *may 'exclude more than*

*they encourage*'. Fellowships and similar programmes should be mined for maximum system benefit through using participants to encourage others and spread the learning.

Leadership includes an understanding of business processes and tools i.e. aspects of management are integral to the leadership task. Furthermore, as the aim of leadership development is to ensure continuous improvement in care and population health, quality improvement should be a fundamental component of all levels.

## **5. Clarity**

A leadership development offer should convey a clear sense of purpose (e.g. improving the health and care of populations, both today and tomorrow) and intended programme outcomes. It should be clearly structured, attractive and easily accessible. Uptake will also be encouraged if it can be made social and is timely i.e. provided when needed.<sup>16</sup> Expectations and milestones should be clear and straightforward with clear routes of progression and signposting to further development such as access to alumni programmes.

## **6. Flexibility**

Flexibility is important allowing learners to access opportunities when the time is right for them. Bite-size chunks are favoured by both busy clinicians and 'millennials' and for the latter, choice is important but within a clear framework. A variety of methods should be available and teaching and learning interventions should be evidence-based wherever possible.

## **7. Multimodal**

Leadership is a complex area of development and no single approach is sufficient to deliver what is required. A variety of interventions should be provided and assembled programmatically guided by the 70:20:10 'rule'. Effective leadership development programmes typically deploy the following inventions:

- Structured workplace experiences
- Project work
- Action learning
- Coaching and mentoring
- Multisource (360) feedback
- Psychometric tools and personality inventories
- Short courses, seminars and workshops
- Technology enhanced learning

## **8. Multiprofessional**

In the real world, diverse perspectives matter - including challenge from other professional groups - so design interprofessional learning in wherever possible. The more senior the trainee, the more complex the workplace experience, the more essential this becomes. Foster collective and collaborative approaches to leadership and use postgraduate medical programmes to

leverage team-based learning in workplace settings where other groups may not have the same access or permissions. There is also a need to recognise differences in orientation to learning and preparedness to engage with leadership. No one size fits all, all the time.

## **9. Workplaces invitational to leadership learning**

The 'invitational qualities of the workplace' are the ways in which the workplace provides and supports learning from work activity<sup>17</sup>. This is hugely important in developing individuals in social processes such as leadership and management.

Improving trust engagement with the trainee workforce is a cultural task for the chief executive and his/her senior leadership team. Many trainees are oblivious, and unknown, to their CEO or medical director and a new compact between organisation and trainee is required with providers needing to see the junior workforce as their 'talent pool'.

If the learning culture is set from the top, support on the ground should follow. Examples of organisational practices that improve access to leadership learning include:

- support for multiprofessional quality improvement project work that is aligned to organisational objectives
- participation or leadership of patient safety initiatives e.g. root cause analysis
- buddying schemes between trainees and managers
- better induction and on-boarding
- longer placements
- place-based training across groups of organisations
- structured opportunities to step up into greater responsibility e.g. chief resident programmes
- structured shadowing opportunities
- invitations to participate in senior team meetings

The creation of high quality workplace experiences will require employers, trainees and programme leads to work collaboratively together. In practice this is likely to involve medical directors, directors of medical education and learning and development leads in trusts and across community providers.

## **10. Formal learning designed to leverage work experience**

*'the 10% is like salt, you don't need much, but the 70 and 20% don't make much sense without it'*

Taught programmes don't make leaders, but there is a role for supporting workshops and courses to provide a space for reflection on the lived experience and to provide theoretical models to help learners navigate and deepen their understanding of the world. Formal teaching should therefore be structured around real world experiences and designed to enhance and illuminate those experiences.

There is a delivery role here for HEE working in partnership with local leadership academies, service organisations and higher education institutions, but a need to go beyond single specialty, 'school-based' provision.

### **11. Exploit the potential of simulation**

Simulation is widely deployed in postgraduate medical programmes and there are overlaps here with training human factors and 'skills and drills'. There is an opportunity to increase the attention paid in simulated exercises to interpersonal skills, team relationships and performance, leadership and followership. Also, where possible, opportunities should be made available for doctors in training to learn together with other early career professionals.

### **12. Make time for developmental conversation**

Leadership learners need access to 'safe' developmental conversations centred on potential and aspiration not just performance. This is particularly important at key transitional stages such as between foundation and core training, core to higher and at the end of higher specialist training. Such conversations should ideally be offered in the form of coaching before acquiring a Certificate of Completion of Training (CCT). Access to coaching networks should be improved and promoted and a programme of advanced supervisor development considered.

Annual reviews (ARCPs), as currently constructed, appear to be ineffective places for talent conversations. Work is needed, and has already been initiated, with ARCP panellists to help them understand their role in encouraging and promoting the development of leadership and management capability within the junior doctor workforce.

### **13. Faculty development**

Leadership development requires structured support from faculty (e.g. trainers, training programme directors, supervisors) but faculty also need support themselves to understand the 'territory' and their role. This includes:

- providing access to learning experiences and supporting participation in leadership activity of graded complexity
- holding developmental conversations about potential and aspiration including recognising, valuing and exploring relevant activity recorded in portfolios
- reframing; helping trainees to see leadership as integral to learning to be a clinician

This will require faculty to think differently about their role and be more confident in brokering leadership learning. A programme of faculty development should therefore be run alongside any leadership development offer. This could usefully be supported by the NHS Leadership Academy and Faculty of Medical Leadership and Management.

N.B. 'Faculty' includes senior clinical leaders who may act as champions, viewed as role models and preside over access to organisational experiences and learning.

#### **14. Demystify and normalise leadership**

Name the activity. Too many leadership courses rely on high profile speakers with seemingly impossible jobs. It is important to invite local clinicians to talk about and reflect on what they do and to use the newly 'certified' to share their journey i.e. by bringing leadership closer to home and making it real, it becomes a normal expectation of all, rather than an exceptional activity of the few. Selection of positive role models is important as is awareness that different specialties may use language differently and have a particular relationship with leadership and management.

#### **15. Focus on the future**

Leadership development for doctors in training needs to maintain a focus on the future. This means providing exposure to aspects of health and care that may not be available in the local organisation and includes issues such as system awareness and working (e.g. wider system appreciation including social care, third sector and local government), a shift in thinking about 'treating disease' to 'promoting wellness' (e.g. creating healthy communities, improving population and public health) and preparing doctors for a future of coproduction (e.g. through working alongside patients and citizens in project work, the use of patient stories and involvement of patient leaders in development programmes).

#### **16. Assess with purpose**

Assessment drives learning, but only useful if feedback is effective and constructive, and developmental opportunities are available subsequently. In the light of forthcoming curriculum changes there is an urgent need for better formative tools to support the trainee's leadership journey. More widespread use of the Leadership Academy Healthcare Leadership 360 would be a good, and easy, start.

#### **17. Co-create with doctors in training**

Use the experience of doctors in training (and those of newly qualified consultants and GPs) to structure and phase development appropriately and engage users in delivery. Tailor to pace, energy and learning preferences, maintaining an awareness of generational differences. Provide support and guidance for trainee-led initiatives. Create expectation and a sense of entitlement.

#### **18. Promote a common approach**

Providing a common approach to leadership and leadership development enables everyone to be able to identify and discuss the activity. It also permits fair and consistent access to high quality programmes - the overall aim of these recommendations - and allows for portability and transferability across the country.

Our national NHS frameworks and other resources are freely available, but these are not always used or indeed known. Local resources should be shared and where gaps exist, teams should work with the local and national leadership academy teams to source or develop what



they need. The Faculty of Medical Leadership and Management has a key role to play here in relation to its work around the professionalisation of medical leadership and the establishment and promotion of national standards.<sup>18</sup> A common approach would be supported through the identification of a lead for leadership in every HEE local team coming together as a national special interest group to provide a coordinating function and to curate a shared repository of resources and materials.

## **19. Synergistic design**

Reduce duplication and aim for a coordinated relationship between provision led by the service, HEE, local leadership academies and the profession. Collaboration and partnership working is key. Share resources and stop reinventing the wheel. Deliver locally where possible, but with the acknowledgement that there may be regional differences in how this plays out in different areas. Learning and development leads in trusts and community education provider networks are key stakeholders in supporting local delivery.

## **20. Sustainability**

Future provision needs to be sustainable long term and seen as core, not optional. Longitudinal programmes of development, such as Fellowship programmes, require a multiyear commitment to invest whereas to date, most development funding has come from discretionary or one-off funding. Consideration should be given to using placement funding and there may be a need to pool funding from different sources. HEE and local academies should work together to co-develop/commission activity and agree prioritisation of resources and alternative sources of funding (e.g. through partnerships) may need to be sought.

## **21. Start early**

By the time a doctor enters postgraduate training he or she will have spent 5-6 years at medical school during a highly influential stage of development. This is where leadership journey needs to start but universities will need the support and help of service providers and postgraduate deans to ensure that students on clinical placements are not just passive observers of opaque social phenomena, but are invited in to engage meaningfully as active peripheral participants in a community of clinician leaders. There is potential here for Health Education England to hold providers of clinical placements to account through its quality framework, and the Faculty of Medical Leadership and Management to work with the General Medical Council and support universities in developing their approaches to leadership development in the undergraduate curriculum.

## **22. Nurture talent**

In a fair and inclusive training programme everyone is afforded access to the same opportunities but those with ambition and potential to develop as positional leaders should be supported to do so. We are currently profligate with the outputs of our leadership development offers for trainees (e.g. little support or follow up is provided on return into clinical training following Fellowships) and this large staff group tends to be left out of structured talent

management programmes. If we are to realise the potential of this bright, highly motivated and energetic staff group, this situation must change.

### **23. Consider leadership development as a continuum**

Leadership learning doesn't begin or end at any particular stage of education and training. It is a life-long process and attention should be paid to ensuing connectivity across the phases and transitions of medical education, from undergraduate to postgraduate to continuing professional development. Particular attention should be paid on the transition to independent practice.

### **24. Evaluate, monitor and review**

Leadership development interventions should be evaluated, their availability and uptake measured and monitored with periodic reviews of the whole to ensure that the needs of patients and populations are continuing to be met.

## Recommendations and next steps

1. Postgraduate deans, working together with their local leadership academy, should ensure that a clear development offer is available, and accessible, to all doctors in postgraduate training built on the principles in this report. The workforce boards of sustainability and transformation partnerships should be engaged in this process. ACTION Postgraduate deans and local leadership academies.
2. Postgraduate deans and local leadership academies should engage in a three-way conversation with employers about how to create workplaces that support and invite leadership learning. This report should be used as the basis for those discussions. ACTION Postgraduate deans and local leadership academies.
3. Health Education England's national quality framework should be used to ensure leadership development opportunities are available as an integral part of all clinical placements. ACTION HEE Directorate of Education Quality, postgraduate deans.
4. A national implementation group of leads for postgraduate medical leadership development, representing all localities, should be established for the purpose of sharing best practice and resources, and developing a common approach. ACTION HEE Postgraduate Deans.
5. HEE should work with the Academy of Medical Royal Colleges and the Faculty of Medical Leadership and Management to ensure that local delivery, and curricula requirements and support are aligned. ACTION NHS Leadership Academy
6. Explicit measures of progress should be established, including a baseline assessment, and nationally coordinated monitoring and reporting. ACTION NHS Leadership Academy.
7. Implementation plans should be developed locally in line with this guidance and progress reported through HEE Postgraduate Deans (subject to governance review) and the Management Board of the NHS Leadership Academy. Overall accountability for clinical leadership development rests with Director of the Leadership Academy reporting to HEE Executive. ACTION HEE Postgraduate Deans and NHS Leadership Academy.

## Conclusion

'A foolish consistency is the hobgoblin of little minds' wrote Emerson. The purpose of this document is not to create such a consistency but to reduce variability of access to leadership development opportunities for the GPs and consultants of tomorrow. Leadership and management should no longer be seen as additional, but woven in to the fabric of all training programmes, and therefore available to all. And if leadership development is to be rooted in real world activity, then leadership development must be delivered locally. This will require collaboration and partnership between those responsible for the training, those being trained, their employers and those with leadership development expertise. And if the purpose of leadership development really is to improve the health of populations, then patients and citizens must be involved every step of the way.

## Annexe A

### Sources and acknowledgements

The findings and recommendations of report arise from a number of sources.

Four regional stakeholder events were held in Birmingham, Leeds, Bristol and London between 28th March- 6th April 2017. Over 200 participants attended the four events including doctors in training, service leaders, patient and lay representatives, HEE local postgraduate dean teams and members of their educational networks, local leadership academy staff and associates, trust and community learning and development leads and representatives of higher education institutions. Each event was designed along similar lines; an outline of the current context, an uncovering of current practice and a consensus building exercise designed to develop a set of principles to underpin future delivery and investment.

Although a number of doctors in training attended the stakeholder events, three focus groups were also held with leadership 'fellows' in Manchester, Sheffield and London in January and February 2017. The focus groups set out to address the question 'what do doctors in training think about their leadership development'. The themes from the focus groups were fed back into the stakeholder events and form a significant input into the design principles. The quotes in italics were taken down verbatim from focus groups or discussions at the stakeholder events.

The report also draws from the supporting documentation of a number of local programmes run in various parts of the country which were presented or discussed at the stakeholder events.

A number of key literature reviews have also informed this report and are listed in Annexe B.

Acknowledgements and thanks are proffered to colleagues from across Health Education England and the local leadership academies that have contributed to, and informed this report. A particular debt of gratitude is expressed to the teams in the local leadership academies of Yorkshire and Humber, South West, West Midlands and London that supported the stakeholder events early this year.

The report was compiled and drafted for Health Education England on behalf of the NHS Leadership Academy by Dr Tim Swanwick, Senior Clinical Adviser and Postgraduate Dean, Health Education England.

## Annexe B

### Key references

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- <sup>1</sup> Miller P & Sitton-Kent L (2016) Leadership & Leadership Development in the NHS: A Short Review [www.southwestleadership.nhs.uk](http://www.southwestleadership.nhs.uk).
- <sup>2</sup> Hunt J (2016) NHS Providers annual conference keynote speech <https://www.gov.uk/government/speeches/nhs-providers-annual-conference-keynote-speech>
- <sup>3</sup> Dickinson H, Ham C, Snelling I and Spurgeon P. (2013) Are We There Yet? Models of Medical Leadership and their effectiveness: An Exploratory Study. Final report. NIHR Service Delivery and Organisation programme.
- <sup>4</sup> West M et al (2015) Leadership and leadership development in healthcare. The evidence base. <https://www.fmlm.ac.uk/resources/leadership-and-leadership-development-in-health-care-the-evidence-base>
- <sup>5</sup> Academy of Medical Royal Colleges (2010) Medical Leadership Competency Framework (3e) <https://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Leadership-Framework-Medical-Leadership-Competency-Framework-3rd-ed.pdf>
- <sup>6</sup> NHS Improvement (2016) Developing People - Improving Care <https://improvement.nhs.uk/resources/developing-people-improving-care/>
- <sup>7</sup> General Medical Council (2015) Generic Professional Capabilities [http://www.gmc-uk.org/Generic\\_professional\\_capabilities\\_framework\\_0517.pdf\\_70417127.pdf](http://www.gmc-uk.org/Generic_professional_capabilities_framework_0517.pdf_70417127.pdf)
- <sup>8</sup> Health Education England (2017) Enhancing Junior Doctors' Working Lives <https://www.hee.nhs.uk/our-work/developing-our-workforce/supporting-doctors-training/enhancing-junior-doctors-working-lives>
- <sup>9</sup> NHS Healthcare Leadership Model (2013) <http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/>
- <sup>10</sup> Aggarwal R and Swanwick T (2015) Clinical leadership development in postgraduate medical education and training: policy, strategy, and delivery in the UK National Health Service *Journal of Healthcare Leadership* 7:109-122.
- <sup>11</sup> Antonacopoulou EP (2004) Methods of learning leadership: Taught and experiential. In: Storey J (ed.) *Leadership in organizations: Current issues and key trends*. Routledge, Abingdon.
- <sup>12</sup> Lombardo MM and Eichinger RW (1996). *The Career Architect Development Planner*. Lominger, Minneapolis.
- <sup>13</sup> Health Education England (2015) Mind the Gap <https://www.hee.nhs.uk/hee-your-area/west-midlands/our-work/research-innovation/mind-gap>
- <sup>14</sup> Fuller A and Unwin L (2003) Learning as Apprentices in the Contemporary UK Workplace: creating and managing expansive and restrictive participation *Journal Of Education And Work* 16(4):407-426.
- <sup>15</sup> NHS Constitution [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/480482/NHS\\_Constitution\\_WEB.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf)
- <sup>16</sup> Behavioural Insights Team (2014) EAST Four simple ways to apply behavioural insights [http://38r8om2xjhh125mw24492dir.wpengine.netdna-cdn.com/wp-content/uploads/2015/07/BIT-Publication-EAST\\_FA\\_WEB.pdf](http://38r8om2xjhh125mw24492dir.wpengine.netdna-cdn.com/wp-content/uploads/2015/07/BIT-Publication-EAST_FA_WEB.pdf)
- <sup>17</sup> Stephen Billett (2004) Workplace participatory practices: Conceptualising workplaces as learning environments *Journal of Workplace Learning* 16(6): 312-324.
- <sup>18</sup> Faculty of Medical Leadership and Management (2016) *Leadership and Management. Standards for Medical Professionals (2e)* FMLM, London.