

Developing clinical leadership capacity among UK foundation trainees

This article provides a guide to how junior doctors can act as leaders within their workplace using various leadership and management tools, and discusses a novel academic foundation programme in clinical leadership and management.

Active leadership and management is being called for from all professionals working in the NHS. Doctors are required to 'lead change as well as manage it', and it is proposed that medical leadership should be developed at all levels across the organization (Department of Health, 2002; Darzi, 2008).

The Medical Leadership Competency Framework (NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2010) sets out leadership competencies needed for doctors to become more involved in transforming health services supported by a growing body of evidence that indicates that doctors' appropriate involvement in clinical leadership and management has a positive effect on organizational performance and health improvements (Hamilton et al, 2008).

At the foundation stage, the Medical Leadership Competency Framework competencies have been developed into the academic foundation programme competencies, a subset of which refer specifically to clinical leadership and management (UK Foundation Programme Office, 2010). Together, these documents provide a framework for

training junior doctors in leadership and management. This framework informed the design of an academic programme in clinical leadership and management, a collaboration between the University of Leicester, East Midlands Foundation School and University Hospitals of Leicester NHS Trust emergency department. The programme is described in this article.

The Leicester academic foundation programme in clinical leadership and management

The 1-year academic foundation programme commenced in 2009, providing a cohort of twelve second year foundation trainees with the opportunity to develop management and leadership practice alongside workplace-based learning (with two-thirds of time spent in the emergency department) and masters' level study (comprising one third of the time). All trainees are expected to achieve clinical competences as laid out in the foundation curriculum in addition to studying for a Postgraduate Certificate in Clinical Leadership and Management. The Postgraduate Certificate curriculum is mapped onto the Medical Leadership Competency Framework and was developed from an existing, successful Postgraduate Certificate in Higher Education Leadership offered by the University of Leicester. Successful participants can go on to study at masters' level if they choose.

Throughout the year, trainees attend eight contact days at the University which include aspects of leadership and management theory, health policy and organizational systems, self development, group activities, case studies and action learning sets. Topics covered are set out in *Figure 1*.

The philosophy of the programme is that learners need to understand and

engage with relevant underpinning theory which is applied to a wide range of clinical contexts to deepen awareness and recognition of how their own and others' leadership and management approaches affect clinical practice and health outcomes. Self development and insight is fundamental to effective leadership and the programme participants engage in a variety of self-development activities, at an both individual and group level. Written assessments are closely aligned to workplace-based learning and reflect contemporary best practice in leadership and management development:

- An essay applying theory to workplace-based clinical practice
- A workplace-based project management report
- A reflective and evaluative portfolio.

The workplace-based project is a vital part of the programme, requiring the development and application of leadership and management skills in a real-life situation. This takes place through engagement in supervised projects, pre-determined by the Trust, carried out across a range of hospital departments. The project is carried out over 6–8 months, supervised by a named supervisor in the Trust who works with the trainee to identify and agree project aims, assist with access to people and departments, and provide support when things get tough.

Health improvement projects in the first year of the programme included:

- Responding to the European Working Time Directive by reallocating roles in the trauma unit
- Improving the content, utility and timeliness of discharges in the emergency department to allow electronic delivery
- Improving practice in blood transfusion in a hospital medical directorate
- Lean working in the emergency department

Professor Judy McKimm is Dean and Professor of Medical Education, College of Medicine, Swansea University, Swansea SA2 8PP. **Dr Junie Wong** is Core Medical Trainee, Emergency Department, John Radcliffe Hospital, Oxford. **Dr Richard Wright** is Consultant in Emergency Medicine, Leicester Royal Infirmary, Leicester and **Dr Helen O'Sullivan** is Director of the Centre for Excellence in Evidence Based Learning and Teaching, Faculty of Health and Life Sciences, The University of Liverpool, Liverpool

Correspondence to Professor J McKimm

- Exploring delayed discharges in the intensive therapy unit
- Improving theatre efficiency through establishing a 'day of surgical arrivals' unit.

The academic components of the programme aim to provide trainees with the knowledge, skills, interpersonal approaches and support to take on leadership roles in the Trust and successfully engage in change management and health innovation projects. Here, one of the trainees shares her experience of how the programme worked in practice using her work on implementing change at the Trust's transient ischaemic attack clinic. She identifies issues and strategies for junior doctors taking on leadership roles within their workplace and how application of relevant theory and models enables more effective junior doctor leadership.

The transient ischaemic attack clinic project: a junior doctor's experience

This project was carried out over 7 months in parallel with clinical work in the emergency department and academic study for

the Postgraduate Certificate. A performance audit had established that a limited proportion of patients were seen within national time targets, partly as a result of doctors' delay in triaging patients. Meetings with the project supervisor discussed results of analyses and suggested changes. An automatic nursing triage system was introduced and re-audit found this was successful in improving the proportion of transient ischaemic attack patients assessed in accordance with national guidelines.

Project initiation

Identifying a good project supervisor who can provide high level support and facilitate the progress of your project is vital. Support from the clinical lead within the Department of Stroke Medicine was invaluable in empowering me to introduce changes to the transient ischaemic attack clinic. Drawing up a project initiation document which incorporates the 'who, why and what' of your project and discussing it with your supervisor allows you to establish a clear understanding of the project's aim and scope. It also acts as a

reference point throughout the project, preventing you from sidetracking from objectives or activities identified at the outset.

Effective leaders need to understand the working environment and identify why change is necessary. When planning for change, a SWOT analysis (listing internal strengths and weaknesses and external opportunities and threats) helps identify key issues, encouraging you to strategize your actions to exploit strengths and opportunities while minimizing weaknesses and threats. Identifying external forces (which included national targets) coupled with internal audit (demonstrating lack of conformance with national guidelines) supported suggested changes in the transient ischaemic attack clinic.

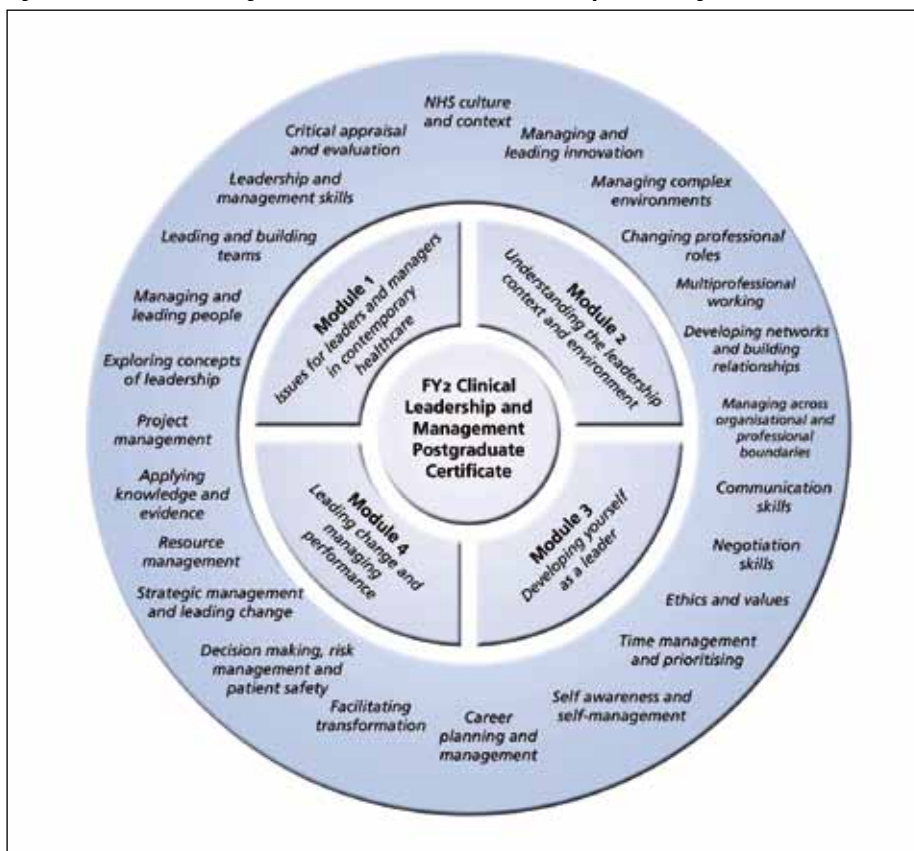
Working with complex adaptive systems

Even small-scale health-care systems such as the transient ischaemic attack clinic can be complex. The large number of stakeholders (including doctors, nurses, patients) involved in running the clinic and the existing connections between them can result in constant and discontinuous change, i.e. reflecting a complex adaptive system (Marion and Bacon, 2000). Within such systems, there is a tendency to maintain generally bounded behaviour, or attractor patterns in response to change. Stakeholders may be attracted to some elements of the change and resistant to others, evaluating change from their individual perspective. As such, junior doctors need to recognize that implementing change in health-care systems can be extremely slow and, as even relatively small changes may impinge on many systems, multiple adjustments may need to be made to the original project plan.

Understanding and introducing change

Change can be viewed in four ways: psychologically, structurally, culturally and politically (Bolman and Deal, 2003). This 'framing' helps you consider multiple dimensions of change. Psychological aspects include personal feelings involved during a change process, e.g. uncertainty among nurses having to triage patients.

Figure 1. The Leicester Postgraduate Certificate in Clinical Leadership and Management.



Thinking structurally enables a consideration of formal roles and relationships. Cultural aspects include existing organizational values, beliefs and routines. Finally, when thinking politically, the arenas of competing interests and how to influence and negotiate change have to be considered. The junior doctor's (with little affiliation to the department) attempt to implement change may intrude on the political and cultural context of change.

To plan, introduce and monitor the impact of change, Kotter's (1995) change model is helpful, particularly in helping to identify where things might be going wrong (Table 1).

Good leaders need to make sense of the work environment by understanding the issues, communicating these to colleagues and actively moulding their responses (McKimm and Phillips, 2009). This can be achieved by actively collaborating with others and building relationships to secure commitment and involvement to deliver sustainable change and improvement.

Challenges and opportunities

Until recently, leadership and management were not necessarily seen as essential components of undergraduate medical programmes and there was little training in these areas at postgraduate level. The move to (re)engage doctors in clinical leadership has stimulated a wide range of initiatives, including doctors being involved in change management projects supported by e-learning (e.g. LeAD, www.e-lfh.org.uk/projects/lead/index.html) and local training programmes. All foundation trainees are required to participate in short workshops and e-learning

on management and leadership as well as carry out a clinical audit, and academic foundation programmes provide an opportunity for those with a particular interest in leadership and management to progress.

Academic foundation programmes

A number of deaneries have introduced more comprehensive leadership development programmes as part of the academic foundation programmes, including that of Leicestershire, Northamptonshire and Rutland Healthcare Workforce Deanery, one of the early proponents of clinical leadership and management programmes (Gallen et al, 2007). This programme was originally an interprofessional programme which enabled the participants to learn from other health professionals on an accredited programme while engaging in two 6-month rotations in general medicine and general practice. Following evaluation, the programme is now more targeted towards the specific needs of the trainees and attracts a large number of applicants.

The Leicestershire, Northamptonshire and Rutland approach echoes that of the Leicester academic programme described above. It is vital to ensure that there is some stability in the clinical environment (either a year-long placement or two 6-month placements would seem ideal) so that trainees can have the best opportunity to achieve the foundation competencies while undertaking an academic award-bearing programme.

Evaluation of the Leicester programme indicates that the workplace-based project

is vitally important to the trainees' success on the leadership programme. Good supervision is required so that the trainees are fully supported in what is often a difficult task. The project and the trainee's specific role within it needs to be clearly identified and communicated to all stakeholders. Trainees agree that the most effective role for them is as 'project champion' and for that they need to learn specific project management skills, how the organization is structured and functions, and how people within it work and relate to one another. This is a key area of learning for the trainees and one which has not typically been learned at medical school. The other learning gain of participating in the project is that of developing their own personal leadership style and approaches as they learn to navigate complex systems. Action learning sets, tutor and supervisor support and personal management skills are vital pieces of the jigsaw that enable achievement.

Challenges remain in applying the Medical Leadership Competency Framework to the large number of foundation doctors and enabling them to develop appropriate leadership skills. Current foundation assessments do not specifically measure clinical leadership and management relating to health systems or organizations or intra- and inter-personal leadership skills (McKimm and Petersen, 2010). While the current understanding of clinical management and leadership among some junior doctors may be poor, many already participate in leadership activities, e.g. team leadership, management meetings or audits but without a theoretical or practical underpinning.

Palmer and colleagues (2008) investigated 196 second year foundation trainee doctors studying a team work and leadership module as part of the West Midlands foundation programme and found that the three competencies that were felt to be most important for the development of clinical leadership in the NHS were 'drive for improvement', 'collaborative working' and 'personal integrity'. They felt that the 'personal qualities' domain from the Medical Leadership Competency Framework was the most important and, strikingly, did not mention 'self management', 'political astuteness' or 'holding to account' at all.

Table 1. Actions for leading change

Kotter's change model	What was done
Creating urgency	Conducted an audit against national targets
Forming a powerful coalition	Worked with clinical lead of the department and other key stakeholders
Communicating the vision	Created a proposal and presented to stakeholders
Empowering others	Introduced changes beneficial to stakeholders which they carried out
Creating short-term wins	Implemented small changes instead of big changes which could be quickly put in place
Building on change	Re-audit and proposing new changes
Anchoring changes	Proving to key personnel that changes worked and making these 'the way we do things round here'

From Kotter (1995)

Junior doctors tend to work within a transactional, or power and reward concept of leadership, associating leadership with the structure of the medical hierarchy (Barrow et al, 2011) and Palmer et al (2008) suggest that 'the majority of them [second year foundation trainees] accept the system as it is at the moment, and are probably more concerned about the acquisition of clinical skills and the care of patients than about looking for improvements and change'. This perspective probably reflects their duties at the time and the demands of the foundation programme and, as Palmer et al acknowledge, the views of doctors about leadership will change with experience, maturity and seniority. This is very apparent when considering the changing perspectives and growth of trainees on academic leadership programmes as they learn and reflect more about leadership in both theory and practice.

Conclusions: engaging junior doctors in leadership

The vast majority of trainees will not engage in an intensive, supported exposure to leadership and management theory and practice as have the Leicester and other academic second year foundation trainees. For many junior doctors therefore, effective leadership may more closely reflect Kelley's concept of active or exemplary followership which emphasizes self-directed leadership in the absence of the power of a job title, encouraging the exploitation of the 'power of expertise, influence and persuasion' so that, through active participation and team-working, they become leaders at their workplace (Kelley, 1992; Fullan, 2004).

As the Medical Leadership Competency Framework suggests, all junior doctors should be able to manage themselves, recognize their impact on others and work collaboratively in teams, while facilitating improvement and provision of high quality, safe health service delivery. This requires:

- A much greater awareness of leadership and management concepts and approaches from supervisors
- Robust and meaningful leadership development activities locked into organizational and health system needs and improvement

- Specific assessments of clinical leadership and management skills and behaviours which are not just tick box exercises or rather superficial multi-source feedback assessments
- A clearer definition of what junior doctors are expected to lead and manage
- The provision of supported opportunities for engagement in management activities
- Management training geared to improving services within trainees' micro-environment.

Full engagement of doctors in leadership and management must include effective leadership and management being modelled 'at all levels' and leadership development which includes all students, trainees and practising clinicians across the NHS. Through a coordinated approach to such initiatives involving health-care and academic partners, doctors at all levels can take appropriate leadership roles in improving organizational performance and developing and sustaining wider health improvements and innovations. **BJHM**

Conflict of interest: none.

Barrow M, McKimm J, Gasquoin S (2011) The policy and the practice: early-career doctors and nurses as leaders and followers in the delivery of health care. *Adv Health Sci Educ Theory Prac* **16**(1): 17–29

Bolman LG, Deal TE (2003) *Reframing Organisations. Artistry, Choice and Leadership*. 3rd edn. Wiley, San Francisco

Darzi AW (2008) *High quality care for all: NHS next stage review final report*. The Stationery Office, London

Department of Health (2002) *Managing for excellence in the NHS*. The Stationery Office,

London

Fullan M (2004) *Leading in a culture of change: personal action guide and workbook*. Jossey Bass, San Francisco

Gallen D, Lynch M, Buckle G (2007) Addressing leadership and management competencies in Foundation Year 2. *Clinician in Management* **15**: 87–93

Hamilton P, Spurgeon P, Clark J, Dent J, Armit K (2008) Engaging Doctors: can doctors influence organisational performance? NHS Institute for Innovation and Improvement, London (www.aomrc.org.uk/publications/reports-guidance/download/197-engaging-doctors-can-doctors-influence-organisational-performance.html accessed 18 June 2011)

Kelley RE (1992) *The power of followership: How to create leaders people want to follow and followers who lead themselves*. Currency Doubleday, New York

Kotter J (1995) Leading Change: Why transformation efforts fail. *Harvard Business Review*. **March-April**: 1–20

Marion R, Bacon J (2000) Organizational Extinction and Complex Systems. *Emergence* **1**(4): 71–96

McKimm J, Petersen S (2010) Developing and testing tools for assessing leadership skills and competencies in emergency medicine trainees. Oral presentation. Ottawa Conference, Miami, 17–21 May (www.ottawaconference.org/images/stories/Ottawa_Conference_2010_Abstracts.5.10_1.pdf accessed 20 June 2011)

McKimm J, Phillips K (2009) *Leadership and management in integrated services*. Learning Matters Ltd, Exeter

NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges (2010) *Medical leadership competency framework: enhancing engagement in medical leadership* 3rd edn. NHS Institute for Innovation and Improvement, Coventry

Palmer R, Cragg R, Wall D, Wilkie V (2008) Team and leadership styles of junior doctors. *The International Journal of Clinical Leadership* **16**: 131–5

UK Foundation Programme Office (2010) Compendium of academic competencies. www.foundationprogramme.nhs.uk/download.asp?file=Compendium_of_Academic_Competences.pdf (accessed 18 June 2011)

KEY POINTS

- Current foundation programmes provide limited opportunities for trainees to develop leadership and management skills with a theoretical underpinning.
- Clinical leadership and management are not assessed fully in the foundation programme.
- Academic foundation programmes provide those with an interest in clinical leadership and management with opportunity to develop skills and gain an award.
- Foundation doctors can make effective contributions to health improvements if given the right support and resources.
- More work needs to be done to determine the most effective ways of developing leadership and management competencies in all foundation trainees.