Faculty of
Medical Leadership
and **Management**

Improving leadership and management training and assessment for doctors in postgraduate training

Report of thought leader survey and interview results

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Introduction

This report sets out the results and findings from semi structured interviews and an online survey of acknowledged and active 'thought leaders' in leadership development for doctors and other health professionals.

During the initial literature review and survey development stage, it became clear that, whilst it is helpful to gather evidence from the published literature and from trainees and trainers 'on the ground', if the team is to produce something highly innovative and contemporary, then tapping into the experience and wisdom of experts in leadership development for doctors and other health professionals was necessary.

Practice in leadership development varies around the world, reflecting differences in cultural, educational, and healthcare policies and practices. The focus on supporting people to better engage in leadership development as a trainer/educator is hugely important and often overlooked or assumed, therefore the project team decided to engage with both UK and international experts in leadership development who are prominent in their field and context to seek their perspectives. This will fill a gap in understanding that cannot be gleaned solely from published literature or practising doctors.

Methods

Mindful of the busy lives of such experts, the team devised a short interview schedule and an online survey utilising the same questions, so that individuals could choose how they preferred to respond. The team designed the questions following an initial literature review and analysis of some survey responses to ascertain whether there were specific areas the team might need to probe.

The team identified an initial group of 20 potential interviewees (as funding for interviews is relatively limited, and these are time consuming to carry out and analyse) from their networks and known experts and sent email invitations out between December 2021 and March 2022. In parallel, a wider group of people involved in leadership development were identified and invitations sent out in the same time period.

Through the interviews and survey, the team wanted to gather information from a range of key international stakeholders on the following:

1. What they have been and are currently involved with re leadership development for doctors/other health professionals
2. What works in leadership development, what doesn't, and where are the gaps
3. What barriers exist and how could we overcome them
4. If 'the world was your oyster' (money no object), what would be the best practice in supporting doctors in training through formal training in leadership and management as well as in the workplace (including all doctors, as well as those with a special interest)
5. What should we be 'teaching' in formal courses? to try to identify some threshold agreed central concepts, models, approaches
6. What specific resources and/or grey literature do you use and find helpful
7. What specific activities should doctors in training engage in in the workplace to develop

their leadership/management skills – here we are thinking about both clinical and management situations

8. How best should we assess, and what should/could we be assessing
9. Any other thoughts or ideas about leadership development for doctors in training.

Responses and demographic data

Twenty-five interviews were carried out and 26 survey responses were received: a total of 51 respondents. Detailed demographic data was not gathered for these respondents, other than professional background, role and experience in leadership development for health professionals. The majority of respondents were doctors (all but three) and currently, or had recently directed or managed leadership development programmes for doctors or other health professionals. Thirty-one had acted in senior leadership positions including Deans of Medical Schools, Postgraduate Deans and Policy/strategy advisers for Departments of Health. All had been involved in leadership development for at least seven years.

Summary of findings from experts in leadership development

The core findings and recommendations for further consideration and exploration are as follows:

Formal courses

1. There is good consensus on what should be provided via formal courses in terms of content, with a strong emphasis on developing leadership skills relating to self and others, understanding how organisations and systems work, and putting theory into practice with real life examples
2. There is also strong consensus on the approaches that should be taken to facilitate learning: a focus on reflection; theory tied to practice; small group activities, discussion and debate; interactive learning; blended and hybrid learning to facilitate access and flexibility; a programmatic approach recognising that leadership development is longitudinal
3. For award bearing programmes, there is a consistent view on the types and purpose of assessments, including a range of written, practical, and behavioural summative and formative methods
4. In both formal education/training as well as workplace learning, opportunities for practice and feedback, guided reflection, and theories and activities being made relevant to the workplace and the individuals' own context and stage of development are all deemed essential.

Workplace learning and assessment

5. The workplace is defined by all as the place where doctors should primarily learn to develop their leadership capabilities in both clinical and managerial situations
6. Leadership activities, learning and feedback should be embedded into all aspects of clinical work and long-term experiential development is the most appropriate way for doctors to acquire their knowledge and skills
7. Examples of learning approaches include blended learning; shadowing junior/senior leaders; small group discussions; case work/studies, mixing specialities; embedding opportunities for reflective practice, and centralised e-learning to cover theoretical basics and philosophy supplemented with local workshops (blended learning with options improves accessibility).
8. Projects are seen as central so doctors can get their teeth into something real and apply theory to practice.
9. Learning should be scaffolded according to stage of training and individual development,

supported by consistent coaching and mentoring

10. Supervisors are key to the development experience, however role modelling and support from the senior leadership team is vital to set a culture where leadership is valued and nurtured at all levels
11. Supervisors must be willing, engaging role models who understand leadership development and must offer support and be able to identify opportunities for supervisees to engage in 'real life' practice
12. There was a general consensus that supervisors were much more confident in and familiar with assessing leadership, management and followership in the clinical context than in management situations.
13. Leadership and management capabilities can be evidenced through leadership of specific clinical situations such as a crisis, trauma, ward round or discharge, or contextual assessments such as emergency medicine doctors being observed leading the department
14. Leadership situations and expectations will be different across the specialities and different contexts, so will need to be tailored accordingly
15. Respondents felt strongly that leadership development (in common with most personal and professional development) should not rely on high-stakes assessment events (such as examinations) but should be programmatic
16. Summative assessment is seen as more problematic and difficult
17. Whereas some respondents said there should be no specific assessment of leadership and that it should be integrated with other workplace assessments, most said that leadership should be assessed as a discrete topic, for example though observation, multisource feedback, workplace assessments, portfolios and reflection
18. There was strong support for the development of EPAs (*Entrustable Professional Activities*) in terms of leadership.

Challenges, issues and recommendations

19. Access to leadership development is often inequitable, with huge variability across the UK and in different specialities
20. Many respondents mentioned the lack of educators available who are clinically trained, have a theoretical knowledge of leadership and management as well as significant leadership experience
21. The practicalities of 'learning leadership' in busy clinical environments for trainees
    a. trainees need guidance on how to spot leadership and development opportunities and obtain feedback
22. Educational and clinical supervisors often feel like 'imposters' when asked to 'teach leadership' or support trainees in their leadership journey and did not see themselves as credible leaders
    a. trained and confident facilitators are needed to support self-development and team working
23. A 'training the trainers' programme is needed for supervisors, to include:
    a. some theoretical concepts and management models, linked to day-to-day practice
    b. case studies and scenario examples
    c. training in facilitating interactive and self-development activities and dealing with issues
    d. training in how to teach/facilitate learning, give feedback and assess leadership both 'on

the run' in the workplace and in more formal classroom settings

24. Respondents mentioned the lack of training and development opportunities for them as 'leaders of leadership development' and their struggles to keep abreast of the massive literature and remain contemporary and credible
    a. Opportunities for networking and developing practice would be welcomed
25. A strong theme that emerged throughout was the need to develop a shared 'language of leadership', to not shy away from identifying situations where leadership is needed and use the *'l'* word in everyday conversation.
    a. This needs to be explored further in terms of raising awareness of the importance of using the language of leadership and management in clinical as well as management situations: this means using some management jargon as well as identifying situations/activities as being leadership, management or followership
    b. be more equitable and inclusive in terms of access, targeting and language
26. A strong emerging theme from UK-based respondents was that there are too many expectations/frameworks which are not aligned with one another, for example: FMLM standards. GMC professional capabilities; Royal College curricula; health leadership model, etc.
    a. Some respondents suggested that a 'national indicative curriculum' would be helpful, similar to the Canadian model or linking existing standards frameworks together with examples of how to facilitate learning, give feedback and embed leadership development into formal workplace assessments.

Specific challenges were described by all around workplace learning and assessment, at all levels, including:

27. The healthcare system which tends to provide training and experiences in a 'just in time' manner and does not emphasise succession planning, except for more senior staff in organisations
28. This is exacerbated by training programme structures which require trainees to move from rotation to rotation, and to different organisations, so the department or organisation does not see the benefits of its investment and trainees themselves are unable to lead long term quality or service improvement projects
29. Opportunities for meaningful assessments of leadership/management abilities are not embedded in formal assessments of training, therefore not deemed as important as 'clinical' expertise
    a. prepare doctors for managing challenging situations in a range of contexts, not just clinical situations
30. A change in culture is needed from where leadership is considered an 'extra' or only relevant to 'managers' or senior clinicians to something that is integrated in every aspect of training
    a. start leadership development early and make it a core skill set, not an add on for senior people
    b. tailor leadership development to level and areas of practice
    c. build leadership development into schedules as an expectation, rather than an 'add-on'
    d. ensure that trainees are appropriately renumerated and have enough time to focus on long-term leadership development; provide more mentoring opportunities
    e. development needs to be centred around longitudinal personal and professional development in the workplace, supplemented by more formal training, not the other way round
31. Lack of time was cited as the most common barrier to dedicate to coaching, learning, or

mentoring due to clinical workload, crowded curricula, or unsupportive managers
    a. senior leadership therefore needs to preserve training and development as a core activity.

Detailed findings from surveys and interviews

The series of questions in the interviews and surveys were designed to get a sense of what these experienced, expert faculty developers saw as the core elements of effective leadership development, what approaches were inappropriate and ineffective and what gaps existed in leadership development and why.
The project team also explored their ideas around the future for leadership development and the approaches that would help develop and sustain a health and medical workforce equipped to lead and manage effective health services focussed on improving health outcomes.

Findings from the interviews and survey questionnaires are reported here under two sections: one relating to formal courses and one relating to workplace-based learning. In each section, the project team consider what the 'thought leaders' see as best practice in learning, teaching, and facilitating, what gaps and barriers exist, how leadership development should be assessed and broader ideas around the future of leadership development. As the question set was the same, respondents from both data sets have been coded together from R1 to R51.

Formal courses

All UK doctors in training are required to engage in some formal education around their leadership development as are new consultants. Each of the health education bodies in the UK provides a range of short courses or workshops and these are supplemented by offerings from regional and local providers, including the Royal Colleges. Doctors in training who have a deeper interest in developing their leadership and management skills can apply competitively for various schemes such as national, regional and speciality-based fellowship programmes, funding for postgraduate award-bearing courses, or can fund themselves, although may not be given study leave.

Best practice in teaching and facilitating learning

Formal learning opportunities were highlighted as something that was working well, with many respondents praising their blended learning programmes. Developed in response to the pandemic. Several mentioned the importance of providing flexible, intensive workshops, rather than longer, theory-based lecture-based programmes. Many expressed the need for leadership development to be geared towards improving patient care, with examples and case studies utilised to demonstrate the relevance to participants at various levels.

R25: "What works are intensive workshops that are relevant to the contexts and have practical application. It is healthful to include leadership in complex systems and discussions on power."

It is clear that a broad consensus exists around the nature and approach to formal leadership development: courses, workshops and award bearing programmes. These typically offer webinars or workshop style events that include the levels at which leadership operates: developing self, leading and working in teams, organisational and system leadership.
Change leadership and management is a thread that runs through many programmes. The project team explored the concept of 'threshold concepts' with interviewees and although this was felt to

be very hard to define and needed more time, below is a summary of what respondent's feel are the most important content areas of the programmes.

What experts define as the important things to teach/learn

- Why leadership is important, what leadership is, what it involves; can build on existing frameworks e.g., FMLM standards, AoME professional standards
- Leadership, management and followership: the importance of each
- Leadership styles, theories, concepts and models
- Teamwork, understanding team dynamics; communication (e.g., having difficult conversations), working with patients, colleagues, stakeholders, etc; how to influence; conflict management; building community, networking; vision setting
- Emotional, social and cultural intelligence
- Resilience, problem solving, humility
- Self-awareness, reflection, integrity
- Managing and leading change, shifting mindsets
- Systems and complexity; NHS structures, policy, finance; public affairs; government relationships, governance
- Adaptive leadership, collaborative leadership
- Strategic thinking.

What every respondent highlighted is that any 'theory' must be tied closely to the doctors' day to day practice, so that theory becomes 'theory in use' and is meaningful to the doctors' practice. For example, R47 explained:

"For leading teams we talk about what is it that you need to do to lead a team, how, what kind of a leader you need to be, authenticity and psychological safety comes into it but in a way that makes them think about their own personal journey as opposed to it being, Amy Edmundson said this and this is her journal article, go and read it. It's more about how you actually put it into practice."

This quote also highlights the importance of reflective practice and its centrality to leadership development. Various approaches to embedding and encouraging this were described, including promoting interactive facilitation and discussion; break out groups; action learning sets; stepback groups; story telling; reflective writing and using self-development instruments such as MBTI and NEO-PI etc. Some respondents expressed doubts about the value of using personal development instruments whereas others found them a helpful trigger for working with their participants to gain more self-insight. There was however broad agreement that well trained facilitators are needed to support self-development and team working because of issues that may arise, and that self-development activities need to be carefully planned and introduced within a programmatic approach, not just bolted on.

Broad consensus also exists on the approaches to teaching and facilitating learning. All respondents highlighted the need to utilise the participants' own workplace opportunities and current challenges to put theory into practice.
A very common example cited involved the doctors' engagement in workplace quality improvement projects, linking QI tools with theories of change leadership.

R32: "To introduce leadership concepts and ideas that you can apply to real world problems, and in the context for a health authority or a professional and body and say, give us a leadership challenge that you're facing right now. Go away for a week as a group to provide a solution informed by the discipline of leadership. We've always taken the perspective that there is a discipline to leadership that it's not an ad hoc notion …The team report back to CEO or other senior person the solutions and ideas that they came up with, and in the process we taught team dynamics, because we put the cohort into teams to seven or eight."

R23: "My experience has been that leadership development works best when it is closely linked to workplace activity. Theory and practice need to be closely linked […] it needs to be specific for the trainee's clinical role or specific for a leadership role for established practitioner. Theory without practice is less successful, Leadership to get through consultant interviews isn't a good idea - it shows at interview because [the learning is] not deep seated."

What the experts say works

- Reflection: Understanding the need to reflect on their experience (rather than just being taught)
- Formal learning, blended flexible programme formats, mixing reflection/theory/practice with 'real work'; small chunks of learning; case studies; online and face to face
- Coaching, action learning sets, mentoring (especially long-term), shadowing, peer learning, webinars, workshops
- Engaging in day-to-day practice, providing 'real-life' case studies or opportunities to apply theory to practice
- Many programmes invite senior leaders in to share their stories and journeys and give learners the opportunity to ask questions and share their thoughts
- Discussion and engagement with others; deep reciprocal relationships; community building
- Opportunities to develop emotional intelligence, self-insight and interpersonal skills
- Explaining NHS context, structure, policy and financial aspects; explain complex systems and power dynamics.

Most respondents felt that formal programmes should be delivered interprofessionally and that many opportunities are currently missed as the focus is often on uni-professional learning and this reinforces siloed working. However, two interviewees felt that programmes should not be interprofessional and that doctors have unique needs which can only be met through 'doctors only' programmes.

Assessment

Short courses, webinars and workshops are not typically assessed formally although the vast majority require an evaluation which includes a reflective component on what the participant has learned and how they plan to put this into practice. Because of cost and time implications these are not usually followed up with the participants, although doctors will often provide a reflection on these in their portfolios.

These short courses tend therefore to be one-off, stand-alone experiences that are not directly related to the participants' ongoing practice and development: they therefore run the risk of becoming just another tick box exercise along with other mandatory training.

Award bearing programmes (postgraduate certificates, diplomas, and masters) utilise a range of assessment methods which reflect the specified learning outcomes in relation to knowledge, practical skills, and professional behaviours.

- *Written assessment* methods include essays (e.g., putting leadership theories into a healthcare context, demonstrating understanding of theories and concepts); project management reports (e.g., of a work-based project); literature reviews (of books or articles on leadership or of a topic area of interest to the student); short answer or multiple-choice questions (less used in the UK) and reflective narratives (e.g., concerning a critical event or leadership journey).
- *Practical skills assessment* methods are less utilised for summative assessment, but examples provided include presentations (individual or group); debate; leading a group activity and being given feedback and group teamworking activities.
- *Professional behaviours' assessment* methods tend to be formative in nature and involve a strong reflective component (these maybe incorporated into written and practical assessments or standalone), they include 360 (multisource) feedback; self-development instruments and feedback; critical or significant event analysis; analysis of effective leadership, and team and group activity leadership and feedback.

Gaps, barriers and suggestions

- The main barrier relating to formal programmes is that not all trainees have equal access to development programmes and disparities were highlighted from many respondents in the UK, Canada and Australasia.
- In terms of assessment, individual doctors' experiences on short courses or workshops should be much better integrated within a programmatic, 'vertical' approach to leadership development.
  R12: "What works is if the curriculum uses real challenges and provides the support for meaning-making. What does not work is to look at this as pure skill acquisition, without vertical development."
- Many respondents mentioned the lack of educators available who are clinically trained, have a theoretical knowledge of leadership and management as well as significant leadership experience. Many mentioned that educational and clinical supervisors often feel like 'imposters' when asked to 'teach leadership' or support trainees in their leadership journey and did not see themselves as credible leaders. This reinforces the need for a 'training the trainers' programme.
- Respondents also mentioned the lack of training and development opportunities for them as 'leaders of leadership development'. It is hard to keep abreast of the massive literature and remain contemporary and credible so opportunities for networking and developing practice would be welcomed
- A strong theme that emerged throughout was the need to develop a shared 'language of leadership', to not shy away from identifying situations where leadership is needed and use the *'I'* word in everyday conversation.

- A strong emerging theme from UK-based respondents was that there are too many expectations/frameworks which are not aligned with one another, for example: FMLM standards. GMC professional capabilities; Royal College curricula; health leadership model, etc.
- Some respondents therefore suggested that a 'national indicative curriculum' would be helpful, similar to the Canadian model or linking existing standards frameworks together with examples of how to facilitate learning, give feedback and embed leadership development into formal workplace assessments

Workplace based learning

Best practice in teaching and facilitating learning

The main message that emerged from these responses is that whilst supervisors are key to the development experience, role modelling and support from the senior leadership team is vital to set a culture where leadership is valued and nurtured at all levels. Many examples were cited in which these experts felt they were battling a system which did not see doctors in training as leaders, therefore leadership development for this group of clinicians is not prized or foregrounded. This might reflect a combination of a lack of resources, a failure to understand what contemporary medical leadership looks like, and a 'generational lag' where because existing senior clinicians did not have any formal leadership development themselves, they do not see its importance.

Supervisors must be willing, engaging role models and participants who understand leadership development and must offer support and be able to identify opportunities to engage in 'real life' practice. Experiential opportunities were highlighted as an important gap, with several interviewees stressing that this gap was the chance for trainees to practice 'real' leadership throughout their programmes.

R25 "I've had some success by engaging a very good leadership consultant to work with my team over 3 years. This included extensive assessment of our individual leadership styles and using this data to develop our strategic approach taking advantage of our individual strengths and how we work together as a leadership team. What doesn't work is compulsory workshops and dry, didactic sessions. The gaps are accessible, affordable leadership development, and diversity in health leadership (including cultural diversity, disability and gender equality) and leadership in certain contexts such as rural health. Also student leadership development integrated in health curricula."

Respondents feel that leadership activities, learning and feedback should be embedded into all aspects of clinical work and that long-term experiential development is the most appropriate way for doctors to acquire their knowledge and skills. This is not consistent with the way many postgraduate training programmes are structured, with relatively short rotations in different contexts.

R2: "It isn't about money, but about time and motivation. Best practice probably would be an integrated programme, so that what is covered in educational sessions is then picked up and developed in the workplace. That requires workplace supervisors and the environment to be encouraged to support not just attendance by trainees at educational sessions but also follow up in terms of individual discussions and then opportunities to get involved in real workplace projects and other leadership activities."

Examples of learning approaches included blended learning; shadowing junior/senior leaders; small group discussions; case work/studies, mixing specialities; embedding opportunities for reflective practice, and centralised e-learning to cover theoretical basics and philosophy supplemented with local workshops (blended learning with options improves accessibility).
Projects were seen as central so doctors can get their teeth into something real and apply theory to practice. Learning should be scaffolded according to stage of training and individual development, supported by consistent coaching and mentoring.

R4: "As with clinical medicine, need to give examples of practical problems that need leadership to fix; work through these (eg QI) as a real piece of work, using leadership development to help progress the work, and using the work to help make the leadership learning more relevant, focused, and meaningful. A virtuous circle where leadership is learned by doing leadership, and doing leadership is improved by learning about it. At every level, emphasise the relationship between leadership, staff wellbeing and experience, and patient quality outcomes."

What experts suggest that doctors in training should engage in

- Recognise that leadership opportunities are all around them: get involved in ongoing projects, e.g., quality improvement, or tasks e.g., rota design, job planning, auditing, service planning, HR tasks
- Let them have a chance to lead
- Coaching, shadowing, mentoring, reflective practice
- Chairing meetings, attending meetings with higher ups, and observing trust boards/committees – to get an understanding of how things work
- Leading ward rounds/MDTs
- Managing trainees, providing juniors with coaching/mentoring
- Community engagement,

R17: "*Exercises that help doctors in training define leadership in the medical culture and situate themselves within that framework. Exploring a physician's reality regarding making mistakes and a leader's reality regarding making mistakes."*

Assessment

There was a general consensus that supervisors were much more confident in and familiar with assessing leadership, management and followership in the clinical context than in management situations. Despite this however, examples were given of opportunities that were rarely taken to observe or provide feedback on leadership and how these need to be signposted to both trainees and supervisors, e.g., handover, team leadership, behaviours in meetings, managing rotas and other managerial activities. It was acknowledged that lack of time is a problem and also supervisors need to be trained to spot 'learnable moments' and give feedback 'on the run'.

Respondents described how leadership and management might be evidenced through leadership of specific clinical situations such as a crisis, trauma, ward round or discharge. Examples were provided of contextual assessments such as emergency medicine doctors being observed leading the department for a specified time, however many respondents noted that leadership situations would be different across the specialities and different contexts.

These would need to be specified and included in formal assessments.

Summative assessment was generally described as *"difficult; first you must decide what you are assessing, and how and this hasn't been done for leadership"* (R27). Some respondents said there should be no specific assessment of leadership and that it should be integrated with other workplace assessments such as TAB, Mini-CEX, and multisource feedback. Others said assessment could be done of leadership, drawing from evidence of reflection in portfolios, QIP, of impacts/outcomes/results delivered, via feedback. Simulation could also be used to help develop teamworking and the OSCE could include stations requiring leadership. Several mentioned 360 feedback was a useful tool (although one mentioned not liking this).

Using a programmatic approach, they could be asked to *"be able to demonstrate that they could support and lead at an individual level before asking them to lead a team if that's the setting*" (R44). Observation and portfolios were most cited as the most appropriate methods of assessment of leadership.

R20: "I think this has to be through mature self-appraisal and reflection. So the assessment would come from the individual undertaking the development, and not from an assessor 'ticking' a score. Being assessed = their willingness to reflect and demonstrating that they are effective, willing and harmonious team players in the workplace. Actually, I think the PGS framework is really helpful for this, and Educational Supervisors are beginning to use it in this way, too."

R44: "What would be most useful would really be say a portfolio, where you have a relationship with the person who knows you and is actually looking for development, not just the endpoint goals, I think that would be important. I really feel very mixed about it at a high stakes level, having said that, assessment still drives learning."

Most respondents felt strongly that leadership development (in common with most personal and professional development) should not rely on high stakes events but should be programmatic. For example:

R35: "how to shift the culture away from episodic moments of high stakes, assessments to a programmatic assessment approach whereby the majority of things that people are doing intended to be part of a formative cyclical developmental process, but that there are moments that agreed in advance and laid out within a program where collective faculty judgments inform entrustment decisions."

The concept of EPAs (*Entrustable Professional Activities*) was discussed with later interviewees and there was strong support for this approach. Some work has already been done in this area in anaesthetics from a clinical perspective and the GMC is developing a new professional capabilities framework, but more work is required to develop this in terms of leadership, management and followership.

Gaps, barriers and suggestions

Time was the most common barrier, as respondents described lack of time to dedicate to coaching, learning, or mentoring due to clinical workload, crowded curricula, or unsupportive managers.

Several also described barriers related to 'lack of vision' and understanding of leadership, in that it wasn't valued as much as other 'hard' clinical skills.
For example, some respondents said that managers saw leadership as 'fluffy', not a priority, elitist, separate/disconnected from clinical work, or something that only occurs in uni-professional silos.

Ways to overcome these barriers included building leadership development into schedules as an expectation, rather than an 'add-on'; ensuring that trainees are appropriately renumerated and have enough time to focus on long-term leadership development; providing more mentoring opportunities.

Diversity was also highlighted as a barrier: "*Prioritizing diversity, equity and inclusion in leadership training, diverse people at the table planning curriculum. If a future leader feels excluded or is not represented in the curriculum, this is a non-starter."* (R11)

R4: "The medical model trains doctors in biomedical scientific thinking. For leadership they need to embrace a psychosocial mindset and adopt different attitudes to evidence, knowledge and the value of ideas. They need to recognise that leadership is an applied skill that has useful theory needing application and practice...so lectures don't do it! Practice, reflection, practice. Also issues still about how leadership is valued, and the time (not) given to doing it or developing skills."

R17: "Lack of vision is a barrier: medical leaders often have a physician-lens of problem-solving and being informed in order to lead but should instead value outside the box thinking and encourage collaborative thinking."

R25: "The major barriers are rooted in neoliberalism and power discrepancies inherent in the organisational culture in health both education institutions and health services. People who are in power aren't willing to support others to develop their leadership. Therefore, deep cultural change, leadership in the professions and policy development is needed to maximise opportunities for aspiring leaders to gain leadership education and experience."

Summary of issues and gaps

- The opportunity for doctors in training to practice 'real' leadership
- Support from organisations/supervisors/TPDs
- Trainees/supervisors don't have time to discuss leadership properly
- Supervisors might not have 'bought into' leadership development or are unwilling participants
- Supervisors need to identify opportunities to engage in day-to-day practice
- Hostile/dysfunctional environments; establishing psychological safety
- Developing the culture – embedding leadership as 'natural'
- Dry, theoretical lectures are off-putting and not the answer to attract people to learning leadership
- Diversity in leadership development is needed
- Accessibility and affordability is a big problem.

Leadership development needs therefore to:

- Start early and be seen as a core skill set: '*it should be a spiral process, starting in medical school and continuing throughout medical training.'* and '*Leadership skills need to be seen as a core skill for every doctor. They need meaningful opportunities to make change and influence care to really understand what is involved.'*
- Be tailored to level and areas of practice*: 'I think everyone should have the opportunity to be able to enter some form of formal leadership training and appropriate at their level' and 'tailor this for different areas of practice*.'
- Be more equitable and inclusive in terms of access, targeting and language: *'The majority of Trust and deanery seems to be given more opportunity to people at already higher level in their organisations and not diverse enough. It seems there are less people from BAME having the opportunity to do that.'* '*We need to pay attention to equitable participation - so much leadership language is gendered and aimed at people with high social capital/status - this doesn't help to recruit people who have been told their whole lives that they are not important.'*
- Be centred around longitudinal personal and professional development in the workplace, supplemented by more formal training, not the other way round. '*It needs to be inspired, not taught; demonstrated not theorised and directed to a purpose, not stuck on a line on an MSF form.' 'You can't teach someone to be a leader in a couple of courses. It requires ongoing mentorship, experience, and reflection.' 'Trainees must understand that good leadership is not about time in the job or your title, or even necessarily about qualifications. It is much more about communication and people skills, personal insight and integrity, true inclusion and about a flat hierarchy where the doctor does not always know best.'*
- Prepare doctors for managing challenging situations in a range of contexts, not just clinical. '*I think we underprepare our trainees for the challenges of leadership in a senior medical role. Most of the really challenging times I have encountered since becoming a consultant have not been clinical.'*

Finally, the time for all education and training is hugely pressured by clinical workloads therefore senior leadership needs to preserve training and development as a core activity. Embedding leadership development as a routine workplace activity might well help address the workload and many other issues facing healthcare services.

'Workloads are so heavy in almost all areas of clinical practice that the thing that is sacrificed earliest is training - greater staffing/reduced clinical pressures would enable greater time for training in all aspects of healthcare.'