



Faculty of
**Medical Leadership
and Management**

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

Report of educator survey results

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Introduction

This report sets out the results and findings from an online survey of medical educators not currently involved in leadership development. This online survey (carried out in partnership with the Academy of Medical Educators) was designed to gather the perspectives of educators who were currently not directly or formally involved in leadership development for doctors in training. The team used structured survey questionnaires as one of the main methods to gather data on the perspectives of trainees, trainers, and potential leadership educators. The surveys drew from existing evidence around leadership development and were developed in collaboration with various stakeholders, including doctors in training. This survey was piloted and refined prior to final dissemination via social media, networks, newsletters and targeted emails from October 2021 – March 2022.

Responses and demographic data

A total of 123 responses were received. The majority of responses were from Health Education West Midlands (21.95%), Health Education North East (17%), and Northern Ireland Medical and Dental Training Agency (17%). There were six responses from Scotland and four from Wales. A total of 81% of respondents indicated they had formal training in teaching/education. This included degrees/diplomas/certificates, train the trainer courses, GMC trainers' course, and other local/national courses. Only 15% held a formal leadership qualification e.g., MBA/MSc.

What does clinical leadership mean to you?

This question was designed to get a sense of how these educators viewed clinical leadership. Many respondents described general aspects of leadership, such as being a good role model, leading the team in the 'right' way, supporting others, facilitating others to do their job, inspiring others, communicating with their team, and getting the best out of others. General managerial qualities such as being organised and being able to manage others and make plans were also described. All these aspects were contextualised around the delivery of good patient care. Indicative quotes include:

'Ability for clinicians to positively influence and transform the health system.'

'Taking initiative, responsibility and leading the clinical care and improving patient care. Also improving training and learning for the trainees and nurses.'

'Setting the appropriate example to trainees about how to conduct oneself professionally (and how to keep challenging oneself to continuing to develop) whilst looking after and caring for our patients.'

'Building relationships to empower others to be the best they can be.'

'Being a role-model to trainees, taking on responsibility for certain projects within a department, providing clarity about wider projects within the trust for the department.'

'Educating myself through CPD and others. Leading (having vision), seeing opportunities for improvement and making them. Supporting colleagues. Listening to the views of staff and patients, then reflecting on what they mean. Enthusing others. Team working. Mentoring trainees. Embracing change. Optimism.'

'Supporting and encouraging clinicians to develop personal skills to influence and effect positive change for better health (in its widest sense) at individual level and across systems/populations.'

'Developing leadership qualities to trainees across specialities, disciplines and grades. Allowing space for individuals to develop their own leadership style in their sphere of work. I think it means recognising the importance of leadership training - it is not sufficient to be a clinician leading a team with recognised training and evidence-based approaches.'

What do you currently do in your work that you consider to be leadership development?

This question was designed to elicit ideas about how educators saw leadership development in their own work context. Some respondents indicated that their role in itself demonstrated that they were leaders, e.g., being a consultant or GP partner. Others explained the specific activities they undertook that they considered leadership development. These included personal/professional development activities, such as self-reflection, attending conferences/workshops/webinars and hosting/attending MDT meetings. They also included interpersonal and managerial activities, such as line managing, engaging their team, delegating tasks, working on projects, providing development opportunities, and mentoring. Others mentioned educational activities such as running leadership courses for trainees, developing training programmes. Finally, several also listed patient-focused areas such as trying to improve service provision. 12% of respondents answered 'nothing' or 'not sure'.

What key situations and activities should doctors in training be able to lead and manage by the end of their training?

This question was designed to gather ideas about some of the key clinical and managerial/administrative activities doctors must be able to lead. Many of these answers summarised clinical situations, such as leading ward rounds, managing clinics, running theatre lists, discussing cases, implementing new services, and dealing with patients. Other skills listed included communication, responding to complaints, supervising junior staff, time management and quality improvement. Indicative quotes include:

'People management, effectively communicating with teams, confident public speaking, understanding of the health and social care system, participation in clinical governance, demonstrate QI/project management skills.'

'Managing juniors in their departments in terms of their career progression and educational needs. As well as logistical planning for rotas/ workforce etc. 2. Support struggling clinical staff. 3. Develop specific QI initiatives and implement change.'

'Lead a team meeting / ward round. Take the lead on a QI project. Co-lead a service development. Lead on programme delivery for junior trainees or other staff groups.'

'Clinical situations e.g. emergencies Ability to supervise more junior drs and ACP/PA/nursing colleagues - knowing how to supervise is a skill that is not often taught well. Identifying positive changes that could be made and putting these into place.'

'Quality Improvement project, ideally service development involving data gathering and analysis, plan development/implementation and review of success. In addition running meetings for staff or patients, IT development etc.'

'Developing clinical guidelines; leading and carrying out quality improvement projects; service development; bringing about small but significant changes in the areas they are working where a gap is found/performing a gap analysis; organising and delivering teaching sessions for UG and PG students/trainees; running research projects in the department.'

What learning and teaching methods would you want to include in that training?

This question aimed to gather the educators' views on methods of learning and teaching leadership. Respondents listed a variety of methods that could be delivered face-to-face, online, or in a hybrid manner, including:

- Mentoring and coaching
- Interactive reflective exercises
- Lectures, leadership theory, reading and writing exercises to understand the background
- Group exercises (small and large) – discussion, role plays, simulations, team working, problem solving
- Immersion, experiential learning, practical case studies, 'learning by doing', self-managed elements
- MBTI
- Action learning sets
- Workshops – on QI, feedback, communication skills.

Several respondents highlighted the need to assess the starting point for each doctor in training before beginning education, such as through survey questionnaires. Several also stressed the need to ensure that training was delivered by reputable, credible trainers. Ensuring that the theory was grounded in practical, 'real life' examples was important to many respondents, as was including self-reflection and other self-managed elements in a course.

What topics or content would you want to include in the training?

This question aimed to drill down into a bit more detail about the topics the educators felt were important to include, linking this with other pieces of work around 'threshold concepts'. Indicative quotes include:

'The specific dimensions relating to leadership within the NHS, including the structures of leadership hierarchy within NHS systems. Having difficult conversations. Teambuilding.'

'How to engage others, creating a vision, challenging others / ideas in non-confrontational ways. Structure of local and national healthcare management. Business case formation.'

'Managing a budget for a clinical team (if relevant to their role) working in a crisis (e.g., pandemic, skeleton staff, redeployment).'

'Leadership models, how to give feedback, teaching when time is limited.'

'Brief introduction of their own personality traits and why are they important. Understanding different types of leaders. Conflict resolution. Introduction to educational leadership.'

'When it all goes well; when it all goes wrong; difficult situations; getting help for others; getting help for oneself.'

What concerns might you have about delivering this training?

The project team asked this question to help identify some of the barriers that might be encountered in planning and implementing the 'training the trainers' course and support materials. Concerns included: resources, time, funding, 'buy-in', high-level managerial support, faculty/admin support, adequate trainer knowledge, capacity, size of cohorts, overloading trainees, not being able to run F2F sessions, knowledge gaps, level of participation.

Several respondents indicated that they felt concerned that their own level of knowledge was not enough to deliver a training course (i.e., they felt unqualified), or that they felt inexperienced as a credible leader in their own right. This points to the train the trainer course as something that could be of great value to those who wish to deliver clinical leadership education but perhaps feel they are not experienced or knowledgeable enough to do it on their own yet.

What would make training helpful?

This question also aimed to help the team in the design and delivery of the train the trainers programme. Forty-seven respondents (38%) said that training in 'teaching leadership' would be helpful, with some caveats: if it came from a place of authority, if it had a framework, if it included coaching, if it signposted to good resources, or if it included templates or guidance for them to deliver their own courses. Some were unsure, stating reasons such as not enough time, too many similar courses, or being unsure about what content would be useful and who would deliver the course.

In terms of what resources would be helpful, respondents said online resources, frameworks, lesson plans, learning outcomes, toolkits, exercises to engage groups, signposting to best literature, short videos, slides and presentations, case studies. Indicative quotes include:

'A framework of leadership competencies, ideas of how you demonstrate them and ways of assessing it. Valuing leadership as important as being good clinically. Too often seen as "moving to the dark side".'

'Not sure. There are plenty of resources out there. It depends on what the topic of the training is. Perhaps if FMLM could design specific training modules on various topics which trainers can just pick up from then that would be good. E.g. slides, videos etc.'

'I think that providing support for leadership in the workplace needs support that will work in the workplace. I think that a series of well put together resources based around real situations including case based material would help. eg A business case for a new service, leading a clinical team, leading a group of trainers, disseminating guidelines effectively, dealing with a difficult colleague, Its something about the difference between using a text book to answer a real life clinical problem and using a combination of experienced colleagues, and sources for evidence based practice. One is easy but won't really help, the other is a bit more challenging but likely to help you with the problem and other problems in the future.'

'There has been a shift in medical training from doing random audits and papers to quality improvement projects. However there is no recognition of the time commitment that should go there if they were real QI. In effect the system wants something for free when it is already short staffed. If leadership is to be developed that has to be done with clear time commitment and support with mentoring and teaching. With IT content is easy to access so we don't really need people to tell us how to make a Gantt chart. YouTube can do it the same if not better. What is needed is direction, mentoring and protected time.'

Assessment

The final question asked the educators to specify the types of assessment they felt would be most appropriate, for both formal courses and workplace-based assessment. A combination of informal and formal assessment methods were cited as the best options.

For example, it was suggested that informal assessment could take place via observation and feedback, this being less stressful and time-consuming. Several respondents suggested formal assessments, such as reflective essays or diaries, accredited courses, 360 feedback, or workplace-based assessments.

The project team also asked educators to identify situations or activities that would enable them to know when a doctor in training can be trusted to lead, this links with other activities in the project around defining 'entrustable professional activities' (EPAs). Respondents said that generally this would be known via observation or by trainees achieving generic competences. Evidence for this could come from feedback, supervision (which is gradually reduced and trainees are offered more independence upon demonstrating they can carry out a task), verbal or written reflections, or in the eportfolio.

Other comments

Several additional useful comments and suggestions were provided by the respondents. Leadership development needs 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. *'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.'*