Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Editorial

Clinical leadership training: a clinician's perspective

Introduction

In recent years, there has been heightened interest in the role clinicians, and particularly doctors, can play in leading transformational change, with a strong focus on improving patient safety and quality. Studies have suggested that the increasing presence of clinicians in leadership positions can result in more credibility with frontline clinical staff, and a greater emphasis on patient care.[1] Although medical engagement is seen as vital to organisational performance and the implementation of change, engaging clinicians in the leadership and management of service becomes even more pressing in the face of a financially constrained environment. Nicol *et al.* (2014) cited concerns expressed by non-medical healthcare practitioners that the term "clinical leadership" had started to be monopolised by the medical profession. They proposed the term "healthcare leadership" to incorporate non-medical and managerial staff with a role to play in multidisciplinary leadership.[2] This article recognises the essential role of multidisciplinary leadership, but is written from the perspective of medical clinicians.

Swanwick and McKimm (2011) argue that doctors hold considerable power over these limited resources, and are able to argue from an authoritative and (sometimes) evidence-based position. They suggest doctors occupy the moral high ground of patient advocacy, and patients want their clinicians to be involved in rationing and allocation decisions that inevitably have to be made.[3] Dickinson and Ham (2008) also conclude that without medical engagement, care continues to be delivered in disconnected clinical pockets, and coordinated action to produce system-wide improvement is prevented.[4]

Indeed, the COVID-19 pandemic has highlighted the importance of medical leadership both at the clinical and organisational levels, encompassing a broad number of issues ranging from critical clinical decision making to individual and team wellbeing. There is need for adaptation and learning from other healthcare systems,[5] while adopting strategies that enable local preparedness: re-structuring systems, re-prioritising service delivery, shoring up supply chains, and mobilising resources. Stoller (2020) summarises the key characteristics of organisational leadership to meet the challenge of a pandemic, detailing the need for governance while ensuring an environment that is psychologically secure for healthcare teams to function in, and inspire innovation across all sectors within an organisation while increasing communication channels.[6] The COVID-19 pandemic demonstrates the need for leadership at all levels of the National Health Service (NHS), to meet the unprecedented demand for healthcare, highlighting that we need to place an emphasis on developing these skills throughout a clinician's working lifetime to continue to meet such challenges.

In 2007, under Ara Darzi's leadership, the Department of Health launched a wave of policies encapsulated in their policy document, *A High Quality Workforce: NHS Next Stage Review.*[7] Darzi's vision was to put quality at the heart of health service provision, and for clinicians to accept three key roles: practitioner, partner, and leader. This new emphasis on clinical leadership, which other successful health providers (such as Kaiser Permanente in the USA) have adopted, has since captured the national imagination. The subsequent publication of a UK-wide *Medical Leadership Competency Framework* (MLCF)[8] by The Academy of Medical Royal Colleges (AoMRC) with the NHS Institute for Innovation and Improvement, and the creation of a National Leadership Council, and more recently, the Leadership Academy, have further embedded clinical leadership as central to the onwards development of the NHS.

The need for more robust leadership training for clinicians was re-emphasised after the Francis Enquiry (2013)[9] by Jeremy Hunt MP (then Secretary of State for Health and Social Care) who commissioned the Faculty of Medical Leadership and Management (FMLM) to review the issues that might stop clinicians transferring into management roles. Indeed, in a speech to NHS providers he went on to say, "We should today ask whether the NHS made a historic mistake in the 1980s by deliberately creating a manager class who were not clinicians… I would like to see a greater proportion of clinician chief executives raised in the next

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decade".[10] Subsequently, there has been development of a clinical executive fast-track scheme by the NHS Leadership Academy to support clinicians who wish to develop their leadership capacity at executive level (Fig 1).[11] Such programmes, however, are limited to a small number of doctors requiring a significant dedicated time commitment.

In a key report of leadership and management in the NHS commissioned to the Kings Fund (2011), one of the recommendations by Ham and colleagues stated that, "Leadership development needs to extend 'from the board to the ward'. One of the biggest weaknesses of the NHS has been its failure to engage clinicians — particularly, but not only, doctors — in a sustained way in management and leadership. Individuals within the service, and its providers, need to be given both the ability and the confidence to challenge poor practice. Management and leadership need to be shared between managers and clinicians and equally valued by both".[12] The report also suggests that the type of leadership in the NHS has to change and adapt to work across organisations and systems in order to deliver transformational improvements.

Until relatively recently, very few doctors underwent formal training in leadership and management, a point highlighted by Perry and colleagues (2017) in a recent edition of the *Harvard Business Review*, which supported more formalised leadership training for doctors.[13] As a result doctors have not been equipped with the basic "tools" to undertake leadership roles in their own organisation and may not have an understanding of either their own organisational structure or the wider health system in which they work, and the role of their institution within the system.

Engaging doctors in availing training in leadership and management can be challenging, for multiple reasons but two themes commonly emerge. Firstly, there may be a "cultural" aspect towards the perception of management and to a lesser extent leadership training. As Bohmer (2010) describes, "perhaps the biggest impediment is that practising doctors do not see themselves as leaders, nor do they see leadership as vital for the care of patients".[14] Medical training in fact, emphasises the opposite: individual action and accountability. With greater awareness of the benefits of leadership and management training, there does seem to be a cultural, perhaps generational shift, in perception by doctors in training. In a survey of 400 doctors in training undertaken by the FMLM,[15] 97% of respondents agreed that training in leadership and management was important, and that around 50% of respondents felt their own training was inadequate to implement change, even at a local level. Secondly, there is a lack of access to training programmes. Hynes and colleagues (2017) describe how only 50% had access to adequate training and felt they could only lead change locally. They described barriers to undertaking improvement initiatives: 50% did not have sufficient senior support, and 82% found a lack of time as being prohibitive.[15] There is an emphasis in current leadership educational

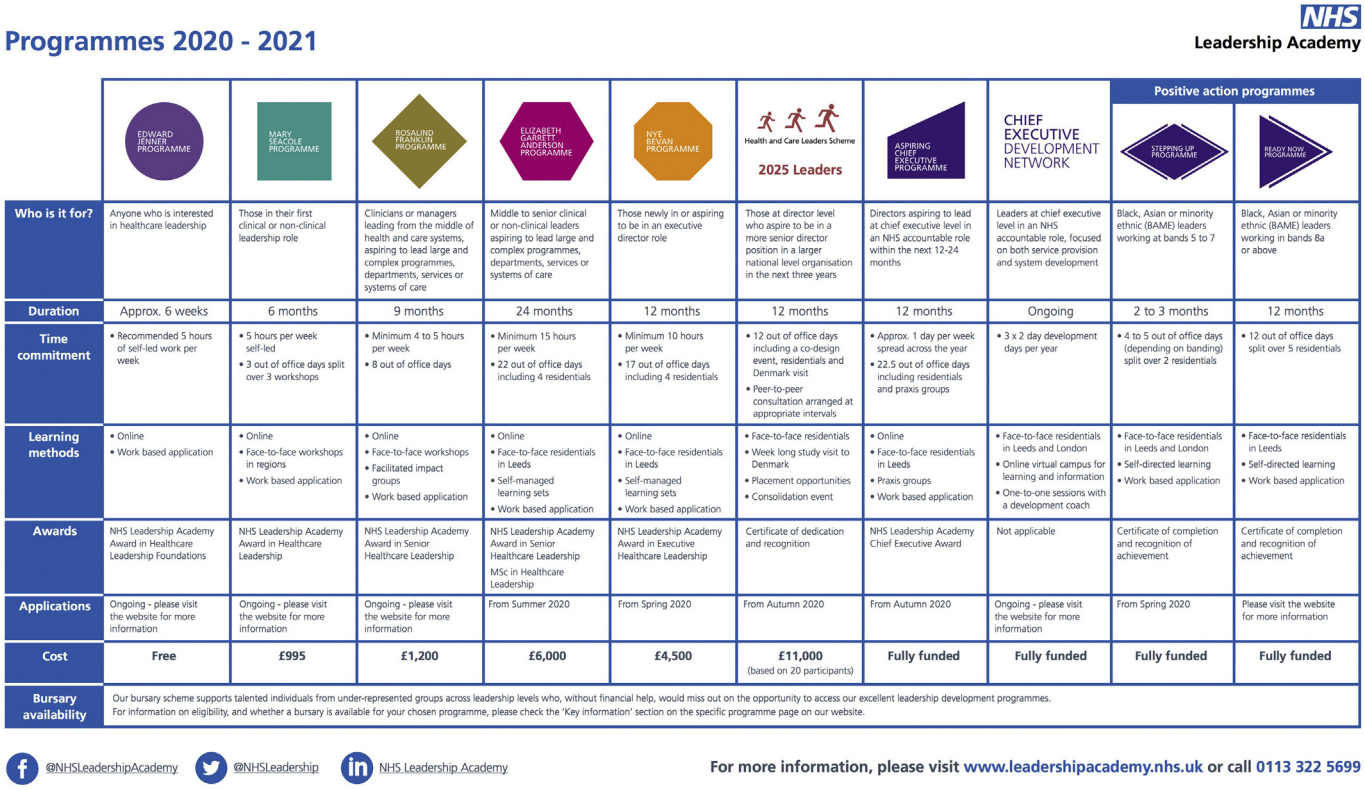

Figure 1 Available leadership programmes for clinicians from the NHS Leadership Academy, to meet a range of abilities and leadership experience, with detailed breakdown by course. Available online at: https://www.leadershipacademy.nhs.uk/wp-content/uploads/2020/01/NHS-Programme-2020.pdf

programmes on the inclusion of coaching and/or mentoring as valuable strategies in supporting delegates' leadership development.

Although a range of programmes exist for medical and multiprofessional audiences, it still remains unclear where the focus for training should lie. Although there is general agreement that clinical leadership is about bringing about *change*, it is argued that the concept of clinical leadership lacks clarity.[1,16] Furthermore, many available programmes are often focused around development of the individual rather than the organisation they work for.[17,18]

A number of initiatives have attempted to improve the focus of training. In 2008, in the MLCF, the AoMRC identified 20 elements essential for effective medical leadership. These are divided into five leadership competency domains needed to plan, deliver, and transform health services. The revised version from 2010 is included in Fig 2.[19] It aims to embed acquisition of leadership and management skills as a core function as opposed to an extracurricular activity. In 2013, the NHS Leadership Academy, established a year earlier, launched a number of national programmes designed to support staff from a diverse range of clinical and non-clinical backgrounds. Alongside this, the development of a new framework underpinned its work: the Healthcare Leadership Model.[11] The Model describes nine dimensions: leading with care, inspiring shared purpose, evaluating information, connecting the service, sharing the vision, holding to account, engaging the team, influencing for results and developing capability. The level of proficiency at each of these dimensions will depend on prior experience, stage of training, where one is within their career development, and previous training in leadership. This applies to both doctors in training and consultants, encompassing the role of the individual within the organisation.

Many postgraduate curricula, including those for Royal College of Radiologists, are being revised to include leadership training within medical specialty training, but findings have suggested that in the past these have come too late in a trainee's course to be fully effective, with priority given to practical and clinical accomplishments.[20] The General Medical Council's "Generic professional capabilities framework" (2017), has leadership and team working, and quality improvement and patient safety as two of its nine key domains. The new curriculum in clinical radiology specialty training implemented by the Royal College of Radiologists in August 2020 maps the generic professional capabilities onto the generic and specialty specific "capabilities in practice", which describe the professional capabilities expected of a consultant radiologist (https://www.gmc-uk.org/-/media/documents/clinical-radiology-curriculum-2020). This goes some way to integrating management and leadership training with clinical roles from an early stage, with an aim to consolidate these as important components of a doctor's role,[21] rather than being an "add on". The recommendation of Health Education England (HEE) to develop an offer for leadership training to all doctors in training in the UK is ambitious but driven by the desire of the Secretary of State for Health at

Figure 2 The five domains on the Clinical Leadership Competency Framework and the Medical Leadership Competency Framework. Available online at: https://www.aomrc.org.uk/wp-content/uploads/2016/05/NHS_Leadership_Framework_11.pdf, page 8.

the time "to examine how clinical leadership can be incorporated as a core component of all specialty training".[22] This is reflected in a number of programmes, but exemplified by the approach from the Leadership Academy, which outlines a pathway through specialty training and practically outlines tiered learning at three levels: early years (foundation to ST1–2), middle years (ST3–5), and later years (ST6 to consultant).[23] These provide a pragmatic approach to how leadership and management training can be delivered at a postgraduate level, but perhaps it can be argued, would benefit from being more explicitly embedded within new specialty curricula.

What is described by HEE is an emphasis on trainee introspection and reflection, and less on successful project outcomes, with ongoing personal evaluation through the Annual Review of Competency Progression (ARCP) process, rather than single project entities. This is a valuable turning point for trainee learning, aiding identification of their own needs and encouraging them to seek out experience to meet these needs. Hopefully, this will overcome the current discordance between trainee expectations about a "tick-box culture" surrounding leadership and management and what they believe they can actually achieve for quality improvement within an NHS setting. The role of the clinical supervisor is crucial in the successful delivery of training, and the role would change to one of engagement and mentoring to encourage reflection on the part of the trainee, facilitating them to achieve what they have identified as personally important. This will empower trainees to guide their own learning. Conversations stimulated in this trainee–supervisor setting would propagate beyond this, leading to trainees supporting each other in leadership roles they can better understand.

Leadership development opportunities

Although developing frameworks such as MLCF might help to increase the profile of leadership training and widen the access,[24] critics suggest that learning through competency frameworks may be too restrictive and may not satisfy the needs for those who wish to develop their skills in leadership and management. For those individuals, there are many opportunities available. These include in-house programmes run by Trusts, national programmes run by the NHS Leadership Academy, and programmes run by other organisations. For each provider a range of programmes is offered according to the needs of different audiences, many of which are for multidisciplinary groups where others are unidisciplinary.

For example, Fig 1 shows the NHS Leadership Academy "Programmes at a Glance" schematic for programmes on offer in 2020–2021. They range in the mode of delivery (i.e., some are online, others involve face-to-face taught sessions and others use action learning methodology). The costs for participation also vary (ranging from the Edward Jenner Programme being free, to £4,500 for the Nye Bevan Programme, and £11,000 for the 2025 Leaders Programme).

For doctors in training, out-of-programme experience is offered through several Leadership Fellowships, such as the Darzi Fellowship and, more recently, the Royal College of Physicians Chief Registrar programme, but only a limited capacity remains for trainees with considerable interest in management and leadership. Likewise, these roles potentially mean stepping out of a usual clinical role and focusing on professional skills in isolation, with little increase in overall trainee management experience. As Lega *et al.* (2013) point out, "doctor-leaders are better able to influence their colleagues' clinical activities ... but also struggle to win over fellow doctors in asserting the importance of management".[25] What is needed is a means by which to reach a large cohort of doctors.

Locally, the Chief Resident Programme was rolled out in 2009–2010, with pan-speciality access. This programme is a collaborative effort between the university's business school, local clinician managers, and those with significant NHS management experience. It delivers an annual 10-month leadership experience to approximately 70 senior registrars throughout the region, from both primary and secondary care. They are known as "Chief Residents". Unlike other out-of-programme courses, the Chief Resident must complete three elements during their time, alongside their usual clinical work: attendance at 10 taught days delivered by experts, completion of a quality-improvement project of local importance, and mentoring and leadership for junior doctor colleagues within their NHS Trust.

The Chief Resident Programme is one of three leadership courses run by our local Healthcare Partnership, in conjunction with national and local experts in leadership. The other two courses were established as a "tiered" learning approach for leadership and management skills the first for those in their early years as consultant, and the second aimed at consultant staff in or aspiring to clinical director leadership.

More recently, specialty-specific leadership and management programmes are beginning to emerge. For example the American College of Radiologists now have a Radiology Leadership Institute, which "delivers professional development programming, leadership skills training, and networking opportunities for radiologists who want to advance their careers and master the challenges of today's rapidly evolving health care landscape." (https://www.acr.org/Practice-Management-Quality-Informatics/Radiology-Leadership-Institute). In the UK, the Royal College of Psychiatrists have launched a fellowship in Leadership and management commencing 2020–2021.

Although the benefit of leadership and management training within a specialty has clear benefits for the individual to understand the challenges within that specialty, many of the skills that need to be acquired are generic. The benefits of cross-specialty and multidisciplinary interaction and networking should not be underestimated, which enhances the ability of the individual to have a broader, system-wide approach to healthcare challenges.

Evaluation of programmes

Hofmann and Vermunt (2017) cite the work of others who note the paucity of rigorous evaluation of clinical leadership development programmes.[26] They state that although the literature suggests a positive relationship between clinical leadership and quality improvement, empirical evidence of direct causal links remains underdeveloped, noting that, "it is crucial that the field makes progress in systematically evaluating such programmes". They suggest that an empirically based conceptual framework, and operational model, of what clinical leadership development might achieve and how it is developed is required. They cite the work of Lornudd and colleagues (2016), who state evaluating randomised controlled trials on the impact of clinical leadership development has been made difficult by the absence of operational models of what such impact could look like.[27] There are a number of purposes for evaluation of educational programmes including ascertaining if: (1) the educational aims and outcomes have been achieved; (2) it has met the course delegates' personal learning requirements; (3) the programme is value for money; (4) key areas for the curriculum have been covered adequately; and (5) any major or emerging issues have been covered.

The majority of programmes will include formative evaluation, i.e., collection of qualitative comments and quantitative ratings from delegates on completion of programme elements. This information serves to assist programme leaders to make any adjustments during the course of a programme (and indeed for future delivery of programmes). Some will also include summative evaluation, i.e., asking delegates to sum up evidence of the impact the programme has had. Summative evaluation can assist with

answering the question of whether the programme has met the stated learning aims and objectives for the delegates. These evaluation techniques are usually carried out by the programme faculty providing rapid feedback from the individual delegate's perspective, and using internal staff, thereby not creating additional costs for the programme budget; however, an externally run evaluation may add greater objectivity to evaluation and seek to assess the impact for the delegates' organisations in addition to their personal development. The Chief Resident Programme, outlined above, was evaluated independently using a mixed methods evaluation of the programme, after the seventh cohort of trainees.[26] They used in-depth interviews with the programme steering group and past participants, and a detailed survey to all past participants. The findings showed successful impact for participants' capability, willingness and likelihood to engage in service improvement, with the related positive impact of service improvements for their organisations. They reported increased resilience regarding the risks and stress associated with such clinical leadership projects. Importantly, there was sustained involvement in project development, capacity building, and a better understanding of the NHS structure and organisation amongst delegates.

An earlier study, undertaken by Boaden (2006), also concluded that a leadership development programme for aspiring or newly appointed NHS Directors was successful in impacting on personal and organisational contributions in terms of managing people effectively in the context of change.[28] In order to fully understand the need of NHS organisations around the development of clinical leaders and to modify programme delivery accordingly, it would seem that development of evaluation tools to collect feedback from the sponsoring organisations would be of value and would complement the feedback collected from the delegates and course faculty.

Conclusion

The need to expand leadership and management training to develop clinical leadership capability is well accepted, but to achieve this needs "buy in" from both the individual and the organisation(s). Although content of training programmes will need to be adapted as a result of the current change of the clinical landscape, the basic principles of leadership and management remain applicable. There is an imperative to engage clinicians, maintain their interest in leadership and management, and give them the "tools" to lead in a challenging healthcare environment. As organisations adapt to the new "post-COVID" environment, the leadership challenges will need to be identified at a local, regional, and national level, and institutions should provide support for clinicians to develop their skills. This support should include adequate allocation of time and resources to support training and provide access to targeted programmes, which have been appropriately evaluated to benefit both the individual and the health system. Monitoring and progress of individuals in their leadership training journey with adequate supervision is crucial to the success of skills uptake and implementation. The new healthcare environment that will emerge as result of COVID-19 represents an opportunity to develop the next generation of clinical leaders, appropriately trained for what will be a seismic shift in how we deliver high-quality healthcare in the future.

Conflict of interest

The authors declare no conflict of interest.

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