# The Trainee Leadership Board – Learning about NHS leadership

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**KEYWORDS**

Clinical leadership, medical leadership, management, trainees, career development

**ABSTRACT**

The development of a new generation of clinical leaders in the NHS has been increasingly endorsed by most recent literature in medical leadership and management. Despite providing academic rationale and argument however, current training programmes fail to integrate the theoretical and practical aspects of clinical leadership and to implement them in practice within medical training curricula. In Oxford Health NHS Foundation Trust, a Trainee Leadership Board programme was offered to a small group of next-generation clinical leaders as an opportunity to learn about current leadership and management in the Trust. This programme provided insights and practical experiences through an integrated educational and experiential approach in resolving a real issue facing the Trust. Overall, the programme proved successful in creating a culture of increased interest and promoting change in attitude and behaviour around leadership and management. Time constraints and implementation of change represented significant challenges for the Trainee Leadership Board. However, the programme holds promise for its diffusion across the country.

**INTRODUCTION**

In recent years, much has been written about the need to develop the next generation of clinical leaders in the NHS.[1, 2] Post-Francis, the case for clinical leadership is clear, leading to the increasing demand by regulatory bodies for the acquisition of leadership skills.[3] A variety of programmes have been developed to address the evident shortfall of training opportunities, providing theoretical understanding of leadership models, assessment of personal leadership styles, and awareness of leadership conundrums.[4-6] But despite offering trainees opportunities to consider tasks likely to be required in their future roles as consultants, this has not provided what NHS training otherwise strives to achieve, i.e. learning through hands-on experience. UK medical training typically involves simultaneous practical and theoretical skills development; however, leadership skills training has largely remained an academically taught subject.

There is ample evidence that learning by doing and reflecting is the most effective way of embedding knowledge, developing skills, and shaping attitudes in adults.[7] Especially for older learners, an integrated problem-based approach with real world consequences is likely to be both effective and motivating.[8] Elsewhere this has been applied to the development of leadership competence. For instance, the 70:20:10 Model for Learning and Development is a commonly used formula to describe the optimum sources of learning by successful managers,[9] as the model's founder Meena Surie Wilson says: "The underlying assumption is that leadership is learned". This requires three types of experience: challenging assignments (70%); developmental relationships (20%); coursework and training (10%). The model argues that hands-on experience (70%) is the most beneficial because it

enables people to discover and refine their job-related skills, make decisions, address challenges and interact with influential colleagues within work settings. They also learn from mistakes, receiving immediate feedback on performance. Learning from others (20%) is achieved through activities such as social learning, coaching, mentoring, collaboration, and peer-group support. This provides participants with encouragement and feedback. The remaining 10% of professional development, coursework, and training comes from formal and traditional instruction, which are seen as amplifiers, aiming to clarify, support, and boost individuals' learning.

This paper contributes to the debate by describing the Oxford Health NHS Foundation Trust's (OHFT) Trainee Leadership Board (TLB). This is a modular course comprising academic as well as practical leadership skills, roughly following the 70:20:10 structure, which was offered to medical trainees in OHFT with the intention of building leadership capability. It is leadership, at all levels of the organisation, that makes the real difference and which transforms policy into lived cultural realities. If our actions are only informed by the paradigms, experiences and positions that created the present situation, very little is likely to change. OHFT has adopted a dialogic approach to organisational development with conversations at its heart and this programme forms part of a wider organisational development strategy, aiming to foster a positive organisational culture by focussing on team working, leadership development, and quality improvement.

**METHODS**

The TLB programme 2016-2017 offered a small group of next-generation clinical leaders an opportunity to learn about the current leadership and management of OHFT. This was achieved by providing insights into and real experiences of OHFT structures, governance, and decision-making. The TLB worked as a leadership team on real problems faced by the Trust, and proposed workable solutions to the Board of Directors. This also allowed the current OHFT Board to observe how a different leadership group tackled challenges facing the organisation.

All core psychiatry trainees in their second or third year of training and all higher specialty trainees were invited to participate. Ten volunteers attended a meeting to discuss the timeline and modules of the TLB.

**Step 1**: Overview of the TLB programme, including the expectation that trainees would review material on relevant NHS leadership topics and observe a full OHFT Board meeting. Questionnaires about the trainees' leadership knowledge and attitudes were completed.

**Step 2**: Teaching by members of OHFT's Executive Board and other Trust staff about general NHS leadership models and OHFT's leadership structure. This allowed the TLB to understand the roles and

remits of those involved in leadership, governance structures, and line management accountabilities. Teaching was also provided on team working and Trust strategy.

**Step 3**: Assignment of an executive or non-executive Board member mentor to each TLB member. Trainees were asked to meet with their mentors. Feedback was obtained from trainees who had already observed a Board meeting.

**Step 4**: Introduction of problem 1 (i.e. staff car parking), recently managed by the OHFT Board, the aim being to support the TLB's learning about issues raised at Board level, how these are developed, discussed, and resolved/concluded. Next, problem 2 was introduced (i.e. medicine management and the drug budget). The TLB was encouraged to adopt mirroring responsibilities to those held by Board members (e.g. finances, clinical remit) and to gather relevant information. This involved liaising with appropriate senior clinicians and managers, analysing national and local drug-spend data, and developing an in-depth understanding of the various issues pertinent to OHFT's medicine management. Based on this, the TLB compiled a report with action plan and recommendations.

**Step 5**: Presentation of TLB findings and proposed solutions at a full OHFT Board meeting. A 'question & answer' session was followed by OHFT's CEO congratulating TLB members on their completion of the training by handing out certificates. Trainees were asked to complete the knowledge and attitude questionnaires again, and qualitative evaluation was gathered from trainees and Board members.

**RESULTS**

The TLB programme 2016-2017 recruited a range of OHFT trainees across all stages of training, although not surprisingly most participants were close to the end of their training (figure 1).

Quantitative data from the trainee questionnaire was analysed using the Wilcoxon signed-rank test (table 1). Overall, results showed a significant increase ($p<.001$) in understanding of leadership and management, knowledge of how Trusts are led, belief in own ability to influence, feeling of capability to lead, and likelihood of seeking a future leadership role. There was no change in the amount of time trainees felt doctors should spend on leadership and management.

**Table 1 Quantitative data from the TLB survey, before and after completion of the TLB programme 2016-2017** ($N$=10)

| | Mean (before) | Mean (after) | *p* value |
|---|---|---|---|
| **Q1. Understanding of leadership and management** | 4.5 | 7.7 | <.001 |
| **Q2. Knowledge of how Trusts are led** | 4.1 | 8.0 | <.001 |

| | | | |
|---|---|---|---|
| **Q3. Belief in own ability to influence** | 3.1 | 7.0 | <.001 |
| **Q4. Feeling of capability to lead** | 3.9 | 7.7 | <.001 |
| **Q5. Likelihood of seeking a future leadership role** | 7.0 | 8.5 | <.001 |
| **Q6. Time doctors should spend on leadership and management** | 7.6 | 7.0 | NS |

Qualitative findings showed that at the end of the programme, 80% of participants declared their interest in pursuing a formal leadership and management role and being involved in further leadership and management projects. They rated their experience as *"unique, ahead of the curve nationally"*. They particularly enjoyed *"the observation and frequent liaison with the OHFT Board of Directors"* and *"the real-time involvement in a leadership and management project"*. They suggested some improvements including *"allocated protected time for leadership and management activities"* and *"potentially involving a multidisciplinary team"*. They took home *"understanding, knowledge, skills, solution-focussed work, enthusiasm, and hope"*, proposing to use this know-how as *"a basis for developing a leadership and management clinical fellowship, on the model of current academic clinical fellowships "*.

TLB members were also asked to lead implementation within the Trust of some of the recommendations of the TLB on medicines management, for instance establishing drug-spending review groups and improving the value of prescribed drugs in collaboration with pharmacy and the Centre for Quality and Safety.

## CONCLUSION

Whilst this is a small pilot study, it suggests that the TLB programme provides an excellent opportunity to change attitudes and behaviour around medical leadership and management. This could help establish the foundations of future leadership and management clinical fellowship schemes and place leadership at the centre of the clinician's role. There are caveats: time constraints linked to clinical activity may impair the successful completion of the programme, and therefore allocated protected

time for leadership and management training is needed. Trust Board members also need to allocate time, and to trust the recommendations of the trainees. While we have demonstrated significant changes in trainees' attitudes and knowledge, full implementation of the recommendations made by the TLB in the daily work of the Trust requires longer-term commitment by both TLB members and the extant Board, and is still work in progress.

Clinical leadership is essential for the future of the NHS. Like many other skills, leadership and management competencies are probably developed best at the early stages of clinical careers. However, the implementation of a leadership and management curriculum in clinical training has proved challenging. Programmes such as the TLB could provide opportunity for trainees to become involved and to actively participate in leadership and management processes within Trusts, and would make leadership an attractive option for clinicians, place clinicians at the centre of the value agenda, and incorporate leadership development into formal training.

**CONTRIBUTORSHIP STATEMENT**

GS is responsible for the overall content as guarantor. GS, DL, and SL planned the study and delivered the programme described. SL and RDG conducted the survey and analysed the findings. GS, SL, and RDG wrote the manuscript. RDG submitted the article.

**COMPETING INTERESTS**

None declared.

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## FIGURE LEGENDS

Fig. 1 Distribution of TLB members according to their level of training (N=10)