Training and education in healthcare leadership: Is it time for a NHS healthcare academy?

Authors: Edward D Nicol,[A] Kay Mohanna,[B] Jenny Cowpe[C]

ABSTRACT

In his report into Mid-Staffordshire NHS Foundation Trust, Robert Francis QC suggested the need for a physical NHS 'staff college' to support the strengthening of clinical leadership in the NHS. We present qualitative research data from a series of semistructured interviews with senior healthcare leaders in the UK that highlights their thoughts on the state of both clinician's managerial and leadership knowledge and training in the UK and the opportunities and challenges that a 'staff college' model would present using the UK Armed Forces Defence Academy as an existing public sector model. While progress has been made towards strengthening leadership and management training for NHS staff since this research was performed, this research suggests the need for a more inclusive, corporate, multi-disciplinary approach to delivery, pooling the existing expertise and ensuring a whole workforce approach to the corporate NHS agenda.

KEYWORDS: Healthcare leadership and management, clinical leadership, medical leadership, education and training

Introduction

The National Health Service (NHS) is currently under intense pressure to balance its mission of delivering high quality, safe and cost-effective care against the concurrent need to make massive efficiency savings, at a time of radical structural change. Recent NHS failings have been detailed by the Keogh[1] and Francis[2] reports while cultural change is demanded by that of Berwick.[3] The service is composed of several hundred semi-autonomous and often disparate organisations and yet must evolve as a single entity to deal effectively with an aging population, to control costs against the backdrop of escalating technological advances, and to deal with increased patient and political expectations. While a vision of how this might be delivered has been proposed, in part, by the Royal College of Physicians' Future Hospital Commission,[4] the need for a corporate approach to which all staff can adhere has never been more pressing if the NHS is to achieve against these expectations.

A central recommendation of the Francis report was that clinicians need to be recruited to senior management roles in the NHS; indeed, it has been recognised previously that a lack of medical leadership can lead to poor performance and corporate negligence.[5] Francis recommended that a physical 'Staff College' be developed to deliver this leadership agenda. In its response, the government agreed, but went further in stating that leadership needed to be encouraged at all levels in the health service.[6] This call to action is not new; Lord Darzi's White Papers[7,8] foresaw this requirement in 2008, stating that a clinically led NHS was essential for a safe, high quality and patient-focused healthcare system. Darzi recommended that all healthcare professionals should engage with the NHS delivery agenda, acting in a tri-partite capacity as practitioners, partners and leaders. This systematic approach was lauded at the time but delivery of his more corporate agenda lacked detail and arguably gained only limited traction in the intervening five years despite much evidence that increased engagement, especially with doctors, drives up organisational performance and outcomes[9–11] and supports a more stable, loyal and productive workforce.[12,13]

Leadership academies are not a new concept, even in the public sector. Indeed, the UK Armed Forces have long had staff colleges, and those of the Army, Royal Navy (RN) and Royal Air Force (RAF) were amalgamated into the Joint Services Command and Staff College (JSCSC) in 1998, based at Shrivenham. JSCSC makes up part of the UK Defence Academy (Box 1). Military personnel are inducted on joining their respective military academies at Dartmouth (RN), Sandhurst (Army) or Cranwell (RAF). Those destined for the highest levels of the Armed Forces customarily spend up to a year at the Royal College of Defence Studies (RCDS) in London prior to taking up their appointments, but all officers will spend some time at JSCSC.

Views on the prevailing leadership culture in the NHS, the term 'clinical leadership' and what attributes are required for success as a healthcare leader have been published previously.[14] The primary aim of this qualitative research was therefore to capture the views of senior leaders on the requirement for training and education in healthcare leadership using the Armed Forces leadership model as a potential template for an NHS delivery model. Secondly, we aimed to identify potential challenges to implementing a similar, NHS-focused health academy model.

Authors: [A]honorary senior lecturer, Clinical Leadership Academy, Keele University, Staffordshire, and consultant cardiologist, Royal Brompton Hospital and Harefield NHS Trust; [B]director of postgraduate medical education, Clinical Leadership Academy, Keele University, Staffordshire; [C]director of leadership and management, Clinical Leadership Academy, Keele University, Staffordshire.

Box 1. The Colleges of the Defence Academy

The Royal College of Defence Studies (RCDS)

The RCDS provides postgraduate level education in defence and international security. Its internationally renowned programme of strategic studies attracts members from around the world.

The Joint Services Command and Staff College (JSCSC)

JSCSC trains the future commanders and staff officers of all three UK Armed Services and those from many countries around the world.

The College of Management and Technology

The College of Management and Technology provides high quality education, training and advice in technology, management and leadership, together with relevant aspects of security and resilience to students in defence and the wider security area in order to enhance the delivery of defence capability.

The Armed Forces Chaplaincy Centre

The Armed Forces Chaplaincy Centre develops, promotes and provides spiritual, moral and pastoral care, education and training in the Armed Forces in order to sustain service personnel and their families.

National School of Government International (NSGI)

NSGI is a cross-cutting civil service unit supported and governed by the Department for International Development (DFID), Ministry of Defence (MOD), Foreign and Commonwealth Office (FCO) and the Cabinet Office (CO).

Adapted from www.da.mod.uk/colleges.

Methods

Design

Targeted semi-structured questions were designed to explore the views of senior staff involved in leadership within the UK healthcare sector. The specific questions are shown in Box 2 and the Armed Forces Leadership Model in Table 1.

Design and development of questions

To ensure questions were appropriate and robust, a focus group was conducted. This group contained a mix of senior NHS leaders, external consultants involved in delivering leadership training in the UK and previous participants of leadership programmes. The focus group deemed the questions to be sufficient in scope, appropriate and unambiguous. The focus group highlighted the need for the interviewer to avoid asking leading questions or appearing to give support or credence to responses either directly or via non-verbal cues.

Box 2. Questions used in focus group and semi-structured interviews

- At what stage do you think management and leadership skills should be taught, or gained?
- What barriers are preventing this happening at present in the NHS?
- Do you think a corporate education model along the lines of the Military Defence Academy would work for the NHS?
- If yes, how would you modify it? If No, how do you think the NHS could deliver a corporate education strategy?

Sampling and recruitment

Following the focus group, semi-structured interviews were undertaken between 2010 and 2011 with 20 senior healthcare leaders selected as part of a purposive sample, based upon seniority and representing the full spectrum of healthcare leadership activity and influence (political, clinical, managerial, educational, medically qualified vs. managerially qualified). Written consent of the interviewees was gained immediately before the interview commenced. Interviews lasted 60–90 minutes and the questions were used as a basis for wider discussion.

Data capture

All interviews were recorded and transcribed. Observational notes were taken at the time by the investigator to capture the immediate thoughts and reactions of the interviewer and provide a basis for reflection.

Data analysis

Full transcripts were analysed according to the principles of grounded theory,[15,16] using NVivo software (NVivo 8, QSR international) to assist with coding. Coding of interview data continued in parallel with subsequent interviews so that emerging data could inform and be tested in new interviews. Interviews continued until it was deemed that no new ideas were being advanced. A single interviewer was employed (EN) who developed the themes, and grouped them into supra-categories (nodes) which eventually accounted for all the data recorded. A second coder checked for negative instances and agreed that the codes were appropriate.

Results

Twenty-two senior leaders were approached; 20 agreed and 2 declined to take part. The interviewed cohort (n=20) included a former health minister; NHS strategic health authority, PCT and acute trust chief executives; medical directors; deans of medical schools; and other key representatives of the medical leadership arena (National Leadership Council, commentators, and commercial and charitable providers of health leadership programmes). The majority (75%) of respondents were male, 85% were aged over 50, 90% had over 25 years of healthcare experience in the UK and 60% of respondents were clinically qualified, although not necessarily in current practice.

The questions posed covered six major themes. These were history, culture and changing attitudes towards health leadership; perceptions of clinical leadership; attributes required for success as a healthcare leader; training and education in health leadership; and views of the Armed Forces Leadership Model and on delivery of a national health leadership model. While defined as separate themes, these topics are enmeshed and intertwined with much overlap

Table 1. The Armed Forces leadership model (RAF model).

Title	Mandatory or by selection	Duration	Rank/MO Stage of Career	Content
Non-higher-level training				
Initial Officer Training	Mandatory for all MOs, NOs, AHPs	2 months residential	Student Officers (medical student equivalent)	> Single service history (ie RAF) > Military ethos > Leadership > Doctrine > Presentation skills > Military skills
Junior Officer Command Course (JOCC)	Mandatory for promotion to Squadron Leader	3 × 1 week residential	Flight Lieutenant (SHO equivalent)	> Single service history (ie RAF) > Defence studies
Intermediate Command and Staff Course (ICSC)	Selection	8 weeks residential	Squadron Leader (SpR or junior accredited GP)	> Political studies > Leadership > Teaching skills > Media training > Finance > Human resources > Change management > Project management > Myers Briggs (MBTI)
Higher-level training				
Advanced Command and Staff Course (ACSC)	Competitive selection	40 weeks residential	Wing Commander (consultant/ accredited GP)	> As above > Tri-service focus > Military history > Command leadership > International affairs > Comparative tours
Higher Command and Staff Course (HCSC)	Competitive selection	12 weeks residential	Group Captain (senior consultant or GP); likely to have dedicated staff and command role	> As above > Strategic leadership > Organisational management > Political awareness
Royal College for Defence Studies (RCDS)	Competitive selection	16 weeks residential	Senior Group Captain/Air Commodore (senior clinician) in strategic command and staff role	> As above > Strategic leadership > Political awareness

AHP = Allied Health Professional; MO = Medical Officer; NO = Nursing Officer; SHO = Senior House Officer; SpR = Specialist Registrar

between them. This manuscript focuses on the latter three major themes as the former three have been published previously elsewhere.[14]

Box 3 gives a guide to the qualitative terminology used below.

Box 3. Guide to qualitative terminology.

For the purposes of qualitative research, descriptive terminology has been used in the results section. As a guide for the reader the following terms approximate to a more quantitative descriptor:

- Several: >30%
- Many: >50%
- Most: >70%
- Nearly all: >90%

Training and education in healthcare leadership

Many respondents shared the view that 'leadership training is too random and accidental in NHS [and therefore] does not deliver the numbers of leaders we need'.[Respondent 1] The responses from interviewees were varied and diverse but could be broken down into five main sub-topics: the training

requirement; the timing of training and education; content; selection; and assessment and feedback.

The training requirement

Most respondents felt that there is a pressing requirement to identify and develop capable individuals, from across the whole NHS, who not only have the attributes required, but are also 'comfortable in both the clinical and managerial leadership roles'.[Respondent 2] There was a consistent opinion stating the absolute need for significant investment in this area. This sentiment was captured by the statement: 'If the NHS really means business it will have to invest significantly in this agenda; it depends what it really wants'.[Respondent 3]

It was felt that the current approach to identifying and nurturing talent for the future in the NHS was 'confused and not joined up, with everyone doing their own thing'.[Respondent 4] Interviewees described doctors' corporate knowledge, in particular, as 'appalling',[Respondent 5] 'very, very disappointing'[Respondent 1] and 'poor', while one specifically stated that, for doctors, the 'training need is just not met'.[Respondent 6]

There was a lack of agreement between respondents as to how training organisations might deliver the requirement for training; however, it was specifically stated that 'teaching of [these leadership and management] skills must not be left to partially the organisation that employs you, partially to the Colleges and partially left to the deaneries, an incoherent triumvirate'.[Respondent 4] It was also stated that 'developing the [wider corporate and leadership] attitudes is difficult when clinicians are so focussed on achieving their clinical training',[Respondent 3] while many felt that a simple NHS induction developing a more corporate mentality from the outset of an individual's career was missing.

There was a broad agreement that the 'value of leadership and management is not well understood in the NHS'[Respondent 7] and that generic funding opportunities for this learning have been sparse: 'historically individuals funded [their own] managerial professional development'.[Respondent 8] It was argued that while motivated individuals invested in themselves, their employing, educational and professional organisations did not, often taking the view that 'the problem in investing in this area is financial and this training requirement has not been written into the budget nor the opportunity costs considered'.[Respondent 4]

This opinion was tempered by several respondents who felt the cost of this investment would be easily countered as 'the benefits of [a] corporate approach are huge; return on investment is massive',[Respondent 2] while in the longer term this would also potentially reduce the need for the 'massive investment in external management consultancy in the NHS, which is a scandalous waste of public money when we have such a capable workforce.'[Respondent 6] In conclusion nearly all respondents felt that 'these [management and leadership] skills should be as core to the clinician's portfolio on graduation as their clinical skills'.[Respondent 9]

The timing of training and education

The timing of management and leadership training and education was contentious. Some respondents felt it should commence at the outset of professional training, with a broader emphasis on healthcare education for clinicians in particular. This is exemplified by the quote: 'medical schools focus on the pure science of it [medicine] and if we don't change the context of medical training to include the wider system we will continue to struggle'.[Respondent 6] Those pushing for an immediate corporate strand in undergraduate medical education argued that 'the evidence would suggest the earlier you do it the more enthusiastic individuals are as they are [more] open to suggestion [and] they are not yet indoctrinated and cynical,'[Respondent 3] and 'it is bizarre that medical schools do not induct people into the NHS'.[Respondent 7] However, it was agreed that this should not be overemphasised at undergraduate level and the question of 'what would you take out of the clinical curriculum?' was raised by several respondents and not resolved by the end of the research.

For those already working within the NHS there was a split in opinion as to when the optimal time for corporate training should be. Some felt that the need to deliver a minimum corporate requirement could be underpinned by an NHS induction, stating both that 'It is ridiculous that healthcare workers are not inducted into the NHS'[Respondent 7] and that the failure to do so has missed an opportunity 'to engender a loyalty to the NHS from the outset that has led to a complex set of loyalties'.[Respondent 14]

Others felt that clinical training must take priority in the early years, with a graduated increase in focus on the broader corporate issues as one neared independent practitioner status. It was argued that all clinicians 'required experience to be credible'[Respondent 10] but 'senior trainee doctors are a good target, [as they are] starting to learn that there are many other attributes that make them a good doctor'.[Respondent 11] The current focus on senior trainees was also felt to be appropriate as these individuals would 'rapidly become junior consultants with a real opportunity to deliver change'.[Respondent 9]

Content of leadership training

As might be expected, the Medical Leadership Competency Framework (MLCF) was cited as a good example for both broad content and a step-wise approach to titrating the knowledge required with an individual's career development and progression. It was argued that independent practitioners should, as a minimum, 'have basic understandings of finance, the structure of the organisation in which they operate and the strengths and weakness of their directorate in the organisation'.[Respondent 9]

From the responses gathered it appeared that collectively respondents thought that the aims for the generic corporate training should be twofold. The firstly aim should be to improve organisational and corporate knowledge, to 'translate narrow clinical work into [the] broader picture'[Respondent 12] and to get NHS staff to 'understand [healthcare] processes, flows of work, systems and how they work and fit together'.[Respondent 9] This 'must include exposure to other areas of healthcare i.e. 'management' and breakdown the 'negative stereotyping that starts very early in people's careers'.[Respondent 3]

Secondly, and almost universally, respondents highlighted the need for individuals to develop emotional intelligence and a much broader set of relationship skills from very early stages in their careers. This would allow individuals to 'understand themselves, their personal skills and attributes and how they play out in interaction with others'[Respondent 6] but

also to 'understanding the system and [how to] lead service improvement'.[Respondent 4]

Many respondents believed that multi-disciplinary learning was the most appropriate forum for this type of training, from the outset, with much stronger early interaction between all forms of clinicians and their managerial colleagues.

Selection

There was a division as to whether all NHS staff should be trained in corporate partnership skills and leadership or whether all should have the former while only those with particular potential in that direction should be selected for the latter. There was also significant disagreement as to whether training should be mandatory of voluntary.

While many shared the view that 'corporate skills need to be routine for all',[Respondent 7] as 'clinicians are the people who use resources and define how the money is spent',[Respondent 9] most did not believe that everyone should be given higher leadership training. '[Higher] leadership for all misses the point' [Respondent 12] and 'financial constraints deter the extent everyone can be exposed to high end leadership training'[Respondent 5]. One respondent stated 'it would be an ill-advised approach even if financially viable'. [Respondent 13] It was felt that higher leadership training should be voluntary and predicated on enthusiasm, talent spotting, assessment and selection. It was also suggested that 'poor team working kills patients whilst good leadership defines high quality care',[Respondent 9] mandating full investment in both.

For those selected for higher leadership training two additional requirements were deemed important. Firstly, it was felt by many that there was a requirement for a much greater depth of understanding of the health system but also a fundamental requirement to 'understand the bigger picture and the interplay between stakeholders'.[Respondent 14] Focus on strategic thinking was felt to be important and a skill set 'most clinicians do not inherently have'.[Respondent 5] It was felt that higher level training should include 'horizon scanning [and an understanding of the] interplay between the hard stuff (contracts and KPIs) and soft [relationship] skills'.[Respondent 2] These skills were felt to be required to lead effectively at higher levels. It was suggested that this level of training might incorporate 'interplay with finance and management training programmes, that were multi-professional [in their approach and delivery] and not just health related but should also include [traditional] finance and management.'[Respondent 4]

Assessment and feedback

It was felt that to support talent identification, both robust assessment of individuals taking part in initial training, and honest and robust feedback was required. Most respondents felt 'not everyone wants to be a leader and some don't have the required skills';[Respondent 5] therefore 'for higher leadership there will be a need for further assessment of broad managerial and leadership competence'.[Respondent 1] Most respondents felt individuals should be formally assessed in any education and training programme, such as with clinical competence, and this would identify and allow those with an interest and aptitude 'to be picked up early in their careers, [and demonstrate] the thirst and commitment to seek out the opportunities [to develop further]'.[Respondent 16] To be useful to the NHS as a whole the results of assessment must be available to both clinical educational supervisors (to form part of the individual's annual appraisal) and more broadly to those looking to develop future leaders, locally, regionally and nationally. One respondent stated that 'a common reporting and appraisal system for this type of training would certainly help; with e-portfolios and twenty-first century IT this would not be impossible to do'.[Respondent 3]

There was a feeling among many respondents that the unintended consequence of the current 'clinical leadership' agenda was that many junior doctors now had 'unrealistic expectations as to their broad leadership competence' and a 'mismatch between their own self- belief versus those around them' was common. It was felt that this was largely due to a failure of constructive feedback.

Views of the Armed Forces Leadership Model

Having discussed the management and leadership training need in detail, the Armed Forces Leadership model was introduced (Table 1) and respondents were asked to comment on whether the model could be used to deliver an NHS corporate training requirement. The model was broadly well received by non-military interviewees, with comments such as 'it is brilliant in its concept', [Respondent 2] 'thought through rationally',[Respondent 4] 'having complete validity', [Respondent 1] and 'I would love to see this implemented as it would almost quality assure leadership'[Respondent 6] highlighting interviewees' enthusiasm for the overall concept. In particular the 'modular approach'[Respondent 3] and 'comprehensive content'[Respondent 5] were seen as positive features, with the 'idea of defining entry points to schemes being good, the multi-disciplinary approach key, and breaking down silos between different groups very helpful'.[Respondent 7] Others commented positively on the 'consistency of approach'[Respondent 11] and the fact that this model 'illuminates the path for potential clinical leaders',[Respondent 8] while it could be used support the existing 'MLCF continuum of development between undergraduate and postgraduate training'.[Respondent 4] There was broad agreement that 'clear, explicit structure allows people know what they have to do'[Respondent 9] and the model 'gives you a curriculum you could link to the MLCF'.[Respondent 2] Furthermore, for higher levels of training 'serially gated competition'[Respondent 7] was deemed appropriate and the model could ultimately 'provide an accredited pool of individuals, allowing a chief executive who wanted someone with these skills from this talent pool to be recognised as ready'.[Respondent 10]

Senior military healthcare leaders added that 'it is a different way of nurturing people from the beginning; trained from the outset in corporate and plc. business',[Respondent 12] that 'there was no "dark side" in the military and we select the best and the brightest to do it regardless of specialty background'[Respondent 15] and 'this training is also an integral part of the system, it influences the managerial context of job and further selects individuals whom we encourage to take the specialist managerial route'.[Respondent 16] Moreover, anecdotal evidence from deanery level suggests that military trainees are often held in high regard: 'At a recent ARCP [Annual Review of Competence Progression] panel it was said that "These [Defence Medical Services] trainees are a cut above their NHS colleagues"' [Respondent 17] and this is a common theme and is the most obvious manifestation of their 'ability to demonstrate their leadership and management competencies'.[Respondent 12]

By contrast, others expressed reservations about both the model itself and its applicability to the NHS. Caution was advocated as 'This is not the core business of the NHS in the same way it is in the military'[Respondent 17] and the 'sheer size of the NHS and its semi-feudal structure may make delivery nigh-on impossible'.[Respondent 1] Others felt that no single organisation 'should be a monopoly provider at higher levels'[Respondent 10] and there must be room for organisations to 'use external organisations'[Respondent 7] if that was more appropriate for their needs.

Given the size difference between the military and the NHS and the structural challenges presented by the NHS, further discussion of the need to adapt the model then focussed debate on how one could deliver a health leadership model in the NHS.

Challenges to implementing a health academy model in the NHS

The biggest challenge to implementing a health academy model akin to that seen in the Armed Forces was seen to be that 'the NHS does not operate as one employer'.[Respondent 10] Key stakeholders required to buy into any attempt to deliver a national model included DH, NHS England, clinical commissioning groups (CCGs), acute provider trusts, royal colleges (medical, mursing and allied health professionals) and local education and training boards (LETBs). Although there was much debate about potential delivery mechanisms, a general trend of opinion suggested that training could be 'centrally owned if it was the norm, with central funding, and a centrally devised curriculum and standards but with local implementation and interpretation encouraged'. [Respondent 4] 'The role of the National Leadership Council (NLC) (now Academy [NLA]) and NHS Institute (NHSI) (as was) could be to define the high level framework and curriculum'[Respondent 6] in 'close conjunction with the Academy of Royal Colleges'.[Respondent 9]

The actual delivery of training was felt to be dependent on whether it was generic or higher-level leadership training; it was thought that the former could become the responsibility of the regional NHS England offices, with national strategic oversight at NHS England medical director level as 'East of England, Northwest, South Central and London [strategic health authorities] have previously developed very good programmes and should come together in this kind of endeavour'.[Respondent 1] Delivery could be done either in-house, 'such as at University College London Hospitals',[Respondent 7] through 'regional health academies (as in the North West)',[Respondent 8] 'sub-regionally through Health, Innovation and Education Clusters (HIECs)'[Respondent 10] or via 'lead NHS organisations within the region'.[Respondent 11] It could also be 'put out to the marketplace, either shared with commercial partners or tendered in its entirety, while delivered against the NHS framework from the NLC/NHSI'. [Respondent 10] Organisations such as the Kings Fund, Ashridge, Unipart, Birbeck, the Royal Colleges and academic partners were all cited as potential interested commercial partners. Several respondents argued that the principle of 'subsidiarity' was important; delivering centrally only what could not be delivered regionally, or locally.

Higher leadership training was seen as more contentious. Several of those interviewed argued that 'management in medicine needs to be recognised with a more academic, respected and acknowledged focus'[Respondent 9] but while innovative initiatives such as 'formal "Walport"-style academic training in management and leadership for doctors'[Respondent 1] was favoured by some it garnered a lukewarm response from others, partly being seen as lacking a multi-professional focus. Likewise the concept of a 'College of Health Management'[Respondent 16] was positively favoured by many for higher level health leadership training but others dismissed this as elitist and expensive. This model however could become the professional home for health leadership and it was argued succinctly that 'given the size, complexity and cost of the NHS then it [a College of Health Management and Leadership College] could be money well spent. It should not just deliver training and teaching but also is a place to be used to re-invigorate, share ideas and learn from colleagues at the same level, from chief executive downwards. It could if necessary offer two-day courses to several months, again with commercial partnership to keep it fresh and innovative'. [Respondent 17]

Discussion

It is recognised that this research was undertaken prior to the recent fundamental changes witnessed in the NHS following the implementation of the Health and Social Care Act (2012) and that this study was performed prior to the publication of the Francis, Keogh and Berwick reports. However, the senior individuals interviewed both acknowledged and had clearly already considered much of what emerged in those publications and nearly all have retained senior and influential positions in the new system. Above all, the requirement was seen for a cultural shift (as demanded by the Berwick report) within the NHS to maximise the potential of existing staff and inculcating a corporate agenda in all healthcare staff.

Several key themes emerged from this research. First, it suggests that generic corporate training and closer attention to the social model of medicine from undergraduate education onwards would be invaluable. Specifically, consideration should be given to weaving this into the fabric of undergraduate and postgraduate training for all healthcare professionals, but especially doctors. There is a belief that this has to become 'the norm' for it to be successful and it had the potential, if associated with a rigorous assessment, appraisal and feedback process, to capture future talent and identify, at an early stage, potential future healthcare leaders. Second, it concludes that individuals who show promise through improving local service delivery and quality improvement should be encouraged and selected for more focused, higher leadership training and experiential leadership opportunities. It was felt that whilst the current focus on senior trainees had yielded successes and, to a degree, generated a broad social movement especially among trainee doctors and new consultants, there is a real need for experiential learning and actual leadership to be demonstrated before individuals are deemed credible and selected for the very highest and intensive levels of investment.

Third, it was perceived strongly that the NHS could utilise a model such as used by the Armed Forces model (AFM), albeit with some caveats. Thus, the overall response to the model was positive, particularly in relation to the well-defined structure, clear pathway and titrated training process with serially gated competition. Additionally, the military annual

appraisal system that supports selection for higher training and incorporates both technical (clinical) and corporate aspects of performance and potential was highlighted as a process from which the NHS could learn. The emphasis on future potential was deemed to be particularly valuable in this context.

It has been argued that the effect of a concomitant clinical and corporate approach, as used in the military, is to allow individuals to develop managerial and leadership confidence and to appreciate they have both a clinical role and a wider responsibility to the organisation for which they work. This is not dissimilar from having to work in a strategic management context in the NHS.[17] There has, in fact, been previous interest from the NHS in the military health leadership agenda. Monitor has suggested sending Foundation Trust directors to Sandhurst for leadership education[18] and a formal Ministry of Defence/Department of Health/NHS Leadership Encounter took place in early 2010 at the JSCSC.

By contrast, significant caveats also emerged. The scale and structure of the NHS and disparate allegiances within the system are significant barriers to applying the AFM. Buy-in from the highest levels and willingness for NHS England (as commissioners) or Monitor or the Trust Development Agency to assume centralised responsibility for funding and delivery of a high-level health leadership framework would be needed. There would be a requirement to focus on both the generic training for all and the higher level training for tomorrow's future NHS leaders. The principle of subsidiarity would also be key, delivering centrally only those things that cannot be delivered locally, and allowing local delivery against a higher level, centrally owned, health leadership framework. In reality, this research suggests that generic training would likely be delivered locally, while specific and higher-level training should be more appropriately delivered through a more central mechanism. This chimes with the suggestion in the Francis report for a physical NHS Leadership Academy. Adjusting the appraisal system to support selection of the best candidates would take time, but through collaboration with other agencies such as Royal Colleges should not be insurmountable.

Since the interviews took place the Faculty of Medical Leadership and Management (FMLM) has been established (in 2011) and has tackled several of the issues identified within this manuscript, driving forward the agenda of establishing healthcare leadership and management competencies for doctors. This initiative was lauded in the Francis report. The FMLM argues for a more central role for both healthcare management and leadership emanating from medical school through all levels of clinical practice, to chief executive level. It fulfils the requirement for a high-quality, credible, virtual resource and a meeting place for like-minded medical staff who are engaged with the healthcare leadership agenda. The FMLM also recognises the need for, and is continually developing, resources for continuing professional development, revalidation, coaching and mentoring and is in the process of undertaking a review of standards for accreditation in this area, just as with other areas of doctor's practice.

The FMLM has made significant and positive strides in placing the leadership and management agendas more centrally for doctors, using a predominantly virtual platform (along with high-quality and well attended annual conferences). Alongside this the National Leadership Academy continues to invest in a five-tier system delivering training in compassionate healthcare, predominantly, but not exclusively, to nursing staff. This remains a programme requiring self-nomination and while more multi-disciplinary in its approach it still fails to engage the majority of the NHS workforce. Both Francis and the evidence presented within this manuscript would suggest that we need to build on these initiatives to translate this progress more widely, to the whole NHS workforce. A more multi-disciplinary approach to delivery, achieved by developing a physical academy and pooling the various resources and expertise that already exists into a more coherent, corporate and substantial endeavour, would also be desirable.

Conclusion

To deliver a successful national model for management and leadership in the NHS, several key political barriers must be overcome. Top level ownership of the health leadership strategy could sit with NHS England. A national framework and curriculum for both generic and higher-level health leadership training could be defined by the NLA and NHSI working in collaboration with the Academy of Royal Colleges, the FMLM and Health Education England. A modified national appraisal system could be initiated along the lines of e-portfolios used by trainee doctors today. Responsibility for the delivery of generic training could fall under the remit of the regional leadership academies and LETBs, while front-line delivery of generic leadership training could be delivered either in-house within the regions, or put out to tender. This would be a matter for local determination.

Higher level training should be both practical and have a strong academic component. This should be both in terms of delivery to participants but also to develop evidence to support the funding of such an initiative. Overall, the research in this dissertation supported the development of a College of Health Management and Leadership. This perfectly echoes the recommendation in the Francis report. This institution could house the NLA, FMLM and NHSI and bring together the NHS Management scheme and clinical leadership pathways (from all professional groups). The College could be both an academic institution and be responsible for delivery of higher level training. It should have both an international focus (to learn from comparative healthcare and also to share best practice and the strengths of a leading national health service) and a wider inter-governmental focus, as with the National School of Government. It was suggested in this study that this would be most appropriately delivered in conjunction with external providers, both to maintain innovation and allow cross pollination with partners in finance, management, law and academia. It could also run training programmes for specific professional groups, where appropriate, but always aiming to engender a corporate cross-professional ethos. This model would also allow the NHS and its various bodies to have access to data on individuals who may be appropriate for senior appointments and to whom NHS organisations could turn to when seeking director or board level appointments. It should be acknowledged that the FMLM, NLA and other groups have already started instigating strands of the ideas expressed in this research; however the establishment of a physical NHS Healthcare Academy would send a powerful message that the NHS and UK Plc is committed to the necessary investment to

ensure a safe, high quality service, investing in its undoubtedly talented workforce for the benefits of all patients both now and in the future. ■

Conflict of interest

EDN is a Royal Air Force Medical Officer and a member of the Defence Medical Services who has undertaken training at both RAF College Cranwell and JSCSC.

References

1 Keogh B. *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report.* NHS, 2013. Available online at www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf. [Accessed 13 December 2013].

2 Francis R (Chair). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* Available online at www.midstaffspublicinquiry.com/news/2013/02/publication-inquiry-final-report. [Accessed 13 December 2013].

3 Berwick D (Chair). *A promise to learn, a commitment to act: improving patient safety in England. Report of the national advisory group for patient safety in England.* Department of Health, 2013. Available online at www.nhshistory.net/Berwick_Report%20(1).pdf. [Accessed 13 December 2013].

4 Future Hospital Commission. *Future hospital: caring for medical patients.* A report from the Future Hospital Commission to the Royal College of Physicians. London: Royal College of Physicians, 2013.

5 Warren OJ, Carnall R. Medical leadership: why it's important, what is required and how we develop it. *Postgrad Med J* 2011:87;27–32.

6 Moberly T. Government announces scheme to 'fast track' clinicians into senior management after Francis report. *BMJ Careers* 2013; 30 November.

7 Darzi A. High Quality Care for All - NHS Next Stage Review Final Report. London: HMSO, 2008.

8 Darzi A. NHS Next Stage Review: A High Quality Workforce. London: HMSO, 2008.

9 West M, Borrill C, Dawson J *et al.* The link between the management of employees and the patient mortality in acute hospitals. *Int J Hum Resour Man* 2002:13;1299–310.

10 Armit K, Roberts H. Engaging doctors: the NHS needs the very best leaders. *Asia Pac J Health Man* 2009:4;47–52.

11 Atkinson S, Spurgeon P, Clark J *et al. Engaging doctors: what can we learn from trusts with high levels of medical engagement.* Coventry: NHS Institute for Innovation and Improvement and Academy of Royal Colleges, 2011.

12 Harter JK, Smidt FL, Keyes CLM. Well-being in the workplace and its relationship to business outcomes: a review of the Gallup studies. In: CLM Keyes, J Haidt (eds), *Flourishing: positive psychology and the life well-lived.* Washington DC: American Psychology Association, 2002:205–24.

13 Salanova M, Agut J, Piero JM. Linking organisational facilitators and work enagement to employee performance and customer loyalty: the mediation of service climate. *J Appl Psychol* 2005;90:1217–27.

14 Nicol E, Mohanna K, Cowpe J. Perspectives on clinical leadership: a qualitative study of the views of senior healthcare leaders in the UK. *J R Soc Med* 2014, in press.

15 Glaser B.G and Strauss AL. *The discovery of grounded theory: strategies for qualitative research.* New York, NY: Aldine Publishing Company, 1967.

16 Bowling A. Social science and grounded theory. In *Research Methods in health.* Buckingham, UK: Open University Press, 2008:125–6.

17 Nicol E NHS Clinical Leaders: take a leaf from the military's book. *Health Science J,* 2009. Available online at www.hsj.co.uk/home/clinical-leaders/nhs-clinical-leaders-take-a-leaf-from-the-military's-book/5001387.article [Accessed 20 December 2013].

18 West D. Monitor sends FT directors to Sandhurst. *Health Science J,* 2009. Available online at www.hsj.co.uk/5005548.article [Accessed 23 April 2014].

Address for correspondence: Dr Edward Nicol, honorary senior lecturer, Clinical Leadership Academy, Clinical Education Centre, Newcastle Rd, Stoke-on-Trent, Staffordshire, ST4 6QG. Email: cyprusdoc@doctors.org.uk