



**The
Higher
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**Medicine,
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Special Report 5

FDTL4 Leadership Development Programme
**Developing Tomorrow's Leaders
in Health and Social Care Education**

**Case studies in leadership
in medical and health care
education**

Judy McKimm

October 2004

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About the author

Judy McKimm is the Project Manager of the FDTL4 funded project, *Developing Tomorrow's Leaders in Health and Social Care Education* led by Leicester University. Further information about the project, the leadership development programme and many resources on leadership in health and social care education is available from the project website www.le.ac.uk/sm/le/projects/fdtl/index.html

Judy was Head of Curriculum Development (Undergraduate Medicine) at Imperial College London until August 2003. Her main role was developing and implementing the new undergraduate medical curriculum initially at Charing Cross & Westminster Medical School and, following organisational merger, at Imperial College School of Medicine. In addition to working at Imperial College, she has worked with a number of other UK schools of medicine and nursing, assisting with curriculum and staff development programmes and with developing educational quality and evaluation systems. She is a Senior Adviser (Registration and Accreditation) for the Higher Education Academy and has been a subject reviewer in Medicine for both the English and Welsh Funding Councils. Prior to working in medical education she worked as a nurse and a lecturer in Community Studies in Further Education.

Her independent UK based project management work includes managing a project funded by the London Deanery on producing a web based distance learning programme for clinical teachers and directing an NHSE project on preparing medical students for clinical practice. Her international work includes working on projects in Portugal (undergraduate medical education and quality assurance); Georgia (accreditation of Higher Education); Central Asia (two USAID projects on evaluating undergraduate medical facilities); Uzbekistan (World Bank and DfID health reform project in reviewing undergraduate medical education and developing a licensing programme for doctors) and Bosnia and Herzegovina (World Bank project to develop a health management programme).

Foreword

In the late 1960s the Royal College of General Practitioners (RCGP) launched the brand new vocational training for general practice. Those of us involved at that time made three basic decisions. First, we would professionalise learning and teaching, as the Americans had done but specialist medicine in the UK had not. Second, recognising the power of role modelling in shaping and influencing professional attitudes and behaviour, we decided that the new trainers had to be known as 'good' doctors in 'good' practices. And third, because of their potential as leaders, we would put the professional development of our newly chosen trainers, as both doctors and teachers, at the heart of the new training. So the professionalisations of teaching and clinical leadership development were brought together as a deliberate act of national policy. The appropriate investment in the necessary infrastructure followed.

The translation from theory into practice began in 1972 with what were known as the London Teachers Workshops. Between 1973-75 the best people from around the country were brought together by the RCGP to join what were called the 'Nuffield Courses'. The object was to kick-start the regionalisation of educational expertise and leadership so that the new vocational training would be well founded. That was reinforced in the 1980s by the MSD Foundation leadership courses, which had the same purpose but targeted the next generation. Both Nuffield and MSD had inspirational teachers leading them – the late Professor Paul Freeling and Professor Marshal Marinker respectively. They had a lasting and powerful effect on their alumni, and were absolutely fundamental in bringing about the important improvements that were needed to patient care in general practice.

All of which may explain to the reader why I find this set of case studies on leadership in medical education so timely and so interesting. In her thoughtful, altogether excellent report Judy McKimm has based her analysis and conclusions on the stories of the experiences and thinking of leaders in health professions today. She is absolutely right to do that, for they tell it as it is. She raises questions about the future direction of leadership in health and social care education. These are important particularly since both fields now involve so much more interprofessional working, and call for leadership of a different outlook and style in the world of the autonomous patient and client. And she points to the opportunities that are there for those who seek them out.

But she leaves us with a serious question, which remains unanswered in my mind, and I suspect in hers too. When will our policy makers really understand that excellence in practice, education and management are indivisible parts of professionalism in health and social care today? Such true professionalism all depends on leadership. Perhaps a sign of that understanding will come when the nurturing of professionalism is seen as the natural first priority in our educational and service establishments. That was the lesson the GP trainers learnt all those years ago, and it repaid handsomely.

Section 1

Introduction

Top organisations understand the difference between what should never change and what should be open for change. (Collins & Porras, 2004)

The idea for this report was conceived during a discussion with Professor Reg Jordan, Director of LTSN-01 (now part of the Higher Education Academy) following an interview I carried out with him as part of the development of a new programme for aspiring leaders in healthcare education. I mentioned that we had gathered a substantial amount of new data from leaders in medical education as part of the project about the topic of leadership and it was suggested that this might be of interest to a wider audience. In our original discussion, we thought that we would produce a small number of paradigm case studies based on the interviews with experts, participants and mentors. These case studies would be loosely based on some of the typical routes into leadership, for example a clinician, a basic scientist, a medical educator or someone with a non-medical background. In carrying out the analysis of the data, I found that the picture was much more complex than that. We therefore decided to look at the topic of leadership in medical and healthcare education from a broader perspective and to explore some of the key issues, barriers and critical success factors involved in becoming a leader in contemporary medical education. We aim to highlight some of the common aspects that enable individuals to sustain and develop their leadership potential. The report will also give some pointers to medical schools from an organisational perspective on how issues such as succession planning might be considered at strategic level.

The report describes the background to the project and explains how and why the primary research was carried out. It then goes on to locate the concept of leadership within some of the literature on the topic and describes the key findings from the research. The report centres around the 'stories' told to us by a selection of today's leaders in medical and healthcare education, highlights some of the essential attributes of healthcare education leaders and identifies some of the issues that exist in leading and managing contemporary medical and healthcare institutions.

The report is very much a snapshot of issues as seen by leading practitioners in the field and marks the introduction of a formalised leadership development programme for aspiring leaders in health and social care education. The focus of the report is on medical education leadership but many of the issues and stories will resonate with other health educators and leaders. With the establishment of the Leadership Foundation for Higher Education (LFHE), it is timely to consider wider aspects of leadership development and succession planning for all areas in HE, and how generic programmes co-exist with discipline or profession specific programmes. Initial evaluation of the first programme indicates that the participants themselves have gained much from the programme. Longer-term evaluation will reveal whether the programme has had an impact on the organisational development of healthcare education institutions.

We have tried to make the content relevant to people working at many levels and in different roles, whether you see yourself as a leader already or aspire to a leadership role, we hope you will find it an interesting and useful read.

Section 2

Background – the FDTL4 project

Developing tomorrow's leaders in health and social care education

The challenge facing all those who aspire to be leaders is to be themselves but with more skill. (Goffee & Jones, 2004)

The project, *Developing tomorrow's leaders in health and social care education*, was developed to address issues arising from a lack of succession planning in health and social care institutions. HEFCE awarded this three-year project to the University of Leicester in partnership with four other Universities – Imperial College, London; University of Leeds; University College Northampton and Liverpool John Moore's University. The project is supported by the Council of Heads of Medical Schools and the Deans of Faculties for Nursing, Midwifery and Health Visiting, HESDA (now part of the Leadership Foundation for HE) and three Higher Education Subject Centres (LTSN-01, Health Sciences and Practice and SWAP). HESDA (now part of the Leadership Foundation for HE) is also participating in the design and evaluation of the project.

The *NHS Plan*¹ and *A health service for all the talents*² emphasise that a hugely expanded workforce educated to work in very different ways will be required to support a 'modernised' health service. Providers of health and social care education will have to rise to multiple challenges: increased student numbers, new inter-professional ways of educating and working, ensuring good retention of students, changes in funding streams for different groups of students and dealing with issues arising from widening participation and access in relation to employability. There are also problems faced more generally across higher education in response to the impact of new technologies, increasing participation rates, changing legislation, the impact of research and teaching assessments and dealing effectively with diversity. Success will depend critically on effective leadership and management by a relatively small number of senior health and social care education leaders distributed across many institutions.

One of the problems in medical education is that many current leaders are close to retirement, and succession planning is limited. There are no specifically tailored programmes to develop new educational managers/leaders who are equipped to work at the demanding interface between higher education and rapidly changing health and social care services. The project aimed to address this urgent need.

1 www.dh.gov.uk/assetRoot/04/05/57/83/04055783.pdf

2 www.dh.gov.uk/assetRoot/04/08/02/58/04080258.pdf

Current health and social care managers are no strangers to change management. Medical schools have planned and implemented new undergraduate curricula following the GMC's publication of *Tomorrow's Doctors*, the recommendations of the GMC Education Committee on undergraduate medical education (in 1994 and 2002). Project 2000 had a huge impact on nurse education and further radical changes are in progress following the UKCC *Fitness for Practice & Purpose*.³ So far, the few senior people managing these changes have acquired their skills by personal experience, occasional staff development and informal peer networks. There is widespread recognition of the need for more formal development programmes, and much evidence (eg from Investors in People awards and the Management Charter Initiative) that the development of senior managers is a key factor in the effectiveness and efficiency of an organisation.

A few international initiatives support the development of management and leadership skills. Harvard Medical School runs, with Harvard Business School, the 'Harvard Macy' programme for leaders in healthcare education, which has been attended by the leaders of this project and ASME also organises a UK 'Harvard Macy' course. The University of New Mexico runs a development course for 'Scholars in Medical Education'. This is an ongoing, personalised programme, where staff are mentored by colleagues and supported by resources.

The UK Higher Education Staff Development Agency (HESDA), which is now part of the Leadership Foundation for HE www.leadership-he.com/ will play a major role in this project. The LFHE runs a top managers' programme, but it does not currently link to the NHS. Within the NHS there is currently great emphasis on the development of leadership skills, for example with the development of the clinical leadership centre and programmes, see www.nhsleadershipqualities.nhs.uk. *Working Together – Learning Together: a framework for lifelong learning for the NHS*⁴ emphasises how good leadership and management are crucial to improving all aspects of healthcare. The same is true of health and social care education where the benefits of effective leadership spread first to the students and then to their future clients. Links to HEIs have been strengthened by the joint DH/HEFCE *Statement of Strategic Alliance for Health and Social Care*,⁵ which includes as a shared principle and approach 'supporting, valuing and developing health professional staff working across the HE/NHS interface' and 'disseminating good practice (eg human resource management) between the HE and NHS and social care sectors, particularly in relation to increasing diversity and retention in the student population and HE workforce'.

The FDTL4 Leadership Development project therefore places emphasis on the development of leaders who can successfully manage educational institutions that straddle the interface between HE and the health and social care sectors. This will require an understanding of the specific context combined with a responsive and flexible approach to the dual demands of HE and health & social care. This project links to the FDTL priorities, in generic and subjects allied to medicine, for staff development, in medicine for developing systems for managing & assuring quality, and in nursing for management of practice learning.

3 www.nmc-uk.org/nmc/main/publications/fitnessPpPages.pdf

4 www.dh.gov.uk/assetRoot/04/05/88/96/04058896.pdf

5 www.dh.gov.uk/assetRoot/04/08/28/01/04082801.pdf

Aim of the FDTL4 Leadership Development project

The project aims to enhance the future management of health and social care education in the face of dramatic change by identifying future leaders. The project will achieve this by setting up and evaluating the impact of a sustainable health and social care leaders' development programme. Participants are supported in meeting their identified needs by learning from current leaders, experts in NHS and University management, and one another.

The aim of the project is to design a development programme for continued leadership development, modelled on an agreed framework defining the skills and competencies of health and social care education leaders. The framework includes the opportunity for up to 70 staff to be equipped with the skills necessary to:

- Manage and enhance the quality of students' learning experience across the HEI/NHS/Social care interface
- Manage change and the development of health and social care education
- Work within a well established network to ensure rapid spread of good practice

Outcomes of the project

The specific outcomes of the project are to:

- identify the skills and competencies required for effective management and enhancement of health and social care education in the new NHS environment by working with current leaders and experts in educational and health and social care management
- identify good practice and relevant learning opportunities from organisations such as HESDA, HEIs, the NHS and abroad, and recruit experienced mentors and expert input to the programme
- identify, in consultation with providers, 30-70 staff distributed over medical schools, schools of nursing & midwifery and allied health professions, and schools of social work who aspire to leadership
- establish a validated, accredited and tested educational leadership programme available to institutions which can be embedded in organisational staff development programmes which will:
 - enable participants to audit their skills and competencies against the identified list, and identify their individual needs
 - provide a wide range of opportunities for development including
 - a personalised development programme
 - mentorship by experienced leaders
 - action learning sets
 - formal training events with expert facilitators
 - access to relevant training in the NHS & HE sector
 - a virtual learning environment and website
 - assess participants' progress by formal appraisal and other methods

- work with senior staff in providers to facilitate more effective succession planning
- evaluate the effectiveness of the programme by qualitative and quantitative techniques involving the participants, staff in HEI's, students and clients
- obtain accreditation via HESDA/SEDA
- work with the LTSN subject centres, now part of the Higher Education Academy, and the providers of health and social care education to ensure the continuing support of the programme through embedding it into institutional and sector staff development strategies

The leadership development programme

Through liaison with a network of institutional contacts we received over 50 nominations for the first cohort of participants from institutions for people who would benefit from participating in the leadership development programme and be eligible for institutional support. From this group we recruited 24 participants from a range of UK medical and dental schools and healthcare institutions. The programme for the first cohort ran from October 2003 to November 2004, and two additional cohorts (in total, approximately 50 aspiring leaders) started in October 2004 (middle managers, typically senior lecturers) and January 2005 (more senior managers, typically heads of department). We decided to recruit participants from medical and healthcare education for the first programme and to recruit a greater number of participants from social care in the second and third programmes.

There were no stringent entry criteria for participants on the first leadership development programme. The programme was intended for people seeking a career in educational management and leadership. Some were individuals who, because of their interest and previous experience, were likely to become educational managers in two to three years time. Others were established managers or recently appointed managers responsible for a significant proportion of a health care programme. We made changes in the recruitment and delivery of the second and third programmes, partly because of increased awareness of the programme in the sector and partly through feedback from evaluation of the first programme. The first change we made was to run two programmes in Year 2 of the project instead of one. Both programmes have a very similar structure and format to the first programme and cover the same topics. One of the programmes, however, is for aspiring leaders at the same level as the majority of those on the first programme (senior/principal lecturer level), whereas the other programme is for individuals who aspire to move into senior management in the near future. Secondly, due to demand for places on the programme, we devised entry criteria and established a selection panel to consider all applications. Thirdly, as we found that some participants were not well supported by their institution (because the first programme was still evolving and partly because the programme is free to participants), we set up workplace visits to all participants which include a meeting with the individual's line manager in order to clarify issues and encourage more active support. All participants are required to be nominated by a named 'organisational sponsor', in this way we aim to lock the participant's development directly into the needs of their organisation.

The final major change we made was to develop the programme into an accredited award. This development was carried out in response to requests from some participants and agreed in consultation with the National Co-ordination Team. The initial view when developing the project bid was that individuals would participate in a highly individualised programme, tapping into training events hosted at their own organisation supported by a set of events run

by the project team on various leadership topics. In discussion with the participants, it became clear early on that they wanted a more highly structured programme and felt that having some tangible evidence of their attendance and participation would enhance their career prospects. Participants who choose to do so can now work towards the SEDA *Developing Leaders* award, which is part of the Professional Development Framework, and/or a Postgraduate Certificate in Higher Education Leadership validated by the University of Leicester.

All participants were consulted about their specific learning needs in relation to educational leadership so that they can be addressed in the programme. We have designed the programme flexibly and support is provided for participants at both national and local levels. The programme aims to meet the professional development needs of individuals whilst equipping all participants with a capacity to progress into positions of educational leadership.

Specifically, participants are enabled to:

- Audit their skills and competencies against an agreed specification
- Draw up a personal development plan
- Be supported by a named and trained mentor
- Participate in a network of Action Learning Sets
- Access formal training events with expert facilitators
- Access a virtual learning environment containing resources on educational leadership

Core topics covered in the leadership programme

- Exploring concepts of leadership (and how this differs from management)
- Understanding the HE and NHS context and environment
- Managing and leading change, creative management, horizon scanning
- Managing and leading people
- Decision making and risk taking
- Quality and performance - using performance indicators
- Personal leadership (leadership style, empowering, inspiring etc.)
- Self-awareness
- Vision and values
- Time management and prioritising
- Communication and interpersonal skills, including emotional intelligence
- Leading and building teams
- Career planning and management

The project activities, including the development of the programme, have been overseen by a Project Steering Group which has been most helpful in providing specific guidance and ideas and providing a forum for discussion and debate.

Integrating the project into the HE sector

One of the main aims of the project is to develop a leadership development programme for aspiring leaders that meets the needs of health and social care education and that is sustainable within the sector in the long term. We have been active in working directly with over sixty HEIs, as well as with national bodies such as the Councils of Deans, LTSN Subject Centres (now part of the Higher Education Academy), HESDA (now incorporated into the LFHE) and SEDA, to promote the programme and discuss ways in which the programme, or a similar model, can be continued once the project is finished. One of the methods under discussion is that the final version of the programme will be rolled out to HEIs and embedded in institutional staff development programmes to assist organisations in succession planning for leaders in health and social care education. The programme is already accredited by SEDA under their Professional Development Framework and participants can also, if they wish, work towards the Postgraduate Certificate in Higher Education Leadership. The other way in which the programme may be made available to the sector is through the LFHE and this is one of the key organisations with which we are liaising on an ongoing basis.

In the development phase, we aimed to involve a large number of HEIs in the project through the active participation of individuals to advise and assist us in the development, delivery, evaluation and dissemination of the programme. In our initial contacts with HEIs, which were carried out through the relevant LTSNs, the Council of Medical School Deans and the Staff Development Network, we obtained suggestions from institutions for senior staff who were willing to act as mentors to participants and also those who would be willing to participate in other activities.

The main role of mentors is to provide support and assistance for their mentees in achieving specified tasks including an audit of existing skills and competencies, the completion of personal action plans and reviewing career options and opportunities. From the senior individuals identified through networking, we have trained and/or briefed over seventy mentors so that each participant has a named mentor. The mentors are mainly senior managers in institutions that deliver high quality health and social care education. For the first cohort, as far as possible given geographical and institutional constraints, each of the participants was assigned a mentor from outside their own discipline or subject area. The majority of mentors attended a short training programme designed to enable them to learn more about current challenges facing leaders in health and social care education and develop relevant mentoring skills. The training was evaluated as both useful and enjoyable. For the second and third cohorts, we decided to ask participants if they wanted to select their own mentor. It was felt that this would facilitate meetings and the development of a good working relationship, as feedback from the first cohort indicated that distance was a barrier to meeting their mentor regularly. The majority of participants have selected a mentor from their own or a nearby institution, some have selected a mentor from the list we provided.

Other leaders in healthcare education and specialists in management and leadership have been involved through participation in the residential and one day events that run throughout the programme. We aim to involve individuals who are currently practitioners in educational leadership as well as experts in various aspects of leadership and management to provide specific knowledge and facilitate a discussion forum for participants. We plan over the final stages of the project to involve additional individuals from a wider range of HEIs, particularly those delivering social care programmes as well as medical and healthcare education.

Section 3

Method of developing this report

The information presented in this report was gathered from a range of sources and activities, including

- a literature review on leadership and a survey of relevant leadership development programmes
- a questionnaire survey of programme participants prior to joining the programme
- focus group discussions with mentors during the briefing/training event
- discussions with key stakeholders in the project
- a residential event for senior managers and leaders in medical and health care education
- face-to-face and telephone interviews with 22 senior managers and leaders in health and medical education, selected to cover a range of institutions, levels and roles within organisations

The data gathered from these activities has resulted in a large amount of information relating to aspects of leadership in medical education, presented in the *Key findings from primary research* section below. It should be noted that the information was not gathered through a systematically designed and administered research protocol as this was not one of the aims of the project. However, some interesting issues have emerged arising from the intensive development work, which was the first phase of the project and resulted in the leadership development programme. The way in which the programme was developed is described in more detail below.

The first stage of development of the programme was concerned with development of the 'skills' framework for the leadership development programme. When the project bid was written, it was envisaged that a consultation exercise would be carried out with senior staff in health and social care institutions, probably by questionnaire. As the cohorts of participants, mentors and experts began to be identified, we realised that there was a huge amount of expertise and information within these groups to which we had unique and unparalleled access. We also needed to identify key issues from the vast amount of literature available on leadership and learn from the many other courses and programmes on offer relating to educational leadership worldwide.

We therefore carried out two main activities as part of the development of the programme and which have been written up in this report.

Firstly, a review of the literature on leadership in health and social care education was commissioned. This included a review of current leadership programmes in education and health care. The literature review provided a synthesis of some of the current literature and a summary of leadership programmes in the UK and overseas. The review was carried out by Dr Rifat Atun from the Tanaka Business School, Imperial College London, one of the partner institutions (see section 4 for a summary of the key findings of this review).

Secondly, the project team carried out primary research in order to elicit some of the main themes and issues concerning leadership, and to identify the needs of contemporary leaders in HE in medical and health education. This research involved carrying out one to one interviews and a group meeting with leaders in healthcare education, a questionnaire survey of all the potential participants on the programme and carrying out focus groups with the mentors. From these activities, key themes and topics relating to contemporary healthcare education, which could form part of the leadership development programme, were identified.

These issues provided a framework for discussion at a residential event held in May 2003 to which a group of 'leaders and shapers' in healthcare education were invited.

The aim of the residential event was to:

- Identify key skills and competencies of leaders
- Build a network to support the project
- Define what current leaders would have liked to have had
- Refine the planned leadership development programme
- Propose ways to deliver it without overwhelming participants or contributors

This event brought together 22 senior managers from HE in the UK and overseas with practical expertise of leadership in healthcare education for a debate and discussion about contemporary leadership issues and succession planning. The event also enabled a wider discussion to take place about the content, structure, purpose and assessment elements of the programme. Following the event, the first draft framework for the leadership programme was distributed to those who had participated and, in the light of the comments received, the framework and key activities of the leadership development programme were finalised. A set of additional interviews were carried out between December 2003 and February 2004 with a selected sample of leaders from UK medical and healthcare education to consider some further issues concerning leadership in healthcare education from a practitioner perspective.

Section 4

Summary of findings from primary research

Management is the effective handling of complex situations and demands to deliver what should be happening.

Leadership is creating and 'making happen what wouldn't otherwise happen'. Above all it is getting significant new things done. (I&DeA, 2003)

This section briefly summarises the key findings from the interviews, focus groups, questionnaires and discussions that were carried out during the development of the leadership programme. This summary is developed further in Section 7.

Profiles of senior medical education and healthcare leaders

- The vast majority of those in leadership positions are clinically qualified
- The majority of those in leadership positions have a higher degree, however most of the medical education leaders have a PhD whereas the healthcare education leaders tend to be educated to Masters' level
- Most of the medical education leaders are male whereas there are many more women in leadership positions in healthcare institutions
- The majority of leaders had gained experience in a clinical leadership role or postgraduate education role prior to moving into HE educational leadership
- Many leaders have gained wide experience outside their own institution in clinical, research and educational fields
- Few leaders have taken formal management or leadership programmes designed for HE, although many have attended short courses on specific topics such as finance or NHS management and leadership courses

Moving into a leadership role

- The majority of leaders had made conscious decisions to go into leadership, management or administration
- The route for medical school leaders is typically via a subject based, research route (eg. to Head of Department) whereas for healthcare education leaders, the typical route is through management of a curriculum component or programme
- Although participation in educational development has not been the norm for medical school leaders, many people had seized opportunities to participate in curriculum development activities (eg. through the implementation of *Tomorrow's Doctors*) and had thus found a new route into leadership

- There is a perceived lack of support and absence of formal training for aspiring leaders and people in management roles, this is in stark contrast for the amount of training for the clinical role
- Networking, both within and outside the organisation, is seen as very important in ensuring visibility and widening the sphere of influence
- The majority of interviewees and participants on the programme had received no formal career planning advice nor participated in leadership development activities
- Leaders have to acknowledge that they will have to give up some activities as they move up the career ladder, there are issues which individuals have to address so as achieve a balance between maintaining credibility and failing to manage both clinical and academic (teaching, research and administration) commitments
- Successful leaders plan their careers, but are prepared to seize opportunities and to move jobs/organisations fairly frequently if needed

Support for leadership development

- Few formal support mechanisms (eg, mentoring schemes) existed for medical school leaders, although some healthcare education leaders had received some coaching, mentoring or self-development opportunities which were deemed helpful
- Informal support mechanisms included colleagues, seniors and support from domestic partners
- Being supported by line management is a very important and many examples were cited of how mentoring (in the traditional sense) occurred through nurturing, providing opportunities for development and risk-taking and offering a sounding board and opportunity for self reflection to aspiring leaders
- Role models (both positive and negative) were influential in shaping future leaders' behaviour and philosophies

Distinguishing between leadership and management

- The majority of leaders thought there were clear differences between leadership and management
- In practice, however, many of the differences between leadership and management were blurred because of the volume of day to day work and tensions between trying to implement the strategic vision within operational and tactical constraints
- The leaders felt that all leaders should have some management skills and experience (they should work up 'through the ranks') so that they can bridge the gap between managers and leaders

Key qualities, attributes and skills of successful leaders in healthcare education:

The following list of personal qualities, attributes and skills of successful leaders in healthcare education has been generated through interviews, focus groups, questionnaires and discussion with aspiring and current leaders:

- Vision
- Core values and beliefs
- Strategic management
- Ability to see the big picture
- Managers of change
- Knowing your environment
- Understanding the HE/NHS interface
- Analytical skills
- Clarity of thought
- Having good judgement
- Recognising and seizing opportunities
- Risk taking
- Working with paradox and tensions
- Self awareness
- Effective interpersonal and 'people' skills
 - Resilience and internal locus of control
 - Communication skills
 - Emotional intelligence
 - Being able to enthuse, inspire and empower
 - Confidence
 - Credibility
 - Integrity
 - Charisma
- Effective leadership style should incorporate:
 - Flexibility
 - Elements of transformational leadership

Learning how to be a leader

- Aspiring leaders wanted to develop their leadership style and skills in a more formal setting and consolidate existing skills
- Many aspiring leaders felt that the leadership development programme would help them move into more senior academic positions and be better prepared to seize opportunities
- They also felt that the leadership development programme would help them to reflect on their professional development and provide a support mechanism not available to them in their own organisation
- Most of the current leaders interviewed had acquired their leadership skills through experience of being a manager and a leader and through observation of others
- Many leaders said that they felt they had a natural inclination towards leadership and an ongoing interest in management theory and its application to their own practice
- Many of the leaders had been in a variety of leadership roles both within and outside their work role and these experiences had helped them to develop leadership and management skills, particularly 'people skills'
- The structure and ethos of an organisation is very important in providing the right environment in which aspiring leaders can flourish and be enabled and nurtured
- Some leaders felt that leaders should be more formally prepared to deal with the rapid changes and complexity of both HE and NHS systems through more formal educational credentials and/or management qualifications
- Many of the aspiring leaders had not been seen as eligible for management or leadership development programmes by their own organisations because they were not yet in leadership positions
- Successful leaders need to have experience of both HE and the NHS, an awareness of the interface between the two and opportunity to reflect and discuss the issues concerned with managing across boundaries

Issues and challenges facing healthcare education leaders

Personal issues

- Maintaining an appropriate work life balance was often difficult for leaders, especially those with domestic commitments
- The culture of senior management practice (particularly the long hours and evening meetings and engagements) in both clinical and academic life has impact on career progression for those with domestic responsibilities
- Although some people said that there were no particular issues concerned with being a woman in medical education leadership, others said that for women who have children there are issues concerning career breaks, domestic commitments the existence of the 'glass ceiling'
- Leaders who had trained as clinicians had to make decisions as to how to manage a clinical career and a career in educational management and whether or when to leave clinical practice
- Decisions over leaving clinical practice are tied in with maintaining credibility as a leader
- The educational role is often perceived by aspiring leaders as undervalued by organisations, but this appears to be improving due in part to the drivers of assessment and scrutiny of HEIs by external agencies
- Aspiring leaders of Higher Education Institutions with non-traditional career backgrounds (ie, non academic) feel as if they will be overlooked in consideration for senior management positions

Organisational and cultural issues

- Leaders identified that there are many barriers to leadership which are determined by the structure and/or culture of an organisation
- It is important that aspiring and current leaders understand the history and anthropology of their own organisation and how organisations work in more general terms
- Managing and leading people and ensuring they are in the right roles and positions is one of the important skills of a leader
- Understanding of organisational strengths and the contexts within which an organisation functions are essential for effective change management
- Some leaders were attempting to address work life balance issues and change the culture and work ethos of their organisations
- The leaders' decision-making style (authoritarian vs consultative) is an important barometer of the culture of an organisation, many leaders felt that consultation is vital in an academic setting
- Hierarchical and centrally controlled structures can impede change management
- It is difficult for leaders who are not in senior management positions to effect change unless they are empowered and supported

- Some interviewees feel that their profession, discipline or clinical specialty is perceived in a stereotyped way by others, they are somehow seen as less 'serious' than others and that these viewpoints have impeded their progress into a leadership role in medical education
- There is a perception that heads of medical schools will be drawn from a certain cadre of individuals and this can lead to people failing to apply (or be recruited) for senior positions in medical schools
- Some leaders feel that there are more senior career opportunities outside medical schools (eg. in postgraduate medical education or healthcare education) for people coming from an less traditional academic background
- Some clinicians find it difficult to reduce clinical workloads and make the shift into educational roles
- It may be easier for clinicians from some specialties (eg. histopathology, general practice) to cope with the dual demands of clinical and academic life than those in other, hospital-based specialties
- Leading and managing independent clinical practitioners who are also autonomous academics can be difficult, leadership has to be strong and visible and leaders have to have high level communication and people management skills

Balancing competing agendas

- The overwhelming issue identified by those working as leaders in medical and healthcare education was that of working with the rapid and complex changes affecting the NHS
- The dual demands of working in HE, which is increasingly accountable, and an NHS undergoing rapid change puts greater strain on health care education leaders than those in other sectors of HE
- There is conflict between the core values and demands of the NHS (patient led, service driven) and those of HE (student and research led) and there are tensions between the institutional character and cultures of the two sectors
- We should not assume that doctors (who are trained to be clinical leaders) can automatically assume academic leadership roles, although many of the skills are transferable
- Management styles differ between universities and the NHS. University staff can resent over-management and seek autonomy, whereas NHS staff are used to working in formal hierarchies with a more vertical management style. Healthcare education leaders who are managing staff from clinical as well as academic backgrounds therefore need an awareness of differing organisational norms and values
- Health care education leaders work in a 'crowded stage' with multiple task masters, leaders have to predict and meet the needs of both the NHS and HE, they have to enable staff to deal with the NHS and create partnerships and collaborations, whilst ensuring that the needs of the wider university are met
- The pace and complexity of change in the NHS makes it difficult to make long term decisions or contracts

- Healthcare education leaders have to deal with the needs of professional and statutory bodies/agencies as well as those that monitor and fund HE and this places additional demands eg. in terms of funding, contracting, quality monitoring and review
- Leaders also have to manage the competing research and teaching agendas within their own organisation. The drive in medical schools towards research and the difficulty of gaining promotion on the basis of educational activity makes it harder to motivate a large group of people towards effective educational activity
- It is particularly difficult to motivate clinicians who have heavy clinical workloads, and academics who are being pushed into generating research output. This can impact on the delivery of teaching, already being designed around more resource intensive models (eg. small group teaching, OSCEs etc.)
- Some leaders saw that these tensions are underpinned by a world view that thinks that education just 'happens' whereas research needs sustained and consistent effort
- Leaders acknowledged that changes are occurring, but slowly, and the input of 'educationalists' is becoming more acceptable in making changes and improvements to teaching and learning

The wider agenda

- Healthcare education leaders should be aware of their influential role in changing and improving healthcare systems and structures through partnership and education
- There is a need for a national accessible forum for discussion of advanced medical education and change by senior medical education leaders
- Leaders need to be aware of the wider educational agendas and help to drive and address issues such as multi-professional learning, diversity and promoting innovation in learning strategies

Section 5

Overview of general leadership and management issues

By leadership, I mean influencing others' actions in achieving desirable ends. Leaders are people who shape the goals, motivations and actions of others. Frequently they initiate change to reach existing and new goals...leadership...takes...much ingenuity, energy and skill... Managing is maintaining efficiently and effectively current organisational arrangements. While managing well often exhibits leadership skills, the overall function is toward maintenance rather than change. I prize both managing and leading and attach no special value to either since different settings and times call for different responses (Cuban, 1988)

This section was written by Dr Rifat Atun and Rachael Addicott, The Tanaka Business School, Imperial College London. It summarises some generic topics and issues in leadership development as well as highlighting some issues relating to leadership development in health care.

Continuous and rapid change in UK health and social care has meant that many professionals in the sector are undertaking new and challenging roles. Some of these professionals are not trained or experience in leading and managing these changes and it is therefore necessary that sufficient and dedicated education be provided. Within the NHS, clinical (medical, nursing and social) staff are increasingly being required to perform managerial duties, the responsibility of which is not necessarily part of their basic training (Empey, Peskett & Lees, 2002). Further, clinical managers often have difficulties in performing dual roles as they can be easily distracted by operational demands and conflicting priorities. Various generic and applied opportunities for management training are available – through formal educational institutions, in-house activities and private organisations.

Alternatively, very few formal and dedicated leadership training opportunities exist.

Leadership development in the NHS has always been ad hoc and incoherent with too few clinicians in leadership roles and too little opportunity for board members to develop leadership skills. That will now change (National Health Service, 2000: 87).

Management and leadership are exclusive roles, with different (and sometimes contradictory) objectives and functions. Simpson and Calman (Simpson & Calman, 2000) propose that there are three avenues for learning to lead – through trial and error, developing relationships, and education. This paper focuses on formal educational activities. Formal leadership education needs to begin at medical school. '*Tomorrow's doctors* must be fully equipped to take on leadership roles with enthusiasm and confidence' (Simpson & Calman, 2000: 211).

Some authors question whether leadership can be 'taught' at all (Washburn, 1998; Zaleznik, 1977). 'There is no known way to train great leaders' (Zaleznik, 1977: 68). Regardless of this debate, the principles of management training cannot automatically be applied to leadership

education. If leadership education is to emerge as a recognised developmental activity, considerable attention needs to be given to the differences between management and leadership and the role of, and challenges facing, leaders.

This section will examine some definitions and concepts of leadership and explore how leadership differs from management.

What is leadership?

Yukl (Yukl, 2002) suggests that leadership is often confused with concepts such as power, authority, management, administration, control and supervision. However, the essence of the leadership role and process is to inspire, develop and empower followers.

Leadership is the process of influencing others to understand and agree about what needs to be done and how it can be done effectively, and the process of facilitating individual and collective efforts to accomplish the shared objectives. (Yukl, 2002: 7)

The NHS Modernisation Agency (NHS Modernisation Agency, 2002) states that the role of leaders in the NHS is to:

- Improve patients' care, treatment and experience
- Promote a healthier population
- Enhance the NHS's reputation as a well-managed and accountable organisation
- Motivate and develop staff.

Grint (Grint, 2000) argues that there would be no leaders without followers, and the relationship between the two requires a sense of community. Successful leadership requires a clear strategic vision that resonates with the community. Leaders must be able to generate and sustain trust among the community, but also question the assumed objectives and processes (Bennis & Nanus, 1997).

Leaders are responsible for drawing attention to the cultural factors that impede organisational learning, to ensure that the organisation can avoid controlling the symptoms rather than underlying causes. Leaders need to create processes by which problems can be defined and ways in which organisational members can convey their reality and avoid dominant and culturally acceptable definitions of the problem (Berthoin Antal, Lenhardt & Rosenbrock, 2001).

Kets de Vries (Kets de Vries, 1980) suggests that emotions in organisational life are often repressed, suppressed or dismissed – seen to be taking away from the 'real' business of the organisation. However, 'the consequence of this attitude is that ritualistic activities and rationalization of behavior seem to be the norm and have become the more acceptable ways of dealing with the routines of management' (Kets de Vries, 1980: 2). The importance of emotions is exemplified through the manifestation of stress-related conditions, such as premature death of executives, output problems, work inefficiencies, labour turnover, strikes and absenteeism.

There is a need for greater awareness of the reasons and motivations for individual and organisational action, and recognition of the emotional costs of corporate life. This might lead to recognition of the limitations of rationality in organisational life. Kets de Vries (Kets de Vries, 1980) argues that everyone has the capacity for this type of learning – however, there is a

pressure to conform to previously learnt behaviours. This leads to a neglect of dependency, affection, hostility, shame and guilt. Competent leadership requires congruence between internal values and external reality – the greater the disparity, the greater the need to exercise power. Leaders have the potential to become paranoid – if this paranoia becomes pathological – through illusions of grandeur or delusions of persecution – it can be self destructive to both the individual and the organisation

In a later work, Kets de Vries and Miller (Kets de Vries & Miller, 1984) propose that organisations can be neurotic – paranoid, compulsive or depressive. Sometimes these neuroses reflect the leadership style from the top, which permeates the entire organisation. The neuroses then threaten the well-being and ultimate survival of the organisation.

Change management is an area where effective leadership is paramount to successful organisational development. More change requires more leadership – many organisations have difficulties adapting to change (Kotter, 1990). The ability to manage change is a key characteristic of a transformational leader. Transformational leaders must be visionary, proactive, creative, innovative and supportive of alternate viewpoints (Empey, Peskett & Lees, 2002).

MacFarlane et al (MacFarlane, Gantley & Murray, 2002) analysed a complex change management project, involving collaboration between five North London medical schools to develop community-based aspects of the undergraduate medical curriculum. Among other problems such as, organisational tensions, role boundaries and conflicting aims, leadership tension was one of the primary factors which mediated the success of the change management project. Leaders were confused about the aims of the project, which filtered through to the individual organisations – administrators were then confused regarding the priorities of the project. MacFarlane et al propose that at the commencement of a change management project, an innovative leader is required – a charismatic visionary. The necessary skills and abilities then change according to the subsequent development and maintenance of the project – attention needs to be given to this development otherwise the aims of the project can become confused and conflicts can arise

Goleman's (Goleman, 2000) research suggests that leaders who achieve the best results do not rely on one leadership style, but incorporate multiple styles seamlessly depending upon the situation. Leaders can achieve this by building a team with members who employ the styles that the leader lacks, or by expanding one's own style repertoire.

In different stages of organisation, different kinds of leadership are appropriate. In a mature or declining culture, such as the NHS, leaders need to overcome constraining cultural assumptions. Declining cultures may be based upon behaviours which were in the past appropriate, but are no longer so. Leaders must notice changes in external conditions, reflect on them and respond appropriately. If an organisation does not adapt to its changing environment it will die. A leader must be able to span boundaries, and be aware of marginal sub-cultures and the over-riding cultural context.

In order to develop as a leader, it is important that there is a learning culture where resources are allocated to development, and learning is rewarded (Yukl, 2002). Further, leaders within learning cultures must accept that their own wisdom and experience is limited and encourage a shared responsibility for learning. Hence, a leader needs to know a culture before trying to change it, have vision for it and yet be open to different perceptions of reality, embrace contradictions and acknowledge mistakes.

Kotter (Kotter, 1996) proposes an eight stage process for leading change:

- Establish a sense of urgency
- Create a guiding coalition
- Develop a vision and strategy
- Communicate the change vision
- Empower employees for broad-based action
- Generate short-term wins
- Consolidate gains and produce more change
- Anchor new approaches in the culture

Schein (Schein, 1985) proposes that organisational leaders create learning cultures by recognising and rewarding appropriate behaviour and through managing and containing anxiety. For this they must look inside themselves and question their own assumptions – the prevailing cultures may reflect a leaders' own assumptions, including their neuroses. Schein believes that leaders must be comfortable within their own weaknesses and open to diverse experiences.

We cannot achieve the cultural humility required to live in a turbulent culturally diverse world unless we see cultural assumptions within ourselves. In the end, cultural understanding and cultural learning start with self-insight. (Schein, 1985: 392)

Empey et al (Empey, Peskett & Lees, 2002) propose that effective leadership should incorporate various elements relating to knowledge, skills and competencies and personal characteristics and behaviours. Figure 1 outlines the specific traits within each of these elements, which are believed to relate to effective leadership.

Figure 1. Effective leadership – The key elements (Empey, Peskett & Lees, 2002)



Berthoin Antal et al (Berthoin Antal, Lenhardt & Rosenbrock, 2001) propose that personal characteristics are a more important indicator of successful leadership than an actual job description. Personal traits, such as commitment to an issue and an ability to develop linkages between perspectives and objectives, have considerable influence on the effectiveness of a leader.

There is an alternative argument that, although personal characteristics are important indicators of successful leadership, situational variables have the capacity to moderate and constrain the relationship between attributes and effectiveness. The characteristics of the followers, the nature of the work, the type of organisation and the nature of the external environment all influence what would be considered to be the most appropriate leadership style (Yukl, 2002). Kotter (Kotter, 2001) also proposes that personality is not necessarily an indicator of successful leadership.

Leadership versus management

Methods ...are as important as knowledge, understanding and value orientation ...Erecting this kind of dichotomy between something pure called 'leadership' and something 'dirty' called 'management', or between values and purposes on the one hand and methods and skills on the other, would be disastrous. (Glatter, 1997, p.189)

Management and leadership are diverse roles which require different characteristics and functions. Although the roles are often contradictory, they are complementary – one cannot function without the other. Managers typically promote stability while leaders promote change (Kotter, 2001). Figure 2 outlines some of the key comparisons between management and leadership.

Figure 2. Comparing management and leadership (Kotter, 1990)

	Management	Leadership
Creating an agenda	Planning and budgeting	Establishing direction
Developing a human network for achieving the agenda	Organising and staffing	Aligning people
Execution	Controlling and problem solving	Motivating and inspiring
Outcomes	Predictability and order	Change

Kotter (Kotter, 2001) suggests that leadership sets a direction and develops a vision for the future. However, management is more concerned with planning which is deductive and orderly, not a process of producing change. Planning should complement direction setting. Kotter proposes that most US organisations are overmanaged and underled.

One of the most frequent mistakes that overmanaged and underled corporations make is to embrace long-term planning as a panacea for their lack of direction and inability to adapt to an increasingly competitive and dynamic business environment. (Kotter, 2001: 87)

Kotter (Kotter, 2001) proposes that organisations cannot wait for leaders to emerge, but must seek them out and develop their potential. Therefore, formal leadership education and training should be of great importance to organisations.

Leadership education and training

Just as we need more people to provide leadership in the complex organizations that dominate our world today, we also need more people to develop the culture that will create that leadership (Kotter, 2001: 96).

Yukl (Yukl, 2002) suggests the following rules for successful leadership:

- Articulate a clear and appealing vision
- Explain how the vision can be attained
- Act confidently and optimistically
- Express confidence in followers
- Use dramatic, symbolic actions to emphasise key values
- Lead by example
- Empower people to achieve the vision.

Most leadership training programmes are designed to increase generic skills and behaviours necessary for effectiveness and advancement. Effective training should involve clear learning objectives, clear and meaningful content, appropriate sequencing of content, appropriate mix of training methods, opportunity for active practice, relevant and timely feedback, enhancement of trainee self-confidence and appropriate follow-up activities. Many leadership training programmes utilise particular techniques such as, behaviour role modelling (demonstration and role playing in order to enhance interpersonal skills), case discussion, business games and simulation (analysis of complex problems and decision-making) (Yukl, 2002).

However, Yukl (Yukl, 2002) states that the most essential leadership skills are learnt from experience, rather than through formal training programmes. However, learning from experience is affected by the amount of challenge, the variety of tasks or assignments, and the quality of feedback. Yukl proposes that action learning and multisource feedback (such as 360-degree appraisal) are useful methods of enhancing the learning from experience process.

It has been suggested that the term 'training' should not be used when referring to leadership education. 'Training' implies the idea of receiving knowledge while a focus on 'development' or 'learning' demonstrates the autonomy of the leadership role (Garrett, 2000).

Conclusion

This literature review has identified that leadership involves conceptualising a course of action and influencing others to understand and agree on how it can be executed effectively (Yukl, 2002: 7). This review has explained that leadership and management are exclusive concepts. While management is more concerned with promoting stability and following a directive, the role of leadership is to create a vision and promote organisational change. 'Institutionalizing a leadership-centred culture is the ultimate act of leadership' (Kotter, 2001: 96).

There is some contention in the literature as to whether leadership can be taught or learned – is effective leadership linked to specific personality characteristics, indicating that only certain individuals naturally make good leaders? Kotter (Kotter, 2001) proposes that effective leadership has little to do with inherent personality characteristics. Yukl (Yukl, 2002) further suggests that there is little evidence of a correlation between supposed leadership attributes and ultimate success. If it is assumed that leadership can be formally developed, the literature would suggest that leadership can not, and should not, be taught through traditional educational activities aimed at management, (such as MBA programmes) but that it needs to be developed through dedicated educational activities.

Section 6

Leadership development programmes

We may not be able to turn everyone into an exemplary leader, but we can, through focused development, enable individuals to improve their leadership skills, provided we are clear about what we want those skills to be

(van Zwanenberg, 2003)

A review of leadership programmes in education and health care was carried out in 2003 as part of the development phase of the project by Dr Rifat Atun and Rachael Addicott from the Tanaka Business School, Imperial College London. This section summarises some of the findings of their report and includes some additional and updated information relating to leadership and management development for education practitioners.

Bush (2003, pp. 9-10) describes the many examples of leadership and management development in the schools and FE college sector. To support the schools sector, a number of universities run courses on school and college management, but these are underpinned by national initiatives. These include the National Development Centre for School Management Training at Bristol University, which was established in 1983; the School Management Task Force, set up in 1989 which established mentoring schemes for new head-teachers; the establishment of the Teacher Training Agency, which took an interest in leadership and set up the National Professional Qualification for Headship (NPQH) which is planned to be made mandatory for new heads from 2004. In November 2000, the National College for School Leadership was set up and this now runs leadership development programmes such as the NPQH, induction programmes for new heads and 'Leading from the middle' for subject leaders and other middle managers. The College runs as a 'virtual college', it carries out research functions and has an international perspective. Its activities emphasise the link between effective leadership and high quality education in terms of 'continuous improvement and major system transformation' (NCSL, 2001a, p.5). The English Learning and Skills sector is planning to establish a leadership centre for managers in FE colleges. A new body, the Leadership Foundation for Higher Education was established in 2003, the Chief Executive, Ewart Wooldridge was appointed in November 2003 and the Foundation was formally launched in Spring 2004.

The Leadership Foundation for Higher Education is a ground-breaking international initiative backed by Universities UK and the Standing Conference of Principals (SCOP). Its aim is to develop talent and leadership in higher education and to become a centre of excellence, identifying best practice and commissioning tailor-made training for current and future higher education leaders. The Chief Executive will take forward this vision, develop the Foundation's business strategy and have overall responsibility for its operation, promoting equality and diversity in higher education to the highest standard.

The four UK higher education funding bodies have committed £10 million funding during the first three years of the Leadership Foundation's operation. Ewart Wooldridge said: 'The prospect of creating an entirely new leadership organisation to serve such an important sector of our economy is very exciting. I will bring to the role substantial experience of leadership and management development and sensitivity to a fascinating and complex set of institutions and stakeholder relationships. I will want to build on the success of the current Top Management Programme run by HESDA.' Professor Roderick Floud, chair of the interim Board of the Leadership Foundation, said: 'Ewart's appointment is an exciting step in the creation of the Leadership Foundation. At a time of rapid change and continuing funding uncertainty, the higher education sector faces ever greater challenges - the Foundation has a key role to play in equipping higher education leaders to meet those challenges. Ewart's experience, dynamism and expertise will be crucial in ensuring the Foundation becomes a key player in shaping the future of higher education in the UK.' www.leadership-uk.com

While many of the organisations detailed purport to foster and provide leadership development, several of these US organisations in particular seem to focus more on management initiatives. A number of UK and US formal, tertiary qualifications were identified relating to leadership. The Association for the Study of Medical Education offers an *Educational Leadership Course* for aspiring medical education leaders in association with the Harvard Macy Institute in the US. There are many other examples of programmes offered by institutes such as the Leadership Institute at the University of Cambridge or the USA based Foundation for Advancement of International Medical Education and Research (FAIMER), who offer world-renowned generic programmes in leadership development.

The NHS Modernisation Leadership Centre, www.modern.nhs.uk/home/default.asp?site_id=58&id=1115 is a UK based example of an applied approach to work with leaders at all levels within the NHS, from front line leaders to those in the most senior positions. The aim of the Centre is to foster leadership qualities to ensure that individuals can lead and deliver real change for patients. The Centre focuses on both managerial and leadership skills and understands the distinction between the two. The British Association for Medical Managers (BAMM) at www.bamm.co.uk has recently introduced a coaching skills programme for medical managers and is planning a new clinical leadership modular masters' degree. Both programmes will form part of the *Fit to Lead* framework for medical management CPD. Other sectors of health care have established leadership development programmes including the European Nursing Leadership Foundation (ENLF) which was founded in February 2003. It states that 'our leadership and management practice is grounded in nursing and we are proud of our nursing background. We work with both clinical and non-clinical staff and have experience in areas of general management, business and director level work' www.nursingleadership.org.uk.

It is necessary that any leadership education in health and social care incorporates both academic and applied understanding. Leadership programmes in health and social care education will most probably be aimed at senior professionals, who have an intense and time-consuming workload, often with clinical commitments. Therefore it is important to ensure the learning style and time required from participants is appropriate for participants before developing programmes. Furthermore, given that leaders bring much of their personality to the role, it is vital that individuals undertaking leadership development have the opportunity for self-awareness and to reflect on the aspects of their character that may or may not be congruent with effective leadership. The 'character' of an organisation often reflects the personality of the leaders within that organisation, therefore it is necessary that a great deal of attention be given to identifying and developing these leaders.

The search for existing educational initiatives for leadership revealed few international opportunities specifically for development in health and, in particular, social care education. It is therefore timely that a formal, recognised leadership programme be developed in the UK, to assist emerging leaders in health and social care education. One of the major differences between the FDTL *Developing Tomorrow's Leaders in Health and Social Care Education* programme and other existing leadership development programmes is the focus on inter-professional learning that will occur in the mixed groups. It is also important that the programme is locked into national initiatives to meet government agendas in both the higher education and the NHS/social care sectors. The review of existing programmes highlighted the need for such a programme.

Section 7

Key findings from primary research

Profiles of medical education and healthcare leaders

In terms of thinking, acquiring and using knowledge, leaders now have to bring an appreciation of the context in which they are operating – political, social, technological and economic, to the policy table.

(van Zwanenberg, 2003)

The 22 individuals that we interviewed were asked a number of questions about their own background and experience to try to elicit some of the common factors behind how and why these people had come to educational leadership positions.

We asked the interviewees how they got into their leadership position. A number of 'routes' were mentioned. All except two of the interviewees, who said that they 'drifted' into an educational leadership role, said that they made conscious decisions to go into educational leadership although the routes varied.

Background of the leaders

The vast majority of those in leadership positions were clinically qualified. From the medical education interviewees, twelve had trained as a doctor, two were scientists and one was a nurse. The person who had initially trained as a nurse was not yet in a very senior position. All except one of the healthcare education leaders were clinically qualified, including three nurses, one physiotherapist, one radiographer and one occupational therapist.

Although the majority of those in leadership positions also have a higher degree, there is a difference in the level and subject of these degrees between the medical education leaders and the healthcare education leaders. At least nine (two interviewees did not say whether they had a PhD or not) of the medical education leaders have a PhD, seven of these are in medicine related subjects and two are in other subjects (one in medical education and one in political science). Two individuals have an MD and two have a Masters' degree in Medical Education. This contrasts with the healthcare education leaders amongst which only one has a PhD (in Organisational Change in Health Care) and six have a Masters' degree covering subjects such as general management and health management. One interviewee who is a Deputy Director of School does not have a higher degree.

Twelve of the medical and healthcare education leaders mentioned having significant clinical leadership roles prior to becoming interested and involved in education. Eleven people said that they consciously chose to go into a broader educational leadership role. Many people became involved in educational activities through routes external to their organisation eg. national professional, statutory or educational organisations (GMC, BMA, NMC, LTSN, etc.); by being involved in NHS or Royal College working parties; working as an external examiner or QAA subject reviewer; belonging to educational associations such as ASME or working

with charities such as the Wellcome Trust. Six of the medical education leaders had been or were currently involved in postgraduate clinical training. Eight of the leaders actively sought an academic management and administrative leadership role, such as being a Head of Department or Dean. For all the medical education leaders this involved working through a traditional 'subject' based research route prior to moving more overtly into educational management. In contrast, for healthcare education leaders the pathway is often through managing a specific undergraduate or postgraduate programme or part of the curriculum. Seven of the individuals said that they went into a leadership role through participating in curriculum development activities. One person noted that she 'was given the freedom and space to undertake an educational role effectively and... a particularly important feature of that environment was that although research was valued, it was not valued at the expense of education' (Interviewee 1).

We asked the interviewees whether they had taken any formal management or leadership courses. From the medical education leaders, three have been on no formal management/leadership courses; two have been on NHS management courses and three have been on NHS leadership courses; one has attended a year long management and leadership course for academic managers; five have attended a number of short courses on management; two people have studied leadership and management through their Masters' degree studies and one has attended a general management course. The healthcare education leaders had a similar pattern in that four people have studied leadership and management as part of their Masters courses; three people have taken short courses and two have not been on any formal management or leadership courses.

Advice for aspiring leaders

Take some training/education in management – a formal management education is vital

Moving into a leadership role

Although it is acknowledged that leadership can occur at many levels of an organisation, across organisations or in task based activities, we were interested to explore how and when the shift into a more senior or significant leadership role occurred. Many of the interviewees said that they found themselves in positions of leadership through a mixture of opportunity and deliberate planning.

Advice for aspiring leaders

You have to be a little leader first and get there in small steps by gaining experience, confidence and competence

For medical education leaders, there have been many new opportunities to become involved with course development at undergraduate level since 1993 with the implementation of the GMC's Recommendations on Undergraduate Training (*Tomorrow's doctors*, 1993). 'I got into a leadership role mainly by happenstance, I must have had some facility for it but it was not mapped out. I was always committed to clinical practice, but realised that there would be an opportunity for academic development in the Department and in 6 years I was appointed as chair when the then Head of Department retired. My appointment was on my track record of research not in education and my educational involvement and extended role has come since that time. This was partly fortuitous and to do with the timing eg. *Tomorrow's Doctors*, curriculum changes etc. and there was a realisation that GPs would be very relevant to curriculum developments. I chaired curriculum committees and what's really happened since then is that my research has shrunk over time and my educational role has expanded. If I had had no interest in education then I could have minimised my role in education and focussed more on the research side' (Interviewee 21). These new opportunities have led to a shift, which is yet to be fully realised, from the more traditional routes into academic leadership. For example, 'it seemed like it was a fairly natural progression, as I am an organiser, to move into the undergraduate medical education side at the medical school. I was heavily involved in the development of the new Graduate Entry Programme and also in developing the new undergraduate medical curriculum. I ended up being on the Senior Management team of the medical school and that is how I got into Senior Management' (Interviewee 18).

Advice for aspiring leaders

- Identify why you want to be a leader and what you expect to get out of it
- Think about where you want to go and where this will take you – don't get trapped in a post and get somewhere by default
- It's important to recognise when to step off the ladder and know your limits
- Know where you're going but contextualise that within the reality and capability of the organisation
- Have a game plan and get involved in things which will take you where you want to go

The leaders commented that it is not always possible for the 'natural progression' to a leadership role to occur, 'we need a proper career structure for leaders in health education – it's not good enough simply to have a master's programme – that is not enough to create the stars, ie we need PhD programmes in healthcare professional education' (Interviewee 20). Interviewee 1 said that it is important that organisations provide opportunities and support for people to develop interests and expertise in educational activities. 'I took some good advice about career opportunities. It is very important to have good career advice and it is all about having choice given your domestic commitments' (Interviewee 22) and Interviewee 2 noted that 'I was fortunate that my mentor pointed out the pitfalls of where my career might go and also that the Universities in which I worked changed their criteria for promotion to include educational criteria' (Interviewee 3). 'There are a whole variety of things common to academic leadership, one of the features is the business of on the one hand having a failure of the

modern system to mentor people and nurture careers effectively, some of this is down to the RAE, some is the passage of time and how fashions change. Now we don't have patronage which is good but also we have lost some of the support and networking opportunities' (Interviewee 19). And Interviewee 3 noted that one of the things he should have done differently is that 'I have not always looked after subordinates as well as I could and helped them with career planning and advice'.

We asked the participants on the first cohort of the leadership development programme prior to joining the programme to identify some of their key issues or concerns about moving into a leadership role. One of the main concerns identified by six participants was the lack of organisational support for people aspiring to a leadership or senior management position, allied to a lack of training and support for people in management roles to function effectively. This is exacerbated by a general lack of career planning/ succession management, particularly in research-led universities and also by a lack of formal training for educational or management roles. One participant commented that this was in contrast to 'the huge amount of training for the clinical role' and another noted that he was very familiar with management and leadership from his clinical role but needed to be able to transfer those skills to a Higher Education setting. Another aspect of the lack of support was mentioned by two participants who said that taking on additional leadership roles can have an adverse effect on career progression. One respondent said that taking on leadership development would mean that they had to 'curtail research activity to allow time for leadership development' and this again may exacerbate internal career progression.

Networking activities were mentioned by many people, such activities included networking both within the organisation and also in the wider health care and education worlds. 'One of the key things has been networking and my Head of Department introduced me to people locally and nationally. Being able to network and find out what's going on elsewhere is important and then you can bring back ideas to your own organisation with an evidence base. The best leaders are influential locally and also in other organisations and countries' (Interviewee 9). This importance of networking is highlighted by this description of how an influential national leader in medical education used her networks to progress her career.

'My move into academic medical and into leadership roles took place when I decided to leave full-time General Practice and went to Canada to do a Postgraduate degree in medical education. On my return to the UK I had an academic post, although still maintained my practice as a GP. Over time the networks I was moving in got wider and I started to have some influence. The emphasis is more on why I decided to take on the roles rather than how I got there. I have a strong commitment to social justice and a broad view of the world, which, combined with my strong personality, has led to me finding myself leading more and more initiatives. I did not have a set career plan but was committed to achieving certain things related to my principles of social justice. My national roles are not in the same light as my role within the medical school, they are not the same type of leadership role' (Interviewee 20). This description also highlights some of the other issues in leadership development which were mentioned by many of the interviewees and which will be discussed below.

Academics (particularly clinical academics) 'are not good at stopping things, they just take on more and more' (Interviewee 19). Many interviewees said that it was vital that people recognised this and made some decisions about what their focus should be. For example, Interviewee 3 said that 'you can't blend more than two roles or activities, so you have to ask yourself where you want to be in ten years. I was remarkably lucky in being in the right place at the right time, but you have to plan your career. Many effective leaders never stayed in a

job more than five years and you can ask yourself what is a realistic set of achievements you can do within a set time'.

Advice to aspiring leaders

When things have lost their sparkle, move on...

For many of the people we interviewed, there had been a pivotal moment when they realised that they had come to a point where they had to make some career decisions, some of these were due to 'pull' factors, for example, an opening up of new opportunities either within the organisation or elsewhere: 'I came to a career crossroads and when my current job in medical education came up, I saw it as an opportunity to make a change and narrow down to two pathways – clinical practice and education...I feel that training people can make a real difference...people often arrive at a career crossroads and need help in career planning' (Interviewee 5). 'I was approached to become Dean when the University virtually went bankrupt... I left there to go to my next post to form the new school of medicine and I was then asked to apply for my current post as VC' (Interviewee 17). For others, although at some career points, there were 'pull' factors and an awareness of seizing opportunities ie. 'my move into leadership was a reflection of circumstance and an opportunity to do something personally and a willingness to make things work. When a vacuum emerged in the Dean's office, I took on the post. I found that I could do this, and held the post of acting dean for two and a half years. Then I was asked to sort out undergraduate education and it was hard to say no to that job', later on 'push' factors became more relevant. 'Taking on doing two jobs (HOD and Head of Undergraduate Education) was really difficult and in the second year of doing this, life was too difficult and it really wasn't sustainable. I decided to move on and give up the job of Head of Undergraduate Education because I felt I was more of a scientist and I believe that Universities should do both education and research but I started to realise that for me the scientific side was more important. The other thing was the realisation that I was an academic manager with a good grasp of institutional aspects relating to leading a Division and a task or project' (Interviewee 19). Many of the leaders demonstrated that they were not only aware of their own strengths, expertise and interests, but also that they were very aware of the organisation in which they were working. They considered whether their career needs and interests could be met there, in terms of the job or role opportunities but also that 'you have to look at the culture you're in and see if it suits you and be willing to explore other options' (Interviewee 9).

Support for leadership development

The interviewees identified a number of support structures that had been available to them, the majority of which were relatively informal. Eleven interviewees identified their sources of support as colleagues, peers, a supportive work environment and through working with like-minded groups and individuals. Interviewee 3 said that as a leader himself 'it is all about colleagues, the team and the whole essence of support and I try not to have demarcations between academic staff and administrators and hope that all staff members feel part of the team. I try to be hands on as well as lead from the top'. Nine people mentioned the

importance of supportive seniors, for example one interviewee said that he had been very fortunate in that he 'had the benefit of being nurtured by a couple of immensely able seniors' (Interviewee 19). This meant that he knew what was going on in the organisation and was able to seek out opportunities. Another noted that she wanted to 'highlight the importance of my Head of Department's role in enabling/ facilitating networking in both the organisation and the wider medical education field' (Interviewee 9). Good seniors give 'enormous freedom, didn't interfere and provided excellent support' (Interviewee 3). Ten people mentioned the importance of having both positive and 'negative' role models. For example, one healthcare respondent (interviewee 10) said that he had consciously modelled his leadership behaviour on the basis of a senior colleague who was what he regarded as a tangible model of what a health professional should be. Another commented that 'I had some good (clinical) role models who united their teams with a common focus and looked after members of the team as well as patients, they were willing to learn, roll up their sleeves and learn from other health professionals' (interviewee 8). Interviewee 19 advised that 'if you see yourself as a potential leader then you have to do your best to identify and cultivate suitable role models for yourself who will empower, encourage and advance others'.

What would you have done differently?

In retrospect I appreciate more now the huge support that is available from good experienced administrators and I would have structured my environment so that I had more of these high quality people on tap (Interviewee 6).

Some people also identified the importance of being able to identify 'negative' role models 'so that you can learn from others' mistakes'. For example, Interviewee 18 said 'I would have happily have left management to others, but I ended up working to put things right, I looked round me and thought that I could do a better job so negative role models made me want to gain control of the decision-making myself. There have been some good people, but these are generally middle managers who are very effective and maybe they aren't going anywhere in career terms but they keep the machine going.'

Advice for aspiring leaders

- If you see yourself as a potential leader then you have to do your best to identify and cultivate suitable role models for yourself
- Find yourself a good role model or mentor

No medical school interviewees had experienced formal mentoring schemes or been offered other self-development opportunities, although some felt that they had been mentored informally by senior colleagues in their organisation. Three of the healthcare education leaders mentioned formal opportunities that existed; one person was part of a formal mentoring system and two people had access to in-house 'coaching' systems and self-development days which had been very helpful. Two interviewees had been on NHS

leadership development programmes and said that these had provided a network of support which had been helpful to them. Interviewee 7 commented that there was very little real support available in his organisation in terms of specific medical education development. This highlights the importance of people having some sort of mentor who is not necessarily a senior person but who will enable the leader to engage in critical and effective reflection. It is also important that people feel that they are supported by the organisation in their development. 'In my first job, I wanted to have time off to study for a part time degree, but I wasn't allowed and so I moved jobs as I couldn't work anywhere where I wasn't supported in my professional development. Being supported makes you loyal to an organisation, I have modelled my own style on this and set out to enable staff' (Interviewee 9).

Finally, the importance of support at home was mentioned by many interviewees, such as Interviewee 6 who said that one of the important things for her was 'a supportive home life which allows me not to worry about them when I am not there.'

Advice for aspiring leaders

You've got to be brave, but you have to have support

Distinguishing between leadership and management

Leading and managing are distinct, but both are important. Organisations which are over managed but under led eventually lose any sense of spirit or purpose. Poorly managed organisations with strong charismatic leaders may soar temporarily only to crash shortly thereafter. The challenge of modern organisations requires the objective perspective of the manager as well as the flashes of vision and commitment wise leadership provides.

(Bolman and Deal, 1997, pp. xiii-xiv).

The majority of the senior managers thought that there were clear differences between leadership and management, however many leaders operated as both leaders and managers, either at certain times in their career or depending on the specific task being performed. For example 'my role is leader of medical education unit and this is a leadership role, but with management responsibilities such as budgeting, staff management, etc. A lot of the time is trying to define and suggest where one is going and putting effort into the right activities to get results'(Interviewee 5). 'The difference between leaders and managers is that leaders think about where they and their organisations are going in the future, it is about ideas and forward thinking, how are we going to get there and what needs to be in place. Managers are more operational and get things to happen, whereas good leaders get other people to do the management and put the ideas into practice' (Interviewee 4). Mentor group 1 noted that 'you cannot lead unless you can get people to follow you', so leadership is more

about people than management. Management is often seen as 'harder' and a more concrete role, including aspects such as strategic planning, ensuring funding, managing resources and staff, managing the organisation, human resource management ('having the right people in the right place at the right time and working to the right goals', interviewee 9). However, some interviewees described a picture that was less clear. 'Leaders at first tend to be just a cog in the wheel and are not concerned with the wider picture. Leadership and role modelling should be at all levels of an organisation, even if a person is just delivering a teaching session they should keep to the corporate agenda with their students' (Interviewee 3). A similar view was expressed by Interviewee 8, whose leadership role is at curriculum level, and who said 'in leadership you have a personal responsibility to make things happen and rolling your sleeves up is an important part of being a leader, at the end of the day the buck stops with the leader if something doesn't happen or if something goes wrong. This is onerous and if you shirk those responsibilities then this is not doing a leadership role properly.'

It seems that often in practice there is no clear demarcation between leadership and management roles: 'there is an inherent tension between leadership and management functions, a risk of being drawn into the detail of day-to-day management and as a result losing the capacity for strategic thinking' (Interviewee 1). The reasons for people being drawn 'back' into management are due to various factors, some of which were mentioned by Interviewee 6. 'I would like to be a leader but I feel as if I am more of a manager. The problem is that there is so much to do in medical education that you constantly get pulled down from strategy into tactics, ie how to get things done in the shortest space of time with the least funding rather than what we should be doing. Also there are not enough support staff and administrative staff to deliver activity, so you end up managing the activities and keeping the show on the road' (Interviewee 6). Five of the respondents to the pre-programme questionnaire for participants on the leadership development programme said that they felt that they had responsibility without strategic power or resources (human or physical) in their current role and this was a big issue for them. An interesting discussion in mentor focus group 2 was stimulated by someone asking if core management skills should be taken as given to become a leader. This highlights some of the issues concerned with contemporary leadership and management. It is echoed by most of the interviewees who said that all leaders have to have some management skills, and that because many leaders have 'grown up through the ranks' and therefore worked in a managerial capacity they have had practical experience as a manager. At the least, 'leaders should be aware of management issues and needs and should bridge the gap between managers and leaders' (mentor group 2) and, as Interviewee 3 noted, 'leaders need trusted lieutenants, especially to do things that they are not good at'. Good leaders need to be able to build and sustain effective teams.

Advice for aspiring leaders

You have got to be confident of your skills when dealing with other management professionals such as finance or estates managers

Key qualities, attributes and skills of successful leaders in health care education

In this section, we look at some of the personal qualities, attributes and skills that contemporary healthcare education leaders need to possess.

Leaders were defined in various ways, but a consistent thread running through the descriptions of leaders was that of **vision**. The ability to 'establish, develop and implement a vision' (Interviewee 10) was identified by all the interviewees as one of the key features that marked out a successful leader. 'The first role of leadership is to provide vision of where we are going in an uncertain world but 'vision without action is hallucination'' (Interviewee 3). We asked where they thought 'vision' came from, many said that it was derived from specific **core values or beliefs**. Some interviewees expanded on the need for leaders to 'understand where you come from in terms of values and integrity, you can't take on leadership roles if you don't believe these are right. You also have to be secure and certain that what you're doing is right' (Interviewee 22). Mentor group 2 defined one of the core skills of leaders as 'being explicit about your values, being able to articulate values and link this to vision'. 'You need courage and bravery and to know your own values and principles. Sometimes when people get difficult and people attack you, you need to know how and why you have got into a particular position. You need to hold on to what made you go there in the first place. Knowing your values and letting other people see where you are coming from and keeping promises is important' (Interviewee 20).

Advice for aspiring leaders

- Know what your values are and stick to them
- Keep your integrity with all that this means
- You have to be true to yourself, your values and principles and always be yourself as a leader

One of the challenges for leaders is to translate the vision into tangible day-to-day activities. Leaders need to be able to translate the micro into the macro and back again in a flexible, iterative cycle. It is acknowledged that it can be difficult to create a vision which is sufficiently well formed to inspire others, but not so well formed that others feel they cannot change it. 'Vision is all about setting big targets which have both personal and organisational goals, but also about giving the plasticity of this vision to others and ensuring sufficient ownership so that the leader can move onto the next role once this has occurred' (Interviewee 1). The leaders who met at the residential event in May 2003, defined some of the key attributes of leaders as:

- having vision within a practical context (being grounded)
- being able to appreciate the complex relationship between vision and values
- being able to translate vision into shorter term clear objectives and to build strategic plans to achieve these which are adaptable to outside factors

Within the organisation, 'good leadership is about defining corporate direction and then building departments and teams that all move in the right direction for the organisation. Your face has to fit and you have to get on with and understand different political agendas' (Interviewee 3). This comment also relates to aspects of **strategic management** and **change management** which are vital components of translating the vision into practical strategy. 'Leaders of the future need to be realistic, they must have a good understanding of the way things work, where the power bases are and where the levers for change reside' (Interviewee 20). In making the move (as the majority of the interviewees had) from being a clinical practitioner to assuming a leadership or management role in Higher Education, 'people have got to be confident of their skills sets when dealing with other management professionals. They are used to being a healthcare professional and they have a reasonable idea of the health service and the different roles within it. They have to learn about what other professionals do eg. estates, finance etc. The most obvious area is finance, when you are faced with spreadsheets, you have to understand what is your responsibility and what is finance's responsibility and often people are scared and they haven't got an understanding of this' (Interviewee 18).

Another key feature of successful leaders is that they have the **ability to see the big picture**. Being able to see the big picture is how a successful leader can 'add value' and turn the vision into strategy to achieve the goals. For example, interviewee 3 told how he became involved in national developments in medical education through having a good mentor and being introduced into a network of those working nationally on the implementation of *Tomorrow's Doctors*. This enabled him to question the essence of medical education and look at and understand the bigger picture. Mentor group 2 mentioned the skill of 'helicoptering' in order to see the broad picture. Leaders need to realise how big the picture is and how to handle it. This involves an integration and understanding of the various factors that influence the educational environment and impact on the organisation, such as socio-cultural, political, technological and international changes and developments. The interviewees often linked this external awareness to an understanding of internal organisational policies and strategic management and direction, but many said that it was often difficult to distinguish and disentangle strategic management issues from 'true' leadership issues. Interviewee 14 noted that 'leadership is about looking outward/externally from the University and also looking to the future which involves a broad scanning of the horizon. It also includes having a connection with the bigger picture eg. the multi-professional agenda, to help people to work together to try to meet the agenda, but implementing issues such as timetabling etc. based on ensuring the students get the right experience.'

One of the main elements involved in the 'big picture' is that leaders must **know their environment**. The leaders' residential group defined such attributes as:

- an understanding of the historical context of the organisation and related organisations (how did it end up like this?)
- an understanding of trends in development
- an understanding of the interface between HE and the NHS
- an understanding of the key people to work with
- the ability to harness resources within the organisation and beyond

For medical and healthcare education, however, one of the major components of the educational environment is the relationship HEIs have with the NHS: they must be able to

demonstrate **understanding of the HE/NHS interface**. It is not enough for education leaders to know about their own organisation, but they must also be aware of the key trends and developments in the wider HE sector and the NHS. 'Knowledge is contextual, today's leaders need to know the current processes and procedures and modernisation of the NHS (eg. foundation hospitals, access to healthcare for the population, building capacity 'if we do what we did, we'll get what we've got', PCTs etc.) and understand the political agendas of the day. A good health care system is based on having the right people with the right skills, so we must be training people in different ways if we want to change the education agenda and know that education is the means to effect change – but this needs strong and effective leadership. We must also know about HE and education in general, keep up with contextual changes and education leaders need real knowledge and understanding of these two domains' (Interviewee 3). This sounds a daunting agenda and although it is acknowledged that 'looking at the external environment is important...(leaders) need to get the balance between breadth and focus. In their daily work as clinicians they can focus on a patient problem and they can manage it in their heads, it is clearly defined. Once you get into starting external environmental analysis, people don't know where the boundaries are and although they think they need to have a deep understanding of all the issues, the external environment is too massive and too changeable' (Interviewee 18).

Advice for aspiring leaders

- Read as widely as you can about your areas (HE, NHS) – 'knowledge is power'.
- Gain wider (national or international) experience that you can put to good use

There are also personal considerations for leaders working within health care education institutions and successful leaders need to align and position themselves appropriately within the organisation. 'You have to know how your organisation works, not just your department but the whole University, so that you can play the management game and get what you want. But you have also to be able to realise when your time has expired and move on. You have to look at things in organisational terms and decide what does the organisation who pays your salary want from you? People in medical education tend to be more aligned with their disciplines than they are to the organisation, reflecting their 'academic tribes and territories' - it is important to remember that knowledge and information is power, so you need to have a full understanding of how the organisation works. For example if you are trying to develop an integrated curriculum you have to break down the hegemony of heads of department, you have to understand the structures and you have to get people to have a loyalty to the organisation' (Interviewee 3).

Leaders at the residential event defined a set of important attributes of a leader as being able to demonstrate an **understanding of issues**, an **ability to assimilate knowledge** and an ability to **apply knowledge effectively**. Underpinning this, leaders require the ability to **analyse trends** and evidence and translate this in order to communicate with others. 'The qualities that you need to lead include clarity of analysis and clarity of vision. Plus you have to be able to communicate your analysis, the problems that you have identified and their solutions to other people. You have to be able to persuade people. Some people are better at communication than others but a lot can be learned. It is a question of trying to put yourself in the other person's position. Some managers come in new and want to change everything

and no one understands why they are doing it. Management is a two stage process, the first step is a critical analysis and then in effect you have to persuade people that the status quo is impossible and they have to look at alternatives. People won't change just for the sake of change. In the NHS it is like a game, you go round after a few years and get a feeling of déjà vu, and you ask yourself what have we been doing these past few years? This is due to a failure to have clear analysis and no clear vision of what is happening, it is the same as in medicine, it is always clear that making the diagnosis comes before treatment and if you do it the other way round then it is highly dangerous' (Interviewee 17). The leaders at the residential event summed this up as **clarity of thought**.

Successful leaders also demonstrate the ability to draw on their analytical skills in assessing situations in order to make appropriate decisions. This was defined as **having good judgement** but based on experience, knowledge and understanding. 'You need a lot of knowledge and understanding to take stock, to see the opportunities for the organisation and then implement the change' (Interviewee 3).

What would you have done differently?

Nothing. Opportunities have arisen and you have to weigh up the issues, then once the decision has been made you have to stick with it (Interviewee 3).

Leaders are also able to **recognise and seize opportunities** and demonstrate a **willingness to take risks**, 'I am a risk taker prepared to push forward an agenda even when many others feel that it may fail' (Interviewee 1). This agenda can be both for themselves and their career development as well as for the organisation. 'I began by developing the undergraduate timetables for the Faculty and this was the first (cross) Faculty post I held...it was a bit of a chore at first...but I developed an overview of the whole course and was able to make contacts across the whole Faculty. I learned a lot about how the course fitted together and about sequencing and identifying key topics. This led to being offered the post of Sub Dean for Curriculum...to revising the course and implementing *Tomorrow's Doctors*. I wanted to get a chair and missed research so started to develop an R&D line in medical education and eventually got a chair in medical education' (Interviewee 3). Mentor group 1 said that risk management also involved 'getting people out of their 'comfort zone', being able to manage the risks on a personal level'.

Advice for aspiring leaders

- Seize the opportunities (take the right risks)
- Build a good team (share the risk)

The concept of leaders as **managers of change** was central to many of the interviewees' stories, 'it is important to be able to facilitate change, so that you can realise the vision and translate it into action. As a leader, you have to be able to respond to change effectively and

flexibly.' (Interviewee 3). Leaders have to be aware of the 'effect of change on people and organisations' (Mentor group 1) and leaders have also to act as more than change managers: 'managing change is important, but leading change is equally so and leaders have to be involved' (Interviewee 9). Associated with the ability to facilitate change is the ability to **be able to work with paradox and manage tensions** which was agreed as one of the key attributes by the leaders at the residential event. One of the mentors in Group 2 described this as 'plate spinning in an uncertain world'. Mentor group 1 noted that that 'the benefits of bringing about change have to be more than the downside' and this has to be assessed and communicated to colleagues. It is important also to tap into support from colleagues if change management is to be successful. 'I am very practically oriented, if I am doing a management or lead role then I have to have influence over the people who can implement the change, having support from colleagues is the most important thing to effect real change' (interviewee 18). Some interviewees also mentioned that there are implications for leaders at a personal level if they cannot cope with change. 'You can get bypassed if you don't respond to change effectively. Build a windmill not a wall if the winds are changing' (Interviewee 3).

If the leadership role is to be effective, then individual leaders must engage in some self reflection or self appraisal in order to evaluate the impact of their role and actions on the organisation and its aims. The leaders at the residential event identified **self-awareness** (an understanding of their own strengths and weaknesses) as one of the key attributes of successful leaders. As interviewee 3 commented 'you need to know yourself and listen to others, in transformational management you have to be a good communicator, be enthusiastic and have insight into what is achievable' (Interviewee 3). Interviewee 7 said that he thought this should be achieved by 'continuous self appraisal by obtaining the views of people around you, such as a 360o appraisal, so that you understand how you work in the organisation.' Interviewee 12 said that 'self knowledge and self-awareness is really important, if you are very driven internally it can be very difficult for others if you're not always thinking and sometimes I have not been as sensitive to this as I should have been'. It is important to be able to achieve a balance between achieving the task and managing people.

Advice for aspiring leaders

Develop a mechanism (through mentor, coach, colleagues) that enables you to get to know your strengths and development needs, then you are self aware

Associated with self awareness and the need to be clear about your core values were **resilience** and **an internal locus of control** both of which were noted by the leaders at the residential meeting. Other related attributes include confidence, the 'ability to handle uncertainty at times of change and provide reassurance without being complacent...the ability to show confidence and be confident' (Interviewee 1) and self motivation: 'you have to be self-motivated to become a good leader and be able to forge your own path' (Interviewee 3).

Advice for aspiring leaders

- Don't go into management unless you think you are going to enjoy it as you are going to have to make tough decisions
- Learn that you will have to make unpopular decisions and that you will sometimes be unpopular
- Make positive decisions and stick with them

Interpersonal skills and qualities were identified by many people as vital to being an effective leader. One of the most important of such skills sets is **communication skills**. 'Leadership has a lot to do with role modelling, about being clear in your role and the purpose of that role, about being able to communicate things to people so that you don't alienate them. Communication is an incredibly strong part of leadership, you have to understand professional and organisational cultures' (Interviewee 9). Many aspects of communication skills were identified, including 'being able to put a positive spin on any changes that are proposed so that people feel good about them and are prepared to effect those changes' (Interviewee 8); 'negotiation skills' and 'facilitation skills' (mentor groups 1 and 2); the 'ability to understand when to reveal and when to conceal ones emotions' (Interviewee 1); the ability to listen actively ('Listening skills are very important for a leader, in fact probably the most important thing', Interviewee 5) and to give feedback and support to others 'People always want feedback and an opportunity to talk and they want to use their managers and others as a sounding board' (Interviewee 18).

Advice for aspiring leaders

- Listen to people
- Learn to listen actively
- Develop good listening skills and use them

Emotional intelligence (the knowledge of self and others and the relationships between people) was identified as very important by the interviewees, leaders at the residential event and the mentors. 'Building relationships with key people, knowing yourself and your own values, but also understanding the value systems of those around you so you can provide support for others' (Interviewee 1). Mentor Group 1 commented that the best leaders have a high EQ, they are aware of how things affect people emotionally and how people around them are responding to situations, so they can channel things productively. Other people saw managing people as one of the key activities of a leader. 'One of the issues for leaders is how to handle difficult people. All leaders use people but you have to learn how to do it with sensitivity' (Interviewee 3). 'Relating to people is one of the key aspects of the job. When you are trying to analyse situations and then implement change in response to your analysis then the key to your success will be that you have worked well with people. You have to try to work

with people effectively and this is a key issue. Organisations are all about people and your success will be that people see that decisions are to their benefit and so they will support your changes. You have got to set goals for the organisation and stretch people beyond what they think they can achieve' (Interviewee 17).

Leaders must therefore be able to use their communication skills to **enthuse, inspire and empower others**. Leaders at the residential event identified various ways to achieve this including 'delegation with fulfilment', nurturing and active succession planning. Leaders have to be able to inspire ownership of decisions amongst colleagues and they have to variously be able 'to cajole, to persuade, to use the carrot and the stick' (Interviewee 10). 'Effective leadership provides guidance to followers, which enables them to feel comfortable and clear as to what their role is without restricting their creativity, so that the guidance is often vague in specification. The key is to judge finely the degree of vagueness in order to get the right compromise between compromise and creativity' (Interviewee 1). Interviewee 12 commented that the main thing that marks out leaders is their 'passion to make a difference linked with an ability to motivate and empower people'.

What would you have done differently?

Inevitably there are always things in handling people that you realise you could have done better. In meetings for example, you upset the dominant extrovert who thinks you are telling them to shut up or the quiet one who hasn't anything to say and resents being asked for their opinion (Interviewee 18).

Good 'people skills' are needed whatever the task and level of leader in the organisation, whether it is about leading through a difficult period for the organisation, such as a restructuring, or about the co-ordination of people to deliver the curriculum or carry out an assessment. 'The main skills and qualities are people skills, a willingness to learn from others and co-ordination of activities. Leadership is often about getting quite disparate groups of people to agree on a common theme, eg. if running an OSCE we have to ask what are the skills being tested? What are the fundamental questions? Communication skills are vital in trying to keep people on course and focussed on the task' (Interviewee 8). 'The main skill has been what I would call enabling skills, which is encouraging people to work collaboratively in the development and evaluation of courses, examinations etc.' (Interviewee 6).

Advice for aspiring leaders

- Develop good working relationships, this can make the difference between being a good leader or a mediocre leader
- Relating to people is one of the key aspects of the job and you have to be able to work with people effectively

Leaders need personal skills when dealing with people, 'you have to have **confidence** and an inner strength to facilitate other people's development' (Interviewee 9). 'Personal qualities are important, it is really about demonstrating an understanding of what's going on and a political awareness, so you don't tread on people's toes and you have to be a good communicator. You have to be able to speak with authority and you have to have a good understanding of what's going to be a good leader, you mustn't be at the limits of your knowledge. You can be very effective if you know what's going on, good leaders can access and process information quickly and embed this into their own thinking, performance and articulation. Leaders have to try to be inclusive of people but with an understanding of people's limits and boundaries, so you end up using different mechanisms for different staff at different levels' (Interviewee 9). Interviewee 20 also noted that it was vital to be 'kind to people and not abuse your position of power. Working in team and leading or letting others lead as appropriate, encouraging others to develop their leadership role so that they can become leaders when you need more leaders. Treating people the same whoever they are' (Interviewee 20). It must also be enjoyable, both for the leader themselves and also for those around the leader. 'If it is not fun and people aren't enjoying it then you need to rethink what it is all about. That approach and atmosphere filters down, if you are doing adult education for professionals then it has to be enjoyable, the cultural attitude starts with whether the people managing the courses are enjoying the job. You have to make people see that meetings etc. are productive, no-one wants to be on a treadmill and you have to maintain a work life balance' (interviewee 18).

Advice for aspiring leaders

- Recognise your own strengths and limitations, ensure that you deliver if you say you can, have the humility to say when you got it wrong and also when you have it right, be balanced and don't beat yourself up
- See yourself as a person, be authentic and real, then people will feel confident in you and trust you

Leaders need **integrity** to be able to engender respect from others. They must also have consistent vision and core values, be seen to do what they say, deliver what they promise and not abuse their power. 'The personal power of a leader derives from a facilitative role grounded in solid core values which followers can respect and understand while they work in a flexible role around him' (Interviewee 7). Leaders have to have the 'ability to be a role model, be a figurehead, be articulate, be out and about and be seen in both formal and informal circumstances' (Interviewee 1).

What would you have done differently?

I would have benefited by being less impatient and if I had taken the time to reflect on a decision it would have been a better one. I would have engaged in personal appraisal earlier in my career development and I have to keep reminding myself about my core values as there is a constant need to return to those values as you get distracted with day to day issues. (Interviewee 10)

One of the main attributes of a leader, which was mentioned by almost all of those who participated in the interviews and discussions, was that of **credibility**. Some of the interviewees identified what they saw as important elements in ensuring credibility. Some of these related to professional or discipline based background and expertise. 'Leaders must achieve a balance and be seen as capable of working at the coalface, some clinical colleagues have very narrow mindsets in terms of education although this is changing. You have to look at your career as a portfolio and try to teach, or do something else at the coalface for credibility. This can be the price you pay the higher up the ladder you go and you have to keep this in mind as you go upwards as there simply aren't enough hours in the day to do everything. So you need to recognise what you still need and what you have to lose but try to remain as a practitioner as long as you can' (Interviewee 3). Other clinicians also feel it is important to maintain a clinical presence for credibility. 'The ability to continue to work in medical education whilst holding down a day job, so that my **street credibility** is maintained amongst my clinical colleagues' (Interviewee 6). 'A major issue is about keeping some clinical work. I was advised it was unwise to drop all my clinical work, but a lot of people have the problem of keeping this on. It is easier to do this if you are in a specialty like Histopathology than if you are in patient-led clinical work' (Interviewee 18). However, some of the non-clinicians felt that 'I don't think it matters not being clinical, I agree it is a more unusual experience but there are other non-clinical leaders and getting credibility is the most important thing, if you have that then to a large extent your discipline background doesn't matter' (Interviewee 19). Interviewee 15, who qualified as a physiotherapist said that one of the important things that gave her credibility in HE management was doing her PhD: 'it has given me credibility and status and was a good thing to do. I did it when the children were small and it was really hard, but I feel that I would have got no further without it.' 'You have to have a critical ingredient and make your own vision and luck' (Interviewee 3). Defining the 'critical ingredient' is part of the skill needed to become a successful leader.

Advice for aspiring leaders

- If you are a clinician, maintain a clinical presence, you have to establish and maintain credibility
- If you are a non-clinician, people have a certain perspective of you and you might not be part of the club, so you have to find yourself a niche and be knowledgeable and a resource

There are difficulties in generating or maintaining credibility for those who give up their clinical or scientific work and move into education. 'Leaders must be able to keep their feet on the ground and retain some contact with the basic business of education' (Interviewee 7). It appears therefore that being a 'practitioner' is an important part of being a credible leader, at least until reaching such a level of seniority that the role is purely that of a leader or senior manager and that an individual has gained credibility as a leader. How 'practitioner' is defined in medical education is still within the narrow boundaries of being a clinician (preferred) or a scientist (OK) but not simply a teacher or an educationalist. 'Some people plan their careers and give up the subject base but you can easily fail as there is no career structure for people who want to go into education...many people are promoted on the basis of research and clinical activity, not pedagogical activities, and as soon as you are promoted you do a different job from the one in which you had been successful' (Interviewee 3).

Some of these difficulties can be overcome by training and development, whether initiated by the individual themselves or by the organisation through management or other development programmes. 'I gained a lot of knowledge from being in Canada and taking a medical education qualification, plus all the various postgraduate qualifications and research I have done, and all the groups I have worked with doing research and also becoming confident in public speaking.' (Interviewee 20). Some interviewees also felt that the 'the leaders of the future probably need to have a better, stronger theoretical base in terms of education itself but also in terms of management, leadership and the HE sector. I feel that for myself I have a weakness in that I haven't got a formal educational background. Some of this can only be experientially learned but there is a theoretical base that when you look at key leaders they have a strong methodological and theoretical base in what they do. This gives them credibility and gravitas with others. My sense is that the kind of people that we are identifying for this project and younger people that we see here are more professional in terms of their knowledge and skills. Ten or twenty years ago people were sceptical about medical education but this is changing' (Interviewee 21).

What would you have done differently?

I wish that I had a more academic background in education, but now the time would be difficult and also I am expected to have all the answers (Interviewee 5).

Interviewee 6 said that you need to be 'perhaps just one step ahead of your peers on why you are making a decision educationally' whereas Interviewee 20 said that she thought that there had to be a much more academically oriented approach to education, underpinned by a research base. 'Doing research is crucial in providing skills and building confidence. Health care leaders of the future need a proper understanding of theory underpinning education and to do some high powered and high quality research in medical education. They need to understand the interaction between social accountability and health education, the link between undergraduate/postgraduate health education and society and understand the multidisciplinary dimensions of health care education.'

The other aspect mentioned by many interviewees was the concept of leaders having to have a presence or **charisma**. 'Leaders have to present a persona and have gravitas, almost have to have a presence and charisma. Presence is hard to define, but you can learn some of it eg. being trained in public speaking. When you are talking to very senior people, you have to have a different way of doing things and expressing yourself. You have to be well read, embed things from other people and then assimilate these into your own consciousness and viewpoint so you can have a personal impact. But you have to know what you're talking about and be very well prepared, so it important to spend time in thinking, listening and preparation so that you can make sensible decisions and advise people appropriately' (Interviewee 5). Interviewee 22 explains how she sees many of the attributes described above as interrelated. 'You have to be expert in knowledge and skills as this gives you credibility, you don't lead just because your office has the power, the thing that makes you an effective leader is whether or not the people you have a leadership role with give you the authority. Power you take but authority is given to you by people, if you lose this you can't do it, this is

why some CEs fail as they don't take people with them. You have to have humility. Alongside this is a whole raft of skills, listening, negotiating, etc. and which you can develop, some things you have innately...I do believe in charisma, and the idea of natural leadership. Natural leaders are people who others are willing to share and give them authority, not just follow them but actually give over some of their own power. They are articulate and good communicators, how you look and how you speak is really important and also if people believe in you.'

Alongside the key attributes described above is the approach individuals bring to the leadership role, described as **leadership style**. Many of the interviewees had clearly reflected on their own style and how their personalities contributed, for better or for worse, to their success as a leader. 'I suppose my management style is something that has sometimes caused me some difficulty. I don't go looking for confrontation as I am a strong believer in compromise. From time to time people think I may have not been strong enough in leading and I sometimes haven't been directorial enough where it might have been more helpful. I think this is a style thing and what flows from this is that on occasions I have failed to anticipate problems and find out about issues that have become bigger subsequently. This also reflects my style of doctoring as a GP, where we find that most things will get better if you manage them without rushing in and doing heroic things. This is a more facilitative approach in which you take on other points of view and perspectives and this is a strength that I have brought into decisions and committees' (Interviewee 21). 'I am not a controlling leader, I want to give people power to make decisions themselves. People often expect an old style of leadership, leading from the front and not getting involved with people, I think it is important to 'walk the job' and meet people on a regular basis. If you know what your staff are doing then you can pre-empt problems and address issues early. Most problems can be solved if you are flexible and seek solutions to problems' (Interviewee 11).

Many interviewees mentioned **flexibility** as important, both in terms of approach and career development. 'What I have learned is that with most things you should always try to be flexible and re-look at it if needed, don't dig your heels in and refuse to look at things, be prepared to reconsider. It is like in medicine, you have to realise when the situation has changed and draw a line under your previous decision and acknowledge things have changed' (Interviewee 17). 'People must be able to change their job or role, even if they do not change their institution' (Interviewee 1). It is however important that leaders maintain sight of the vision within this flexible approach. Interviewee 19 said that it was essential that leaders act as role models and examples and that this should be remembered and incorporated into the leadership style. 'If you are going to lead, then you really do have to recognise the importance of leading by example. The leader sets the tone and that is your overriding responsibility, you have to think about the messages you give out, everything you do has got to be instinctive, way you dress, talk to people and it is the little things as much as the big things' (interviewee 19). Other aspects of leadership style mentioned included the importance of avoiding arrogance and impatience, and taking time to reflect on decisions. Many leaders mentioned that the desirable leadership style is **transformational**: engaging with people, role modelling and making the vision happen, rather than transactional, which is based on reward.

Learning how to be a leader

Leadership does not simply happen, it can be taught, learned, developed. Those who influenced me...all contributed valuable elements to my philosophy Rudolph C. Giuliani, *Leadership*, 2003

Aspiring leaders' views

As part of the development work for the first leadership development programme, we wanted to explore the reasons why the participants felt the need for such a programme. This was partly to ensure that we designed a programme that met the majority of the learning needs of the participants, but also to help us with future recruitment. The participants were asked through the pre-programme questionnaire:

What are your main reasons for wanting to come on the programme?

Sixteen respondents emphasised that the main reason was to develop their own personal leadership and management skills, with a particular focus on leadership as opposed to 'management'. Many people noted that they enjoy their current leadership role and often receive good feedback from others but that they wanted to develop their skills more formally. Seven respondents commented that they felt that they had already gained management and leadership skills (eg. from clinical activities, running research groups and managing parts of a curriculum) and that they felt that the programme would provide them with the opportunity to consolidate and develop existing skills and knowledge. Three people said that they hoped that the programme would help them to develop their academic interests in leadership and one that they felt the programme would offer a formal 'acknowledgement of her own expertise'. One respondent commented 'I want more formal development of these leadership skills. The hit or miss method I have had to employ to date is not the most efficient way of preparing me for a more substantive role in the future'.

Nine people mentioned that the programme would help them be more effective in their current role and six mentioned that they hoped that it would help them to move into more senior academic management positions. For some respondents, it had been suggested by others that they formally develop their leadership potential and skills. One respondent for example, commented that he had recently applied for a senior management post in medical education and that feedback from the interview had indicated that he should continue to pursue his ambitions 'to develop a leadership role'.

Four people noted that they felt there were good career opportunities in health and medical education but that there was also a 'real challenge in producing high quality education and to move traditional methods and structures on, particularly in undergraduate teaching and high volume training'. They felt that the programme would help them to be better prepared for seizing opportunities that may come their way in the future. For example, one respondent noted that they wanted 'to learn more about the behind-the-scenes management of universities / higher education as part of continuing professional development' and another that they wanted to 'ensure that I am adopting best evidenced practice in the management and leadership roles that I currently undertake and to prepare me for future leadership challenges'.

Participants also commented that they would 'value the opportunity to reflect upon and consider their experience ' in a context outside their own organisation. Four participants noted that they felt that the programme would provide them with the support which they were not currently receiving from within their organisation. One respondent said, 'I feel I need support to develop my role as year coordinator as this is a very different role from course coordinator. I feel that joining the programme would ensure that I make time for my own personal development and I would value having an external mentor'. Another commented, 'We are a small department so there is little support or guidance available to new managers and I have felt quite isolated'.

Current leaders' views

We asked the interviewees how they acquired their leadership skills. Most people acquired their leadership skills 'largely through experience and by observation of a wide range of role models, rather than any individuals' (Interviewee 1). For some people this has been a conscious process, 'I have drawn upon the effective skills that I have seen in action in a variety of different colleagues and then picked their brains to get them to explain what it is they are doing and why' (Interviewee 1). Others have had a 'natural' leaning towards leadership in many activities, both inside and outside work. 'It (leadership skill) has to be natural as I have been on no courses, there have been a significant set of opportunities and I have learned through experiences. A lot of that hinges in being at the side or at the knee of very able people while they have been doing important things, it is a combination of having good role models and learning through osmosis and grasping opportunities. I now realise that much of my extra curricular activities helped in years gone by, just in terms of team forming etc. It is a characteristic of mine to seek out responsibility, I don't avoid it, I look to get involved and find it relatively easy to see an institutional aspect. I am ambitious and I suppose people see me as having made the most of opportunities when very senior people have had confidence in me' (Interviewee 19). Interviewee 11 said that she felt it was important that she 'grew into a manager role first (eg. producing reports and focussing on specific issues) and then developed on the personal side with other people and learning how to empower them'. Others have read widely and apply management theory to their own practice, 'I have always been interested in management, I formed a management group when at university. I have read a lot and try to apply management theory to practice. Management is a synthesis of different disciplines but it was resisted in the UK as a valid university subject for a long time. It was seen as not having an intellectual purity and so our managers often haven't got the right skills to lead and manage complex organisations. But also you have to learn from your own and others' major mistakes. For example a principal of one of the medical schools, who was a really bright and intelligent man, got too far ahead of the pack, he didn't take people with him and that taught me that you can't lose sight of where you are going. He had a vote of no confidence from his staff, you have to have a sort of sixth sense of knowing where you are at the time and what can be achieved' (Interviewee 17).

Advice for aspiring leaders

You have got to lead with the agreement and co-operation of others – remember that you only lead because people let you

For some leaders, their knowledge and skills have been acquired informally: 'If I look at my CV, then from the start I got involved in local working groups and committees, this helped me to learn how groups functioned and gave me a good grounding in those kinds of skills and also to understand the way in which the NHS works at local level. This continues, my involvement in NHS groups and research groups all contributes to a global understanding of how the NHS works and similarly how HE works. I started later in HE than in the NHS but got involved in committees and working groups, eg. Royal College committees. This was done out of interest and because I wanted to get involved and not with particular career goals in mind. I didn't set out with a career plan, but there have been some major stopping off points such as going part time in clinical practice to include academic work or when I decided to apply for the HOD post. Both these decisions opened up more doors and opportunities.

I have been involved in academic primary care, QAA review and benchmarking and in NHS national committees. Being involved in these is sometimes chicken and egg because when you have a title and are Head of an academic department then doors open for you but to get to that position you need to have been involved in a variety of things and to have gained experience. Being a HOD also brings a load of responsibilities but on balance it is a very positive thing and if I had gone down a more clinical route I would have had a very different life. I have done some formal management training eg. an academic management programme for newly appointed HODs. The way things are structured, you very much have to pick these things up along the way rather than get a single course on management or leadership and there is no formal succession planning as such' (Interviewee 21). This description highlights the way in which an individual seemed to have a gradual and 'natural' route into leadership, but demonstrated an interest in education throughout, took some risks and became involved in many activities both within and outside his own organisation.

Advice for aspiring leaders

- Get some formal training and be a specialist in one area of healthcare education and know what you are talking about
- Don't give up the clinical work too soon, retain a good knowledge and awareness of the context and the reality of the field you're preparing for

Interviewee 19 went on to say that he felt that the organisational environment is very important in developing leaders, nurturing individuals who show potential and giving them opportunities that are appropriate to their ability. 'I think leadership is an instinctive thing, I haven't been on any management courses. I am about to become a director of a strategic health authority and so I am learning about finance and strategy in that context. I have learned on the job and have been fortunate to learn and come up to speed slowly, I have not been exposed too quickly, for example I was deputy dean for a while, then Head of Division. I find it quite easy to work with a new group of people and learn about new things such as new hospitals, etc. rather than to come to terms with the University agenda. I have been fortunate in having worked in a system with defined responsibilities with a cabinet-style of government, so I have been used to hearing some of the key issues and this is a good way to do it, slow and steady' (Interviewee 19). For other individuals, the lack of a structure in medical education is inhibiting 'The ability to talk to other people undertaking my role is very important, but it has not been easy to achieve as there is no formal structure within which I can work.' (Interviewee 7).

Some interviewees commented that leaving succession planning in medical education to 'happenstance' might not be the most appropriate in this complex and changing educational environment. 'We are now in a transition period and people might need more formal educational credentials, it would improve medical education if it became more professionalized and things were not just done on the hoof. We shouldn't be prescriptive but there is a lot to be gained by increasing knowledge and application of theory to practice. If I had time I would like to do a Masters in Education to gain a wider understanding of education and educational literature' (Interviewee 5).

What would you have done differently?

I would finish my PhD, I got promoted before I finished it and was persuaded it didn't matter, but for my own personal satisfaction I regret not completing it. I also might have had more of a career plan (Interviewee 20).

Others acknowledged the usefulness and importance of management or leadership training and development. 'I was in a managerial role and was sent on a year long management and leadership course run by the northern group of universities, for people from all subjects... I found it enormously helpful' (Interviewee 3). However, these courses have to be matched by being able to acquire relevant experience. 'You can learn management and leadership strategies. I went on a management course which gave good strategies such as how and why to do a SWOT analysis, how to cope with different staff. The problem for many people is that learning it in the abstract is one thing and being able to translate that into practical aspects is another. Issues and situations don't always match with the theory. You have to be able to have a go at things and get experience. It is really important that people are encouraged to have ideas and that they are able to discuss them in a safe environment' (Interviewee 9).

The participants on the first leadership development programme were asked if they were aware of any formal management development or succession planning programmes in their own organisation. Eight participants replied that some programmes existed in their organisation although they had not necessarily been invited to attend, or were not eligible for the courses. For example, two participants said that programmes existed but they could not access them because they were for Heads of Department or other specific staff groups. The programmes on offer include 'a series of staff development programmes for co-ordinators', some short courses, a 'Leadership Development Programme over 2 years' and 'a first time manager course'.

Eleven participants replied that no such programmes were offered in their organisation, although four of these noted that that programmes may exist but they were not aware of them. Three participants highlighted that there is an informal learning process in which 'people who deliver a lot of teaching tend to become course convenors and then progress to curriculum co-ordinators, Deputy Heads of Division (Teaching) and other related administrative posts' but that this was not supported by a formal development process. Another summed up what seems to be typical succession planning in health and social care educational organisations: 'there are many opportunities within the School of Healthcare Studies to gain experience in key roles, and applications are usually invited when roles

become available. I'm not sure about any formal management or succession planning programmes within the School. Others exist within the university but usually for specific roles e.g. managing research projects or heads of departments'. One commented that 'leaders in medical education emerge from the ranks, often on the basis of successful research careers in non-educational areas'.

The participants were also asked about their own participation in management or leadership development programmes. Sixteen of the nineteen respondents had not attended any formal management or leadership development programmes at their current institutions. However, all participants had participated in staff development activities but these tended to be related to development in clinical activities, to broad issues concerning Higher Education such as 'managing diversity and preparation for quality assessment' or to development of teaching and supervision skills such as '*Teaching tomorrow's doctors*'. Three of the respondents have participated in formal management and leadership development programmes. One through the Masters in Educational Management degree which had components on educational management (including leadership and managing change), one is currently on the *Athena* Programme run by the King's Fund and one who had attended the NHS LEO 3-day Workshop. This participant had also 'undertaken Health Service Management programmes in the past'.

Formal training and development has, however, to be closely coupled with experience. 'Going on management courses is helpful, but the real job is all about solving problems and managing people, and you can only learn that by experience and having opportunities. It is exactly the same thing as the clinical skills side of medicine, you can learn the theory in skills labs and from videos, but you only really learn how to manage patients and examine them when you do it for real. When I was a consultant, there were no management courses. We felt that SpRs should be involved but this was impossible and all you had them doing was sitting in on committees, but the serious side of leadership and management is about running people and line managing, about forming good relationships with people and team leadership' (Interviewee 18). And Interviewee 22 said that it is a mistake to rely on 'classroom' teaching for leadership either in education or in healthcare. 'It makes me angry that people think that leadership and management development is in the domain of HE rather than healthcare, you have to do it in practice. You can only do so much in a classroom, you have to work in the workplace, learn from your mistakes and have feedback. We are talking about performance changing development and skills and these have to be grounded in practice'. And Interviewee 21 summed up the inter-relationship between training/qualifications, experience and opportunities for reflective practice when she said that 'people need to have not only formal learning and qualifications but also an awareness of the HE/NHS/clinical context which can only be learned through experience and reflecting about the context and their own practice.'

What would you have done differently?

It is all about learning from experience. For example if you are going to set up a round the world yachting team the task is easy, you would select people with specific skills who all wanted to participate and the task is clear. It is harder in more complex environments to be a leader as it is harder to define the task (Interviewee 8).

Issues and challenges facing health care education leaders

Leadership is about being, not doing. This means thinking about how you are as an individual in your life and work...if you want to succeed, you must be clear about your aims, you must be committed to success and you must be ready to learn new the attitudes, skills and knowledge you need

(Ball, 2004, p.3).

The interviewees were asked to identify what they thought were some of the key issues and barriers involved in being a leader in health care education. A number of issues were identified, ranging from the personal to the wider educational and cultural context.

Personal issues

Some of the interviewees mentioned issues concerned with the demands of domestic commitments and having young children. Interviewee 22 commented that 'there is a potential issue of domestic commitments but I think this is a personal issue, if you choose to have children then the rest of society shouldn't pay for that, you don't have special rights. You have to accept the consequences of your decisions.' She went on to say that throughout her career, she has had unfailing support from her husband and family and this was one of the key things that enabled her to make a career change into medicine in the first place and then to progress through being a hospital Chief Executive and then into postgraduate medicine. One of the 'consequences of decisions' is the culture of senior management practice in both academic and clinical life. This has impact on anyone, not only women, with domestic responsibilities. 'At a personal level, I didn't get into doing any of the interesting senior management stuff until my children were 12-14. Having small children and domestic responsibilities was a major barrier for me. All senior management committee meetings started at 5pm or 6pm and this excludes anyone who has domestic responsibilities. I consciously didn't devote the time to this until I could manage to put in the long hours. The more senior you get though the worse it is, for example, say this week or last week, I was at a dinner two nights in a row and if I had a family then this job would be impossible. There is also the travelling around and you can't do this with small children. There are enough males in the same position as well which means it is very difficult for a lot of people' (Interviewee 18). Some interviewees thought that there were particular issues for women who have children. For example, Interviewee 15 commented 'the timing of when or whether you have children is important for women, issues such as career breaks, work life balance and flexible posts indicate inequalities between the genders. I have always worked full time, but taken most of the domestic responsibilities and though now I have a very flexible job, I still take a lot of work home with me and the children resent that so it feels like a trap'.

'It is hard to keep a balance between family commitments and work, there is an issue about how important the institution takes domestic issues...we need people (men and women) to say that domestic commitments are important even when they move up the ranks' (Interviewee 11). Others acknowledged that the key was too keep reminding themselves of the work/life balance and not place too much emphasis on work. 'You need a balance

between work and home, life should be seen as a whole and I have seen a lot of people who ended their careers disgruntled because their work hasn't lived up to expectations and they have little life outside their work. Home life is really supportive and people need the stability of home. There is a real price to pay if you have tension because of work pressures, but you have to keep addressing this and making compromises' (Interviewee 3). 'Some of the main barriers are being tired with too much to do, unrealistic demands, which are in part the demands I make on myself, and a poor work-life balance. There are no particular barriers as a result of being a woman' (Interviewee 20). One of the respondents to the pre-programme questionnaire for participants on the leadership development programme said that she felt there are 'issues with being a woman in an environment that is essentially hostile to management'. Interviewee 18, now a Dean, is making efforts to change the culture of the organisation and address the work/life balance issue. 'As a point of principle, we have advertised every post on a part time basis, especially the non clinical posts, but have had no responses to these posts. In fact we have had a lot of criticism as people have said that making them part time made them look like second class jobs. We are trying to highlight and address the work life balance, but people just don't come forward. What is happening though is that people hitting 60-65 who have lots of energy are coming back into teaching and if you have a lot of senior part time individuals then the climate may change. We have about six people, especially in general practice, but including a former professor of surgery, who are employed to do special teaching clinics.'

One interviewee mentioned that an issue for her was that of isolation. 'Isolation is one of the big things, especially if you have come up through the ranks. Staff see a leader differently, it is probably easier if you move institutions. You have to be prepared to be different, the attitude to you is different when you are a leader and your approach to others has to be different as well' (Interviewee 11). The other personal issue which many interviewees mentioned was how to achieve a balance between conflicting work roles, and when (or whether) to make the decision to leave clinical practice and concentrate solely on a senior management and leadership role. 'I think it depends on whether you come from a professional or an educational background, so the question is how do you manage your clinical career and also get into management? eg, it is a great problem for nurses. This gets worse as you go into higher leadership. For example, as a CE I had to give up clinical work, and one of the benefits of going into PG medical education was that at first I could do some clinical work again. There is this discrepancy in terms of keeping up to date with your clinical skills, maintaining a clinical role and your credibility, and being able to manage the high level job. There is a tension in that you have to maintain clinical work to keep credibility but you haven't time when you are in a very senior position. But, if you want to do it, it is perfectly manageable with hard work and awareness' (Interviewee 22).

This also relates to the culture within an organisation which can often impede moving into an 'educational' role. 'If we talk about medical education or health care education then it is about managing time commitments dedicated to education alongside clinical commitments and this is also related to how institutions value the educational leadership role. This has improved in the last five years or so, there is now widespread acceptance for the need for good educational performance by an HEI, they are more thoroughly assessed by external agencies, although the actual commitment to supporting educational activities is sometimes a bit grudging' (Interviewee 21). 'Leadership in HE can be a lot about waiting for dead men's shoes, there is often a lack of opportunity to move into leadership roles. The style of the leader at the top also affects the whole culture of an organisation, if you have a leader with a controlling and autocratic style at the top then other people don't feel they can take risks and

they don't feel empowered. And if you are not careful then you create a culture where taking on a leadership role is all about being the blue eyed boy or girl (a halo effect) and also people feel that they should be rewarded financially and by title for taking on a leadership role. I have been told how many PLs I can have based on budget and student numbers but this doesn't relate to the actual leaders I need for doing the tasks and this sort of thing can hinder leaders at all levels' (Interviewee 23). There are also issues for people who want to take (or have taken) different career paths from the traditional routes into academia. Interviewee 15 told us that she made a wrong career decision in 'deciding to move out of the NHS into the private sector for a while...it was difficult to get back into the public sector and Higher Education and the cultures were so very different...it wasn't a good career move'.

What would you have done differently?

I think I made an important wrong career decision in leaving my post as hospital Chief Executive. It was partly the result of circumstances that made me decide to leave. If you have led an organisation and have been able to innovate and then you go somewhere where you don't lead, from having the final push when it comes to shove and then not having it, it was a terrible move for me. Not only in career terms but in personal terms, I was a doctor and had those responsibilities so was used to that but becoming a CE was a huge shift, it was a particular circumstance and belief in making things right and a commitment. I left because didn't want to build bricks and mortar, I wanted the excitement of change. I can recognise the position and know who bears the accountability. You have to be able to have insight into yourself as an individual and your roles. So you have to have some insight into what comes along and how it affects you (Interviewee 22).

Organisational and cultural issues

Effective leadership and management are essential if schools and colleges are to achieve the wide ranging objectives set by them by their many stakeholders. As environmental pressures intensify, managers require greater understanding, skill and resilience to sustain their institutions. Heads, principals and other staff need an appreciation of the theory, as well as the practice, of educational management. Competence comprises an appreciation of concepts as well as a penchant for successful action.
(Bush, 2003)

The interviewees identified that structural or cultural issues within their own organisations could often lead to difficulties for them as individual leaders or for the organisation itself.

One of the keys to overcoming such difficulties is for leaders to understand the history and 'anthropology' of the organisation. 'You have to have the capacity to understand the anthropology of organisations and to bring agendas to the table in a way that will be expected and provides solutions, not problems. It is important to understand the history of an organisation so that you understand how people feel about their position within it and are able to place them effectively' (Interviewee10). 'I think it is important that people know about institutions, their own and others, and how they work. I think I am really good at knowing about institutions, education is done in institutions and I instinctively I know how institutions work, know how to get on in institutions. I have never really worked hard at doing it and I have been involved in a few key institutions such as the Church of England, the NHS and education' (Interviewee 19).

What would you have done differently?

I would have asked different questions of the organisation in which I found myself, I would find out more about the environment and find out more about the challenges involved before I began my work (Interviewee 1)

Understanding how organisations work in generic terms might also help leaders to work more effectively with the people within it. 'Leaders have to get the right people into the right places in an organisation, many leaders do not achieve this at the first attempt and then regret the decisions they have made. The trick is to be able to reorganise people without upsetting them' (Interviewee 10). More formal skills and knowledge might help leaders manage and lead their human resources more effectively. Interviewee 7, for example, noted that he 'would have liked to develop further the research skill of analysing an organisation structure in human terms, so that I could better see how to motivate and place the people within it.' It is also helpful for leaders to understand specific organisational strengths and context as part of a change management approach: 'people need knowledge and understanding to take stock, to see opportunities for the organisation and then to implement the change' (Interviewee 3). However change must be led from the top: 'medical schools have their own personalities, the culture of a medical school is influenced by the dean and if the dean doesn't drive change it won't happen' (Interviewee 9). Change is driven by the head of an organisation and reflects the ways in which decision-making happens, this can be a more consultative approach based on real involvement or an autocratic approach: 'I have worked under two different deans, one who wasn't consultative and now one who is and the culture has changed significantly for the better. If staff have a perception that no-one is interested in what they think then leaders have to set up real systems where consultation can occur. The downside of being consultative is that things take longer and decisions/actions are slower, but if dictatorial then things happen faster but people don't always own or go along with the changes. In an academic setting, consultation is vital, as having consulted with people they can own decisions or actions as they feel they have helped and the activity is more likely to succeed. Creating an organisation that listens, that takes note of its members' views in a real way and utilises its members' skills in contributing to style and direction of the organisation is important' (Interviewee13).

What would you have done differently?

If you are new in an organisation or to a leadership position, take time to learn about the history of the organisation and of the people within it, learn about their skills and capabilities before you put them into specific positions. (Interviewee 10)

Interviewee 1 mentioned that the structure of an organisation can impede leadership, especially when trying to push forward changes and developments. 'Hierarchical structures are a major barrier to becoming an effective leader, especially when you are in the middle of an organisation, because you need authority but with limits...It is difficult to engender a change culture whilst at the same time creating hierarchical and centrally controlled structures.' She also pointed to another feature of UK Higher Education organisations, 'many organisations are risk-averse and they therefore constrain change because of the fear of its consequences. University administrators can be particularly change averse.' Although some of the key attributes of leaders include risk taking and being effective managers of change, it is difficult for leaders who are not senior managers to effect real change unless the organisation itself is structured and led in such a way as to encourage and support change. This is particularly relevant to the current climate of shifting organisational boundaries in medical education, so 'it is important to get people into power who can effect change in medical education' (Interviewee 20).

What would you have done differently?

I would have developed a different organisation, which was more flexible and engaged in less formal project planning. The management style of having highly detailed project plans is too restrictive for effective leadership, they should not be fixed too early and they should be allowed to evolve under the influence of both the leader and the managers (Interviewee 1)

Some of the interviewees highlighted career development or promotion barriers that existed because of the way their profession or discipline was perceived by others. For example, Interviewee 20 said that 'there were perhaps barriers as a result of being a General Practitioner early in my career as there was the perception that GPs become GPs because they 'could not be a doctor in another area'. This is perhaps more apparent for people working in medical education who are not 'even' doctors and who have to fight for credibility and professional respect. 'When I worked in my first medical education post...I was a nurse and this was sometimes a barrier. Sometimes I couldn't get rid of the baggage. I led a team of nurses teaching medical students and the nurses needed leadership to give them awareness of a different professional culture and to get rid of the hostility towards doctors. Some of these nurses had been senior clinical nurses and then took a pay cut to work in medical education and if on top of that they were treated badly, then this needed careful handling. You have to be aware of professional hostility and learn how to handle this. In my new post, I am accepted for what I am. Nurses sometimes have a difficult time working on the same level as

doctors, you have to rely on your own skills and expertise and sometimes this is in an education role rather than a clinical role' (Interviewee 9). It also seems that there is a perception, perhaps based on an outmoded, stereotyped view of medical education leadership, that heads of medical schools are drawn from a specific cadre of individuals. 'There are other issues such as gender issues and the glass ceiling for women in medical education – these should be open up and discussed openly' (Interviewee 8). Such perceptions can lead to medical schools losing or failing to recruit potential expertise in leadership. 'If you were to ask what I saw as my next career opportunity I would have said that I would be seriously interested in being a head of a medical school, but I don't believe there is a hope for me. The Deans are still from traditional academic backgrounds and I don't fit the bill. Perhaps I might be more successful in thinking about being a dean of a healthcare faculty' (Interviewee 22).

Advice for aspiring leaders

- Be open to learning from others outside the relatively narrow medical education spectrum, you can learn a lot from educationalists but the prevalent view is that you could only teach or manage medical education if you had been through it yourself
- My philosophy is that if you employ good people you let them get on with it and you only intervene when you need to.

Despite early setbacks however, people do overcome the barriers and move into positions of leadership in medical education, though this may well be outside medical schools. 'I work all the time with different disciplines eg. in my role as Vice-Chair of the Academy of Royal Colleges and do not feel I have experienced any 'undue' problems/barriers during my working life. It is important to be confident in yourself. Don't apologise for being a generalist, I am interested in issues which go right across the profession and are not of narrow relevance just for GPs' (Interviewee 20). For some disciplines, it might be easier to move into educational leadership because of structures which lead to less disjunction between competing roles and thus to less role conflict. Interviewee 18 pointed out that 'there aren't so many organisational barriers for a histopathologist. Traditionally quite a lot of them have ended up in management positions, because of their ability to do the job flexibly, eg. clinicians have outpatient and theatre sessions and these have to be shuffled round, they are hard to juggle unless you have lots of pre-planning time.' Barriers due to competing demands on time can, however, be exacerbated by people being unwilling to give up aspects of their work to move into education. Interviewee 18 went on to describe how she, as Dean, in trying to restructure work roles to enable people to be involved in education is running into difficulties with some individuals. 'As well, there aren't many doctors who are willing to give up clinical sessions. Here we have done a lot of secondment and a lot of clinicians wanted educational roles, but many thought that they wanted to add the educational role on to their other work instead of replacing clinical work with educational work. They seem to have great difficulty in reducing their clinical workload, even when the hospital supports them they are reluctant to give up sessions, I don't know whether this is a control thing, or they feel they would lose respect if they moved into education. You don't tend to find this with GPs, but it is different on the hospital side.'

Advice for aspiring leaders

Don't give up, but don't give up the day job so you keep your street credibility

'Some of the issues and barriers are very similar to the dilemmas people have in health. For example, you often have a group of very able peers and you are not separated out because professional identities mean you are one among many. And the autonomous independent practitioner does not like being over-managed and they don't need massive assistance to manage themselves or their work. There is a fine balance between academic freedom and equity. How do you strike the right balance of management without it being burdensome and also try to maintain people's professional identity, I don't like being reined in by management myself!' (Interviewee 11). The issue of academic autonomy was also noted by Interviewee 15: 'academics are very autonomous workers and because people are individuals, they advocate teamwork, but don't necessarily follow it. When people are autonomous, then leadership has to be visual, there is a high level of trust and you are very much your own boss. You have to be a string personality to cope with this and you have to have high level skills to push things through because you are dealing with people who are very academic and have strong opinions. Academic life has its limitations as well, you are dealing with different personalities, there is a lot of bureaucracy, but the pervasive left wing notions of individuality and policy mean that people tend to try to buck the system'.

Balancing competing agendas

The overwhelming issue identified by those working as leaders in medical and healthcare education was that of working with a rapidly changing, complex and crowded NHS. 'There are issues generic to all HE areas, but in medicine most people have a third element to their job ie. clinical service. It is a fact that we are not only working in highly accountable environment (QAA, RAE) but also working in the NHS. There are special features regarding the NHS, the single biggest thing I do is work with the NHS and it not easy as they don't know what they are doing either, it is a time of amazing flux, and although this creates opportunities it is very difficult working with the WDCs. So for me the main things are about the **HE interface with the NHS**' (Interviewee 19).

One aspect was related to the **different cultural norms and values**, 'there is a conflict between the core values and demands of the NHS and those of HE, and there are tensions between the institutional character and cultures of the two organisations.' (Interviewee 10). 'I found a difference between health care and the HE sector and now having worked in the University side I have noticed that maybe we take it for granted that doctors can fairly automatically take on a leadership role and they are used to working in a hierarchy. There is a difference in cultures between an academic culture when you do everything yourself and the NHS where you have support staff. It is surprising how little the University senior management team have actually done, as the departments are not hierarchical and so they don't get experience say of doing things like managing budgets, carrying out HR issues and actually sorting out team roles, taking unpleasant decisions, etc. Whereas in the NHS there has been lots of rapid change so doctors are well placed to be leaders, they have the level of training to take decisions personally and don't think that they have to present their ideas to a committee. There is of course a criticism of medicine in that because of this doctors can appear to be a

bit arrogant, for instance the University hierarchy have been horrified at the pace at which change happens in medical school eg. they seem deeply critical of the fact that we can write a course in 6 weeks, the time frame of some of the traditional universities is so long. Medicine itself is rapidly changing and so we get used to this rapid pace of change although in the NHS also there is a lot of short termism which isn't often for the good' (Interviewee 18).

Interviewee 13 commented that leaders in health care education 'should accept the sort of culture we work in. We straddle two main areas and if you are thinking about organisational structures eg. specialist matrix of universities, then university lecturers are very difficult to manage. They resent being over-managed, however the opposite is true in the health service, here staff are used to hierarchies which are strict and formal, run on somewhat military lines, so health education managers/leaders are caught between two different cultures. This is unique about programmes that combine university and NHS styles, we have two masters, we have to be mindful of NHS styles and also of management and leadership in HE. There can be some clashes of style and these can produce management issues. As an example, as an ex-NHS person, she was very used to fixed start times and going home times, there were clear rules about timekeeping, boundaries were clear, accountability was transparent, etc. In an academic setting, it is all very flexible, people's hours and time management is all about output and that transition is very difficult for some people. HE leaders have to deal with clinical managers who have a semi-military way of working, decision-making etc. In an academic setting, people are encouraged to have views and make decisions etc. We deal with both groups so there has to be awareness of cultures and organisational structures. Leaders have to understand the reasons behind people perhaps not being able to make decisions themselves and be prepared to work within these cultures.'

Other issues related to the changing nature of the structure and functions of the NHS and professional roles within it. 'For health and social care we have so many task-masters and we can't ignore what the NHS want from the end product. We have to constantly look over our shoulders so that we produce the graduates that the NHS needs, we have to have to keep more balls in air and it isn't easy. Some people can cope better with multi-tasking than others. Different masters have different emphasis and we have to give good education within the funding' (Interviewee 9). 'Health care is about competing agendas, it is about trying to work in a **'crowded stage'**. You have to ensure that you have the structures and capacity to create more if needed and also having the systems and procedures that link you in with partners, to gain opportunities for ongoing dialogue so that both partners will think more broadly...some people see partnership as an opportunity to dominate and it's about being able to challenge that, this has been important with PCT appointments in education and training roles' (interviewee 12). An important part of the job is to form effective relationships with NHS colleagues. 'Leaders have a key role in acting as an interface between the organisation and the group of people that you lead, in particular acting as a form of shield in order to defend the group from the pressure which derives from the organisation so that they can do their job' (Interviewee 7).

Leaders in healthcare education have to cope with **complex and rapid changes** in the NHS. 'One of the problems is that external people and agencies concerned with the NHS change at such a rate that structures and people change so rapidly. It is a balancing act so that you don't make them think that it is a waste of time talking to them until things have stabilised and you have to be careful of this. An example is with a chief executive of one of the WDCs whom I upset because I was negotiating a contract and I wanted clauses to cover the eventuality that the WDCs might cease to exist. If you are negotiating legal contracts with agencies that may have short life span then this can make difficulties with individuals... You can't trust that

people will be in post and have the 'gentleman's agreement' that you could have done before, you have to safeguard the University for tooling up for putting a course that may not run. We have a major monopoly purchaser that is responding to short termism and they don't have much use for University courses that have long lead-in times' (Interviewee 18). Interviewee 11 said that she felt that the relationship with the professional bodies was the real difference between leading health studies organisations and other subjects. 'the professional bodies mean that there is not just the QAA and HEFCE but lots of other masters and there are activities such as contract reviews which other departments don't have. This is a double burden and I am always trying to mobilise clinical and academic staff and emphasise that the external environment is important.' She went on to say that this is why professional credibility is important because you can come into conflict with professional groups when you are a manager or leader.

In addition to having to manage relationships with the NHS and its workforce, leaders in medical education also have to balance the often **competing research and education** agendas. 'One of the major problems for anyone interested in education is the overwhelming drive in medical schools towards research and the difficulty of anyone gaining a promotion on the basis of educational activity. This means that it is difficult to motivate a large group of people towards effective educational activity. There are some advantages in that those who do become involved are clearly very committed because they get involved against their direct interest, but it has the disadvantage that there are many others who might make a good contribution but who cannot easily be persuaded to get involved. For the leader, this means that they do not have at their resource the opportunity to ensure the advancement of their followers' (Interviewee 7). For example, Interviewee 8 commented when she was explaining the difficulties in running an OSCE. 'It was all about trying to get co-operation from people who didn't feel it was their primary job, doing it in their spare time, some were interested and some were coerced into it by superiors. The clinical skills centre staff felt that running the OSCE was a huge additional burden and so did the administrative staff.' Interviewee 6 thought that this tension was underpinned by a 'world view' that education is something that just 'happens' whereas subject or discipline-based research is often seen as one of the key *raison d'être*s of a medical school's existence. 'Being a leader in medical education, one of the main barriers is the lack of recognition of medical education as an academic subject worth its salt. Being a leader in education, it is constantly suggested or thought, but not always stated that you are less academic than those that do more *round* scale research. Therefore you are expected to move into academic management or education management' (Interviewee 6).

'For most of us our barriers are historical and it isn't until the last few years that the ideas changed and doctors are now seen as people who can't do everything (clinical, teaching, managing), but they need other expertise and input. These barriers are being eroded, but there is still some frustration. For example, some doctors often say 'it was good enough for me', and so they think things can't be changed. If they are not aware of what's going on educationally they can get bogged down in this mind set of thinking they have to do everything and deliver everything in the undergraduate course. The course could easily get overloaded and you need people to stand back and say you can't have specialist inputs overcrowding the course, for some this has been quite a hard lesson. Sometimes people have been grateful for input from educationalists, so that doctors can concentrate on what they do best and don't see it as eroding power but as a support mechanism. Gradually if you do a good job you can get acceptance and input and recognition as an educationalist' (Interviewee 9).

The wider agenda

Interviewees and mentors noted many examples of issues concerned with the wider educational and healthcare agenda. For example, Interviewee 17 said that he thought one of the issues for healthcare education leaders was how to influence the health system and structures themselves through partnership and education/training. 'Healthcare education leaders of the future need to have a wider vision of what health care is all about, eg. they need to learn about industry. If healthcare is going to change you have to have a completely different vision of what can be achieved. You have to move into a situation of creating learning hospitals (like learning organisations) in which the organisation learns from its mistakes and you don't repeat them. People in healthcare networks aren't working as a team towards a defined standard and putting more money into the service is not necessarily the best things to solve the problems. We have to recognise that we have to concentrate on service design. Most of the things that are being done today are being done in the same way as they have always been done, the systems have not been designed to deliver a particular service, but for health professionals to get through a workload. We are often facing insoluble problems and in a lot of aspects of health care it doesn't seem that the problems have been solved, some problems have been solved within the separate professions but not when we look at the whole system. If you interviewed 10 members of public about their perceptions of the health service, the tales are terrible, it is hard to blame anyone but effectively there isn't an overview by good managers and the health service has also been tied down by Government to a number of deliverables which are not really relevant. The main thing is to get a better managerial overview of situations.'

Advice for aspiring leaders

- Be sensitive to what's going on around you (organisation, people, politics)
- Try to develop a good understanding of institutional and professional needs

Other individuals commented that there does not seem to be an accessible forum for discussion and change in advanced medical education. 'LTSN-01 has been very successful in providing resources, workshops and guidance on pedagogical matters but there isn't an effective national forum for senior leaders in medical education to get together and talk about advanced issues and make a force for development and change' (Interviewee 5). Other issues that people mentioned were concerned with the learning environment itself. One of the mentors in Group 1 commented that 'you have to have a concern for multi-professional learning, to acknowledge the policy drivers, the sector has made a lot of mistakes in this area already but this form of learning won't go away. People have to develop a positive stance and have a belief in it, it is all part of being strategic and raising awareness'. Another of the mentors in this group said that it was also important that leaders were able to recognise innovation and diversity in determining learning strategies and that leaders had to be sensitive to people learning in different ways.

Section 8

Conclusions

This report has covered a wide range of issues and appears to have raised as many questions as it has provided some answers or solutions. However, the report aims to provide an introduction and stimulus to a discussion about leadership in contemporary health and social care education.

As Paul Ramsden notes in the concluding section to his book *Learning to lead in Higher Education* (1998), although universities have many similar features to other organisations, 'the most fundamental difference lies not in academic values and culture, or in whether universities are businesses or not, but in the main product of higher education. The product of universities is change. The business of a university is learning. The job of academic leaders is to help people learn...universities (should) practise, at all levels, the multiple leadership responsibilities of vision, enabling, developing and learning.'

What, then, are the additional implications for healthcare education leaders in the light of the 21st Century HE context?

As one of the interviewees noted, leaders working in health and social care education have a 'double burden'. They have to consider issues concerned with managing and leading universities in a rapidly changing global environment, and actively lead the organisation in collaboration with a range of NHS partners with potentially competing agendas. Many healthcare education organisations are struggling with change, trying to manage not only the implementation of wider initiatives within the HE sector but also grappling with intra-organisational issues stemming from inherent tensions both within and between professions. For example, many medical schools often retain (and in some cases maintain) the legacy and traditions of a single faculty institution but they may well be part of a huge multi-faculty university or even part of a health sciences faculty. Meeting the government agendas for change and modernisation in the HE and NHS arenas is a huge challenge, calling for the ability to acknowledge and manage power relations, hierarchies, professional boundaries and educational, training and workforce planning issues. Leaders must therefore be aware of appropriate strategies, such as those involved in transformational leadership and managing complex systems, so as to be able to manage organisational, educational and professional change effectively.

Producing the health care professionals of the future who are highly competent practitioners, open to working within the fluidity of professional boundaries and able to manage change (both for themselves as individual practitioners and for their organisations) is a considerable challenge. Healthcare education leaders have to act as positive role models themselves, recognising that they will be shapers and influencers within HE and the NHS. However, if the right role models are not available (for example in terms of profession, gender, race or social class) then it will be difficult to change things at the top. We might, for example, question the evidence that a successful healthcare education leader has to be clinically credible or a top flight clinical researcher. It does not necessarily follow that because a person is successful in leading in one sphere that they can translate these skills to another arena. By selecting 'people like us' it may be that many people with real leadership potential are being overlooked. Selection and recruitment policies and practices should therefore be transparent, inclusive and equitable at all levels and medical schools should actively engage in putting

succession strategies and leadership development activities in place, whether individually or on a regional or national basis.

The FDTL leadership development programme addresses inter-professional issues and directly breaks down barriers between professions with the participants on the leadership development programme. This is achieved by careful selection of the content of the programme, by ensuring all cohorts comprise mixed professional groups, by directly and transparently discussing the inter-professional education agenda and by offering each participant a mentor from a different profession.

Sir Christopher Ball, Chair and founder of the Talent Foundation wrote recently in *Perspectives* about leadership and managing success in Higher Education. His article described how all organisations need to focus on people and successful organisations 'are typically outward-looking, experimental, trying things out without blaming the experimenter when, as most experiments do, they fail. They are developmental, informal and balanced...the challenges of today and tomorrow are equally important. Function determines structure, responsibility is shared and leadership counts' (2004, p.3). In many ways however, healthcare education organisations have little room for 'experimentation', one of the challenges for leaders is how to balance the need to enable dynamic 'learning' organisations to take risks and challenge orthodoxy, whilst also producing a highly trained and skilled NHS workforce. The 'education vs training' debate is nowhere more sharply focussed than in medical and broader healthcare education. The organisation must therefore enable individuals to develop as leaders. It must build in succession planning and include a means by which leadership potential is identified and developed. The organisation should actively reward a range of activities, educational and entrepreneurial as well as the traditional academic activities, so that as diverse a cadre of people as possible is facilitated into leadership roles. Mentoring and internal and external networking are important for people's leadership development, and therefore they should be built into an organisation's activities.

Where do we go next?

The project has raised some interesting areas for further development and research. These include evaluating the need for, and impact of, programmes that focus on a specific professional or discipline group compared with more generic 'top managers' programmes. For those aspiring to leadership within healthcare organisations, a programme must actively and transparently consider the interface between HE and the NHS issues, arising from educating and training future professionals and the role of universities as part of the system. It must also address barriers to individuals as potential leaders when they have been trained within a specific professional and academic culture. One of the main advantages of this programme is that it is offered on a national basis, enabling people from very different organisations to be exposed to other 'ways of doing'. Watching the 'scales fall from individuals' eyes' as they develop through the programme has been rewarding for the programme team and a hugely valuable learning experience for the individuals concerned. This aspect of the programme could be enhanced by enabling aspiring clinical and HE leaders to learn together on a programme, helping to break down further the barriers between the NHS workforce and the HE 'providers'.

There are immense challenges for those working in healthcare education at the moment and the leaders of the future will require the expertise and particular leadership skills and qualities to ensure healthcare education continues to meet the needs of those working in academic

and service cultures. Identifying, supporting and educating aspiring leaders through a combination of training programmes, human resource strategies, organisational development and cultural change will enable healthcare education organisations to develop as effective learning organisations. It will also engender the development of strong networks, collaborations and partnerships which will produce the next generations of healthcare professionals. In parallel with the challenges for healthcare education leaders come great opportunities, particularly as the national agenda aims to address issues identified by the Strategic Learning and Research Committee (StLaR) such as *'a crisis caused by under-recruitment, disparities in pay and reward, and rigid or poorly articulated career opportunities, all of which mitigate against flexible careers that might embrace practice, education and research'* (2004). The Strategic Report goes on to note that HEFCE has done much to raise the standards of teaching and learning and bring about greater parity of esteem, but *'in the fields of health and social care, there is relatively little incentive for teachers in further/higher education to improve their skills, comparatively few opportunities for promotion to more senior positions on the basis of teaching skills or teaching innovation alone. As Boyer argues so cogently, it is imperative to see a situation where teaching and research are valued equally, with opportunity for flexible career advancement in and between both'* (p.8).

Leadership development programmes, whether delivered in-house or on a national or regional basis, clearly have a part to play in helping to provide potential leaders with the knowledge, skills and attitudes that will be helpful in their future roles. HEIs and national bodies must work together to equip the next generation of leaders with the capacity to manage change, embrace opportunity, relish challenge and enhance professional practice.

The FDTL project will continue to provide a discussion forum for the exploration of issues concerning leadership in health and social care education until the project finishes in late 2005. The project team have been active in disseminating information about the project and about the leadership development programme in a range of contexts, and this has enabled broader discussion of some of the issues raised by the project. The Leadership Foundation for HE will be a powerful force for development and change, providing a focus and a forum for discussion and development of research into the effectiveness of leadership development programmes in HE. The Higher Education Academy, particularly in its work on Continuing Professional Development, and the development of professional standards for HE teachers. The work of the Academy subject centres will also provide a focus for developing further the professional and subject dimensions of leadership development programmes. It is important to acknowledge the strengths of existing programmes, such as those offered by ASME and the NHS Leadership Centre. One of the aims of the project will be to facilitate the bringing together of those actively engaged in leadership development programmes with those responsible for delivering healthcare education at both organisational and national levels. This will help to ensure that both organisations and individuals have the opportunity to access evidence-based and appropriate leadership development programmes so that a more systematic approach to succession planning and leadership development is made widely available.

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Annex

Interviewees

Between 4 March and 15 April 2003, fifteen individuals were interviewed, representing a variety of Higher Education organisations and different levels and roles within medical and healthcare education.

Medical Education:

1. Dean of School of Medicine
2. Dean, School of Medicine, Health Policy and Practice
3. Dean of Undergraduate Studies
4. Dean of Clinical Studies
5. Professor of Medical Education
6. Professor of Medical Education
7. Director of Education, School of Medicine
8. Senior Lecturer in Medical Education
9. Senior Fellow in Medical Education

And from other sectors of healthcare education:

10. Dean of Healthcare Sciences Faculty
11. Head of School of Professional Health Studies
12. Associate Head, Department of Nursing
13. Head of Imaging Science and Deputy Director of Learning and Teaching
14. Principal Lecturer and Discipline Leader in Health and Social care Management
15. Senior Lecturer in Organisational Behaviour and Employee Relations

Between 14 January and 13 February 2004, a further group of seven individuals was interviewed. These individuals held senior positions in medical and healthcare education or had recently held such positions.

Medical Education:

16. University Vice Chancellor
17. Dean of Faculty of Healthcare Sciences
18. Dean of School of Medicine
19. Professor of Primary Care and Medical Education
20. Head of Department and Professor of Primary Care
21. Deputy Dean Director, Postgraduate Deanery

And from other sectors of healthcare education:

22. Dean of School of Health

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