PROFESSIONALISM AND EXCELLENCE IN SCOTTISH MEDICINE

A PROGRESS REPORT

The Scottish Government
Riaghaltas na h-Alba

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The Scottish Government, Edinburgh 2014

This document is also available from our website at **www.scotland.gov.uk**.

ISBN: 978-1-78412-206-5

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St Andrew's House
Edinburgh
EH1 3DG

Produced for the Scottish Government by APS Group Scotland
DPPAS303932 (01/14)

Published by the Scottish Government, January 2014

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Foreword

It is 4 years since publication of the SMASAC report on **Promoting Professionalism and Excellence in Scottish Medicine** in 2009. That report which celebrated success and achievement in the first 60 years of the NHS, highlighted several key themes to further enhance the role and contribution of the medical profession across NHSScotland and urged a call to action in a number of areas:

- Promoting better medical leadership at all levels of the service
- More effective team working
- Increasingly evidence based services underpinned by a strong research base
- Doctors as role models for doctors in training and other health professionals
- Doctors as advocates for health services and the health needs of the population.

These themes in the current policy context of NHSScotland with increasing emphasis on Quality-led, person-centred healthcare are ever more relevant. Following definition of a range of actions and an initial implementation phase led by SMASAC in partnership with the Academy of Medical Royal Colleges and Faculties in Scotland this progress report provides a stock-take of current progress and more importantly defines the next steps to increase momentum of delivery and demonstration of further real advancement through a range of initiatives.

The Professionalism agenda is being driven through a number of routes including Medical leadership development, with introduction of Senior Clinical Leadership Fellows, co-ordination of a number of leadership development opportunities and promotion of widespread use of 'paired learning' to promote mutual understanding and to foster a culture between medical leaders and Health Service Management that is driven by service quality improvement rather than performance. Promoting senior clinical engagement at all levels of management is an internationally recognised key to success and high performance in healthcare organisations across the world. Widespread senior medical engagement is enhancing delivery of the Quality Agenda through implementation of the Quality Strategy and in development of the 20:20 vision.

The profession is actively seeking to improve medical recruitment and retention in NHSScotland. This includes ensuring that working patterns and rotations for all trainee doctors are designed to provide a high quality clinical working environment that enhances professional learning and behaviour.

There continues to be much evidence of good medical professionalism at all levels; there is also recognition that this may sometimes be in spite of rather than because of some of the drivers and pressures in the system. Senior medical participation in vital patient safety, medical training and clinical service improvement requires explicit and consistent recognition and support.

The value of individual professionalism in ensuring and enhancing patient safety and quality of care is explicitly recognised in the Berwick response to the recent Francis report into Mid-Staffs trust, '*A promise to learn, a commitment to act'.*[1]

There are a number of stretching, high level aspirations within this stock-take and call to action. While the challenge of achieving them is not to be underestimated, this Progress Report has the endorsement and support of a wide range of individuals and organisations in and allied to NHSScotland, all of whom have made a commitment to actively pursue and deliver this important agenda. Achieving success in these endeavours exemplifies the widespread, cross-agency professional collaboration that has characterised much of our progress in the Scottish Health Service.

On this 65th anniversary year of the foundation of the NHS it is essential that we continue to promote professionalism and excellence in Scottish Medicine. This Progress Report is a reinforcement and reassurance of the explicit commitment of the Scottish medical community to rise to the occasion.

Sir Harry Burns
Chief Medical Officer

Dr John R Colvin
Chair, Scottish Academy

The Berwick Report:[1]

https://www.gov.uk/government/publications/berwick-review-into-patient-safety

Executive Summary

Purpose

This report documents progress achieved since the publication of the Scottish Medical and Scientific Advisory Committee (SMASAC) Report: *Promoting Professionalism and Excellence in Scottish Medicine,* in 2009: www.scotland.gov.uk/Publications/2009/06/12150150/0. The original SMASAC Report was instigated during the 60th anniversary year of the NHS and it is therefore timely to look 5 years on, at progress achieved by the 65th anniversary year.

A number of encouraging strands of work have been taken forward in the last 5 years. There is however much work yet to do and a series of pressing recommendations are made in order to secure further progress.

Process

In 2009, SMASAC commissioned the Scottish Academy of Royal Colleges and Faculties to carry forward the principles and aspirations of the *Promoting Professionalism and Excellence in Scottish Medicine* report. The Scottish Academy established a Working Group on Professionalism and Excellence chaired by Dr John Colvin, in his capacity as present Chairman of the Academy. Members of the Group are listed at the end of this Executive Summary (p7), along with an Acknowledgements Section (p8) which recognises that many individual clinicians and support staff colleagues working in NHSScotland and Scottish Government have been engaged in, and committed to achieving the aims of the original SMASAC Report.

Content

In the introductory **Chapter 1**, the Scottish Government policy context is summarised, including the **Quality Strategy** (2010), which sets out the Quality Ambitions of safe, effective and patient centred care. More recently, the **20:20 Vision for Healthcare in Scotland** (2011), **20:20 Vision Route Map** (2013) and **20:20 Workforce Vision** (2013) have been published to retain a focus on improving quality. The latter document, in particular sets out a commitment to the delivery of high quality healthcare that the people of Scotland expect and to valuing the workforce and treating people well. These values are echoed in the recently published Greenaway Review of the Shape of Training: *Securing the Future of Excellent Patient Care* (2013), which is predicated on patient needs driving how doctors must be trained in the future. In all of this, it will be essential to recognise the paramount importance of professionalism as a key driver in defining new ways of working.

In **Chapter 2**, practical responses to the professionalism 'challenge' in medical education and training are described for both undergraduate and postgraduate medicine in Scotland. The guiding principles and expectations of undergraduate training by Medical Schools are defined in the GMC document: *Tomorrow's Doctors,* with the doctor as professional, as one of 3 key outcomes. The emphasis given to professionalism by the GMC needs to be fully reflected in medical school curricula.

In postgraduate training, the ability to communicate effectively, empathise, be diligent and to lead, are complementary to sound clinical skills. Recent developments in specialty curricula are described, with a move to a more standardised approach and an increasing emphasis on non-clinical elements, reflecting the guidance in the *Medical Leadership Competency Framework* and the *Common Competences Framework.* Explicit reference to professionalism in current postgraduate curricula is inconsistent and greater convergence will be fostered by the GMC and the Greenaway Review will also be key. In leadership development, the roles and contributions of the Scottish Academy, individual Colleges and Faculties, and NHS Education for Scotland (NES) are discussed, including *Launchpad for Leadership* (NES). The UK Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement are also active in this area. Relevant work of the NHSScotland Quality Improvement Hub (QI Hub) is described. A number of key issues for trainees are identified, including: intelligent rota design, continuity of the training team, meaningful clinical induction, specific mentoring, and explicit recognition of trainees as professionals. Specific barriers identified by the Scottish Academy Trainee Doctors Group are listed in **Annex A**. It is also clear that current contractual provisions for doctors in training are a significant obstacle to professionalism and Scottish Government are working with other UK nations and the BMA around a potential review of the Junior Doctors' Contract. All working patterns in Scotland are approved by the Scottish Government's Workforce adviser with best practice feedback on rota patterns and designs.

In **Chapter 3,** specific developments in management and leadership training are described. These include:

- **The Scottish Patient Safety Fellowship Programme** (3.1) – a partnership between Healthcare Improvement Scotland (HIS), NES and territorial boards. Aims and objectives of the Fellowship are described, and Fellows (presently numbering more than 400) typically develop leadership roles in territorial or special NHS Boards or with the Scottish Government.

- **Clinical leadership development for doctors** (3.2) – the Medical Leadership Competency Framework (MLCF – see ***Figure 1*** and the domains of MLCF at **Annex B**) has underpinned postgraduate curricular change and also is included in *Tomorrow's Doctors.* Further support for leadership developments in doctors throughout their careers is also essential and the National Leadership Unit (NLU) of NES is providing a number of programmes to deliver this aspiration (see **Annex C**).

- **Leadership development for Scottish Medical Trainees** (3.3) – NES has developed a flexible range of resources in this area, including the Leadership and Management Programme (LaMP) which offers leadership and management development to all Scottish Trainees in higher training, as part of a conceptual framework which also includes the Management Trainees Scheme, the Clinical Leadership Fellowship Scheme, and Launchpad for Leadership (see ***Figure 2***). The establishment of the Faculty of Medical Leadership and Management (FMLM) of the UK Academy of Medical Royal Colleges, is also an important development with >40% of Scottish trainees joining the Faculty by end 2012.

- **Scottish Clinical Leadership Fellows** (3.4) – two inaugural fellows have been appointed in late 2013, aimed at doctors in training, with a view to increasing the cohort in future years, following evaluation. The Board for Academic Medicine is also seeking support for an enhanced Senior Clinical Fellowship Scheme with a view to recruit and retain the very best early-career clinical academics to harness their future leadership role in improving the health, healthcare and wealth of our nation.

- **Developing Leadership in Primary Care** (3.5) – a joint project initiated in 2012 by the Royal College of General Practitioners (RCGP Scotland) and NES, with the support of SGHSCD Primary Care Directorate. This project aims to enhance the professional role of primary care contractors, specifically general practitioners and pharmacists using an evidence based approach (see also **Annex D**).

- **Delivering the Future** (3.6) – NES established an ongoing high level leadership programme in 2005 which aims to identify senior clinical leaders from across the professions. Longitudinal evaluation indicates that over 87% move on to promoted or expanded roles.

- **Development and Leadership of Quality Improvement (QI)** (3.7) – This NES initiative adopts a tiered approach to education and training in QI methodology for training (see **Figure 3**). The target audience is specialty trainees in the last 18-24 months of training building on prior learning in the LaMP.

- **Paired Learning** (3.8) – A recurring theme in SMASAC Annual Reports, submitted by CMO Specialty Advisers, relates to the typically dysfunctional nature of the consultant/middle management interface throughout NHSScotland and a lack of a shared common understanding. Going forward, improved mutual understanding and more effective working between consultants and middle management colleagues are essential. Experience of a Paired Learning Programme at Imperial College NHS Trust (2010) found that co-development of doctors and managers, has had a powerful and positive impact on participants, resulting in improvements in patient care. The Leading Quality Network hosted by the National Leadership Unit within NES is taking forward this important work in Scotland. The importance of the key interface and reciprocal relationship between managers and doctors was flagged by the original SMASAC Report and this now needs to be promulgated as a reality in day to day working throughout NHSScotland.

In **Chapter 4**, **Next Steps**, a number of specific recommendations are made in the further pursuit of Professionalism and Excellence in Scottish Medicine. If these recommendations are to be realised, a concerted programme of activity will be required on a number of fronts. The recommendations, listed in detail on

pages 23-25 of this report are therefore directed at the bodies with the power to effect further change in this area:

- **Scottish Government**
- **Professionalism and Excellence Group**
- **Scottish Academy, through member Colleges and Faculties**
- **Medical Schools**
- **NHS Education for Scotland (NES)**
- **NHS Board Chairs**
- **NHS Board Chief Executives**
- **NHS Board Medical Directors**
- **Directors of Medical Education**
- **The GMC**

The Professional and Excellence Group, supported by the Scottish Government, will exercise oversight on the implementation of these recommendations, going forward.

Membership of the Professionalism and Excellence Group

Dr John Colvin (Chairman), Chair of the Scottish Academy of Medical Royal Colleges and Faculties and Consultant Anaesthetist, Ninewells Hospital, Dundee

The rest of the members in alphabetical order:

Name	**Organisation**
Colin Brown	Scottish Government
Harry Burns	Scottish Government
Frances Elliot	Scottish Government
Anne Hendry	Scottish Government
Stewart Irvine	NES
Aileen Keel	Scottish Government
Jason Leitch	Scottish Government
Val Millie	Scottish Government
Gary Mires	Undergraduate Medical education
Ros Moore	Scottish Government
Lewis Morrison	BMA
Rose Ann O'Shea	Scottish Government
Lewis Ritchie	SMASAC
Shirley Rogers	Scottish Government
Nicola Steedman	Scottish Government
Rachel Swann	Scottish Academy – Trainees
Jill Vickerman	Scottish Government
Iain Wallace	SAMD
Emma Watson	Directors of Medical Education
Dan Wynne	GMC

Acknowledgements

The Chairman and members of the Professionalism and Excellence Group wish to express their appreciation of many individual clinicians and support staff colleagues working in NHSScotland and Scottish Government who have been engaged in, and committed to achieving the aims of the original SMASAC Report. The work of the Group has been underpinned by the excellent secretariat support provided by Mr John Mullett and Anne Travers, Scottish Government Health and Social Care Directorates.

Chapter 1

Introduction

In 2008, the 60th anniversary year of the NHS, SMASAC produced a paper *'Promoting Professionalism and Excellence in Scottish Medicine'* which was subsequently published as a supplement to the Scottish Medical Journal in February 2009 and separately by the Scottish Government in June 2009 www.scotland.gov.uk/Publications/2009/06/12150150/0. In this the 65th anniversary year of the NHS, SMASAC felt that a progress report in this area would be timely, given the significant changes to the policy context in which NHSScotland is operating since the original publication.

The Quality Strategy www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf published in 2010 sets out the 3 Quality Ambitions of safe, effective and person centred care which have been pursued since then. Allied to these aims has been the 20:20 Vision for Health and Care in Scotland which states that:

> *'**Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.** We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of readmission.'*

In recognition that over the next few years demands for health and social care, and the circumstances in which they will be delivered, will be radically different, a Route Map to the 20:20 Vision www.scotland.gov.uk/Topics/Health/Policy/Quality-Strategy/routemap2020vision has recently be published to retain focus on improving quality, with specific deliverables in 2013/14.

The Route Map includes a number of key features, the first of which is that it:

> *'Develops our strategy for engaging and empowering our workforce, providing our response in Scotland to addressing many of the issues raised by the Mid-Staffordshire/Frances Inquiry, and equipping them to work in an integrated way which reflects the different needs of different people and different cases across Scotland*'.

This is clearly directly relevant to this Progress Report and will be pursued, in particular, through the implementation of the 20:20 Workforce Vision which was launched at the NHSScotland annual event in June 2013 www.scotland.gov.uk/Topics/Health/NHS-Workforce/Policy/2020-Vision. This sets out a commitment to the delivery of high quality healthcare that the people of Scotland expect and deserve, and to valuing the workforce and treating people well. During the consultation period 10,000 people, including many NHS staff and

professional organisations, contributed to developing the values that are shared across Scotland's Health Service. These are defined as:

- Care and Compassion
- Dignity and Respect
- Openness, Honesty and Responsibility
- Quality and Teamwork.

Work is now underway to ensure that the 20:20 Workforce Vision becomes a reality, and this offers a very clear opportunity to put medical professionalism and excellence at the heart of the NHSScotland workforce strategy. Increasing sub specialisation and the adverse impact of modernising medical careers (MMC), the New Deal and the European Working Time Directive (EWTR), on how the medical workforce now has to be structured and organised to deliver the service, was acknowledged in Promoting Professionalism and Excellence in Scottish Medicine. All of these factors have also been under consideration in the UK Review of the Shape of Training, led by Professor David Greenaway, which was published as: *Securing the Future of Excellent Patient Care*,* just as this present progress report was being finalised.
http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf *

NHSScotland (in the widest sense) has participated fully in that review, and presented a cogent set of arguments around the need for change in current systems of medical training. The Greenaway Review makes a number of recommendations to underpin a safe, effective, flexible and sustainable workforce of the future, driven by a growing number of people with multiple co-morbidities, an ageing population, health inequalities and increasing patient needs and expectations. The Greenaway Review is predicated on patient needs driving how doctors must be trained in the future and cites the original SMASAC Report, which recognises the paramount importance of professionalism as a key driver in defining new ways of working.

Chapter 2

Response to the Professionalism 'Challenge' in Medical Education and Training

2.1 Undergraduate Training

'Tomorrow's Doctors' www.gmc-uk.org/education/undergraduate/tomorrows_doctors_2009.asp defines the outcomes which the GMC expects medical schools to deliver and what employers of new graduates can expect to receive. The outcomes are grouped as follows:

- Outcome 1 – The doctor as a scholar and scientist
- Outcome 2 – The doctor as a practitioner
- **Outcome 3 – The doctor as a professional**

The third of these details 27 specific actions required of the graduate, who is expected to:

- Behave according to ethical and legal principles
- Reflect, learn and teach others
- Learn and work effectively with a multi – professional team and
- Protect patients and improve care.

The parameters of medical professionalism are therefore clearly set out from the date of graduation for '*tomorrow's doctors'*.

2.2 Postgraduate Training

Unarguably, the quality of clinical expertise, the ability to educate junior colleagues and above all the ability to lead, are common to all specialties. It is entirely reasonable to expect all trainees to possess or to develop the ability to communicate effectively, empathise, be diligent and conscientious, and lead. These are the kinds of knowledge, skills and behaviours which are complementary to doctors' clinical skills but which, crucially, are integral to their professional practice.

Over the last 6 years there has been a shift towards a more standardised approach to the requirements for all specialty curricula. To set this in context, currently there are some 65 medical specialties and 36 sub specialties each with its own curriculum approved by the GMC. These are delivered in over 100 approved training programmes across the UK. The standards for *Curricula and Assessment Systems,* originally introduced in 2006, were a step forward in bringing greater consistency to the design and expectations for curricula delivery. In 2009/10, when curricula were reviewed, the opportunity was taken to incorporate some non-clinical elements considered relevant to trainees in all specialties, as preparation for their future roles as consultants or GPs. Recommended by colleges and faculties and approved by the GMC, the new elements reflected the guidance in the *Medical Leadership Competency Framework* and also the *Common Competences Framework for*

Doctors. However there remains variability in the coverage and depth of non-clinical aspects in curricula across the medical specialties.

The GMC is currently examining the scope for introducing some generic streams into the postgraduate specialty curricula, and over the next year, working with partners, will attempt to establish consensus on these themes, and how they can be expressed and assessed as outcomes. Explicit reference to professionalism in current postgraduate curricula is inconsistent, but the expectation is that convergence will be achieved through the GMC work on generic competencies associated with professionalism. The Scottish Academy of Royal Colleges has indicated it is happy to take the lead in this area. There are already examples around professionalism being explicitly adopted into curricula, for example that of the Royal College of Anaesthetists: *Professionalism in Medical Practice* www.rcoa.ac.uk/CCT/AnnexA.

The Scottish Academy is a lead partner in the Professionalism and Excellence agenda and is centrally involved in promoting and supporting medical leadership development, and promoting specialism through quality improvement. This builds on the work of various colleges including the Royal College of Physicians: *Learning to make a difference*; the Royal College of Surgeons of Edinburgh work on *Human Factors in Training* and the Royal College on Anaesthetists training module on improvement science. The work links with that of NES in the *Launchpad for Leadership,* and will complement quality improvement training and development in foundation training (see Chapter 3).

Quality improvement methodology is currently being promoted by the UK Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement as part of their medical leadership competency framework. Improvement science is recognised as a powerful tool in implementing meaningful change and it is recognised there is a link between change management and leadership as well as professional attitudes to work. Section 13 of *Good Medical Practice* (April 2013): www.gmc-uk.org/guidance/good_medical_practice.asp states that doctors *'must take steps to monitor and improve the quality of their work'.* Doctors are also required to produce evidence of QI activity as part of their appraisal and revalidation documentation. The Scottish Academy's objective is to promote cross specialty spread of improvement training in the postgraduate curricula and in the delivery of the postgraduate training programmes.

NHSScotland Quality Improvement Hub (QI Hub) www.qihub.scot.nhs.uk/home.aspx was formed in 2010 to provide a focus for the collective professional aspirations in this area. It is a national collaboration between Special Health Boards and Scottish Government Health Directorates which aims to support NHS Boards with implementation of the Healthcare Quality Strategy through provision of support, education, training and technical expertise in improvement science.

The work of the Hub is organised around 4 key workstreams:

- Implementation support that is flexible and responsive
- Education and learning opportunities that are accessible and relevant
- Measurement for quality improvement that is meaningful

- Facilitation of quality improvement networks for NHS staff.

The QI Hub works directly with clinicians, frontline staff and managers on a range of programmes and activities designed to build capacity and capability in improvement. The QI Hub web site also provides a wide range of educational and improvement resources focused around the improvement journey.

Key issues for trainees

As has already been stated, changes including the New Deal, EWTR, introduction of the Foundation Programme and MMC have reduced both time spent in training, and the proportion of trainees' time spent in the base team. Given the importance of mentoring by senior colleagues in the development of a set of professional values and behaviours, this breakdown of the traditional team structure (a loss regretted by the medical profession, particularly in secondary care), can only have had a negative effect on the development of professionalism.

The Scottish Academy Trainee Doctors Group has developed a number of themes in a paper on rotas, rotation, working patterns and professionalism with 5 key recommendations:

1. Intelligent rota design is key to providing a framework for training and service to be delivered in complement rather than conflict to each other. A centralised electronic platform with sharing of best practice will help facilitate this.
2. Continuity of the training team within on-call rotas and rotation blocks is imperative to enable adequate mentoring and evaluation of professional skills.
3. A meaningful clinical induction establishing roles, responsibilities and training opportunities for all trainees should be offered by each unit.
4. Development of professionalism requires mentoring and supervised practice within the context of service provision. Training opportunities within the working week need to be identified and made explicit.
5. Treating trainees as professionals will encourage professional behaviour in return.

This work is being developed in partnership with the Scottish Directors of Medical Education (DME) group, SGHSCD Workforce, and with member Colleges & Faculties through the Scottish Academy.

The Scottish Academy Trainee Doctors Group has described barriers to professionalism in some detail, covered at **Annex A**.

2.3 Scottish Government work on rota design

The current contractual provisions for doctors in training are a significant barrier to professionalism. The 'compliance' culture in which trainee doctors have been working for the last 13 years has resulted in a large degree of inflexibility and can create a difficult working environment. Scottish Government is therefore working with the other UK nations and the BMA around a potential review of the Junior Doctors' contract. This is supported by the DME Group who feel that

organisationally, NHSScotland must look again at all doctors' contracts, within primary and secondary care, to ensure that these support professionalism.

As part of the modernisation of rostering practices, Scottish Government continues to work towards a Full Business Case for the development and procurement of an electronic rostering system. It is believed that automation of rostering will bring multiple benefits to trainee doctors, giving them the tools to take greater control over the rostering process. Automation of the process also has the ability to end the practice of fixed annual leave which has been raised as a concern by the Scottish Academy Trainee Doctors Group.

All working patterns in Scotland continue to be approved by the Scottish Government's Medical Workforce Adviser, who provides best practice feedback on rota patterns and designs. Examples of well designed rotas have been published on www.newdealsupport-wp.scot.nhs.uk/ and the Trainee Doctors Group has been asked to continue to send examples for publication.

Chapter 3

Developments in Management and Leadership

3.1 Scottish Patient Safety Fellows

The Scottish Patient Safety Fellowship Programme: www.scottishpatientsafetyprogramme.scot.nhs.uk/programme/fellowship-programme was introduced to develop and strengthen clinical leadership and improvement capability in NHSScotland in order to support the implementation of the Scottish Patient Safety Programme (SPSP). The Fellowship Programme is led by HIS, in partnership with NES and NHSScotland territorial boards.

The specific aims and objectives of the Fellowship are:

- to develop and strengthen clinical leadership capability to support the SPSP
- to contribute to the development of a long term quality improvement and patient safety culture
- to establish a learning support network for transformational leadership
- to strengthen existing collaborations within NHSScotland

The Fellowship Programme seeks to develop clinicians working on the front line in NHS Boards to become patient safety and quality improvement experts within their own Boards, equipping them with the skills to lead local change programmes in order to ensure that the patient safety is well integrated within NHS Boards.

Fellows typically develop leadership roles within their original NHS Board, or nationally (with the Scottish Government or special health boards such as Healthcare Improvement Scotland). The Fellowship Programme is currently recruiting to its sixth cohort of Fellows and has a network of over 400 Clinical Fellows based across Scotland and internationally.

3.2 Clinical Leadership Development for Doctors

NHSScotland needs to ensure increasing engagement and participation of doctors in management and leadership roles. Although the challenges will vary according to context, there are common themes which are underpinned by:

- The recognition that service improvements can on occasions be blocked or frustrated by powerful clinical groups (sometimes associated with unprofessional behaviour) – unless clinicians feel directly involved in the designing and planning of these changes
- Current and future financial pressures will require innovation and radical change which in turn needs to be driven by committed, engaged clinicians.

For contemporary doctors in training the MLCF (produced by the NHS Institute for Innovation and Improvement and the Academy of Medical Royal Colleges in 2008 and updated in 2010) has driven postgraduate curricular change. The domains of the Framework (see ***Figure 1***) are listed at **Annex B**. The Framework is designed for clinical and non clinical staff and has been incorporated into the education and

training of all doctors in the UK through inclusion in professional standards and outcome statements. At undergraduate level, this is through its inclusion in *Tomorrow's Doctors*. At postgraduate level the Framework has been integrated into the Foundation Programme curriculum and the 2010 Specialty Training curricula, which are all approved across the UK by the General Medical Council.

Scotland has its own strategic approach to leadership development, of which the MLCF is a part. However, there is recognition that additional efforts are needed, which is why the Scottish approach (led by NES through its National Leadership Unit – NLU) is to ensure that doctors at every level who need leadership development have a route to achieving this. Further detail of the programmes provided by NLU can be found at **Annex C.**

Figure 1: The Leadership Framework[1]

3.3 Leadership Development for Scottish Medical Trainees

In Scotland, NES has developed a flexible range of resources in this area, recognising that trainees will enter the leadership and management component of their training from a range of different backgrounds. However, there is a clear recognition that every trainee needs some competence, that some will seek extended skills, and that a few will want to integrate a leadership and management track within their clinical training, in whatever specialty. NES is a provider of core resources through the LaMP approach, currently set up to offer foundation and leadership and management development to all Scottish trainees in higher training –

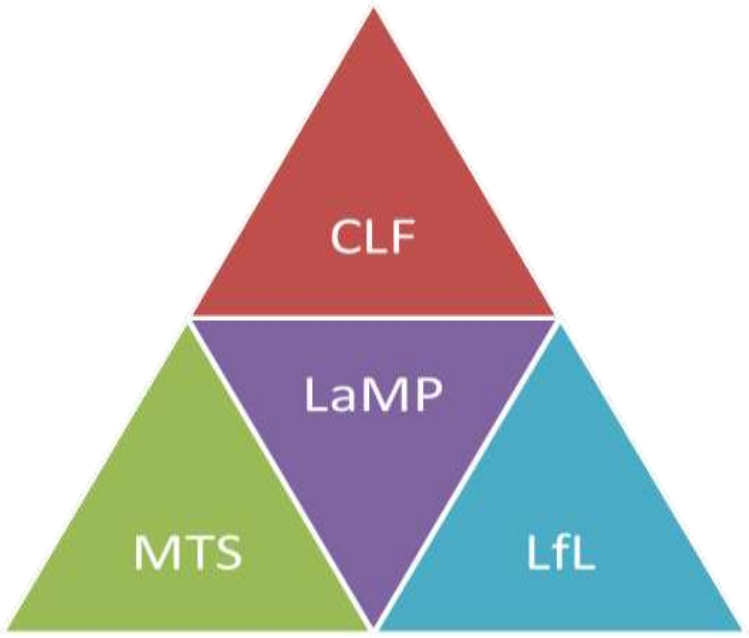
[1] The Leadership Framework is currently under review by the Leadership Academy within NHS England. The revised Framework is due to be available by October 2013.

[1] Once the revised Framework is available, the NLU will work with colleagues across NHSScotland to ensure that supporting materials and approaches are aligned to the Scottish context.

around 500 individuals per annum. Further development of leadership and management training will inevitably require access to external provision from a range of organisations.

The National Management Trainees Scheme (MTS) has a group learning framework designed to bring together emerging leaders from clinical and non-clinical professions to learn together (as well as from each other – see also 'Paired Learning' below). The MTS model for national management trainees and trainee doctors has been in place since 2005 and in 2012 was extended to include other non-medical clinical staff. ***Figure 2*** below illustrates NES' planned conceptual approach to leadership and management development for medical trainees.

Figure 2: Planned menu of leadership development options for Scottish Medical Trainees



<u>Key to abbreviations</u>:
MTS = Management Trainee Scheme / National Management Trainees' Group Learning Framework
CLF = Clinical Leadership Fellowship scheme
LfL = Launchpad for Leadership
LaMP = Medical Leadership and Management Programme

The establishment of the FMLM of the UK Academy of Medical Royal Colleges is an important development. By late 2012, nearly 40% of Scottish trainees had joined the Faculty. In England and Wales this initiative has led to the establishment of a number of Clinical Leadership Fellowships offering medical trainees the opportunity to spend a year working with senior colleagues in a range of national organisations, including the Department of Health. In the first year 11 trainees were appointed and this has now risen to 16 for 2012/13, ranging in seniority from FY2 to ST6. A wide range of host organisations have agreed to mentor the appointees including the

GMC, NHS Commissioning Boards, the National Institute for Healthcare and Clinical Excellence (NICE) and the Academy of Medical Royal Colleges.

3.4 Scottish Clinical Leadership Fellows

A decision has been taken that Scotland will mirror this development and funding has been recently secured for 2 Fellowships who have been appointed in late 2013, with a view to increasing the cohort in future years, following evaluation. The Fellowships are aimed at doctors in training and aim to introduce the appointees to policy and strategic work at national level in Scotland, linked to the 5 domains of the MLCF, referred to above. NES are responsible for the selection and recruitment of these Fellows, who will be hosted by a variety of organisations including Scottish Government, Health Boards, and the GMC.

In a parallel development, the Board for Academic Medicine is seeking support for an enhanced Scottish Senior Clinical Fellowship scheme. This builds on the current successful programme that was well evaluated in terms of impact and value for NHSScotland and the wider Scottish economy.

This scheme would ensure that Scotland is able to recruit and retain the very best early-career clinical academics who will play a crucial role in improving the health, healthcare and wealth of our nation. If approved, it will build progressively over a 5 year period to support 20 Fellows in total with a rigorous appointment process and evaluation, as was the case with the first Scottish Senior Clinical Fellowship scheme.

3.5 NHS Education for Scotland and Royal College of General Practitioners Scotland project: 'Developing Leadership in Primary Care'

This joint project was initiated in 2012 with support from SGHD Primary Care Directorate. It originated from recognition by both organisations that the success of the 20:20 Vision and the forthcoming integration of health and social care will require an enhanced professional leadership role for primary care contractors, specifically general practitioners and pharmacists. The NHS of the future requires systems thinking. This will involve ensuring that professionals, who are geographically disaggregated or disadvantaged, are able to provide leadership for flagship NHS policies *from within* primary care. There are currently disparities of access for contracted professions which require to be addressed if their leadership contribution to government policy is to be fully realised.

Using an evidence-based approach, the project has identified 3 strands of activity needed for the development of primary care leadership capacity and capability:

- Creating the **right conditions** for leadership development, including changing current incentives and drivers for GPs and other professions.

- Development of **direct and formal** approaches for leadership development at different levels. Currently Action Learning Sets involving cross sector teams working on real problems facing them and the communities in which they work

is being trialled. A network of capability, involving NES, RCGP, NLU and possibly private providers is envisaged.

- Using **informal and indirect** approaches to embed primary care issues within existing leadership development programmes. Liaison is taking place with the NLU about primary care engagement with the currently available national leadership programmes. Discussions are also taking place with NES on how better to embed leadership in the GP appraisal and revalidation processes.

The project has commissioned a Practice Based Small Group Learning (PBSGL) module *'Introduction to Leadership'*, which is now being piloted. It will be available this autumn to 1,600 GPs (30% of the Scottish GP workforce) as well as pharmacists and practice nurses.

This project will run for a further year, during which further progress on **direct and formal** approaches will be made and a second phase project developed. Further details are available in **Annex D**.

3.6 Delivering the Future

NES has established a high level leadership development programme which aims to identify senior clinical leaders from across the clinical professions and prepare them for future roles at Board, regional and national level. The programme commenced in November 2005 and NES are now recruiting for the ninth cohort which will commence in November 2013.

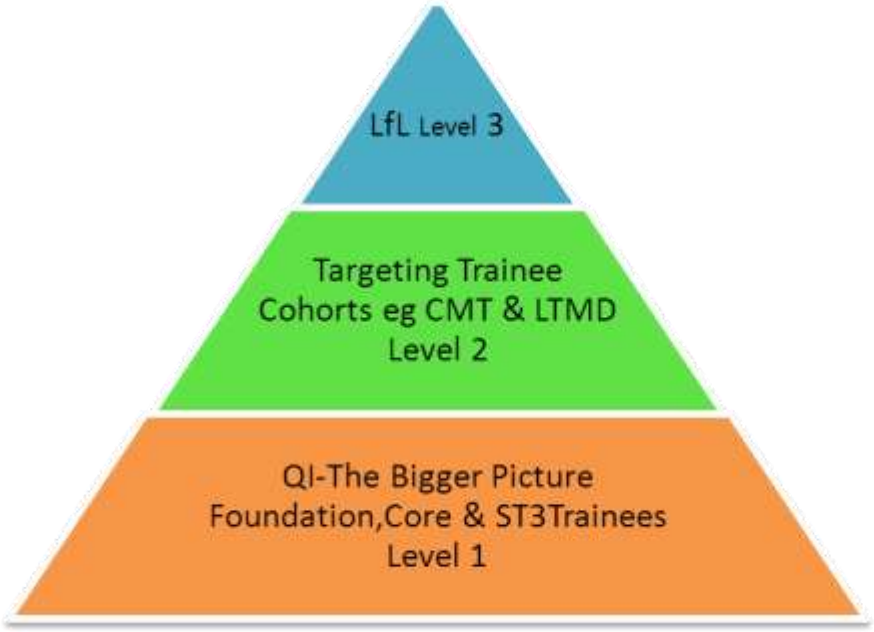
While the specific roles that participants currently hold will vary across Boards, participants are normally already in strategic clinical leadership roles but are a couple of years from undertaking Board, regional and national roles.

Each cohort consists of 24 participants selected by a local (Board level) recruitment process. Over the 9 cohorts around 40 – 50% are doctors. Longitudinal evaluation of the programme indicates that over 87% move on to promoted or expanded roles.

3.7 NES proposals for development in (and leadership of) Quality Improvement (QI)

A further NES proposal aims to align leadership development and training with the Quality Strategy and 20:20 Vision for NHSScotland. It embeds a strategic, tiered approach to education and training in QI methodology for trainees, as depicted in ***Figure 3.***

Figure 3: Tiered approach to education and training in Quality Improvement (QI) methodology for training



The vast majority of doctors in Scotland will be well aware of the many Scottish Patient Safety Programme initiatives but may sometimes feel that they are the target of such initiatives, rather than stakeholders, or even leaders, and drivers of improvements in patient care. This proposal aims to overcome such barriers, starting at level 1 with Foundation, Core and ST 3 trainees and culminating in Level 3 (Launchpad for Leadership – LFL), with QI training integrated with leadership development and training. The target audience is higher specialty trainees in the last 18–24 months of training, building on learning in LaMP, to prepare them in their future roles as consultants and GP leaders. Further detail of NES training in QI is found at **Annex E**. A key feature of level 3, the LFL programme, is to 'buddy' trainees with management trainees (see below).

3.8 Paired Learning

A recurring concern in the Annual Reports submitted by the CMO Specialty Advisers, and also in discussions in SMASAC, relates to the consultant/middle management interface, where all too often there seems to be a lack of shared common understanding of the other party's agenda and motivation. This lack of common understanding has sometimes been described as a 'chasm', and has the clear potential to generate lack of trust between senior clinicians and management. Given the list of challenges facing NHSScotland, including the need for better service planning, this is an area that needs serious consideration of measures that might be put in place to improve mutual understanding between consultants and their middle management colleagues. Paired learning might be one such means of achieving this.

A seminal report published in February 2012 by NHS London describes the 'Paired Learning' leadership development established at Imperial College Healthcare NHS Trust in 2010:
www.imperial.nhs.uk/prdcons/groups/public/@corporate/@communications/documents/doc/id_033648.pdf

In this initiative, Specialist Registrar doctors and band 7-8 managers were paired up in order to learn from each other's expertise, and gain a different perspective into each other's roles. The following is an extract from the Executive Summary of that report:

> ***'The study found the Paired Learning Programme to significantly increase preparedness for leadership roles for both Specialist Registrar doctors and managers across a wide range of domains. The qualitative analysis demonstrated that the co-development of managers and doctors had a powerful impact on the personal learning, attitudes and behaviour of participants. In addition there were a number of demonstrable wider organisational benefits, resulting in improvements in patient care through the collaborative work done within the programme.'***

This kind of low cost, work based peer learning is also being taken forward in NHSScotland through the Leading Quality Network hosted by the NLU within NES. The Network supports clinicians and managers to learn together and to increase their collective capacity and capability in applying QI methodologies and leadership, to increase the pace of transformation towards the 20:20 Vision. Scottish Government approved a 3 year funding programme (2012–15) to develop and implement the work programme for the Network.

3.9 Conclusion

It is clear that in the 4–5 years since the publication of the Professionalism and Excellence Report there have been a number of very positive developments, particularly in relation to the postgraduate curricula, and opportunities for management and leadership training for clinicians. NHS Boards and NES need to ensure that trainees in particular are aware of these throughout their career.

SMASAC has maintained the profile of Professionalism and Excellence in a number of ways, including asking Specialty Advisers to provide information in their annual reports on involvement in relevant activities at local, regional or national level, and using its annual meeting with Specialty Advisers as a forum for discussion of this area.

However, there remains much to be done to address the concerns of trainee doctors and Directors of Medical Education, and to bridge the perceived consultant/middle management 'chasm' referred to above. In addition, the statement in the 2009 SMASAC Report that:

> ***'The role of management in service development and the reciprocal relationship between managers and doctors is seen as very important.***

Management expertise is increasingly seen as a valuable skill set with the need for better mutual understanding, development skills for doctors and for managers to help clinicians drive forward service development….'

This needs to be made a reality in day to day working. The next chapter outlines potential ways of achieving this.

Chapter 4

Next Steps

If further progress is to be made in the pursuit of Professionalism and Excellence in Scottish Medicine, a concerted programme of activity will be required on a number of fronts. The following recommendations are therefore directed at the bodies with the power to effect further change in this area, with the important overall aim of improving the patent experience and the overall quality of patient care:

- **Scottish Government to:**

  Promulgate and facilitate implementation of this report, in particular through SMASAC, the Specialty Advisors and the Professionalism and Excellence Group.

- **Professionalism and Excellence Group to:**

  i. Support the Scottish Academy and work with the GMC to ensure explicit recognition of professionalism in all postgraduate curricula.

  ii. Work with Scottish Government Health Workforce colleagues to ensure that there is explicit recognition of professionalism in the Workforce 20:20 Vision.

  iii. Oversee implementation of all recommendations arising from this report through the development of a workplan.

- **Scottish Academy, through member Colleges and Faculties to:**

  i. Develop a collaborative work programme on promoting professionalism through, rotations, working patterns, and rota design with Scottish Government Health Workforce colleagues.

  ii. Promote recognition of Quality Improvement Training in postgraduate training curricula.

  iii. Work to encourage a supportive positive culture amongst senior doctors with respect to juniors.

  iv. Promote professional behaviour according to principles of the 'Berwick Report' www.gov.uk/government/publications/berwick-review-into-patient-safety.

  v. Support and co-host Scottish Clinical Leadership Fellows.

- **Medical Schools to:**

  Ensure that professionalism is a key feature of undergraduate training programmes

- **NES to:**

  i. Review the current 'landscape' of medical leadership and QI opportunities on offer, with the aim of making this more comprehensible and accessible, in particular for trainee doctors.

  ii. In conjunction with NHS Boards, build on current paired learning initiatives, to scale these up to involve all trainees, and also offer these opportunities to the consultant workforce. Consideration should be given to pooling resources with Healthcare Improvement Scotland to increase traction in this area.

  iii. Continue to support the joint NES/RCGP project on developing leadership in Primary Care beyond 2014.

- **NHS Board Chairs to:**

  Promulgate and facilitate implementation of this report and, in particular, ensure that non-executive directors understand the importance of professionalism and excellence in medicine in relation to the planning and delivery of NHS services, clinical leadership, and education and training.

- **NHS Board Chief Executives to:**

  i. Maximise the contribution of clinicians to quality improvement and service redesign by ensuring that all doctors who have participated in management/leadership training are identified as a resource to their Board.

  ii. In conjunction with Medical Directors, facilitate paired learning for clinicians and managers.

- **NHS Board Medical Directors to:**

  i. Provide opportunities for trainees and career grade doctors to undertake leadership roles within local systems with a particular emphasis on paired learning.

  ii. Offer placements for Scottish Clinical Leadership Fellows.

  iii. Contribute to leadership training locally and nationally.

  iv. Ensure clinicians are directly involved in service improvement and are offered appropriate training opportunities (for example QI methodology) to maximise the effectiveness of their contribution.

  v. In conjunction with Board Chief Executives and senior medical colleagues, act on the views expressed by trainees and DMEs),

particularly in relation to valuing the trainees' contribution to service delivery.

- **Directors of Medical Education to:**

  Facilitate and support implementation of this report, particularly in relation to recommendations relevant to trainees.

- **GMC to:**

  i. Take a lead on the work to develop generic capabilities in line with their role in postgraduate curricula.

  ii. Continue to deliver events on medical professionalism at all Scottish Medical Schools to 1st, 3rd and 5th year students.

  iii. Host a Clinical Leadership Fellow in its Edinburgh office in 2014.

  iv. Continue to take forward the process of agreeing a Memorandum of Understanding with HIS which would support closer working to share concerns where professional standards may be falling short of expectations, with view to completing it in 2014.

ANNEX A

Themes from the Scottish Academy Trainee Doctors Group

The Scottish Academy Trainee Doctors Group considered a range of issues with regard to enhancing professionalism (and the factors which might inhibit it). A number of themes emerged from this analysis which underlined the importance of:

- identifying opportunities for greater continuity with regard to patient outcomes – for example by seeking to ensure stable working patterns and avoiding frequent rotations between wards and specialties, particularly at foundation level

- improving transition phases – for example through enhanced organisation and management at the August changeover; and more tailored induction and training opportunities

- ensuring an appropriate balance between training and service components – for example good planning of compulsory training days; providing opportunities for research and other experience; and making the most of clinical and non-clinical training opportunities

- being valued as a professional – for example ensuring there is flexibility for trainees to meet their own training goals; and being proactive with regard to the design and dissemination of rotas

- enhancing patient safety – for example by ensuring a ‘safe space’ for trainees to discuss, report and learn from incidents

- developing workplace assessment processes – for example avoiding a ‘tick box’ culture and ensuring the intended educational component is achieved

Annex B

Domains of the Leadership Competency Framework

<table>
<tr><th colspan="2">A. The 5 basic domains of the Medical Leadership Competency Framework</th></tr>
<tr><td>Demonstrating Personal Qualities
Developing Self- Awareness
Managing Yourself
Continuing Personal Development
Acting With Integrity</td><td>Improving Services
Ensuring Patient Safety
Critically Evaluating
Encouraging Improvement and Innovation
Facilitating Transformation</td></tr>
<tr><td>Working with Others
Developing Networks
Building and Maintaining Relationships
Encouraging Contribution
Working within Teams</td><td>Setting Direction
Identifying the Contexts for Change
Applying Knowledge and Evidence
Making Decisions
Evaluating Impact</td></tr>
<tr><td>Managing Services
Planning
Managing Resources
Managing People
Managing Performance</td><td></td></tr>
<tr><th colspan="2">B. Additional domains aimed at senior leaders in hierarchical/ positional roles</th></tr>
<tr><td>Creating the vision
Developing the Vision for the Organisation
Influencing the Vision of the Wider Healthcare System
Communicating the Vision
Embodying the Vision</td><td>Delivering the Strategy
Framing the Strategy
Developing the Strategy
Implementing the Strategy
Embedding the Strategy</td></tr>
</table>

Annex C

Role of the National Leadership Unit

The National Leadership Unit is responsible for delivering a number of national leadership development programmes and activities. These are outlined below, with particular reference to their relevance for doctors' leadership development opportunities:

- ***Delivering the Future***, a development programme aimed at preparing senior clinical leaders from across the clinical professions for future roles at Board, regional and national level. The programme which commenced in November 2005 is now recruiting for the ninth cohort (commencing in November 2013). Each cohort consists of 24 participants selected by a local (Health Board level) recruitment process. Over the 9 cohorts, around 40 – 50% are doctors.

- ***Leading for the Future***, an innovative package of leadership and management development which has been designed specifically for those in senior leadership positions in health (both clinical and non-clinical) and social care who are on the cusp between facing operational and more strategic leadership challenges. It is currently run in partnership across 17 Health Boards and one Local Authority in Scotland and facilitated by in-house Organisational Development (OD) professionals. Over the past 2 years, in particular, the number of medical leaders participating in the programme has increased markedly: from 4 (out of 76) in the 2nd cohort, to 15 (out of 106) in the 3rd, and 27 (out of 132) in the current cohort.

- ***Raising your Game***, a tailored programme of executive coaching and national master classes which is aimed at senior leaders who have recently taken on Executive level leadership roles.

- ***Playing to your strengths***, a brief development intervention which is aimed at those in senior executive leadership roles and supports them (through a development centre and targeted coaching) to build on their strengths and formulate a targeted personal development plan.

- ***Leading Quality Network***, which connects existing clinical and non-clinical networks, communities and partner organisations to increase our collective capacity and capability in applying QI methodologies and leadership to improve quality and outcomes across Scotland. The primary driver for the creation of the LQN is the recognition that the ongoing implementation of the Healthcare Quality Strategy requires people at all levels of the health & social care system to focus on quality improvement. There is wide recognition that quality improvement requires leadership and an enabling learning culture. Therefore, the network aims to capitalise and build on the development of individuals' QI and leadership expertise and skills on national programmes by bringing together programme alumni and others who are interested in QI and/or leadership and enabling shared learning and spread of practice.

- ***Management Trainee Scheme***, a fast-track scheme to develop leadership capacity and potential in NHSScotland; provides opportunities to 'pair' learners in general management and medical trainees as well as other clinical trainees.

A number of additional development priorities have been identified through the review of the 2009-2012 NHSScotland leadership development strategy, all of which have relevance for leadership development provision for doctors. A number of development offerings will be developed in 2013-14, in collaboration between the NLU, colleagues across NES and local Health Board partners:

- ***Emerging leaders***, i.e., those who are currently in front line leader roles, or who have the potential to take on a more formal leadership role, or who demonstrate personal leadership, e.g., in how they lead a specific quality improvement initiative or delivery of care.
- ***Leading wider systems change***, i.e., provision of leadership development and networking opportunities for people who are skilled in quality improvement science.
- ***Medical and clinical leadership development including primary care***, i.e., making much clearer connections between the stages of leadership development available at local, regional and national levels.

Annex D

Leadership Development for Independent Contractors in NHSScotland

Background

Primary care faces the complex challenges associated with an exponentially ageing population and rapid healthcare technology advances set against a backdrop of global financial constraint and health inequalities. Meeting these complex challenges effectively is dependent on transformation. Now more than ever, an increase in effective leadership **from** primary care, from all disciplines, is essential to support the design and delivery of safe, effective and person centred health and social care for the people of Scotland.

Health and social care integration and more collaboration within healthcare will require people to let go of longstanding, very trusted and familiar ways of designing services and delivering care. New collaborative and innovative ways of doing things can seem very alien at times. Transformation and changing the culture across professions and importantly, taking the profession with us in a way which resonates with their values, goes well beyond 'just being a professional'. Effective leadership is needed. In this context leadership is framed as a social process through which change can be effected. This social process is; informed by knowledge, open to innovation, driven by professional values and critically can be developed within teams and individuals through learning.

Using an evidence-based approach, the RCGP Scotland and NES leadership project has identified 3 strands of activity needed for the development of primary care leadership capacity and capability: (1) creating the **right conditions** for leadership development; (2) development of **direct and formal** approaches for leadership development; and (3) exploiting **informal and indirect** approaches to embed primary care issues within existing leadership development programmes.

1. Creating the conditions for primary care leadership development

Developing leadership capability alone will be inadequate to achieve the aim of the project. The following are needed to ensure that primary care leadership delivers the 20:20 Vision:

1.1 Leadership from primary care requires different drivers and incentives within our current systems. These drivers and incentives are required both within primary care and importantly within secondary care and social care. Truly integrated patient pathways and service development should be rewarded. That is to say, health boards and social care should be asking themselves what is the incentive for their practitioners to fully embrace and incorporate advice and leadership from primary care regarding design and delivery of their services. This will be new for many;

1.2 The issue of capacity in primary care leadership needs to be addressed. Throughout the scoping exercise the need for protected time both to

undertake leadership development and leadership activity has been cited by all 4 primary care contractors;

1.3 Engagement with all levels of the primary care workforce will be critical to success. Leadership should be reframed or conceptualised as a means of delivering better clinical outcomes, for example, quality improvement in patient care through leadership should be visible to the primary care workforce. Leadership which is seen as a dissonant top down imposition is unhelpful. Improvement initiatives and innovation should be supported and encouraged from all levels of the workforce;

1.4 Primary care independent contractors and their leadership development needs should be integrated with, have clear links with, and be explicitly included in the frameworks of health board Organisational Development departments.

1.5 The RCGP Scotland and NES developing leadership project also supports the national Primary Care Leads Group assertion that consistent national recommendations should be developed with regard to specific positional leadership roles in primary care. This should include recommended roles, remits and pay scales although the specifics of this are outwith the remit of this project.

If the full benefit of leadership from primary care to the 20:20 Vision is to be realised, it is essential to establish these conditions to maximise the benefits of the formal and informal development interventions below.

2. Direct and formal approaches for primary care leadership development

To develop the leadership capability from the primary care independently contracted professional groups we have considered the various options and from now, would like to focus upon;

Locality/Cluster Cross Sector Team development

We suggest and are working in partnership with the NLU to develop Action Learning Sets involving cross sector teams working on real problems facing them and the communities in which they work. Cross sector teams should include: GPs; community pharmacy; social work; health boards; district nursing; and any other appropriate stakeholders from the communities concerned. Independently contracted GPs or staff not in positional leadership roles will require backfill to attend, however the collaborative and innovative approach and focus on real challenges will ensure return on investment. Such Action Learning Sets can focus upon any topic relevant to local priorities: reducing health inequalities in communities, caring for people with multiple morbidities and chronic illnesses at home or in a homely setting, disease prevention, more effective integration, unscheduled care provision etc.

Individual Personal Development

We suggest and would like to develop a leadership programme aimed at those GPs and GP staff who have the ability, energy and motivation to provide clinical leadership for locality/clusters but who have not previously been enabled to do so. Once tested this development opportunity should be extended to the other primary care disciplines. This should be done in conjunction with the experience, advice and contacts of the NLU of NES but be administered by RCGP Scotland. Our scoping suggests that there is currently a gap in the provision of leadership development for such individuals, particularly those with an established career, but who are not employed in a positional leadership role within their local board area. This gap shrinks the pool from which future strategic and positional leaders are drawn. More leadership development for individuals will increase the number of positive role models and mentors in primary care.

A blended learning approach should be used and this could involve the use of eLearning, coaching, 360s and some face to face workshops. Independently contracted practitioners will require back fill for the latter for these. It is neither practical nor sensible to write a leadership programme from scratch and as such we will make use of materials already available or that can be easily modified. Ideally a cohort of individuals drawn from each of the area health boards would be the most appropriate place to start.

Continuing Professional Development (CPD)

We will continue to liaise and have open dialogue with NES providers to establish Continuing Professional Development (CPD) which can be delivered to larger volumes of multi-disciplinary primary care practitioners. This includes approaches such as short video updates, e-modules and the standard Leadership and Management Programme (LaMP). These are placed at the start of the leadership development journey. We have also commissioned a Practice Based Small Group Learning (PBSGL) Module ‘An Introduction to Leadership’. 1,600 GPs in Scotland study PBSGL modules in communities of practice across Scotland. All GP trainees have access to PBSGL during their training. There are multi-disciplinary groups, GP Nurse groups and pharmacist groups.

3. **Indirect and informal approaches for primary care leadership development**

We will establish a primary care leadership narrative capable of being embedded in existing leadership development programmes. We will liaise with and have open dialogue with the NLU about primary care engagement with the currently available national leadership programmes.

Other Considerations

Appraisal and Revalidation

We will open a dialogue with NES colleagues involved in delivery of GP appraisal. This is the main route to revalidation for GPs and could act as a lever to promote positive leadership behaviours. Such learning and development could be by formal routes such as programmes and CPD and informal routes such as mentoring and role modelling.

Annex E

NHS Education for Scotland (NES)

Training in Quality Improvement (QI) and Training for Leadership in QI

Level 1

Target audience: all Foundation, all Core (incl. CMT, CST & ACCS) & all ST3 trainees on entry to training programmes.

Aim: To align fully with the objectives of the (2010) Healthcare Quality Strategy for NHSScotland.

Themes:
- Quality in NHSScotland's healthcare
- Healthcare policy in action
- FYs, CTs, STs – being led or taking the lead

Level 2

Target audience: specific trainee cohorts e.g. CMTs & Learning to Make a Difference.

Aims: To align fully with the objectives of the (2010) Healthcare Quality Strategy for NHSScotland.

Themes:
- Quality in NHSScotland's healthcare
- Healthcare policy in action
- Learning through action: delivering a QI project

Level 3

The Launchpad for Leadership Programme

ISBN: 978-1-78412-206-5

This document is also available on the Scottish Government website:
www.scotland.gov.uk

APS Group Scotland
DPPAS303932 (01/14)