Maximising Leadership Learning in the Pre-Registration Healthcare Curricula

Model and Guidelines for Healthcare Education Providers: 2018

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Foreword from Ian Cumming

Leadership is a core part of every healthcare professional's role. It transcends professional backgrounds and binds us together with a common thread. Driven by this belief - and Health Education England's commitment to ensuring that our current and future workforce has the right skills, values and behaviours to deliver high quality care - this guidance document has been co-designed to enable our health education partners to deliver leadership development through a simple, flexible and evidence-based framework within pre-registration healthcare curricula.

Ensuring all healthcare students graduate with a clear, shared understanding of how they can be excellent leaders will help drive positive change in healthcare services from the grass-roots upwards. It will empower our highly skilled workforce to continuously improve the quality of our healthcare services from the start of their professional careers and, ultimately, it will mean better experiences for service users in times of need.

Professor Ian Cumming OBE
Chief Executive
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Foreword from Stephen Hart

In the 70th year of the NHS, it is fitting to look to the future and to describe our ambitions for the coming decades. At the NHS Leadership Academy, our philosophy is simple – great leadership development improves leadership behaviours and skills, in turn that leads to better patient care, experience and outcomes. We have always had a vision of supporting leaders at every level and in every role in NHS funded care. Into the future we will be expanding this scope to include the leadership development needs of those yet to join the workforce. We will be working in partnership with those who train and develop pre-registration health professionals to equip them with leadership knowledge, skills, attitudes and behaviours from the very beginning of their career.

This work starts from an existing high standard. There are excellent examples of Higher Education Institutions across England supporting leadership development for health professionals. Using these examples of excellent practice, we have identified the kind of leadership interventions that should be available to all learners. Nye Bevan said at the inception of the NHS that we needed to 'universalise the best'. This plan supports the ambition to have leadership development as an integral part of all health professional education so that everyone entering the health and care workforce has the foundations of leadership from day one. This document contains guidelines and practical help so that every Higher Education Institution can support in setting the foundations for outstanding leadership in the future workforce.

Stephen Hart
Director of Leadership Development
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Foreword from the co-production design team:

What if every newly qualified healthcare professional graduated already thinking as a leader? What if they'd been able to embrace personal insights about themselves that arose from exploring 'what makes me, me' during their undergraduate professional development journey? What if they all entered our healthcare services with the seamless ability to inclusively connect to and lead a diversity of other people? What if they were all equipped with knowledge and holding in their hand a practical toolbox of improvement skills to lead change? What would our healthcare service be like in 20 years' time if every new professional felt empowered to lead and improve their area of healthcare from day one of their professional careers? What difference would this make to how our communities experience the care that we provide?

These questions motivated our original ambitious research study into maximising leadership in the pre-registration healthcare curricula (Health Education England (HEE), 2015). Since then, leadership and improvement skills have become an increasingly important focus area for all of our healthcare workforce. The leadership and improvement framework for the NHS in England, Developing People, Improving Care (NHS Improvement, 2016), clearly identifies the need for leadership development and service improvement skills to be equally embedded within our entire pre-registration clinical curricula.

The skills, knowledge, values and behaviours of a healthcare leader are a common thread that binds all of us as healthcare workers together, regardless of our professional background. As healthcare professionals, our positional authority may change as we advance our careers. However, our power to act as leaders and influence change is something that we can all enact at any point. We are all leaders as much as we are all followers. It is our duty to not only provide compassionate, inclusive and expert clinical care at the times people need us most, but it is also every professional's duty to continually improve the services that we deliver. Continual improvement will keep our healthcare service quality-focused, contemporary and innovative so that we can meet the challenges we face now and those that we will face into our future.

These guidelines and model to maximise leadership learning in the pre-registration healthcare curricula present the outputs of our evidence-based work for consideration and adaptation by all healthcare education providers. Our model offers a simple and logical way of developing leadership and improvement skills over the natural life-cycle of a pre-registration programme. It inclusively builds on appreciating ourselves as unique and diverse individuals. It enables us to connect to others and offers the skills and practical tools required when leading change and improvement as leaders in healthcare.

Our ambition is to enable all newly qualified healthcare professionals to enter healthcare as empowered leaders. Our hope in co-designing these guidelines with academic, practice and regulatory partners is that all clinical healthcare education providers will integrate and build on our model to bring leadership and improvement skills to life for their students, in every pre-registration curricula they lead.

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3. Executive Summary

These guidelines have been developed by the national NHS Leadership Academy as part of Health Education England. They are designed to help education providers to maximise leadership learning in the pre-registration healthcare curricula. They are built on over 3 years of research and co-design in partnership with education, practice and regulatory partners.

The ambition of these guidelines is to enable each newly qualified healthcare professional to graduate and enter the healthcare workforce with the skills, knowledge, mindset, behaviours and tools to be a leader of people and service improvement at the start of their careers. Being a leader will become a conscious part of every healthcare professional's identity and their normal daily lives.

Our ambition is in direct contrast to how leadership development currently operates within healthcare, where we historically develop leaders when they reach positions of authority. This is too late. We believe that our newly qualified workforce should feel enabled to be leaders and improvement agents as part of their professional identity from the start of their careers. This will change how healthcare works from the front-line upwards, making a positive difference to our workforce, our service users and the diverse communities we serve.

Through our research, we know that leadership learning does form parts of many existing healthcare curricula, however it is often disjointed or not explicit. Therefore, our guidelines and model have been co-designed to be flexible and adaptable to each pre-registration programme. They will help education providers to identify, structure, enhance and maximise leadership learning. Our guidelines and model are mapped to professional body standards, existing leadership models, current evidence-based literature and wider primary research into leadership practice

in the NHS. By integrating our guidelines and model, education providers will meet all of the requirements and ambitions for leadership development in pre-registration during curricula review and enhancement procedures.

The model proposes 3 stages of developing as a leader to integrate within the pre-registration programme. It also offers 3 phases of integrating these guidelines into the pre-registration curricula in a flexible way.

The **3 stages** of developing as a leader during pre-registration education are identified as:

Stage 1: Focus on self: developing self-awareness and self-efficacy to foster understanding of one's own beliefs, attitudes, values, knowledge, attributes and skills in order to build and develop leadership behaviours.

Stage 2: Working with others: understanding how one interacts and connects with the diversity of other people in organisations and learning how to develop positive team working in a multi-professional and complex clinical environment.

Stage 3: Improving healthcare: developing and leading teams to instigate and action positive change in practice to assure quality, safety of care and continuous improvement of services through evidence-based approaches.

Stage 3 Improving healthcare

Stage 2 Working with others

Stage 1 Focus on self

Phase 3
Key approaches to teaching and learning

Phase 2
Key programme content

Phase 1
Principles of programme design
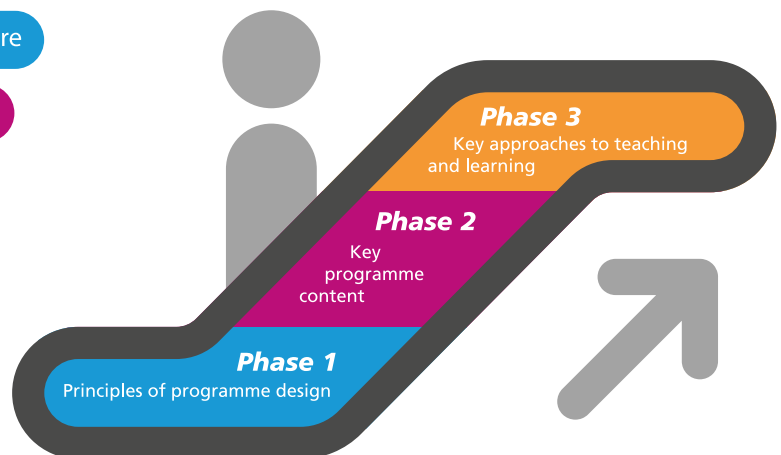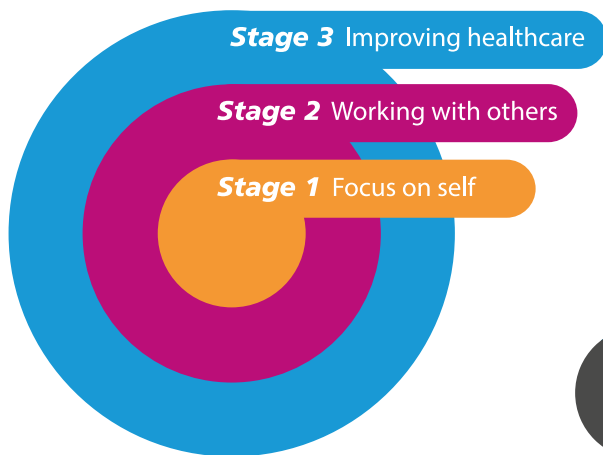
The **3 phases** of ensuring these fundamental aspects are incorporated into the curricula are proposed as:

Phase 1: Principles of programme design: simple guiding principles to follow to successfully embed leadership learning, based on our research and co-production work into pre-registration leadership development programme design.

Phase 2: Key programme content: providing content in a logical flow relating to the 3-stage leadership learning development model, mapped to current thinking, good practice and professional body requirements.

Phase 3: Key approaches to teaching and learning: offering educational methods, tools and approaches to leadership learning, based on good practice in healthcare leadership development approaches.

Throughout the remainder of this document, our model and guidelines are presented in detail. This is followed by the evidence to illustrate how these guidelines were formed, underpinned and enabled by a co-design approach.

Our ambitions for the next stages of our work are to extend our co-design group so that we can:

- Increasingly capture case studies and learning from all Health Education partners, to celebrate their achievements in leadership development in the pre-registration curricula and evaluate the impact of this approach.

- Engage with a wide group of Health Education partners to test, evaluate and capture learning to continually enhance the guidelines as part of a 5-year cycle.

- Work in partnership with education, practice and leadership experts within the NHS to develop a leadership learning 'toolkit' of helpful resources, learning materials and case studies. These will be available to education partners to help them easily integrate leadership development into their programme materials.

- Consider an approach to longitudinal research to investigate the impact of leadership learning at the start of healthcare professional careers as part of pre-registration education.

4. Introduction

4.1 The NHS Leadership Academy

The NHS Leadership Academy is proud to be part of Health Education England and leads on leadership for the entire NHS. These guidelines have been developed by the Leadership Academy through the principles of partnership and co-design with health education providers, practice education and national partners. They form part of the Academy's national commitment to empowering all healthcare staff with the leadership skills required to transform the NHS and deliver outstanding patient care. The original research into maximising leadership in pre-registration learning and the further development of these guidelines was led by West Midlands Leadership Academy on behalf of the national Academy.

4.2 Current position

Clinical leadership has become recognised as increasingly important over the last decade with key reports highlighting the immense impact that the quality of leadership can have on patient care (Francis, 2013). Although patient care is provided by individual clinical professionals –nurses, midwives, dieticians, physiotherapists, speech therapists, podiatrists, scientists or any one of the wider range of professional clinical staff, these individuals are part of a whole system or service which delivers the care to patients and service users.

To be effective in delivering high quality patient care, clinicians must also be able to understand the systems and services they work within and use the resources that are available to them to best effect. Effective clinical leadership therefore is highly important for optimum care delivery. There is already a wealth of evidence-based guidance and professional requirements for leadership development that impacts on clinical leadership. For example, the Healthcare Leadership Model (NHS Leadership Academy, 2013) demonstrates

fundamental leadership development requirements of all professional healthcare staff. The importance of leadership development has been identified by successive governments as well as being evident in theoretical and empirical work. To continue to achieve best outcomes for patients and improve those outcomes, effective leadership by clinical professionals is an imperative for us all. The national NHS leadership and improvement framework, Developing People Improving Care (2016), also outlines the importance of clinical leadership starting from and being integrated into the student curricula, enabling leadership to form an active and conscious part of our healthcare professional's identity from the start of their careers.

Although there has been extensive and valuable work in supporting healthcare qualified staff to develop leadership capabilities, West et al (2015) noted that there is limited evidence of the existence of effective programmes to develop future healthcare leaders. Evidence to demonstrate what could be developed in curricula to support the development of leadership skills, knowledge and behaviours has to date been defined by professional discipline based statutory and regulatory bodies and is specific to each clinical profession. This is supported by existing healthcare leadership models. What is not evident is what is required in pre-registration curricula to support the development of future leaders across health disciplines.

4.3 What is the purpose of this guidance?

From our extensive research and work in co-designing these guidelines in partnership with a variety of stakeholders, we know that the values, skills and knowledge for effective leadership can be learned through theoretical understanding and practical application. We also know that there are already existing guides and professional

requirements identifying leadership development for professional healthcare staff working in the NHS.

The purpose of this guidance is to fill the identified gap of what is required to support structure and enable the development of leadership in the pre-registration healthcare curricula. Therefore, its purpose is to support healthcare education providers to develop curricula which drive the learning of leadership for all pre-registration healthcare students. The focus of the guidance is on healthcare professions other than medicine, where a parallel but connected piece of work is in train through the Faculty of Medical Leadership and Management. The principles of learning about leadership however, are equally applicable across the broad and diverse spectrum of healthcare professions.

The guidance acknowledges and is linked to existing healthcare leadership models. It has been developed and co-created in conjunction with a range of Universities, NHS Trusts, Health Education England, the NHS Leadership Academy, the Nursing and Midwifery Council, the Health Care Professions Council, Student Representatives and a wider group of stakeholders drawn from the worlds of healthcare education and leadership development.

4.4 What is the aim of this guidance?

Our ambition was to co-create a common set of guidelines for healthcare education providers to integrate leadership development and improvement skills into the pre-registration curricula for use when (re)developing, (re) validating or reviewing healthcare curricula.

The aim of the guidance and our leadership learning model is to support the maximisation of leadership development and improvement skills, knowledge and behaviours in pre-registration healthcare programmes. Leadership will form part of the professional role from the start of their career and will not be seen as something 'bolted on' upon qualification and obtaining a first formal leadership position.

Taking this common approach across all curricula through a synthesis of professional body, national drivers, research and evidence-based practice, may enable our newly qualified workforce to affect change from the start of their careers. They will be able to improve care from the 'bottom up' and also reduce the resource requirement for developing leadership skills later when it is too late or less effective.

4.5 How to use this guidance

This guidance can be used as a:

- Tool to facilitate discussion within curricula and programme teams on how to orientate the curricula to maximise leadership and improvement skills in pre-registration healthcare programmes.

- Checklist to identify key programme design ideas.

- Model to support programme development and implementation.

- Aide-memoire to assure key features of learning about leadership are included in each professional programme.

- Basis for a discussion with students about leadership in their programme and future career.

- Information and links to other key resources.

- Springboard for wider national discussion and a co-designed approach to integrating leadership learning within all pre-registration healthcare curricula.

5. The Model: Maximising Leadership Learning in the Pre-Registration Healthcare Curricula

5.1 Introducing the pre-registration leadership learning model

The leadership learning model was developed from the co-production of workstreams and previous research, enabling curriculum designers and developers to maximise leadership learning in the healthcare curricula. The model has been developed to include those aspects of learning about leadership which are fundamental to developing leadership skills, knowledge and behaviours.

3 stages of developing as a leader in pre-registration

These fundamental aspects of the leadership learning model are captured in **3 stages** of developing as a leader. These are the 3 broad, but important, themes which we suggest should be staged across the curricula in a flexible way to suit the specific curricula design. The 3 stages are interrelated and will build on each other.

The **3 stages** of developing as a leader are identified as:

Stage 1: Focus on self: developing self-awareness and self-efficacy to foster understanding of one's own beliefs, attitudes, values, knowledge, attributes and skills in order to build and develop leadership behaviours.

Stage 2: Working with others: understanding how one interacts and connects with the diversity of other people in organisations and learning how to develop positive team working in a multi-professional and complex clinical environment.

Stage 3: Improving healthcare: developing and leading teams to instigate and action positive change in practice to assure quality, safety of care and deliver continuous improvement of services through evidence-based approaches.

Stage 3 Improving healthcare

Stage 2 Working with others

Stage 1 Focus on self
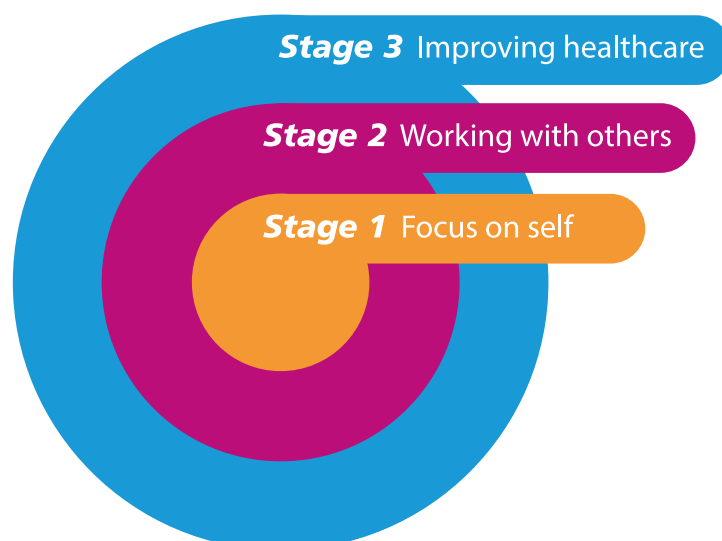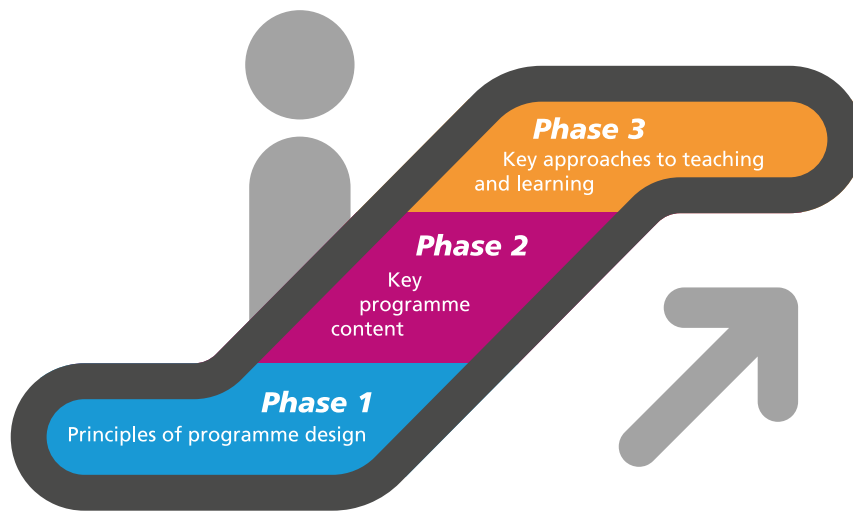
3 phases of integrating leadership learning into the curricula

In addition, we suggest there are **3 phases** to ensure these fundamental aspects are incorporated into the curricula. These 3 phases consist of principles of curricula design, content to be included and effective delivery approaches.

The **3 phases** of developing leadership learning in the curricula are identified as:

Phase 1: Principles of programme design: simple guiding principles to follow to successfully embed leadership learning, based on our research and workstream outputs into pre-registration leadership development programme design.

Phase 2: Key programme content: providing content in a logical flow relating to the 3-stage leadership learning development model, mapped to current thinking, good practice and professional body requirements.

Phase 3: Key approaches to teaching and learning: offering useful educational methods, tools and approaches to leadership learning, based on good practice in healthcare leadership development approaches.

The Leadership Learning Model and this associated guidance can be utilised in a range of ways to support curricula development. It is not discipline specific, so can be used within curricula that have a multi-professional focus or modules of inter-professional learning. The remainder of this chapter outlines how to embed the model in greater detail.

| Facilitate discussion within curriculum development teams | Use as a checklist or aide memoir | Background information and links to literature |

| Support to work towards professional requirements | Model to support programme structure |
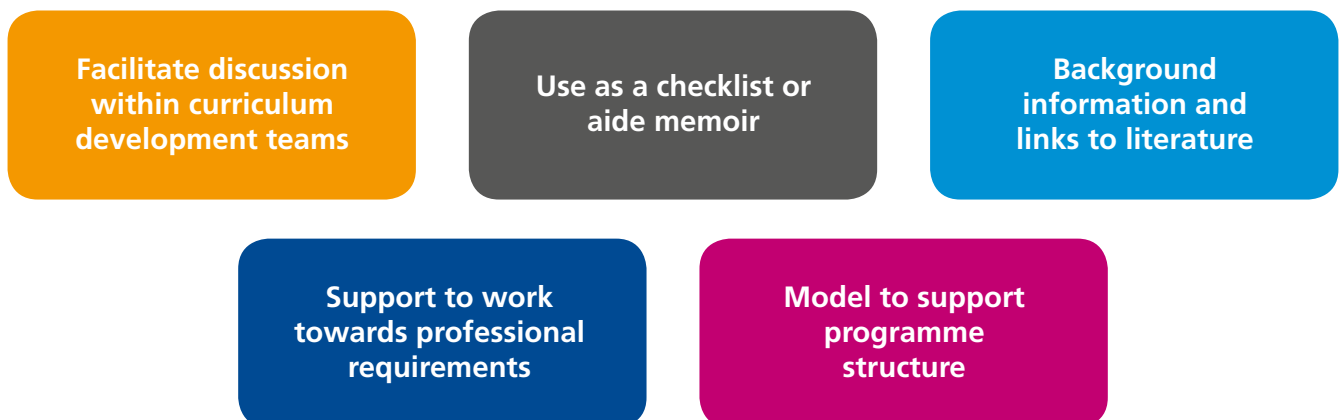
Uses of the Model and Guidance

5.2 The 3 stages of developing as a leader in pre-registration: fundamental skills, knowledge and behaviour

The first '3' stages of the leadership learning model include the elements which are fundamental to developing as a leader. These domains are expressed in different ways in other models, but relate to 'self', 'team' and 'organisation' or 'system'. It is acknowledged that there are numerous definitions of leadership and that it is a contested concept (Kings Fund, 2011). We therefore do not want to commit to one definition of leadership, however acknowledge that models such as the Healthcare Leadership Model (NHS Leadership Academy, 2013) provide an evidence-based overview of what it means to be a leader in healthcare.

We also note that increasing evidence both in literature (Furtner et al, 2013; Weiszbrod, 2015) and from within the healthcare leadership best practice reviewed during our development of this guidance, suggested an 'inside out' model.

By this, it is suggested that individuals should initially understand themselves as leaders working on their self-understanding and emotional intelligence. They should then work outwards to understand how they connect to others and build relationships. Individuals should then logically develop their wider leadership, service improvement skills and practice to be able to effectively lead others and transform change for healthcare.

These 3 stages can be incorporated into pre-registration healthcare curricula in many ways. We suggest that the curricula should build up in stages from 'self', to 'others' and finally 'improvement'. However, the principles can be flexibly applied to any curricula model and aspects may run concurrently, dependent on the type of curriculum model in use. For example, in terms of a spiral curricula (Bruner, 1960), there may be aspects which are developed throughout the entirety of the programme and continually built on and revisited.

Stage 3 Improving healthcare

Stage 2 Working with others

Stage 1 Focus on self
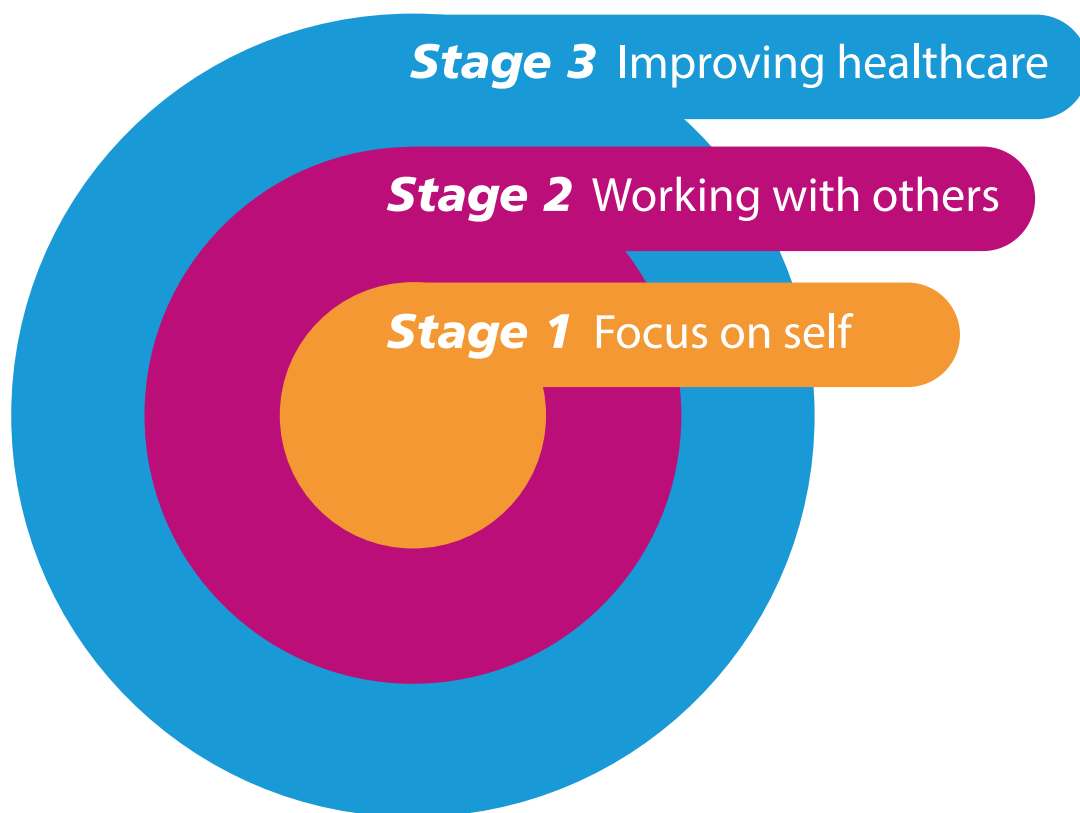
The 3 stages of Leadership Development

The rational for this staged approach is as follows:

Stage 1: Focus on self

To be a good leader it is important to have an intimate understanding of yourself, what drives you, your values, your motivation, your personality. Truly embracing continual curiosity towards understanding yourself acts as a driver and a framework to be curious about others and how we all see the world differently. It develops the emotional intelligence needed to then move onto successfully working with others.

Stage 2: Working with others

Having a good understanding of yourself and having embraced frameworks that enable you to see how we are all different (e.g. personality, values, history etc.), leads on to working with others as part of teams. Appreciating difference and building successful relationships with colleagues is aided by the emotional intelligence built through the focus on self. Appreciating that being part of a team, building of relationships and leveraging each other's strengths is critical to any professional. It is also critical to have experienced this to be a successful leader of change and improving healthcare services. This is true when being a follower within, or a leader of teams.

Stage 3: Improving healthcare

Having understood yourself and how to connect to others to be part of and/or lead a successful team, you are then ready to develop a 'toolkit' for service improvement and change. Understanding the theory and models for service change as well as having practice in implementing service change, allows students to put all of these key elements of leadership into practice. This allows them to embrace being a leadership role model from the point they graduate and enter our healthcare service.

5.3 The 3 phases of integrating leadership learning into the curricula

The second 3 phases of integrating the leadership learning model identify curricula development requirements incorporated into the curriculum as: principles for programme design, guidance on what to deliver and guidance on how to deliver it.
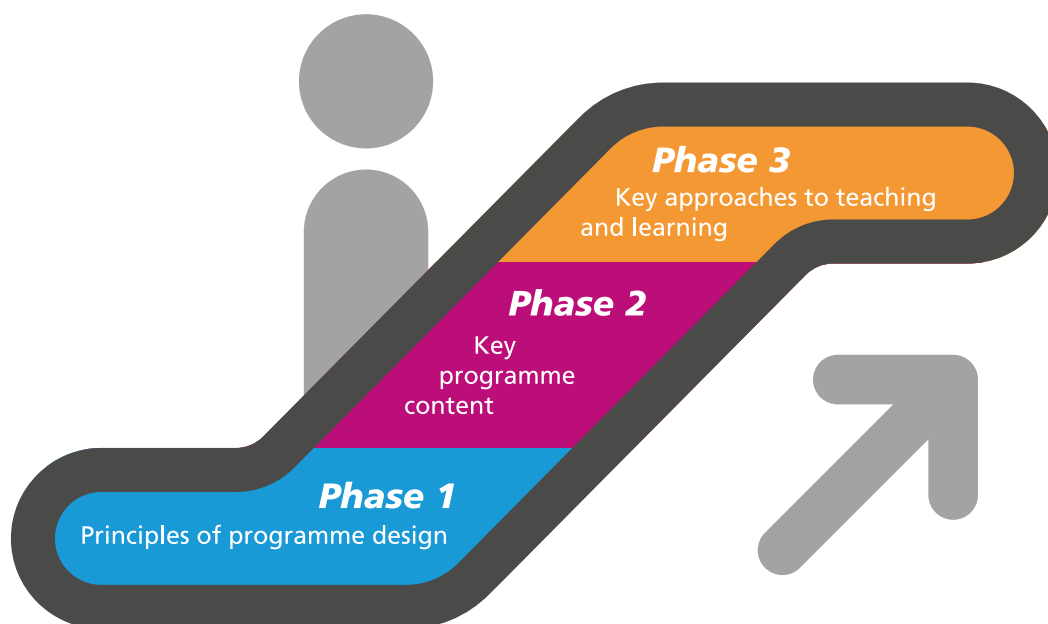
The 3 phases of curricula design

Phase 1: Principles for programme design

Designing any programme of learning for students requires knowledge of curriculum development; models and approaches to teaching and learning, discussions centred on the agreed philosophy of the programme, the aims of the programme and agreement on the learning outcomes the students will achieve on completion (Quinn and Hughes, 2013). These aims and outcomes are usually centred on professional requirements and standards. However, certain principles have been identified which could be considered during the first stages of curriculum development for any discipline in healthcare.

The principles identified here can be flexibly considered relevant to the design of the whole curriculum as well as to specific modules,

dependent on the structure of the programme. If a modular approach is used for example, it may be that the theme of leadership is phased throughout other appropriate modules in the entire programme. Therefore, principles could be integrated throughout the whole programme as well as being applied to specific modules.

The following identifies and explains our principles for programme design which could lead to maximising leadership learning in the pre-registration curricula. In addition, the evidence for inclusion of these principles in this guidance is indicated. Principles can be used as a 'checklist' for existing curricula, or as a springboard for developing innovative curricula design when developing new programmes.

Principle 1 - Leadership from start to finish - start from day one of your programme:

Traditionally, learning about leadership has been placed towards the end of a programme as students have gained the discipline, skills and knowledge to enable them to become more confident practitioners (HEE 2015) throughout the previous years of study. However, our evidence suggests that if students can learn early on that leadership can be practiced at all levels, then it is important to start learning about leadership from the beginning of any programme. It is preferable that it is not allotted exclusively to the final year. Developing as a leader is a journey which can be commenced early in the programme with the first stage in the model of 'a focus on self'. Literature, professional body requirements, current healthcare leadership models and best practice, identify that the development of self-awareness is important in the process of developing as a leader and this type of learning can be incorporated from the very first weeks of programmes. Many students will be expected to work in a team early in their practice. Therefore, the second stage in this model of working with others would usefully be included early on in any programme design. Dependent on programme structure, these may not be separate modules but themes within other identified modules. For example, focused on introduction to professional values and behaviour, professional practice or preparation for practice. Innovative methods to develop a student's self-awareness and learning about working with others can be developed. One curricula model which supports this approach is referred to as the Spiral Curricula. This consists of an integration of topics across the three years in increasing complexity and also in the form of previous topics being returned to and studied in light of learning around more complex topics (Coehlo and Moules, 2015). Other curricula models whether based or not on a constructivist design will allow for this approach to be taken.

Principle 2 - Making leadership visible - 'name it':

Students recognise the need to learn about leadership (Meakin, 2013). However, to what extent students know they are learning about leadership and developing as a leader is debateable (HEE, 2015). This means there is currently a discrepancy between identity as a clinical professional and a leader, when in fact this should be one and the same thing. It is also suggested that to foreground leadership learning in the curricula is important (HEE, 2015). It can be argued that using leadership terminology, overtly identifying leadership attributes, skills and theory throughout the curricula should be clearly recognised by students. This equally applies to learning about leadership in practice. Signposting or 'branding' aspects of learning leadership may enable students (and qualified staff) to value and practice leadership skills and behaviours from an early stage in their development through to registered professional. Identifying the synergies between being a leader and a clinical professional are also important. For example, communication skills are equally important to both as communicating effectively with a patient, with team members or engaging people with the vision for a change project all draw on similar skills and behaviours. It is simply the context that is different.

Principle 3 - Enable development of self-awareness:

Understanding who you are and 'what makes you, you' helps students develop their sense of personal identity as a healthcare professional and defines how students lead. This can be achieved through a range of techniques and tools available in order to help students develop their knowledge of self. This will allow them to understand their own strengths, limitations, preferences, values, attitudes and beliefs in terms of developing leadership skills, knowledge and behaviours. Tools that may be used include psychometric personality profiles such as Myers-Briggs Type Inventory, the Belbin Team Inventory and the 360 feedback assessment including the Healthcare Leadership Model self-assessment and 360 feedback tool. Tools that allow the student to learn about themselves personally, professionally, academically and clinically will be helpful on their leadership journey. Reflective practice as a self-awareness development activity, has been shown to be helpful in developing resilience and self-efficacy and is fundamental to students being able to manage difficult and challenging

situations in practice (Jackson et al, 2011). Ultimately, it is critical that the student explores themselves and harmonises their identity as a professional, a leader and as a unique individual and feels at ease with this.

Principle 4 – Highlight the importance of responsibility to lead:

It is recognised that developing leadership at all levels is paramount in helping to transform our complex healthcare systems positively going forward. It may be that first-year undergraduate students do not always recognise their role in this and their supporters in practice (mentors, supervisors and assessors) may also feel that this can 'wait' until they are nearing qualification. It is important therefore, that when planning curricula, it is recognised by staff and students alike that the responsibility to lead is everyone's business within the context of their professional role. Starting on that journey at the beginning of a pre-registration programme rather than waiting until the end should benefit patients, service users and carers in the future, as well as the unique leadership roles that students play when out on placement.

Principle 5 - Embed multi-disciplinarily approaches in leadership learning:

Understanding the diverse roles and working with other professionals as part of a team is an important factor in developing leadership skills and attributes. In the research supporting this guidance, the importance of inter-professional learning in practice and in theoretical learning was identified as a core recommendation (HEE, 2015). Brewer et al (2016) acknowledge the difficulties in inter-professional learning around leadership when disciplines may have varying understandings of the term 'leadership'. However, multi-disciplinary or inter-professional learning is an area that is crucial in allowing students the opportunity to work with, follow and lead others, and in working to dispel beliefs that current hierarchical structures in practice may prevent positive change. Common leadership themed modules across multi-professional programmes is seen as emerging best practice in this area. However, it is acknowledged that each education

provider will have a varying ability to achieve this based on the diversity of the programmes they offer. It is encouraged that innovative ways are embraced to embed multi-professional learning. Leveraging the commonalities amongst professions surrounding leadership development is a good way to achieve this.

Principle 6 - Use current leadership models to frame learning:

This guidance has already referred to the NHS Healthcare Leadership Model (NHS Leadership Academy, 2013) as being an important framework to demonstrate to students how they can work towards specific behaviours recognised as inherent in leaders, and continue to develop their leadership skills and knowledge once qualified. However, this can also be utilised to support learning about leadership across the curricula in terms of dimensions of leadership behaviours and the importance of personal attributes. Models and frameworks that are familiar and utilised in clinical settings may also support students' learning to make sense of some of their experiences and enable them to navigate their understanding of leadership in the clinical environment.

Principle 7 - Use active learning approaches:

Active learning approaches are indicated in learning about leadership (Meakin, 2013). The use of active learning, experiential learning, enquiry based learning and other approaches outlined later in these guidelines will support students' leadership development across the curricula. The use of simulation for example, has been found in numerous areas to prepare students for practice and its use in developing leadership skills and knowledge, although an area for further research is important (Armstrong et al, 2017). The use of team-based improvement projects are seen as best practice in leadership development in both NHS leadership development practice, and through the case studies we reviewed on how Education Providers are incorporating active learning approaches to leadership.

Principle 8 - Enable support for leadership learning in practice and assessment in practice:

The assessment of leadership skills, attributes and knowledge throughout a programme and throughout practice have been advocated as helpful in developing as a leader (HEE, 2015). This includes enabling support for leadership learning and assessment in practice and may require supportive programmes for mentors, supervisors and clinical assessors to help students learn and achieve their leadership skills and behaviours. Much is written about learning in practice and Billet (2001) identifies the competing demands on learners in the workplace and strategies to enable co-participation at work to support learning. Effective leadership is a crucial part of maintaining the quality of healthcare. Pre-registration healthcare programme providers have an important part to play in designing meaningful clinical or experiential experiences and practice assessments, enabling students to show they have developed competencies at stages throughout their programmes of study. Assessment against being a leader within the safe, developmental environment of a learning programme is also the ideal place to allow students to embrace the developmental feedback from this assessment. They are able to grow as a leader rather than waiting for performance feedback later on when they are in leadership roles in service.

Principle 9 - Use roles models from practice in learning about leadership:

Learning from people who are leaders in practice enables students to relate their theoretical learning to the real world. Situating the learning in practice is important. Role modelling is seen as a helpful tool to enable students to identify with good leadership (HEE, 2015) and identify when things do not go so well. Students we engaged identified how clinical and professional role models provided motivation and inspiration when giving presentations. So, role models can be used effectively in clinical areas as well as in classroom-type situations.

Principle 10 – Use service users and carers in learning about leadership - bringing leadership to life:

The original research supporting this project (HEE, 2015), identified that involving service users and carers in the curriculum would be of value when learning about leadership. Whilst service user experience is often used in programme delivery, focusing on the specific experiences of being at the receiving end of leadership was felt by all stakeholder groups in the research (HEE, 2015) to be of value. Involving service users and carers in curricula delivery has been seen to be of benefit e.g. Use of patient stories (Adams et al 2015).

Phase 2: What to deliver

Pre-registration healthcare students can learn about leadership in a variety of ways and in many environments. However, professional regulators set the standards students must achieve at key course points in both academic and clinical settings. Building upon the students' clinical experience is therefore important for them to learn about effective leadership, develop skills and show they are competent as they progress through their studies. For those that deliver pre-registration healthcare courses, there are aspects to consider that will help their students develop leadership knowledge and skills in practice.

Pre-registration healthcare curricula are developed from standards identified by the relevant professional body and with use of other supporting information e.g. QAA standards. Other information is helpful in determining what should be included in curricula to assure maximisation of learning about leadership. Specifically, for healthcare curricula, this includes the Clinical Leadership Competency Framework (NHS Leadership Academy 2011) and the Healthcare Leadership Model (NHS Leadership Academy 2013). Guidance has been developed to include aspects of the Clinical Leadership Competency Framework into education and training (NHS Leadership Academy 2011).

The following table identifies core areas of learning to include in the curricula, with consideration of the 'inside out' 3 stage leadership learning model, starting with self, working with others and then delivering improvements and change. The suggestions here

on what curricula content to include, have been identified and synthesised from; our original pre-registration leadership research, the mapping and review of the statutory and professional body requirements and standards, the literature review, consideration towards existing leadership models, input from leadership development practitioners in practice and co-design workshops held with the task and finish group and stakeholders.

Examples of leadership learning content mapped to the 3-stage leadership learning model, best practice and regulatory body requirements		
Model stage mapping	**Area of learning arising from review of PRSB requirements**	**Skills, knowledge and practice areas to cover within curricula**
Stage 1: Focus on self	**Leading self and others**	• Understanding yourself, values, personality and personal drivers. • Attributes and behaviours of leadership. • Identifying as a leader within yourself and your professional practice. • Reflecting on and in practice as a leader. • Developing self-confidence. • Emotional Intelligence.
	Openness and accountability	• Personal and professional values-driven – doing the right thing. • Knowing and leveraging your strengths, boundaries and limits. • Role modelling and leading by example. • Understanding styles of leadership
Stage 2: Working with others	**Communicating for influence**	• Understanding empowerment and personal impact. • Communicating the vision and narrative. • Coaching skills, powerful questions and listening to understand. • Courageous conversations. • Personal resilience. • Engagement and co-design principles. • Political awareness. • Sharing the vision.
	Teamwork	• Understanding others and how teams work. • Leading others and diverse styles of leadership. • Multi-disciplinary working. • Inclusion and diversity in the context of high performing teams. • Engaging difference and an inclusive mind-set. • Conflict resolution. • Theories of teamwork and being part of a team.

Examples of leadership learning content mapped to the 3-stage leadership learning model, best practice and regulatory body requirements

Model stage mapping	Area of learning arising from review of PRSB requirements	Skills, knowledge and practice areas to cover within curricula
Stage 2: Working with others (continued)	**Delegation**	• Followership. • Decision-making. • Professional supervision.
Stage 3: Improving healthcare services	**Managing risk**	• Management skills. • Understanding, analysing and mitigating components of risk. • Critical thinking. • Troubleshooting and problem solving. • Handling challenging situations.
	Quality and service improvement	• Understanding the organisations and systems we work in. • Service improvement models and tools. • Change management theory and tools. • Creative thinking tools. • Role modelling for improvement. • Delivering an improvement project.
	Project planning, monitoring, evaluation and spread	• Project management techniques and tools. • Technological knowledge. • Understanding and applying methods of evaluation. • Scaling and spreading learning.

This is not an exclusive list of content and each programme will have discipline specific requirements as identified above. Whilst we suggest a chronological order based on the 3 stages of the model, it is also appreciated that implementing all of these stages within the complexity of different healthcare curricula is likely not to follow this clear framework. However, it is anticipated that the ideas listed here will provide students with the required fundamental leadership skills, knowledge and behaviour for them to develop clinical leadership across their programme. Introducing these topics and building upon them in the curricula, is at the core of the leadership learning model that we are proposing.

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Phase 3: How to deliver it

Whilst it is acknowledged through our work in this area that there has been little clear evidence on the most effective approaches to learning about leadership in pre-registration healthcare curricula, there is support for active and experiential learning (Jones et al 2013, Armstrong et al 2017), simulation (Felton and Wright 2017) and inter-professional learning (Reeves et al 2017).

Leadership development should start early in a healthcare professional's career when they commence their educational training. However, Daly et al (2014) expressed concern that deficits exist at an undergraduate level related to leadership curricula content. Jones et al (2015) concluded their project work by stating that leadership teaching needs to be more explicit in all pre-registration healthcare programmes, in both the academic and clinical environments. Consequently, if leadership content in pre-registration healthcare courses requires enhancing, programme providers should develop the leadership profile, content and approach to teaching to develop the knowledge, skills and competence of their students.

It is also possible that non-medical programmes can learn from their medical counterparts. Till et al (2017) have provided a number of tips for integrating leadership into undergraduate medical education. These tips are transferable to non-medical education and they provide a useful guide for those developing courses. In brief, some of the tips that link with practice include: reframe leadership as a core part of the professional's identity and raise its course profile in the curricula; develop student reflection to increase self-awareness; enable multi-professional working experiences; assess the development of leadership competence; and explore the hidden curriculum related to peer or near-peer learning that supports leadership development.

Course content and delivery is not the only priority for course teams. Assessment can drive student learning and it is an important consideration for developing leadership knowledge and skills in pre-registration students. Assessment, as with content, is directed by the requirements of the professional regulator, and it is often associated with the assessment of student competence at stages within a programme. However, the challenge for course teams is to

Leadership development should start early in a healthcare professional's career when they commence their educational training.

design assessments that reinforce in students the ongoing link between theory and practice. Allan (2010) has expressed a concern that students uncouple the learning experienced in practice from the related theory. Course teams, therefore, need to design assessments that enable students to align their understanding of theory with their clinical experiences and their development as leaders.

Examples of methods that support these approaches are identified in the following table. These have been identified from our review of practice, literature and wider evidence gathered from our workstreams and engagement that supported the development of this guidance.

How to deliver it:
Pedagogical learning methods to deliver the leadership content

Seminar work	Personal and professional profiling	Coaching and mentoring	Reflection	Self-directed learning
Project work	Action learning	Experiential learning	Problem based learning	Simulation
Inter-professional learning	Group work	Multi-disciplinary learning in practice	Group discussions and debates	Peer learning
Making leadership visible	Integration through assessments	Learning in practice	Scenario simulation	Case study work
Working with service users and carers	Role models sharing practice	Workshops	Peer support networks	Online learning
Feedback	Informal learning	Empowering learning activities	Technology enhanced learning	Values-based learning

We have not identified which type of approach could deliver specific types of content. This would be too prescriptive and consideration would need to be made of the interdependencies of the discipline and the type of curricula. These are therefore, suggested approaches which may be incorporated into the curricula. Further work is needed to provide a more substantive evidence base going forward.

From exploring how the NHS delivers leadership learning for qualified practitioners who are leaders in practice, the following impactful learning approaches have been identified. It is suggested that where possible, these approaches are utilised within the pre-registration curricula.

Common leadership development approaches from within existing NHS leadership professional development programmes	
Established learning method	**How it is used and impact**
Personality and values profiling	There are many forms of personality profiling tools and also ways to help individuals understand their personal values and what drives them that are available. It is useful to explore multiple ways of seeing yourself and therefore it may be helpful not to be restricted to one approach.
	The benefit of helping students to be curious about themselves, their personality and their core values from the start of their careers will give them a framework to understand themselves, and understand and connect to others. This forms the basis of leadership development which many well established professionals often comment "I wish I had known this at the start of my career, I'd be a different leader now". This could be a core self-development activity that is built upon throughout the curricula and co-developed in light of feedback students receive from peers and supporters in practice.
360 degree feedback against a leadership model	This approach is something that is core within most leadership development programmes within the NHS. Receiving feedback will be something that students will be accustomed to within their own practice, taking various perspectives into account from those around them on how they are performing. There are a number of 360 degree feedback models in use, however the Healthcare Leadership Model does offer a way of providing evidence-based 360 degree feedback focused on being a leader.
Inclusive, diverse and inter-professional learning	Bringing together a diversity of perspectives across different professional groups and leveraging how each individual will think differently, provides powerful learning. It breaks down barriers, helping students leverage difference as a strength rather than a barrier, and evolves the ability to work in multi-professional teams as they will when they enter service. It will prepare them to be the inclusive leaders that health services need for the future.
Action learning and peer support networks focused on leadership	Building upon an inter-professional approach and working as a team, encouraging students to learn from each other, utilising action learning or similar approaches to peer support is normally a core aspect of all NHS leadership development programmes. Peer support networks are vital to being a successful professional and leader.
Delivering a change project as a team	Many leadership programmes within the NHS focus on applying all of the theory, tools and models learnt to actually delivering a change project in practice as a standard approach. This has three core benefits. Firstly, it allows students to put theory into practice and learn as a result. Secondly, it allows them to work as a change team in a safe environment. Thirdly, if the change project is based on a real service need this delivers something tangible. This also demonstrates a sense of achievement, return on investment and something that will support and enhance their CVs.

Students must be supported to be confident to grow in their own leadership styles and resilient when facing established healthcare professionals who do not recognise their own leadership responsibilities.

Educating the educators and encouraging leadership role modelling

In the original research (HEE 2015), we identified the challenges that educators and practice educators may face when supporting students to develop as leaders. One of these is that they themselves may not have had opportunities to develop as leaders. This may suggest that there is a requirement to 'educate the educators' in leadership development. This may mean developing those who support healthcare education to learn about their own leadership style, theory and tools. It may also require a large degree of culture change for professionals who may have developed their career at a time where there was less emphasis on everyone's role in being a leader in healthcare.

From exploring existing NHS leadership development best practice, it is noted that the hardest part of developing established healthcare professionals in leadership development is helping them with what we would call 'stage 1' in our leadership learning model – understanding yourself. This challenges long held beliefs around leadership and personal identity having been a long-standing professional in practice.

This variability in educator attitude to leadership was demonstrated through engagement with our students. One student shared that some practice educators she had worked with had dismissed the importance of leadership learning early in the programme which left the student disengaged and demotivated.

This challenge is not something that education providers should feel they need to tackle alone. The culture change requirements for enabling all healthcare professionals to relate to and role model leadership is clearly articulated nationally in Developing People Improving Care (NHS Improvement, 2016). However, it may be possible to seek ways to engage all educators to be both clinical professional role models, and leadership role models to students. Students must also be supported to be confident to grow in their own leadership styles and resilient when facing established healthcare professionals who do not recognise their own leadership responsibilities.

6. The Journey: Co-Designing the Evidence Base of the Leadership Learning Model

6.1 How this model and guidance has been developed

To be able to utilise our guidance in implementing the leadership learning model, we believe it is important to understand how it was developed. Building upon our original research into maximising leadership development in the pre-registration curricula (HEE 2015), a task and finish stakeholder group was established to co-produce and steer the development of the practice model and guidance. Key areas of work were identified, and workstreams were initiated to take the developments forward.

Original research foundation

Literature review

Leadership models in healthcare

Professional body expectations

Current practice

Co-production approach

Workstreams and methodological values in developing the guidance

Our workstreams focused on the following:

- **Research:** utilisation and integration of the original underpinning pre-registration leadership research (HEE 2015).

- **Literature review:** the literature concerning leadership skills required by newly qualified practitioners and how these could be developed in healthcare curricula.

- **Leadership models in healthcare:** identifying current leadership models in use in healthcare to integrate into our model.

- **Professional body expectations:** identifying the expectations of professional bodies across healthcare curricula and mapping these into our model.

- **Current practice:** identifying positive current practice including; a national scoping activity, a range of case studies of education providers' examples of maximising leadership in the healthcare curricula, as well as the best practice in how the NHS develops its leaders who are already practicing professionals.

The outputs of the final workstreams are discussed below.

Co-production methodological values-driven approach

An aim of the project from its inception was to attempt to implement the notion of 'Co-production' as part of the method of developing this guidance. Ryecroft-Malone et al (2016) whilst speaking about co-production of knowledge in the research setting, do identify that the following are all important aspects of producing knowledge in a collaborative manner:

> *'…including the valuing of both codified and other forms of knowledge; the incremental nature of work within the knowledge endeavour; the acknowledgement of the importance of the complexity of the context in which this endeavour takes place; and meaningful stakeholder participation' (p 221)*

Building on this, our approach aimed to bring about an authentic partnership and engagement with all those interested from the health and education community. We believed we needed to take a holistic approach that leveraged the multi-professional perspectives and expertise of a range of academic and practice partners. This would ensure wide reach, appeal and success of our model.

We utilised a core steering group who led key workstream areas as defined above and leveraged co-chairmanship of both an academic and practice programme lead team. The wider steering group included colleagues from higher education institutions as well as from clinical areas and NHS practitioners in leadership and organisational development. We also included partners from our key professional bodies, the Nursing and Midwifery Council and Health Care Professions Council. Input and steering into the development of the guidance was also gained from practitioners and students. All of this work was complimented by a wider steering group as well as many different forms of engagement events.

How we built the leadership learning model and guidelines

Based on our core workstreams and co-design principles outlined above, we continually built on our knowledge base so that the steering group and core design team synthesised all available data to inform our leadership learning model. When the model was developed and refined, we began to translate this into the guidelines as showcased within section 5 of this document.

6.2 Outputs of co-design workstreams

The following section provides an overview of the key learning from each of the core workstreams we undertook in designing the model and guidelines. This provides context to each of the focus lenses we considered when developing the model as an audit trail and evidence base for our proposed approach to integrating leadership learning in the pre-registration curricula.

6.3 The original research foundation

Underpinning these workstreams was the research undertaken (HEE 2015). Three Universities in collaboration with Health Education England - West Midlands Leadership Academy undertook a research project to explore leadership development at pre-registration level in non-medical healthcare curriculum (NHS Health Education England, 2016). This research had several strands which focused on scoping good practice of learning about leadership, reviewing the literature, working with stakeholders to examine their expectations in terms of two key themes: what was meant by 'good' leadership in healthcare and how should students learn about leadership?

In total, 78 stakeholders (patient service users, students, University educators, clinical staff from 8 participating NHS Trusts recruited by their level of leadership role i.e. senior strategic leaders, early clinical leaders and recently qualified staff) participated in 17 focus groups. Six healthcare professions (Nursing, Midwifery, Physiotherapy, Occupational Therapy, Paramedics and Dieticians) were represented in the study.

Key findings have been integrated into the leadership learning model and guidelines. These include the identification of leadership qualities and knowledge for leadership in practice and considerations for developing leadership learning in the curricula. From these findings, the research partnership team generated a number of recommendations. One recommendation was that leadership should be given a wider profile in courses, suggesting that along with clinical skills, students should demonstrate leadership skills in practice. It was also recommended that clinical educators should undergo leadership training, be good leaders and, therefore, act as role models. Finally, along with a number of course-related recommendations, they suggested that students should be assessed throughout courses, with ongoing monitoring of leadership development and skills acquisition.

We recommend reviewing the full research report (HEE 2015) which can be found here:

https://www.hee.nhs.uk/sites/default/files/ documents/Report - Maximising Leadership in Pre-Reg Curricula Research 2015_0.pdf

6.4 Supporting literature

There is significant literature considering healthcare leadership and its role in improving quality. Both the Healthcare Leadership Model (NHS Leadership Academy, 2013) and the Faculty of Medical Leadership and Management (FMLM) standards are informed by published reviews of the evidence (Storey and Holti, 2013, West et al 2015). Much of the evidence cited in evidence reviews is from outside healthcare and the NHS, and relates to leadership exercised through an appointed position, although there is some evidence of leadership being distributed throughout groups. In this evidence base, the ideas of leadership as a role taken up (individually or as part of a group) and management as a position are not always clearly defined.

To support the development of our model we examined the specific literature relating more narrowly to:

- Leadership exercised by students in placement, or by newly qualified healthcare professionals. We were looking for empirical evidence about leadership that was exercised, or on views about the leadership skills needed by newly qualified healthcare professionals.

- How leadership skills are developed in healthcare curricula – we were looking for published evidence.

Our findings in both of these areas were considered together with the other areas of work as part of co-designing these guidelines and leadership learning model.

A major consideration was the relationship of our work to the medical profession. There is significantly more evidence on leadership undertaken by doctors, particularly relating to quality and safety than there is for other healthcare professionals. There is also literature around the different context of post qualifying development. We restricted our review of the literature to the healthcare professions other than medicine. The Faculty of Medical Leadership and Management have established a *Tomorrow's Leaders, Today* group to address issues similar to those we are addressing here. This includes unwanted variation across medical schools in leadership development activities, and underutilisation of clinical placements for leadership learning (Peake and Swanwick, 2018).

There is scope here for collaboration with the medical profession recognising the different context but acknowledging the common purpose. These guidelines have been developed with input from the national lead for medical education to build on this recommendation arising from literature.

What leadership capability is needed by newly qualified healthcare professionals?

We found no studies that clearly addressed what leadership skills, knowledge and behaviours were required by newly qualified healthcare professionals, or students in placement.

Reviews by Careau et al (2014) and Brewer et al (2016) have both highlighted that most evidence about leadership (in healthcare education programmes, and the inter-professional literature respectively) does not define how leadership is conceptualised. This significantly reduces the value of evidence concerning the leadership learning that newly qualified healthcare professionals need.

Bayliss-Pratt et al (2013) investigated confidence in leadership among the newly qualified. In a small sample across non-medical healthcare professionals (n=59) in the West Midlands, using the NHS Clinical Leadership Competency Framework (2011), they found that confidence was highest in 'demonstrating personal qualities', and in 'working with others'. It was lowest in 'managing and improving services' and 'setting direction'. Given the roles of newly qualified healthcare professionals, these findings might be expected. They highlight the links between skills and knowledge that might relate to 'leadership' and those which are needed for professional practice – here related to personal qualities and working with others.

Maben et al (2006) found that newly qualified nurses finished their training with clear values, but they had difficulties implementing those values in practice, with factors within both the profession and the organisation more widely sabotaging them. Leadership was not specifically identified as one of the values, but the theme of a difficult transition to professional practice has been taken up widely in the literature. Ekstrom and Idvall (2015) describe newly qualified nurses in Sweden feeling 'stranded' in a team leadership role but being able to develop in role. 'Knowing

yourself' was regarded as vital in development in this first period of practice, as was the availability of personal support. Monaghan (2015) reviewed the 'theory-practice' gap in newly qualified nurses in the UK. He concluded that newly qualified nurses often lacked confidence and clinical skills needed in practice. Murray et al (2018) found similarly that the knowledge-practice gap has been widely reported relating to patient safety and practice. Magnusson et al (2017) studies delegation styles of newly qualified nurses and described the most common style as the 'do-it-all' nurse, which was an avoidance of delegation.

Meakin (2013) explored the value of the pre-registration programme for developing student nurses as future clinical leaders. She found that student nurses recognised the need to be prepared for leadership, and asked for skills to deal with difficult conversations, unexpected power struggles, challenging and dealing with inappropriate behaviour and introducing evidence into practice. These findings give some additional perspective to the confidence of newly qualified healthcare practitioners. They add to the picture of newly qualified healthcare practitioners having a difficult transition, where personal leadership skills, as an element of professional skills, are put under some strain in the pressurised environment of healthcare.

What approaches to learning could be used in leadership curricula?

There is very little decisive evidence concerning how leadership might be taught in an undergraduate curriculum, validating our ambition in developing these guidelines. This appears similar to findings in medical education. Till et al (2017) identify 'ambivalence remains about its (*leadership*) place within the curriculum and there is uncertainty about the effectiveness of timing of interventions'.

A number of studies have given case studies of educational initiatives, but there is little comparative evidence across educational approaches. Hills and Levett-Jones (2017) conducted a systematic review of the preferred teaching and learning approaches of 'Generation Y' health professional students. The outcome measure here was students' preference rather than effectiveness. Only 5 studies were found, not relating specifically to studying leadership, and findings were inconsistent across them.

Careau et al (2014) identified 250 reports of health leadership education programmes, two-thirds of which were from the USA, and only 15% of which were for undergraduates. Educational processes used varied considerably. Lecturing/didactic were the most common (27.6%) with other formats including mentoring, reflective exercises, face to face discussion groups, simulated cases, coaching, article review, and workshops. Projects were included in only 8%. There was no evidence about which delivery method was more successful for different contexts, and no detailed analysis relating specifically to the level of the learners. 68% of the programmes were uni-professional and 32% were multi-professional or inter-professional, although the difference between them was not specified. Although this review goes much wider than undergraduate and newly qualified healthcare professionals, it does show how diverse the field, and the evidence, is around formal learning.

Given the close relationship between leadership skills and 'professional skills' is more broadly understood, the literature relating to inter-professional education was considered. One significant issue for our guidance might be whether leadership learning in the undergraduate curriculum is undertaken inter-professionally or uni-professionally. Brewer et al (2016) noted that in inter-professional education, the evidence does not clearly define leadership. Lapkin et al (2013:101) reviewed the effectiveness of inter-professional education. They concluded that students' attitudes towards inter-professional collaboration and clinical decision-making ability may be enhanced through inter-professional education. However, little evidence exists in regard to whether the gains attributed to inter-professional education can be sustained over time. Additionally, the evidence for using inter-professional education to teach inter-professional communications skills, patient care objectives and clinical skills such as resuscitation is inconclusive. Attitudes and communications skills might be regarded as being significant leadership skills, so there is mixed evidence here for inter-professional learning for leadership. Similarly, Reeves et al (2017:101) concluded that inter-professional education is valued by learners and can produce positive effects in reactions, attitudes, knowledge, and skills.

Some studies were available which considered educational processes in healthcare undergraduate programmes relating to professional skills that might be considered as related to leadership. For example, Felton and Wright (2017) considered a simulated learning experience for mental health nursing students to develop complex decision-making skills. Henderson et al (2010) report the involvement of healthcare students from 14 countries in a project to engage students as leaders in helping to promote the World Health Organisation's surgical checklist. This used the Institute of Healthcare Improvement open school courses, and was established as a campaign using students, who achieved learning from it. Although several educational innovations are reported in the literature, there is no clear evidence of comparison between them. This might support variety in educational approach, as well as the need for robust evaluation.

Scurlock-Evans et al (2017) examined an issue which may be relevant to the teaching of leadership – whether learning activities should be embedded across the curriculum or concentrated in a specific module. They examined this issue relating to evidence-based practice and found no significant differences between student learning in curricula based on the different principles.

There is an emphasis on learning about patient safety and quality, particularly in the literature on medical education which, as explained earlier, has not been considered here. Leadership is widely considered an aspect of 'improvement science' although there may sometimes be an emphasis on the tools and techniques.

Armstrong et al (2017) evaluated approaches used to teach quality improvement to pre-registration healthcare professionals in an integrative review. They found only 10 studies, only 3 of which were in a UK context, and all of them report initiatives in nursing. Most of the studies reported experiential learning as the key approach, often combined with other approaches such as didactic learning, simulation, or group work. The experiential learning included being involved in improvement work, hypothetical projects, and observational activities. The review concluded that 'attributing causality to educational intervention proved difficult in light of poor methodological rigour, lack of validated tools, and complex healthcare environments'.

The importance of active learning is a theme in the literature, but there are difficulties in arranging opportunities. Jones et al (2013) reporting on the integration of quality improvement curricula in nursing education in Wales, explain that practical difficulties meant students were not expected to do a project. Some initiatives were able to support some students. For example Baillie et al (2014) report a degree programme where nurses were able to undertake a service improvement project, but advanced diploma students were not. The degree students achieved better results in terms of knowledge and confidence. Similarly, Hendricks et al (2010) report on a practical leadership programme that had limited places, and in this case was also extracurricular.

James et al (2016) report on student nurses' experience of doing a quality improvement in practice. This initiative involved all 230 final year nurses at Stirling University to undertake a project which involved at least two PDSA cycles. There was no requirement to implement a full QI project. Teaching leading up to the 'Practicum' was spread over all three years and used Institute of Healthcare Improvement open school courses. Transformational learning was achieved. The projects also seemed to developed a relationship of 'greater depth and responsibility' with qualified staff. Similarly, Christiansen et al (2010) surveyed student nurses in the North West of England who were able to undertake a service improvement project and found that placement organisations were receptive to projects. Students reported increased confidence to be able to contribute to service improvement.

The importance of mentors was highlighted in this study, although the scheme did not seem to have placed additional demands on them. In the context of newly qualified healthcare professions, the role of preceptorship has been highlighted consistently. Whitehead et al (2013) reviewed evidence from a number of countries and professions (including social worker, probation officers, and teachers) and found strong evidence of the benefits of a 'supported and structured preceptorship'. Erol et al (2016) studied the *Flying Start NHS Programme* in Scotland which had significant online content. This was welcomed, but the role of face to face mentor was key.

A number of conclusions can be drawn from the literature which are relevant, considering what leadership skills newly qualified healthcare professionals need, and how they may be developed in undergraduate education. Most of the evidence considered came from nursing rather than across all professions, but there is little direct evidence available from any of the healthcare professions.

First, the transition to practice from undergraduate studies is a difficult period, fraught with uncertainty. This period is one where clinical skills, and management skills relating to practice are developed rapidly, with the support of preceptorship. Adding additional demands to engage in leadership should be undertaken to support the transition, however need to be clearly considered as part of the developmental programme. Skills like delegation and team working which are core professional skills might be considered a priority for 'leadership' as the lines become blurred between being a 'professional', a 'manager' and a 'leader' in healthcare.

Second, the subjects of quality and safety improvement offer a clearly defined opportunity to learn leadership skills. Although there is no evidence comparing attitudes to quality improvement and leadership, quality improvement may be a term which is more clearly understood and relevant to students and newly qualified practitioners. There is evidence that the term 'leadership' is used inconsistently in education. Considering leadership in the context of service and quality improvement may offer a clearer and more relevant opportunity to develop leadership skills.

Third, inter-professional learning offers some benefits for leadership learning in undergraduate curricula. However, the evidence is still emerging, and practical issues may also be important in developing educational processes that are professional, curricula and education provider specific.

Finally, there is also some evidence that simulation, active and experiential approaches to learning about leadership are effective. Practical learning, involving workplace engagement with real quality improvement projects is widely regarded as most effective. Mentorship for leadership learning is likely to be very important within practice settings.

6.5 Established models of healthcare leadership

Regulatory bodies direct education provider programme teams to the required leadership content of their courses. This guidance provides a framework for what content they could include. However, there will always be some scope to interpret these requirements to meet local need, resources and learning opportunities. Furthermore, course developers can take account of the wider guidance available to them. For example, in 2011, the NHS Leadership Academy published the Clinical Leadership Competency Framework. This framework outlines five domains: demonstrating personal qualities, working with others, managing services, improving services and setting direction. Each domain contains four elements that describe what clinicians should demonstrate from the level of a student to an experienced practitioner. Course teams can use the Clinical Leadership Competency Framework alongside regulatory requirements to develop their courses, including the development of the focus on student learning about leadership in practice.

Acknowledging that there are many models that define healthcare leadership, The Healthcare Leadership Model (NHS Leadership Academy 2013) was then established. It was holistically redeveloped taking a wide-ranging evidence base. It acknowledged that a total refresh was needed to develop a multi-professional model that was relevant for all leaders working in healthcare and to supersede existing silo-professional models. The Model "…is useful for everyone – whether you have formal leadership responsibility or not…. It applies equally to the whole variety of roles and care settings that exist within health and care". It therefore applies to newly qualified healthcare professionals as well as to more senior clinicians. The Healthcare Leadership Model is arranged around 9 dimensions, and each dimension has four levels: essential, strong, proficient, and exemplary.
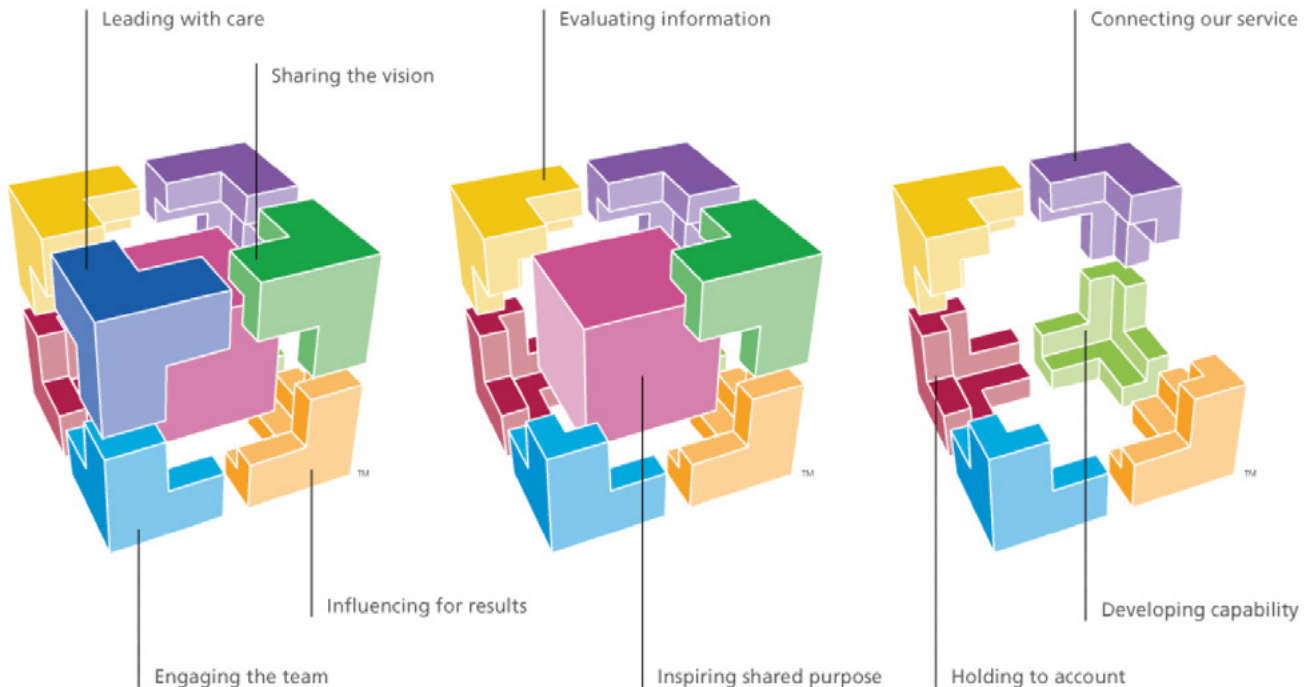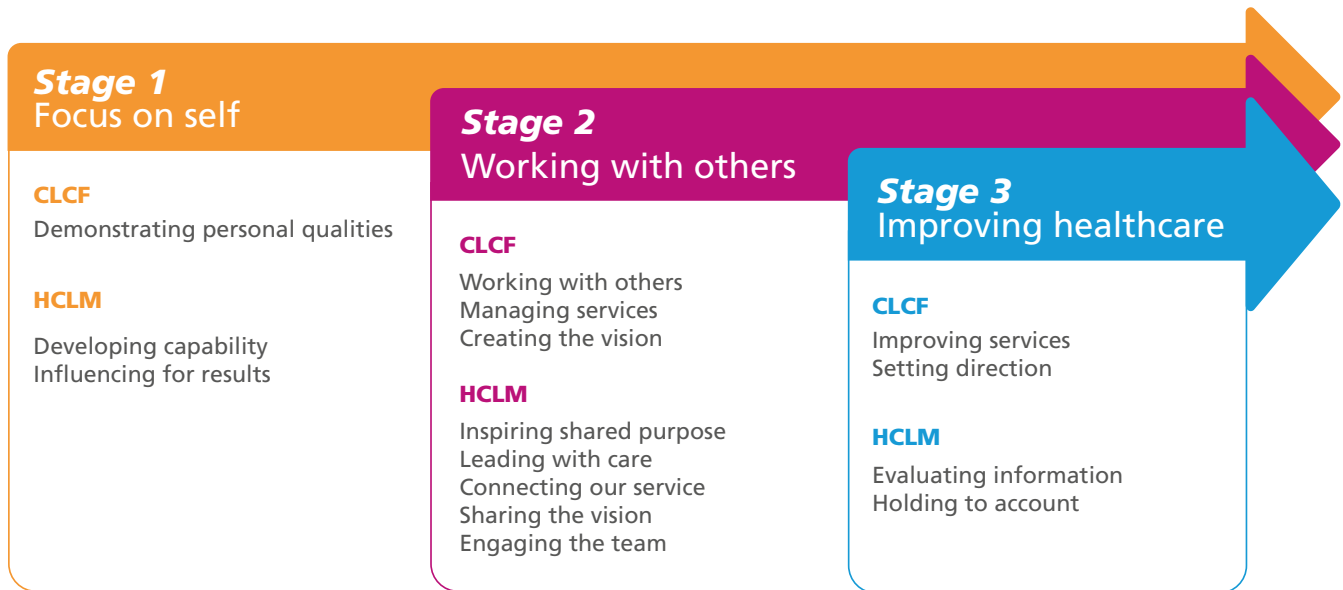

Healthcare Leadership Model (NHS Leadership Academy 2013)

More information is available:
www.leadershipacademy.nhs.uk/resources/ healthcare-leadership-model including how to access a self-assessment and 360 degree feedback tool.

The Healthcare Leadership Model and Clinical Leadership Competency Framework have been mapped into our leadership learning model and guidance. There will be areas within these models that are not as visible in our guidance.

It is specifically for those developing leadership elements within the pre-registration curricula for students, and towards registration as newly qualified healthcare practitioners and leaders. However, we have mapped these models to the 3 stages of our model broadly as follows:

Stage 1
Focus on self

CLCF

Demonstrating personal qualities

HCLM

Developing capability
Influencing for results

Stage 2
Working with others

CLCF

Working with others
Managing services
Creating the vision

HCLM

Inspiring shared purpose
Leading with care
Connecting our service
Sharing the vision
Engaging the team

Stage 3
Improving healthcare

CLCF

Improving services
Setting direction

HCLM

Evaluating information
Holding to account

The 3 elements of leadership development mapped to the Clinical Leadership Competency Framework (CLCF) and the Healthcare Leadership Model (HCLM)

The Healthcare Leadership Model emphasises the importance of self-awareness and other personal qualities but does not highlight them separately. Instead, you will find them throughout the various dimensions. In our model we do highlight the importance of ' 'focus on self' as the first stage. This reflects the importance of self-awareness in professional education and standards, and also that leadership exercised by newly qualified staff is likely to rely very heavily on personal impact, rather than positional authority. We also highlight working with others, particularly in the context of teams. 'Engaging the Team' is one of the Healthcare Leadership Model's 9 dimensions, but

the behaviours described imply the context of a team leader – for example in the reference to 'my team'.

The Faculty of Medical Leadership and Management have published standards for leadership and management, and they too highlight the importance of teams, including being a member of a team: medical leaders 'know when to lead and when to follow' (FMLM 2016). Newly qualified healthcare professionals will be members of teams, and will work with others outside formal teams, and we describe the leadership they can exercise in these contexts.

Finally, we also highlight the importance of healthcare improvement – particularly in quality and safety. Improvement methods, specifically those associated with process improvement, have been applied in the NHS for nearly 20 years, and emphasise the importance of staff engagement. The interlink between improvement and leadership skills are clearly outlined within the NHS Developing People Improving Care (2016) national strategy. Donald Berwick, a pioneer in this field, wrote a report for the Department of Health (National Advisory Group on the Safety of Patients in England, 2013) in which he suggested that all front-line staff should have basic improvement skills including, for example, identifying problems and mapping processes. The subsequent national framework for action on improvement and leadership development (National Improvement and Leadership Development Board 2016), does highlight knowledge of improvement methods as one of 5 conditions "common to high quality systems" and develops action plans to advance this condition. This includes embedding "improvement and leadership development in curricula, revalidation and award schemes".

There are many models and tools to support healthcare quality and service improvement, which can be integrated into healthcare curricula, including those within the Handbook of Quality and Service Improvement Tools (NHS Institute for Innovation and Improvement, 2010).

> **NHS Improvement also hosts an 'Improvement Hub' which has a large variety of quality and service improvement tools and modes and can be found here:**
>
> **https://improvement.nhs.uk/ resources/quality-service- improvement-and-redesign- qsir-tools/**

6.6 The expectations of professional, regulatory and statutory bodies

Standards of professional, regulatory and statutory bodies (PRSBs) clearly identify the requirement for leadership and management competencies to be embedded in the initial education of all healthcare professionals. At the point of registration, all must have a clear understanding of their personal leadership and management responsibilities. This is alongside behaviours expected as a healthcare professional, including how to be a strong member of a multi-professional team. Pre-registration education curricula must therefore include the development of the relevant knowledge, skills and behaviours. To this end, eight key domains were identified from the professional, regulatory and statutory bodies' regulations and which we suggest are required by all or the majority of the registrant bodies. These informed our guidelines as articulated within '5.4.2 Phase 2: What to deliver' section of our guidance, and are as follows:

- Leading self and others.
- Openness and accountability.
- Communicating for influence.
- Teamwork.
- Delegation.
- Quality and service improvement.
- Managing risk.
- Project planning, monitoring, evaluation and spread.

Importantly, pre-registration students are expected to 'demonstrate' ability across these domains, indicating the need for the teaching and practical assessment of applied leadership and management competences and behaviours.

Further leadership and management development will be required as part of the continuing professional development for newly qualified healthcare professionals, linked to future career aspirations. This continuing professional development will then engage and build on the competencies and behaviours explored in the pre-registration phase. It will ensure that individuals have the depth of knowledge and experience to succeed within complex healthcare environments and their wider systems.

To determine the requirements of registrant and professional bodies for healthcare professions and the higher education regulator, a review of all relevant standards was undertaken. This enabled a comprehensive understanding of the key themes required for pre-registration applicants, determining a quality or domain to enhance leadership or management skills. The standards required were clearly available from professional, regulatory and statutory bodies main websites and no further literature searches were undertaken. Some standards were unavailable due to a review taking place by the professional body and previous standards were withdrawn from public accessibility. The new draft NMC standards for Nursing were also included as a comparison (NMC 2018), noting that at point of analysis they were still in consultation period.

The PRSBs included in the review were:

1. Health and Care Professions Council (HCPC) – covering all allied health professionals.

2. Nursing and Midwifery Council (NMC) - covering all registered nurses and midwives.

3. General Medical Council (GMC) – covering all medical doctors.

4. General Dental Council (GDC) – covering all roles within the registered dental healthcare team.

5. General Pharmaceutical Council (GPhC) - covering all roles within the registered pharmacy team.

6. Quality Assurance Agency for Higher Education (QAA) – benchmark statements for healthcare professions.

7. Chartered Society of Physiotherapy (2013) *Physiotherapy Framework.*

8. College of Operating Department Practitioners (2017) *BSc(Hons) in ODP Curriculum Document.*

9. College of Paramedics (Sept 2017) *Paramedic Curriculum Guidance 4th edition.*

10. Institute of Biomedical Science (2015) *Good Professional Practice in Biomedical Science.*

11. Royal College of Occupational Therapy: (2017) *Career Development Framework: Principles of Occupational Therapy.*

The documents included in the review were:

Regulators:

1. **General Dental Council** (May 2015) *Preparing for practice: dental team learning outcomes for registration Revised edition* **www.gdc-uk.org**

2. **General Medical Council** (July 2015) *Outcomes for graduates (Tomorrow's Doctors)* **www.gmc-uk.org**

3. **General Pharmaceutical Council** (May 2017) *Standards for pharmacy professionals* **www.pharmacyregulation.org**

4. **Health and Care Professions Council** (2016) *Standards of conduct, performance and ethics* **www.hcpc-uk.org**

5. **Health and Care Professions Council** (2013) *Standards of Proficiency – Arts Therapist* **www.hcpc-uk.org**

6. **Health and Care Professions Council** (2014) *Standards of Proficiency – Biomedical Scientist* **www.hcpc-uk.org**

7. **Health and Care Professions Council** (2013) *Standards of Proficiency – Chiropodist / podiatrists* **www.hcpc-uk.org**

8. **Health and Care Professions Council** (2014) *Standards of Proficiency – Clinical Scientists* **www.hcpc-uk.org**

9. **Health and Care Professions Council** (2013) *Standards of Proficiency – Dietitians* **www.hcpc-uk.org**

10. **Health and Care Professions Council** (2013) *Standards of Proficiency – Occupational Therapist* **www.hcpc-uk.org**

11. **Health and Care Professions Council** (2014) *Standards of Proficiency – Operating Department Practitioners* **www.hcpc-uk.org**

12. **Health and Care Professions Council** (2013) *Standards of Proficiency – Orthoptists* **www.hcpc-uk.org**

13. **Health and Care Professions Council** (2014) *Standards of Proficiency – Paramedic* **www.hcpc-uk.org**

14. **Health and Care Professions Council** (2013) *Standards of Proficiency –Physiotherapists* **www.hcpc-uk.org**

15. **Health and Care Professions Council** (2015) *Standards of Proficiency – Practitioner Psychologist* **www.hcpc-uk.org**

16. **Health and Care Professions Council** (2013) *Standards of Proficiency –Prosthetists / orthotists* **www.hcpc-uk.org**

17. **Health and Care Professions Council** (2013) *Standards of Proficiency –Radiographer* **www.hcpc-uk.org**

18. **Health and Care Professions Council** (2014) *Standards of Proficiency – Speech and Language Therapist* **www.hcpc-uk.org**

19. **Nursing and Midwifery Council:** (Jan 2015) *The Code: Professional standards of practice and behaviour for nurses and midwives:* Effective from 31 March 2015. **www.nmc-uk.org/code**

20. **Nursing and Midwifery Council:** (2015) *Standards for pre-registration midwifery education:* **www.nmc.org.uk**

21. **Nursing and Midwifery Council:** (2015) *Standards for pre-registration nursing education:* **www.nmc.org.uk**

22. **Quality Assurance Agency for Higher Education:** Subject Benchmark Statements **www.qaa.ac.uk**

   a. Audiology (2006)

   b. Arts Therapy (2006)

   c. Clinical Psychology (2004)

   d. Dental Care Professions (2005)

   e. Dietetics (pre-registration) (2017)

   f. Midwifery (2001)

   g. Nursing (2001)

   h. Occupational Therapy (2001)

   i. Operating Department Practice (2004)

   j. Orthoptics (2001)

   k. Paramedic Science (2004)

   l. Physiotherapy (2001)

   m. Podiatry (20010

   n. Prosthetics and Orthotics (2001)

   o. Radiography (2001)

   p. Speech and Language Therapy (2001)

Professional Bodies (separate guidance documents on pre-registration education standards):

1. **Association of Clinical Scientists:** see HCPC Standards of Proficiency – Clinical Scientists

2. **British Association of Arts Therapist:** see HCPC Standards of Proficiency – Arts Therapist

3. **British Association of Prosthetists and Orthotists:** see HCPC Standards of Proficiency –Prosthetists / orthotists

4. **British Dietetics Association:** see HCPC Standards of Proficiency – Dietitians

5. **British Medical Association:** see GMC guidance

6. **British and Irish Orthoptics Society:** see HCPC Standards of Proficiency – Orthoptics

7. **British Psychological Society:** see HCPC Standards of Proficiency - Practitioner Psychologist

8. **Chartered Society of Physiotherapy** (2013) *Physiotherapy Framework.* **www.csp.org.uk**

9. **College of Operating Department Practitioner**s (2017) *BSc(Hons) in ODP Curriculum Document.* **www.unison.org.uk/uploads**

10. **College of Paramedics** (Sept 2017) *Paramedic Curriculum Guidance 4th edition* **www.collegeofparamedics.co.uk**

11. **Institute of Biomedical Science** (2015) *Good Professional Practice in Biomedical Science* **www.ibms.org**

12. **Royal College of Nursing:** See NMC guidance

13. **Royal College of Midwifes:** See NMC guidance

14. **Royal College of Occupational Therapy:** (2017) Career Development Framework: Principles of Occupational Therapy **www.rcot.co.uk**

15. **Royal College of Speech and Language Therapists:** see HCPC Standards of Proficiency – *Speech and Language Therapist*

16. **Society of Radiographers:** (January 2013) *Education and Career Framework for the Radiography Workforce Indicative Curriculum for Practitioners 3rd edition* **www.sor.org**

Each document was reviewed and interpreted to ascertain its relevance. In order to achieve this, the standards were interrogated to establish the meaning within the sub-section. There is a likeness between leadership and management in the pre-registrant field and only some bodies have specific leadership and management sub-sections within their documents.

The domains determined from this review cover the wide aspect of qualities, skills and attributes required by pre-registrant applicants who are still continuously developing themselves into their profession. The domains will provide insight and guide the individuals to have a basic set of skills required of professionals in their newly qualified stages.

In all the standards considered in this study, the eight leadership and management domains identified were positioned within a curriculum framework which could be broadly divided into four key themes:

1. **Clinical skills and knowledge.**
2. **Professionalism and values.**
3. **Communication skills.**
4. **Leadership behaviours and management skills.**

Each theme has a set of core requirements as defined by the profession and there is significant overlap between them all. A competent practitioner must have clinical expertise within their scope of practice, with advanced communication skills, with both patients and colleagues. They must practice within the standards and values of their profession and organisation, working to positively influence patient care and multi-professional team delivery. This should be evidence-based practice - all within complex and high-pressure environments, where in many cases, decisions may have life and death consequences.

The foundations of a competent and confident practitioner sit in the middle where all four themes harmonise, giving the potential for high quality, patient/service user focused care. Registration as a healthcare professional requires students to develop a broader set of skills, knowledge and behaviours; having the clinical knowledge and skills in itself is not enough. This is perhaps not surprising as healthcare is a human occupation operating within the culture, social norms, legal frameworks and expectations of the society it serves. Healthcare professionals therefore, must develop the attributes and personal resilience to enable them to be effective practitioners within this complex system which requires them to be both leaders and followers. They need to be responsive to people's expectations while espousing evidence-based practice and operating within the financial and management regime of their organisation, all of which may be contradictory. This clearly articulates how the skills and behaviours of being a leader are already fundamentally part of being a healthcare professional.

As a registered professional, they are personally accountable for the people in their care, but do not control or can effectively influence all the factors which affect that care. They must deliver patient-centred care whilst working within multi-professional teams of both peers and hierarchy, navigating up and down power structures, politics and professional cultures, whilst remaining 'team-players'. Decision-making needs to be balanced and objective, whilst demonstrating compassion and personalised care, within a system with increasing demand and a finite supply.

Newly qualified healthcare professionals need to be developed and supported to understand and prosper within this environment, regardless of whether they aspire to a formal management role.

The standards categorised within the eight domains identified in this study do not reference any specific leadership/management literature but tend to focus on a management function or task.

For example:

> **"Make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care."**
>
> (NMC 2015 The Code: Professional standards of practice and behaviour for nurses and midwives)

> **"Demonstrate ability to build team capacity and positive working relationship and undertake various team roles including leadership and the ability to accept leadership of others."**
>
> (GMC 2015 Outcomes for graduates)

> **"You must work in partnership with colleagues, sharing your skills, knowledge and experience where appropriate, for the benefit of service users and carers."**
>
> (HCPC 2016 Standards of conduct, performance and ethics)

Therefore, this guidance and leadership learning model acknowledges and includes the range of key leadership behaviours and management knowledge, skills and behaviours which are critical for healthcare professionals delivering high quality patient care. They can be incorporated into programme design, in accordance with all professional, regulatory and statutory body requirements.

6.7 Current practice: leadership learning in action

One of our critical areas of primary research was to understand current best practice in leadership development. We separated this into three key areas:

- **Current education provider leadership development practice:** what best practice in leadership learning is already taking place? How should this inform our model?

- **Engagement with NHS leadership development practitioners:** How does the NHS develop leaders in practice at various stages of their professional careers? How can this inform leadership developing at pre-registration?

- **Engagement with students:** What can students who are undertaking leadership learning at pre-registration tell us to inform and shape our leadership learning model and guidance?

The following section outlines our learning from this workstream into best practice in more detail.

Scoping the existing leadership development practice of education providers

During 2017, the NHS Leadership Academy looked to establish a baseline as to what was already happening across the pre-registration clinical healthcare curriculum in terms of leadership development activity. The first stage

was to develop a database which pulled together details of the Universities and organisations currently supplying the NHS with its workforce and to then consider the range of courses and programmes offered. This created a data set containing over 600 courses across 88 institutions. In all, 213 individuals were contacted across 88 institutions. Each education provider contacted was asked about the extent to which leadership figures in the curriculum of students studying for a health career. In addition, they were asked if they knew of any innovative practice or if any materials from the NHS Leadership Academy were used.

41 institutions responded and many covered multiple courses of differing healthcare disciplines. Not everyone gave a detailed response. However, 21 responses covering 26 programmes carried very detailed information and some supplied module outlines or handbooks. It was found that the module was often applicable to more than one course. For example, a University would have a common module for different disciplines of nursing which would be contextualised.

Follow up emails and phone calls were undertaken with a very few organisations who said they did not include leadership at all. On further investigation, it was not that they didn't include leadership development, it was more that they didn't overtly promote it as such or badge it as leadership to the students. In these organisations, the leadership activity was found to be topics like teamwork, problem solving and communication skills.

Across everything that was found, leadership learning was most evident in nursing and midwifery programmes and it was here that whole modules seemed to be most prevalent. Usually, a combined Leadership and Management module. Other professions had a generic module on quality management which incorporated a significant leadership element.

Outside of dedicated modules, the largest leadership content was found in programmes where leadership figures in the assessment of the module or demonstrating leadership was a specific learning outcome.

By contrast, the least content – or none at all – was found in areas where the programme is a secondary or post graduate qualification. Further

exploration revealed that this was identified because the programmes were generally shorter and therefore had a more 'crowded' curriculum but also that leadership could already have been covered in previous programmes of study by this group of students.

Leadership already figures in a considerable number of undergraduate health professional programmes delivered nationally as outlined previously. This ranges from a rudimentary level of developing a specific skill through to assessed modules dedicated specifically to leadership and management. Where the input was solely individual sessions, these related to topics such as teamwork or effective communication which enhanced other aspects of what was being covered in the curriculum at that time. Our investigation found that almost every University we contacted had 'leadership' within its curriculum somewhere. What was variable was the extent to which it was badged and foregrounded within programmes. Interestingly, the ones who initially stated that they did not teach leadership in the curriculum, on investigation, were able to identify specifics as given above. It was not, however, explicitly named 'leadership'.

Of all the professional courses considered, it is nursing and midwifery where leadership is embedded most within the curricula, often with a final year module on leadership and management being cited.

Case studies of education provider leadership development best practice mapped to the leadership learning model

The following case studies from the original research (HEE 2015) and the scoping undertaken in the workstreams, have been identified as good practice and shared here to demonstrate 'it can be done'. They illustrate how leadership learning is already being considered in many healthcare curricula.

Key: *Where possible, aspects of the model (i.e. 3 stages, 3 phases and 10 principles) have been mapped to the case study in […] to demonstrate how the model is working in practice.*

Coventry University

The Collaborative Curriculum in Coventry University is underpinned by the centrality of inter-professional leadership development to pre-registration curricula across all health profession courses [Principle 5]. This innovative approach threads leadership competencies throughout all three years of the undergraduate curriculum [Stages 1, 2 and 3].

The undergraduate Collaborative Curriculum aims to reflect contemporary practice issues and spans 2, 3 or 4 years according to the relevant professional course structure [Principle 1]. The curriculum was developed from previous success with an inter-professional learning pathway [Phases 1, 2 and 3]. The Collaborative Curriculum is composed of 5 modules, which embrace the main themes that are central to the development of collaboration in health and social care. The collaborative modules are delivered across the participating health professional courses in a range of delivery methods [Phase 3]. They will engage with the overarching themes of communication, cooperation and collaboration, and at each level, the associated integrated collaborative capability framework.

The final module, "Working Together to Lead Service Improvement" [Stage 3], aims to support students to ongoing reflection so that they can take up leadership roles as reflexive practitioners. The intention is that students are supported to gain a commitment to ongoing reflection and learning. They will underpin their development as competent health and social care professionals to take up leadership roles as reflexive practitioners in complex service delivery environments. Students are supported to work in small inter-professional teams. These teams are normally made up of students from at least three different pre-registration professional courses [Stage 2/3, Principle 5] with local communities, patient, carer and service user groups [Principle 9 and 10] to develop service improvement proposals, which can produce positive, measurable improvements in person-centred care. Student teams produce a project proposal, which is assessed by staff and other student teams with contributions to that assessment from patient, community and service groups.

Students are exposed to self and team development activities and tools which allow them to explore and reflect upon their own professional identity, leadership competency, and increase their self-awareness [Stage 1 and 2]. Individual students then produce a critical analysis of their own team's work and their own contribution to successful collaborative inter-professional practice. The themes underpinning success are inter-professional collaboration, an understanding of "leadership" sympathetic to the tensions within health and social care, relational practice and systems thinking, and a solid underpinning in improvement science [Principle 7 and 8].

The collaborative curriculum responded to feedback gained from students and is foregrounding a framework of communication, cooperation and collaboration. This is within a values-based curriculum implemented through enquiry-based learning [Principle 7]. An underlying focus on patients, on deep change in health and social care through inter-professional [Principle 5] patient-focused collaboration [Principle 10] is immensely significant and understood as applied leadership thinking.

The integration, and propagation, of inter-professional leadership across curricula is not an overly simplistic implementation of "leadership training" but a more nuanced and purposeful understanding of leadership contextualised to health and social care. It is also fully congruent with the conclusions of the HEE (2016) research into leadership in the pre-registration curricula. In the development of the collaborative curriculum, Coventry University can evidence creativity, inter-professional cross-boundary working, compassion and reflexivity. Through strategic networking and intelligence gathering, strategic awareness around leadership and service transformation in health and social care has been developed. The attempt to move curricula towards enquiry-based learning is a cardinal indicator of the University aspiration for pedagogy to match the needs of the health and care sectors for empowered, critical thinkers who can embrace and promote radical change, and service transformation [Principle 7]. The following generative questions are used to sustain continuing development:

- Every struggle in practice is an opportunity for learning and research – how can we help our practice colleagues?

- Are there teams in practice, with whom we could work on service improvement?

- Would our colleagues value the chance for CPD development through this work?

- How can we work with practice partners, and patients and carers, to develop service improvement challenges for students?

This will be developed further through reflexive pedagogy as further modules are implemented through the initial several year roll out. There are aspirations for patients and service users, and our communities, to be commissioners of the service improvement projects undertaken by student teams.

The leadership focus is maintained through an inter-professional, cross-faculty virtual leadership team, or community of practice. The curricula should be ever-changing and reflexively responsive to the needs of partners and students. In organisational development as much as pedagogy, real learning comes from questions rather than answers.

University of East Anglia

The University of East Anglia have incorporated leadership into two programmes for paramedics and show close synergies with the principles above.

They have two paramedic programmes; a work sponsored diploma in higher education and a direct entry BSc. Embedding leadership, mentorship and quality improvement into the paramedic programmes has been a high priority to help develop the culture for paramedic students. The job isn't all about acute and trauma patients as many people think. A large proportion is centred around the needs of an ageing, rural population, so the need for leadership skills is just as important as the clinical and technical skills of the profession. It is not just about physical health either, mental health is increasingly more predominant in the workload, requiring a different kind of leader.

There is also an advanced practice programme across the faculty. They are introduced to leadership around week 15 [Principle 1 and 4]. Their learning is formed of an interactive session based on the Healthcare Leadership Model [Principle 6] which is both interactive and fun [principles 3 & 7]. It uses popular culture with reference to Dragon's Den to show examples of influencing as well as getting the students to self-assess. Students also undertake the online NHS Leadership Academy Edward Jenner Leadership Foundations programme to gain a certificate

of achievement which builds into a portfolio of evidence and reflections [Principle 3 and 7]. There is an element of inter-professional learning around relevant topics such as falls prevention and dementia training [Principle 5]. There are plans to expand this in the future as the curriculum allows.

For the BSc, leadership is formally introduced towards the end of year three, along with mentorship, clinical supervision and service/ quality improvement. This may seem late, but it is the formalised approach to leadership. The students will have been undertaking leadership development such as effective teamwork, problem solving and communication since the beginning [Principle 1]. This is the part of their programme where they are moving into the leadership space and this fits well and is most appropriate at this time. Again, in line with the principles, the module is interactive and scenario based and students are encouraged to complete the Edward Jenner Programme. The need for interactive learning is key. Students have fed back that they work on problem-based learning using scenarios which are different for each cohort but include major incidents and team working. The students are asked to answer questions such as, "so what would you do if x happened?" and "how would you do y and z?". The students are additionally working on a service improvement proposal at this stage and as a result will have already been thinking about change [Stage 2 and 3].

Inter-professional learning takes place throughout the programme [Principle 5] within all faculty professions including medicine and pharmacy, and includes inter-professional shadowing. Future developments plan to include fitness to practice role play in the same way that the nursing faculty currently do in their leadership content.

Feedback from organisations hosting placements about the students and their abilities has been very positive, with comments on the maturity of students and their ability to make difficult decisions. It is also really important that leadership is not minimised once students have qualified, this is just the next phase of their development. The University is considering support for newly qualified practitioners and a new two-year newly qualified programme to support in the transition from being a learner to becoming newly registered.

Keele University

Keele's School of Nursing and Midwifery has an undergraduate pre-registration curriculum which foregrounds the Nursing and Midwifery Council's (2008) Domain of Leadership, Management and Team Working and is innovative in the integration of practice and theory across the programme [Principle 1, 2 and 3]. The teaching of leadership, management, and team working - although a distinct domain - is delivered widely within the other domains and fields of nursing [Principle 5]. Inherent in this design is the concept of reflection which allows students to develop solution focused skills across modules, again facilitating the integration of theory and practice [Principle 8]. Some of the key innovations in the programme include:

- Modules allowing integration of theory and practice learning outcomes and reflective learning on the development of leadership attributes [Stage 1].

- Assessment of leadership abilities formatively and summatively in practice throughout the programme. This includes milestone assessments where students develop skills and knowledge to lead holistic management of care need using a multi-disciplinary approach [Principle 5, 7 and 8].

- A team-working project which allows students to link theoretical ideas about leadership to the actual development of their project. This has been shared with Directors of Nursing across the region [Stage 2 and 3].

- A practice-based dissertation which enables students to consider ways to lead and improve service within their specific area of interest [Stage 3].

- The attainment of an accreditation by the end of the programme of the Institute of Leadership and Management (ILM) award through work in the Distinctive Keele Curriculum.

- The ability to represent their fellow students as part of school committees and the potential to be involved in a range of volunteering and ambassadorial opportunities [Principle 4, Stage 2].

- Participation in faculty inter-professional education with midwifery students, medical students, physiotherapy students and pharmacy students. This develops the understanding of roles across all the Multi-Disciplinary Team, essential in leadership and team-working [Principle 5].

- The leadership, management and team working domain across the three years includes learning about the role of the registered nurse in leadership, theories of leadership and management, behaviours and values, the NHS Leadership Academy, transactional and transformational leadership, authentic leadership, team working and leading a team, skills of delegation, persuasion, and negotiation and leadership in developing quality [Stages 1, 2 and 3].

Midwifery education is also designed according to standards set by the NMC and focuses on students learning to deliver woman centred care. In addition, leadership and management within the undergraduate pre-registration midwifery programme follows the guidance from the distinctive Keele Curriculum and the NHS Leadership Academy. The content builds over the 3 years from a concentration on the development of personal qualities in year one [Stage 1], to an emphasis on working with others in year two [Stage 2]. In the final year, the focus centres on the midwife as leader in understanding services, responding to quality issues and improving services [Stage 3]. Innovations across the midwifery programme include:

- Personal skills development and learning around time management, assertion, negotiation [Stage 1 and 2].

- Developing clinical decision-making through practice scenarios.

- Quality, risk assessment frameworks and tools for investigations of adverse incidents to include whistle blowing and raising concerns.

- Statutory supervision.

- Framework for the management of the maternity services/staffing levels [Principle 2].

- Shadowing clinical leaders to develop clinical leadership ward management [Principle 9].

- The process of audit for service improvement [Stage 3].

- Café style service improvement work [Stage 3].

The School of Health and Rehabilitation at Keele University embeds leadership teaching and learning in academic sessions and practice from the first to final year of physiotherapy study in the pre-registration programme. Leadership is embedded within two main strands of teaching of the BSc (Hons) Physiotherapy programme; professional practice (4 modules across 3 years of UG programme) and the practice-based component (7 placements of 1-5 week duration over the 3 years of the programme) [Principle 1]. The integration of leadership across years and modules of teaching both within the academic setting and the clinical setting means that the concept and relevance of leadership is introduced in several modules. It is reinforced and developed across the spiral curriculum of the three years of the programme [Principle 1].

In the first year, leadership is introduced within the teaching associated with the professional and regulatory body frameworks [Principle 2]. A 'patient experience day' also runs in the first year allowing patients to share their experiences (good and bad) of being assessed and treated by health care professionals [Principle 10]. The concepts of leadership, clear and effective communication, clarity about direction and prognosis are often discussed during the day [Stage 1]. This is developed further and integrated within Preparation for Practice sessions in the second year. The CSP Rules of Professional Conduct and CSP Code of Professional Values and Behaviour are discussed and reinforced with case scenarios to challenge the student to apply the professional requirements. Patient scenarios require the student to consider and apply what they have learnt about leadership [Principle 10]. Within the second year, the qualities of effective leaders, various models of leadership and theories around the development of leaders are reviewed [Principle 2 and 6]. Students are introduced to the Leadership Academy of the NHS and the NHS leadership framework is examined [Principle 6]. This knowledge is then integrated into a clinical context as students are made aware of how therapy managers and senior staff are required to implement the leadership framework within health policy [Principle 4]. To ensure this aspect of leadership is valued by students, this aspect is directly linked to a module assessment [Principle 8]. Students are required to identify a national or local trust policy and write a report based on a local practice/procedure encountered

whilst on clinical placement. A reflection based on their experience(s) of the application of this local practice/procedure is the final aspect of this second-year assessment. The focus on leadership is expanded further within the Professional Practice Strand in the final year of physiotherapy study within the academic setting. Emphasis is placed upon leadership being a part of lifelong learning and especially in clinical practice [Principle 1, 2 and 4]. Led by a local Allied Health Professional (AHP) Lead and Therapy Manager, students are required to identify and debate areas for service developments, evaluating optimal ways to improve the service via audit/ service evaluation methodology [Stage 3]. This is further explored within another third-year practice placement, where students document a report relating to a service improvement from the perspective of patient, clinician, manager and commissioner. The student then defends and justifies their report in light of best evidence from the literature in an oral examination [Stage 3]. Throughout the third-year practice-based component, student leadership and management skills are assessed and graded by practice educators. Additional faculty and university opportunities exist for all undergraduates to participate in cross faculty inter-professional learning where leadership opportunities are often taken up by physiotherapy students [Principle 5].

The University of Worcester

In the undergraduate curricula, various approaches to leadership development are taken. The Academic unit of Nursing, Midwifery and Paramedic Science each take individual but similar approaches to incorporate leadership into the curriculum. The academic unit of Health and Applied Social Sciences (including both Physiotherapy and Occupation Therapy) works collaboratively to educate students in leadership and ensure these skills upon qualification [Principle 5].

Nursing Leadership theory and applied leadership learning is spiralled throughout the curriculum, and learning is evidenced by all students and assessed in every module [Principle 1 and 5]. There is no individual leadership / management module and the nursing students no longer have generic modules, including students from other courses such as midwifery. The approach to leadership is developmental – and becomes

more applied as students progress throughout the course [Principle 1 and 2].

In the first year, most of the content is focused on self-management and personal development [Stage 1, Principle 3]. For example; time management, reflective practice, teamwork theory, and the organisation and structure of health and social care. The second-year module expands on the theoretical aspects, taking a generic approach and covering various leadership theories. Then in the final year, the focus is on applied leadership within clinical settings, split into field-specific content. Assessment through presentations, posters and reflections are included throughout the curriculum, encouraging development of, reflection on, and demonstration of teaching and communication skills [Principle 8]. Teaching of leadership skills includes scenarios to work through, whereby the students are often filmed and given the opportunity to view the recording and reflect on their own skills and way of dealing with a scenario. Skills modules address leadership in depth, however are not assessed specifically. The final third-year assessment in the field specific module includes a question implemented specifically to assess students' ability to manage a situation and recognise leadership within the situation [Principle 8]. The final practice placement reflection also addresses leadership skills [Principle 8].

The entire midwifery curriculum at the University of Worcester takes an Enquiry-Based Learning (EBL) approach [Principle 7]. Throughout the programme, triggers are presented which are directly aimed at exploring and developing leadership skills. Many of these involve planning care on a ward and prioritising workload within the team, whilst focusing on a specific scenario [Principle 7]. In particular, the module 'The lifelong learner' is completed by students in year one, which develops in their second and third years of study [Stages 1, 2, 3]. Similar to the nursing programme, the first-year module focuses particularly on self-management [Stage 1]. In the second year, communication skills and developing identity within inter-professional teams are further explored. In the third year, this module accounts for their independent study [Stages 2]. In 2013, an evaluation of the programme sought students' views on how EBL had impacted upon their learning. Analysis of the questionnaires showed that the positive aspects of EBL that students were most likely to perceive were increases in critical thinking (73%), problem solving skills (68%), and leadership skills (66%). Students' leadership skills are also encouraged and developed through implementation of student-led projects whereby students take responsibility for developing and implementing a new tool for learning and teaching [Stage 3].

Physiotherapy and Occupational Therapy leadership at Worcester University is integrated as a vertical theme throughout the pre-registration curricula [Principle 1 and 2]. The concept of strengths-based leadership is introduced to students in their first week of year 1 [Stage 1]. They are encouraged to undertake a psychometric profile to identify their own strengths, weaknesses, concerns and opportunities before their first placement begins. They are given the opportunity for a one-to-one debrief with a University coach [Principle 3]. They may also choose to have follow-up meetings in the second and third year. Impact is difficult to measure; however, visits to students in practice areas have demonstrated a level of independence in practice which was not necessarily predicted so early in the programme. Physiotherapy and Occupational Therapy students share 2 main modules. 'Effective Communication and Ethical Practice' in the first year of study address communication skills and promoting positive relationships [Stage 1 and 2]. In the second year, the two groups of students complete the module 'Team Working and Enabling Others', which expands on the first-year inter-professional module. It requires students to 'reflect on styles and theories of leadership and management across a range of care settings, and explore, reflect upon and critique own experiences of team working relevant to health and/or care sectors' [Stage 2]. In addition to leadership and organisation development being integrated into the modules at all levels, and culminating in a year 3 module entitled 'Leading for Enhanced Service Delivery', extra modular leadership activities occur. These include one-to-one strengths-based coaching and interdisciplinary action learning sets in relation to their practice-based learning [Stage 3]. Students on these programmes commence clinical placements early on in their course, after only 6 weeks. In addition, instead of full-time placement blocks separated from blocks of university modules, placements are part-time and run alongside University modules. In the first year, students begin clinical placements for

one day per week, and by the end of the second year, placements are 2.5 days per week. Research suggests that experiencing placements early on in the course encourages leadership and personal responsibility within the students.

The Foundation Degree in Paramedic Science runs over 2 years. Throughout the degree, leadership is incorporated both in taught curricula and practice assessments, with a focus on leadership development, including leadership theory [Principle 1, 2 and 3]. Students in their first year of the foundation degree are introduced to leadership roles in practice and assessed on competencies around leading and managing a scene by their practice mentor [Principle 7 and 8]. In the second year, this develops to allow students to manage a scene independently [Stage 2]. In addition, during the second year of the programme, students complete a 30-credit module relating to leadership and research entitled "Research and Professional Practice". Half of this module is assessed through research and the other half is based on leadership theories [Principle 6]. For the assessment, students are required to discuss leadership elements in a given scenario and are assessed on group work [Stage 2 and 3] through a Problem-Based Learning approach [Principle 8]. The programme is innovative from a paramedic science perspective as the approach considers leadership as a core aspect of programme delivery.

Summary of practice

Differences in practice exist in all Universities showcased here; however, there are common themes that emerge:

- Leadership teaching is present at all levels of curricula and introduced early on in programmes and incorporated throughout.

- Activities are present both within specific theory and practice modules and extra-modularly. Students are able to balance learning about leadership theory, with the ability to put it into practice with significant direction towards personal reflection.

- Inter-professional working is used to emphasise leadership skill development. This approach helps students to work across boundaries and removes professional silos.

- Opportunities are made available to increase understanding of personal identity and leadership skills/qualities/behaviours, and also to enhance leadership skills development. This includes aspects such as personal impact and communication, team working, service improvement, change management and resilience.

- In addition, Universities are also incorporating best practice in leadership development such as maximising use of the NHS Leadership Academy resources (e.g. Edward Jenner e-learning, Healthcare Leadership Model Assessment). They are also adding gravitas to leadership development by gaining external accreditation of leadership content (e.g. ILM).

From review of this best practice, a positive approach emerges that supports our leadership learning model. It takes students through a journey of self-discovery, helping them initially to understand themselves as professionals and their personalities/personal identity. They move on to understand their impact on others and working in a team. Finally, they will work collaboratively on a project that encompasses inter-professional learning aspects and requires application of their leadership skills into making a positive change within real life service/practice.

6.8 Engagement with leadership development practitioners and students

Engagement and learning from NHS leadership and organisational development practitioners

As part of our aspirations to develop our students to think as leaders, we also needed to appreciate how leadership and organisational development practitioners in the NHS are developing the professional leaders already practicing within healthcare. Leadership and organisational development practitioners formed part of our steering group. Engagement events were undertaken to explore and document their recommendations for the important things to include when in pre-registration, based on their own practice of developing existing NHS staff as leaders.

This work confirmed and emphasised the importance of our 'inside out' model of developing self, connecting to others and then working on leading service change. They emphasised the importance of understanding one's personality and drivers to build emotional intelligence as a cornerstone of leadership development. This should be undertaken balancing personality and values profiling exercises, against 360-degree feedback to align self to the practice and demonstrated behaviours associated with being a leader. Ongoing curiosity through reflexivity is a further key aspect of developing as a leader.

As well as elements found within the existing Healthcare Leadership Model (NHS Leadership Academy, 2013) emphasis was given on being able to be both a follower and a leader of teams. Political awareness, understanding organisational culture and how organisations and our system is complex, and how to lead change within this environment was also seen as essential. Resilience, confidence and personal impact were also seen as important aspects.

Multi-professional learning was a key focus of leadership programmes as this was seen to break down silo working and encourage diverse and inclusive thinking. Building on this, the inclusion and diversity aspects of leadership were also fundamental, acknowledging that it is important to build on self-understanding and subsequently

being curious and appreciative of how we are all different, and how successful leaders leverage the strengths and diversity of all. Personality tools were seen as a common language that enables the appreciation of self and diversity of others. Ongoing exploration of such models acts as a positive language to connect one's self view, to how others see the world which is important when leading diverse teams.

Thoughts towards talent management were also important, acknowledging that everyone has a different and dynamic form of career potential as both a professional (e.g. clinical) 'expert' and as a 'leader' in healthcare. Individuals should be encouraged to 'grow into themselves' and their potential and actively align this to where they can flourish in their careers and for our healthcare service.

Service improvement is also seen as a core aspect of being a leader. Successful leaders understand themselves, can influence others and work as part of a successful team, whilst also having a 'change toolkit' which enables them to improve services for the greater good of patients and service users.

Finally, a core aspect running across all varieties of healthcare leadership programmes is the ability to put theory into practice. Ongoing real-life, project-based learning opportunities are seen as fundamental to solidifying and embedding learning. Where possible, these should be on projects that can demonstrate a tangible improvement to service. This not only allows for a real-life learning journey, it also demonstrates a tangible return on investment that actively changes practice and improves our healthcare services. Ideally these should be undertaken as part of a multi-professional diverse team.

Engagement and learning from students

As part of developing the model and as with the original research, it was important to get the views and input from those that this model will directly affect – our student body.

We engaged students as part of our steering group through direct engagement with the National Council of Deans of Health 'Top 150 Student Leaders programme'. Students on this programme, had been identified as high potential students, developed as part of a national student leadership approach and were able to

input, shape and refine our model through an engagement workshop.

Having been developed and exposed to leadership development in this targeted way, as part of the Top 150 Student Leaders Programme, it helped these students to advise on our model. They see that leadership learning in pre-registration is vital to their holistic development as healthcare practitioners and leaders of the future.

Students were invited to a workshop held in July 2018, and six students attended. They provided an overview of the Top 150 Student Leaders Programme and were invited to share their experiences in relation to the Learning Leadership Model we have developed.

They identified that there are a range of ways they have learned best about developing their leadership skills, knowledge and behaviours both on the Student Leaders Programme and within their own pre-registration healthcare programme of learning. They identified that the following had helped them develop their learning about leadership:

- Small group work looking at case studies of leadership and identifying leadership qualities.

- Inspirational speakers from clinical practice and linking their experiences with leadership theory.

- Group reflection and discussion activities.

- Reading recommended books.

- Identifying role models.

- Using social media to network and develop leadership contacts.

- Peer support in developing leadership skills, knowledge and behaviours.

The group were also asked to comment on the draft model and were very positive about education providers having guidance to support learning about leadership throughout their programme of study. They suggested that these guidelines would enable understanding of the importance of learning about leadership and be able to provide permission to promote how it is relevant for students, right from the start of the programme. This, they felt, would provide them with confidence to act and think as a leader. They identified that lecturers and supervisors and mentors in practice are often very open to providing learning opportunities for

them and that this framework would enhance those opportunities. They discussed the idea of equality in curricula and that this model may provide some equity for all students to consider their own learning around leadership, which they stated would result in an empowered workforce. The end result here they suggested would be in service improvement across the health sector.

The students also considered what the limitations of the implementation of this guidance may be. They suggested that it may not be accepted by all education providers and so there could be some students who could be disadvantaged if leadership learning was not highlighted within their programme. However, they also acknowledged that some students may feel that it is further pressure on them at the start of a programme of study. Another concern they discussed was that providers may deliver learning about leadership in isolation from clinical practice.

In terms of the model itself, students supported the 3 stages of the model. They felt that stage 1, 'Focus on Self', was key and that it helped to give direction, promote learning of their own personal strengths and limitations and encourage personal growth. They also suggested that this stage would enable the development of resilience and identify that they needed to keep healthy in the broadest sense themselves. They identified that it was important to keep reflecting on self and one's own development throughout the programme of study.

When discussing stage 2, 'Working with others', they identified the importance of creating a compassionate culture and understanding when others are finding a situation stressful and helping them whenever possible. They stated that working inter-professionally was necessary as they had to 'fit' into changing environments during their programme and that adapting to these environments and to working with a range of people was important. Learning about others they suggested, was just as important as learning about themselves.

In relation to stage 3, Improving healthcare, they identified that one could be a leader at any level to improve delivery of care and how important it was to empower students and assure their contribution was recognised and valued. They discussed ownership of activity and that if they can work in a way that embeds the values and principles of the workplace within their own

practice they will be able to work with pride and achieve improvement. They discussed how as students they had a range of fresh ideas which may lead to healthcare improvement and that it was in fact, the reason they were there. To make a difference to people's circumstances.

The student group also discussed the 3 phases of leadership learning and felt that whilst all principles (Phase 1) were important, some to them were more valuable. Students identified that 'using current leadership models to frame learning'; 'embedding multi-disciplinary leadership learning' in the programme; 'enabling development of self-awareness' and; enabling support for leadership learning in practice' were important principles to them when considering the whole curricula.

Students were positive about the range of content identified in Phase 2. They suggested making more explicit the notion of 'compassionate leadership' and highlighted the importance of inter-disciplinary learning as well as the usefulness of self-awareness tools like the Myers-Briggs Inventory. Inter-professional learning and learning in practice were considered to be those ways of learning which would be of most value to the students when they were asked to discuss Phase 3.

Students were enthusiastic and committed to developing as professionals and as leaders and discussed values of importance to them in learning about leadership. They suggested that this guidance would be helpful to programme developers and identified their commitment by confirming that they would like to be involved in any future work on this.

6.9 Synthesis of workstreams into our model

From findings of the original research (HEE 2015), the further 4 work-streams, the workshops held with the task and finish group and ongoing engagement with stakeholders, it has been possible to identify key principles of programme design, key areas of possible content and key approaches to support learning and teaching. These have been synthesised into our leadership learning model to support curriculum development to maximise leadership learning.

7. Future Steps

7.1 Building a leadership development toolkit to support Universities

The leadership learning model and guidelines provide a direction and principles for developing leadership learning in the pre-registration curricula, based on a range of work undertaken to identify areas of good and effective practice.

The steering group and variety of stakeholders engaged in co-designing these guidelines recognise that the production of a toolkit to include useable resources, would be helpful to education providers in their journey to implement leadership learning in their curricula. It is anticipated that this will be part of 'next steps' in our endeavours to enhance our teaching and learning around leadership and to continue our journey of co-production.

7.2 Ongoing review and evaluation

The health service is rapidly changing and new ways of working across professional boundaries are developing at pace. Evidence on best ways of learning about leadership are also developing. This guidance will require a cycle of evaluation, review and improvement in line with the changes that occur in healthcare and education. The aim is to evaluate and review on a regular cycle to assure currency. It is proposed that this will be undertaken over a 5-year lifecycle of these guidelines through ongoing engagement with education providers.

7.3 Further research

The steering group for the development of the guidance identified a range of areas listed below where further research would be useful in supporting leadership development in the curricula.

- Evaluation of the model in practice.
- Identification of effective leadership teaching and learning approaches with long-term follow up and evaluation.
- Evaluation on role transition, student to practitioner to leader.
- Evaluation of new approaches to leadership learning and teaching.
- Identifying how prepared students feel for leadership and is it different between professions?
- Impact on the curricula – perceptions of mentors and supervisors.
- Impact on the curricula - student preparation for registration.
- What makes a workplace more or less invitational to leadership learning?
- Is there any identifiable impact of leadership development in the pre-registration curricula longer term, does it make a difference to our healthcare services and practitioners?
- What issues does the newly qualified practitioner identify and encounter in relation to their undergraduate leadership learning?

8. Contacts and Engagement

If you would like to be included in our national co-design group to both implement, evaluate and enhance these guidelines, as well as explore the development of a toolkit of resources to help implement the guidance within this document, we would be keen to hear from you.

For more information or to enquire to be part of our national group, please contact:

➤ **Website: www.hee.nhs.uk/our-work/ leadership/leadership-healthcare-pre- registration**

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18. **Health and Care Professions Council** (2014) *Standards of Proficiency – Speech and Language Therapist* **www.hcpc-uk.org**

19. **Nursing and Midwifery Council:** (Jan 2015) *The Code: Professional standards of practice and behaviour for nurses and midwives: Effective from 31 March 2015.* **www.nmc-uk.org/code**

20. **Nursing and Midwifery Council:** (2015) *Standards for pre-registration midwifery education:* **www.nmc.org.uk**

21. **Nursing and Midwifery Council:** (2015) *Standards for pre-registration nursing education:* **www.nmc.org.uk**

22. **Quality Assurance Agency for Higher Education:** Subject Benchmark Statements **www.qaa.ac.uk**

    a. Audiology (2006)

    b. Arts Therapy (2006)

    c. Clinical Psychology (2004)

    d. Dental Care Professions (2005)

    e. Dietetics (pre-registration) (2017)

    f. Midwifery (2001)

    g. Nursing (2001)

    h. Occupational Therapy (2001)

    i. Operating Department Practice (2004)

    j. Orthoptics (2001)

    k. Paramedic Science (2004)

    l. Physiotherapy (2001)

    m. Podiatry (20010

    n. Prosthetics and Orthotics (2001)

    o. Radiography (2001)

    p. Speech and Language Therapy (2001)

Professional Bodies
(separate guidance documents on
pre-registration education standards):

1. **Association of Clinical Scientists:** see HCPC Standards of Proficiency – Clinical Scientists

2. **British Association of Arts Therapist:** see HCPC Standards of Proficiency – Arts Therapist

3. **British Association of Prosthetists and Orthotists:** see HCPC Standards of Proficiency –Prosthetists / orthotists

4. **British Dietetics Association:** see HCPC Standards of Proficiency – Dietitians

5. **British Medical Association:** see GMC guidance

6. **British and Irish Orthoptics Society:** see HCPC Standards of Proficiency – Orthoptics

7. **British Psychological Society:** see HCPC Standards of Proficiency - Practitioner Psychologist

8. **Chartered Society of Physiotherapy** (2013) *Physiotherapy Framework.* **www.csp.org.uk**

9. **College of Operating Department Practitioner**s (2017) *BSc(Hons) in ODP Curriculum Document.* **www.unison.org.uk/uploads**

10. **College of Paramedics** (Sept 2017) *Paramedic Curriculum Guidance 4th edition* **www.collegeofparamedics.co.uk**

11. **Institute of Biomedical Science** (2015) *Good Professional Practice in Biomedical Science* **www.ibms.org**

12. **Royal College of Nursing:** See NMC guidance

13. **Royal College of Midwifes:** See NMC guidance

14. **Royal College of Occupational Therapy:** (2017) Career Development Framework: Principles of Occupational Therapy **www.rcot.co.uk**

15. **Royal College of Speech and Language Therapists:** see HCPC Standards of Proficiency – *Speech and Language Therapist*

16. **Society of Radiographers:** (January 2013) *Education and Career Framework for the Radiography Workforce Indicative Curriculum for Practitioners 3rd edition* **www.sor.org**