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Developing Clinical Leadership: trainees' experiences and the supervisor's role

Barbara Mason, Hannah Bowers & Margo Ononaiye.

This paper describes the findings of research exploring factors which may help or hinder the development of clinical leadership among trainee clinical psychologists, and the extent to which trainees gain experience consistent with the Leadership Development Framework.

Introduction:

Clinical leadership has become prominent in the health professions over the past decade, and leadership is now considered to be an integral part of the training of clinical psychologists (British Psychological Society, 2014).

Some of the drivers for this increased focus on clinical leadership within the profession have included the central role given to this topic in the implementation of *New Ways of Working* (BPS, 2007) and the Division of Clinical Psychology (DCP) Leadership Strategy (DCP, 2007), along with the more explicit focus on competencies expected across different grades (e.g. DOH, 2004). This is set against the context of a greater focus on clinical leadership in healthcare more broadly, with a recent development being the publishing of the Healthcare Leadership Model (NHS Leadership Academy, 2013).

In 2010, the DCP published the Clinical Psychology Leadership Development Framework (LDF), which suggests how clinical psychologists might develop and demonstrate leadership across the career span (DCP, 2010). It was designed to map onto the Clinical Leadership Competency Framework (NHS Institute for Innovation & Improvement, 2010) which considered four domains (personal qualities, working with others, managing services, improving services and setting direction), and aimed to provide a common language for understanding leadership across professional groups. Frameworks have been criticised for the reductionist approach they take to a phenomenon as complex as

leadership (e.g. Onyett, 2012); however while they may not be able to capture the complexity of leadership, they can offer a pragmatic starting point for operationalising what this complex process might look like in practice.

The LDF was developed to support clinical psychologists across all grades in their development of leadership; however anecdotal evidence suggested to us that many clinical psychologists were not aware of the LDF and that supervisors were unsure how to facilitate leadership development among trainees on their placements. Therefore, this study aimed to explore the extent to which this perception was supported by the evidence, and more specifically to explore trainees' perceptions of factors that either helped or hindered their development of leadership skills.

The specific questions were:

- To what extent are trainees getting the experiences that the LDF suggests they could be in developing their leadership competencies?
- What do trainees see as facilitating or hindering the development of their leadership competencies?

Method:

An online survey design was used for this study. The sample comprised trainee clinical psychologists registered on a clinical psychology doctorate within the East of England region at the time of the study. A purposive sampling method was used, with all trainee clinical psychologists within the region being invited to participate in the study. Invitations to participate were sent via clinical tutors from the University of Hertfordshire, University of East Anglia and University Essex training programmes.

The survey consisted of an online questionnaire developed for the purposes of this study. The questionnaire included questions relating to trainees' stage in training, demographics and types of placements completed. Participants were not asked to provide any personal identifying information,

or to identify their specific placements or training programme. Questions relating to participants' self-perceived competence in leadership together with their stated familiarity with the LDF followed. Next, participants were asked to identify which of the activities listed in the LDF as exemplars of ways in which someone at trainee grade might *develop* leadership competencies, they had undertaken themselves. Similarly, they were asked to identify which of the exemplars of activities *demonstrating* leadership they had undertaken. The final section of the questionnaire comprised several open-ended questions about factors that participants believed had helped or hindered the development of their leadership competencies.

Ethical approval for the study was granted by the University of Hertfordshire Ethics Committee.

Results:

A total of 30 trainees participated in the survey yielding a response rate of approximately 25 per cent. The modal age range was 25-29 years and 90 per cent of participants were female. The majority (80 per cent) of participants were in their first or second year of training.

Familiarity with the concept of clinical leadership and with the LDF

The majority of participants perceived themselves to have a 'basic understanding' of the concept of clinical leadership (53 per cent), with 37 per cent describing their understanding as 'good' and the remaining 10 per cent indicated that they had 'heard of it' but were not sure what it was. Only 20 per cent of participants said they had read the LDF document.

Regarding experiences trainees had had which might be seen to contribute to their *development* of clinical leadership skills, the most frequently endorsed items were those that would be expected as a part of professional behaviour or part of the clinical role anyway. For example, all respondents indicated that they had 'acted with integrity' and most (93 per cent) indicated that they had 'gained knowledge of other professionals' ways of working and service user views'. Those items that were least endorsed were those that related more explicitly to 'leadership'. For example, only 13 per cent

said that they had 'gained feedback on leadership style from [their] placement supervisor or tutors...'.

A similar pattern of responses was seen in the question pertaining to how participants had *demonstrated* clinical leadership. Here again those items in the LDF that overlapped with competencies one would expect from a trainee clinical psychologist outside of the context of 'leadership' were endorsed by more participants than those that are more specific to 'leadership'.

There was a significant positive correlation ($r_s=.633, p<.001$) between the number of items endorsed by participants on the LDF and their self-perceived understanding of leadership. The more experiences trainees indicated they had had, the greater their self-perceived understanding of leadership. Participants rated their understanding of leadership prior to seeing and responding to the list of leadership experiences. This suggests that this correlation was not merely an artefact of them having endorsed more items, therefore perceiving themselves to have a better understanding. As expected, there was also a positive correlation between the number of experiences participants had had and the number of placements they had completed ($r_s = .466, p=.017$).

What factors do trainees perceive as facilitating or hindering their development of clinical leadership?

In response to the open-ended questions regarding what had helped participants and what had acted as barriers in their development of leadership skills on placement, 28 out of 30 participants offered responses. Thematic content analysis was used to analyse the qualitative responses. Three principal themes emerged: supervision, preparedness and opportunity.

(i) Supervision

'Supervision' was the most prominent theme. Within this theme, supervisors encouraging confidence on the part of trainees and enabling them to take on activities that facilitated development of leadership skills, emerged as a sub-theme. This is illustrated by the following quote:

'Inspirational supervisors, supervisors giving me more responsibility and trusting me to take more of a leadership role'. In contrast, the absence of this encouragement was seen as a barrier to leadership development. For example: *'...lack of support [from my supervisor]'*.

A second sub-theme related to the quality of supervision in providing constructive feedback and facilitating reflective practice. This is illustrated by: *'...receiving feedback from supervisors re. leadership (particularly areas for improvement)'*. In contrast other trainees reflected on the barriers presented by a less positive supervisory relationship, for example, *'taking leadership requires a 'risk' (putting yourself out there) which is difficult if [the] supervisor-trainee relationship [is] difficult'*.

Supervisor knowledge and enthusiasm for the subject of leadership also emerged as a sub-theme within the broader theme of 'Supervision'. For example, *'supervisor awareness of these issues and willingness to highlight and discuss these, as well as providing learning opportunities'* was offered as something that had been helpful. In contrast, other responses demonstrated the barriers created when supervisors did *not* see leadership as a priority, for example, *'lack of time to discuss and plan leadership opportunities in detail during supervision'*.

Other responses brought into focus trainees' preoccupations with clinical work, and the perception that pieces of clinical work were more highly valued by their supervisors and by the training courses. For example, *'supervisor being unwilling/feeling unable to prioritise these opportunities above 1:1 clinical client work'*.

(ii) Preparedness

Several respondents offered responses which related to the theme of 'preparedness' for clinical leadership. Unpreparedness on a personal level captured one element of this theme, for example, *'lack of confidence in my own abilities'*, while lack of knowledge and understanding captured the other aspect of this theme, for example, *'lack of clarity regarding what leadership is and what it looks like'*.

In contrast several respondents referred to the positive impact of aspects of teaching which facilitated their understanding of leadership, and their preparedness for the role. This is illustrated by, *'teaching on the course & course raising awareness of its importance'*.

(iii) Opportunity

The opportunity (or lack thereof) to develop and demonstrate leadership on placement emerged as the third theme. The benefit of observing leadership in practice was a sub-theme. Several respondents made reference to the benefits of observing others engaged in leadership-related activities. For example one participant wrote, *'...observing [my] clinical supervisor and other clinical psychologists in meetings; conversations with managers/clinical leads of services'*. In contrast, supervisors not being in leadership roles themselves therefore limiting the opportunities for trainees to observe leadership in practice was noted as a barrier to development. For example: *'lack of opportunity.... supervisors not necessarily having an explicit leadership role'*.

A second sub-theme related to the nature of the service where the trainee worked. Working in teams was seen as affording opportunities for observing leadership in action, and for trainees to gain stage-appropriate experiences of clinical leadership, for example, presenting a psychological perspective on a case. One participant wrote, *'Presenting cases to the team, observing team dynamics and psychology's role within the team'*. In contrast other participants wrote about the barriers they perceived that related to the service context. For example: *'...difficulties with placement offering opportunities due to disruption in teams caused by service redesign'*.

Finally, within the broader theme of 'opportunity', several respondents made reference to the barriers they perceived relating to their position as a trainee, for example: *'hierarchy - trainee's seen as 'different' to "qualifieds"!'.*

Discussion:

This study suggests that trainees are gaining some of the experiences suggested within the LDF as appropriate to their grade for developing and demonstrating clinical leadership; however there are some important gaps, particularly relating to the activities that might more explicitly be seen as 'leadership'. On the whole knowledge of the LDF was low and the majority of participants described themselves as having no more than a basic understanding of the concept of clinical leadership. Nevertheless, there is support for the activities suggested within the LDF being associated with higher levels of (self-reported) understanding of clinical leadership thereby providing some preliminary evidence for the validity of the LDF items for the trainee grade. However the relatively low knowledge of the LDF suggests that the LDF could be better promoted both by the training programmes and within placements.

A range of themes relating to supervision, preparedness and access to opportunities emerged as important issues in the qualitative data. Supervision was the strongest theme within the factors that trainees perceived to have been helpful in facilitating their developing understanding of leadership. There is a role for clinical training programmes and the DCP in promoting the importance of leadership and in offering opportunities for continuing professional development in leadership for clinical supervisors. The views of the trainees in this sample suggested that supervisor knowledge and engagement with leadership was an important factor in either fostering or hindering trainees' development of leadership competencies. There still seems to be a view among some that leadership is not 'real' clinical work and therefore that this is not the core business of the clinical psychologist. The findings suggest the importance of clinical supervisors being knowledgeable and enthusiastic about leadership, of them modelling leadership behaviours themselves, facilitating access to others in leadership roles, and of them encouraging the trainee to engage in (stage appropriate) leadership activities.

An issue that seems to underpin much of this is the recognition by both trainees and the qualified clinical psychologists who supervise them, that leadership is relevant to all of us, and that much of what constitutes 'clinical leadership' overlaps with what might be considered competent practice within the professional anyway – that leadership is not the sole preserve of those in senior positions.

Relevant teaching was reflected both as a helpful factor (by those who felt they had had this) and a hindrance by those who felt they had not had sufficient. Courses may wish to consider front-loading more of the teaching on leadership so that trainees can make better use of opportunities available on their placements through the duration of their training. It is important to ensure that trainees (and their supervisors) know what is meant by 'clinical leadership' from early in their training and therefore are able to recognise when they are doing 'it'. Finally it is essential that leadership is valued. Course staff have a role to play in encouraging conversations with trainees and supervisors about how leadership can be an integral part of a placement, and ensuring trainees and supervisors see leadership within the domain of 'core' skills rather than as a secondary add-on.

The context of service restructuring and 'efficiency savings' could arguably be the time when clinical leadership is most sorely needed; however the day to day reality for many teams is such that these are times when pressures are highest and day to day service delivery is prioritised. It is important that as a profession we continue to develop our engagement with leadership, and that as supervisors and trainers, we offer those entering the profession the opportunities to develop their understanding of leadership and the confidence to translate this into good practice.

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