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Purpose

This paper reports on trainees' perceptions of leadership and leadership development, to inform the support that may be provided to them. It draws on a formative evaluation of the new role of Clinical Leadership Mentor (CLM), introduced by Health Education England South-West in 2018. CLMs are responsible for "overseeing the process and progress of leadership development amongst the trainees within their Trust/Local Education Provider".

Methods

The evaluation was a formative evaluation, based on interviews with CLMs, trainees and trainers and a survey of trainees and trainers. Recruitment was through 8 of the 19 CLMs in the South West. A report for each CLM was available to support the development of their individual role. In exploring trainees' perceptions of leadership and leadership development, this paper draws on data from trainees: 112 survey returns which included over 7,000 words of free text data, and 13 interviews.

Findings

Our findings suggest a more nuanced understanding of leadership in medical trainees than was previously reported in the literature, and a wider acceptance of their leadership role. We highlight the problem of considering postgraduate doctors as a homogenous group, particularly with reference to specialty. We also highlight that the organisational context for leadership development can be supportive or non-supportive. Leadership learning through genuine leadership experience with appropriate support from trainers and the wider Trust offers opportunities for both trainees and Trusts.

Practical implications

Trainees are accepting of their roles as leaders. The value of leadership learning through genuine leadership experience was highlighted. Improving the environment for leadership development offers Trusts and trainees opportunities for genuine service improvement.

What is already known on this topic

The literature on leadership development strongly reflects the practice of doctors in training attending leadership courses, rather than through local experiential learning. Previous studies have suggested that trainees understand leadership in hierarchical terms, and may be slow to accept their role as a leader.

What this study adds

This study adds to existing literature by showing that trainees, even in early training, do accept their roles as leaders, and value experiential learning opportunities. There is variation in the environments available in trusts for experiential leadership learning. Experiential leadership learning requires a supportive environment.

How this study might affect research, practice or policy

Consistently providing a positive environment for trainee doctors to learn leadership may have wider benefits for Trusts and services. Clinical leadership mentors are well placed to support trainees and Trusts in improving opportunities for leadership development

INTRODUCTION

In 2017 the GMC published the Generic Professional Capabilities (GPC) framework[1] following a major review of medical training[2] which led to the development of outcome based curricula. Royal Colleges implemented new curricula by 2021 which included the GPC with equal status to specialty curricula. GPC has three fundamental domains relating to professional knowledge, skills, and values and behaviours, and six themed domains. Among the themed domains are leadership and team working (Domain 5), and patient safety and quality improvement (Domain 6). Although the GMC in their role of individual professional regulator has been concerned with leadership and teamwork for many years,[3] the revised curricula will mean that leadership, teamwork, patient safety, and quality improvement will formally be part of all post graduate training. Guidance published by the GMC and the Academy of Medical Royal Colleges says that the "inclusion of generic professional capabilities within the new standards for curricula is a significant change in the approach to formalising professionalism within training."[4]

Leadership as a generic professional skill highlights leadership as part of medical practice, rather than in a specific leadership role. This is a distinction widely made, for example in the General Medical Council's 2019 report on the state of medical education and practice[5] which differentiates between "everyday leadership" and "formal leadership". Others characterise leadership within everyday medical practice as "informal leadership".[6] This reflects a wider contemporary sense of distributed leadership which doesn't rely on formal position: the NHS Healthcare Leadership Model[7] for example says it is "is useful for everyone – whether you have formal leadership responsibility or not." Non-technical skills[8] and human factors[9] have wide prominence in the safety literature and practice, and highlight the role of leadership in a distributed sense in developing environments for high quality care. Accounts of "new professionalism" also highlight leadership.[10]

In 2017 Health Education England (HEE) examined the state of leadership development for doctors in postgraduate training, with recommendations for future investment, design and delivery.[11] HEE noted the variability of local leadership development, and also highlighted trends in leadership development that included "a shift in thinking about leadership learning that moves us away from exposure to isolated programmes of teaching and training to a longitudinal process of personal development", where the "location of learning is moving from the classroom to the workplace". This is summed up in the 70:20:10 rule where 70% of leadership learning comes from workplace

experience, 20% through learning about self, and only 10% from formal education. This “rule” seems to be widely cited, although the evidence for it is unclear.[12]

A significant issue for developing medical leadership is how leadership is understood by trainees, and therefore how they perceive themselves as leaders. Although there is a strong leadership discourse favouring distributed leadership, including in the GMC requirements for postgraduate medical training, recent evidence has suggested that trainees identify with an individual, hierarchical understanding of leadership. Lisi Gordon and colleagues[13] analysed leadership narratives that came from interview and focus groups data, and found that trainees were likely to understand leadership from the position of a follower in the traditional hierarchy found in hospitals. A much smaller number of narratives cast the trainees as leaders in an emergent, distributed sense. There was some difference between early and late stage trainees, with late stage trainees more likely to talk of leadership in relational terms rather than in terms of role and hierarchy. Where the narratives came from “unsolicited” talk, i.e in the conversation of the interview rather than in response to a specific question, higher stage trainees too spoke in terms of individuals and hierarchy, which may suggest that understanding of leadership differs between theory and practice.[14] This individualistic understanding of leadership, particularly at the start of postgraduate training was confirmed in a systematic review[15] which also acknowledged that leadership was associated with experience during training. A study from Finland[16] based on reflections in an educational context considered the frames through which trainees understood leadership communication. A “system frame” was identified which recognises hierarchy, but so were an “expertise frame”, and a “collegial frame” which suggest a more complex understanding of leadership as a relational activity in a particular medical context.

Trainees’ perceptions of leadership will affect how they understand their leadership development. A survey of trainees before undertaking a leadership development course asked whether they considered themselves a leader, and only 59.4% said that they did. This increased to 92.7% after the course.[17] This seems an impressive increase, but it does suggest the view identified above of leadership development as an event rather than a process. The literature on leadership development for doctors reflects the significance of leadership development events. The most recent reviews of leadership development programmes for doctors[18,19] identified the poor quality of many studies, and were not able to come to conclusions about which types of leadership development programmes were most effective. As leadership development becomes integrated into postgraduate curricula, the emphasis needs to move to longitudinal development within training

programmes, rather than specific courses.[20] In this paper we add to this limited evidence base, by exploring trainees' perceptions of leadership, and leadership development.

METHODS

Our findings are based on an evaluation of a scheme introduced in 2018 by HEE South West which established new posts of Clinical Leadership Mentors (CLMs) in all 19 Trusts in the region with a nominal time commitment of 2 hours per week. Clinical leadership mentors are "responsible for overseeing the process and progress of leadership development amongst the trainees within their Trust/Local Education Provider." They work with trainees and education supervisors in a variety of ways suiting local circumstances. Educational supervisors are trainers who are "responsible for the overall supervision and management of a specified trainee's educational progress during a training placement or series of placements".[21] They are responsible for the educational agreement for each placement, and for assessment and feedback. Specific tasks undertaken by clinical leadership mentors include highlighting leadership and leadership development opportunities to trainees including at induction, working with trust leaders to facilitate workplace leadership opportunities, developing specific learning programmes, facilitating opportunities for trainers and trainees to reflect on their leadership, and working with individual trainees.

The scheme was evaluated by the University of Birmingham[22] and the scheme[23] and the results[24] were also presented as posters at the Leaders in Health conference in 2020. This was a formative evaluation addressing broad aims through semi structured interviews and surveys of clinical leadership mentors, trainees, educational supervisors and trust managers. A recent survey showed that in South West England, trainees' experiences of leadership development were generally positive before the implementation of the scheme, so there was a local context generally supportive of trainees.[25] Ethical approval for the study was granted by the University of Birmingham.

The evaluation was funded by the NHS Leadership Academy who specified that that emerging findings were fed into the ongoing development of the role. The evaluation was led by the first two authors from the Health Services Management Centre, University of Birmingham, who attended the quarterly meetings of the clinical leadership mentors' group, which were facilitated by the third author, and was the forum in which the evaluation plan and emerging findings were discussed. Discussions in this group guided the evaluation, and included identifying that the questions of how trainees understood leadership and leadership development were relevant to their role.

In the first phase of the evaluation, clinical leadership mentors were interviewed. The second phase included surveys and interviews of trainees and educational supervisors. Recruitment was undertaken by 8 clinical leadership mentors, 4 from acute trusts, 4 from mental health trusts. Clinical leadership mentors were able to add questions to the survey relevant to local contexts. Interviewees were recruited through a question in the survey. The surveys were undertaken in December 2019 – January 2020. By this time some clinical leadership mentors had been in post for around a year, and so the survey results did not represent a 'baseline'. The survey is available as Supplementary file 1. Authors 4 and 5 who were trainees in the region managed the interviews in two Trusts, and the first two authors undertook other interviews. Author 6 led the clinical leadership mentors scheme, and was particularly influential in the design of the evaluation. The evaluation team therefore included 3 non-clinical academics with considerable experience of working with doctors, 2 medical trainees, and an experienced medical educator and leader. The clinical leadership mentors who participated in the recruitment of participants received their local data to support the developments of their individual roles.

We draw on the data from trainees – 13 interviews, and 112 survey returns which included some 7,000 words of qualitative data. The seniority of trainees and specialties are given in tables 1 and 2. In the surveys, we explored the extent to which trainees considered themselves leaders, considered leadership important in their clinical practice, were interested in management and leadership, and thought that leadership required a senior position. Although the quantitative data set is limited, it is possible to consider the questions by stage of training differentiating between "early" (ST3 and earlier) and "late" (ST4 and later) trainees. Non-training grade Trust doctors were included as senior trainees (ST4 and above in the data). Another paper is in preparation exploring the views of educational supervisors and clinical leadership mentors on leadership and leadership development.

All qualitative data were analysed using NVIVO, through a thematic analysis process.[26] The first two authors inductively coded the first four interviews (2 undertaken by each of them) and agreed a set of codes that were applied to all of the interviews by the first author. The first two authors developed the themes and sub-themes. The final report of the evaluation was agreed by the evaluation team and discussed with the clinical leadership mentors' group. Supplementary file 2 gives the final themes and sub-themes with illustrative quotes.

Table 1: seniority of trainee survey respondents

Training Level	**Number**	**Percentage**
Foundation	7	6.3%
CT/ST1/ST2	33	29.5%
ST3ST4ST5	16	14.3%
ST4	10	8.9%
ST5	10	8.9%
ST6	13	11.6%
ST7 or above	12	10.7%
Non-training grade	11	9.8%
Total	112	

Table 2: specialty of trainee survey respondents

Specialty	**Number**	**Percentage**
Surgical specialties	12	10.7%
Ophthalmology	2	1.8%
Anaesthetics	12	10.7%
Medical specialties	26	23.2%
Emergency Medicine	7	6.3%
Paediatrics	8	7.1%
Obstetrics and Gynaecology	4	3.6%
Psychiatry	20	17.9%
Radiology	4	3.6%
Pathology specialties	3	2.7%
General Practice	9	8.0%
Other	5	4.5%
Total	112	

FINDINGS

Table 3 shows that large majorities of trainees consider themselves leaders, and acknowledge leadership is important as part of their practice. The view of leadership as an activity of senior colleagues is held by fewer than 40% of respondents.

Table 3: attitudes and experiences of trainees.

	% Agree	ST3 and earlier	ST4 and later
I consider myself a leader	78%	70%	86%
Leadership is important as a part of my clinical practice	95%	91%	98%
I am interested in management and leadership	83%	79%	88%
Leadership requires a senior position	38%	37%	39%

Table 4 shows a high percentage of trainees have access to leadership development opportunities, and feel supported by the training programme in leadership development. Only a third of early trainees have discussed leadership with their educational supervisor in the past six months, which rises to 68% for late trainees. A slight majority, consistently in early and late trainees, feel supported by their Trust and a large majority feel that the environment for leadership development varies between Trusts. Large majorities of trainees, both early and late, believe that they have further leadership development needs in the next 12 months.

Table 4: leadership development experiences of trainees

	% Agree	ST3 and earlier	ST4 and later
I have access to leadership development opportunities in my current role.	64%	55%	73%
I have discussed leadership with my educational supervisor in the past six months	52%	35%	68%
I feel supported by my training programme in my leadership development.	69%	66%	74%
I feel supported by the Trust in my leadership development	55%	55%	54%
The environment for leadership development varies between the Trusts	86%	85%	87%
I have further leadership development need in the next 12 months	92%	89%	95%

We asked trainees what leadership activities they had undertaken, and which would be of interest in the future. The results are given in table 5. By far the most common development activities that

have been undertaken are quality improvement activities, which 81% had undertaken. Despite this high figure around half of trainees were still interested in QI activity, which may demonstrate its enduring appeal and relevance. There is no pattern of leadership development activity being focused only in later years. Several activities were identified which relatively few trainees had undertaken but for which there was interest. These activities represented opportunities for the clinical leadership mentors. These activities included root cause analysis investigations, and shadowing opportunities, of both management and clinical leadership colleagues. A leadership qualification, which few had undertaken was of interest to around half of trainees.

In the qualitative data from interviews and surveys, we identified differences between specialties and explored understanding of leadership, constraints and opportunities for leadership development, the value of experiential leadership, and the support available from Educational Supervisors.

Table 5: trainees leadership development activity

	Have completed			Of future interest		
	% agree	ST3 and earlier	ST4 and later	% agree	ST3 and earlier	ST4 and later
Quality improvement activity	81%	77%	84%	53%	56%	49%
Root cause analysis investigation	11%	9%	14%	40%	30%	49%
Mentoring or coaching	36%	33%	39%	62%	63%	61%
A leadership course	40%	32%	47%	65%	70%	60%
Non technical skills or human factors course	38%	30%	46%	45%	42%	47%
A leadership qualification	8%	5%	11%	54%	58%	51%
Shadowing management colleagues	9%	7%	11%	43%	37%	49%
Shadowing clinical leadership colleague	9%	5%	12%	49%	49%	49%
Management role in Trust, e.g. rota co-ordinator	23%	11%	35%	27%	26%	28%
On-line leadership programme or course	14%	14%	14%	34%	40%	28%
Sign posted online resources	7%	7%	7%	20%	19%	21%

Differences between specialties

Two specialties with strong representation in the qualitative data were Psychiatry and Emergency Medicine. Psychiatry trainees were prominent in the sample because of the recruitment approach through Trusts. Key supportive issues for psychiatry trainees for leadership development were the flatter hierarchy in psychiatry with an emphasis on multi-disciplinary teams and multi-agency working. Psychiatry trainees also reported more regular supervision, and time allocated for non-clinical development, recognising the importance of generic professional capabilities in practice.

Emergency Medicine was also identified as a specialty where leadership training has a high profile from the College. The 'EMLeaders' programme was developed in partnership between RCEM, Health Education England and NHS Improvement, and is for all trainees. It was developed and implementation through a strategy to address staff retention and burnout within emergency departments. The prominence of leadership, and the training within the specialty was noted by the trainees who were interviewed, but it was also noted that this prominence and the specific programme may reduce the availability of other leadership development opportunities.

Understanding of leadership

Our analysis of the interviews revealed that participants distinguished between leadership in practice and formal leadership. Leadership experience was embedded in clinical roles. The quote below highlights the developing interest in leadership as clinical seniority develops over training. The gradual nature of this realisation is significant here, as is the importance of others in validating a leadership role.

> I think probably when I was a foundation doctor I definitely didn't feel like a leader, I … I felt like a follower, but then I think it's come on slowly over the training as you take on projects, as you take on a more senior role within your clinical team you realise where you are leading day to day. And that it's not necessarily a title that you're given, it's just the way that the teams start looking at you, realise how they respond to your moods and what you're saying! Yeah, I think it's just gradually built over the seven years really as opposed to a definitive moment where I was like 'yes, I'm a leader now'.

In some interviews specific clinical contexts were considered as significant for recognition of the clinical leadership role, such as being on nights where the clinical responsibility may be higher. Several trainees identified the movement from junior trainee to senior trainee as a significant transition, with the term 'Registrar' prominent in accounts:

> certainly in my ST1, ST2, years, it was never talked about or mentioned at all and then as you become a registrar people start talking about 'oh, you're going to be a registrar soon and you have to think about what kind of leader you want to be

This trainee is reflecting others' perceptions of the registrar role, but also identifying the key transition to clinical decision maker. Another trainee identified the importance of appearing knowledgeable and confident in leading teams, reflecting the importance of others' perceptions.

The importance of being clear about the different usages of the term "leadership" was identified as a key learning point during training. One trainee thought that "making it a bit clearer what people mean by leadership early on, earlier on in training" was very important – she had felt early in training that leadership was a "business-y" idea, rather than one directly relevant to clinical practice.

Several interviewees in the sample were a little older than their contemporaries. Two participants had had other careers before coming into medicine, and drew on those experiences in exploring their attitudes to leadership, and their knowledge and skills. Another participant was older because of periods of part time training.

> I'm older …than other trainees at my stage. So I think maybe I've started thinking more about that management leadership stuff than I would have done if I'd just done a full time training and gone straight through.

Although the hours of training had been the same, the time as doctor had been longer, and therefore time to reflect on being a doctor had been longer.

The need to understand the structure of the NHS, and the way the system worked was widely acknowledged. For some this knowledge represented a shift between leadership as part of practice and organisational leadership, but for others, as discussed above, engaging with the organisation is an element of clinical practice.

Constraints and opportunities

A number of specific constraints and opportunities were identified in interviews with trainees. The most clearly reported constraint was the lack of time to engage in leadership development, and the tension between the development of generic skills and what was widely referred to as "clinical training". This reflects wider tension between service provision and postgraduate training. The

following quote expresses this tension. However, the emphasis here is on time outside the clinical setting.

> There is a lot of 'leadership' talk. It is very difficult to translate this arguably over-emphasised aspect of our training into tangible QI. I find it slightly frustrating and moderately stressful to have the constant barrage of leadership requirements yet not a lot of real time or opportunity for it to manifest outside the clinical setting.

Another time related constraint is short rotations, with an acknowledgment that developing effective relationships with colleagues is difficult in a six months rotation, which will also include shifts and possibly different working locations.

A lack of availability of resources for leadership development wasn't a strong theme, although there were comments that activities that were free may be more attractive. Several interviewees had developed activities through being proactive, rather than waiting to hear about them or being encouraged in certain directions. One example is given below of a trainee who identified an opportunity outside medical education and pursued it proactively:

> …the other opportunities are ones that I've created,……. I saw a job description for a …. lead nurse and I just contacted them and said 'oh I didn't know this was, you know, a group that existed, I'd like to be part of it.

However, this trainee also explained that, "as soon as people know that you're interested, stuff just keeps coming up and up and up and it's … something that I'm really struggling with to say no." This might suggest a preference in management for engaging with trainees who are already known, and perhaps are understood to be useful management colleagues.

Another trainee explained that because she had an interest in leadership, she was alert to opportunities, which "jump off the page". This may be another example where opportunities became available to those with an interest and a personal capacity to engage.

The value of experiential learning in variable environments

The usefulness of learning leadership through practice, rather than only in a course was a key theme. However, trainees' experiences of the support available for learning at work was variable, and this was often considered in relation to experiences of QI projects, which have become required for training programmes, and which 81% of the quantitative sample had completed. For example, one trainee said that:

> I think I share the feeling with many of my colleagues that the "enforced" quality improvement projects were very much a box-ticking exercise to get through ARCP - there was not definite guidance and support from senior colleagues, although I recognise this is likely a result of junior doctor engagement as well. I cannot think of any projects from peers that resulted in an actual longstanding process change.

A number of trainees used the words “tick box” as in the quote above, acknowledging the purpose of specific activities like QI projects, but questioning whether they got the most from them, and whether their efforts led to genuine improvement. The trainee quoted above was discussing support available from senior medical colleagues, but others also explored the support available from elsewhere, again in the context of QI projects:

> [Doing a] Q.I. project was good but felt that I had to drive this by myself and was not supported by the trust much to do this. This felt pretty different to my experience [elsewhere] where I was supported in QI by regular meetings with a QI fellow (e.g. junior doctor on a year QI placement) or full time QI employee. [Elsewhere] consultants were also keen on QI and encouraged trainees to take part where as in [Trust] it seems to be something that you only do if you are particularly interested.

Another example of variability in the environment was the involvement in leading rotas. While one trainee said that “I managed a rota in a previous trust. It certainly was an eye-opening experience about how something that seems simple (just a spreadsheet...?) can end up being hugely complicated”, another described an experience in managing the rota where administrative staff were not prepared to help with a review of the rotas, “which was cumbersome, and not of any educational value.” In addition, in this case, when there were problems with compliance of the rota, there was no support for taking this forward.

For some, the Trust context was experienced as unhelpful rather than simply neutral. In the quote below, the trainee, while understanding the need to undertake QI in a systematic way, experienced hurdles in engaging with the trust:

> .. the trust … insists that audits etc be undertaken through the official audit department and has lots of rules such as audits being done across multiple sites etc etc which inevitably puts a huge bureaucratic and organizational hurdle in the way of getting juniors involved in smaller leadership type projects.

These examples highlight the educational value of genuine leadership roles, whether in QI or more generally, where support not only enhances the learning experience, but also the effect on services. These experiences provide some depth to quantitative data that identify the variation between trusts in the environment for leadership development.

One trainee went further than considering support for leadership development, by considering the motivation for learning about leadership in a Trust which didn't seem to be generally engaged with trainees. This seems to be a wider point which connects the issue of trainees' learning about leadership with issues of welfare and engagement.

> I think the Trusts where I didn't feel supported, you just felt like quite invisible in the Trust, …. for example [when] I joined …. there was no welcome, there was no 'these are the opportunities we've got', it was very much you were a little fish in a big pond and you've got to find about everything for yourself and I think when you feel like that you kind of don't then want to almost give back because you're just like 'well, you know, I'm not going to spend my whole day trying to find out what meeting this is and how to do this and that.

Support from Educational Supervisors

The availability of leadership mentoring, particularly through the educational supervisor, was variable. In some cases, discussion of leadership was initiated by the trainee, and for some there was a concentration on management rather than leadership. The time available for supervision was also a constraint.

> My supervisor in my second year was actually quite high up in management and he was quite useful but your time with your educational supervisor is really quite brief, I think, in terms of actually looking at any personal development and they … know you a certain amount …… you get regular contact but you know there's not really enough time to really delve into stuff, I don't think.

Although there was encouragement to access leadership courses, leadership wasn't always included within medical training programmes managed locally. Some welcomed the opportunity to engage with others in leadership development events, which they saw as breaking down specialty silos. Others might be other medical trainees, but also other colleagues, although the availability of interprofessional learning opportunities seemed to be low.

DISCUSSION

Our formative evaluation suggested a more nuanced understanding of leadership in medical trainees than was previously reported in the literature, with a wider acceptance by trainees of their leadership role. We highlight the problem of considering postgraduate doctors as a homogenous group, with particular reference to specialty. We also highlight that the organisational context for leadership development can be supportive or non-supportive. We highlight the value of experiential learning, a finding which is reported in a review of leadership development.[19] Interest in work-

based experiential learning, for example through shadowing leaders, quality improvement, or root cause analysis investigations, and in mentoring and coaching, were all higher that on-line programmes or resources. Our survey was undertaken before the Covid-19 pandemic which caused significant changes in medical education[27] particularly in online learning. How online learning can support experiential learning is an area recommended for future research.

For some leadership experiences the wider organisation will be able to support trainees, for example in shadowing and buddying, or involvement in governance processes. This engagement with medical education is likely to have wider benefits. For example, in the case of quality improvement, an established feature of medical education as demonstrated in our survey, junior doctors can make significant contributions to patient safety and service improvement.[28-30] More generally, better engagement of medical staff, and improved wellbeing, are associated with higher quality care, and the case for engagement of junior doctors particularly is widely made.[31-34] The wellbeing of trainee doctors remains a concern,[35] including for the GMC who published a major report in 2019, *Caring for doctors, caring for* patients[36] addressing "how to transform UK healthcare environments to support doctors and medical students to care for patients".

Trusts who are able to support the leadership development of trainee doctors and the educational faculty who support them, particularly through facilitating and supporting meaningful leadership activities, may well be able to develop a virtuous cycle, similar to that suggested for medical leadership generally.[37] A supportive culture and working conditions are highly significant in the training post application choices of F2 doctors[38], many of whom have taken a break from training[39] and so Trusts who are able to demonstrate a supportive culture, including for leadership development, may enjoy a competitive advantage.

There are limitations to the study. It was a formative evaluation, with self-selection of participating sites through the clinical leadership mentors. Survey returns are not likely to be representative of all trainees, with for example some overrepresentation of psychiatry trainees. The qualitative data is limited by the context of the evaluation. Data collection was completed after the clinical leadership mentors had been in post for up to a year, and so may reflect early impacts of the posts. Caution should be exercised in transferring results from this evaluation.

However, our exploration of trainees perceptions of leadership and leadership development does provide additional perspectives on several issues relevant to leadership training, and in particular it

provided local data to the clinical leadership mentors who participated in the formative evaluation, and to the wider group.

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