

Leadership education and supervision

Leadership already present in SAS practice

Kavita is a composite senior Specialty Doctor in a busy medical service. Colleagues ask her to settle difficult operational decisions, new doctors seek her advice, and managers depend on her to maintain continuity when senior staff change. She organises teaching, reviews incidents and has redesigned part of the referral pathway. None of this appears as a defined responsibility in her job description. Her job plan records clinical activity and a modest allocation for supporting professional activity, but says nothing about service leadership or supervision. When a new clinical lead is appointed, Kavita is thanked for “helping out”. She has influence and responsibility, but uncertain authority, no protected time and little evidence assembled for future progression.

Many SAS doctors will recognise some part of this pattern. Leadership begins before appointment to a leadership title. It may be visible in coordinating a deteriorating service, bringing different professions to a safe decision, identifying an unsafe gap, improving a pathway, helping colleagues work through uncertainty or maintaining standards when systems are under pressure. Education may begin with bedside explanation, induction or feedback before it becomes a named faculty role. Yet it is unhelpful to label every competent act as leadership. Good clinical practice, collegiality and leadership overlap, but they are not interchangeable.

The practical question is not, “Am I a leader?” It is, “What work am I doing, what result am I responsible for, and under whose authority?” This keeps the discussion grounded. A doctor who chairs a meeting may be facilitating rather than deciding. A doctor who notices a recurring problem may contribute evidence without owning the remedy. Conversely, a doctor with no formal title may be making decisions on which the service repeatedly relies. Accurate description protects against both inflation and invisibility.

The GMC expects doctors to contribute to supportive, fair and safe working and learning environments, to use resources responsibly and to raise concerns where patient safety may be compromised. These duties apply in proportion to a doctor’s role; they do not turn every doctor into the accountable manager for organisational failures.^[3] A leadership record

should therefore separate professional conduct expected of all doctors from an additional role carrying defined deliverables and accountability.

Start with observable verbs. “Provided senior clinical coordination during the winter escalation period” is clearer than “showed leadership”. “Designed the induction timetable, recruited faculty and reviewed learner feedback” is stronger than “led education”. Record the setting, dates, people accountable, your contribution, decisions made and what changed. The same discipline used in Chapter 12 for a professional portfolio makes everyday leadership legible without exaggerating it.

Kavita maps one month of work. She discovers that her informal contribution includes a weekly operational meeting, preparation for two teaching sessions, supervision conversations, review of safety reports and repeated calls from colleagues about a pathway for which she has no formal decision right. The map does not prove that every activity deserves a separate programmed activity. It establishes that recurring work exists and allows a proper conversation about purpose, authority, time and evidence.

This chapter is not a condensed substitute for *SAS Leadership in Practice*. That book examines leadership behaviour, power, systems, difficult conversations and organisational change in greater depth. The present task is narrower: to convert contribution into a safe, governable role; distinguish teaching from approved supervision; demonstrate useful impact; and build continuity so that neither the doctor nor the service becomes dependent on unrecorded labour.

Recognition may lead to several different actions. Some contribution belongs within ordinary professional practice and needs only accurate portfolio evidence. Some requires a clearer local mandate. Some has become a substantial recurring duty that should enter the job plan. Some should be stopped because it duplicates another role or lacks governance. The map is therefore a decision tool, not an argument that every helpful action warrants a title. Its value lies in matching the response to the work.

Formal authority role description and accountability

A formal title is valuable only when it clarifies the work. “SAS lead”, “education lead”, “service lead” or “clinical coordinator” can mean different things between organisations. Before accepting a role, ask for a short written description that identifies its purpose, scope, authority, reporting line, term, objectives, resources and review arrangements. If the role already exists informally, use the same questions to convert it into a discussable proposal.

Purpose answers why the role is needed. Scope identifies the services, professions, sites and decisions covered. Authority specifies what the holder

may decide, recommend, approve or escalate. Accountability names the person or committee to which the role reports. Resources include time, administrative help, information, budget, access to systems and deputy cover. Review arrangements establish how priorities may change and how the role can end or transfer. These are not bureaucratic decorations. They prevent responsibility being assigned without the means to discharge it.

Decision rights deserve particular attention. A doctor may gather information and recommend a rota change while another manager has authority to approve it. A clinical lead may set a professional standard but lack authority to employ staff or purchase equipment. An educational supervisor may guide a learner but not make a programme-level progression decision alone. Write the boundaries down. If the role-holder is expected to act in an emergency, identify the immediate authority and the later reporting requirement.

The reporting line should remain usable when the matter concerns the usual manager. A role description can say that routine work reports to the clinical director, with unresolved safety, conduct or resource concerns escalated through a named alternative route. This does not guarantee agreement; it prevents the role from depending on one relationship. Where a role spans organisations, specify who owns each decision and how conflicting instructions will be resolved.

Objectives should describe deliverables that the role can influence. “Improve morale” is too broad for one doctor. “Establish a quarterly multidisciplinary review of two recurring operational risks, agree actions with named owners and report progress to the governance committee” is assessable. Measures can include completion, timeliness, participation, learning or an agreed service outcome, but should not attribute system-wide results to an individual who controls only one component.

The appointment process also matters. Establish whether the role is substantive, fixed term, rotational or acting; whether it was advertised; what preparation is expected; and how performance will be reviewed. A temporary role should have an end point and handover expectation. An acting appointment should not become indefinitely permanent by silence. If the organisation needs continuing responsibility, it should decide how the enduring role is authorised and resourced.

Professional accountability continues alongside organisational accountability. GMC guidance on leadership and management explains that doctors with management responsibilities remain accountable for their decisions and should be clear about roles, resources and risks.^[47] It does not follow that the doctor becomes personally accountable for every outcome

within the service. Record advice given, decisions made by others, constraints reported and action taken within your control. Escalate when the role's authority or resources are inadequate for a material risk.

Kavita proposes a service-development role rather than seeking retrospective praise. The one-page description names three outputs: coordinating a pathway review, reporting agreed measures to governance and maintaining an induction package. It excludes line management, rota approval and final budget decisions. It identifies the clinical director as accountable sponsor, the governance committee as reporting forum and a twelve-month review. The document turns a vague expectation into something both sides can test.

Before accepting, run a failure test. Imagine that the principal objective has not been delivered after six months. What explanation would the organisation reasonably expect from the role-holder, and which missing powers or dependencies could have prevented delivery? If the answer includes recruitment, budget, data or decisions controlled entirely by others, the role description must show how those dependencies will be managed. Ask what happens when the sponsor is absent, priorities conflict or an agreed action is refused. A role is not properly defined if accountability becomes clear only after something goes wrong.

Also establish how concerns about the role-holder will be handled. A leadership appointment should not place ordinary performance discussion, employment management and professional conduct within one vague process. The doctor should know who reviews objectives, which policy applies to employment concerns, and how regulatory or patient-safety matters are routed. This protects fair challenge. Clear accountability is not a shield from scrutiny; it ensures that scrutiny occurs through the correct mechanism and against an agreed remit.

Use this role-definition sheet:

Role title and term: What is the role called, when does it start and when is it reviewed or ended?

Purpose and scope: What problem or function does it address, across which services, sites and groups?

Authority: What may I decide, recommend, approve, delegate or escalate? What remains with someone else?

Accountability: Who is my responsible sponsor? Which committee receives assurance? What is the alternative escalation route?

Outputs and measures: What will be produced or changed, by when, and how will contribution be assessed?

Resources: What time, information, administrative support, training, budget and deputy capacity are agreed?

Boundaries: Which tasks are outside the role? What happens if expectations expand?

Handover: What records, relationships and decisions must be transferable at the end?

Securing time in the job plan

Leadership, education and supervision consume real time. Preparation, reading, meetings, documentation, follow-up and travel do not disappear because the visible event lasts one hour. Chapters 6 and 7 explain the contractual and evidential method in detail. Here, the essential step is to translate the proposed role into activities, frequency, duration, location and outputs, then take that evidence into the applicable job-planning process.

Begin with a prospective workload rather than a desired number of sessions. For a monthly governance meeting, record agenda review, data interpretation, the meeting itself, agreed follow-up and reporting. For an educational role, include learner meetings, review of evidence, written reports, liaison with the training programme, educator development and urgent concerns. Distinguish predictable work from genuinely exceptional demand. Annualise activities that occur irregularly and state the assumptions.

Supporting professional activity terminology and contractual arrangements differ across nations and contracts. The UK SAS job-planning guide provides a practical framework, while current terms and local processes govern the individual agreement.^[33] Do not assume that a familiar allocation from another organisation transfers automatically. Equally, do not allow the absence of a universal number to turn recurring work into unpaid or invisible work. The case should rest on agreed duties and time required.

Avoid double counting. If a teaching session occurs during a clinical session and the planned clinical workload is reduced accordingly, record the arrangement once. If supervision happens informally while clinical work continues at full intensity, that may indicate the need to redesign the timetable rather than to claim the same hour twice. The objective is a safe operating agreement, not the largest possible total.

Show opportunity cost. A weekly hour of supervision may require more than an hour removed from another activity once preparation and documentation are included. If no clinical activity is displaced, ask what work will no longer be done or who will provide it. This reveals whether the

proposed role has been resourced or merely added. Where patient-facing work must continue, the service may need backfill or a staged start.

Link time to outputs. Kavita's proposed role includes a protected weekly block for pathway work and a smaller annualised allowance for induction. The proposal identifies the reports, meetings and review points supported by that time. It also says that substantial new work will trigger job-plan review. This is stronger than asking for recognition in the abstract because the organisation can see what it is agreeing to receive.

Record employer dependencies. A leadership objective requiring data analysis depends on access to validated information. A supervision objective may depend on an eligible learner, approval by the relevant training body and access to the required platform. If the dependency is not delivered, record it at review rather than treating the objective as a personal failure. Where duties materially change, use the review, mediation or appeal arrangements of the applicable contract and local process rather than allowing disagreement to remain informal.

Do not postpone the conversation until appraisal. Appraisal can reflect on the role and identify development needs, but it does not amend the employment contract or allocate organisational resources. The job plan is the operating agreement for recurring work. The role description explains authority. The portfolio evidences contribution. Keeping these documents connected but distinct prevents one favourable appraisal sentence being mistaken for employment agreement.

Prepare the discussion as a service proposal. Bring the agreed role description, a representative work diary, annualised assumptions, the timetable consequence and two options. One option might protect a recurring block and reduce another duty; another might narrow the leadership remit to what existing time can support. State the safety or continuity risk if neither is possible without presenting every disagreement as misconduct. Ask that the decision, reasons and review date are recorded. A staged trial can be sensible when workload is uncertain, provided it has a defined measure and does not become an indefinite experiment.

Review delivery as well as allocation. Protected time can be repeatedly displaced by vacancies, urgent clinical demand or meetings scheduled elsewhere. Record when this happens and what work is deferred. A nominal allocation that cannot be used is not the same as functioning capacity. Equally, if the work takes less time after a process improves, the job plan can change. Evidence supports a credible agreement in both directions.

Clinical and educational supervision

Teaching, clinical supervision and educational supervision are related but different. Teaching may be a planned learning event. Clinical supervision supports safe patient care and development in a particular clinical setting. Educational supervision takes a broader view of progress over time within a defined educational programme. Local titles vary, so establish the actual function rather than inferring it from the label.

The first question is who the learner is and under what framework they are working. A resident doctor in a GMC-approved postgraduate programme has programme requirements, a curriculum and formal governance routes. A locally employed doctor, medical student, advanced practitioner or colleague developing a new skill may be supported under different organisational or professional arrangements. A doctor experienced in teaching one group is not automatically authorised to perform every assessment or sign every outcome for another.

For formal postgraduate medical training roles, the GMC's trainer-recognition framework covers named clinical supervisors and educational supervisors in recognised settings. Local education organisers and postgraduate deans implement recognition and approval arrangements; the employing organisation alone cannot make a signature valid for a programme by giving someone an informal title.^[112] Before taking responsibility, confirm the role's recognition status, required preparation, continuing development, appraisal evidence and access to programme systems. Nation, specialty and training programme arrangements may add requirements.

The GMC's *Promoting excellence* standards place patient safety and the quality of the learning environment at the centre of medical education. Organisations must provide appropriate supervision, resources and governance, while learners must know how to raise concerns.^[113] These are organisational as well as individual responsibilities. A supervisor should not accept an unsafe ratio, unknown scope or unmanageable workload on the assumption that personal vigilance can compensate indefinitely.

At the start of a supervisory relationship, clarify purpose, frequency, availability, confidentiality boundaries and escalation. Review the learner's role, previous experience, intended outcomes and local scope. Agree what the learner may do independently, what requires direct or indirect supervision and how urgent help is obtained. These arrangements should reflect competence and context, not grade title or confidence alone. They must change when evidence changes.

Clinical supervision is active. It includes making sure that the learner understands local systems, providing accessible senior input, observing practice where required, calibrating entrustment and responding to concern. “Call me if worried” is not an adequate plan if the learner cannot recognise the threshold for calling or fears an adverse response. Use explicit triggers: particular clinical presentations, unexpected deterioration, uncertainty outside agreed scope, conflict in advice or system failure.

Educational supervision includes longitudinal review. It should examine evidence against the relevant outcomes, feedback from different settings, the learner’s reflections and agreed development. The supervisor facilitates an honest account; they do not guarantee progression or rewrite weak evidence. Where the role involves formal reports, complete them accurately and on time. Distinguish direct observation from information reported by others, and identify uncertainty rather than smoothing it away.

Feedback should be specific enough to guide action. “Needs more confidence” is ambiguous and can reproduce bias. Describe the observed situation, behaviour, consequence and expected next step: for example, the learner’s presentation omitted the medication history needed for a safe prescribing decision; at the next observed review, use the agreed structure and explicitly reconcile current medicines. Invite the learner’s view and consider whether workload, induction, language, health, disability or supervision design contributed. Explanation is not the same as lowering a necessary safety standard.

When performance or conduct causes concern, act within the framework. Address immediate patient safety, document factual observations, seek advice from the educational lead or training programme and tell the learner what can appropriately be shared. Do not conduct an amateur investigation beyond your remit or make a high-stakes progression decision alone. A supervisor may need to escalate even when the learner would prefer confidentiality. Those boundaries should have been explained at the outset.

The reverse problem also matters: an educator may receive a concern about the learning environment or a senior colleague. Listen without promising secrecy that cannot be kept. Clarify immediate safety and what the learner is asking for. Record and route the concern through the appropriate educational, clinical or speaking-up system. A learner should not be left to confront a powerful individual simply to demonstrate resilience.

Supervisor evidence should include recognition or approval where applicable, preparation, agreed duties, learner meetings, formal reports, feedback on the educator role and continuing development. Preserve only

appropriate records in approved systems. Do not copy identifiable learner material into a personal portfolio merely to prove activity. An authorised confirmation, aggregate evaluation or role record may provide safer evidence.

The Academy of Medical Educators' professional standards offer a useful developmental framework across planning, teaching, assessment, scholarship and educational leadership.^[114] They are not a substitute for the specific approval rules of a programme. Use them to identify development needs: perhaps the doctor delivers strong teaching but has little experience of assessment design, supporting a struggling learner or evaluating an educational programme.

Kavita is asked to “sign off” a locally employed doctor's competence after several informal conversations. She first establishes what the sign-off will be used for, who owns the process and what evidence is required. She can confirm what she directly observed, but refuses to certify unobserved practice. The organisation then creates a defined developmental-supervision arrangement with appropriate assessment, named accountability and time. Her caution protects the learner as much as the service.

Teaching that produces evidence

A teaching record becomes useful when it shows more than attendance and satisfaction. Begin with a learning need. This may arise from a curriculum, governance finding, learner request, service change or observed gap. Describe whose need it is and what evidence supports it. A broad statement such as “staff need sepsis teaching” is less useful than identifying a recurring difficulty in the recognition and escalation process for a particular learner group.

Write outcomes that describe what learners should be able to do. Choose a method suited to those outcomes. A short explanation may support knowledge; a worked case may test reasoning; supervised practice may be needed for performance. The educator should also consider accessibility, prior experience, group size, psychological safety and the effect of teaching on patient care. One method will not suit every need.

Evaluation should match the claim. Attendance shows reach. Immediate feedback explores learners' experience and perceived relevance. A knowledge check can examine defined learning outcomes. Observation may examine performance. Later review may explore whether practice changed, but many other factors affect service outcomes. Do not claim that a popular session reduced harm unless the evidence can support that conclusion.

Kavita redesigns induction after new doctors repeatedly struggle to locate escalation contacts. Her teaching file contains the identified problem, objectives, revised guide, attendance, a brief scenario exercise and anonymous aggregate feedback. Six weeks later, she asks a small sample of doctors to demonstrate how they would escalate three situations and identifies one persistent gap. She revises the guide. The evidence supports responsive educational design and evaluation. It does not prove that she eliminated every escalation delay.

Credit co-design. If administrators produced the guide, nurses developed a scenario and learners suggested the clearest format, say so. Leadership evidence is not strengthened by absorbing other people's work into a single heroic account. Fair attribution shows the ability to mobilise expertise and respond to feedback.

Use a compact teaching evidence record:

Need: What learning problem was identified, for whom and from what evidence?

Outcome: What should learners be able to explain, decide or do afterwards?

Design: Why was this method chosen, and how were accessibility and learner context addressed?

Delivery: What did I contribute, what did others contribute and what changed from plan?

Evaluation: What was measured, what did it show and what could it not show?

Improvement: What will be retained, revised, stopped or tested next?

Governance: Was approval required, were patient or learner data protected and where is the authorised record held?

This creates material for appraisal, educational-role review and competitive applications. Select and explain it for each purpose rather than submitting every slide. A teaching certificate or complimentary email may be included, but neither replaces the account of need, method, evaluation and learning.

Faculty and assessment work require the same precision. Writing one draft question, examining in a structured clinical assessment, contributing to standard setting and chairing an assessment board are different responsibilities. Record the brief, preparation, calibration, quality-assurance process and decision boundary. Do not retain secure assessment material in a personal portfolio. An authorised confirmation of the role and a reflection on learning may be sufficient evidence without compromising examination integrity.

Inclusivity should be designed rather than added after a complaint. Consider timing for less-than-full-time learners, access needs, language load, religious observance, remote participation and whether examples assume knowledge of one NHS culture. Test materials with the intended group. Adapting a method to remove an irrelevant barrier does not remove the clinical or professional standard being taught. Record both the standard and the adjustment.

An educator also needs development. Ask for observation by an experienced colleague, review learner feedback for patterns and identify one deliberate change. A short cycle—plan, deliver, receive feedback, adapt, deliver again—produces better evidence than a list of repeated sessions. If the educational role becomes substantial, consider a recognised programme or peer framework appropriate to the organisation, while remembering that an additional qualification does not itself confer programme authority.

Service improvement and governance leadership

Improvement leadership connects a defined problem with a responsible process for change. It begins with understanding the system, not announcing a solution. Identify the population or pathway affected, the evidence of the problem, the people who perform the work and those who experience its consequences. Establish who owns the risk and who has authority to approve a test. Governance provides the route through which decisions and learning are recorded.

Do not confuse audit, quality improvement, service evaluation and research. Local governance arrangements determine classification and approval, and the same project may involve more than one method. Before collecting data or altering practice, establish what review, information-governance and ethical arrangements apply. A portfolio description should use the classification actually agreed, not whichever label appears most prestigious.

Kavita's pathway review concerns delayed clinical responses to a category of referrals. She resists the request to "fix referrals" alone. The team maps the process and finds several contributing factors: inconsistent referral information, unclear ownership after transfer, variable access to senior advice and no shared measure. Kavita helps define a limited first test, while the operational manager owns staffing and the information team validates the data. The governance committee agrees the risk and review point.

Her leadership contribution can be traced from problem definition through decision, implementation and review. She records the evidence

considered, options rejected, assumptions, responsibilities and measure. When the first change improves completeness of referrals but lengthens administrative processing, the team adapts it. The mixed result becomes evidence of judgement because the record shows learning and correction rather than a manufactured success story.

Measures need a denominator, period and limit. Suppose complete information is present in 21 of 35 sampled referrals before the change and 29 of 35 afterwards: 60 per cent and approximately 83 per cent. The increase is 23 percentage points, but the sample does not establish causation or sustained performance. If time to response did not improve, the team should not imply that documentation alone solved the safety concern. This disciplined explanation makes the evidence more credible.

Governance leadership also means ensuring that unresolved risk remains visible. If the service accepts a temporary mitigation because the preferred resource is unavailable, record the accountable decision, review date and trigger for escalation. Do not let a doctor's repeated informal rescue obscure the underlying system weakness. Conversely, avoid turning every operational inconvenience into a governance crisis. Describe severity, likelihood, affected process and existing controls as accurately as the evidence permits.

Connect improvement with the job plan. Data review, stakeholder work, testing and reporting require time. Once a new process becomes routine, identify who owns maintenance. A project allocation should not silently become permanent oversight. If Kavita is expected to receive monthly data and intervene when performance falls, that is continuing work requiring a defined owner, authority and resource.

The leadership evidence record can use seven rows: problem and evidence; agreed role; stakeholders and authority; actions and decisions; measures and findings; learning and adaptation; continuing ownership. Attach or locate the authorised primary records. Add a two-sentence claim describing what the evidence justifies. This produces a stronger portfolio entry than a slide saying that Kavita "transformed the pathway".

Patient and public involvement may improve understanding of the problem, but it must be meaningful and supported. Do not invite a patient to endorse a predetermined solution or include identifiable testimony without the required agreement. Record how views affected decisions and where they did not, with reasons. Improvement leadership includes handling disagreement honestly.

Close the loop visibly. A governance paper should state what the team agreed, who owns each action, what assurance remains incomplete and

when the issue returns. If a recommendation is rejected, record the accountable decision and the alternative control. If it is accepted but not implemented, distinguish approval from delivery. This prevents meeting attendance from becoming a proxy for improvement.

Sustainability needs an explicit test. Can the measure be produced without exceptional manual work? Do staff understand the new process? Has unintended work shifted to another team? Is the benefit still visible after the initial attention fades? Has the responsible owner accepted ongoing review? A promising pilot may properly remain a pilot when these questions are unanswered. The leadership achievement can be the identification of those limits and a proportionate decision not to scale prematurely.

Where the project crosses organisations, information, money and authority may travel through different routes. Establish a sponsor in each organisation, a common problem statement and a method for resolving incompatible priorities. Do not assume that agreement in one committee commits another employer. Shared governance records should make clear which organisation has accepted which action.

Leading across status and professional boundaries

SAS doctors often lead where formal hierarchies and practical expertise do not align. A senior SAS doctor may know a service more deeply than a newly appointed consultant, while lacking the consultant title assumed by some colleagues to carry authority. A nurse, pharmacist, administrator or therapist may hold essential operational knowledge that a medical leader lacks. Good leadership uses role, expertise and accountability explicitly rather than allowing status to decide whose evidence counts.

Before a difficult decision, map the relevant forms of power. Formal authority permits certain decisions. Expertise makes advice credible. Control of information, access, relationships or resources also shapes outcomes. A respected long-serving doctor may have considerable informal influence. None of these forms of power is inherently improper, but unacknowledged power can silence challenge or produce compliance mistaken for agreement.

Use language that makes participation possible. State the decision to be made, what is fixed, what remains open and who decides. Invite evidence from those closest to the work before the most senior voice frames the answer. Ask for disagreement specifically. Close the meeting by recording the decision, reasons, owner and review point. These simple disciplines reduce dependence on personality.

Grade-based assumptions deserve challenge in both directions. A Specialty Doctor should not be excluded from a role merely because colleagues associate leadership with consultancy. Nor should long service be treated as proof of readiness for any leadership position. Use the role requirements and evidence of capability. The same principle applies to internationally qualified colleagues, less-than-full-time doctors, disabled doctors and people whose influence has developed outside familiar networks.

When authority is ambiguous, say so early. Kavita can advise on a clinical standard while the manager decides staffing; if the staffing decision leaves a risk, she records her clinical advice and uses the governance route. She should not present the manager's decision as her own, but neither should she withdraw from helping the team implement the safest available arrangement. Professional disagreement and organisational cooperation can coexist.

Fair leadership includes access to opportunity. Teaching invitations, acting roles and committee membership often travel through informal sponsorship. Keep a transparent record of how opportunities are offered, what criteria apply and how people can express interest. Rotating chairing, presentation and project roles can develop capability when the work and support are real. Token participation without information or decision access is not development.

Feedback on leadership should come from more than the person who appointed the leader. Seek proportionate views from people affected by the role and examine objective evidence of delivery. Ask what enabled colleagues to contribute, where decisions remained unclear and what the leader should change. Do not conduct an uncontrolled popularity poll or collect identifiable comments without a safe process. The purpose is learning and assurance.

Where conflict arises, separate the issue from identity. A colleague may challenge Kavita's proposal, her authority or the process. She should ask which claim is disputed and what evidence would resolve it. If behaviour becomes disrespectful or discriminatory, Chapter 20 provides different routes. Leadership does not require absorbing mistreatment as the price of influence.

Sponsorship and challenge can coexist. A senior colleague who opens access to a committee should not expect loyalty to every proposal. Set the professional boundary before a contentious decision: support gave access, not ownership of judgement. Similarly, when sponsoring someone else,

describe their work accurately and do not expect them to reproduce your style. The purpose is to widen participation and capability.

Notice who performs the relational work. Translating between groups, calming conflict, welcoming new staff and repairing communication are often essential but poorly recorded. These contributions should be recognised without assigning them automatically to women, minority colleagues or the person seen as most accommodating. Rotate and resource them where possible. Emotional steadiness is valuable; permanent emotional labour is still work.

A useful meeting audit asks four questions: who had the information before the meeting, who spoke first, whose evidence changed the decision and who received the resulting work? Repeated patterns may reveal that nominal inclusion is not effective participation. Change the process—circulate papers, invite frontline evidence, assign actions by authority and check distribution—rather than asking under-heard colleagues simply to speak more confidently.

Succession and distributed capability

A service that can function only when one individual is present is fragile, however capable that individual may be. Succession is therefore part of current leadership, not a task reserved for retirement. It means distributing knowledge, preparing others to exercise defined responsibilities and leaving records from which safe decisions can continue. It does not mean naming a preferred successor outside a fair appointment process.

Identify the work that currently depends on you. Include recurring decisions, key relationships, access rights, tacit knowledge, deadlines and risks. Mark what can be standardised, taught, delegated or shared. Some responsibilities require a formally authorised deputy; others can be distributed among team members. If no one else can perform a safety-critical task, put that dependency on the risk and workforce agenda rather than celebrating indispensability.

Develop deputies through graduated responsibility. Observation alone rarely creates readiness. Agree a task, authority, supervision and review; allow the colleague to make real decisions within that boundary; then discuss the reasoning and outcome. Avoid giving the deputy responsibility without access to information or excluding them from meetings where future decisions are shaped. Record development fairly for their portfolio as well as your succession plan.

Create a living handover. It should explain the role's purpose, current priorities, decision calendar, governance routes, unresolved issues, key

documents and access arrangements. Distinguish facts from your interpretation. Do not create an uncontrolled file of confidential correspondence. Link to approved records and state who may access them. Review the handover while you are still in post by asking another informed person to use it.

Kavita's original service had no deputy because colleagues assumed she would always be available. Her new role description includes deputy development as an output. She invites expressions of interest against transparent criteria, agrees a rotating arrangement and shares chairing and reporting. One colleague develops the induction programme; another learns the pathway data. Kavita retains accountability where required, but the service begins to own its own processes.

Succession also requires permission to let others work differently. A deputy who follows every instruction but never exercises judgement has not been prepared. Agree the non-negotiable standards and the area in which they may choose another method. Review the reasoning, including decisions that differ from yours. Correct unsafe practice promptly, but do not mistake personal preference for governance.

Plan for several timescales. Immediate resilience covers unexpected absence. Medium-term development prepares colleagues to share recurring work. Formal succession addresses the end of an appointment and any recruitment process. The same person need not cover all three. A temporary deputy may hold operational knowledge while a competitive appointment identifies the next substantive lead.

When departure is known, protect time for transfer. List open decisions, upcoming deadlines, significant relationships, current risks and records requiring access. Introduce the successor or interim holder to the relevant forums. Close personal workarounds, such as information sent only to an individual inbox, and replace them with authorised team processes. Agree what support, if any, the outgoing leader will provide after handover so that advice does not become continuing shadow accountability.

The succession checklist is short:

Critical functions: Which decisions or relationships fail if I am absent?

Authority: Who may act, within what boundary, and where is that recorded?

Capability: Who needs observation, practice, feedback or formal preparation?

Information: Which current records, deadlines and risks must be accessible?

Continuity: What cover exists for leave, illness and role transition?

Fairness: How will development and appointment opportunities be offered transparently?

Review: When will the deputy exercise the role, and how will learning be evaluated?

Handover: What must be transferred, closed or escalated when the role changes?

Kavita's final leadership evidence record now contains more than a title. It shows the agreed remit, job-plan time, governance reports, educational design, feedback, adaptation and the development of deputies. It also records constraints and work owned by others. She can use this evidence in appraisal and future applications without claiming sole credit. More importantly, the service is less dependent on her invisible labour.

The reader's next action is to choose one recurring contribution and complete the role-definition sheet. If it is already agreed, test whether time, authority and succession match the expectation. If it is informal, decide whether it should become a defined role, return to ordinary shared work or stop. Leadership becomes sustainable when contribution is recognised accurately, responsibility is governable and capability remains after the individual moves on.