Evaluation of Welsh Clinical Leadership Training Fellowship Programme

Alison Bullock and Suzanne Phillips

August 2014

CUREMeDE
CARDIFF UNIT FOR RESEARCH AND EVALUATION IN MEDICAL AND DENTAL EDUCATION

Cardiff University School of Social Sciences
Glamorgan Building
King Edward VII Avenue
Cardiff
CF10 3WT

bullockad@cardiff.ac.uk Tel: 029 2087 0780

Acknowledgements

We would like to express our appreciation of all the study participants who gave generously of their time in face-to-face and telephone discussions.

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Executive Summary

Background and Purpose

Set up in 2013, the Welsh Clinical Leadership Training (WCLT) Fellowship programme is a collaboration between the Wales Deanery, Academi Wales, Welsh Government and NHS Wales. It is designed for core, higher specialist trainees with an interest in clinical leadership and health service management. In its first year, the Fellowship programme attracted four trainees (Fellows). During the twelve-month programme, Fellows undertake a project in their host organisation, under supervision, and attend leadership training provided by Academi Wales which also provides opportunities to network with and learn from senior medical colleagues from across Welsh health organisations. The projects, identified by the host organisation, are designed to enable Fellows to apply to practice the principles of leadership and management which they have explored within the training modules. In addition to the specific project, other host-based opportunities include attending (and chairing) meetings and working with multi-professional teams. The four projects undertaken during the inaugural year were:

- Clinical Leadership in Wales – Welsh Government
- VOCERA: instant communication for hospital staff on the move – Cardiff & Vale UHB
- Treating acute medical illness in the community – Abertawe Bro Morgannwg UHB
- Emergency service model – Hywel Dda Health Board

Fellows are able to continue with clinical duties up to a maximum of 20% of their time.

Methods

We collected data from interviews and focus groups: two focus group discussions with Fellows and individual interviews with both Fellows and project Supervisors. We also observed some Academi Wales training sessions. The timescale of data collection was:

- 9 September 2013 – initial meeting with Fellows during induction programme
- 17 and 18 September 2013 – a record of motives and expectations of the programme sent via email
- 2 October 2013 – focus group with Fellows, following observation of Academi training
- February 2014 – individual telephone interviews with Fellows
- May 2014 – individual telephone or face-to-face interviews with Supervisors
- 23 July 2014 – final telephone focus group discussion with Fellows

We analysed data collected from interviews with Fellows and Supervisors and from focus group discussions separately. We adopted a thematic approach to the analysis, identifying common issues in the data. This was not a grounded approach as our analysis was shaped by the Kirkpatrick evaluation framework (1979; 1998) and informed by *a priori* themes from the Darzi evaluation (London Deanery, 2010).

Results

The training programme

The Fellows agreed that the joint induction had been a positive experience, providing a forum for ideas and opportunities. Attending the course in Edinburgh with English counterparts had been a bonus. Three Fellows spent a week in Boston (June 2014) which they agreed was worthwhile. Despite initial reticence, the Fellows agreed that the three-day residential course was a useful and valuable exercise. It gave them insight into how teams worked. Training alongside senior colleagues was a valued useful part of the programme and provided opportunities for networking and sharing best practice. Action learning sets (ALS) brought in by Academi Wales and facilitated by an outsider person were particularly valued. They also provided a network of people to whom Fellows could turn to in future. The Fellows were allocated four free coaching sessions during the Fellowship year. They had only been taken up towards the end of the year but were proving valuable. The Fellows would be utilising the sessions once they had returned to their clinical roles.

The training programme provided by Academi Wales, overall, received a favourable response. Attending such a high profile privileged course made the WCLT Fellowship a competitive and world-class scheme, possibly attracting people from outwith Wales.

The workplace experience and project

Learning opportunities depended in part on the host organisation. These included: attending/chairing meetings with senior colleagues; communicating with diverse groups of people; experiencing different leadership behaviours and team working, learning from what works and what doesn't work; developing an understanding of strategy and change management. Fellows need to use their initiative to overcome problems with projects and adopt a proactive, self-directed and flexible approach.

Organisational support and supervision

The level of organisation support and supervision varied. Well supported Fellows worked in organisations whose co-workers had been informed about the Fellowship, where they were introduced at meetings, and where their projects were prioritised. This had impacted on the speed with which Fellows could progress their projects and develop organisation knowledge. The quality of communication distinguished the better Supervisors.

Support from peers

All four Fellows agreed that they had bonded and worked together very well despite being a diverse group in terms of specialty, years of training and experience. One Supervisor had described the group as "a significant collective".

Exit strategies

All Fellows were returning to training and clinical practice but some had also negotiated some on-going involvement with their project.

A summary of barriers and enablers

The success of the programme was facilitated by:

- The relationship and support from the other WCLT Fellows
- Flexible approach to the project
- Regular contact with Supervisors
- Workplace introductions and being valued as a member of the team
- Academi Wales programme, notably the residential course
- Engagement with English counterparts
- Visit to Boston MIT

The success of the programme was challenged by

- Funding issues for projects
- Personal financial constraints

The Fellows suggested that the programme might be improved by:

- Using service improvement leads to identify suitable and achievable projects.
- Clarifying expectations, including that Fellows are responsible for organising their clinical work themselves
- Introducing leadership competencies which combined with clinical duties could count towards specialty training
- Explaining the financial implications of the Fellowship and discussing the benefits and costs of retaining clinical
- Consideration, taking into account individual Fellows learning requirements, given to developing regular links with Welsh Government (unique, mutually beneficial experience and serves to retain the high profile of the Fellowship programme).
- Ensuring supportive Supervisors who meet regularly with Fellows and act as advocates for them and their project
- Introducing an end of year event where Fellows can showcase their projects.

Comparisons with Evaluation of Darzi Fellowship Programme

Both evaluations highlighted the importance of clarity of aims and expectations. The Wales and Darzi Fellowship programmes had a significant impact or 'mind-shift' on the Fellows. They developed leadership skills and a considerable network of peers and leaders. Supervisors in both programmes recognised Fellows' contributions to the service improvement projects. Quality of mentoring or supervision was noted as an important factor in both evaluations.

Conclusions

The Fellows have benefitted enormously from the Fellowship programme and are well placed to be future leaders in the NHS. The host organisations also gained from the input of the Fellow. A longitudinal approach to the evaluation could more fully explore the impact of the year on the Fellows and their workplace achievements.

The Fellowship Programme

The Welsh Clinical Leadership Training (WCLT) Fellowship programme was set up in 2013. The programme is led and managed by the Wales Deanery in collaboration with Academi Wales, Welsh Government and NHS Wales, it is designed for medical or dental trainees who are "considering involvement in clinical leadership and health service management as part of their role on completion of training." (Deanery WCLT project outline document). Tailored to the Welsh health system, the Fellowship programme builds on the successful NHS London Darzi Fellowship Programme (London Deanery, 2010), and is informed by the Medical Leadership Competency Framework development (NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2010).

The Fellowship programme is open to trainee doctors and dentists undertaking core, higher training or less than full time (LTFT) trainees who are able to take one year out of programme. During the 12-month Fellowship, trainees undertake a project in their host organisation, under supervision, and attend leadership training provided by Academi Wales.

Academi Wales runs the NHS Wales Medical Leadership Programme, the core components of which are embedded into the WCLT Fellowship programme. The training provides support to senior doctors and medical leaders to who are equipped to build and lead improvements in healthcare delivery. Programme outcomes are:

- "Support and achievement of organisational objectives through effective management and leadership of people and resources
- Support and delivery of service innovation
- Increased self-awareness and understanding of personal impact on situations with strategies for improved effectiveness"
  (Academi Wales programme, Appendix I)

The structured training programme (Appendix I) also provides opportunities to network with and learn from senior medical colleagues from across Welsh health organisations. Academic accreditation (60-credits at level 7, a Post Graduate Certificate) is available on completion of the project, written and oral presentation and attendance at each component of the programme of 80%.

The projects the Fellows develop are identified by the host organisations and focus on improving services for patients. The projects are designed to enable Fellows to apply to practice the principles of leadership and management which they have explored within the training modules. In addition to the specific project, other host-based opportunities include attending (and chairing) meetings and working with multi-professional teams.

Although the majority of their time is spent working on a service improvement project, Fellows are able to continue with clinical duties up to a maximum of 20% of their time.

Evaluation Framework, Methods and Analysis

As the number of Fellows was small (four), we adopted a qualitative approach to the evaluation. However, it was important to build an evaluation system for the future, where numbers might be larger and where benchmarking with other regions (London) might be feasible.

Kirkpatrick's model of programme evaluation was chosen to guide the data gathering (Kirkpatrick, 1979; 1998). This framework is also used by Academi Wales in their evaluation of leadership programmes. The (modified) framework uses six levels to evaluate programmes. Level 0 looks at participation data and is useful in providing an overview of the characteristics of attendees. Level 1 is concerned with assessing the participants 'reaction' or satisfaction with the experience: for example, does the programme meet participants' expectations? Level 2 is about 'learning' (knowledge and skills): for example, do the participants report gains in knowledge? Level 3 focuses on behaviour change (impact) and the extent to which new learning is applied to practice. Level 4 looks at 'outcomes' exploring whether organisational performance (and ultimately patient outcomes) is improved. Level 5 is added to some evaluations and this is concerned with return on investment (RoI). The challenges related to evaluating outcomes and RoI are well known and studies tend to relay on proxy indicators and estimators.

The Darzi (qualitative) evaluation (London Deanery, 2010) was used to shape the questions we asked allowing for some potential comparisons.

Data collection

The methods employed included focus group (FG) discussion with all four Fellows; telephone or face-to-face interviews (tel int) conducted with both Fellows and their project Supervisors; observation of some training sessions. An initial meeting with Fellows took place on 9th September 2013, during their induction programme. Fellows recorded their motives and expectations of the programme via email after this first meeting (sent on 17th and 18th September 2013). A focus group was held on 2nd October 2013 some two months into the Fellowship, following observation of Academi training. Fellows discussed and exchanged views on their individual experiences. Interviews were conducted with the Fellows in February 2014 (all telephone interviews) and with Supervisors in May 2014 (2 telephone, 2 face-to-face). A final teleconference (teleconf) discussion was held with all Fellows on 23 July 2014.

Analysis

Data collected from interviews with Fellows and Supervisors, and from the focus group discussions were analysed separately. We adopted a thematic approach to the analysis from which we identified common issues in the data. This was not a grounded approach as our analysis was shaped by the Kirkpatrick evaluation framework and informed by a priori themes from the Darzi evaluation (London Deanery, 2010).

The Fellows' interviews provided narrative accounts of the individual experiences. The focus group, which took place early in the Fellows' secondments, provided an insight into their expectations, benefits and barriers they had initially encountered

from which we extrapolated common themes. We were also able to extract common themes from the telephone interviews with Supervisors and with the Fellows.

Participants and Projects

There were nineteen applicants for the first cohort of Fellows and following interviews held on 15th April 2013, the Wales Deanery announced that four trainees had been appointed to undertake Clinical Leadership Fellowships from August 2013. Three of the successful trainees were specialty trainees (at least ST3) and the other, a Research/Academic Fellow. We have anonymised Fellows in the report.

The successful trainees were offered a selection of nine leadership projects, with submissions from Health Boards at Abertawe Bro Morgannwg UHB, Cardiff and Vale UHB, Cwm Taf UHB, Hywel Dda and Powys HB, Velindre NHS Trust and the Welsh Government.

The four projects undertaken during the inaugural year were:

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Appendix II provides further information about the projects.

Results

Participants' motives and expectations

Following the first meeting, we asked the four Fellows to give reasons why they had applied for a Fellowship and how they would assess its success.

In an open response, the most common reasons that they identified for taking up the Fellowship was the desire to (a) develop knowledge and skills in leadership and management (mentioned by three of the four Fellows) and/or (b) influence/ implement change and make a difference (identified by three of the four). Two Fellows also wanted to develop their knowledge of NHS structures. Other reasons they listed included attraction of the project, desire for a new challenge, aspiration for a career in NHS management.

All four Fellows concurred that achieving the postgraduate diploma qualification at the end of the training would signify success to them. Success was also described in terms of a successful project (mentioned by three Fellows); knowledge about how the NHS is run (3); knowledge about how to make effective change (2) and, quite specifically, effective chairing of meetings (2). Other reasons for success included: publications; presentations; networking of NHS leaders; managerial experience; and public speaking.

Responses to the training

Induction

The Fellows thought that having a joint induction with other Fellows had been very good, providing lots of ideas and opportunities they may not otherwise have had. Dr Maddox had found visiting the Nuffield with the English Fellows and working through scenarios particularly useful at the start of the Fellowship. At the October focus group Dr Bryn described the quality of training received to date as "brilliant". He thought the joint induction was a positive experience:

> *… the joint induction was very good. It was one of, probably three of the best days I've probably had in the medical training ever. It was that good and it certainly provided a lot of ideas but also a lot of opportunities that you'd never have otherwise and the quality of the training was brilliant. Like running the health service was the one thing that stood out for me. That was brilliant. (Dr Bryn)*

Edinburgh

The Fellows agreed that attending the course in Edinburgh with their English counterparts had been a bonus.

The Residential

The Fellows had not looked forward to the residential and expressed apprehension or reluctance prior to the event but the experience changed their minds: "in the end …. I was amazed how useful and interesting it really was" (Dr Gwen). She drew attention to the value of seeing how people worked in teams. Teams had been split on their Belbin team roles. She described how one person who was "conflict averse" and another "very conflicting" were grouped together and despite the differences, it worked very well with both recognising the benefit of each other. It had made her realise that it takes all sorts of people to make an effective team. The other Fellows also found it valuable. Dr Kirsty enjoyed having the time away with the other Fellows:

> *…I think that helped especially things like action learning and you know it helped people to get better, more trust and build up that relationship and ….from that point I felt we were a stronger clinical leadership group. (teleconf)*

Dr Kirsty had also found it interesting to observe how more senior colleagues dealt with stressful situations, how they revealed their own need for support, and how more junior members of the team could help.

Although he agreed with his colleagues, Dr Maddox stated that, personally, he had found the residential course "slightly uncomfortable at times" (teleconf).

MIT, Boston

Three of the Fellows spent a week in Boston (June 2014), which they all agreed had been a worthwhile experience. The other Fellow was unable to attend due to personal circumstances, but the Deanery had agreed that they could go next year. The Fellows visited Massachusetts General Hospital and the Institute for Healthcare Improvement (IHI) and undertook a course at Massachusetts Institute of Technology

(MIT). Dr Maddox agreed with Dr Bryn, in that their American counterparts had similar problems to themselves:

> *…it was nice to just sort of have that time to chat with clinicians across the pond and see what their struggles were as well. (Dr Maddox, teleconf)*

In his view the MIT course had been really good.

> *…and it was nice to sort of contrast the styles between the Academi Wales course and MIT and see how actually there was a lot of overlap in the content. It was just delivered in a slightly different way. (Dr Maddox, teleconf)*

Dr Bryn described the experience as "very refreshing" and "a very big highlight of the year" (teleconf). He thought the challenge would be to implement change back home as:

> *…it's easier to talk about it out there but if people won't buy it back here, it's difficult. (Dr Bryn, teleconf)*

Action Learning Sets

One of Dr Gwen's highlights of the year had been the Action Learning Set (ALS) brought in by Academi Wales and facilitated by an outside person. There were five or six people in each ALS, meeting about six times over the year. She had found it personally useful, especially as she and Dr Kirsty had been in the same group which she described as "functional" (Dr Gwen, teleconf); everyone had been open, had brought problems that could actually be worked through and, despite the wide range of people involved, there had been no hierarchy. She remarked:

> *… everyone, no matter where you are in terms of your career, they're all having the same problems basically. (Dr Gwen, teleconf)*

She felt that she had gained a network of people to whom she would not hesitate to contact for help in the future: "a *network of people you can kind of bounce ideas off" (Dr Gwen, teleconf).*

Coaching

The opportunity for coaching had only recently been taken up by the Fellows and consequently would continue once they returned to their clinical roles. Although Dr Bryn had met his coach two or three times and had found the sessions useful. As he would be in the health board for a further year, and continuing with some of his leadership work, he thought continued meetings with the coach would be useful. Dr Maddox had had his first session with his coach. As it happened, it was someone in his ALS. He and the coach had agreed to spread the coaching sessions over the following six months during the transition back to clinical work.

Team working and networking

Notably the Fellows benefitted from team working and networking. One Fellow summed this up:

> *The away team building thing was really, really good, but I think it's also the networks that we're making with the other senior leaders on the course and sharing best practice and learning from them as well. (Dr Kirsty, tel int)*

Dr Maddox found training with consultants a useful part of the programme: "that's a world that you don't get to experience very often." (Dr Maddox). Dr Kirsty made particular mention of the "personality things, the team work stuff" which she'd found "really useful". She too spoke of benefiting from networking with senior leaders on the course, sharing best practice and learning from them as well: "So yes, it's definitely been a positive." (Dr Kirsty). Although Dr Bryn was in agreement with the other Fellows regarding networking, it was difficult to ascertain whether some of the networks he made were a result of the Fellowship, as he already knew a lot of the people beforehand.

Programme Accreditation

The English Clinical Leadership programme is not accredited and in earlier interviews, our Fellows reported that this helped give the Welsh programme an edge. However, there was some delay in Academi Wales securing the accreditation and it transpired that the programme attracted a postgraduate certificate award rather than the initially expected diploma. There were also changes to the assignment requirements, from a 3000 word essay to two 7500 word essays, one of which to reflect on five or six events that had happened during the year. Dr Kirsty thought that it had been poorly planned and that it was difficult to write a reflective piece after "the horse had bolted" (teleconf). She felt it would have been useful to have kept a note of reflections during the year which could then inform the end of year assignment. Dr Gwen agreed. Dr Bryn was somewhat frustrated that:

> *… it was sold as a diploma with a 3000 word essay and it's turned into a certificate with 15,000 words. (teleconf)*

The new cohort had been informed of this change at their welcome meeting (22 July 2014).

Critique

Although the Fellows thought the programme was good, the standard of delivery was variable. Some external speakers had been really good and engaging, but other parts were not thought to have been quite so good. At the focus group, which was at an early stage of the Fellowship, Dr Bryn was somewhat critical of the training programme. He felt there was duplication of sessions that they had had with the English Fellows and therefore did not see the need to attend all sessions.

Dr Maddox expressed some doubts about aspects of the leadership programme. As the group, he thought that the Fellows were practically minded people who liked factual information and he described some parts of the programme as "soft". He did not know whether that was due to the subject or how it was delivered:

> *…but even I find myself sometimes thinking this stuff is not robust enough and sometimes I think 'oh wow, that was really useful' but in the majority of the time I think I'm not sure that the leadership side of things suits my way of thinking because I'm quite fact, research orientated. I don't know whether it's delivered in the right way for me to really hugely engage in it. (Dr Maddox, tel int)*

He had found it difficult to relate some of the content to day-to-day life and thought that the Academi Wales course would have been much stronger if:

…it was a bit more clinically led with some of the theories and concepts in action. (Dr Maddox , teleconf)

He would have preferred more on the practical aspects of running service improvement projects:

I'd much prefer to have lectures on how you run service improvement projects, who the right people are to speak to and are helpful to get these things moving, the practical side I like rather than the broad theory based stuff. (Dr Maddox)

However, he had learned a lot but would not know how useful it was until he returned to clinical practice. In summary, he stated:

So, you know, in three to four months' time I might have changed my view but at the moment I think it's quite difficult translating all that theory into action. (Dr Maddox, teleconf)

Overall

The training programme (Appendix II) provided by Academi Wales had, overall, received a favourable response. Dr Kirsty described the training on leadership and management as "really beneficial", providing background and foundation knowledge that they needed to apply to their project. The Fellows felt that attending high profile, privileged courses made the WCLT Fellowship a competitive and world-class scheme, which could possibly attract people from "across the border". One Fellow stated:

I mean, it only takes one of us to go away and say 'oh we've just got a diploma out of this and we've been sent to Harvard' and immediately ten other people will know about and want to come on the scheme. (Dr Maddox, FG)

Learning from the workplace/projects

Learning experiences differed depending on the host organisation.

Dr Maddox

Workplace learning experiences for Dr Maddox had included information collection, audit and data analysis, helping with a workshop for clinical leadership trainers, attending meetings, including with medical directors across Wales, preparation and internal presentation of papers, preparation of briefings. He reported that one of the main skills learnt during the Fellowship had been:

…working in a team, where in medicine it's almost more self-promotion because you've got to stand out in front of people, it's a lot competition, whereas in (host organisation) it's more to do with real teamwork where you don't have the odd person who shines…. less to do with personal accolade at the end and more to do with a job done. (Dr Maddox, tel int)

Liaising with technical people was a new experience for him "…which again is people that I've never really had anything to do with as part of [specialty] training" (FG).

Another learning experience cited was chairing a meeting in his Supervisors' stead. He had never done it before, so found it really useful to get involved in:

…those sort of situations where I'm asking people to do things and guaranteeing what they've done and setting the direction… (Dr Maddox, tel int)

He reported that within a large department in the host organisation time is spent "telling everyone about it, asking their opinion, getting feedback and it's a lot more to do with large group working here and trying to fit systems together" (Dr Maddox, tel int). He highlighted the contrast between working in a small group or individually such as undertaking a thesis, where one is concentrating on the detail, with the situation in the workplace where he was:

… now I'm doing strategic work engaging lots of people where the details aren't as much of a concern, it's more the direction. To have experience of those two different ends of the spectrum is really useful. It means I can jump back and forth between those skills I think when they're needed. (Dr Maddox, tel int)

Another learning outcome from the workplace was the contrast between the highly competitive world of academia, where there is a lot of pressure on getting grants, funding, getting one's work out first and keeping one's work to oneself until ready to publish, and the host organisation where "it's policy work, it's people's opinion and valuing it rather than just creating a wall around the work that you're doing" (tel int). Although he found this latter way of working frustrating at times in having to consult with different groups, he added:

…but I think the NHS could probably benefit a lot from that as well because a lot of the time there's different departments working on their own whereas a bit of joined up thinking might be useful. (Dr Maddox, tel int)

He also commented on learning other skills, such as negotiating and influencing people. He described the pathway from medical school to consultant as somewhat isolated where "you think that one way is the only way to do things" (Dr Maddox, tel int). He remarked:

Just having the experience to see how other people work is useful. (tel int)

Dr Maddox thought his experience would enable him to make better decisions on healthcare in general when he reached the position of mid to late consultant level. Without the experience of how the organisation worked, he felt:

I think I'd struggle a lot to understand why people weren't listening to me and having that overall appreciation of what the right this is to do. (Dr Maddox, tel int)

Dr Maddox's Supervisor thought he had learned a lot about leadership behaviours during the Fellowship and how they might differ in this organisation and the Supervisor thought:

…he's learned quite a lot about the behaviours required of senior leadership…. I think it has been a very rich experience for him. (Supervisor, tel int)

Working within a non-NHS institution proved a somewhat difficult transition, having to adapt to a completely different way of working. The Fellow commented on the different language and a complete change of working pattern, from a busy department to sitting in an office, which was hard to adapt to at first:

…if someone had even just explained that to me before I started the job that actually you have to change your way of thinking completely, and you have to step

back from the details, that would have been useful. But I'm sort of working it out slowly myself. (Dr Maddox, FG)

Within the host organisation "stuff happens very quickly" (Supervisor, int). Also, the Fellow had found the bureaucracy a hurdle at first. However, the Supervisor felt Dr Maddox had achieved a great deal despite this:

…I think if one has influencing skills and negotiating skills, one can work one's way through it, but there's quite a lot of it and there are a lot of natural barriers to improvement in here. (Supervisor,int)

The other area the Fellow had struggled with a bit was the political context during a particularly sensitive time for NHS Wales. The Supervisor noted that:

…there's a particular code in here which takes a bit of getting used to, get your head around. … I had to point that kind of thing out… because we all have to be quite mindful of the fact that we can't be political. (Supervisor, int)

Dr. Maddox's Supervisor was complimentary about his capabilities, describing how well he had fitted in the organisation and delivery of his work:

He's not fazed by stuff, so he gets on with it, you know, he delivers, so he's a very high quality individual. (Supervisor, tel int)

He felt the Fellow had coped remarkably well despite his not coming from that background, but it had been part of his learning experience, and in a wider perspective he felt the Fellow was "a changed person". The Supervisor reflected:

…when he came I think he had a lot of ability but I just think he's just gained a totally different perspective on health services strategically in Wales as a whole. (Supervisor, int)

The Supervisor felt that the organisation had also benefited from having a Fellow. Having someone of his clinical background and context, who brought that "richness of experience to the role" has enabled the Fellow to make "a significant contribution to policy within (organisation)" (Supervisor int). He summed this up:

I think he's shown that having people in at that kind of slightly more junior level, with ongoing NHS involvement and engagement, I think is really helpful (Supervisor, int)

Dr Gwen

Dr Gwen had experienced some major issues with her project from the beginning of the Fellowship, but this had been part of her learning process:

I think maybe the things that I have learnt most from have been the things that to be honest that haven't worked. (Dr Gwen,tel int)

The Supervisor's aim for the project was to have a Fellow to take the lead on expanding the system into other areas within the Health Board. However, the Supervisor concurred that Dr Gwen had had to overcome "significant challenges and obstacles and hurdles" at the start of the project.

…people always resist change, you know what that's like…..the challenge in changing culture and behaviour of people. (Supervisor ,tel int)

Despite the challenges, the Supervisor praised Dr Gwen's communication skills. She had met with IT managers and executives and been active in writing and publishing a document which had made a case for supporting an expansion to the system. This had been forwarded to the Finance Director for consideration on the priority agenda. At the time of the Supervisor's telephone interview, no progress had been made but:

> *…it's now on sort of not high priority but not the lowest priority, so it's getting there. (Supervisor, tel int)*

The Fellow had also written leaflets for various groups who had engaged with the system and because attendance at training days had been somewhat poor, she had:

> *She's been actually coming in, in her own time, to train people and come in the evening at handover to capture people. (Supervisor ,tel int)*

The Fellow had shadowed both Medical Director and Finance Director, which the Supervisor believed had been a good experience for her. Dr. Gwen felt she had learnt a lot about high level engagement:

> *… for something to work you need to have basically executives pushing it because if you haven't got that you won't get any money and it won't happen. (Dr Gwen, tel int)*

The experience had also developed self-awareness:

> *My own sense of resilience as well and that maybe I'm not always that good at letting stuff go. I tend to think when it doesn't work I take it quite personally. (Dr Gwen, tel int)*

Dr Kirsty

Dr Kirsty had also learnt from difficulties with project progress especially as there had been no established project at the outset and therefore it had been difficult to achieve something within the Fellowship year. She added:

> *… I think there's a lot of learning to be had from all the problems that you encounter on the way. (tel int)*

As her main project had been put on hold until funding had been resolved, she had concentrated on those smaller, more achievable projects which were not impacted by the lack of funds, staffing issues or cross specialty/directorate involvement.

Her Supervisor commented that she had been "very proactive and self-directed" in her approach to the project. She had engaged with project from "a developmental perspective" but had also been keen to get involved with "the nitty gritty" aspects:

> *Assisting with project development and management, taking on individual projects herself and driving those forward and being proactive in reaching out. (Supervisor, tel int)*

Her Supervisor felt that Dr Kirsty had achieved quite a lot during her time in the organisation. Some parts of the project had evolved after she had taken up the post, and the Supervisor commented on how s/he guided Dr Kirsty to things "which would have educational benefit to her" (Supervisor tel int). S/he reported that Dr Kirsty had shadowed other members of the senior health board management "at executive

level" (Supervisor tel int), which had been a beneficial learning experience for her. Another learning experience had been her participation in "the selection process of our new [title of post] so she's done a wide variety of things" (Supervisor tel int). Her Supervisor praised the Fellow's proactive approach and commented:

> *So she has not had to have a huge amount of hand holding and sort of just comes along to meetings, sitting there and observing, but actually being proactive at driving these things forward as an individual. (Supervisor,tel int)*

Dr Bryn

Dr Bryn reported that he had been well-supported (by his "minder", a coach and several mentors) from day one. He was given opportunity to shadow the clinical and medical directors, attend a variety of meetings, including operation boards and commissioning groups, and had submitted evidence to the executive committee of health board and presented to a county directors meeting. He reported that this had given him opportunity to "learn about the [organisational] structure as well" (Dr Bryn, FG).

Dr. Bryn felt that he had learnt tactics from observing what strategies leaders employ to get the best out of various 'characters' in meetings. However, he expressed his frustration with the Health Board's approach to communicating with the public, in that they didn't engage with social media and did not explain what they were doing. His offers of helping with social media were rebuffed.

Dr. Bryn's Supervisor stated that the team had invested a lot in communicating the project to a wider audience, both within and outwith the Health Board, and his previous experience around communication had been really helpful. However, regarding social media, the Supervisor exercised some caution:

> *I guess one of the big things is to help them understand that… once they're [Fellows] in a leadership role…that puts them into a very different position. (Superviso, tel int)*

The Supervisor, however, thought that despite some challenging setbacks, Dr Bryn had overcome "criticism" from a senior level. His Supervisor said that the project had come through "turbulent waters… however it's very smooth at the moment." (Supervisor, int). At the outset, there was no clinical buy-in and there was public and political as well as organisational executive level scepticism. However, through a process of engagement, media coverage and clinical buy-in, the project was being advocated as "a good piece of work" (Supervisor, int). The Supervisor stated that Dr Bryn had brought another clinical voice "with different expertise to my own and different perspective" (Supervisor int) which had strengthened the team. S/he was impressed with his drive and initiative: he had driven his part of the project forward extremely well". (Supervisor, int).

Change Management

At the focus group, the Fellows discussed 'change management' within the health service. Dr Kirsty had sat in on some meetings which made her wonder why, despite the majority of people talking about "change for the better", there are still managers on programme boards within hospitals who were "quite old fashioned in their way of thinking" (Dr Kirsty, FG). Later her Supervisor comment that Dr Kirsty had:

…encountered the usual frustrations of trying to effect change in a leviathan-like organisation. (Supervisor, tel int)

Dr Maddox suggested there was a need for the Fellows to be "slightly arrogant" and think:

…right, if you're going to judge me for trying to be dynamic and try to change things and I'm not going to progress because of that……I want to work with a team that's really dynamic and will allow changes to happen. (Dr Maddox ,FG)

Dr Bryn commented that in other sectors, managers who failed in their outcomes would no longer be in post, but:

… the feeling ... I've got is that certain people will always be there (Dr Bryn,FG)

All Fellows agreed that the biggest change they could make would be "not getting... trodden down" (Dr Gwen, FG).

Link Cymru

Linked to issues of change management, the Fellows had set up the Link Cymru website (www.linkcymru.org) and hoped that it would flourish over the forthcoming year. It is an open, virtual network for quality improvement projects which allows trainee doctors to upload and share projects with other trainees. It would:

…make it easier to get involved with projects when you move from one place to another…and it's always kept in silos, so I think it will hopefully break down the silo sort of mentality as well. (Dr Bryn, teleconf)

By disseminating projects throughout Wales, it would facilitate knowledge mobilisation. Dr Bryn hoped that the current Fellows would put a conference together next year with a prize presented by the Chief Medical Officer. The website had been discussed with the new cohort during their induction day (22nd July 2014)

Barriers and Facilitators

Organisational support

At the focus group, Fellows gave their initial thoughts about their placements within the host organisations. Dr Bryn felt fortunate to have previously worked in the host organisation and felt that he benefited from being known:

My direct Supervisor knows who I am and other people around (the Supervisor) knew who I was from the start.

However, it was not only knowing people and being known that helped: organisational support was offered in terms of "a minder":

I always had a minder with me in the meetings so they could say 'Dr Bryn's here. He's the new Welsh Clinical Fellow', brief explanation and they actually went round the room telling me what their roles were as well, you know, in those initial meetings. (Dr Bryn, FG)

However, some Fellows had found their host organisations somewhat lacking in support, in part because people had neither been informed that a WCLT Fellow would be taking up a post nor told what the Fellowship programme was about. There were instances also of Fellows not being introduced at meetings, including in situations where they did not know anyone. One of Dr Gwen's initial problems was that the host organisation had not communicated about the project or about her being in the Fellowship post: "They knew nothing about me before I arrived essentially." Similarly, Dr Kirsty commented:

> *It would have been quite good if they had known we were coming and just to get an idea, when you sit in a meeting, of what people do. So it gives you right from the start a better overview and understanding of what's happening rather than sort of just sort of finding your feet two months in kind of getting who, how everyone fits in. So I think that's been the biggest problem sort of I've had. So just trying to figure out who everyone is and you don't know anybody. (Dr Kirsty,FG)*

Dr Kirsty commented that it was challenging to engage one's ideas at meetings where:

> *…a) people don't know you, b) I'm a female and there are not many females unless they're from a nursing background and c) they're so much older… (Dr Kirsty, FG)*

Dr Maddox and Dr Bryn agreed with her. Introductions, or lack of them, were a factor affecting the speed with which Fellows could progress their projects and develop their organisational knowledge. Dr Kirsty also highlighted the challenge when she took up the post in August as both project Supervisor and main Supervisor were on holiday for much of the month. This prompted her to take a proactive approach:

> *I had two days with them and then they went on holiday. So it was either sit on my own in the office or go and be proactive and do something which is what I did. (Dr Kirsty, FG)*

Her Supervisor agreed that starting in August was a difficult time, but had suggested several areas to progress during his absence. Dr Kirsty felt it may have been helpful if the Supervisor had contacted some of the key players to tell them who she was, but "…unfortunately a lot of the key players were also on holiday" (Dr Kirsty, FG). However, she attended meetings, despite it being a bit "nerve wracking", as otherwise she was concerned about potentially wasted three weeks. As it was she felt "like I'm a month behind on my project" (Dr Kirsty, FG). Her Supervisor, however, thought he had introduced her to key people so that there were "things to be got on with" (Supervisor, tel int).

An ongoing challenge, experienced by all Fellows to some degree was other events taking priority. Meetings could be cancelled at the last minute if something of greater importance came up. Dr Kirsty elaborated: "We're not exactly anyone's priority when it comes to meetings or our projects" (FG). However, she did feel the host organisation had been supportive of her.

Support from colleagues and seniors

Some Fellows encountered a negative attitude to the Fellowship programme and projects. Dr Bryn elaborated his experience:

…and from the clinician side of things, it was very much 'oh what are you doing that for?' I didn't really think that,… the one comment off a [specialist] was 'we are coal face workers [specialty]. We don't normally get involved with stuff like that'. Because obviously I'm a [specialty] trainee, so immediately that's a very negative statement to make to someone who actually wants to get involved. (Dr Bryn, FG)

He was then informed that no-one had stood for [group] from the particular specialty, which Dr Bryn thought was ironic:

So there's a lack of leaders in [specialty] he's saying, but then he's putting me down for actually doing these projects. (Dr Bryn, FG)

Dr Kirsty agreed with Dr Bryn as she, too, had come across negative attitudes:

So a lot of [specialists] have put the programme down quite considerably like, 'you're wasting your time, what are you doing?' Which is quite difficult when you've just started a new job and you're actually feeling a bit nervous and a bit isolated. (Dr Kirsty, FG)

Thus on occasions, the Fellows had to justify to their colleagues and seniors the choices they have made.

Supervision

At the Focus group, Fellows discussed their experiences of supervision. At the outset Dr Bryn was having input into a whole programme and was meeting his Supervisors almost daily to discuss how things were progressing and things that need to be done.

His Supervisor stated that throughout the year, they had not formalised meetings but the team, which comprised two senior managers, the Fellow and him/herself met regularly. S/he stated that the team worked very closely together and stressed that "the senior managers would tell me if they were concerned." (Supervisor, int). Dr Bryn's Supervisor stated that it was important to have a level of trust in a Fellow which allows people to push to the edge of their competency and:

Knowing when to step in, when to rein back, when to check and there's a real balance in that. Because otherwise they're not being leaders…then they're not developing leadership skills so there is that balance of trust. (Supervisor ,int)

There were demands on a Supervisors' time, which could be a challenge, but s/he felt:

…you have to be willing to devote time um and um you have to be willing to prioritise it, and that's often the challenge…balancing all the day-to-day operational demands and something which actually could often be put off a little bit. (Supervisor, int)

However, s/he thought that the project had long term yield and importance, so it had to be prioritised. The Fellow had to feel that they were an important part of the team and if meetings were cancelled, it sent out the wrong message about their value in the team. She explained:

…I think for them to take on challenging and situations, they have to feel valued…I think um our clinical leadership Fellow is really highly valued in the team and that makes him quite ambitious, which is good for the whole project. (Supervisor, tel int)

Dr Maddox stated that he and his Supervisor were quite different people, which he felt was a good thing. More practically, at the early stage he remarked: "I think we're still finding our feet at the moment in terms of supervision" (Dr Maddox FG). His feeling was that as the host organisation had not had another registrar undertaking the kind of work his project involved, there would be an initial element of uncertainty regarding his capabilities, expectations and supervision and he understood this. He went on to explain:

> *[Supervisor] and I have been quite frank with each other about what needs to get done and what we need to do in order to get the most out of this year, so I think we're getting to a point now where we've got a real understanding. (Dr Maddox, FG)*

They had already worked through one project together during the first two months of the Fellowship. Although there had been a lot to take on in the first couple of weeks, "looking back I think it's been worthwhile." (Dr Maddox, FG)

According to the Supervisor, at the beginning of the Fellowship, Dr Maddox and his Supervisor met on a fairly regular basis, but as the Fellow settled into the work very quickly and "became part of the team" (Supervisor, int) meetings were held when necessary. The Fellow had accompanied the Supervisor on various "road trips" around Wales for various purposes.

Although Dr Gwen's project was "well defined and actually quite straightforward" (FG) compared to some of the other Fellows' projects, and she was able to get on with it, the lack of engagement with the Clinical Director (CD) was a problem:

> *…two and half months whatever it is down the line, … I've been to one meeting with CD. He just won't engage with it at all. (Dr Gwen, FG)*

To overcome this, Dr Gwen approached the Chief Executive and others within the host organisation:

> *…because he (Chief Executive) actually came and spoke to us on that first day when we were in the Welsh Government building and I just sent him an email…. and he was great. (Dr Gwen, FG)*

Contrary to Dr Gwen's comment about lack of engagement, the Supervisor stated that they had met several times and communicated via "emails and texts and phone calls". S/he stated that:

> *…because when she needs help or something, or …support from me, I'm always there for her… she finds where I am and comes to see me if something needs to be done on that day. (Supervisor, tel int)*

These comments highlighted the different perceptions of communication and engagement between Fellow and Supervisor.

Dr Kirsty had been assigned a mentor within the organisation. The Supervisor had met with both Fellow and mentor individually to discuss the project but not all three together.

The teleconference (23 July 2014) gave the Fellows the opportunity to reflect on the role of the Supervisor. All Fellows agreed that Supervisors need to actively support

the learning process of the Fellows. Dr. Kirsty reiterated her early problems of not having support at the initial stage of her post, which had held up her project for almost two months. She thought the commitment to investing time in supervision should be a prerequisite to an organisation taking part in the scheme. Concern was expressed by Dr Maddox (teleconf) regarding how Fellows and projects were assigned at the beginning of the year, and suggested a more rigorous approach should be adopted "to try and prevent, you know, problems with Supervisors not taking things seriously" (Dr Maddox, teleconf).

Although mindful that Supervisors worked in different ways, Dr Gwen agreed that Supervisors should be proactive in facilitating the needs of the Fellow. Even though Fellows had a "reasonable amount of clinical credibility" within their normal working environment, in this new role they had "absolutely no credibility" (Dr Gwen, teleconf) and "the only person who can give you that credibility is your Supervisor" (Dr Gwen, teleconf).

Dr Bryn had had "an amazing Supervisor" during his year and had still been catching up with them about twice a week. He stated that his Supervisor had been "the model Supervisor" (Dr Bryn, teleconf), the type of person that you would want in the role for the future.

> *So I think I've been really lucky and it's certainly made my life a lot easier this year. (Dr Bryn, teleconf)*

The other three Fellows saw how Bryn's Supervisor had ensured "that he got the most out of the year" (Dr Kirsty, teleconf). Dr Kirsty commented on how Dr Bryn's Supervisor had taken him:

> *… to the right meetings, raising his profile and knowing that actually he works for her and he was important. (Dr Kirsty, teleconf)*

She added.

> *It doesn't matter if you don't get on that well, it's just being given the opportunities. (Dr Kirsty, teleconf)*

Support from Peers – the Camaraderie

For Dr Kirsty, a particular highlight of the Fellowship was "having such a supportive network of friends really" (Dr Kirsty, teleconf). She appreciated the diversity of the small group in terms of their specialty, years of training and experience. She emphasised the importance of the early time away from Wales during the induction which helped to bond the group and worried that perhaps the next cohort would miss out on getting to know each other as well since that part of the programme had changed. Dr Gwen did not think that enlarging the Fellowship group in Wales would be particularly problematic. She suggested that Fellows would be embedded within their host organisations. She was grateful to have the other Fellows who had experienced similar problems and as the organisation of the Fellowship improved, the new cohort might not need such a supportive group of peers: "it would be easier for them" (Dr Gwen, teleconf).

Although Dr Bryn said they "had joked about it" (Dr Bryn, teleconf) all four had felt that despite being very different people, they had got on well throughout the year.

> *I think we've been really lucky as a group…. We have quite genuine good working relationships. (Dr Bryn, teleconf)*

Dr Bryn felt this had been very different from some of their English counterparts, where the group of Fellows had been much larger and more competitive.

Dr Maddox's Supervisor also commented on how well the Fellows had worked together and described the group as "quite a significant collective" *(Supervisor, int)*

The Projects

As a set of four, the projects were diverse. The progress of each had its challenges to a greater or less degree. At the focus group, the Fellows described briefly what was happening with their projects in the first two months of the Fellowship. Dr Maddox reported that his project was going well at this stage, despite the different way of working. Dr Bryn remarked:

> *The project is very much moving forward live and you can feel that it's changing every day as well. (Dr Bryn, FG)*

He was also involved with other work streams, which was helping him in "creating my little group" (FG). However, at this point in time, he wasn't entirely sure that his part of the project was achievable by the end of the Fellowship but was confident that he would "certainly have some outcome that I will have achieved" (Dr Bryn, FG). It was essentially a two-year project, and he planned to retain some involvement beyond the end of the Fellowship.

Dr Kirsty experienced problems with her project. Despite attending a variety of meetings, her biggest problem had been:

> *…trying to focus them down on the project and make sure that the aims are realistic and that's the biggest problem I've got…. Flight of ideas. They go off and they go 'we can do this, we can do this, we can do this' and I was like 'I just want one project, one project. (Dr Kirsty, FG)*

She was grateful for all the work that she had been given but was mindful:

> *…that I need something to show at the end of the year and that is a big problem I've got at the minute. …My project's meandering around. [Name] hospital are undergoing massive reconfiguration which I think is changing the path of my project very quickly. … And I'm worried that if I'm not careful I'm not going to have anything. (Dr Kirsty, FG)*

Securing financial backing for the project was difficult:

> *So there's quite a lot I'm involved in but it's just whether we can get any money for anything. That's the main hindrance to my projects. Because no matter how much I work and put the business plan in…. if there's no money, they're just throwing them out no matter. (Dr Kirsty, FG)*

She was facing many challenges but commented, "I'm adaptable" which was necessary as she was "having lots of unexpected events" (Dr Kirsty, FG). Dr Bryn asked

if she had presented on her progress, as it could have given a powerful message. Unfortunately, Dr Kirsty had not been allowed to present the business plan as they had over a hundred to go through at the meeting. Even though some things were moving forward and she had ideas and plans, various financial hurdles were preventing them reaching fruition.

> *It just doesn't feel like I'm achieving much because you work really hard at something and then it just gets dismissed like that, when it took me two weeks to write the business plan. (Dr Kirsty, FG)*

The other Fellows gave their encouragement and felt that despite the obstacles, Dr Kirsty had achieved quite a lot during the first two months. Dr Bryn commented that even though there may not be actual outcomes, "at the end of the year you can say you've put the business case together" (Dr Bryn, FG). He went on to add that if it had been a time of prosperity, the plan may have had every chance of becoming an effective service. This was a learning opportunity about medical management and how dysfunctional it can be.

Dr Gwen began her project by getting on with "low lying easy things" such as what peoples' experience of the current system was, and that could be finished quickly. She experienced more difficulty with the project later and thought there were historical problems with the set up. There appeared to be no strategic plan about how it was going to work:

> *…to be quite honest and all the way through it's been quite badly implemented. (Dr Gwen, tel int)*

One lesson she had learned was to be flexible: if something did not work, then try something different.

Dr Maddox's Supervisor discussed the difficulty of formulating projects some six to twelve months in advance. S/he stated:

> *I mean I think everywhere it's quite difficult to know what improvement you're going to want to do in a year's time, or six months' time. (Supervisor, int)*

S/he explained that the original project was an unknown until s/he was asked to look at the suggestion: "we didn't know we were going to do that before" (Supervisor, int). The Supervisor had found a gap in the wider project, and it turned out to be a very good fit with "our leadership Fellow's clinical background" (Supervisor, int). However, s/he stressed that even if that gap had not been identified, the project had been sufficiently structured so the Fellow could have slotted in elsewhere.

Dr Bryn's Supervisor agreed with Dr Maddox's that it was difficult to write specific objectives some six months in advance because the NHS "moves quite quickly" (Supervisor, int). S/he suggested that the application process for the projects needed to be looked as:

> *It was quite challenging to meet the requirements to put the objectives in and yet ... know that they would be meaningful in six months when the trainee took up post. So that was a challenge.…That very structured objective doesn't necessarily fit with the reality on the ground in the NHS and that may put off some people… who might be able to offer quite good projects. (Supervisor ,tel int)*

S/he felt projects needed to be fairly broad so that a niche could be found that suited the Fellow. A particular strength of the current project was:

> *..that it was fairly broad. There was a very strong management team in it, so that allowed us to fit the trainee in a place which suited his strengths. (Supervisor, int)*

Dr Kirsty recommended that future Fellowship projects should be linked to an established group, be achievable within the Fellowship year with "definite sort of outcome measures", and have suitable financial backing. Her Supervisor was somewhat uncertain on whether it was better to have a project embedded within an established project plan or a project that a Fellow could take from start to finish without being part of a fully formed plan. S/he thought that understanding the difficulties and complexities would be very useful for a future leader and "how funereally slowly things can change within the NHS" (Supervisor, tel int).

Dr Gwen reflected that if a project was too specific, it would be difficult to see how it would fit within the wider Health Board strategy, but if a project was slightly broader then it would be more strategic. Dr Gwen's Supervisor, however, expressed a preference for projects which were really specific and had "clear end points". S/he stated: "I actually prefer this type of project because I can actually control it" (Supervisor, tel int). However, s/he stressed that the type of project would depend on an organisation's needs and priorities for improvement.

Post Fellowship Plans

All four Fellows had given thought to their exit strategies from the Fellowship year. Dr Bryn had negotiated a "day a week beyond the end of the Fellowship." The Deanery seemed in favour of this, but he knew he needed to work it out with the training programme. He had made a strong case about the leadership experience being recognised as a valid part of the training. He did not feel he could 'delay' his progression to consultant and thought that one day a week of the Fellowship should be a recognised part of the training.

With her CCT approaching within a year and job pressures, her programme lead was keen for Dr Kirsty to return to 100% training. She felt her training programme had been "very kind to give me the year out" (Dr Kirsty, tel int) and although she had hoped to return less than full time training, "they can't sort of take me going back less than full time at the minute. (Dr Kirsty, tel int). Although she would be moving to another Health Board and would not be able to continue any work, her plan was to link with one of the Medical Directors and try to "keep her hand in" (Dr Kirsty, tel int) even it was just for one day per month. She stated that she needed to "crack on" (Dr Kirsty, tel int) and finish the project as there were jobs coming up in her particular field in August (2014) and had been advised from a career point of view by her programme lead that it would be better to get back into the training programme and then reassess the job market. She added:

> *The area where I really want to work they've already earmarked me as their next sort of person who goes into that role within their department, because no one ever wants to take it on. (Dr Kirsty, tel int)*

Dr Maddox had spoken to the Wales Deanery about returning to his previous department which had undergone changes in terms of management and future vision. He felt that:

…he could continue using the skills that I've learnt in the last year to help progress that [department]…I prefer to use the skills that I learnt here [host organisation] in more of a sort of innovation and research environment. (Dr Maddox, tel int)

Although the Fellow would not be able to access data from the host organisation, he planned to feedback on some group work that could be carried out within his home NHS organisation. There would be work that he could continue to undertake from a national perspective in Wales:

…so I think we will need to keep involving him and I think he'll be an asset to us. (Supervisor, int)

However, the Supervisor stressed that s/he had not had final conversations with the Fellow regarding the work he could complete while still in post. Given Dr Maddox's experience of the different workplace culture on the Fellowship, his Supervisor wondered if he might find it difficult on returning to his home organisation, as he would experience "more localised, more elemental, primitive type situations where I think he'll experience a degree of frustration" (Supervisor, int) and would probably miss the wider experience he had during the Fellowship.

Dr Gwen was staying within the Health Board from August 2014 and hoped to have some role in taking things forward, especially if the Health Board has another Fellow who would take on the specific project. However, she did realise that a full time clinical role would limit what she could offer in terms of time.

Impacts of the Fellowship Scheme

Financial impact on Fellows

In taking up the Fellowship, Fellows experienced a pay cut which some felt was insufficiently explained to them at the application stage. Dr Kirsty reported that:

I'm having to take on quite a lot of locum work… I've taken quite a considerable pay cut which I wasn't, I don't think any of us were that aware. (Dr Kirsty, FG)

This was in contrast to the English Fellows whose pay is better:

We know they're paid more than us and that's an inferiority issue but it's also an issue that will put people off I think. (Dr Bryn, FG)

Dr Bryn was aware that if the Wales Deanery wanted to attract quality candidates then they would have to think about the difference. Dr Bryn agreed commented on was being paid less money than he had ever been paid and undertaking locum work at weekends, had put a strain on his personal relationship as he was now "working more than I used to". At the induction the Fellows were told "you are the future leaders" (Dr Bryn, FG) but thought it "counterintuitive" to make "the future, the best of the best… take a pay cut".

Another financial implication for the Fellows was the rise in medical insurance because they were not in training posts. Undertaking out-of-hours locums also impacted on their MDU (Medical Defence Union) subscriptions.

Career impact

Having undertaken a higher degree in the two years prior to the Fellowship, Dr. Maddox was aware he would be "rusty" but he had kept up skills during locum work. Dr Bryn concurred that that the locums were "…keeping me in clinical practice" (Dr Bryn, FG). Dr Gwen stated that she had kept up the 20% allowed for clinical work within the Fellowship scheme and had undertaken on-calls, but wanted to give them up despite it being a "monetary hit" (Dr Gwen, FG) and would advise future Fellows to undertake no more than one day clinical activities per week:

> *…I just feel like it's impinging on my ability to commit properly to the actual Fellowship frankly. (Dr Gwen, FG)*

Dr Kirsty suggested that leadership competencies might be introduced which in combination with clinical duties could count towards time off the training programme. She argued that Fellows would find it useful to know they were gaining some generic skills to aid progression and that all Fellows were having the same basic skill set.

Impact of the Fellowship – Supervisors' perspectives

The positives of having a Fellow, from the Supervisors' point of view, were having a keen and eager addition to their team, which added value to new or existing projects. Fellows could bring a fresh perspective to an organisation or project. They were perceived as an asset to the organisation, although this did not always translate to what actually happened on the ground. The Fellows had experienced variable levels of supervision during their year. Some had very motivated Supervisors, who had met them on a regular basis to discuss their project, introduce them to key people and generally guide and support them. Others had been more left to their own devices at times. Fellows need the support of their Supervisors to raise their profile.

According to his Supervisor, Dr Maddox had fully integrated into the project, mindful of high public profile and political context within which he was working. The initial part of the project was achieved quite quickly, and it had been handed over to the technical team within the organisation. The Supervisor described this as "a significant achievement" and added that his contribution was "highly valued in here" (Supervisor, tel int).

This Supervisor felt that there had been "many more benefits than drawbacks" (Supervisor, tel int) to having a Fellow in the organisation. The relative youth of the Fellow, his engagement with the NHS and his "*perspective on life has been a bit of a breath of fresh air in here"* (Supervisor, tel int). Having a Fellow had been a very positive experience for both Fellow and host organisation, and that:

> *…if we didn't have one [Fellow] at any stage I think that would be a real missed opportunity. (Supervisor, tel int)*

Dr Gwen's Supervisor was mindful of the obstacles at the start of the project, but felt she had overcome these and successfully implemented the system for [specialty] and had secured financial support from the Finance Director for one aspect of the system. S/he also commented that Feedback from users had been very positive.

Dr Kirsty's Supervisor was keen to stress that Dr Kirsty had been:

…an important additional member of our management team… and things have happened that wouldn't have happened if she wasn't with us. (Supervisor, tel int)

The Supervisor added that within the wider management team within the directorate she's been seen as "a huge bonus to have around really" (Supervisor, tel int). S/he observed that the Fellowship scheme provided an opportunity for understanding how things "operate on a day-to-day basis" and that:

…doctors are perhaps not very enthusiastic always of being involved in clinical management. So any project to give people exposure to it and to promote enthusiasm in that area would be a good idea. (Supervisor, tel int)

From an organisational point of view, s/he thought:

…having people in that role who go on to become clinical leaders and managers in the future, it can only be a benefit on a more longer-term basis. (Supervisor, tel int)

S/he further commented that s/he was wholly positive about the Fellowship:

I would think that both from the individual trainee and based on conversations and also from my personal and organisational perspective, it's been a hugely positive thing. (Supervisor, tel int)

From the outset, Dr Bryn's Supervisor thought:

I personally would benefit from having a trainee around. Someone to challenge me and my thinking, and it's been all those things. It's been really positive. (Supervisor, int)

S/he felt that having a Fellow and in particular Dr Bryn, with his background in [organisation] and ambition had been very advantageous for the project. However, s/he was less sure that there was a real understanding of the added value the Fellows bring to a project or organisation:

…I think probably we need to think about working with the [Wales] Deanery to look at how we can ensure that the value is appreciated at executive and chief executive level. (Supervisor ,int)

One idea s/he suggested was profiling them:

There probably needs to be at the end of the year some sort of presentation where the great and the good are invited to see what they've achieved during their year or something like that. (Supervisor, int)

Changes to Programme for new cohort

The Fellows are 'mentoring' to the new cohort. Dr Kirsty had already met with her mentee and introduced her to key people within the organisation, especially her Supervisor, who would potentially be on leave at the start of the Fellowship. Dr Maddox and Dr Gwen had talked to their respective mentees at the 'welcome' meeting on 22 July 2014. The Fellows envisaged that meetings with mentees would be on an informal basis.

Comparisons with Evaluation of Darzi Fellowship Programme

A key driver for both the NHS London 'Darzi' Fellowship Programme and the WCLT Fellowship programme was to ensure "a continuous supply of high quality leaders" (London Deanery, 2010). We compared of outcomes of the evaluation of the Darzi Fellowship Programme with the Wales programme and found similarities in both successes and issues. We highlight some of these but note first that there were 39 Fellows in the first cohort in the London Deanery, compared with just four in the Wales Deanery. This limits the extent of meaningful comparison.

The evaluation of both the Darzi and the WCLT Fellowship programme highlighted the importance of clarity of aims and expectations: the aims of the Fellowship need to be clear to potential applicants and the expectations of host organisation and the Fellows role within it also need to be clear. Both English and Welsh Fellows were, on occasions, faced with "unrealistic projects … and inaccessibility of support." (London Deanery, 2010).

The WCLT Fellowship programme, like the Darzi Fellowships had a significant impact, on the Fellows or "mind-shift". The programmes developed Fellows' skills in communication, action learning and gave them networks of peers and leaders, both within and outwith their organisations. Although some doubts were voiced about how knowledge could be translated into clinical practice, Fellows in England and in Wales expressed their eagerness to use the knowledge gained in their clinical roles. Supervisors recognised how the Fellows had contributed to service improvement changes, even if on a small scale.

The 'Darzi' programme evaluation highlighted the role of quality of mentoring. This was also raised in discussion with the Welsh Fellows.

Conclusions

Following induction, the Fellows were asked how they would assess the success of their Fellowship year. They identified a number of indicators. One that they all agreed on was achieving the postgraduate diploma at the end of the training. This expectation was only partially realised as the programme ended up attracting a Post Graduate Certificate, not diploma, although they had the option to put the credits towards a certificate. They were unhappy that the assignment requirements had increased:

> *It was sold as a diploma with a 3000 word essay and it's turned into a certificate with 15,000 words. (Dr Bryn, teleconf)*

Another indicator of success for the Fellows related to projects. Even though some of the Fellows had experienced problems in either setting up or overcoming barriers within their organisation, the overall feeling was that the workplace projects had been successful, at least to some degree. Through the projects, the Fellows gained insight into leadership and a management including an understanding of strategy, how to effect change, the impact of funding on decisions, political influence on strategy, the nature of the NHS as a whole.

The projects were an important part of the programme. Fellows suggested that rather than specific single projects, continuous service improvement (CSI) leads might identify" an array of projects" within a work stream "which you could potentially get involved with" (Dr Gwen, teleconf). Dr Gwen had opted for a project in her own specialty but reflected that it may have been better "doing something completely different" (teleconf) which would have given her a wider perspective.

Experience of chairing meetings was specifically mentioned as a measure of success. Although not all specifically mentioned gaining such experience, all had attended meetings at various levels during the year. The meetings gave them opportunity to meet and network with key people within the organisation and provided insight into leadership in action and group interaction. Other measures of success that were mentioned included managerial experience, publications and presentations, aspects of which all Fellows had experienced. They were involved in preparing briefing papers; writing and publishing project support documents and leaflets; internal presentations to senior management and participation in selection processes within their host organisation and involvement in the interview process for new Fellowship cohort.

Suggested improvements

The teleconference elicited ideas for improvements to the Fellowship and training programme. These have been noted earlier and are briefly summarised:

- Using service improvement leads to identify suitable and achievable projects.
- Clarifying expectations, including that Fellows are responsible for organising their clinical work themselves
- Introducing leadership competencies which combined with clinical duties could count towards specialty training
- Explaining the financial implications of the Fellowship and discussing the benefits and costs of retaining clinical
- Consideration, taking into account individual Fellows learning requirements, given to developing regular links with Welsh Government (unique, mutually beneficial experience and serves to retain the high profile of the Fellowship programme).
- Ensuring supportive Supervisors who meet regularly with Fellows and act as advocates for them and their project
- Introducing an end of year event where Fellows can showcase their projects.

Appendix I: Academi Wales Clinical Leadership Programme

Clinical Leadership Training Fellows Development Programme

'Putting Doctors at the heart of transformation, leading from the front'

October 2014—September 2015

1. Introduction

The Clinical Leadership Training Fellowship programme, led by the Wales Deanery in collaboration with Academi Wales, Welsh Government, aims to provide training and "hands-on" experience in clinical leadership and management. Equipping fellows with a range of knowledge and skills required to be credible and influential medical leaders.

The NHS Next Stage Review: High Quality Care for All (Darzi 2008) highlighted the importance of effective leadership in the NHS and, in particular, the need for greater involvement of clinicians in leadership. A factor increasingly recognised as critical for high performance and successful improvement and transformation in the NHS.

Tomorrow's Doctors underlines the need for all doctors to be leaders, and the link between leadership and quality improvement is made clear: "It is not enough for a clinician to act as a practitioner in their own discipline. They must act as partners to their colleagues, accepting shared accountability for the service provided to their patients. They are also expected to offer leadership and to work with others to change systems when it is necessary for the benefit of patients" (GMC 2009).

The underpinning training and qualification programme offered here builds on the design of the successful NHS London Darzi Leadership Fellowship programme, tailored to reflect the welsh health system changes and policies. Content is also informed by the Medical Leadership Competency Framework developed by the NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges (2010),

Fellows will join a cohort of the NHS Wales Medical Leadership Programme, which prepares and supports senior doctors and medical leaders with the development of leadership skills, competencies and behaviours. Joining the cohort will provide the opportunity to network with, and learn from the experiences of senior colleagues from across welsh health organisations.

2. Programme Overview

The programme is designed to develop understanding of effective management as well as the individual's capacity to effect service improvement and leadership.

Programme outcomes include:

Clinical Leadership Training Fellows Development Programme

"Putting Doctors at the heart of transformation, leading from the front"

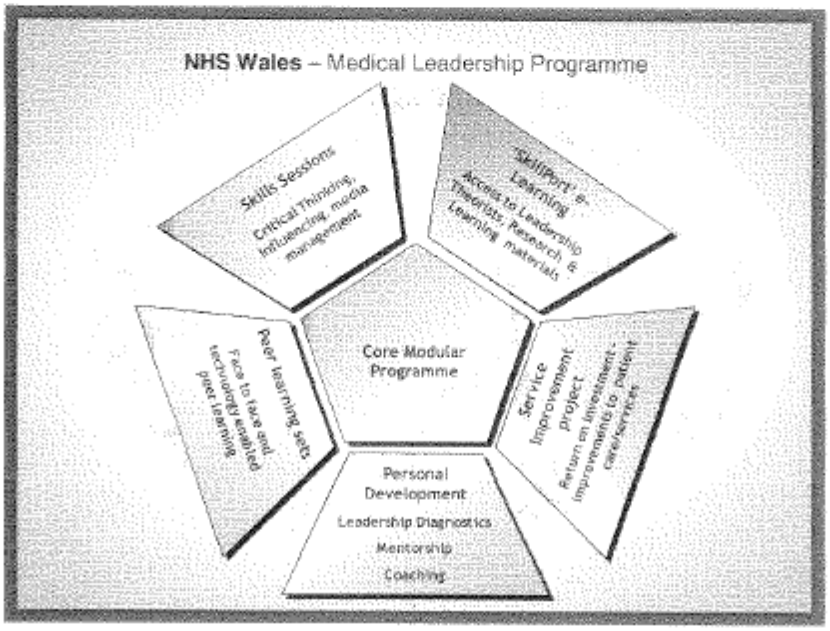
Contents

- Support and achievement of organisational objectives through effective management and leadership of people and resources.
- Support and delivery of service innovation
- Increased self awareness and understanding of personal impact on situations with strategies for improved effectiveness.

The programme aims to provide a blended learning approach with a range of learning and development opportunities (Fig 1). The core components of the medical leadership programme include:

- Service improvement /change project
- Modular Workshops
- SkillPort online leadership resources in support of each module, with a pathway of identified learning to include seminars, lectures, books and articles.
- Residential Learning Community (3 day 2 night)
- Action Learning sets
- Skills sessions
- Leadership Diagnostics
- Mentorship by an Executive Director

Fig 1. Medical leadership programme of learning and development opportunities

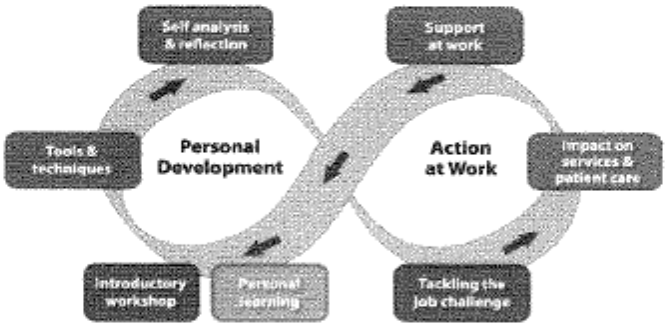


2a. Service Improvement Projects:

The learning framework is supported by a service improvement / change project/s, the focus of which will need to be identified by the individual participant and stakeholders within their organisation prior to commencement. The project supports the learning in practice allowing immediate application of principles explored within each module. This is known as double-loop learning (Fig 2).

The project focus should be related to improving services for patients. Delivery of the project will enable the participant to further develop their leadership, change and improvement skills. In addition it is expected that the presentation of the findings of the project will serve to promote the participant within their organisation and the wider health community. All the projects will be promoted through the Academi Wales Learning Channel, as well as the participant's Health Board/Trust communication channels.

Fig 2.



Derived from Ashridge articles

2b. Modular Workshops.

The programme will explore a number of leadership themes which will be presented in modular format. Each module will be supported by a workshop and a range of 'SkillPort' online resources accessed via the Academi Wales Learning Channel. Workshops will consist of thought leaders and speakers, group work and discussion as well as experiential opportunities.

To equip participants with access to research and skills training, participants will be able to access the Academi Wales Learning Channel and web enabled resources.

Programme Module titles:

- Introduction and project management
- Understanding the political and strategic context
- Leading improvement
- Leading people and teams
- Leading engagement
- Leading across organisational boundaries
- Leading the Quality and Safety Agenda
- Leading through effective communication

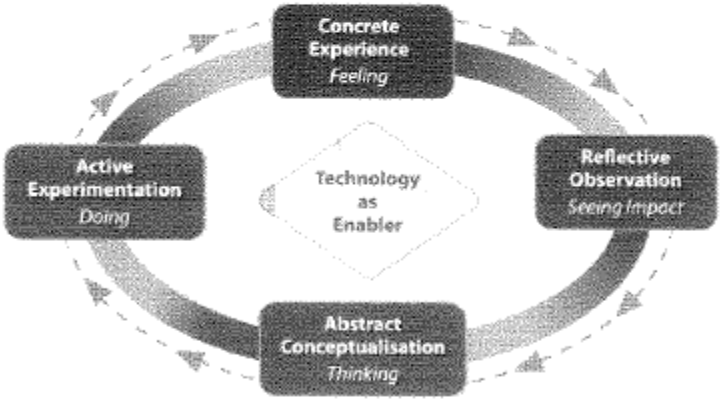
2c. Residential Learning Community

The 'Leading People and Teams' module will be delivered via a residential learning community which will require a 3 day, 2 night stay. Content contains a mixture of theoretical instruction and experiential opportunity. Learning can immediately be put into action, with leaders testing their skills in unfamiliar situations and surroundings.

2d. Peer Action Learning sets / Skills Sessions

These sessions will be delivered face to face over a half day with the remainder of the day, where a full day is scheduled, focused on skills training. Based on the well researched Kolb learning cycle (Fig 3) the process encourages research, action in the workplace, reflection and improvement to services.

Fig 3.



The skills based sessions may include critical thinking exercises; influencing skills and needs led activities.

2e. Coaching

Fellows will be able to access a coach of their choice through the "face book style" 'Coaching Wales', accessed via the Academi Wales Learning Channel https://www.learningwales.tv. Many coaches offer their services free of charge to NHS Employees and where necessary fellows can utilise mobile and web enabled technology to access support (the exact methods to be agreed by you and your coach). Alternatively you may find a coach from within your or a neighbouring Health Board/Trust.

2f. Diagnostics – Leadership Framework 360° feedback

Each fellow will complete a Healthcare Leadership Model 360° appraisal (NHS Leadership Academy) and receive feedback from a qualified feedback facilitator. This will be undertaken towards the end of their clinical leadership fellowship and inform their future development plan. A number of other individual diagnostic tools may be undertaken during the development programme as part of skills sessions and coaching.

2g. Mentorship by Executive Director

To enhance the learning from the programme each participant will be required to identify a sponsor/mentor at executive level, this may or may not be the Medical Director. There will be an expectation that the participant will meet formally with their sponsor/mentor at least 3 times during the course of the programme.

Executive Director mentors are also able to access a Professional Certificate in Mentoring accredited by Strathclyde University Business School.

3. Academic Accreditation

The Medical Leadership Programme is accredited by the University of Wales, Trinity Saint David and a Postgraduate Certificate in Professional Practice (Clinical Leadership) - Level 7/Masters (60 credits), will be awarded to those who successfully complete the Academi Wales Medical Leadership Programme.

Successful completion will involve ensuring 80% attendance at workshops and action learning in addition to meeting the learning outcomes and assessment criteria of two modules required for the Award of Postgraduate Certificate. Further details can be found over page.

- **Module 1 Leading Service Improvement**

Aim: To enable learners to pursue an individual work-based leadership project which improves health care services.

Learning Outcomes

- Upon successful completion of this module, the learner should be able to demonstrate the ability to:

- Evidence detailed knowledge which supports the achievement of organisational objectives through effective management and leadership;

- Identify and apply a range of leadership and organisational change tools, models and theories to complex systems and develop innovative leadership strategies to effect patient focussed improvement;

- Negotiate a substantial, methodologically sound investigative study related to improving services for patients demonstrating due regard to value-conflicts and ethical issues;

Assessment Criteria:

Coursework: Work-based project - 100% (7500 words or equivalent – 30 credits)

Assessment Component 1 – (10% 500 -1000 words)
Project Proposal including ethical consideration and approval if required

Assessment Component 2 – (60% 4000 - 4500 words)
A work-related project to improve health care services.
Participants will be required to complete a project report which will be marked and assessed by the University or its associates This will include a rationale, a workplace implementation study and evaluation.

Assessment Component 3: (30%) An oral presentation focusing on the impact of the project on the workplace for all stakeholders.
Participants will present their project and wider learning to a panel consisting of University and Academi Wales representatives and Health Board/Trust Executive Director representatives to include your sponsor/mentor

- **Module 2 Reflection on Clinical Leadership**

Aim: To provide learners with the knowledge and skills necessary to deliver effective clinical leadership.

Learning Outcomes

Upon successful completion of this module, the learner should be able to demonstrate the ability to:

- Evaluate and critically reflect upon the impact of their personal leadership style identifying strategies for development;
- Demonstrate advanced knowledge and application of clinical leadership strategies and influencing skills within their scope of responsibility;
- Demonstrate a critical appreciation of a wide range of leadership skills and apply them to complex collaborative leadership contexts within NHS Wales;

Assessment Criteria

Coursework – 7500 words or equivalent – 30 credits

Assessment Component 1 – A critical analysis of personal leadership style and a personal leadership development plan. (20% - 1500)

Assessment Component 2 – Reflective Accounts (80% - 6000)

A range of reflective accounts focusing on the application of all aspects of leadership development will be required

4. Evaluation

It is expected that an evaluation study of the programme will be undertaken to identify successes, lessons learnt and return on investment.

5. Funding

Academi Wales will provide full funding for CLT Fellows to attend the Medical Development Programme to include accommodation costs relating to the residential community. Fellows and their organisations will be responsible for travel expenses and any overnight accommodation required outside of the residential learning community.

6. Programme Commitment

The development programme will be delivered over a 12 month period. Commitment for attendance on the development programme is outlined below:

- Introductory Workshop x 1 day and Celebration / Final Presentations x 1 day
- 1.5 - 2 hour 360° Healthcare Leadership Model feedback session
- 10 module workshop days (to include residential community)
- 4 Action learning/Skills workshops
- 2 x 3.5 hour (half day) Action Learning Sets
- Skillport e learning leadership related materials via Academi Wales Learning Channel

Total commitment:

The equivalent of 17 days not accounting for feedback and additional e-learning and coaching hours.

7. Medical Leadership Programme Schedule

Date	Activity
Thursday 2nd October 2014	**Introductory Workshop** Programme structure / expectations Scoping Project / Service Change Project Planning
Wednesday 22nd October 2014	**Understanding Political and Strategic Context Workshop**
Tuesday 18th and Wednesday 19th November 2014 (2 Day workshop)	**Leading Improvement Workshop** Improvement Methodology includes Silver Level 'Improving Quality Together'
November 2014	**Executive Sponsor meeting** Suggested timeframe
Wednesday 17th December 2014	**Introduction to Action Learning**
Thursday 8th January 2015	**Leading Engagement Workshop**
Tuesday 27th January 2015	**Action Learning / Skills Workshop**
February 2015	**Executive sponsor meeting** Suggested timeframe
Wednesday 11th – Friday 13th February 2015	**Residential Learning Community: Leading People & Teams** (Team Theory and Culture Change)
Thursday 5th March 2015	**Action Learning (½ day am)**
Tuesday 24th March 2015	**Leading across Organisational Boundaries Workshop**
Wednesday 22nd April 2015	**Action Learning /Skills workshop**
Tuesday 19th May 2015	**Leading the Quality and Safety Agenda Workshop**

June 2015	**Executive sponsor meeting** Suggested timeframe
Thursday 11th June 2015	**Action Learning (½ day am)**
Wednesday 1st July 2015	**Leading Organisational Communication**
June/ July 2015	**Set up and complete online 360° Healthcare Leadership Model appraisal** **(40 mins -1 hour)**
Tuesday 28th July 2015	**Action Learning / Skills Workshop**
August 2015	**Receive 360° Healthcare Leadership Model feedback** **(1.5-2 hours)** **Date and time to be negotiated with your feedback facilitator**
16th September 2015	**Celebration Event – Patient Impact / Service Change Presentations**

Venues to be confirmed - will be mainly along the M4 Corridor, South Wales.

Programme Schedule – October 2013 Cohort

Date	Activity	Venue
July 18th 2013	Briefing Session with Supervisors (½ day)	
August 2013	Local Induction by Host Organisation	
2nd-4th September 2013	Induction to Fellowship (with FMLM Fellows – England)	
9th September 2013	Visit to Welsh Government Understanding the role of Welsh Government and NHS in Wales	
10th & 11th September 2013	Induction to Fellowship (with FMLM Fellows – England)	
2nd October 2013	Introductory Workshop Programme structure/expectations Scoping Project/Service Change Project Planning	Wallis Room, All Nations Centre, Cardiff
23rd October 2013	Understanding Political and Strategic Context Workshop	Pro-Copy Lounge, SWALEC Stadium, Sophia Walk, Cardiff CF11 9SZ
20th & 21st November 2013 (2 Day workshop)	Leading Improvement Workshop Improvement Methodology Includes Silver Level 'Improving Quality Together'	Leckwith Suite Cardiff City Stadium, Leckwith Road, Cardiff University CF11 8AZ
November 2013	Coaching Session Suggested timeframe	
17th December 2013	Introduction to Action Learning	Main conference room, Welsh Government, Llys-y-ddraig, Penllergaer Business Park, Swansea SA4 9NX

8th January 2014	Leading Engagement Workshop	Main conference room, Welsh Government, Llys-y-ddraig, Penllergaer Business Park, Swansea SA4 9NX
29th January 2014	Action Learning/Skills Workshop	Leckwith Suite Cardiff City Stadium, Leckwith Road, Cardiff University CF11 8AZ
January/February 2014	Coaching Session Suggested timeframe	
19th-21st February 2014	Residential Learning Community: Leading People and Teams (Team Theory and Culture Change) 13.00 on 19th Feb to 13.20 21st Feb to allow travel time	Elan Valley Lodge, Elan Village, Rhayader, Powys LD6 5HP
13th March 2014	Action Learning (½ day am)	Will wait until groups have formed for best location
1st April 2014	Leading across Organisational Boundaries Workshop	Main conference room, Welsh Government, Llys-y-ddraig, Penllergaer Business Park, Swansea SA4 9NX
30th April 2014	Action Learning/Skills workshop	Leckwith Suite Cardiff City Stadium, Leckwith Road, Cardiff University CF11 8AZ
April/May 2014	Coaching Session Suggested timeframe	
May 2014	Set up and complete online 360º Leadership Framework appraisal	

15th May 2014	Quality and Safety Workshop	Main conference room, Welsh Government, Llys-y-ddraig, Penllergaer Business Park, Swansea SA4 9NX
5th June 2014	Action Learning/Skills workshop	Leckwith Suite Cardiff City Stadium, Leckwith Road, Cardiff University CF11 8AZ
June 2014	Coaching Session Suggested timeframe	
June 2014	Visit to Boston, Massachusetts (MIT, Massachusetts General Hospital, etc)	
25th June 2014	Innovative Leadership Workshop	Main conference room, Welsh Government, Llys-y-ddraig, Penllergaer Business Park, Swansea SA4 9NX
15th July 2014	Action Learning (½ day am)	Will wait until groups have formed for best location
July 2014	Receive 360º Leadership Framework feedback (1.5-2 hours)	Date and time to be negotiated with your feedback facilitator
August/September 2014 Date TBC	Celebration Event – Patient Impact/Service Change Presentations	Venue to be confirmed

Appendix II: Information on the Projects

Project Title:	Treating acute medical illness in the community
Medical Director:	Dr Pushpinder Mangat
Organisation:	Abertawe Bro Morgannwg University Health Board

Project Summary:

The successful candidate will undertake an exciting project around the reconfiguration of Acute Medical Services in Swansea to develop a robust system for providing appropriate levels of care in the correct environment, be that in the Community, Hospital Ward or Higher Level Unit. This project is aimed at delivering the integration of care across Primary care and the hospital acute assessment areas.

Project Title:	VOCERA – Instant communication for hospital staff on the move
Medical Director:	Dr Graham Shortland
Organisation:	Cardiff and Vale University Health Board

Project Summary:

The main premise of the project will be the introduction of the VOCERA hands free communication system in main theatre complex in University Hospital of Wales. The current bleep system is an indirect mode of communication that necessitates the use of telephones, which relies heavily on the availability of telephones which, in an emergency clinical situation, is not only impractical but potentially dangerous.

The fluid uncompromising environment of operating theatres demands effective and timely communication to ensure productivity and patient safety. A hands free speech device allows appropriate communication with the person who needs to be contacted while operating for example. This will lead to improved efficiency and less waste of theatre and personnel time. We have already invested £20,000 in the capital for the devices – the roll out to main theatres and surgical wards will be the next phase.

Project Title:	The development of an integrated primary, community and secondary care emergency service model for the population of Llanelli
Medical Director:	Dr Sue Fish
Organisation:	Hywel Dda Health Board

Project Summary:

The 2 year programme will be led by a Clinical Manager (Dr Sian Lewis, Associate Director for Clinical Support Services) and a General Manager (Mr Mansell Bennett). Dr Sian Lewis will take on the role of educational manager and line manager for the 12 month post. The general project requirements are as follows:

1. To work with a project board to develop a Project Initiation Document:
    - Defining the background to the project (ie the problem it's trying to solve) and its scope
    - Defining the benefits and timescales
    - Identifying and managing risk
    - Identifying roles and responsibilities
    - Developing a project plan
2. To provide Clinical Leadership for Implementation of the project plan and chair project group meetings in association with either the Clinical or General Manager leading on the project
3. To jointly project manage the workstream, monitoring timescales and mitigating as necessary
4. To provide reporting documents as necessary for the Programme Board, County Management Teams and Health Board Executive Teams as necessary
5. To undertake programme evaluation based on recent academic theory regarding evaluation of quality improvement within the health service

Project Title:	Clinical Leadership in Wales
Medical Director:	Dr Ruth Hussey OBE
Organisation:	Welsh Government

Project Summary:

This role involves the development and delivery of an all Wales clinical leadership programme for the Chief Medical Officer (CMO) for Wales, Dr Ruth Hussey OBE, and Deputy Chief Medical Officer (DCMO) for Wales, Dr Chris Jones.

The leadership Fellow will be based in the Office of the Chief Medical Officer (OCMO) in Cathays Park, Cardiff. Key Tasks will include:

- Overseeing leadership training and development locally and nationally in Local Health Boards and Trusts.
- Working with Medical Directors and UK colleagues to develop the Welsh Regional Faculty of Medical Leadership and Management.
- Ensuring talent pipelines are designed and implemented in Local Health Boards and Trusts.
- Monitoring Medical Engagement Scale work in Local Health Boards.
- Working with multi-disciplinary colleagues to produce programmes to develop and accredit managers and clinical/management team building.
- Being part of the CMO's Task and Finish Group on Clinical Leadership, supporting the development of a strategy for clinical leadership development at all levels across all Wales NHS organisations.
- Developing and implementing a clinical engagement strategy aimed at ensuring clinicians are kept informed about developments and are able to contribute views/ideas through a wide range of mediums.
- Working with colleagues in OCMO and Communications to support a CMO/DCMO engagement strategy encompassing:
  - a leadership component to the current CMO update;
  - a CMO blog;
  - CMO social media presence (Twitter, Facebook, etc);
  - CMO workshops (perhaps one each month on an ongoing basis around Wales)