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Longitudinal Impact of Welsh Clinical Leadership Fellowship

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Title: Longitudinal Impact of Welsh Clinical Leadership Fellowship

Abstract

Purpose: To evaluate the longer-term impact of the 12-month Welsh Clinical Leadership Fellowship.

Design/methodology/approach: Semi-structured interviews with ten out of 14 trainee doctors who were fellows between 2013-2016, exploring how leadership knowledge and skills were used in clinical practice, impact on patient care, and influence on careers. Data~~ were~~ gathered in 2017, when participants had completed the Fellowship between one-three years ago, were analysed thematically.

Findings: All found the Fellowship rewarding. The experience was felt to advantage them in consultant interviews. They gained insight into the wider influences on organisations and the complexity of issues facing senior clinicians. Although subtle, impact was significant, equipping fellows with negotiation skills, enabling them to better influence change. Indirect impact on clinical practice was evidenced by enhanced confidence, teamworking skills and progression of improvement projects. However, use of skills was limited by lack of seniority within teams, demands of medical training and examinations. The negativity of others towards management and leadership was also noted by some.

Research limitations/implications: Small participant numbers limit generalisability.

Practical implications: The Fellowship is designed to equip participants with skills to lead improvements in healthcare delivery. Those more advanced in their medical training had greater opportunity and seniority to lead change and were better placed to apply the learning. This has implications to whom the training should be targeted.

Originality/value: A rare study exploring the longer-term impact of a leadership programme on later clinical practice which adds to the body of knowledge of impact and efficacy of leadership training programmes in healthcare environments.

Keywords Clinical Leadership, Evaluation, Wales

Paper type Research paper

Background and Purpose

The importance of medical leadership and management in the complex organisation that is the National Health Service (NHS) has been advocated in the literature (Griffiths, 1983; Darzi, 2008; Francis, 2013). The General Medical Council guidelines outline the wider management and leadership responsibilities of doctors within the workplace (GMC, 2012). Exercising these responsibilities depends on seniority of role within an organisation, notwithstanding the primary duty of all doctors which is "the care and safety of patients" (GMC, 2012). Over the last decade or so, a variety of training programmes have been set up in the UK to overcome the low level of engagement, as noted by Bohmer (2012), of doctors in leadership and management (Darzi, 2008). These include the National Medical Director's Clinical Fellow Scheme; Yorkshire and Humber Improvement Academy Clinical Leadership Training Programme; Scottish Clinical Leadership Fellowship; Northern Ireland Medical and Dental Leadership Fellows' programme; as well as the Welsh Clinical Leadership Training Fellowship. Although eligibility criteria and the content of programmes differ, in essence their aim is to provide trainee doctors with the skills and theoretical knowledge to undertake leadership and management roles in their future careers.

Set up in 2013, the Welsh Clinical Leadership Training Fellowship (WCLT) is a 12-month programme representing a collaboration between Health Education and Improvement Wales (HEIW) (formerly the Wales Deanery), Academi Wales, Welsh Government and NHS Wales. The aim of the Fellowship is to provide doctors and dentists with opportunities to enhance skills, knowledge and understanding of healthcare management, leadership and policy and to develop clinical managers capable of building and leading improvements in healthcare delivery in the NHS.

The WCLT is open to trainee doctors and dentists undertaking core or higher specialty training. As part of the programme, fellows undertake a leadership project, under supervision, within their host organisation, which is typically health boards. Projects are identified by the host organisations and focus on improving services for patients. They are designed to enable fellows to apply to practice the principles of leadership and management which they explore within the training modules. Fellows are encouraged to engage with other host-based opportunities, including attending meetings and working with multi-professional teams.

During the year, fellows attend a structured leadership training programme run by Academi Wales, which provides opportunities to network with and learn from senior medical colleagues across Welsh health organisations. Although the majority of their week is spent on the service improvement project, fellows are allowed to continue with clinical duties for up to a maximum of 20% of their time.

The literature identifies many different models of leadership and leadership training, most of which comprise similar core competencies. The CanMEDS (Canadian Medical Education Directions for Specialists) Framework (Royal College of Physicians and Surgeons of Canada, 2005; Viches *et al, 2016)* outlines seven roles which are fulfilled by medical experts. One of the roles is 'leader' which entails responsibility for the ongoing operation and improvement of the healthcare system; contribution to administration, teaching and scholarship; efficient use of resources; and improving practice at personal, team, organisation and system levels. This framework has been widely adopted. For example, both the Royal Australian College of Medical Administrators (RACMA) medical leadership and management curriculum and the Danish Health and Medicines Authority (2014) are organised around the CanMEDS framework.

In the UK, the NHS Leadership Qualities Framework (LQF) (2003) model comprises fifteen qualities, arranged in three clusters: personal qualities; setting direction; and delivering the service. This model is a general framework aimed at all staff in the health service. Similarly in the UK, the Medical Leadership Competency Framework (MLCF) model (2010), as designed by the NHS Institute for Innovation and Improvement and The Academy of Medical Royal Colleges, is specifically aimed at doctors and has five domains: demonstrating personal qualities; working with others; managing services; improving services; setting direction

The Academi Wales leadership programme was informed by the MLCF (2010) (Table 1) and designed to develop or enhance leadership skills, competencies and behaviours for medical leaders of the future.

Table 1: How the Academi Wales Leadership Programme relates to the Medical Leadership Competency Framework

Academi Wales Medical Leadership Programme	Medical Leadership Competency Framework (MLCF)

Self-awareness	Personal qualities
Effective management and leadership of people and resources	Working with others Managing services
Delivery of service innovation	Improving services
Strategies for improved effectiveness	Setting direction

The competencies of the WCLF programme, achieved through service improvement projects and the academic programme, are designed to: support and achieve organisational objectives through effective management and leadership of people and resources; positively impact on patients through support and delivery of service innovation; increase self-awareness and understanding of personal impact on situations and provide strategies for improved effectiveness. The projects are a key part of the programme, and as noted by Ten Cate et al (2010), competence means not only knowledge and skills but also their application. The projects provide opportunity to further develop and apply leadership skills.

We have reported our earlier evaluation of the programme, drawing on data collected during the course of the programme (Phillips and Bullock, 2018). Effective evaluation needs to be part of the overall development strategy (Phillips and Phillips, 2001) and only a small proportion of evaluation programmes have assessed long-term impact (Kellogg Foundation, 2002). The aim of this study, therefore, was to evaluate the longer-term impact of the WCLF on the work of former Fellows: how, and in what ways, do fellows use the knowledge and skills acquired during the Fellowship year within their clinical practice; what impact, if any, did the programme have on fellows' clinical practice and patient care; and what was the influence of the Fellowship on careers?

Method

We adopted a qualitative, interview-based longitudinal approach focused on the first three cohorts of the WCLF programme. A total of 14 fellows undertook the programme from its inception in August 2013 to those who completed the Fellowship year in July 2016.

An initial email was sent to all fourteen prospective participants, and follow-up emails sent to non-responders, inviting them to take part in a semi-structured interview by telephone or face-to-face according to their preference. Ethical approval for the study was granted (28

February 2017) by the research ethics committee of Postgraduate Medical and Dental Education at Cardiff University. For the purpose of the study, all fellows' names were anonymised. We include reference to the year in which participants undertook the WCLF programme such that C1 is cohort 1 (2013-14), C2 cohort 2 (2014-15) and C3 cohort 3 (2015-16).

Interviews were recorded, transcribed and anonymised. We adopted a thematic approach to the analysis of the data (Ritchie & Spencer, 1993). We followed the well-used six-step approach to thematic analysis described by Braun and Clarke (2006). This began with a process of data familiarisation through checking transcription accuracy and reading and re-reading the transcripts. One author (SP) coded the data manually (using highlighters and margin notes). The assignment of codes to themes was finalised through and a process of independent mapping whereby each author grouped the codes and discussed and agreed the outcomes. The grouping of the codes into themes broadly ~~identifying common themes~~ aligned to our three objectives: (1) use of the leadership knowledge and skills acquired during the Fellowship year within current clinical practice (key codes included transferable learning from the project, application of knowledge about leadership and change management, use of insights about personalities and teamworking, and value of wider insights into organisational systems – governance, finance, resources, priorities); (2) (indirect) impact on clinical practice and patient care (key codes included personal development - greater confidence, leadership, resilience, and quality improvement work); and (3) influence on career developments (key codes included preparation for applications and interviews, career planning, and opinions on what is the best career point to undertake the fellowship). We grouped a further set of codes (including time to use skills, demands of training, lack of seniority, limited leadership opportunities, and colleagues' negativity) under the theme ~~The analysis also revealed~~ barriers to impact.

Results

Ten (out of 14) former fellows agreed to take part in the study: nine interviews were conducted by telephone and one face-to-face. Table 2 shows the distribution of study participants by cohort. We note that there were more non-participants from cohort 1 than from the other two cohorts.

Table 2: Participants

Cohort	Number of Fellows in Cohort	Number of Fellows in study	Response rate
Cohort 1 (2013-14)	4	2	50%
Cohort 2 (2014-15)	4	3	75%
Cohort 3 (2015-16)	6	5	83%
Total Fellows	14	10	71%

On completion of the Fellowship, all fellows continued training, re-entering at points ranging from CT2/ST2 (Core Training year 2/Specialty Training year 2) to ST7 (Specialty Training year 7). Some fellows were near completion of specialty training when their Fellowship year ended, and at the time of interview, two had been appointed as consultants. Of the four non-participants, it was not possible to establish the stage of training they had reached or where they were currently based.

Use of leadership knowledge and skills within current clinical practice

All projects focussed on improving services for patients and were designed to enable fellows to apply the principles of leadership and management to practice. The projects were diverse. In cohort 1, for example, one project focused on the integration of emergency services in one town, across primary, community and secondary care. The fellow worked with a project board to develop the plan and provided clinical leadership for project implementation and the evaluation of quality improvement within the health service. In an example from cohort 2, one project concerned the integration of health and social care of older people with complex needs. This required the fellow to liaise with general practitioners (GPs), the health board and third sector organisations to use data from various sources to identify those at greater risk. One project from cohort 3 involved the fellow in the development of a new service which engaged the fellow in developing patient pathways and resolving problems, supported by clinical directors of theatres and critical care.

Daya (C3) stated his main learning experience had come from the project:

> *Not so much the content of what we were doing, but how to actually get the project going and how to sustain it. (Daya, C3)*

Fellows did not necessarily select projects within their own specialty; six fellows chose projects outside of their training specialty. For example, a General Practice trainee undertook a surgical services project; the project for a trainee in plastic surgery was

concerned with care services for the elderly. Gwen (C1), who undertook a project within her specialty, noted that all skills learned during the Fellowship year were, in her opinion, "*completely transferable*".

The Fellowship provided an insight into the influence of government and politics and the implications of financial constraints and pressures on the NHS, and opportunities to shadow Medical and Clinical directors as well as the Welsh Health Minister augmented this knowledge. It also afforded fellows a greater understanding of where their individual specialties sat within the wider scope of the NHS. It equipped them with an awareness of wider and more complex issues faced by senior clinicians, leading one fellow (Emlyn, C2) to appreciate that it was *"unrealistic"* to think problems could be solved merely by getting more people and money, rather the importance of focussing on *"how we can change what we do"*.

Fellows thought that the experience of the projects and these wider insights had influenced their current practice, although the impact was subtle rather than obvious. Morgan (C2), for example, commented that the knowledge of management and leadership had given him a greater appreciation of *"behind-the-scenes systems" and that this knowledge was "useful"*. He stated that he had learned:

> *…how the leadership structure in hospitals work, how that looks organisationally and how it functions and useful to know who those people are and what they do if I want to effect any change. (Morgan ,C2)*

Fellows learned that successful implementation of change was facilitated by knowing structures and systems, fitting with organisational priorities and gaining the support of key players.

Emlyn (C2) recognised the importance of knowing Health Board priorities and challenges and ensuring any proposed changes matched such priorities, *"then people are much more likely to listen".* Fellows used this knowledge in their quality improvement work: it helped them to identify key healthcare improvement issues and aided discussion about projects and where to find information.

Fellows reported the academic work on personality traits and teamworking as particularly useful,-providing methods to approach problems, ways to interact with difficult colleagues and negotiate solutions. Eight fellows reported that the Fellowship had enhanced their team-working skills and had improved their people skills. For example, as a result of the

Fellowship, Bryn (C1) had developed a better understanding of how people think and act and how to negotiate with people within a team:

> *We did a lot of work on personality traits and type of teamwork. I understand now why they think and act the way they do. So that's been extremely useful from a clinical [team] point of view. (Bryn, C1)*

He noted that having such an understanding of people "*definitely*" impacted on his own behaviour, in engaging with people, who in the past, he would not have got on with *"because I just got frustrated with them".*

Daya (C3) reported spending time with team members on a *"one-to-one"* basis, to get everyone on side to achieve goals; and the knowledge of personality types and team dynamics had improved Amadi's (C3) confidence in leading a team and his ability to get more out of team members. Some of the techniques learned had become embedded into practice as revealed by the following comments:

> *I think I'm actually subconsciously using some of the techniques, and I'm not even aware that I'm doing it. (Amadi, C3)*

> *It's in my head now. You can't take that out. (Daya, C3)*

Although the Fellowship had not changed her day-to-day interaction with patients, Gwen (C1) acknowledged that it had modified the way she interacted with hospital staff. She tended to be a little less tolerant of excuses and was:

> *… a bit more willing to question people these days than I would have been before I did it [the Fellowship]. Get people to look for solutions rather than necessarily just complaining about problems. (Gwen, C1)*

Vivian (C3) reflected that the Fellowship had armed her with new skills and new ways to deal with problems and how to *"interact with difficult colleagues*". She reported making better use of team members by delegating tasks that she did not like to those who did. She made specific reference to how teamworking skills had become embedded:

> *…you do learn without realising and it's often only later that you realise how much you learnt…. The Fellowship has shaped who I am now, given me more awareness of who I am, my role within a team … All I've learned is now embedded, it's just always there and that's who I am now post-Fellowship. (Vivian, C3)*

Lindsay (C3) felt the Fellowship had given her the *"the ability to look at the world through new eyes".* There were both positive and negative aspects to this new view of the world. As someone who had always been keen to make changes and get involved, positive aspects gave her *"the knowledge and bravery to actually get involved".* On the negative side, however, she was cognisant that although keen and enthusiastic, she could not make all the changes she would like to or tell people what she thought they were doing badly. Her strategy was, therefore, *"to be positive and negotiate with people".*

Skills learnt in terms of how to negotiate and write proposals, enhanced fellows' ability to put forward business cases for new patient services in the future and four fellows reported that their continued contact with HEIW had led to: writing papers for publication; participating in and leading sessions on leadership; organising training days. At interview, Vivian (C3) reported that she had become a member of the Quality Improvement Skills Training (QIST) steering group at HEIW.

The fellows reported varied continued involvement with projects. Four fellows had had no further involvement in the projects. Although Parker (C3) would have liked to continue working on some aspects of the project, there just was not sufficient time:

> *It's time pressure…It's not that the will isn't there. There is just a physical limit to how much stuff you can get out of a week. (Parker, C3)*

Morgan (C2) had left Wales and therefore had no further contact with his project. However, he reported that he had been able to transfer the skills learned during the Fellowship on workforce planning to his new Trust. Emlyn (C2) had moved health boards, so had no further involvement with the project, but he too reported transferring some of the ideas and skills learned.

Impact on clinical practice and patient care

Although fellows found it hard to identify the *direct* impact on their practice and patient care, some of them reported use of the knowledge and skills of leadership and teamworking as described above, had *indirect* impact. Part of this indirect impact was revealed in how the doctors talked about their personal development. Emlyn (C2), Amadi (C3), Gwen (C1) and Francis (C2) stated that the Fellowship had taught them a lot about themselves. Since undertaking the Fellowship, Emlyn (C2) reported that he felt *"more confident"* in his role as a

consultant; Amadi (C3) noted the WCLF had given him an understanding of team dynamics and he now felt *"more confident in leading a team".* Gwen (C1) commented:

> *I think it's made me a bit more resilient and also given me a few more coping strategies when things don't actually work the way I wanted them to. (Gwen, C1)*

Our suggestion here is that such insights and strategies equipped the doctors with skills and attitudes that enabled them to perform better in their clinical practice, to the benefit of patient care. A little more directly, Daya (C3) commented that prior to the Fellowship he had not taken a very *"methodical approach"* in recognising areas that he could improve. It therefore helped him to identify:

> *the important aspects of the day-to-day role of the team I work in that should be focused on improving care. (Daya, C3)*

On their return to clinical training, both Bryn (C1) and Francis (C2) had opportunities to take part in and supervise quality improvement projects. Emlyn (C2) reported having taken on the lead for a quality improvement project that involved:

> *setting up and running a quality improvement group within our paediatric department multidisciplinary group. (Emlyn, C2)*

Influence on career development

Fellows considered that the Fellowship as a whole, and the knowledge of management and leadership in particular, was beneficial for them when applying for further training and consultant posts. Gwen (C1) felt the Fellowship provided an understanding of what it would be like to be a consultant within the NHS before actually becoming one. She remarked it had exposed her to the struggles of being able to get something done and to change some things.

Both Emlyn (C2) and Gwen (C1) thought that the knowledge of leadership and management gained during their Fellowship had prepared them for consultant interviews and the questions about management. As Emlyn (C2) stated:

> *A lot of the questions are all about, management and leadership and understanding the NHS and the work with the Health Boards. So I think it gave me a huge understanding of that. (Emlyn, C2)*

He further declared that the knowledge enabled him to answer questions at interview, which some of his colleagues had found challenging, and he was able to use his Fellowship experience to exemplify his answers. Gwen (C1) added that the skills she had developed during the Fellowship had made her *"very sellable in terms of actually what I can give as a consultant".* In a similar fashion, Morgan (C2) noted that the Fellowship provided something extra to offer at consultant level interviews. Observing and shadowing senior management provided an insight into the challenges they face, and what being a Clinical or Medical Director actually involved on a day-to-day basis. For Amadi (C3) observing the work of his Clinical Director had proved *"valuable in terms of my own career planning and future career".*

Although at different stages of training and seniority, nine of the former Fellows personally felt they had undertaken the Fellowship at the *"right point"* in their careers.

Although Parker (C3) and Lindsay (C3) were juniors and undertook the Fellowship before going into specialty training programmes, neither felt this had been a disadvantage. Lindsay (C3) was not of the opinion leadership training should be restricted to later in a career pathway. Lindsay (C3) stated that in her clinical role:

> *People look to me for leadership. There's a lot of opportunities. And the idea that I'm not senior enough to learn about leadership is a bit of nonsense really. (Lindsay, C3)*

Amadi (C3) stated he could have done the Fellowship at any other point in his training, but having done one year of the specialty training programme felt:

> *It was the right time to have that year away from the clinical setting. Kind of reset the clock. Learn some new skills and then use those when I go back to clinical. (Amadi, C3)*

Morgan (C2) felt the fellowship afforded *"a little bit of breathing space"* from the standardisation of clinical training, and provide time to reflect on his future career pathway. However, Emlyn's (C2) comment also recognises that leadership development is not just about innate qualities: it requires hard work too:

> *… it really depends on how you work as a person. It's not an easy year…It's hard work, and it's not just a year off. (Emlyn, C2)*

Former Fellows' responses suggest that the best time for a trainee to undertake the Fellowship comes down to a personal sense of when the time is right. As Parker (C3) succinctly put it:

> *The number [year of training] is not an indictment of competence. (Parker, C3)*

Barriers to impact

In this section we consider barriers to impact as raised by the fellows we interviewed. Time to use skills was a significant factor. On returning to clinical practice, fellows' time in their respective training programmes varied, thus it is difficult to generalise about the opportunities to apply the skills acquired during the fellowship year.

Although there were differences in opinion as to the best stage of training for undertaking the Fellowship, seven former Fellows acknowledged that the personality of the individual trainee was an important factor. Having said that, there was some evidence to suggest that the career stage of the Fellow could impede the use of the leadership skills. Although most (nine fellows), judged that it had been the right time in their career path to undertake the Fellowship, there were examples where their more junior positions lessened the scope for them to use their leadership skills. Morgan (C2), for example, felt that on reflection, *"I don't think it was the perfect time for me".* He felt his lack of experience had held him back somewhat, and perhaps he should have waited until further into training and had built up credibility: "*I was so very junior, between FT1 and FT2".* Gwen (C1) further commented that at Foundation level, others' expectations may limit the impact of the Fellows:

> *You're too junior to almost have an opinion which is nonsense, but that unfortunately is the way that people will look at you from the outside. (Gwen, C1)*

Although Daya (C3) accepted that there could be benefits of doing the Fellowship at an early stage in training, being a long way off a consultant role provided little "*time dedicated to work on improvements and management type activity".* Personally, therefore, he felt it should be undertaken when *"you're established on your clinical training path". (*Daya, C3). Bryn (C1) commented *"if you don't use your skills, they get lost very quickly"* and noted that only consultants were able to undertake certain functions. Post-Fellowship, therefore, fellows were limited in the leadership roles they were able to undertake. Both Parker (C3) and Daya (C3) concurred that leadership is not considered part of clinical training programmes.

One of the major hurdles to making improvements and implementing change, were the challenges and resistance of medical colleagues and Emlyn (C2) understood why people *"get exhausted"* trying. Gwen (C1) admitted that there were still some people whom she would hesitate to tell she had done the Fellowship, because the attitude would be *"oh you want to be a manager".* She felt that they looked down at her for having an interest in management or leadership and felt the need to make excuses for having done the programme. Bryn (C1) concurred that the attitude of going over to the 'dark side' (Hayden, 2017; Loh *et al*, 2016) still prevailed among some senior staff in spite of an increase in medical leadership posts and involvement in quality improvement. However, he felt that the creation of more medical leadership programmes and posts in the UK had improved the attitude of seniors somewhat.

Discussion

This is a small-scale study and not all of the former fellows agreed to take part. We are thus wary of extending the conclusions beyond the confines of this sample. It is difficult to generalise the impact of the Fellowship as all the cases were unique. There was variation in terms of what stage they were at when they did the Fellowship, the time since completion of the programme, and how their careers had progressed. That said, our findings serve to highlight the value of the Fellowship programme and provide specific examples of how former fellows' current practice benefits from the skills they developed. Certainly for those former fellows who had proceeded to consultant level, a knowledge of leadership within the NHS had proved immensely useful at interview. It had made the interview process more straightforward and helped them to secure consultant posts.

Some individuals naturally possess the personal qualities and characteristics necessary for leadership (Northouse, 2018), but as well as such 'innate' qualities, fellows recognised that the fellowship year required hard work. In general, the more junior fellows did not feel at a disadvantage at undertaking the fellowship at such an early stage of their careers and success was, in part, dependent on the fellows themselves. However, opportunities to apply the skills learned during the fellowship year varied. The Fellowship is designed to equip participants with skills to lead improvements in healthcare delivery. Those more advanced in their medical training had greater opportunity and seniority to lead change and were better placed to apply the learning. This has implications for whom the training should be targeted. It is notable that the Scottish Clinical Leadership Fellowship (www.scotlanddeanery.nhs.scot)

restricts entry to trainees at CT2/ST2 (Core Training 2/Specialty Training 2) or above, and the Northern Ireland Clinical Leadership Fellowship programme (www.nimdta.gov.uk/adept/) which restricts entry to ST4, or ST3 for GP and Dental trainees.

A constraint on using their leadership skills was the reported perception of the culture in the NHS. Both hierarchy, whereby only consultants can undertake certain leadership activities, and a dismissive attitude to those showing an interest in leadership, limited trainees' involvement in leadership activities and their contribution to the implementation of change and improvements for the benefit of patients.

Although direct impact on clinical practice and patient care was difficult to identify, indirect impact was evident through personal development, in gaining confidence in leading teams and a greater awareness of their role within a larger organisation. Such insights and strategies enhanced performance in clinical practice, which could benefit patient care. One of the more useful aspects of the fellowship was gaining an understanding of teamworking. Learning about teamworking was of particular value when they returned to clinical practice, enhancing how former fellows interacted with their teams. Not only did the Fellowship provide techniques to interact with difficult colleagues and negotiate solutions, it also impacted on fellows' own behaviour towards colleagues within the clinical setting. Their confidence within the team setting improved, and delegation skills were also enhanced. Such knowledge had become embedded into practice and used subconsciously.

Conclusion

This study has revealed some of the longer-term impacts of the clinical leadership fellowship in Wales. A knowledge of how management and leadership functions within the NHS provided a greater understanding of the complex issues faced by senior clinicians. Through teamworking and continuing projects focussed on improving patient care fellows were able to identify the indirect impact of the Fellowship on patient care. Notwithstanding the transient nature of teams within the health service where establishing relationships could be somewhat challenging, a greater understanding of team dynamics had increased fellows' confidence in both managing and leading teams. However, on returning to clinical practice, fellows were at different levels within their specialty training, so it was not always feasible to transfer and use the leadership skills learned. Concentrating on completing clinical training

was a priority for the fellows at the end of the WCLF. This limited the time, opportunity or capacity to participate in on-going leadership activities.

Arising from our findings we suggest that further consideration might be given to whether applicants for the fellowship should have attained a minimum stage in their career, whether the fellowship programme should include a structured assessment of competencies and whether there is a need to further support trainees on return to the workplace with continued leadership opportunities. We have noted the difficulty of demonstrating impact on patient care. Although challenging, further research might include measures of patient outcomes and cost of care, for example. Perhaps more realistically, we also suggest that insight into the impact on patient care might be gained from analysing feedback from stakeholders in the leadership project the fellows undertake.

~~This longitudinal study of the WCLT adds to the body of knowledge of the impact and efficacy of leadership training programmes.~~

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