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Assignment Title: **Reflection On Clinical Leadership**

Module Code: **DSAW7057**

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Learning Log for Dr Nicola Lomax For the period 17/10/2017 to 15/10/2018

Date	Title of the CPD activity	Description of the activity	Learning Outcome	Impact at work
18/10/2017	Medical Leadership Programme (MLP) 6 Introductory workshop	Structured learning- lectures		
18/10/2017	MLP 6 Action Learning Set	Structured interactive learning	Own learning about a current life situation. A way of considering and reflecting on problems as a group from all angles	Action learning has provided another strategy to use for challenging, difficult to resolve issues
09/11/2017	MLP Understanding the political and Strategic context	Structured learning- a series of lectures regarding the NHS and how it is influenced by politics		A better understanding of how the day to day running of the NHS is subject to ever changing external influences meaning that consistency is difficult
5-6/12/2017	MLP Leading Improvement	Structured learning covering aspects of improvement techniques and strategies	Consolidated knowledge of the different improvement techniques that can be used in healthcare e.g. PDSA cycles. Helpful review of human factors and also the need to use process mapping to understand a problem with a process fully	Improved confidence with using improvement tools within the department and my project for MLP benefited from PDSA cycles
16/01/2018	MLP Skills workshop Understanding self and others workshop	Structured learning with some interactive components	Better understanding of myself and the Myers Brigg model. Consideration of definition of emotional intelligence is was helpful.	The Myers Brigg analysis has helped me to understand why I behave as I do at work and also helped me to understand why my personality type means that I find some situations harder to cope with that others e.g. chairing meetings

16/01/2018	MLP Action Learning	Structured interactive learning- I presented an issue myself in this set	A way of confidentially considering problems as a group from all angles	Gained clarity around the personal issue which enabled me to make a decision
31/01/2018	MLP Leading the Quality and Safety Agenda	Structured learning with interactive session	A better understanding of the qualities of good leaders. Increased awareness of risk management and the Welsh risk pool as well as a better understanding of Healthcare Inspectorate Wales	Heightened awareness of the aspects of the service that I lead that are most likely to lead to risk and more focus on mitigating risk in these areas of the service
15/02/2018	MLP Leading engagement/Leading across Boundaries	Structured learning	An appreciation of the different cultures that occur in the NHS environment as a result of different leadership styles. An understanding of staff engagement and factors that influence it	Reflection over my own leadership style and the culture that I am striving to develop. Reflection over how to improve staff engagement resulting in SBAR for each staff group and action plan development
21-23 March 2018	MLP Residential Learning community: leading people and teams	Mixture of structured sessions and team based interactive sessions	An appreciation of the different roles within the team (Belbin) and how that can impact on performance. Belbin personal analysis was very illuminating.	As a result of undertaking the Belbin analysis it has provided insight into the aspects of team work and leadership that are weaker for me- enabling me to focus on this.
25/04/2018	MLP Skills workshop- project presentations	Structured session	Useful feedback on how to interpret project findings and present to audience	Highlighted some aspects of project that could be altered
25/04/2018	MLP Action learning Set	Structured interactive learning	Own learning about a current life situation. A way of considering and reflecting on problems as a	AL has provided another strategy to use for challenging, difficult to resolve issues

			group from all angles	
23/05/2018	MLP Coaching for Performance	Structured learning	Now able to understand the difference between coaching and mentoring and an understanding of the 'OSCAR model'	I'm now more aware of when to use Coaching style and situations where mentoring is more appropriate
05/06/2018	MLP Action learning set	Structured interactive learning	Own learning about a current life situation. A way of considering and reflecting on problems as a group from all angles	AL has provided another strategy to use for challenging, difficult to resolve issues
20/06/2018	MLP Leading and Communicating with Impact	Structured interactive learning	Understanding of the impact of social media today and how that will be incorporated into healthcare in the future. Media training was very helpful to identify techniques for communicating with the press.	More confident personally and as a team to utilize social media and a better appreciation of how important it will be for engaging with younger patients.
05/07/2018	MLP Applying Positive Psychology	Structured Learning	The importance of positive psychology and how this has the potential influence the success of a team	Utilisation of positive psychology with the team
05/07/2018	MLP Action learning set	Structured interactive learning- this time we walked as a group and discussed our problems	Own learning about a current life situation. A way of considering and reflecting on problems as a group from all angles	AL has provided another strategy to use for challenging, difficult to resolve issues
13/09/2018	MLP Patient Impact presentation	Structured session-delivering results of patient focused project		

Development Action Plan (DAP) for Dr Nicola Lomax
For the period 17/10/2017 to 14/10/2018

Development Objective	Start Date	Target Date	Development Outcome	Planned CPD Actions
Consolidate management of clinical governance concerns and demonstrate improved visibility of holding my team to account	01/11/2017	01/12/2018	Improved feedback from the team that clinical governance concerns are dealt with in a timely and appropriate manner	Review of the Departmental Quality and Safety (Q+S) meeting (including terms of reference for this meeting) Review of the Q+S processes within the department to ensure feedback to staff adequate Include regular review of 'near miss' cases with whole department Attend further teaching sessions about risk management
Review style of change management and leadership to ensure that staff competency within the department is developed by delegating appropriately	20/10/2017	20/10/2018	Should result in improving my confidence that other members of staff can manage issues competently. Increased ability to delegate tasks should release time for me to focus on more strategic aspects of the service and will make sure I'm using participatory style of leadership as often as possible to	Reduce pace of change in the department Ensure all changes are agreed by the Senior management team (SMT) Review roles and responsibilities to see which roles could be delegated.

			improve team ownership of issues	
Communicate more effectively with my team	18/10/2017	01/05/2018	The team will feel more confident about the service and will increase staff engagement if they are regularly updated	Review all current ways of communication with staff Consider other options of weekly communication in addition to monthly newsletter Communication skills training
Continue Psychosexual training	Ongoing	01/09/2019	Being able to focus on a clinical area of interest will assist in maintain resilience in my role as CD	Attend IPM psychosexual seminars and conferences
Develop Influencing Skills to use both internally within Health Board and externally	15/08/2013	Ongoing	Improved ability to influence will result in DOSH having a higher profile within the Health Board and also externally	Attend relevant Clinical Board meetings and actively seek out other opportunities to raise the profile of DOSH

Component 1

Personal Leadership Style

Undertaking the Academi Wales Medical Leadership Programme (MLP) has resulted in a much better understanding of my own leadership style, and how my personality impacts on my leadership. MLP has also highlighted some areas that I can focus on in order to develop further skills as a leader, as documented in the personal development plan (PDP).

When I was appointed as Clinical Director (CD) for the Department of Sexual Health (DOSH) in 2013, I was aware of the need to be as effective a leader as possible and I now appreciate that my leadership needed to be visionary (Goleman) at that time as the service was old fashioned and struggling to meet capacity. I felt daunted by the task ahead as the service was in need of a huge amount of change. I was also aware of the need to inspire the team and to provide long term direction in line with Goleman's description of visionary leadership style.

I had some very clear ideas about how the service should be developed and modernised based on my experience of working in other similar services. I was aware that I was facing a number of very significant challenges and constraints both at a local departmental and Health Board level but I was also extremely aware of the wider political context of the NHS, and the financial pressures (austerity) faced by both the NHS and Welsh Government (WG). There was no doubt that although change was required it would need to be cost neutral or cost saving and on reflection the changes that have been achieved in DOSH couldn't have occurred without a collective (King's Fund report, 2014) leadership approach; the team played a crucial role in modernising the service.

The Sexual Health service has been transformed over the last 5 years as a result of both my leadership and the current senior team. Over the last 12 months I have been able to spend some time reflecting over my behavior in my role as CD and how I could further improve my effectiveness as a leader. I was also keen to consider staff engagement and how this could be improved as a result of undertaking MLP. Having some protected time out of my day- to- day role has been of great value.

As part of MLP I have undertaken a Belbin Team Role assessment as well as a Myers-Brigg personality assessment. I found both of these tools very helpful to improve my awareness of 'self' and the Belbin analysis revealed that I had a fairly even spread of team roles. This matched my expectations, as I was aware that I have had a number of different roles within the team over the last 5 years. It didn't come as a surprise that the top two roles were as coordinator (Belbin states that coordinators are mature and confident, able to clarify goals and delegate effectively), and team worker (described as co-operative, perceptive and diplomatic). I thought it would be interesting to see if this was matched by comments on the multisource feedback (MSF) from my colleagues as the Belbin analysis is based on self-perception only. Considering the areas where I had the lowest score have also enabled me to identify areas for further personal development.

The lowest scores on the Belbin scale were for 'completer finisher' (Belbin describes this role as painstaking and anxious) and 'specialist' (provides knowledge and skills in rare supply). I think that both of these are important attributes to ensure that projects are completed before moving onto the next task and this is an area for me to focus on in the future. I also need to appreciate that sometimes time and focus is required to consider the technicalities of a given situation.

As mentioned above undertaking an MSF was also part of the process of helping me to understand how I function as a leader, and receiving feedback from peers and direct reports can be invaluable. Discussion with the facilitator when reading through the report initially was very illuminating, as we were able to discuss that my perception of situations as a leader maybe entirely different to the perception of my direct reports, highlighting the crucial role of effective communication and feedback within a team.

It was very reassuring and rewarding to receive feedback through the MSF that my line manager, peers and direct reports (26 respondents in total) rated me as strong across all the domains of inspiring shared purpose, leading with care, evaluating information, connecting our service, sharing the vision, engaging the team, holding to account, developing capability and influencing results. Generally this matched well with my self-perception except for engaging the team where the self-score was lower.

The hidden strengths and blind spots were also a crucial part of the MSF in terms of informing future areas for development. Reviewing the break down of results has revealed that there is certainly scope for me to improve on holding people to account as I was identified only as proficient in this by a number of raters; I am keen to strive

to be considered strong or exemplary in all domains. Focusing on this further there was a comment stating that there was concern that that I don't always act on concerns regarding other staff or if I do they are not fed back to the individual or the team raising the concern. This has certainly provided me with an area to work upon in terms of being more visible within the team from the point of view of holding people to account. Effectively communicating the outcomes of holding the team to account is also crucial as this work is certainly being undertaken but I need to ensure that the team is aware of it.

Over the last 12 months I have also considered ways of improving our Quality and Safety (Q+S) processes as a department. An example of a Q+S area that I would like to improve upon is as follows; recently the medical team made a decision at a meeting (whilst I was on leave) to change our departmental treatment for pelvic infection. This change wasn't discussed with me and the nursing team was informed via email. Not surprisingly the nurses reported that they were unaware of the change and were frustrated to be told that they had provided the wrong treatment for patients. This example highlighted to me the need for all changes to be implemented properly with due consideration. The proposed change in this instance was well intentioned as it was in line with new national treatment guidelines, but communicating the changes effectively (not by email) and explaining why a change was required is crucial.

Effective communication within the wider team has always been challenging for our department and although communication has improved I feel this is something that there is still more scope for me to improve upon. Understanding the barriers that restrict communication is key to this and will be a focus area for me over the next few months.

The Myers- Briggs personality type indicator revealed that I have an ESTJ (which stands for extraversion, sensing, thinking, judgment) personality and this helps to explain how I manage to be decisive even with complex decisions for the service and the team. I think my personality type explains why sometimes I have used pacesetting style of leadership (Goleman) when I should have delegated tasks more and need to strive to be a more participative leader. Initially pacesetting was required as the amount of change needed was extensive, more recently a participatory style has proved to be effective when changing the system for patients to access the department as described in my leading service improvement project.

Although I have identified areas for development one of the aspects of my leadership that I feel confident about is my resilience and mental toughness. I have a very busy job and family life, so I'm aware of the need for work life balance and the pressures that can result from a stressful job and home life. Lopez and Snyder define resilience as "a class of phenomena characterized by patterns of positive adaptation in the context of significant adversity or risk" (Snyder & Lopez, 2002).

As I have reflected over my role as CD I have realised that I have dealt with a number of challenges some of which were very longstanding. My resilience and persistence has allowed me to successfully resolve problems that had held the service back for a number of years. Intellectual interest is known to be one of the factors that aids resilience as described by Balme et al (2015) and one of the things that I believe has helped me to maintain resilience is maintaining focus on my clinical work. As part of my ongoing commitment to clinical work I have continued to train in Psychosexual Medicine. This training provides an opportunity to engage myself in developing new skills and can provide a welcome break from management issues.

In addition to the above I think being emotionally intelligent (Goleman, 1999) has helped me to lead the sexual health service. I am very aware of my emotions and capable of controlling them; I have been a consistent positive influence for the department. There is certainly scope for further developing the emotional intelligence of the team in DOSH as a whole.

In terms of future development I have identified areas to focus on in the next twelve months as highlighted in the PDP. I will aim to be more visible in holding the team to account and continue to strive to communicate more effectively with my team, as well as defining proper pathways for change management within the department. In addition I am keen to continue to further develop my specialist clinical skills in order to preserve my resilience. I also need to ensure that I develop better influencing skills so that I can raise awareness of issues both internally within the Health Board and externally; this will increase my visibility as a leader.

Component Two

Reflection One

Coaching and Mentoring

I found the MLP coaching and mentoring session particularly interesting to reflect upon, particularly in view of further developing my leadership skills. Members of staff will regularly come to see me to discuss issues within our service and I have always felt obliged to offer solutions and to problem solve on their behalf. After the coaching session I realised that this approach means that the staff I am working with are not developing their own strategies for dealing with such issues or learning to problem solve for themselves, as they aren't being given the opportunity, this is an area where I could change my approach and develop further as a leader.

In the long term using a coaching approach should lead to less dependence on me and other members of the senior team, and should ultimately lead to other members of staff being able to coach as well. In order to be able to coach expert knowledge of the issue being discussed is not necessarily required as long as you have the framework within in which to discuss it; as often the person bringing the issue for discussion will be an expert in terms of the knowledge of the topic. This was an important realisation for me as I have often wondered how senior leaders within the Health Board can advise about problems that are not within their realm of expertise.

There is a lot of cross over between mentoring and coaching. Sometimes within our role we will need to use both techniques for example when working with trainee doctors.

In terms of reflecting over my own use of coaching and mentoring using *Gibb's reflective cycle*, I would like to use the example of supervising a senior trainee doctor and one of the projects that I have coached her through in recent months. I am her educational supervisor (this is a more traditional mentoring role), but I was aware that as she was close to becoming a consultant she needed to learn to lead on service development projects herself. Such a project would also allow her to develop her own sense of personal responsibility in line with the current Cardiff and Vale UHB values.

The recent Public Health Wales (PHW) Review of Sexual Health services in Wales (2018) highlighted the increasing demand for services so it is vital that we start to consider other innovative ways of providing care.

As a service we had been very keen to implement a pathway for patients without symptoms to test rapidly for Sexually Transmitted Infections (STIs) ideally without having to attend our department and I thought that this project would be something that the trainee could lead on and develop with my support.

When I look back on how I supported this doctor through the process I can see that the OSCAR (outcome, situation, choices and consequences, actions and review) coaching model (Gilbert and Whittleworth 2009) was applicable as I asked her to develop the quick test service (the outcome), we were well aware of the current situation and the choices we had. With support I was able to allow her to take the next steps (or actions) to design this service, implement it and review it and amend as needed (in line with plan, do study and act or PDSA cycles).

We met regularly to review progress but as a result of coaching someone through this process it meant that she took ownership of the day-to-day management of the project thus improving her confidence.

From a leadership perspective this project was very successful as I delegated the day-to-day running of this service, and I felt reassured that it was being run effectively and from a clinical governance (risk) perspective it was safe as I had asked her to consider all the potential risks before we started and then we subsequently discussed the issues that arose.

The 'Quicktest' service has been very popular with patients and we are considering extending testing outside of DOSH. I felt after this experience that I would have the confidence to coach other staff with similar service developments. Working in this way has highlighted how more capacity can be released by coaching staff.

As part of the MLP we have spent time considering all the different styles of leadership and delegation is key to effective leadership as described by Goleman. The example given above demonstrates that a coaching style has been successful on this occasion. This project also required a participative or democratic style of leadership as described by Lewin (1944), as both the reception staff and the team of healthcare support workers in the department were crucial to the success of this initiative as they advised patients about the service (reception) and then processed the samples. Good communication and engagement with both of these staff groups was key and as part of the coaching we discussed ways in which to achieve this. One of the keys to the success of this was the regular feedback to both staff groups

about how popular the new 'Quicktest' service was in terms of the number of tests taken and also how many STIs we had identified. I think this communication enabled the staff to see the benefits of the service.

As I have spent some time reflecting over the Quicktest project it made me realise that some of the aspects of this project tie in very well with Kline's 'ten component's of the thinking environment' and has revealed for me that thinking in a different way can result in unexpected and very positive outcomes.

Kline explains that attention is crucial for us to produce our finest thinking. When I reflect over this project I can see that our meetings were very focused. Kline also promotes 'encouragement' so that internal competition is avoided allowing us to push ideas to the boundary, which is what was needed here; we were looking for a solution. The 'Quicktest' project was something that we put in place to due to the lack of funding for postal kits in Wales and although a very simple concept hasn't been done before. Asking the question 'why haven't we done this before?' and 'why shouldn't we do it?' to both my trainee and the senior team allowed us to discuss the possible risks and benefits but the key aspect was that we focused on the issue and tried to think innovatively.

Discussing as a group is also very helpful according to Kline, as diversity of thinking is a very positive thing and I have always been aware within my team of those who will always think about issues in a completely different way to me and this allows us to explore issues from all angles and again allows a participative leadership style to be utilised allowing the team to feel valued.

As I mentioned above thinking about STI testing differently has been of benefit to the service but actually extends beyond our service. GPs are now very interested in adopting this type of testing service as this will help to relieve pressure on their service as well, and can also be used at community sites in the future and so will allow us to offer testing to some 'hard to reach' populations who generally don't access care. This is an unexpected outcome of the project for me, so in addition to my coaching experience has also shown the benefits of think creatively about delivering services differently which is widely applicable across a number of healthcare domains. This experience has also now led me onto encourage and coach a different doctor to run a "Rapid Repeat" project. This project involves self-completion of assessment paperwork for women who have run out of their oral contraceptive pills and need a repeat prescription. These patients previously placed a lot of demand on our service but by thinking differently we have a new service.

As demand continues to increase for our services we are being forced to think more creatively about how we can deliver care and both of these initiatives have been good examples of innovative healthcare delivery.

I'm keen to continue utilising coaching skills within my role as CD. I'm also excited by the prospect of finding other new ways of working by harnessing the different views of my team. Both of these initiatives have increased my confidence in coaching staff to lead on such innovative projects.

Reflection Two

Consolidation of Community Clinics

In this reflection I would like to discuss one of the areas that I feel has been successful during my time as clinical director (CD) for the Sexual Health service.

When I joined the department in 2010 the service was run from a central site at CRI with multiple community clinics running throughout the week across Cardiff and the Vale. This was causing significant strain on the service as staff spent excessive amounts of time travelling between clinics and setting clinics up and this was a constant 'drain' on staffing our busiest site at CRI where the most complex patients were seen and we regularly had to turn patients away.

Discussions around consolidating the clinics had been ongoing for a long time but had never resulted in any change due to several barriers in particular the Community Health Council (CHC).

Reflecting over this using *Rolfe's model* (What?, So What? And Now What?) I can see the tremendous progress that has occurred since 2013 and I will describe how different leadership styles were required to achieve progress. From a strategic perspective there were a number of issues that as a CD I was very concerned about regarding the community aspect of our service; maintaining the status quo wasn't an option.

Duplication within our service was a major issue as patients would often attend a community clinic and then be advised to attend the central service at CRI. This goes against the principles of prudent healthcare (Drakeford, 2013). Even if patients were diagnosed with an STI in the community clinics they would have to attend CRI to receive medication, as these weren't stocked at the community clinics. The introduction of medication into community sites had been suggested by a UHB review of the service some years earlier but had never been implemented due to a lack of clinical leadership within the service.

As CD I also had clinical governance concerns as results processes were very different at the community sites, and robust processes were not in place to ensure that test results were followed up in a timely fashion. The notes were all paper based resulting in risk especially from a safeguarding of young people perspective. In

addition to this there were also some clinics that had very low attendance rates meanwhile demand at the CRI was extremely high and patients were frequently turned away. Some of the clinics were geographically close to CRI but there was still a perception from staff that we wouldn't be able to close those parts of the service.

Our aim to consolidate the community service was very much in keeping with the Cardiff and Vale UHB 'Shaping our future wellbeing strategy' 2015-2025. This was published shortly after we started this project but the strategy promotes joined up care and avoiding waste, and urges teams to achieve outcomes through the minimum appropriate interventions.

The complexity of this issue seemed overwhelming although the need for change was obvious; I believe this is the reason why nothing had happened previously in terms of consolidating the service. Reflecting over this further I think the culture of the department was also a barrier to change. There had been a Dionysus culture as described by Handy, where individuals had pursued their own interests and a shift away from this to perhaps a more Athena style (task culture) was required. Bureaucracy within the NHS can be a barrier to change and the hierarchy within the NHS can also prevent individual decisions from being taken; this was well observed by Powell in his 2016 Kings Fund report. Powell also comments that organisations that regulate too much are unable to innovate. It has certainly been my experience that it is a real challenge to introduce innovative ways of working into the NHS. The Cardiff and Vale strategy as noted above urges clinical teams to excel with innovation.

On reflection one of the key factors from a leadership perspective that resulted in change was persistence; I think persistently raising awareness of both the duplication and clinical governance risk at clinical board level and with the CHC finally led to change. I have learnt that even though an issue maybe very complex it doesn't mean that solutions can't be found. Staff and patient engagement was also crucial. In terms of the Cardiff and Vale Health Board values I felt a huge amount of personal responsibility to address this issue even though I was well aware it was a team and service wide problem. Considering improvement methodology was also important here. As a senior team we needed to use Six Sigma tools to consider options for improving the results governance processes. Lean thinking was also used, as we needed to identify the parts of the pathway that actually added value for patients.

Collective leadership (King's Fund 2014) was required for moving forward with this problem and although we were clear about the vision for the service to be after a senior team away day implementing the changes was a challenge. Identifying roles and responsibilities within the senior team helped to improve our effectiveness and it was clear that a clinical lead for the community service was required. If I had used De Bono's six thinking hats I would have realised that an area that I struggled with is creative thinking (the green hat). I was very clear about the 'yellow hat' aspects of this project- the benefits and feasibility of changing the service and knew that I was more than capable of managing the thinking and setting the focus (blue hat). Fortunately the Consultant who is now community lead has a very creative way of thinking and hence we were able together to move forward on this very refractory aspect of the service.

Initially we decided as a senior team what the function of the community sites should be and what services the clinic at CRI should provide (group exercise). We also reviewed which community sites were crucial and needed to be maintained. Some of the quieter clinics closer to CRI were an obvious choice for consolidating. In terms of staff engagement with the process an all staff away day to discuss shaping of the service was helpful as it allowed us to explain the rationale for consolidation but there was reluctance to close one of our large community sites which was only ten minutes walk from CRI due to perceptions from the staff that patients really liked attending that clinic. A patient survey at that site was undertaken and specifically asked patients if they would attend CRI and an overwhelming majority of patients said that they would. This highlights the importance of both staff and patient engagement.

The first change implemented was introduction of medication into the community sites, which was very easy to facilitate; all I had to do was to discuss the stocks needed with a pharmacist who then arranged for the relevant stock to be delivered to the clinics. The senior nurse then communicated all the changes to nurses and ensured that all and that all the nurses were adequately trained.

Engagement with the CHC was also a key component of the project as previously we had received negative feedback from the CHC about access to our service. A proposal for the changes to the community service was prepared for the CHC, to highlight the benefits of the changes as well as acknowledging some of the challenges that the service would still face and I met with the CHC with one of the locality managers. This meeting was much more productive than anticipated and the

CHC agreed that it would be sensible for us to pilot our proposed changes which we did. The service now has 7 community sites with 2 'hub' sites, one in Cardiff (CRI) and 1 in Barry to allow equity between Cardiff and the Vale.

Reviewing progress of the changes has also been important and a Task and Finish (T&F) group was set up to meet regularly to review the changes from a PDSA view and also to ensure that momentum with the project is maintained. The T&F group has also allowed the governance issues to be addressed; an example of this is that the results processes were made uniform across the service.

From a leadership perspective I think the community consolidation project has allowed me to use a huge variety of leadership styles and tools. I feel that significant progress has been made which has resulted in improvement for patients both in terms of access but also safety of the service. I think my personality type as revealed by Myers Briggs analysis has enabled me to be successful in this project. My ESTJ personality means that I am comfortable in setting goals and getting things done and on this occasion this has had a positive impact for the service. Although initially a vision was required for how to shape the service the team engagement was crucial, and the clinical lead for the community was also vital as I was able to support her in implementing the changes as she dealt with some the operational issues leaving me to focus on the bigger picture or 'strategic view'. As a leader I had to engage both within the organisation and externally with the CHC and also with patients to ensure that their voice was heard so influencing was also key in this project. Consolidation of the community clinics was very closely linked to our project for introducing electronic patient records across the service, as I was very aware that this would resolve a number of the governance problems experienced by the community service.

In conclusion the 'Now What?' Aspect of this experience means that my confidence in dealing with more complex operational problems has been increased and I have no doubt that the success of our consolidation project could be applied to other areas of the UHB and the wider NHS; I would be very happy to work on other similar projects in the future and won't avoid tackling issues that on initial discussion seem intractable.

Reflection Three

Relocation of Administration team

I would like to reflect over an issue that arose in the last year within DOSH using the *Brookfield reflection tool*. The difficulty that arose was not a positive experience for the team in DOSH, and in retrospect faced with a similar situation again I would approach it differently. I felt that this situation really challenged me both personally and from a leadership perspective. *Brookfield's reflective model* is often used to reflect over teaching experiences but I think the concept of considering the situation from different vantage points or through different lenses is a helpful way of reflecting over this issue.

As a consequence of trying to promote staff engagement and in attempt to continue to engage in a more democratic style of leadership as described by Goleman, I requested feedback from staff in the department in the form of a brief questionnaire requesting information about what they enjoyed about their job and what they found were constraining factors. The information received from the staff was collated into themes and was then discussed at our senior team away day. I was keen for us to take on board the feedback from staff and from the perspective of lean processes try to change some of the smaller issues than can really impact on productivity in the team.

One of the themes that was noted was how cramped the administration (admin) team's office had become as their team had expanded since we moved into our current premises in 2013. As a result of this there was a suggestion proposed by the administration manager that the admin team could move into a larger office on the first floor and the Health Advising (HA) team could move into the old admin office on the ground floor. When this idea was suggested at the DOSH management meeting we thought as a senior team (*colleague lens*) that it seemed like the right decision (and this decision was arrived at very quickly) and personally (*autobiographical lens*) I thought moving the SHA team to the ground floor office would be ideal for a number of reasons. Initially the office on the ground floor had been intended for the HA team but a decision was taken when we moved into the new premises that the admin team would be located there. Since the move into the new department I had found that having the SHA team located away from the main clinic floor was a disadvantage as I felt it had removed them from the rest of the clinical team and given the HA team the sense that they were different from the nurses. I was keen to try and improve the

team dynamics and eliminate the 'them and us culture', which I had noticed in our department.

I was shocked when the initial discussions began with the HA team and our senior nurse about the possibility of moving downstairs at the responses we received and the reactions of some of the HA staff that followed.

Reflecting over this situation in retrospect has highlighted to me that certain personalities within the team do have the power to cause disruption to entire teams, despite issues being approached in a fair and open way. The reaction from the HA team about the office move was so negative and caused a huge amount of friction between the HA and admin team (*staff lens*). As a leader I found this deeply disappointing. One of my concerns is that this episode has demonstrated that if staff do not agree with a proposed change then it is within their power to prevent the change (even though the change maybe for the benefit of the wider team) and that some staff will not respect the decision of the senior team, their line manager and CD. As a leader I am emotionally intelligent (Goleman, 1995) as I was able to recognize my feelings and those of the team and so was able to stay calm, but this situation has demonstrated that not all members of the team are able to control their feelings and emotions and unfortunately this can get in the way of what is right for the service.

To try and resolve this resistance to move the immediate line manager for the HAs met with them to explain the benefits and disadvantages for each team of the proposed move. The HA team elected to involve their unions which I understand is their right however I felt this was an over reaction and as a consequence of the union involvement a compromise proposal had to be made. The current status is that both teams are still in their original offices; in short nothing has changed.

Reflecting on this experience through the '*theoretical lens*' I have found this a very negative experience on a personal and leadership level. I tried unsuccessfully to utilise a democratic style of leadership (Goleman) on this occasion. As a result I am now very cautious about requesting any feedback from the team in future as reflecting over what actually happened has shown that despite having feedback and plenty of evidence from the admin team about the need to move this did not happen. I'm sure the current status has affected the admin team's perception of my leadership and effectiveness. Some of the behaviour that I witnessed goes against

the Health Board values of trust and respect. As a leader I will now be much more cautious in my approach to similar issues and will spend time considering the situation through all lenses as this is of value before deciding whether to proceed with a suggested change.

Reflection Four

Action Learning and Communication

An important element of the MLP course was to participate in the action learning sets. Action learning was a concept that was new to me but I found the sets a particularly helpful aspect of the programme and using *Gibb's reflective cycle* I will reflect over why I found them so useful. Revans established the concept of action learning and said that 'there can be no learning without action and no action without learning'. He promoted the concept of learning from best practice and was the first person to introduce this concept into the NHS.

One of the key reasons I found action learning so useful was because it was a protected environment in which we discussed some very complex issues as a group and I found it very interesting to obtain the views of the other members of the group and also to gain peer support.

One of the key issues that I have encountered whilst being a CD is that it can feel quite isolating at times when there are difficult decisions that have to be made for the service or the team, as it can be difficult to feel that anyone within the team can offer an objective opinion. Part of the role of being a CD is to maintain safety within the service and line management for the medical team as well. Some members of the team can be skeptical about management and the decisions made as well, so another key role for a CD is to have a 'foot in both camps' which again can make decisions difficult as you can feel pulled in both directions, and at times I have been anxious about the view of the clinical team regarding decisions that have been taken although I did feel reassured by the MSF feedback that I received.

Action learning sets were valuable as it highlighted to me that everyone in clinical leadership roles appears to be trying to deal with very similar issues, some of which are very refractory and there aren't any quick solutions to a number of these problems. It felt like a supportive and confidential environment in which difficulties could be explored with the aim of finding creative solutions.

We utilized a number of different styles for action learning and it was interesting to observe that some members of the group were much more comfortable with the concept of action learning than others; this was a reminder for me that one style of learning doesn't suit all and this is very applicable to my own team at work. Of the

different styles of action learning used I would like to reflect over the 2 styles that I found most beneficial. We used a model called 'the fishbowl' model as described by Odgers, which involved one person presenting the issue and then sitting outside of the group but within earshot so that they could hear the discussion that ensued. I think this was very useful as it allows the person to focus completely on the discussion and concentrate completely on what is being said.

The other type of action learning that I think could be applicable to my own team was the walking action learning set, where we walked as a group of three and discussed a number of issues. I had a particularly challenging clinical case to discuss involving a patient who was also medically qualified and had reported some issues and behaviours, which if they continued would be in breach of the General Medical Council (GMC) duties of a doctor. This provoked much discussion but we were also able to conclude what the correct course of action should be (this case was discussed with the medical director as well). I found the walking action set really dynamic and I found my concentration was better than when I was sitting in a group. As a consequence I am keen to consider utilising action learning within our team as I think it can be an effective tool for both personal and professional development.

Reflecting over the action learning sets has also highlighted the importance of communication, as this is really what action learning sets were, communicating as a group about difficult issues. Communication and how to be a successful communicator has been a recurrent theme throughout my reflections. To be an effective leader we need to communicate well with the team to enable the team to share the vision and feel that they have ownership of the vision too.

Another communication (and how different it can be for different personality types) example that I would like to reflect upon from the MLP happened whilst we were on the residential course. One of first tasks was to successfully get across a maze (and there was only one way that you could achieve this) yet only one person at a time could see the maze and I was the first member of my team to go to the maze and I then tried to get as far across as I could and then ran back to the team report my progress.

This task made me realize that I should be clearer with my verbal communication. When I returned from my attempt to get across the maze and one of my team members asked me 'But what does it look like?', this was such an obvious question

but I had completely omitted to describe the appearance of the maze to them and in retrospect that was the most crucial piece of information they needed from me to enable us to be successful in this task!.

The maze task was a good example of how we all learn differently but also demonstrated nicely *Kolb's learning cycle*, as we were able to use my experience to reflect over the information that we actually needed to share as a team. We then learnt from that experience and trialed other methods to find a way to succeed in getting across the maze. The second option we tried was too complicated on reflection so after further modification of the process we found a method that worked for all members of the team.

Reflecting over this task and the action learning sets have reinforced for me the need to be an extremely effective communicator in order to be a successful leader (Olenski, 2016); the vision of what is trying to be achieved needs to be clear to all the team. Empathetic listening as described by Olenski, may improve communication with the team in addition to communicating with clarity. As a result of this I have included improving communication with my team in my PDP and I also plan to trial walking action learning within our department as well.

Reflection Five

Influencing and Leadership

The ability to influence is a key component of being an effective leader and in order to be able to influence it is important to exhibit warmth and be likeable as a leader (Harvard Business Review, 2017). I had a comment in my MSF from my line manager that as 'overall progress with the vision for our service has been more rapid than expected that I should spend some time managing the environment external to the Directorate to influence issues early on/before they arise and maintain organizational support for the Directorate and key aligned partners e.g. ID/GPs'.

I found this feedback very useful as I am aware that I have spent a lot of time focusing inwards directly on the service over the last 5 years and actually I do need to spend some more time networking and 'influencing' for DOSH now. I would like to reflect over how this could be possible using *Rolfe's model* and consider measures that I can put in place as CD to facilitate more networking and increase my opportunities to influence.

From a personal perspective I am aware that I find the prospect of trying to influence intimidating at times but raising the profile of our service is crucial and my awareness of how our service fits into the bigger picture for Cardiff and Vale UHB is also crucial. Personal responsibility is one of the UHB's values and reflecting over what this means for me as CD (*so what?*) is important as my role should be not only about maintaining quality and safety within the service but ensuring that the issues within our service are escalated higher up within the Health Board when needed so that if changes are required there is an understanding of the issues.

As I have reflected over this I feel that this ties in very well with the current situation regarding Sexual Health from a Welsh Government (WG) and Public Health Wales (PHW) perspective. The Sexual Health action plan expired in 2015 and as a group of professionals we raised concerns regarding this, as there was nothing to replace it leaving sexual health services in a vulnerable position, as effectively there wasn't any active directive from Welsh Government about which Sexual Health services should be provided. At that time I was the Wales British Association of Sexual Health and HIV (BASHH) representative and met with the President of BASHH to express my concerns regarding Sexual Health services in Wales and in particular concerns regarding our funding which had not changed for a number of years. As a result of

extensive lobbying as part of BASHH Wales and with support from a PR company utilised by BASHH WG agreed to undertake a review of Sexual Health services. We are currently awaiting a service specification and auditable outcomes for Sexual Health services; this is due to be published in 2019.

Although this has been a lengthy process the review of Sexual Health services was very useful particularly for our service. The review highlighted the very different budgets that the different sexual health services in Wales have and demonstrated to WG that despite our service managing the most complex cohort of patients in Wales our service has a much smaller pay budget than other services; this obviously has ramifications for our service as it means that we will always struggle to meet demand especially as we have less staff than other services who have a less complex caseload to deal with.

Once this information had been highlighted I felt that it was my responsibility to discuss this at Health Board level (this was the '*now what?*' aspect of the reflective model). As a department we were asked to comment on the review findings, which we did however, to date there hasn't been anything specifically fed back to DOSH as a result of this except that we have been asked to complete a work force plan for our service, which is currently ongoing. Being able to benchmark our service against others has been very useful for informing this and as CD I am very conscious of the need for 'future proofing' the service as Cardiff is an expanding city with a very popular university and I feel that this is something which hasn't been adequately planned for either by DOSH or the UHB.

In the last few weeks I feel that I have needed to use my influencing strategies due to concerns within my department. A number of members of staff from the administration team left in short succession and nursing sickness rates are very high currently. The impact of losing members of the administration team became very obvious rapidly. Booking patients in at reception became slower and the staff left behind were very stressed and there had been a few comments from patients about how long they had waited in queues just to book in. The phones also weren't being answered. The consequence of increased nursing sickness rates is that we are unable to accept as many patients and so have to turn people away. Rather than letting this situation continue and risk more admin staff leaving due to the pressure I took a decision to be very proactive, as I felt I needed to be in order to avoid formal complaints from patients and I was very concerned about the team's wellbeing.

I flagged my concerns with the senior nurses within my directorate as well as my line manager and as a consequence I was called to a meeting to discuss the issues in more detail. One of the benefits of raising my concerns and suggesting that any risk needed to be mitigated was that a contingency plan for staffing reception was put into place. This happened as I highlighted that as our service is open access it would cease to function if reception was unable to operate due to lack of staff, and I was concerned about protecting the experienced staff as their skills were even more crucial if a lot of new staff were going to join the service.

As I have reflected over these recent events, it has highlighted to me that my confidence as a leader has increased and I have started to develop my ability to influence. In this particular example my experience told me that I needed to act swiftly and communicate effectively the extent of my concerns; in the past I would have felt more anxious about being so direct. Moving forwards I am aware that I need to be proactive in my role as a leader to protect the team in DOSH from the undue pressures that staff face on a day to day basis. I plan to consolidate my influencing skills further by seeking opportunities to discuss issues both internally within Cardiff and Vale UHB but also externally with PHW and also WG.

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