A key issue in the development of global health is the lack of formal leadership training in LMIC. Newly-qualified consultants are frequently required to lead entire departments or hospitals, advocate at national level for increased access to funding, drugs and equipment, and teach large numbers of healthcare staff, with little or no formal leadership training.

In partnership, the Zambia Anaesthesia Development Program and Western Sussex NHS Trust developed a four-week leadership fellowship in the NHS for Consultants from LMIC. This fellowship combined training in the clinical environment, lectures, interactive workshops and seminars and simulation training.

Thirty-nine UK professionals volunteered training, including Chief Executives, Consultants and senior nurses. Leadership fellows were mentored by a project manager in developing a quality improvement project (QIP) for their institution.

We formally evaluated the fellowship using a focus-group interview and online survey. In the interview, the group were asked to design the fellowship for the following year enabling insight into what was gained, additional training needs and exploration of learning as a group and as individuals. An end-of-fellowship online survey used six free-text questions to explore benefits, learning needs and local implementation. Data were analysed thematically.

Five Consultants from Zambia and Malawi (Anaesthesia 3, Urology 2) participated. All reported they enjoyed the fellowship and found it useful. Most common themes identified by participants were exposure to multidisciplinary learning, outcomes associated with quality improvement training and skills for working with colleagues. At three-months, all leadership fellows reported their QIP was still active, and two had run leadership training locally training a further twenty-one healthcare providers.

Developing a fellowship in the UK was an efficient way to utilise the diverse skills and experiences available in the NHS.

We formulated a list of ‘essential’ clerking items. RCOG states that a working diagnosis should be presented within 24 hours of admission, a plan should be documented for all unscheduled admissions, and each woman should be seen by a consultant gynaecologist within 14 hours of admission; these were included. We formalised this into 21 ‘clerking criteria’.

25 emergency gynaecology admissions were randomly selected from one month. Notes were retrospectively analysed, clerking documents were assessed for each criterion. The Results showed room for improvement; consultant responsible was 0% recorded. The mean recording of the 21 criteria was 50.8%.

We then created a proforma, which was subsequently peer-reviewed, and implemented. 25 proformas were randomly selected and retrospectively analysed from one month. We held our proforma to the original set of 21 criteria.

Documentation significantly improved with use of the proforma. Documentation of 20 of 21 criteria improved. The responsible consultant documentation improved from 0% to 68%. Documentation of a working diagnosis rose from 40% to 92%. The mean overall documentation was 78%.

We became leaders because we noticed an aspect of our daily work that could be improved, and we took initiative to create a solution, and to objectively assess the improvement. Despite being FY2 doctors, we were able to make a positive change affecting both the team and the patient. The rotation of juniors is often viewed as a negative for the departments; new doctors require more supervision. However, we believe it allows transfer of ideas between departments, for the betterment of each.