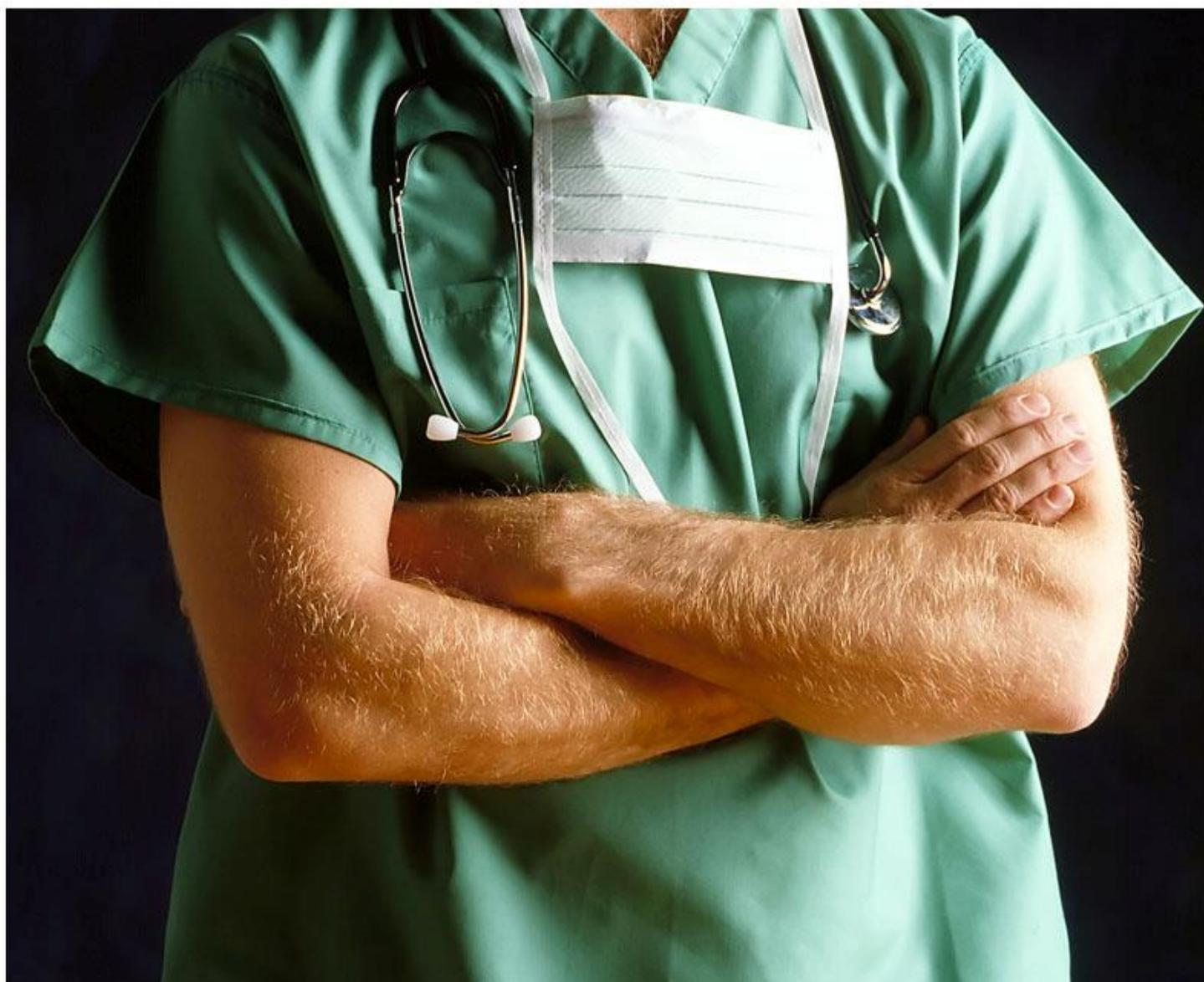**London**Deanery

MIND SHIFT

An Evaluation of the NHS London 'Darzi' Fellowships in Clinical Leadership Programme

PROFESSOR LOUISE STOLL, JULIA FOSTER-TURNER AND MELI GLENN
JUNE 2010

CONTACT
Professor Louise Stoll
London Centre for Leadership in Learning
Institute of Education

20 Bedford Way
London WC1H 0AL
Tel: 020 7612 6412
Email: l.stoll@ioe.ac.uk

NHS
London

CONTENTS

EXECUTIVE SUMMARY

1. Clinical leadership – an imperative

Involving clinicians in leadership is increasingly recognised as critical for high performance, successful improvement and transformation in the NHS. The NHS Next Stage Review – *High Quality Care for All*[1] – promotes locally-led, patient-centred and clinically driven change with a quality focus "at the heart of everything we do". The report concludes that "Leadership has been the neglected element of the reforms of recent years. That must now change". Ensuring a continuing supply of high quality leaders is therefore a top priority.

2. Developing clinical leaders

High quality leadership development is essential to develop future leaders who can relate to others, collaborate productively, and negotiate their way through the complexity and challenges of their organisational and system context, to bring about service change and quality improvement.

3. NHS London 'Darzi' Fellowships in Clinical Leadership Programme

The NHS London 'Darzi' Fellowships in Clinical Leadership Programme was designed to address these issues. Commencing in April 2009, 39 Fellows participated in the first cohort, taking one year out from their specialty training programmes. Located in Primary, Acute, Foundation and Mental Health Trusts, they were sponsored and mentored by a nominated Medical or Clinical Director, spending most of their time working closely with this person, the Trust and local community on three clinical service change, improvement and capacity building projects. This project work was supported by a leadership development programme designed for the first cohort by the Centre for Innovation in Health Management (CIHM) at the University of Leeds, with the Kings Fund and Manchester University taking over the supporting programme for the second cohort in 2010-11. The supporting programme offered a range of learning experiences, with the aim to help Fellows find solutions, bring about change, and develop their capacity for reflective practice. Clinical practice was maintained through a small number of clinical sessions each week. The cost for the first cohort was £3.2 million.

4. Independent evaluation of impact

This independent external evaluation was commissioned in November 2009 with a brief to explore the Programme's impact thus far on participating Fellows, organisations and stakeholders, and make recommendations for the future. The evaluation team carried out 47 interviews with Fellows, Medical Directors, stakeholders in Trusts and originators and designers of the Fellowship and designers of the learning support programme, including case studies of Fellows in four Trusts. Questionnaire responses were received from 30 Fellows (77%) and 14 stakeholders (39% of those contacted), internal mid-term evaluations were examined, and the team attended the concluding event at which Fellows presented posters outlining the work and achievements of Fellows and their Trusts.

5. Impact

Impact thus far can be seen at several levels: on Fellows' own learning and professional goals; on sponsoring Trusts and local specialty training programmes; and emerging signs of wider system impact.

Impact on Fellows has generally been far reaching and, in many cases, profound. Six areas of impact have been identified: growth in self understanding and personal skills; increased knowledge and understanding of the organisation and system context of change; enhanced understanding and skills in working with others; change management, service improvement and capacity building knowledge, understanding and skills; changed beliefs and values; and some revised career aspirations. Personal change has been significant, with a 'mind shift' in the way most Fellows view

clinicians' role in service change. A group of young leaders has been equipped with knowledge and understanding of the NHS, complex organisations and themselves, and personal, interpersonal, quality improvement and change skills to support and sometimes lead service change, improvement and leadership capacity building projects.

Impact on Trusts is evident both in the extent of application of Fellows' learning and in a range of outcomes of that applied learning. While outcomes can rarely be attributed to individual Fellows, because of support and engagement of other stakeholders, the inclusive, creative and tenacious ways Fellows have applied their learning has resulted in or contributed to many projects that have been successfully developed and implemented, including some roll outs in Fellows' own Trusts and other Trusts, leadership development programmes designed for other trainees, and processes, tools and prototypes that provide concrete legacies for Trusts that can be used and adapted to suit other situations. Outcomes have also been demonstrated, with a range of indicators of improved healthcare outcomes, as well as enhanced leadership development capacity as evidenced by other SpRs in Fellows' Trusts who have become engaged in service change and quality or safety improvement projects. Examples of culture change can also be found among stakeholders in many of the Trusts.

Impact on the wider system – It is early days to be thinking of the Fellowship's impact on the wider system as a 'movement', although interest has been stimulated by an enthusiastic and active Fellowship cohort who have started spreading the word, leading to greater interest in the Fellowship and other clinical leadership programmes for senior trainees. The experience of the few Fellows who have moved into new positions has also been welcomed by hiring Trusts.

6. Factors influencing impact

Eight factors have particularly influenced the nature and extent of impact of the Fellowships Programme in its first year.

Committed and learning-oriented Medical Director (MD) – MDs viewed the Fellowship's purposes in different ways. Reasons for wanting a Fellowship also diverged; some were attracted by offering learning opportunities to young clinical leaders, others by 'another pair of hands', the Fellowship's prestige or, for Primary Care Trusts (PCTs), the potential for engaging other local, young doctors. These reasons weren't mutually exclusive and were often associated with MDs' expectations of Fellows. MDs needed to maintain a strategic oversight, convey the Fellow's role clearly to colleagues and ensure access to mentoring, senior leaders and support.

Supportive Trust culture – Fellows found their tasks easier in Trust cultures that were one or more of the following: people-oriented, open to innovative ideas and practices, already very committed to clinical leadership; and/or strongly focused on learning and leadership development. Some Trusts gave greater consideration to where the Fellow was physically located and ensuring access to necessary resources and supportive colleagues.

Working on 'ambitious but appropriate' live projects – Most Fellows considered their projects a valuable aspect of their Fellowship due to the scope they gave to learn from practice, apply theory-based learning, gain experience of management and challenge, and see the fruits of their efforts. Clarity of project aims was important as was manageability in terms of project size. Some connection between the projects was also beneficial.

High quality mentoring – Approximately two thirds of Fellows' main mentor was their MD. Whoever the mentor was, most crucial was the quality of mentoring and relationship. Sixty per cent of Fellows rated mentoring as very valuable. They felt greatly supported when the relationship was positive, with regular access to the mentor and informal opportunities to 'check in' or seek feedback on an issue, and having mentors connected with different projects was helpful. Mentors varied considerably in their mentoring skills and some mentoring MDs would have appreciated more opportunities to connect and share experiences with other mentors.

Learning programme that targets transformational change –The transformational personal experience for many Fellows, introduction of transformation projects and, in some cases, roll outs,

and the range of outcomes demonstrated were enhanced by the breadth of learning opportunities made available to Fellows. Learning from theory helped them understand their practice; deep reflection enabled them to gain in self awareness, challenge thinking patterns and consider alternative options; collaborative problem solving supported them in dealing with challenging issues; and accreditation was motivating for some. At times, Fellows were challenged by the pace of demands of academic study.

Combining workplace and external learning – No one set of learning activities addressed the needs of all Fellows, but the combination of learning through supported project work in Trusts and an external learning programme added up to a more powerful experience. Despite times when Fellows felt overstretched, the projects gave them concrete, hands-on workplace learning and experience of leadership with dedicated mentoring support, while the supporting learning programme provided the theoretical backdrop, enabled them to process issues with peers and facilitators, and to reflect on their own leadership.

Network of support – Part of the supporting learning design, a strong web of support was generated between a group of Fellows brought together by a shared interest in developing their clinical leadership and facing similar issues and challenges. Valued more than any other aspect of the Fellowship, and initially facilitated through other learning strategies, such as action learning sets, communities of practice and groupings for the programme modules, networks began to take on a life of their own as groups of Fellows developed joint projects, got together socially and planned to stay in touch.

Ongoing monitoring and adaptation addressing Programme issues – All programmes require refinement, especially new ones. Designers of the programme modules responded rapidly to feedback, and the internal mid-term evaluation and other feedback highlighted issues, most of which are being addressed in the second iteration of the Fellowship. An opportunity also arose in the middle of the year to offer some small extra grants for leadership capacity development projects, leading to a Dragon's Den bidding process.

7. Successes

Successes of the first year of the Fellowships Programme include:

'Mind shift' of Fellows – the Programme's major impact on these young clinicians professionally and, sometimes, personally.

Increasing belief in young clinical leaders' potential – stakeholders in Trusts seeing how well-supported young leaders can bring about service and improvement-related change.

Creating impetus for leadership capacity building in Trusts – heightened awareness and desirability of clinical leadership development.

Leveraging relationships and networks – networks that have become integral to Fellows' modus operandi of change leadership, and a potential source of momentum for wider change.

Material outcomes of change and improvement projects – many Fellowship projects have created policies, pathways, protocols and partnerships to capture, formalise and consolidate better ways of working.

8. Issues

Challenges for the Fellowships Programme include:

Uncertainty about aims – overall aims that were not entirely clear, leading to MDs and Trust stakeholders having different expectations of Fellows.

Mutual engagement and ownership – MDs who were not actively engaged in contributing to the support programme and weren't always clear of its connection to project work in Trusts.

Trust learning context – some Fellows struggling with unrealistic Trust projects and/or experiencing limited support or interest.

Mentoring quality – variability in mentoring, with it sometimes insufficiently oriented to the Fellow's needs, and some mentors not possessing the necessary skills.

Ensuring sustainability – although energy and activity were stimulated, it is unclear whether the foundations set will be deep enough to maintain commitment, energy, focused activity and pursuit of impact over time.

9. Recommendations for future iterations of the Fellowship Programme

The majority of participants, MDs and stakeholders agreed that the Fellowship had exceeded expectations while offering suggestions for improvement of future iterations. Some of the recommendations that follow may already have been incorporated into the second iteration of the Fellowship but would also be pertinent to other similar programmes.

Recommendations for the overall design of the Fellowship Programme
Communicating the purpose and aims of the Fellowship more clearly is likely to help Trusts set expectations accordingly and target support. This will be aided by assessing or training mentors to ensure they have the appropriate skills, building stronger links between project and supporting learning components, finding ways to monitor the quality of support received by Fellows, and communicating to MDs about results of ongoing monitoring and evaluation of Fellows' and Programme progress. As more potential applicants hear about the Fellowship, being able to identify 'the right people' will become increasingly important. Maintaining the diversity of specialist interest subjects from which Fellows are recruited is also necessary while ensuring sufficient numbers representing types of Trusts to generate the necessary breadth of networked support. Opportunities to include non-sector professionals might also be considered.

Recommendations for the learning programme
Introducing more practical skills early on is more likely to enable Fellows to 'hit the ground running' and workload pressure can be alleviated by timing assignments to achieve the right balance between demands study, project work and clinical practice. Potential exists for greater involvement of MDs in the learning support programme. Greater attention should also be given to how the learning programme can help with planning for sustainability through Fellows maintaining their learning and connections.

Recommendations for sponsoring Trusts
Sponsoring a Fellowship requires total Trust commitment, ensuring that organisational support is available as needed, arranging high quality mentoring and planning suitable projects connected to a theory of change.[2] Further benefits can be accrued by thinking strategically about the Fellowship as a means of enhancing leadership capacity building in the Trust and planning accordingly.

10. Lessons for other leadership development

Clinical leadership training opportunities throughout the medical career should be expanded. The experience of this Fellowship suggests that such development might combine experiential, project-based learning with theoretical learning and opportunities for reflection and collaboration, although this evaluation has not explored online learning and, therefore, can't make any comparative judgments about its potential as a means of blended learning. There seems to be potential to increase local leadership development opportunities and the Fellowship has several models that can be offered here. Better networking methodologies could be developed, and multi-professional leadership development seems to be a fruitful avenue to pursue.

11. Tracking sustainability and impact over time

The NHS London 'Darzi' Fellowships in Clinical Leadership Programme is an ambitious and innovative programme, with an ultimate aim to affect and spawn clinical leadership throughout the system, thereby influencing individual professional practice and bringing about system-wide change to address the needs of a rapidly changing health service. Forty doctors have completed or almost completed their Fellowship and a second cohort, with a further 30 participants, is underway. Impact on individual Fellows and their Trusts has been demonstrated in various ways. But what is likely to happen over time? Longer-term follow up evaluation over a period of years should explore further impact on Fellows and Trusts. At a broader system level, indicators should also be developed to track the development of critical mass in terms of development of clinical leadership knowledge, understanding, skills and beliefs and expectations throughout the system. A Fellowship available to a small number of junior doctors is not likely to achieve this on its own.

12. Conclusion

In this evaluation, we considered the NHS London 'Darzi' Fellowships in Clinical Leadership Programme in terms of its impact on Fellows, participating Trusts and other stakeholders. Time will tell whether impact on Fellows and sponsoring Trusts can be sustained, but much has already been achieved in one year. Findings of this evaluation suggest there is much of value to be learnt about clinical leadership development from the NHS London 'Darzi' Fellowships in Clinical Leadership Programme.

The simplified model that follows is based on the evaluation findings. It highlights how successful programme design of similar clinical leadership development programmes containing work-based and supporting learning programme elements needs to be underpinned by certain principles that are oriented short- and longer term impact and sustainability. The full model is explained at the end of the main report.

A model of clinical leadership programme design combining workplace and external learning that is focused on impact and sustainability
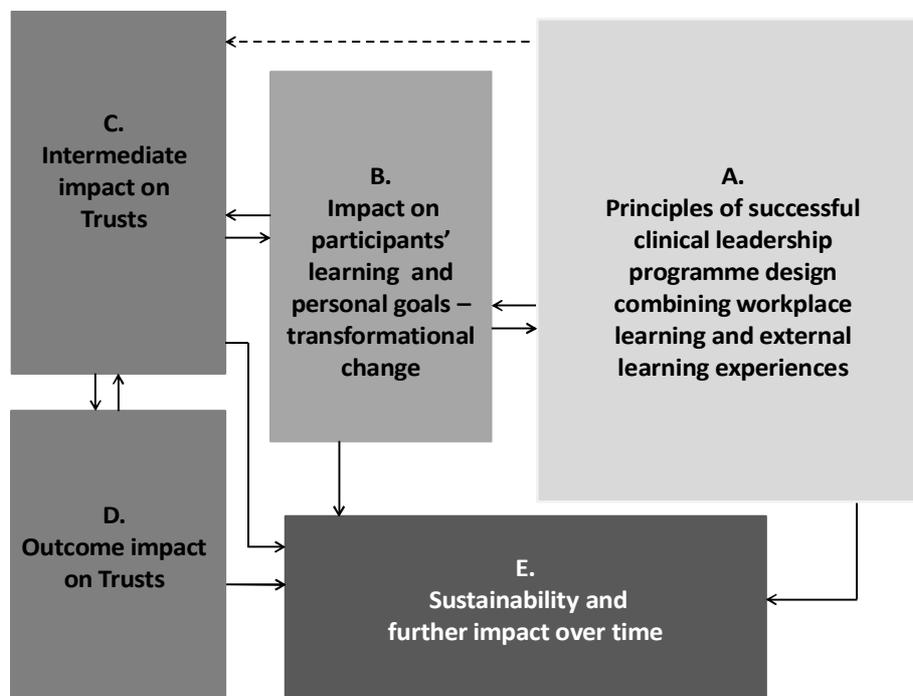
The model needs to be tested but may provide a starting point for those interested in designing programmes similar to the NHS London 'Darzi' Fellowships in Clinical Leadership Programme.

1. INTRODUCTION

Clinical leadership is an increasing priority for the NHS, with associated interest in designing high quality experiences to develop future clinical leaders. Work-based learning is common within the health sector, but it is an innovative idea to create a leadership fellowship for new leaders, with leadership learning through work experience at its core and a supporting development programme. Furthermore, although fellowships emphasising service transformation and quality improvement have been available to senior clinicians, the idea of offering such opportunities to those nearing the end of their training is also new.

The 'Darzi' Fellowships in Clinical Leadership Programme, based on these ideas, started in April 2009 and is nearing the end of its first iteration. This report is the outcome of an independent external evaluation that began in November 2009. Its brief was to explore the impact of the Programme thus far on participating Fellows, organisations in which they spent their Fellowship year and stakeholders, and make recommendations for the future.

The report is set out as follows. In Section 2 we discuss the context of the Fellowship, following this with an outline of the aims and design of the Fellowship in Section 3. Next, in Section 4, the evaluation framework, methodology and analysis are described. Key results of the evaluation are presented in Sections 5 and 6. These sections focus on findings about the impact of the Fellowship and factors that influence impact. In Sections 7 and 8 we identify successes of the Fellowships Programme and key issues, making recommendations for future iterations of the Fellowship and other leadership development programmes in Sections 9 and 10. We conclude in Sections 11 and 12 by considering the future and possibilities for longer term follow up, and proposing a model for a clinical leadership programme design that is oriented towards impact and sustainability.

2. CONTEXT OF THE FELLOWSHIP

2.1 The leadership imperative

The NHS faces intense pressure to respond to the demands of rapidly evolving technical infrastructures, changing patient demographics and an increasingly discriminating general public. This requires transformation through overhauling and improving health care systems, and ensuring they have the ability and quality to deliver what is needed in the right place, at the right time and at the right cost.[3]

Leadership has been identified across the public, private and third sectors as critical to high performance, successful improvement and transformation.[4] A McKinsey & Company review argues that 'Health care systems that are serious about transforming themselves must harness the energies of their clinicians as organizational leaders".[5] This echoes The NHS Next Stage Review – *High Quality Care for All*[6] that promotes locally-led, patient-centred and clinically driven change with a quality focus "at the heart of everything we do". The report concludes that "Leadership has been the neglected element of the reforms of recent years. That must now change".

However the NHS Confederation[7] has highlighted a shortage of high calibre leaders, with a consequent need to extend leadership development beyond executive level, to those coming through the pipeline. This research revealed a relatively high proportion of candidates who exhibit a troubling level of passivity and risk aversion, lacking sufficient entrepreneurial flair or the willingness to take the initiative. Such individuals also have an overly short term focus with an inability to understand the wider system and to think strategically. This is attributed to the systems in which they operate and behaviours they learn. A core element of such systems has been described by Ham and Dickenson[8] as professional bureaucracies, collections of microcosms, characterised by tribalism and turf wars between professionals, who identify more strongly with their part of the organisation than with the organisation as a whole.

2.2 Leadership required

A major challenge is that leadership requirements have changed, in response to complex health care systems within the NHS.[9] The need now is for leadership to have greater involvement in clinical issues, to balance a large number of different and potential conflicting objectives, to be more connected to current research and leading edge thinking, and to work at a much faster pace. In terms of NHS professional bureaucracies,[10] where control and co-ordination is primarily horizontal rather than hierarchical, leadership needs to be highly distributed through large numbers of clinicians at different levels and through professional networks both within and between organisations. There is also a need for collective leadership in health care organisations, moving away from charismatic individuals to leadership teams and bringing together constellations of leaders at different levels when major change programmes are undertaken.[11]

2.3 Developing clinical leadership – focus and content

Ensuring a continuing supply of high quality leaders is therefore a top priority. High quality leadership development is essential, especially that which develops future leaders who are strategic, can inspire and relate to others, collaborate productively with others, negotiate their way through challenges, and take charge of change.[12] Writing from a business perspective, Gill[13] suggests that leadership development programmes should be based on articulated strategic issues, objectives and competences. Furthermore, content and learning methods are needed that deliver 'moments of truth' in order to improve self knowledge and self worth, reshape perspectives and mindsets, allow testing of behaviours and ideas, improve skills and relationships, provide leadership behaviour models, provide opportunities for participating in change direction and culture of the organisation, provide a global focus, and link up with other people relevant to participants' jobs.

The Health Foundation[14] complements this perspective by underlining the importance of leadership programmes in encouraging participants to become more aware of perspectives of others – patients, families, colleagues, the wider organisation and the health economy; to behave authentically taking these multiple and overlapping perspectives into account, and to focus on improving patient care as the key aim of leadership. Also, the Health Foundation indicates the principle of developing participants' understanding of how to release energy and resourcefulness in the organisation/system, to create the conditions for innovation and problem solving and the ability to use information and relationships effectively to spread what works.

The human side of change is also highlighted. For example, NHS North West's Chief Executive, Mike Farrar says that learning to deal with the emotional aspects of organisational life is as important, if not more, than the technical skills in managing complex change especially when this involves talking with people honestly about difficult issues and seeking to change behaviour amongst clinicians, service users and the public.[15]

The Medical Leadership Competency Framework, developed by the Academy of Royal Medical Colleges and the NHS Institute for Innovation and Improvement,[16] aims to identify and bring together the leadership competencies needed by doctors to become more actively involved in planning, delivery and changing and transforming services. It can be used, among other things to help design training curricular and development programmes. The competencies are focused around personal qualities, working with others, managing services, improving services and setting direction. The framework indicates the learning outcomes that should be developed at each of three main career stages – end of undergraduate training, end of post graduate training and up to five years or equivalent continuing practice, describing different ways of demonstrating these competences depending on the doctor's career path, level of experience and training.

2.4　Leadership development methods

A number of leadership development approaches have been developed to try to meet these aims and aspirations and help leaders achieve competence. Despite the shift from 'single' mode classroom learning to a menu of learning opportunities and experiences facilitated at personal, peer or team learning levels, a recent handbook of leadership, management and organisational development recommends that time in the classroom incorporating carefully facilitated reflection on practice is still important.[17] The growing emphasis on experiential based models for leadership learning, however, highlights benefits of combining self directed study, theory and action learning[18]. The latter is both a mechanism for linking leadership development to 'real world' situations, and is intended to provide an opportunity to connect doctors, group and organisational learning and to facilitate multi disciplinary, team-based leadership development.

Fellowships frequently combine experiential and classroom elements of learning.　Many fellowships provide the opportunity for fellows to apply learning from taught modules in their own work settings and local communities. While work-based learning through apprenticeships and communities of practice is common within the health sector,[19] creating a leadership fellowship for new leaders, with leadership learning through work experience at its core and a supporting development programme, is an innovative idea. A number of health organisations in the UK and elsewhere offer Fellowships with an increase in those oriented towards quality improvement[20] and evidence-based practice.[21] Many of these target senior leaders,[22] but examples exist of identifying potential leaders at a much earlier stage of their career and providing them with leadership development fellowship opportunities.[23]

Two other leadership development methods well supported for their benefits are mentoring and coaching[24]. Mentoring is used to support personal development and the development of leadership competencies. Especially when mentors are senior managers, it can offer an opportunity to learn about leadership challenges in strategic contexts and in building mental cognitively complex and mental representations of these. Less positive aspects are potential gender differences in mentoring impact and risks of over dependence on the mentor. However, where strong interpersonal relationships between mentor and mentee exist, the mentee will work harder, express greater commitment and shoulder greater responsibility. New employees, who have a strong relationship with their mentor develop high job satisfaction, commitment and are more likely to stay within their job.[25]

Coaching is selected for its effects in providing different mental models of events, encouraging reflection, developing interpersonal and emotional intelligence, enhancing productivity and also supporting the building of networks in and outside of organisations. The ability to build networks is viewed as a crucial competency of leadership, through enabling people to share tacit as well as explicit knowledge, by sharing stories, anecdotes and metaphors otherwise hard to grasps. Networking also widens the range of contacts inside and outside of the organisation, thus enabling leaders to access a greater range of information, perspectives and views and to challenge assumptions.[26]

2.5　Leadership development outcomes

Reported development outcomes from the literature predominantly fall into two main categories, those related to the individual and organisational /service impact. Examples of changes found at an individual level include increased self awareness, self control, self confidence, more reflective and broader thinking and a heightened sense for other people's behaviours and actions[27] as well as skills acquisition such as learning about useful management tools to undertake change management.[28]

The NHS confederation[29] states that leadership development should be measured by its impact on the organisation as well as on the individual. Despite findings that empirical evidence of

organisational influence or impact of leadership development can be inadequate, there seems to be emerging evidence connecting leadership development with positive organisational and service impact. For example, McAlearney[30] found that leadership development programmes provided four opportunities to improve quality and efficiency in healthcare, by: increasing the calibre of the workforce; enhancing efficiency in the organisation's education and development activities; reducing turnover and related expenses, and focusing organisational attention on specific strategic priorities. In another example, a large scale UK project connecting leadership development with redesigning pathways for patients with stroke and hip fractures, created significant impact on length of stay, mortality and costs, all of which fell by 30 per cent. The project also raised enthusiasm for leading service improvements more generally and lasted beyond completion of the formal programme.[31] Further evidence is needed.

2.6   Contexts that support leadership development

Organisational commitment to leadership development is required to ensure that programmes are effectively designed, delivered and sustained. This, in turn, is influenced by resource availability for leadership development, level of senior leadership support, expectations of leadership, perceived value of leadership development programme relative to other priorities, and sustainability of commitments to leadership development. It has also been found important to link the programme with human resources and other organisational development functions.[32] A particular challenge for sustainability and mutual commitment of senior leadership to trainees and vice versa, is the rotation system whereby trainees spend between six months and a year in a Trust and, within that, are on 3-4 month rotations in different specialty departments.

Leadership development can be seen as an integral part of organisational development. This fits with the concept of distributed leadership and of leadership development being a process of developing the organisation's social capital rather than the individual capital of leadership participants.[33] In this sense, leaders' ability to build capacity through developing other leaders and promoting professional learning communities is increasingly important in the public sector.[34] In practice this requires that leadership development be most appropriately effected through organisation-wide initiatives rather than just programmes for individuals.[35] It also has to be devolved down the organisation, so that line managers see leadership and management development as a core part of their role,[36] and if health care practices are to be transformed, it shouldn't be undertaken in silos.[37]

3.   AIMS AND DESIGN OF THE FELLOWSHIP

3.1   Aims and desired outcomes

The NHS London "Darzi" Fellowships in Clinical Leadership Programme was designed to address many of these issues; developing influential leaders of change who can network and provide system leadership, with the support of formal leaders and through developing other leaders. Developing clinical leadership was seen as essential by all of the programme originators, giving one of whom summarised key reasons:

> Why do we want clinicians as leaders? In the planning and delivery of healthcare services if the clinician's voice is not taken into consideration, we have a sizeable chunk of the very able workforce not even being engaged in the process and that's very dangerous on a lot of grounds: the lack of evidence-based thinking about what are priorities and allocation of resources; an incredibly able population of people with so much to contribute and if they are not given opportunity to contribute, it's divisive to a system that shouldn't be divisive; and there has been a culture within the health service of 'them and us' – managers and doctors – if they don't work together, it breeds a feeling of disempowerment and feeling of frustration . . . it's not setting up a healthy system.

A critical issue has been that the identification and development of clinical leaders is often left to chance:

> Currently and in the future, clinical leadership is essential to management. Leaders currently arrive by accident. They are lucky if they fall into a development programme and get the right support.

> We are very good at training doctors to look after individual patients. We fail miserably to train doctors to look after the system of care. . . We teach people to look after individual patients then go on management courses and there is no link. . . Junior doctors are incredibly able and energetic but we fail to engage them. There's enormous potential from harnessing the energy of junior doctors. As a group, they are the most able, energetic group in the Trusts. . . . We are missing a trick. From the age of 25-65 in most organisations you gradually get responsibility. In medicine it's different. Suddenly you become a consultant. It's a steep rise. . . . When I became a consultant I went on an intense three week course. . . . There's a need for our future doctors to look at what they do and get appropriate organisational skills – these are benefits for tomorrow. And for today, if we harness junior doctors in their Trust, we would benefit today, for example reducing prescription error rate. We would make a significant change.

From a senior NHS London perspective, the Fellowship was seen as offering a systematic means to identify clinical leaders of the future; not just those that would become Chief Executives but also Clinical Directors and, possibly, Medical Directors:

> The sooner we identify them the better so there's a pipeline. Clinicians interested in leadership don't become apparent later. Identify potential leaders early in their career and provide leadership beyond their clinical responsibilities.

It was also hoped that "some of the brightest and best" would become interested in taking forward the strategies in *Healthcare for London*, "as frontline clinicians involved in thinking about how changes can be implemented in the best ways to improve patient care and how they can be taking forward change in their own right and be supported to do so". A further hope of the Programme originators was: "to seed the idea in the Trust. Once they have seen these people they will have a different idea about these people's potential".

The Fellowship is a major undertaking, backed by significant resources. The cost for the first cohort was £3.2 million. Arguing the case for such programmes is not easy, especially in times of fiscal constraint. Senior leaders in NHS London, however, were absolutely committed to its potential as a significant stimulus for change and supported it throughout, attending the launch and final poster session in which Fellows shared the fruits of the year's learning.

The Programme also benefitted from being associated with Lord Darzi, a champion of clinical leadership in the NHS *Next Stage Review* who agreed to have his name affiliated to it and attended the launch. There was some sense that this 'branding' with the name of a well known London doctor had given the Fellowship profile, even though over time, as new policy leaders emerge, it might be less pertinent.

As stated in the Programme launch flyer, the intended outcomes of the Fellowships Programme are:

- To manage people and relationships to support organisational goals, specifically, the Framework for Action.
- To support sound management and service innovation within the organisation.
- For Fellows to develop reflective practices to analyse their own impact on situations and to devise strategies for being more effective with others.

3.2 Design

The choice of a Fellowship was its "deep-rooted work-based focus" and its currency within the health service and medicine – "to give a leadership/management route in medicine similar kudos to a research fellowship". Lord Darzi agreed to have his name associated with it, given the emphasis placed on clinical leadership within the NHS *Next Stage Review* and its focus on service change and quality improvement.

The overall design is to locate Fellows in Primary, Acute, Foundation and Mental Health Trusts in a 12-month 'out of programme experience' from their own specialty training programmes, sponsored and mentored by a nominated Medical or Clinical Director. The majority of their time is spent working with their Medical or Clinical Director or designated mentor, Trust and local community on agreed clinical service change, improvement and capacity building projects. They are supported in this by a leadership development programme run by the Centre for Innovation in Health Management (CIHM) at the University of Leeds in the first year (2009-2010) and the kings Fund and the University of Manchester in the second year (2010-11) that offers a diverse range of learning experiences aimed at helping them focus on finding solutions and bringing about change, and offering them opportunities for reflection. The Trust receives salary replacement costs for one year for an SpR Fellow to work with them.

Fiona Moss, Post Graduate Dean at the London Deanery telephoned every MD in London to elicit feedback on the idea, finding only two who did not immediately respond positively, one of whom called back within 24 hours to say that they wanted three Fellows: "The face validity was fantastic, unbelievable . . . the response was stunning"

The Fellowship was established in 2009, involving 41 Fellows in its first year, although one trainee left soon after the programme started and a second Fellow had moved to a new position by the time the evaluation started. In its second year, 30 Fellows are involved.

3.3 Live projects in a Trust

In the first year, the Fellowship included three work-based 'live' project components. These were:

Service change management project

Working closely with the Medical Director or nominated deputy to support development of service changes across the system of care, in keeping with the principles of the *NHS Next Stage Review*. The intention here was that Fellows would learn about change implementation and management across organisational boundaries within a local health economy.

Quality improvement / safety improvement / clinical governance project

Devising, leading and delivering a local quality improvement, safety improvement or clinical governance initiative within their Trust. Here, it was intended that Fellows would learn how the Trust organisation worked and gain valuable experience implementing organisational change within that organisation.

Supporting capacity building within the Trust for training and generic skills

Working with various departments within the Trust to develop the capacity for training in essential organisational skills. Documentation sent to MDs suggested that the Fellow might identify and co-develop a leadership/organisational development module to generic organisational skills such as team working, and then roll this out to SpRs and other health care professionals within the Trust.

NHS London had wanted:

. . . a common thread" to hold the project work together and "because we're trying to seed through a programme of major change that's got clear, common elements in it, we wanted to connect them all to that. . . We wanted to connect it back to [Lord] Darzi's vision for London.

One of the Programme's designers elaborated on the choice of the three project elements:

> The patient safety/quality project was to emphasise that you cannot and you should not be driving a service change without considering this. If they are savvy, they will be thinking of the two other elements every single day when they do the first [service change management]. What impact does this have for patient safety, what impact for capacity building? And that would be your standard question for every part of the change process. And again for the OD piece. If we move this to this and we are shifting this service to these staff, do they have skills to deliver, what are we doing about skill development, are we working with the education and training department at an early enough time? That again should be part of their checklist. The reason for it was to get them to develop that mindset. We are stating these as three separate columns but by the end what we are expecting to them to have the skills for thinking: 'What's my safety checklist? What's my quality checklist? What's my training checklist?' And also to ensure they don't develop a concept of project management as I come in, I deliver, I go because projects need to be sustainable. I come in, I deliver and I set up systems to ensure this runs without me. Any good project manager does themselves out of a job.

The projects are therefore intended to be mutually supportive and reinforcing as elements of sustainable change introduced by clinical leaders. We have represented the intended connections in Figure 1.

Figure 1:   Intended integration between project components of 'Darzi' Fellowshipsin Clinical Leadership Programme

3.4   Support from within the Trust

Programme documentation sent to MDs stated that the Fellowship should include:

Support and commitment from the sponsoring MD or PEC chair

The Fellowship came with 12 months funding for the Fellows' salary and on costs. To secure a Fellowship, the MD, on behalf of the Trust, including the Human Resources Director, CEO and Financial Director, had to outline possible projects in the three areas, commit to supporting the Fellow in these projects. Acceptance of a Fellowship also included signed confirmation from the MD that the live project work "will indeed cross systems boundaries" and that the MD would "help support the important task of evaluating these posts". The MD also had to commit to providing supervision and mentorship for the Fellow, a major feature of the within-Trust support commitment, and was invited to contribute to the SpR organisational programme if they so wished.

The role description of the MD or PEC chair's responsibilities included sponsorship, recruitment, induction support, teaching, mediation, mentoring, provision of and commitment to resources, protection where needed, release of the Fellow to attend educational components, and attendance at joint London Deanery meetings to support Fellows' learning. This aligned with a strong belief within NHS London that the Fellows needed to be connected to their MDs, in part as a means to harness the leadership energy of MDs.

Clinical commitment

Fellows would continue to undertake a limited amount of clinical work, up to three sessions, to be negotiated locally, start after the first month in their post and include clearly identified clinical supervision.

Other Trust-based opportunities and support

The Trust would provide other developmental opportunities, eg attendance at board meetings, working with multi-professional teams, project management experience, and exposure to Trust financial management.

3.5   Supporting leadership learning programme

The launch flyer highlighted that the learning support programme commissioned from the Centre for Innovation in Health Management (CIHM) at the University of Leeds was "designed to develop doctors' understanding of organising and organisations; the contribution of effective management and ways of supporting change". To this end, it aimed to help Fellows to:

- engage in change in their local context;
- develop the ability to read 'political environments;
- understand how modern service organisations work;
- uncover their assumptions and explore other perspectives about organisational change; and the roles of clinical and managerial professionals;
- learn how to support systems to act intelligently;
- build a network of colleagues facing similar challenges; and
- gain real experience of working differently in teams and systems.

The designers of the learning support programme elaborated on these aims, explaining how The Fellowship was therefore constructed to: help junior doctors work more effectively with managers and within management structures; get them to think about their role and relationships in new ways both as an individual, within a team, in their organisation and across systems as well as help them realise what they did not know about working at the system level; involve them in real projects and have real experience of managing organisational change; understand "organisational architecture" so they could work within it and know about decision making process and how they could make a difference; and thinking and learning about services beyond their organisation and seeing how they fit together and function. It was also about "making an impact at system level, being radical".

CIHM was commissioned to provide 24 days of structured learning within the Fellowship. This bended programme of support, designed specifically for the Fellowship, consisted of:

- *Six classroom-based modules*
  These were designed to introduce ideas that would underpin developing practices and intended to develop effectiveness at the individual, team, organisational and systems level. These modules focused on an introduction to health service policy, understanding organisations and change, leadership and innovation, medical management, co-production and governance.

- *Four action learning sets*
  Comprising of six or seven Fellows and a facilitator, these were designed to support organisational change and foster personal enterprise, and to give Fellows opportunities to raise concerns and build their practice capacity.

- *Communities of Practice (CoPs)*
  The aim of these was to support skills development in relation to specific themes, in which Fellows would participate in two out of six on offer.

- *Design surgeries*
  Hourly meetings or phone calls with facilitators were available to support live projects.

- *Coaching*
  Five individual and confidential sessions throughout the year were built in, to challenge and support Fellows to reflect on their experiences with the projects, in the workplace and in the learning programme. Up to three of these were also made available for the MD/mentor to join the meeting.

- *Stakeholder events and occasional meetings*
  These events involved sponsoring Medical Directors, with a focus on leadership and learning in context.

- *Accreditation for a Post Graduate Certificate in Management*
  This optional qualification from Leeds University required the submission of four essays, three of which were related to modules and the last which covered learning about change throughout the programme.

- *A network of colleagues*
  As a whole cohort and through division into two groups for modules, six mixed action learning sets and theme-based interest groups in CoPs, the intention was to help develop connections and support with others facing similar issues and challenges.

The different elements of the supporting learning programme were drawn from a range of evidence bases on effective leadership learning and organisational change.

3.6   Other Programme elements

In addition to the live projects, Trust-based support and supporting learning programme, other elements of support were built in, either at the beginning or over time.

- *Web-based community*
  A dedicated site was set up on the London Deanery's virtual learning environment to encourage and facilitate collaborative working and knowledge sharing.

- *National and regional opportunities*
  There was an expectation that Fellows would attend national and regional events appropriate to their role, giving presentations at some.

- *Support from the Programme Manager*
  Providing a bridge between all of the stakeholders and a link between the Fellows and the outside world, the Manager negotiated on Fellows' behalf when there were requests, and also raised any issues Fellows had "with the right person".

- *'Dragon's Den' funding*
  Part way through the year, and based on feedback and observations that the leadership capacity building live project was proving difficult to develop, the London Deanery used a small amount of funding and, with the support of CIHM, designed a competition where Fellows could bid for small grants to help them in this aspect of their project work. Nine projects were funded, several of which were for collaborative projects across participating Trusts or across London.

Figure 2 presents a representation of the NHS London 'Darzi' Fellowships in Clinical Leadership Programme.

Figure 2: The NHS London 'Darzi' Fellowships in Clinical Leadership Programme

4. EVALUATION FRAMEWORK, METHODOLOGY AND ANALYSIS

The primary evaluation research question our research team set out to answer was: *What is the impact of the 'Darzi' Fellowships in Clinical Leadership Programme on participants, organisations and stakeholders?*

Subsidiary questions that the evaluation sought to address included:

1. What are the actual learning outcomes of a Fellowship?
2. To what extent have the aims of the supporting programme been met?

3. To what extent did the supporting programme contribute to workplace performance?
4. How did the work experiences in the Fellowship contribute to trainee learning?
5. What professional beliefs and values are developed during the Fellowship?
6. What additional value, if any is brought both to the Trust and local specialty training programme?
7. What effect has the Fellowship had on career aspirations of the postholder?
8. What practical issues have arisen in the Fellowship programme as a whole?
9. What do stakeholders perceive that would improve future iterations of the Fellowship programme as a whole?
10. In the light of the experience of the first cohort, how might the job description and person specification for Fellows be modified in future
11. What can be learned from the Fellowship programme as a whole to inform embedding leadership development across all training programmes?
12. What recommendations can be made for longer term follow up?

4.1 Evaluation framework

In developing an evaluation framework we drew on Kirkpatrick's four-level impact evaluation model[38] that measures reactions, learning, transfer and results, and added Guskey's impact model for evaluating professional development in education settings because it also looks at contextual influences on learning and transfer.[39] Other factors needed to be considered. In the Fellowships programme, the leadership development experience is iterative. The integral work experience is, in itself, workplace learning, although it is informed and supported by another learning programme. Furthermore, we needed to draw from more conventional models of evaluation to examine and analyse the programme's purposes, design, planning and operation.[40] Building on this understanding about evaluation and its relationship to the research questions, we developed an impact evaluation framework, using this to guide the evaluation plan and activities (see Annex 1 for an explanation of the framework).

4.2 Methodology

The methodology included a review of relevant literature, Programme documents and data previously collected; interviews with originators, designers and facilitators of the learning support programme, Fellows and MDs; online questionnaires for Fellows and stakeholders; case studies of four Fellows, also involving their MDs and other stakeholders; and observation of a learning support module session and the Fellows' final poster session. Full details of the methodology and sample can be found in Annex 2.

4.3 Analysis

Analysis broadly followed the impact evaluation framework with a focus on answering the research questions. Each data set was analysed separately and then with other data sets to identify key themes. Interview data from the four case studies were analysed in two ways: first, to provide a short 'story' of the four Fellowship experiences (see Annex 3); second, to add to other data collected from different constituent groups, Fellows, MDs and stakeholders.

The findings represent a summary of qualitative and quantitative data analysis. In reporting findings, percentages of responses are given when referring to numerical data from the Fellows' questionnaire, and numbers of responses normally used when referring to numerical data from the stakeholder questionnaire (due to small sample size). Quotes from interviews and open-ended questionnaire responses illustrate findings.

We now move to the evaluation findings. In the next section, starting with the end in mind we explore the impact of the Fellowship thus far, before examining factors that appear to have influenced impact.

5.   TRACKING IMPACT

The main research question of this evaluation is '*What is the impact of the 'Darzi' Fellowships in Clinical Leadership Programme on participants, organisations and stakeholders?* In a one-year Programme, impact is hard to assess which necessitates taking an approach over time. Also, finding appropriate measures to assess impact is complex.   Nonetheless, we have examined various aspects of impact thus far at several levels, connecting these back with the evaluation framework (see Annex 1): impact on Fellows' learning and professional goals; impact on the sponsoring Trusts and local specialty training programmes through experiential leadership learning and applied learning and value added to stakeholders; and wider impact.

5.1   Impact on Fellows' learning and professional goals

The hopes of Programme originators had been:

> . . . that as clinicians they have made the journey from seeing the relationship with the patient to seeing that the system is based on an enormous machine of which they are part and couldn't exist without that apparatus. It's their responsibility to improve that environment. A key role is to make sure services are improved to the best of their ability. . . . They shouldn't be shut away to the hallow ground of the doctor/patient relationship. They need to make the system operate effectively. The programme aims to get that shift and feeling of taking responsibility. For the last 20 years clinicians had autonomy. In the 1980s the Griffiths report introduced general management and they became sidelined. They are being invited back in now. They have to be prepared.

In this section we explore the ways and extent to which Fellows appear to be and feel 'prepared'.

Fellows had various reasons for applying for a Fellowship. Some thought it would be useful for their curriculum vitae ("I realised I needed to do something different to advance my career options"), others wanted to improve leadership skills, gain better understanding about the NHS and management, get more informed in order to become more involved in the community, or were interested in service development. Some already had some management experience in the Trust where they became a Fellow. The opportunity to learn more, have a year out either doing something practical that would help them understand the issues and make a difference, or with time to reflect and "the opportunity to get head space" were also appealing. Some really didn't know what to expect, having been encouraged to apply or having spotted the advertisement. Others were attracted by what seemed an "exciting and interesting opportunity". Many had several reasons or expectations, and these expectations have largely been met or surpassed, with Fellows commenting: "it was beyond my expectations"; "I had a fantastic year".

The Fellowship seems to have had a profound impact on Fellows. We have grouped this impact under six headings, although those involved often spoke of effects in a holistic sense. Impact has been demonstrated through growth or change in:

- self understanding and personal skills;
- organisational and system knowledge and understanding;
- working with others;
- change management, service improvement and capacity building;
- belief and values;
- career aspirations.

5.1.1   Self understanding and personal skills

Demonstrating personal qualities, including self awareness, is viewed as a critical competence for medical leaders (AMRC and NHS Institute of Improvement, 2009). Development of self understanding and personal development was a significant learning outcome, with practice

suggesting that Fellows were frequently operating at the continuing practice level of the Medical Competency Framework.

Table 1: Fellows' ratings of self understanding and personal development outcomes

To what extent do you consider that your experience on the Fellowship has:	*% to a considerable/ great extent (N=30)*
promoted a better understanding of your own learning?	90
helped you develop self-awareness as a leader of change?	83
developed your confidence as a leader?	77
enhanced your own clinical practice?	50

As Table 1 demonstrates, most Fellows felt they had a better understanding of their own learning and that the Fellowship and helped them develop self-awareness as a leader of change. A number considered this increased self understanding as one of their greatest learnings:

> I have learnt huge amounts about myself and my potential to influence.

> Learning about myself in relation to working effectively with others and being productive and effective within my organisation – particularly my learning/working styles, personal preferences, best use of my strengths and my assets.

This was also noted by MDs and stakeholders with whom they came into contact. As one commented: "She is . . . aware of her impact on others", while another noted that: "He has learnt he needs to modify personal style to be maximally effective".

Fellows were more reflective:

> I have often gone along with meetings accepting them as is, but after the last module I have realised the importance of reflecting on the role of each person and how they work together and will be more thoughtful about who's who and their role and effectiveness in a team/workgroup from now on.

And new ways of thinking were learnt that impacted on them both professionally and personally:

> My thinking process has changed. Diane and Martin did an excellent job at teaching us new ways of thinking, of saying 'you don't have to work with the same assumptions you have for years. Look at it from a different perspective'.

> People outside work have commented they've seen changes in how I see things.

> Leadership is not about shouting loudly and wearing a nice suit, but going out and doing things, taking yourself somewhere not necessarily leading others. Leading yourself as much as leading others.

A large number of this first group of Fellows were already fairly confident and self assured at the start of the Fellowship year – "Her general level of ability and confidence is awe inspiring" (MD) – but many Fellows felt considerably more confident one year on. Resilience and persistence were frequently mentioned by Fellows, MDs and stakeholders; they felt less sensitive when things didn't work out to plan or people responded badly:

> At the beginning it was harder for him not to take things personally. (Stakeholder)

> It is a challenging role, conflict is certain, you learn how to . . . manage yourself, you learn to keep personal emotions out of the decision making process. (Fellow)

Flexibility was another feature, and Fellows spoke of increased confidence to 'give something a go' and put themselves forward:

> It gives me greater confidence to take on certain projects and care pathways that would be beneficial to the patient.

> I am braver about challenging things and voicing my opinion, how we can improve things.

MDs, mentors and stakeholders also noted a growth in confidence, several expressing increased confidence in the Fellow:

> She has become very competent. She's more like my assistant now! . . . If there are things I want her to address, she will understand where I am coming from. (MD)

> I feel confident he could lead and manage that level of complexity in future. (MD)

> They have a certain maturity now. They understand what needs to be done. They don't have to be told. [MD of more than one Fellow]

Self management skills were developed. Improvements were described in time management, ability to prioritise and presenting work to audiences, as well as writing skills, with some Fellows having conference papers accepted.

Although impact of the Fellowship experience on Fellows' clinical practice wasn't rated as highly as other outcomes, half of the Fellows considered that their own clinical practice had been enhanced to a great or considerable extent as a result of the Fellowship.

5.1.2   Organisational and system knowledge and understanding – the context of change

A key feature of the Fellowship has been exposing Fellows to the 'big picture' of the NHS as a complex system. Survey ratings demonstrated significant agreement that Fellows' understanding of the workings of modern health organisations, the dynamics of organisations and complex systems had been enhanced through the Programme (see Table 2).

Table 2:   Fellows' ratings knowledge and understanding of the context of change

To what extent do you consider that your experience on the Fellowship has:	*% to a considerable/ great extent (N=30)*
enhanced your understanding of how modern health service organisations work?	90
given you a better understanding of the dynamics of organisations?	90
helped you understand complex systems?	90

Fellows had a much greater understanding of the 'bigger picture' of working within the NHS, how services are set up, the complexity of Trusts and "how they run stuff that is behind the scenes" (Fellow),

> He understands the complexities of organisational systems and complex paradigms together. To do that, you have to show reciprocity. He understands that now. (MD)

> My Fellow has been very conscientious in learning about the NHS management environment to the degree that I am convinced she understands more about the aforementioned elements than an average consultant with over 20 years experience in a consultant role. (MD)

He has had his eyes opened on how the Trust works behind the scenes, which few people have. (Mentor)

5.1.3 Working with others – people and change

People are the lifeblood of change, and working with others is another core competence of medical leaders (AMRC and NHS Institute of Improvement, 2009). Fellows' experiences in this area suggested that many, if not all, frequently operated at the continuing practice level of the Medical Competency Framework. Ratings were fairly consistent across the items – just under three quarters thought that their knowledge, understanding and skills related to working with others had been greatly or considerably enhanced by the Fellowship experience (see Table 3).

Table 3:   Fellows' ratings of their knowledge, understanding and skills about working with others

To what extent do you consider that your experience on the Fellowship has:	% to a considerable/ great extent (N=30)
developed your ability to engage stakeholders at all levels of the system in change processes?	73
provided you with skills to work across groups and organisations?	73
developed your understanding of effective teamwork?	70
equipped you with skills to negotiate organisational politics?	70

Many examples of Fellows' growth were cited, with an emphasis on relationships with colleagues in the organisation and external stakeholders:

> [I've learnt] You must not be too rigid in your thinking, if you are obsessed with your project you need to be collaborative. You need to act in a way which is strategic you can't work in isolation in that way. (Fellow)

> [Fellow's name] thinks of things and I think of things, we bounce ideas off each other. We are generating the way to get best care for the patients. . . We work together well as a team. He is very understanding if something has not happened. (Stakeholder)

> He's much more able to handle the [Title] team, and engage people to get the best out of people. He has the competence to do it. [MD]

When stakeholders were asked what knowledge, understanding, skills or attitudes the Fellow displayed that contributed to success of projects, they highlighted relationships, interpersonal negotiation skills and the ability to get people to work together:

> . . . interested in the views and perspectives of others and valuing their contributions. (Stakeholder)

> Great interpersonal skills, including multi-professional engagement. (Stakeholder)

> . . . a determination to bring together clinicians and managers to work constructively together, which has been facilitated by her engaging style. (Stakeholder)

5.1.4 Change management, service improvement and capacity building

This area focuses on those learning outcomes related to specific aims of live projects and associated knowledge, understanding and skills.

Fellows' ratings of their knowledge, understanding and skills about change management, service improvement and capacity building

To what extent do you consider that your experience on the Fellowship has:	*%* *to a considerable/* *great extent (N=30)*
made you think about effective ways to develop clinical leaders?	87
equipped you with skills to shape and develop change efforts in a local context?	80
helped you develop skills related to patient safety/quality improvement and clinical governance?	80
provided you with skills to support the development of leadership skills within a Trust?	80
developed your ability to manage service change?	70
enhanced your understanding of patient safety/quality improvement and clinical governance?	67

Results of Fellows' improved knowledge, understanding and skills will be discussed in the next section when we explore impact on Trusts. However, as Table 4 demonstrates, the Fellows had been equipped with valuable change skills that would help them in the live project areas:

> [I've learnt that] using data and measurement are for both judgment and improvement and internal improvement we need to have both measures, and have the wisdom to use both. You need both quantitative and qualitative data. You must give stories; there's more value to have the whole picture. (Fellow)

> Determination to collect data accurately and get to the heart of the issue. Tenacity in ensuring all data collected over the 6 month pilot was robust. (Stakeholder)

Furthermore, it had given most of them ideas about effective ways to develop clinical leaders. Ability to develop audits, use action inquiry, analyse, synthesise, develop a business case, write grants, secure financial resources to implement projects were frequently mentioned. A slightly lower percentage of Fellows thought that the Fellowship experience had significantly developed their ability to manage service change and enhanced their understanding of patient safety/quality improvement and clinical governance, although this was still two thirds or more. For some, projects may not have given them experience in all of these areas, even if the learning support programme had helped to develop the skills. However, they understood change much better:

> Change is much more complicated and fragile than I thought it was. Sometimes it takes a lot longer and is more iterative than I thought as a junior doctor. The NHS is a living complicated system, not just a hierarchy and change will always be resisted. (Fellow)

MDs also commented on Fellows' growth in this area:

> He has a better map in his mind of what needs to happen to effect change. He understands how long it takes, how to get wins and to approach barriers. He appreciates the complexity of the change agenda and organisation of [name of Trust] and that there are tiers of management. (MD)

> They have a breadth of knowledge. They can now talk about change management, bureaucracy, clinical leadership compared to managerial leadership which took me years to get the concept. (MD of more than one Fellow)

In reality, it was hard for Fellows to separate out different aspects of learning gained through the Fellowship, as articulated by this Fellow in describing her own change:

> Before the Fellowship as a pure clinician, I wasn't clear about the level of work that goes on behind the scenes, all the external relationship work. I had no awareness of it. When I go back to clinical work . . . , it is because of the commissioning body and the costs of managing the buildings and staff recruitment and I have more awareness of how to make one clinic happen. Part of that is thinking ahead as a consultant, I have ideas about working in a service thinking about what I would want to happen and embedding clinical governance structures, having good relationships with everyone, building in user feedback sessions, so that on a weekly basis I would be making sure there were positive experiences. I know the way to make things happen, if I run a service, and how to build a business plan, I know the key people to make it happen. In a nutshell it is about being a better consultant.

5.1.5   Beliefs and values

There have been significant gains in knowledge, understanding and skills, but to what extent have beliefs and values been challenged or changed? NHS London and the London Deanery are not only looking for clinical leaders who understood the system and organisational change and how to effect this; they want clinical leaders with drive and passion about playing their role in improving the system or, as one Fellow described successful clinical leadership:

> A genuine motivation to make the change and then have ways of being energised to push that change on . . . and to be able to motivate the people around you.

We identified 4 specific belief changes attributable to the Fellowship Programme.

Belief in their own leadership capacity – Confidence has already been noted, but for a number of Fellows the way it was articulated took it a step further, as they realised they had it within them to become successful clinical leaders:

> I see myself as a potential leader. When I started, I didn't.

> I can lead! I stuck my neck out for a cause that I believed in . . . I was able to persuade others not only to share my vision, but into backing me to shape it further.

Belief that being a leader and manager and making things happen within a service is part of the clinician's role – There was a considerable shift in many Fellows' mind in relation to how they thought about clinicians' role in service change as Table 5 demonstrates.

Table 5:   Fellows' perceptions of the extent of their belief change about clinical
               leadership attributable to the Fellowship

To what extent has the Fellowship led you to think differently about the role of clinicians in service change:	*% to a considerable/ great extent (N=30)*
	83

Some already believed it was important but the experience had crystallised the reasons:

> [I] already thought it was important, have seen yet more examples of how it can be both crucial and very effective. The main barrier is other clinicians, as well as other managers. But service change can't proceed without clinical leadership - clinicians have the ability to block any change (through inactivity as much as anything else) unless they see the value for it.

For a larger number, the belief had been less fully formed:

> . . .realising it is imperative for modern day clinicians to learn about how the NHS has evolved and works now and how for it to remain sustainably a free NHS, clinicians must work for the bigger picture service change, and not simply the individual doctor-patient interaction that we are schooled to prioritise during professional training.

> I used to think of clinical leadership as something a bit odd. I thought the real value for me was clinical contact . . . but then over my training I started to think these people are interesting and that clinical leadership is vital. Alone, the general managers can't perform the roles they say they can. We need to get the leg between the two, clinical leadership is the way to change things in the future.

The Fellows believed that it is important for doctors to see they are part of a wider organisation and healthcare system and play an active role in developing their organisation and healthcare system:

> Not just focusing on individual patients – also think about the whole organisation and population. Think about the greater good of everybody else as well.

Belief that engaging others and taking them with you is essential to successful change leadership – Fellows learnt teamwork and partnership skills, but were also clear that collaboration is essential to successful change:

> Everyone is an expert; include everyone. You can never have enough engagement. . . . you should always have a plan, not about one person but a group plan, involving as many stakeholders as possible . . . You shouldn't be the only person to possess that knowledge, improve communication, and be loyal to our network of care when we have negative feedback. If people are involved from the beginning the project will be more sustainable.

> As a doctor you work autonomously; there is often a vacuum. If there is a problem, instead of thinking you have the answer, try and set up circumstance so that people can find their own answer. Instead of coming in autocratically, think of helping them find the problem more clearly and finding more solutions.

Belief that networking is a critical source of learning and professional support – Most Fellows were completing the Fellowship with a strong belief that it was important to develop and sustain a network of colleagues (see Table 6), and two thirds considered that the Fellowship had been greatly influential in this.

Table 6:   Fellows' perceptions of how the Fellowship has affected their belief abut developing networks

To what extent do you consider that your experience on the Fellowship has:	*%* *to a considerable/ great extent (N=30)*
Made you think it's important to develop and sustain a network of colleagues facing similar challenges?	87

Furthermore, when asked about the value of different aspects of the Fellowship programme, networking with Fellows was rated as very valuable by almost all of the Fellows (90%), a higher rating than all other aspects. Half of the Fellows also ranked it as one of the two most valued aspects. As one articulated it:

> It has been great to become a part of a community of doctors striving to achieve similar improvements in services I hope we continue to reciprocate the ongoing support over

23

coming years. It is also helped me realise that I should continue to cast my net wide in nurturing networks throughout my work, and include not only peers, but senior figures who are often very willing to offer advice support and mentorship.

Elsewhere in the report we explore why Fellows found networking valuable. It will also be important to see to what extent this belief about the value of networking is sustained (see Looking Forwards section).

5.1.6   Career aspirations

Although some Fellows started their year thinking about potential benefits for their CVs – "it would make me attractive to future employers"; "I want to be working in a London teaching hospital – I need these additional skills to make me more of an asset" – others had no such ideas: "I didn't come into this thinking 'this is going to start climbing the managerial ladder'".

In the short term at least, many Fellows wanted to pursue a clinical path and take on projects where they could use the knowledge and skills gained during the Fellowship.

> I have some time of clinical training left, but . . . the NHS is evolving and everything I have learned is useful to share with other people. I have built a profile for myself over the year and it will help me to share my knowledge when I move post.

For some, even if they intended to use the year's experience, thinking beyond completion of training and gaining a first consultancy post was beyond imagination or very much 'down the road':

> I want to retreat back to a job then come back to it later. It's too scary to contemplate! I still have one year as a trainee then four to five years as a consultant with bits of management roles. . . If in the future I am interested in developing a service or setting up a service, I'll be better equipped to do it.

Becoming a Medical Director or Chief Executive was not in some Fellows' career plan – "It's confirmed that this is not for me . . . I have no aspirations to run a hospital"; "I never wanted to be an MD". Nonetheless, they intended to put their experience to use by taking on projects. In contrast, for others the experience meant a shift of direction or a confirmation of prior interest:

> It rekindles my passion for the NHS. I still want to be a consultant but would like to be in leadership or service development. I am interested in taking this forward . . . I will be looking in the future.

> I can see applying for a consultant post within the Trust . . .but it has inspired me to take a formal clinical leadership role in the future.

> This has been a truly transformational year – genuinely changing how I wish to practice and my future career plans.

Although a few Fellows had already found a consultant's position – "She walked straight into a consultant's job. They want the breadth of her skills rather than her [specialism] skills" (MD); "He has the job he wanted next" (MD) – openings aren't always easy to come by. MDs were, however, generally confident that having the Fellowship 'under their belts' would set Fellows in good stead for the future:

> I would like to think he won't just become a rank and file consultant . . . .He's aware he will start better equipped to sew change and develop reform. He'll be better placed when opportunities arise for management responsibility. (MD)

> She will be quite an invaluable resource anywhere she goes. (MD)

He will finish his training year and I imagine he will be an incredibly sought after [specialist] for a major department because [his specialism] lacks clinical leaders. . . . My guess is that in 10 years time he will be an MD. (MD)

The Fellowship had proved valuable at job interviews and in new jobs:

I'm impressed is how pro-clinical leadership my new consultancy post is. The 'Darzi' Fellowship came up a lot in the job interview. I was able to use those experiences usefully. (Fellow)

I have just started my consultant post and am already being utilised as a clinician with change management experience. (Fellow)

And an MD whose Fellow had found a position had asked the hiring hospital why they gave her the job:

They said: 'We could find five [specialists in this field] but we wanted one who's ready to run and take on a wider role as fast as possible".

Cautions, however, were offered. There was some feeling that it was important not to push Fellows too quickly:

I'd offer a caution to him not to go in wanting to change jobs. The first year is very hard. There's a feeling that they're on a trajectory to being a Chief Executive, but you have to be a good consultant first . . . They'll lose respect of their colleagues if they don't get on with the job. (MD)

This year is not enough itself to learn about leadership and management. It is a beginning. My concern is that I am a junior registrar and I will need to make sure my skills are retained. (Fellow)

If you go in too early the learning is so overwhelming that it puts people off. If they have a few years in the bag it may be easier to adapt to the training and learning programme, for better output. I think they are too junior for this Fellowship. (MD)

The situation in primary care created particular challenges because limited clinical leadership opportunities meant that Fellows would be "back to being an ordinary GP looking for a job":

I'll just be a GP . . . . I don't' know what is out there for me. There is no progression from here. It is just the job market. There isn't much opportunity for a GP to get into management. It's not about the programme; just the structure and next steps for a GP. There's no real next step for GPs in management. That's not the fault of the Fellowship. (Fellow)

The crux of the issue was that:

I can never go back to being a salaried GP so I need to have a management role. I need to have work that includes change. This Fellowship has confirmed this. (Fellow)

It's never going to be 'an ordinary GP' again. . . . Once you've gone through the door of management, scales fall from your eyes and you see the dark side of the moon and you can't forget that. It's transformative and you can't go back where you've come from. You will never see the world in the same way. . . It takes readjustment. I am a completely different colleague in my practice because of management. I think differently and relate to things differently. (MD)

Time will tell what will happen to the Fellows (see Section 11).

In summary, impact on Fellows has, for the most part, been far reaching and in many cases profound. Personal change has been significant, with a mind shift in the way most view the role of clinicians in service change. A group of young leaders has been equipped with knowledge and

understanding of the NHS, complex organisations and themselves, and personal, interpersonal, quality improvement and change skills to support and sometimes lead service change, improvement and leadership capacity building projects.

5.2 Impact on Trusts and local specialty training programmes

One evaluation research question focused on the additional value brought to Trusts and local specialty training programmes. Overall, MDs and stakeholders were impressed with what had been achieved. Most MDs' expectations had been more than met:

> They've shown it's possible to achieve change. For them to see a project through is a huge achievement. We are developing people with the right skills. I felt very proud to be part of it. At the presentations last week, I was stunned with the diversity of projects and what has been achieved. (MD)

> She has been a real power for good and change within her area. (MD)

> This doubled my time in being able to lead projects, but had a bigger effect because of broadening leadership with the other trainees. Things have moved on a great deal. (MD)

> He was there to learn but he's made a significant contribution which has enabled it to go faster and better. (MD)

This view, while predominant, was not universal:

> One year is hardly enough time to assess the impact. To be truthful I don't think [the Fellow's] presence has done anything positive in the Trust. (MD)

So, what impact can be seen thus far? We have summarised findings in terms of:

- *Intermediate outcomes through applied learning* – developed and successfully implemented projects, including roll outs and designed programmes, processes and tools

- *Impact outcomes* – outcomes related to improved healthcare, enhanced leadership development capacity, and culture change.

Before reporting our findings, it should be noted that the results that follow demonstrate the initial stages of impact. The Fellowship is only for one year, and taking account time for start up of projects, it would be unreasonable to expect extensive impact at this stage. Furthermore, in many cases, impact outcomes can't easily be attributable solely to a particular Fellow. Even when they led projects, Fellows drew on support of other colleagues, and played a supporting role in other projects. In considering impact, we have focused on Fellowship projects that Fellows stated that they had led or were involved in as participants. The impact, therefore, is related to the project, although we have highlighted where this is particularly attributed to the role of a Fellow.

5.2.1 *Intermediate outcomes through applied learning*

Effort, energy, creativity and flexibility involved in developing and implementing projects shouldn't be underestimated. Fellows "sped up the time that change would have taken place in the Trust, 'in months rather than years'" (MD feedback, midyear review). Their efforts frequently involved serious negotiation and dealing with political agendas and vigorous resistance. Fellows drew on knowledge and applied techniques learnt in the supporting learning programme as well as 'learning on the job' through feedback and support from MDs, mentors and others in the Trust.

5.2.1.1   Engaged stakeholders

There were many stories about how persistent and respectful Fellows were in engaging stakeholders, often from many disciplines, getting 'buy in' and, in a good number of cases, engendering enthusiasm. Many Trusts also benefitted from Fellows who helped strengthen links between various stakeholders such as Clinical Governance, Performance Management, and Information Teams. There was also considerable engagement with junior and senior doctors in the Trust with regards to management/strategic issues:

> Partnership between managers and clinicians in change management process means that the implementation proposals are robust and have credibility across stakeholders. (Stakeholder)

> Engagement of local team in receiving customer feedback (Stakeholder)

> There has been considerable engagement with junior and senior doctors in the Trust with regards to management/strategic issues. (Stakeholder)

5.2.1.2   Reduced resistance and negative perceptions

'Darzi' Fellows were no different to any other change agents in that they came across resistance. Many fellows found that negotiating their role within the project was sometimes difficult due to resistance to change or lack of motivation among stakeholders at many levels:

> The biggest challenge is challenging the challenging people. (Fellow)

> I have been surprised at an apparent lack of interest from managers in including clinicians in the processes of change where I assumed that any such resistance/erection of barriers would come almost exclusively from the clinicians. (Fellow)

> A lot of work needs to go on nurturing relationships and that was the biggest challenge. I met with a lot of negative 'you can't do that'. (Fellow)

Negotiating other people's perceptions of them and particular projects they were trying to carry out was also necessary:

> I was seen as 'going over to the dark side' . . . (Fellow)

Fellows drew on all their resources, including support programme learning, to navigate their way through what was often very difficult territory. Some Fellows had a head start with strong natural, interpersonal skills including listening and empathy Developing a 'thick skin' as well as tenacity to see projects through was important.

5.2.1.3   Successfully implemented service change and quality improvement/safety improvement/clinical governance projects

Fellows devoted considerable time and energy in developing and enhancing service provision through auditing the situation, analysing results, action planning and developing models, guidelines and policies, as well as testing these out in pilots with constituent groups. A few examples demonstrating the focus of projects can be seen in Table 7:

Table 7:   *Examples of projects successfully implementing service change or quality improvement/safety improvement/clinical governance projects*

Sexual health, fully engaged strategy for Chlamydia and HIV. Completion of commission needs assessment, governance structure formed and contract reviewed and new contracts
Introduction and implantation of oxygen prescribing policy - oxygen prescription is now on new drug charts

Model established for developing an acute oncology service - interest created around England
North Central Sector clinical network in paediatric gastroenterology up and running, with joint guidelines, educational sessions and remote access information sharing
Ongoing development of North London hyper acute stroke services; developing new theatre documentation to improve quality and accuracy of operative data and designing a revised process whereby "doing the checks will become 'second nature' for every patient"
'Going live' with new style of education and service provision in partnership with acute hospitals

Common characteristics of many of these projects were high levels of engagement and collaboration used in the services developed, thus strengthening ownership across different clinical, management and service user groups; the rigour of evidence base on which decisions and changes were made; innovation balanced, in some cases, by sustainability through built in opportunities to review projects, mould development needs over time and disseminate learning to wider groups and networks across the healthcare system.

5.2.1.4   *Designed and initiated leadership capacity building projects*

The brief here was to work with various departments within the Trust to develop the capacity for training in essential organisational skills. Table 8 gives examples that illustrate the range of initiatives in this area.

Table 8:   *Illustrative examples of leadership capacity building projects*

Several leadership development programmes based on the 'Darzi' Fellowships in Clinical Leadership Programme projects and using learning process from the learning support programme
A programme for trainees on conflict resolution and leading teams using actors and role play
A Trust-wide induction for new doctors to the borough helping SPRs to identify and engage more with their organisation and learning how they can get things done. The content incorporated management training on financial processes and structures, with perspectives from the Medical Director and Head of Operations
Delivery of several talks around the management structure of the NHS and management training to MRCP trainees, Obstetrics and Gynaecology trainees and midwives.
A network developed to engage young and non-principal GPs in clinical leadership activities

A number of 'projects' designed to enhance leadership capacity were 'mini Darzis', programmes that incorporated similar elements to the Fellows' own programme run for SpRs in the Trust. Common to all 'mini Darzis' was the inclusion of experiential learning though undertaking a live project, specific learning around organisational/leadership topics, plus other Fellowship Programme constituents to varying degrees, such as coaching, supervision, action learning and opportunities for participants to understand and perceive themselves as part of the 'bigger NHS picture' e.g. through meeting and sharing understanding with senior trust staff including Heads of Finance and Clinical Governance. Audits frequently informed the content of the workshop sessions.

Unlike the majority of other leadership projects, one 'mini Darzi' programme was multidisciplinary. This was viewed by the Trust as highly significant:

> . . . introduced this concept into the Trust to break some disciplinary splits by getting people to work in teams to improve the service - doctors, managers, nurses and others. (Mentor)

Most 'mini Darzi' programmes were designed to run within Trusts; however the nine psychiatry Fellows noticed that: "not a lot goes on between Trusts so we created ELMS – Experiential Leadership and Management Skills, a programme serving the trainees of ten mental health Trusts". Working with the School of Psychiatry at the Deanery, they designed a programme for

SpRs in their final year, who would take a year to undertake a project of strategic significance, meet and take part in learning, allowing cross-fertilisation of ideas to occur between colleagues.

Several 'mini Darzis' incorporated various forms of clinical leadership awareness raising and acknowledging accomplishment at individual and organisational level. To this end, one 'mini Darzi' programme culminated in a high profile Trust event, where projects were presented, evaluated by a panel and a prize given of educational materials or a course. Two of the 'mini Darzis' were designed to offer the opportunity of formal endorsement or academic accreditation, one with ILM (Institute of Leadership and Management) endorsement another with Middlesex University incorporating a 4 day course and 30 credit assignment.

Initial progress in the area of leadership capacity development projects was slower than for the other two project areas. However, further ideas and enthusiasm was stimulated when a small amount of funds became available to create a Dragons Den at which Fellows could competitively 'pitch' their business case in the hope of securing a proportion of the funds. This drew a number of creative proposals from both individuals and groups of Fellows.

5.2.1.5   Rolled out pilots

Moves to embed and sustain Fellowship initiatives were being made in a significant number of cases by rolling out pilots or setting up plans to do so. In a few situations, Fellowship initiatives were also being rolled out in other Trusts. Examples in Table 9 demonstrate some of those initiatives:

Table 9:   Examples of Fellowship projects that have been rolled out/will shortly be rolled out

In a number of Trusts, patient safety programmes have been rolled out, in others improvements have already been noted
The COPD discharge project is being rolled-out to other trusts in NW Thames
SLaM produced training DVD that was adopted by all participating Trusts in the pilot, used to train clinical staff in Mental Health Clustering Tool. Trained 80% of staff. As a result, they are more confident with the process of PbR, with plans to roll out the training to all WAA and MHOA directories in the Trust
Patient pathways are due to be rolled out and are being shared with another hospital Trust. These were co-designed with fellow SpRs who were keen to be involved in the project
The clinical documentation project is about to roll out

Rollouts had been preceded by evaluations of pilots, corrections and adjustments based on evaluation findings and exploration of suitable locations for rollout. They involved accessing and allocating resources and developing further training.

5.2.1.6   Banks of tools, prototypes and learning resources

Through their projects, a number of Fellows created processes, tools and learning resources for use in the Trusts and, in some cases, by other Trusts. Sometimes funded as a result of Fellows putting together business cases and securing extra resources, in some instances, these have become prototypes for similar processes or tools in another aspect of the Trust's service delivery. Table 10 presents examples.

Table 10: Examples of tools, prototypes and learning resources

A care pathways process being used in other areas. "There's a formula for it. It's a lasting legacy of the Fellowship". (MD)

Development of new ways of working especially focusing on safe handover. The Trust is now committed to using SBAR tool (Situation, Background, Assessment, Recommendations) in all handovers between healthcare professionals.
Development of the Board Quality Dashboard and project managing and putting together the Trust Quality account. "This has both raised the profile of quality internally as well as enhanced the reputation of the Trust externally. Particularly useful has been the role played in getting service user and carer involvement". (Stakeholder)
Design for a CAMHS prototype needs assessment tool that has been accepted by the pan London CAMHS currency board.
A hospital oxygen policy and teaching materials for doctors and AHPs
Experience-based design methodology that has established a new and creative way of working with carers and service users moving beyond consultation.
LeMA, *Leadership and Management for All,* an educational tool designed to inform junior doctors of key issues within the NHS that will confront them throughout their careers, consisting of modules with podcasts from expert speakers and downloadable materials and links to support further learning. Alongside these are frameworks for locally delivered workshops to reinforce learning and engage junior doctors within their organisation.

Key to the effectiveness of these tools, processes and prototypes are that they are user friendly, accessible and timely. In the case of LeMA, a learning resource to support leadership development, eight Fellows from across Acute Trusts and PCTs received funding from the Dragons Den process to support its development The Fellows secured expert and inspirational speakers, edited the podcasts, and developed downloadable materials and an institutive user interface. They also identified and engaged clinical tutors and educational supervisors throughout London to provide locally based workshops. Their aim is for this training to be formally integrated into the training programme for junior trainees throughout London and to inspire the next generation of clinical leaders.

5.2.2 Improvement outcomes

In addition to all of the applied learning outcomes described, evidence has already started emerging of improvement outcomes. We have grouped these under three headings: indicators of improved healthcare outcomes, increased leadership capacity and culture change.

5.2.2.1 Indicators of improved healthcare outcomes

In many projects, data have been gathered to demonstrate a range of specific quality and service improvement outcomes. Table 11 demonstrates the type and range of outcomes.

Table 11   Indicators of improved healthcare outcomes

Mobile clinic: successful in projects with qualitative and quantitative evidence for smoking cessation, diabetes and other activities on the vehicle.
Range of patient, staff and financial outcomes related to Think Glucose pilot
Steady improvement in 'door-needle' times within existing resource constraints
Safety incidents during handover reduced
Improved speed of assessment of patients referred by GPs
Patient waiting times have been reduced
New patient pathway has reduced (statistically significant) the number of biopsies, endoscopies, blood tests and length of stay. Costs reduced from £6000 to £4000, although this did not quite reach statistical significance
PCDU pilot has halved the percentage of paediatric admissions via PED compared to the previous year
Percentage of children that attend ED that are admitted to the ward has halved since the opening of the CDU
Reduction in length of stay and financial savings in relation to an acute oncology model of

care
Time between patient discharge and making contact with local support has been reduced, saving money for the Trust
Positive and statistically significant differences in patient experience between users of ophthalmic polyclinic and those in secondary and tertiary care settings
The PCT is able to communicate via email with 100+ non-principals, building capacity
Improved paediatric team presence and working in the ED, with reports of improved atmosphere and satisfaction by doctors and nurses.
Increased joint working across primary and secondary care.
Fantastic feedback from 1st module of Leadership Programme

Initial indictors for a number of projects geared to improving and developing pathways, protocols and services and have shown one or more of the following: increase speed of patient assessment and treatment, reduced waiting times, reduced admissions, reduction in unnecessary procedures for patients and length of stay, reduced safety incidents, increase efficiency and effective use of resources including some cost reduction, improved patient experience and outcomes and local access to treatment.

Evaluations of some of these projects also captured data relating to positive impact on organisational climate, culture and practice, including better atmosphere and team working, improved within-trust communication, and increased joint working across primary and secondary care, greater satisfaction of doctors and nurses and high ratings for the first module on a leadership development project.

5.2.2.2   *Increased leadership capacity*

It is early days to be able to judge impact of the leadership capacity building projects, although initial signs are very positive. As an example, in one Trust, 12 SpRs participated in the 'mini Darzi' this year and 18 are already signed up for next year. Stakeholders are excited about its results and future potential:

> It's shown that when it's done appropriately, change management projects can be used as a learning methodology both for the individual and, simultaneously, as a benefit to the Trust. It's been a wonderful outcome. (Stakeholder)

The Fellow will be contributing one day a week to the programme next year, with teaching and management. A small grant had been received, partly for set up and the remainder for one year:

> We're also looking (for funding) for next year from learning and development or study budgets – it needs evaluation. (Fellow)

Following attendance of the first day of another 'mini Darzi' programme workshop, 100 per cent of the trainees (n=34) stated they had gained new insights into the structure and organisation of the NHS. The Trust's MD reflected:

> It has been highly successful. The management training scheme is now incorporated into the doctors' formal training, 1 week in 6 is around management. The feedback is that this is much better than other standard management courses – it is better as we have a good mix of speakers e.g. senior NHS managers, we got it on the website etc. It would not have worked without the ferocious effort and input of a group of highly motivated consultants, the CEO and others. It wasn't just the 'Darzi' Fellows who drove this. They all gave a lot of effort, time and pride. The challenge will be maintaining it, keeping up the quality of input.

A mentor linked to this project stated: "He has helped revolutionise the training we have set up – being a trainee himself he can get other trainees engaged".

5.2.2.3   Culture change

Here, we were seeking changes in mind set – people seeing things differently, new ways of talking about clinical leadership, new patterns of working. Some MDs and stakeholders noted marked enthusiasm for clinical engagement and successors for the projects.

A majority of stakeholders said they plan to involve junior clinical leaders in future service change/quality or safety improvement/clinical governance initiatives, although some noted that they would have done this without the Fellowship. There seems to have been a shift in attitude in a number of Trusts that it is acceptable for clinicians to develop projects within the Trust and that capability does not necessarily mean seniority. Nine out of 14 stakeholders responding to the questionnaire reported that they now think differently about clinicians' role in service change as a result of their experience of the Fellowship work.

> We have a 2nd Clinical Leadership programme to be delivered in October 2010. I really hope our 2nd 'Darzi' Fellow who has started in April will be able to sustain the work started to get managers and clinicians working in the same direction. (Stakeholder)

> The project has prompted a slow but steady change of culture in the way clinicians go about their daily business. The teams are now a lot more 'PbR aware' and clinicians and managers are engaging in a different kind of dialogues. (Stakeholder)

Other feedback endorsed these views:

> What I value most is the infectiousness of his enthusiasm with other SpRs and getting them interested in management. (MD)

> The project has meant wider cultural involvement. It has been good for the department and will continue to be. (MD)

> She is a strong representative of the clinical role. . . . Managers now see doctors as part of the team. (MD)

> Multiple patient safety education and engagement activities that wouldn't have happened without [Fellow's] leadership, resulting in a higher patient safety awareness amongst clinical staff especially junior doctors and a more nuanced understanding of the cultural dimensions of patient safety work. Generated deeper understanding of challenges about workload and safety at night. (Stakeholder)

There were also positive signs for the future:

> Quality in general is taking a central place in the organisation's future work plan. (Fellow)

> The leadership development project has invited much interest from peers within the organisation and some of the lead clinicians and organisational development staff are keen to help sustain this initiative after I leave the Fellowship post. (Fellow)

What underlay changes, however, wasn't always clear:

> Nurses are more cooperative now. It's difficult to know if they are more trusting or they can't resist any more. (Stakeholder)

And culture change had some way to go in many Trusts:

> The issue of engagement of other middle grades is a tough one to crack, and probably generic to most hospitals; this will need better planning if we are to improve this relationship in future, and I am sure that the 'Darzi' Fellows are in a crucial position to contribute to this. (MD)

The potential for cultural change and changes in structures and processes to promote and support

this was particularly notable in senior stakeholders' feedback whose own thinking had shifted as a result of the Fellowship, and had consequently changed plans as a result:

> I have gained a much better understanding of training that SpRs go through; where they are at this point in their career, how they view Trusts and clinical teams in thinking about what jobs to apply for. . . . his experience and clinical skills was fantastically helpful. . . . . having a doctor 'on tap' has been superb. (Stakeholder)

> What this programme has shown me is that decisions that the Trust takes will be much stronger and better if they're based on good clinical care. And that means training good doctors and nurses from the beginning. It seems an obvious statement, but the pathways aren't there. We should be picking up bright sparks right from when they start. So what we really need is a leadership fellowship scheme [like this] for all the clinical professionals. (Stakeholder involved in training programmes)

> I want this to continue. It's so useful to have someone who is 'with it' from the leadership management point of view with high level clinical awareness – like a consultant clinician, with all the management skills, but young/flexible enough not to be stuck in old fashioned ideas. You can't get a clinician, consultant or manager to be able to do this. Clinicians don't have the skills, consultants don't have the time and managers don't have the clinical understanding. The work he has done can be extended across the Trust. (Mentor)

5.3   Impact on the wider system

It is early days to be considering the impact of the Fellowship on the wider system. One of the originators of the Fellowship was, however, excited by interest that already appears to have been stimulated by the Fellowship cohort.

> They have raised the profile of clinical leadership, and the concept and notion that individuals can be developed is permeating through the learner system. . . .The most important outcome is the enthusiasm these people are spreading across their peers. Frequently when you have enthusiastic people, the cynics become more entrenched. One of most interesting things is we have a group of very enthusiastic individuals starting to spread the word and others are coming through to access our programmes.

Numbers are relatively small, but if they are added to NHS London's Prepare to Lead programme graduates and those embarking on two new programmes sponsored by the London Deanery – the Post Graduate Certificate in Clinical Leadership and Learn to Lead – senior leaders in NHS London are hoping that these "will give us something of a movement". This will need to be tracked over time (see Section 10).

6.   FACTORS RELATED TO IMPACT

As the previous section demonstrates, the evidence of impact of the 'Darzi' Fellowships in Clinical Leadership Programme at various levels is already considerable and seems to be increasing. What has contributed to this impact? In this section we examine factors that the evaluation has identified as influencing the extent of impact.

- Committed and learning oriented MD
- Supportive Trust culture
- Working on 'ambitious but appropriate' live projects
- High quality mentoring
- Learning programme that targets transformational change
- Combining workplace and external learning
- Network of support – from formal to informal social learning
- Ongoing monitoring and adaptation addressing Programme issues

6.1 Committed and learning oriented Medical Director

The MD's role emerged as a key factor in influencing Fellows' experience, learning and applied learning through project work. There was divergence in the ways MDs interpreted and carried out their role. Their views on the Fellowship's purpose and expectations of Fellows differed. While all understood it as the development of clinical leadership and giving Fellows experience of management, some cast this mainly in terms of 'plugging a gap' in training, whereas for others it was more about "grooming the next generation of clinical leaders" who would become the core of a "movement for change in the implementation of Healthcare for London".

> To recognise that you can't just be a good clinician to deliver your services properly – you must be able to manage the services and lead the . . . team. (MD)

> To increase the profile of clinical management and leadership, and doctors becoming involved in management, money and targets – change being a medical business. (MD)

> . . . the big advantage of 'Darzi' is that it gives people time out rather than a training programme for SpRs over a few days where you hear the great and the good with 2-3 days conversation, no time out, and you're just skimming the surface. It's getting a group who really have time to think about it. It ties in very nicely with what we're trying to do around quality – these are the people who are going to help us drive that. (MD)

6.1.1 Reasons for sponsoring Fellows

Reasons why MDs applied to sponsor Fellows broadly fell into 4 categories; not always mutually exclusive.

Learning and developing clinical leadership – in many cases the MD was interested in exposing trainees to experiences that it had taken them many years to accumulate, often by chance rather through development opportunities. For some of these, the main point seemed to be exposing Fellows to the life of a senior manager 'warts and all':

> An opportunity to challenge colleagues internally on the credibility of critical leadership and determination to create a cadre of management. (MD)

> To give [Fellows] some exposure to higher medical management to whet their appetite or put them off completely. So if they decide to take on a managerial position in the future, they will take it on and move things much faster. (MD)

For others a deep interest in learning gave them almost a sense of moral purpose that here was something they could contribute to the growth of senior trainees. In these cases, the MD was almost always the main mentor and spoke with reluctance about not being able to give even more time than they did, which often already was substantial. There was also a sense with these MDs that they saw the Fellowship as a learning opportunity for the Trust, and clinical leadership development was generally a strategic priority.

> I was interested because I have a background in succession planning and the skills that will be needed. (MD)

> . . . the NHS needs clinical leaders. There's a skill set to gain and this is one way to do it. I saw the projects as subsidiary, but important as a learning tool. Projects would need to be happening anyway. I didn't see the 'Darzi' Fellow as a project manager but the job being educational. I wanted to find someone who was a typical SpR with more leadership potential than the average, cultivate it and at end the output would be a confident leader in waiting. (MD)

I'm very enthusiastic about the idea. I enjoy training. . . Until 1½ years ago doctors got so little opportunity to develop their leadership and management. Current consultants have less knowledge than trainees about the issues of management and governance, and the complexity of how they have to be dealt with and it's a shame. This was the opportunity to change that. Some of us have learnt it because we were interested, but this was much more of a structured opportunity to embed it. (MD)

Extra 'capacity' – elsewhere in the Fellowship and the report, the term 'capacity' refers to development of potential; preparing people to be ready to embrace and lead change and improvement. Here, MDs referred to it in terms of feeling 'stretched' and the welcome use of 'another pair of hands'. There were two different orientations: the first, often closely aligned to a learning orientation, was that the MD was attracted by the idea of someone who could work with and to them to achieve some of their own key targets:

He hasn't been autonomous. He's done very little that hasn't been under my direction. (MD)

Taking a trainee and helping them with a project we wanted to do. Also to help the clinical team by giving them some additional capacity at a high level – a trainee at a high level. (MD)

The other key reason for doing the Fellowship was that I was conscious I had a lot to do to develop things and could not do it all myself – wanted to delegate to people who I knew could do it. (MD)

The second orientation was a more general sense that there were many things that needed doing in the Trust and the Fellowship would provide someone, at no or little cost, who could take on some of these initiatives:

We had a number of projects running in the Trust. I was encouraged by the suggestion that a 'Darzi' Fellow could help us create more capacity. A trainee who would spend a lot of time in management and would get support from non-clinical colleagues (MD)

In contrast to the MDs who connected Fellows to their own personal agendas and, therefore, stood to lose a lot if these were not successful, sometime the latter expressed less concern about the outcomes of their Fellowship.

Feather in the cap – the Fellowship has a certain cachet; for some MDs this appeared particularly important. They saw it was prestigious and wanted their Trust to be involved. It was also innovative, and that was of appeal. Where this perspective was linked to a drive to develop clinical leadership and/or a learning perspective, the other seemed to take greater precedence.

Also, [name of Trust] likes to be at the forefront. (MD)

Engaging with young doctors in the locality – a particular interest of PCTs was the potential of how having a young clinical leader 'on board' might help them connect more effectively with younger non-principal GPs in the locality:

Someone young and enthusiastic to give us a perspective from a younger GP, to help us engage more effectively and develop links with young GPs and non-partners. There are a lot and we could be better at this. (MD)

Medical Directors deal with many demands so it is absolutely reasonable that they would not be expected to oversee all aspects of Fellows' work, even though some chose to be 'hands on'. Nonetheless, it seemed critical that they maintained a strategic oversight of Fellows and their activity, including conveying the Fellowship's purpose and Fellows' role clearly to colleagues and that they should not just be seen as 'a spare pair of hands'. Some Fellows 'picked up' several projects as the Fellowship progressed, sometimes making it difficult for them to focus attention on meeting targets with their original ones.

6.1.2 MD's expectations of Fellows

Expectations MDs had of Fellows were often associated with their perspective(s), so those with a learning orientation, while having high expectations of their Fellows, were most concerned that Fellows' learning was as great as possible, rather than every aspect of the projects being 'delivered'. They also tended to adjust projects as the need arose in order to ensure that Fellows had the best learning experience (see also Section 9.3.3):

> I expected a completed project. But if you train 20 Fellows, then if 5 pursue a medical management role and become a clinical director, it's been worthwhile. . . .If 15 just have better understanding and become better corporate citizens in their consultancy; that alone is worthwhile – better understanding and connection and bring that understanding to their colleagues. It was clear we will have that from the posters [the final poster session where Fellows shared the outcomes of their Fellowships]. (MD)

In some ways, MDs didn't know exactly what to expect from their Fellows, given that this was a new initiative:

> I didn't expect a lot, I would be the training person. Because of their junior training status they are very green junior and it takes them some time to learn what is expected of them and takes some time before they become productive. The first 6 months is about getting [the Fellow] to understand the whole system in the entirety . . . . and is an eye opener for them to see what keeps an organization like this ticking over. The next 6 months they were doing homework and there were many courses to attend. There were so many half days to take out. (MD)

Occasionally the expectation was that the Fellow was likely to benefit, but not the Trust. While this may have been expressed in subtle ways, the message was received loud and clear:

> He thought this year was going to be beneficial for me and he couldn't quite see what the Trust would get out of it. . . . He didn't realise that while it was a useful year for me it could also be a useful year for the trust". (Fellow)

6.1.3 Other support from MDs

Commitment to the Fellow and Fellowship was displayed in other ways. In the vast majority of cases, MDs 'opened' doors for the Fellows, getting them access to many senior colleagues in the Trusts and, in some cases, to strategic and often sensitive meetings. It was helpful where MDs personally introduced Fellows to colleagues and also communicated with colleagues to let them know that they had a Fellow, what the Fellow would be doing, that support would be appreciated and not to treat them as a "junior lowly doctor sitting in a management meeting". A few Fellows had to find their way around:

> I wasn't formally introduced to people. I circuitously found useful people and took a while to get to that point. (Fellow)

> My MD didn't know I had started until 3-4 months after I got there. It required someone to contact someone else . . . (Fellow)

Findings about mentoring are discussed separately (see the following section), but modelling was also something taken particularly seriously by some MDs, as was reassuring them when dealing with political situations:

> If you look at being involved political changes, the 'Darzi' Fellow can learn lot by intimate involvement although not leading it; they can see how you tackle it especially if you talk it through with them; they can watch it unfold. Another thing you want is to give them responsibility for leading themselves, so they learn about tripping up and being picked up. I

try to give them a breadth of educational experience. I want to bring in as many aspects of learning as possible. (MD)

Regarding getting into politically sensitive positions – I tell them if you have not upset someone badly, at some point, you are not doing your job. (MD)

Fellows were extremely aware of how busy MDs were but attending at least some of the Fellowship sessions, or sending another colleague, was also valued by Fellows. In particular, where no-one from the Trust attended the induction, Fellows were somewhat at a disadvantage. MDs did find the role demanding, even when pleasurable:

I know some of the other medical directors have found it a burden having a 'Darzi' Fellow. Personally I find it very exciting and challenging to help the Fellow with her varied tasks, but I think having a lead consultant working with a Fellow on a day-to-day basis is vital. (MD)

6.2 Supportive Trust culture

As well as support and backing from the MD, and mentor if a different person, the context of and support within different Trusts influenced Fellows' experience and ability to 'deliver' on project work.

6.2.1 Trust culture

Trust culture can vary significantly; Fellows seemed to find it easier where the culture was more intimate, open and people-oriented:

The Trust is friendly, welcoming of initiatives. Being keen to try pilots is in our culture. There's good team working. People coming in are welcomed, supported. It's easy to come in and have impact; people work closely and small groups. (MD)

It's extremely female and very maternal . . . very supportive and enabling which is rather unusual. It's always been a support and enable culture rather than command and control which is more difficult to navigate. The whole mentorship ethos is important. (MD)

There's an openness to it and recognition that it's important. Cultures are always interesting and hospitals are always different. I didn't realised how different until I moved myself. This Trust is friendly and open. It's big enough but not so huge that people get lost. (MD)

Commitment to innovative ideas and quality improvement practices also helped:

Our Trust has a good history of transformation projects, being at the forefront and pushing boundaries. It's an innovating Trust. If someone says 'I'm the 'Darzi' Fellow', people will say 'oh great, come in'. (MD)

The whole research base that this Trust operates on has been very helpful. It's something that our (Stakeholder) teams in the main are very familiar with, is deep in our culture and is well embraced. So [the Fellow] is just seen as another strand in that. It helps considerably. Nobody felt it was particularly unique and no-one struggled to get to grips with what he was trying to promote. (Stakeholder)

And Trusts that already had a commitment to clinical leadership and/or were strongly focused on learning and leadership development were also welcome 'homes' for Fellows:

[The Trust's] culture is a profound passionate ethos on the importance of developing clinical leaders and leaders taking responsibility. That's the way the organisation is run. It's not unique in the NHS but there are only a half a dozen in NHS where clinicians have such clearly defined leadership roles. (MD)

6.2.2   Structural resources

Availability of resources often seemed to be connected to the overall mindset described previously. Virtually all had access to 'basic' resources, such as a mobile, IT and some administrative support. But, where the Fellow was physically located was given serious thought in some Trusts:

> I had him sit 10 yards outside my office. He met a lot of senior leadership people and was surrounded by senior important people. He could see me when he wanted. (MD)

> I embedded him. There was a little opposition to him having my desk because I share an office with [another senior leader], but he could hot desk, and it gave him credibility as one of the troops. (MD)

> The Fellow is located in with the clinical governance team which has meant that individual members of the team have been there to help. (Stakeholder)

Others either paid this less attention to this or had to make do with limited available space.

> We couldn't give him his own office but he shared with a part-time consultant with whom he was been doing clinical work. . . Space was where could find a solution; it all happened quickly. (MD)

6.2.3   Support and 'buy in' from senior leaders, managers and consultants

Support of other leaders in Trusts eg Finance Directors, HR Directors, Governance Directors, Project Managers etc was greatly appreciated and valued by Fellows:

> Our CEO is incredibly supportive of the whole scheme he came into the training with me, and the chair supports this. So the Fellows can get into any meeting, and they have freedom to join into the senior leadership team and highly welcome. (MD)

> There is complete consultant buy in to this sort of thing, they all know it is very valuable - this is a no brainer. It gives you [a Fellow] enormous credibility. (MD)

Often they would take the Fellow 'under their wing' or just be available:

> One of the senior project managers from the Trust is leading one of the projects I have been working on. We have been discussing problems and brainstorming together. That has been a good experience. It has been a cherished part of it; someone senior has looked at me with a fresh set of eyes, brainstorming together and made me feel very valued in the Trust. (Fellow)

As the previous quote demonstrates, many Fellows had a really positive Trust experience that made them feel valued. At the other end of the spectrum, lack of support left a few Fellows feeling somewhat jaded:

> If you asked me now to take on another project in the same Trust I would be very sceptical because of all the knock backs I had.

6.3   Working on 'ambitious but appropriate' live projects

Experiential learning is increasingly popular within leadership development.[41] When asked how valuable different aspects of the Fellowship had been, most Fellows (87%) reported that their live projects in the Trust were very valuable and over a third (37%) rated these as one of the two most valued aspects of the Fellowship. Their reasons and other reasons given when we had follow up

interviews with some Fellows included learning from practice, ability to apply theory-based learning, the experience of management and challenge, and seeing the fruits of their efforts:

> Having live projects to work on has been immensely valuable. In my opinion nothing can replace experience and challenges that working on projects produce and the learning that arises from having to deal with the challenges.

> The Trust-based projects are essentially a crash-course in management! Although I did not select my projects, and I wish we had been offered some project management training at the outset, I did learn about areas of the Trust's work I might not have otherwise have access to had I chosen my own projects. One of the projects is a major undertaking for the Trust and I feel privileged to be associated with the success of this.

> The projects have been crucial to my learning and their outcomes have represented probably my biggest achievements and the areas in which I am most proud of my efforts.

> Live project work is essential. You have to have something experiential. Being taught things goes in one ear and out the other unless you have a chance to practice.

> Immersing yourself in a real project is key to your personal development.

Clarity about projects was important. Fellows fared better when prior thought had been given to making sure aims were clear and key senior staff were on board. Although timelines for applying for a Fellowship and advertising the post were short, Trusts differed in the attention given to preparing the ground, and in a few cases, it took several months for the Fellow 'to get going'.

It also seemed helpful when projects were in some way connected. One example was in a Trust where an SpR involved in the Fellow's leadership capacity building project was involved in an aspect of another Fellowship project. Another Fellow explained how he didn't take on three distinct three projects, but "a set of work around patient safety", describing this as: "a much more fluid experience than just three projects".

The projects needed to be manageable in size if the Fellow was taking a major leadership role. Non-completion or getting seriously 'stuck' often followed from the Fellow being assigned a project that others before him or her had tried to implement and failed. As one interviewee reflected:

> People were assuming that junior doctors would make something happen, deal with an issue that has not been solved for years.

In contrast, some Fellows felt much more comfortable about what was being expected of them and were also given projects that were important to the Trust; this also made a difference:

> I was given jobs that were real and doable. The small and relevant three projects set by [the MD] were doable. I think some Fellows felt that many projects were too big or unwanted. You are asked to do things that no-one has done before, things that are not popular and it takes time to influence.

> Other people have had a mixed experience. It depends on the projects. It can be demoralising. I was lucky I had a good project. . . . .There was Trust momentum already; I was helping on a strand of work. The ground work had already been done.

Some MDs spoke about ensuring that Fellows weren't just left to get on with projects:

> Some of mentoring MDs weren't on same page. They saw someone as doing a project for them. The project has to stand and fall on itself. [Our Trust's Fellow] is coming to learn and change. He's not a spare pair of hands. They're coming to learn and change.

> The core things were that the projects [the Fellow] were working on would be part of my objectives of the year. They were core to the Trust's business. If he didn't succeed in doing

them, I would have to pick up and do them. It was vital that this would achieve its objective. It's not just a nice thing to do.

Having a project that was core to the Trust's agenda also made 'buy' in from others in the organisation more likely.

Recognising the Fellow's strengths and ensuring that these were made best use of in project work was also important. Trusts with more than one Fellow were able to assign different tasks to Fellows according to perceptions of strengths; for example one had strong people skills for liaising and negotiating with stakeholders while the other excelled in attention to detail for follow through on project planning

6.4   High quality mentoring

Mentoring, one of the key support elements offered by Trusts, is a popular leadership development strategy, with some evidence of success, particularly in informal situations.[42] In the Fellowship application process, the MD had to commit to mentoring the Fellow, or ensuring that mentoring was provided. Approximately one third of the Fellows' mentors either had a mentor who was not their MD or the MD shared the official mentoring role with one or more colleagues – "I wanted to bring people with different skills to help him" (MD). In other cases, as the year progressed, a senior colleague in the Trust or someone with whom the Fellow came into contact through a project often took on an additional informal mentoring role, particularly where an MD's other commitments meant restricted availability over time. A few mentors changed during the year, if MDs left or when negotiated by the Fellow, generally due to lack of time on the MD's part.

6.4.1   Mentoring arrangements and relationship

The effectiveness of the mentoring relationship did not relate to who the main mentor was, as long as the MD was committed to the Fellowship in other ways. What came through as most important was quality of mentoring and the mentoring relationship. Where the relationship was positive, with regular access to the mentor and informal opportunities to 'check in' or seek feedback on an issue, Fellows felt greatly supported. Sixty per cent of Fellows rated the mentoring they received as very valuable, and a little under half (43%) viewed mentoring as one of their two most valued aspects of the Fellowship.

Formal mentoring sessions were generally held 2-4 weekly, but informal access between these times appeared to help. Mentors established a variety of arrangements with Fellows, in some cases including expectations about lists of tasks for discussion or to be completed, verbal or email reporting on what they had done. In some cases, this was akin to supervision. Over time, some mentoring relationships became more informal, with the mentor being available if the Fellow needed support, and some mentors learnt to adapt the degree of direction and input proffered as Fellows' experience and confidence grew:

> Initially my commitment was the same as I offer to clinical trainees: an hour of my time. . . . I always say 'pop up and see me if I am available, send me email correspondence to check or read'. I've become busier over time so it's hard to catch me, but he's become more capable. His projects have taken on a life of their own. (MD/mentor)

> I give him more specific things to do now than I used to. I give him clearer direction than I used to. He has learnt to get on with it rather than waiting to be told to do things. He can function semi-autonomously now. (MD/mentor)

> He knew that if I had a task to do he wouldn't have to look after my shoulder. It made the project easier to push forward. (Fellow)

Some MDs reduced the amount of mentoring time as the year progressed because the meetings were hard to arrange:

> We set up monthly meetings, to see how things were going, to review progress and feeding back . . . For the first 4 months it worked well. The continuation of support is there; however the one-to-one regular support has stopped, mostly because he is so busy. The pre-booked meetings were being cancelled. He was too busy for that form of mentorship. . . . He just didn't have the time. (Fellow)

Understanding the Fellow and their needs was important, although this didn't stop many mentors from viewing challenge as an important part of their role, and this was appreciated by Fellows:

> I might work slightly differently with different people but not softer – I would be as robust again. (MD/mentor)

> My mentor knew me from before and knew of my capabilities. (Fellow)

> She felt she could sense when I was happy to be let loose and when I need more support. There were a few weeks when I didn't see her and felt disoriented and lost but then quickly got supported. I felt her to be very easy to get along with; what she says I tend to agree with. She is observant of me and she is so full of ideas. She gives you lots of things to do. (Fellow)

6.4.2   Number of mentors

Having two mentors worked well for several Fellows. A few arranged occasional joint meetings, but the main benefit for the support from people with different expertise:

> With the duality of the improvement team and innovation methodology, rather than one mentor I had two. I had a doctor mentor and a manager mentor. (Fellow)

> I've had 2 mentors. I have met my MD every month and he has offered me his ear and support as needed throughout and we have had challenging conversations as well as me challenging him. . . . I have had a lot of mentoring. There's a clinical mentor as well who I see weekly and who I work on with other projects. . . .The mentoring, above all, has been most useful. (Fellow)

Arranging for other mentors helped address the critical issue of time that prevented many MDs for giving their Fellow as much attention as they wished. This was a particular challenge for MDs with more than one Fellow, particularly if they were the main mentor.

> I gave him a lot of time over the first two months. I would have liked to give him more. There was an extremely good clinician who saw him more often and various other clinical leaders talked to him who had things to offer. (MD/mentor)

> Although it would have been nice to have a meeting with the MD once per week for five minutes, it would not have been realisable, so it had to be someone who could give the time. (Fellow)

But it was noticed by Fellows if the mentor was consistently unavailable, even when they were in the same room:

> I tried to institute one-to-one mentorship, to meet once a month, but he answered emails while we were talking. It wasn't very useful. (Fellow)

6.4.3 Mentoring skills

Some variability of skill existed among MDs and other mentors. Some were experienced trainers and/or had taken courses. Others had little experience. Mentoring a Fellow was also seen by some mentors and Fellows as different from mentoring a specialist registrar or GP registrar.

> The relationship evolved gradually. He was very clear what he wanted to get out of the year. Having reviewed it, he achieved his relationships. It's not like being with a registrar; it's finding the right balance. It took a while but we're getting there. (MD/mentor)

> We quickly realised the 'Darzi' Fellowship gave us training that was unique, so our outlook was different from the people mentoring us. They didn't have formal leadership training. The Trust did have leadership courses it offered but it was still developing. (Fellow)

> She would say 'I don't have leadership and management skills'. She has them as a consultant and developed them but hasn't had specific training and she felt that she wasn't offering me the best mentorship. Her character is in control and she talks a lot, so I don't get to lead the meeting or make the decisions. (Fellow)

Overall, while Fellows differed, some seeking more autonomy than others, most particularly appreciated a good working relationship, their mentor being accessible and willing to listen, mentors' experience, guidance and direction, willingness to let them see and hear about the wider challenges of their role through an apprenticeship approach, problem solving and troubleshooting abilities, and challenging and focusing them:

> My clinical director was . . . my 'go to' person. He has invited me to attend every weekly meeting with the general management team, brought me to many meetings, told me about different challenges he has been facing that are not related to my projects but he thought would be good for me to learn about leadership. I see him at most weeks. Overall I've had really good mentoring. I'm really lucky he became my mentor. I renegotiated who was my mentor. He involved me in so many things. He tells me where he thinks he is going.

> I met my mentor once a month. I was also supported by a [specialty] consultant. I felt supported. It was interesting. He has been an MD for many years. He is very interesting to talk through how policy gets implemented. I had the opportunity to talk about things. Expectations were met, it was enabling. He encouraged me to overcome barriers. I felt I could go out there and he would support me. I didn't feel he was micromanaging me, and would give me direction and would make you to get your own routes there.

Helping Fellows to process and connect their external learning with the work of the Trust and Fellowship projects also appeared to enhance the Fellow's contribution, and encouraging them during the 'dip in confidence' that many experienced part way through as to whether they would achieve anything was also greatly valued:

> Having access to mentoring from my MD has been really valuable because of the unique perspective and experience they have. Also my MD has been able to add context to a lot of health policies and directions which gives me a valuable insight into health organisations and how they work.

> The knowledge and experience of my MD was inspiring and he was very generous with his time. He reassured me that my work would have a relevant impact at times when I couldn't see it myself.

When mentoring was effective, Fellows benefitted considerably, for which they were extremely grateful:

> . . . mentoring perfected 'intangible' generic skills . . .

My MD has been extremely supportive and without his guidance and backing I would not have been able to have achieved what I have done in this Fellowship. I have also learnt so much from seeing how he works.

. . . a more highly placed and experienced individual was helping me personally to think through how I used the year and developed myself.

6.5 Learning programme that targets transformational change

As well as introducing important theoretical perspectives and knowledge about the organisational and system context in which they would be trying to affect change, the support programme offered a range of ways in which Fellows could make sense of, interpret and validate their experiences, learn and develop their ideas about themselves and consider how they could apply this, both to their development as leaders and to the leadership challenges that they were addressing in their workplaces. As the previous section has demonstrated, the Fellowship proved to be a transformational personal experience for many Fellows and enabled them, with the support of other leaders and stakeholders, to introduce many transformation projects and, in some cases, see these rolled out on a wider scale. We identify here how this transformational process occurred through the breadth of learning opportunities available. We have highlighted themes that influenced progress and development although, in reality, these were frequently interwoven.

6.5.1 From theory to practice

Fellows valued the opportunity to learn from theory in order to develop their leadership practice. Much of this occurred through the six classroom-based modules the aims of which were described by CIHM in the launch flyer as giving Fellows: "…frameworks and approaches that would help them shape problems and solutions". Fellows frequently commended learning about context and systems, both in terms of understanding the NHS/healthcare system and the ability to think systemically:

> I'm much more aware of the NHS system and how the money flows in the NHS and how will affect me and the consultants. . . . (Fellow)

Using theory helped Fellows develop or reframe their personal views of what things are, how they work and interrelate:

> The theoretical academic part has been interesting. That has broadened my horizon and integrated how governance and management integrate clinical views. (Fellow)

They also helped to create key understanding to inform practice:

> . . . the module on innovation and leadership – it was important to understand the meat and potatoes of what you are doing. (Fellow)

The reading and written elements of the programme also proved beneficial:

> It has exceeded my expectations, it has opened up new avenues, even reading Harvard Business Review, the books recommended through our tutors. The books that have been shared have been highly useful. (Fellow)

> I would be the type of person that would get in there and develop and get things going but I have learnt through the essays that I need to be a better strategic planner. To get other people to help me with that.

6.5.2   Promoting deep reflection

An important element of the learning support programme, as stated in the launch flyer, was for Fellows to develop reflective practices. Spaces were created to step back from situations, consider what was going on beneath the surface, and the impact Fellows' own behaviour might have had or could have, before moving into action. For example, ground rules established by facilitators the first time action learning sets met included:

> . . . that we were not there to say "have you thought about doing this or have you thought about doing that" but trying to reflect on what was happening. It was really well structured. (Fellow)

Reflective activities, including self audits, were used to challenge thinking patterns and raise self awareness. For example, undertaking the Myers Briggs Type Indicator provided insights: "… awareness of my personality traits and how I work with others…" and:

> In terms of personal development we had a module on understanding ourselves, and that was absolutely important to know yourself when you are taken out of your comfort zone. (Fellow)

Coaching also provided a useful vehicle for reflection, personal insight, developing personal skills and planning how to take these forward into action. Working one-to-one with an individual external to the Trust enabled Fellows to work things through or try them out 'for size' and have someone help them pinpoint the way they wanted to move forward:

> The coaching was phenomenally helpful, unexpectedly helpful. My personal skills developed. I found it great. (Fellow)

> Coaching was very valuable. It was a bit like counselling, developing skills on how I see myself and how I project myself … to help get over some of the problems. (Fellow)

> I was invited to give a speech at a conference, and I was terrified and had never given public speaking like that before, so my coach prepared me with that experience. I was finding the workload unmanageable and hard to prioritise and delegate and tried to get an understanding of how I might be able to rectify that without burning out. It was helpful to understand my style and how to make the best of my strengths and where I needed to do work. (Fellow)

Developing the skills and creating the space and time to do this was highly prized by the Fellows as an aid to learning on and in action.[43]

> . . . [being able to] reflect your own methods of leadership as you go along. (Fellow)

> . . . reflecting on what has been going on, and learning from them. (Fellow)

6.5.3   Collaborative problem solving

Developing relatively inexperienced leaders by requiring them to design and complete often very ambitious projects, meant that problems were inevitable. Indeed, for transformational leadership development to occur, major challenge is an absolute requirement where previous action logic[44] no longer works. A significant mode of learning on the Fellowship has been through working on problems either one-to-one with a coach or with peers and a facilitator. Fellows found a range of approaches within the learning support programme helpful in working through problems together as well as dealing with more practical matters.

Design surgeries proved helpful in the early stages of project development, both in terms of technical elements and in leading the human aspect of change:

> The design surgeries were particularly useful because they were about our different projects and how to run them, for example designing a workshop, or writing a letter and how to compose them.

> The design of a project, getting everyone on board at the beginning so you design it so everybody is enthusiastic . . .

Action learning groups provided a peer group and facilitation by a coach to talk through difficult and often sensitive matters and provide ongoing support:

> The action learning sets were the best part of the programme and sitting in a room and going through your problems with peers, to frame the problem and think differently was really powerful. I was in a good action learning set with good Fellows.

> Dealing with senior people is a big challenge. But I had plenty of time to talk in learning sets to talk about these difficult conversations.

Communities of practice (CoPs) created another opportunity to work on particular changes through developing skills needed to address them:

> I attending 3 of them [CoPs], one on conflict, one on education communication and one on bosses and managing difficult people; all three were useful .

CoPs proved less popular than most other approaches, with fewer than half of the Fellows (47%) who responded to the questionnaire rating them as very valuable. There was a sense that, unlike other learning approaches used, in CoPs Fellows had less personal responsibility to "drive the solutions" and, although they could choose which CoPS they attended, these were from a number of pre-designated topics.

6.5.4 Addressing different learning needs and orientations

As detailed at the beginning of this report, the range of ways in which Fellows were supported in their learning was considerable. The majority of these were highly rated (see Table 12). However, when questioned, different respondents varied in stating which combinations of learning elements they most preferred (see Annex 4), thus the ability to offer choice and be flexible is particularly important in leadership development.

Table 12:   Extent to which Fellows considered aspects of the Fellowship support learning programme valuable (N=30)

Aspect	% of less value	% of some value	% of considerable value
Networking with other Fellows	0	10	90
Modules	4	18	78
Accreditation for PGCert	3	20	77
Access to significant health leaders	10	23	67
Coaching	13	27	60
Design surgeries	14	31	55
Communities of Practice	20	33	47
Stakeholder events	20	40	40

The learning support programme shares many features of many blended learning designs.[45] These are based on principles of learning and teaching, and underpinned by an understanding that no one learning model can meet all learners' needs. Starting with the aims of the particular programme and learning outcomes desired, decisions are made about the configuration and mix of learning strategies, theories, technologies etc. The missing blended learning element in the Fellowships Programme is online learning which is fast becoming a leadership development technique and is prominently featured in two new programmes offered by the London Deanery, the Post Graduate Certificate in Clinical Leadership, an Open University and BMJ Learning collaboration, and Learn to Lead designed by the British Association of Medical Managers (BAMM). The scope of this evaluation does not allow us to assess the influence of online learning on clinical leadership development. However with the emergence of LeMA, Fellows were working hard to bring together valuable online resources for junior colleagues developing their leadership skills and the Fellows themselves to access. They will use The London Deanery's learning platform, Synapse, from which to do this. Synapse to this date has not gained positive press with the students, however Fellows intend to enhance their online facility by resources such as podcasts, facilitation and a user-friendly interface.

6.5.5 Motivation associated with accreditation

Most Fellows appreciated the potential to gain academic credit. Over three quarters (77%) of Fellows who responded to the survey thought that accreditation was a valuable aspect of the Fellowship. There were two main reasons. The first was that it gave some Fellows the impetus to 'pull together' their learning and they were also able to feed the associated academic study into their work:

> The PGCert assignments have reinforced the learning. (Fellow)

> For the PGCERT I picked up on a lot of useful literature that informed a lot of work and references it in a report. (Fellow)

The second was its value as a qualification to add to their CVs:

> PGCert allowed for attainment of a 'tangible' qualification from the fellowship year. (Fellow)

> PG Cert helped me to learn and consolidate information. It is also something which can be added to our CV and adds validity to the course. (Fellow)

There was some feeling that it would have been preferable if accreditation had been at a higher level, for example a Masters degree:

> . . . to think we did a year and got a PGCERT. We had a lot of time. We could have got more given there was a year off. (Fellow)

6.5.6 Pacing the learning

At one time or another many of the Fellows experienced 'overload'.

Timetabling issues also created some periods of additional stress. The number of assignments and reading material was heavily concentrated during one period (October to January). Some Fellows appeared almost overwhelmed by the "treadmill" demands of the combination of project work, supporting programme attendance and the writing required for accreditation:

> There was almost no breathing space. By the time one essay was finished, there wasn't enough feedback in time. (Fellow)

Been in general practice half the week, the essays X 4 and the modules and PCT project work, absolutely exhausting! (Fellow)

Recently people found it stressful. There was a lot of extra work on our day jobs. I wrote to CIHM to ask if there was any chance of altering the dates and was told I don't have to do it. I didn't realise. There were 130 papers for clinical governance!"

6.6   Combining workplace and external learning

We have already described the benefits of the Trust-based projects and the external learning programme, but in reality, it was the blend of the two that added up to a more powerful experience. Despite times when Fellows felt overstretched by the combination of commitments in the Trust, demands of the learning programme and, in particular, assignments and maintaining their clinical practice while still trying to have a home life, the projects gave them the concrete, hands on workplace learning and experience of leadership with dedicated mentoring support, while the supporting learning programme provided the theoretical backdrop, enabled them to process issues and reflect on their own leadership.

> It's really important to emphasise that the way the programme was delivered, exactly fitted what we needed to know to do the projects, the deep theory of change and systems and how they work, really strongly emphasised. (Fellow)

> I have . . . learnt a great deal from actually doing projects . . . .However, I am sure they would not have been as valuable without the support of all of the other aspects of the Fellowship. (Fellow)

> I've got more tools to make change successful. Every bit of what we did made a difference. You can't do the projects without the study behind it, the live projects you were learning while doing something. It was a process. (Fellow)

The support programme also, on occasions, became a resource to mediate between Fellow and the MD:

> Coaching was brilliant because I ran into a stumbling block with my MD and I invited my coach to come down with my MD. (Fellow)

> We were all given a coach . . . my coach was an advocate for me and to help the mentor help me. (Fellow)

Fellows' preferences for different aspects of the Programme clearly varied. When we asked them to tell us the two aspects they valued most highly, nearly two thirds of those who responded to the questionnaire (63%) selected one in the Trust and one in the learning support programme, while just under a third (30%) chose two features of the learning support programme and the remainder (7%) selected two Trust-based aspects, the projects and the mentoring (see Annex 4).

While the Fellows were making connections between their workplace projects and the external learning support, the same was often not the case for their MDs who often did not know what the Fellows had been doing when they were out of the Trust on learning support days and sometimes even saw this as a bit of distraction from the task at hand:

> I didn't see her very much at that point . . . .she was too busy. (MD)

Because the MDs were not closely engaged as contributors to the learning programme or sharing experiences with other MDs about what was happening in different Trusts, they could not always see the links and connections between Fellowship activity in their Trusts and the theoretical and practical external support that was designed to support Fellows' project work.

6.7 Network of support - from formal to informal social learning

Of all aspects of the Fellowships Programme, networking with other Fellows was rated as being most valuable (see Table 13 and Table 12 on p.49).

How valuable have the following aspects of the Fellowship programme been to you? (1= of limited value, 5 = extremely valuable) (N= 30, 77% of those circulated)	% Less value	% Some value	% Considerable value
Networking with Fellows	0	10	90

Half of the Fellows responding to the questionnaire viewed this as one of two aspects they valued most highly. We have discussed the influence of social learning, and networking is an example, but developing networks, partnerships and collaborative working is increasingly seen as a powerful development strategy within the health sector and, more broadly, across the public sector.[46]

Some Fellows had anticipated the benefits of a diverse network:

> When I started with Fellowship I didn't just want to meet with psychiatry Fellows. Being able to speak to GPs about what they expect in PCTs, getting that sort of knowledge was really useful. (Fellow)

Fellows' reasons for rating networking so highly indicate that it was often the mutual support that was particularly important, as well as a sense that here was a community that they could call on in the future:

> The network of colleagues enabled informal support through the year, a resource for working together and will be a valuable resource in the future beyond the Fellowship. (Fellow)

> Networking with fellows has allowed discussion on topics and problems to become surmountable and allowed realisation of everyone having similar issues within the Fellowship. (Fellow)

> The network that has been established has provided a wealth of knowledge and experience to draw on during the year and will continue to be a valuable resource for the future. (Fellow)

A significant proportion of formal learning within the support programme was learning together with others. As already reported, this was considered a desirable and powerful way to learn. As CIHM's mid-term review stated:

> . . . among the fellows there is an increasing sense of group identity wherein they are keen to learn together and work together in the future.

While there were occasional tensions, as in any groups, and perceptions of 'posturing' among some Fellows, the overwhelming sense was that Fellows provided emotional support as well as sharing similar experiences. Furthermore, by virtue of having applied for the Fellowship, they were broadly like-minded in their willingness to participate in what was likely to be a challenging and, to some extent, uncertain year:

> Building a network of like minded colleagues working across different specialities and trusts has been invaluable in offering support to each other in dealing with difficulties and learning from each others' experiences, and hearing that similar challenges are faced in different situations. (Fellow)

> The best thing has been learning in the group, comparatively to other groups we don't seem to be careerist, we all seem to be liberal and inquisitive and open minded . . . and it has been a real pleasure to meet a group like that. (Fellow)

Various mechanism were used by designers of the learning support programme to bring Fellows together – dividing them into two groups for the modules, six action learning sets and also those who chose to attend specific Communities of Practice. Some Fellows were also drawn towards each other through shared interests. In particular, the nine Mental Health Trust Fellows connected with each other and started working on joint projects, culminating in a shared leadership development programme and plans to remained networked after the Fellowship ended.

Not all of the potential networking resources were deemed valuable. The virtual learning community set up for the Fellows' use was overwhelmingly seen as the least valuable aspect of the Fellowship (77% rated it as of little value and 87% viewed it as one of the two least valued elements). It may be that Fellows set up social networking sites and that it was just that this particular web-based system was not helpful. Certainly, online communities serve various functions but facilitating, task focus and emphasising relationships are essential aspects of successful online communities.[47]

As we noted earlier, one impact of the Fellowship has been in developing the strong belief amongst Fellows about the importance of developing a strong network of colleagues facing similar challenges. Development of networking as a key feature of the Programme clearly served its purpose, and Fellows also extended their social learning and support through arranging to gather socially.

> Quite few people got on well and we know each other beyond the Fellowship. It's a nice cohort. A social event is being organised. There are discussions about how to meet up. . . .There's nothing formalised. (Fellow)

6.8   Ongoing monitoring and amendments to Programme

With a new Programme, there is an element of uncertainty about how things will work and what issues will arise. Checks and balances built into the learning design enabled a number of amendments to be made throughout the year. The Fellows were divided into two cohorts for the learning support modules. After one module was rated less favourably by Fellows in the first group, CIHM responded at extremely short notice redesigning the module for the second group. This was greatly appreciated by Fellows:

> The changes were remarkable. If something wasn't working they managed to change it quite quickly. And they were very accessible. (Fellow)

The mid-year review carried out by NHS London and the London Deanery highlighted issues that also led to changes in the Programme for the second cohort, including a named project supervisor and greater integration of the three project components

It also became clear that some Fellows were finding it hard to get the leadership capacity building project off the ground. Using a small amount of money, the Deanery came up with the idea for a Dragon's Den competition where Fellows would bid for leadership development project funds, the top ones being awarded a small development grant. Through design surgeries, CIHM supported Fellows in developing their bids. The stimulus of the funding and work required to develop these projects may have focused some Fellows' activity in this area. Also, because Fellows knew each other well by this stage, there were some collaborative bids, with potential for wider reach of outcomes.

Being flexible and building in feedback loops in these kinds of ways enables adaptations to be made to programmes as necessary to address needs of any particular cohort and their contexts.

Having explored the impact and factors that appear to influence impact, we now summarise the main successes of the Fellowship and some key issues before turning to recommendations for the future.

7. SUCCESSES

Reflecting on these findings has led us to identify a number of successes of the 'Darzi' Fellowships in Clinical Leadership Programme.

7.1   'Mind shift' of Fellows

The Programme has had a major impact on young clinicians professionally and, sometimes, personally. Almost without exception, Fellows wanted to apply their new knowledge, understanding and skills in the future, whether in clinical leadership positions or just within their future practice as consultants or GPs who feel committed to the ideal of clinicians playing a significant role in service change. The learning has been profound and the learning curve steep, but the vast majority were energised and excited about clinical leadership, even if some of the impact will not be realised for a few years.

7.2   Increasing belief in young clinical leaders' potential

MDs and other stakeholders saw for themselves how young leaders, if well supported, can bring about significant and positive service and improvement-related change in a short space of time. Some also experienced the benefits of a wider group of SpRs in their Trusts engaging in the work of clinical leadership. Cultural shifts were beginning to occur as managers in these Trusts realised the power of 'bottom up' energy for and commitment to change.

7.3   Creating impetus for leadership capacity building in Trusts

The Fellowship has heightened awareness and desirability of clinical leadership development. In several Trusts, there was greater interest from junior and other doctors in being involved in service change and quality and safety improvement. Aspirations were converted into pragmatics by developing practical ways to involve clinicians in developing their leadership skills, abilities and a broader mind set, as well as contributing real and positive change for Trusts and the systems in which they function.

7.4   Leveraging relationships and networks

Opportunities for social learning within this Fellowship were considerable. Encouraged by the supporting programme, Fellows had multiple opportunities to connect with each other through action learning sets, module groups, Communities of Practice etc. This created fertile ground for relationships to develop and extend into networks. Fellows used these networks, not only as a source of support and encouragement, but also as a base from which to innovate, develop services and enhance capacity. Additionally, through their mentors and others, Fellows accessed and created links with key leaders within and beyond their Trusts who can help them leverage the changes and development they want to make in the future. Networks have become an integral part of the modus operandi of change leadership for these Fellows, with the potential to become an important source of momentum for organisational and cultural change.

7.5   Material outcomes of change and improvement projects

Many Fellowship projects created policies, pathways, protocols and partnerships for use within and across Trusts and between Trusts and other organisations, as a means of capturing, formalising and consolidating better ways of working, whether linked with improving existing services or creating new ones. A few products have potential for national roll out. Other designs for easily accessible learning resources around leadership, organisational knowledge and skills can be used to develop individuals and practitioner networks across Trusts. Alongside these process development successes, evidence of projects' impact on service quality, improvement and capacity building has been emerging from evaluation data. Quantitative data from some projects reveals a range of initial outcomes including one or more of the following: increased speed of patient assessment and treatment, reduced waiting times, reduced admissions, reduction in un-necessary procedures for patients and length of stay, reduced safety incidents, increased efficiency and effective use of resources including some cost reduction, improved patient experience and outcomes, and local access to treatment.

8. ISSUES

8.1 Uncertainty about aims

While aims of the supporting learning programme were clearly stated, the overall aims of the Fellowship weren't entirely clear to a number of those interviewed from various different constituent groups. As a consequence, with different perceptions of the key purposes, MDs and Trust colleagues have had different expectations of Fellows, and sometimes even different from each other. This created either unrealistic demands on Fellows or left them feeling uncertain about what they should be doing and where in the Trust they could turn to for support in this. It also sometimes led to a lack of clarity about what should be expected in terms of impact.

8.2 Mutual engagement and ownership

MDs and other key stakeholders weren't seeing all of the connections intended by those who designed the Programme. So while the external learning programme was designed to support the 'live' work in Trusts, Trusts sometimes didn't perceive the external support programme as central to the Fellows' learning and achievement of the projects. Although invited to stakeholder events, MDs weren't actively engaged in being part of the support programme. Because of limited engagement and feedback about Fellows' learning and progress from the external support programme, MDs and/or mentors may have been inhibited from giving adequate and appropriate support to Fellows. Quite often the MD/mentor didn't know what the Fellow was covering in their external learning programme that might potentially support Trust project work. This is a missed opportunity for MDs/mentors to draw from and contribute to the significant knowledge base that underpins the Programme and ultimately could enhance the achievements of the Fellow and Fellowship projects.

8.3 Suitability of Trust learning context

For some Fellows, the Trust learning context and culture presented them with a number of issues. Fellows struggled when faced with unrealistic projects both in scope or number that they were expected to lead, inaccessibility of support, if they were located in unsuitable accommodation away from other leadership colleagues, or there was general disinterest in what they were trying to achieve. In these cases, project progress was slower and the Fellow found it hard to maintain motivation.

8.4 Mentoring quality

Mentoring for Fellows was variable. Where the mentor considered the Fellow as an extra pair of hands the focus was often taken away from developing the Fellow as a leader and the relationship more oriented towards the mentor's needs rather than those of the mentee. It was quite difficult for some Fellows to maintain contact with their mentor and this could lead to feelings of isolation as well as having unresolved issues in relation to their project. Furthermore, some mentors didn't possess all of the necessary skills to support and bring out the best in Fellows. Mentors didn't get together so they did not have the opportunity to discuss with other mentors how best to help their Fellows or to hear about good practice in other projects that might be fed in to their Fellows' activity.

8.5 Ensuring sustainability

The Fellowship has stimulated energy and activity around clinical leadership for service change, improvement and capacity building. But there is a question about sustainability. It is unclear whether the foundations that have been set are deep enough to maintain commitment, energy, focused activity and pursuit of impact over time. For the Fellows, will the effects of this enriching experience remain once the input and support no longer remains and they return to the key focus of developing their clinical practice? For Trusts, have systems, structures and cultures been addressed in such ways that projects started will continue and be supported through to ensuring positive outcomes? For the wider system, in a time of financial constraints and political change, how can the commitment to and support for clinical development be sustained?

9. RECOMMENDATIONS FOR FUTURE ITERATIONS OF THE FELLOWSHIPS PROGRAMME

Findings of this evaluation highlight suggestions for future iterations of the Fellowships Programme. These are embellished with further suggestions from interviewees and those who completed questionnaires.

The vast majority of Fellows had an incredible experience which, as one MD said, "speaks for itself". One Fellow summarised the experience:

> I think the Fellowship has been excellent overall. It needs tweaking in parts but I consider myself very fortunate to be given such a unique and fantastic opportunity.

In answering the research question about improvements that might be made to future iterations of the Fellowship, we focus on those areas that may "need tweaking in parts". Messages are grouped in three categories: those for the overall design; those for the learning support programme; and those for sponsoring Trusts.

9.1 Recommendations for the overall design

9.1.1. *Being clear about aims and expectations*

A new programme takes time to find its feet and increased clarity often comes with time. Some sponsoring Trusts appeared unclear about the specific purpose of the Fellowship, which made it difficult for MDs to gear their expectations, particularly in relation to impact. Was this ultimately meant to be a year of learning, nurturing a young leader and helping to prepare them for future clinical leadership by exposing them to the types of projects and issues they will face? Or was this an extra pair of hands who could help them with service change and ensure delivery of some projects? Or both? This uncertainty led to different responses. With the Fellowship in its second iteration, ongoing communication of aims and aspirations is likely to aid Trusts in focusing and maintaining projects and support. Information on the aims needs to be readily available, for example on the Trust's intranet, so that stakeholders and mentors to have a clear understanding of the Fellowship.

Although greater clarity would be helpful, it will also be important to ensure that flexibility is maintained. This is a new venture and represents a major change for many Trusts. Their ownership and ability to shape the Fellowship in a contextualised and tailored way will also be important.

Recommendation: Fellowship aims need to be clear, but sufficiently flexible to enable Trusts to tailor the Fellowship to their contextual needs.

9.1.2 *Ensuring mentors have the skills they need*

Mentoring has been shown to be an important and valued feature of the Fellowship, when done well. There were some expert and experienced mentors, but this was not universal. As the following MD articulates, more thought may need to be given to assessing or training mentors to ensure they have the appropriate skills:

> I knew how to do this [mentoring]. I have not been formally trained in the competencies but have drawn extensively on these competencies which have been absolutely necessary. Not all 'Darzi' Fellows have had benefit of this and some were cast adrift. . . It's about ensuring people who support them have the right skills and can make it safe for them to do this; that

they can support them. These people have a hyperlink into the highest level, an insight into how NHS works at the highest level. . . . Access to an educator who can contextualise, debrief, support them to reflect and make the necessary connections, identify skills they have learning needs in, how use in future is vital etc. You may double the running costs, but they need it, otherwise they struggle. (MD)

The MDs had not been offered support with mentoring. While some thought that training might not be necessary, most felt it would be valuable to be connected with other mentors and discuss their experiences. The idea of a mentors' network was mentioned during the mid-year review meeting, and one MD suggested coaching for mentors. Other suggestions for mentors included that they come up with a framework of expectations of the Fellow that includes guidance but offers flexibility, and that "I [a mentor] would read the Fellowship handbook more thoroughly if there was one".

Recommendation: Provide guidance and support for mentors, including networking opportunities.

9.1.3 *Building mutual engagement between workplace learning and supporting learning components*

Earlier, we noted that having both live projects with Trust-based support and a support programme is an important factor in achieving impact. The educational support programme is an important factor in achieving impact, while 'wrap around', was not totally integrated with the project work. In some instances closer integration occurred, largely where an MD/mentor had a particular interest in the supporting programme or extra time to discuss it once the list of project tasks had been addressed. This is potentially one of the most powerful features of the Fellowship. Although it doesn't come without expense, this 'Rolls Royce' model incorporates many features of high quality leadership learning that have been demonstrated to lead to positive outcomes. Trust's mentors have an important role they could play here in helping to make these connections, but only if they are aware of the learning support programme elements and how each has been designed to support project work. Offering a couple of meetings each year with facilitated two-way sharing of projects and the learning support would raise awareness and understanding and mutual engagement amongin both parties to help support Fellows' project work and their learning more effectively. As part of this process, incorporating themes and issues emerging from action learning and coaching within these meetings could also be valuable in dealing with or pre-empting problems arising from Fellows' experiences and feed into the organisational learning process.[48]

Learning support providers also need to be fully aware of project details so that they are able to take on challenges. Another possibility would be to have greater alignment between PG Certificate assignments and projects. This already occurs with one assignment but this number might be increased. Finally, design surgeries provided an opportunity to see how Fellows were progressing but these were separate from the Trusts. It might be useful to think of a way to bring the two closer together.

Recommendation: Find ways to ensure closer connections and mutual engagement between Trust and supporting learning components.

9.1.4 *Monitoring and evaluating process and progress and communicating this to MDs*

Despite the internal mid-term evaluation, CIHM's evaluation of all of the elements of their supporting learning programme and their own associated evaluation, and this external evaluation, a number of MDs were keen to receive more ongoing feedback about the progress of their Fellows from the Programme's perspective – they wanted an outside lens on their Fellow:

> Better dialogue and communication from the centre throughout the year would be good – what they [the Fellows] are doing in NHS London, what are they learning, what can we expect from them half or three quarters of the way through?

It would be advisable to set in place a linked tutor for each Fellow, and a mid Fellowship review between linked tutor, mentor and Fellow in order to review progress, highlight issues and targets and identify any additional support required. There also needs to be a final meeting between the Fellow and their mentor to provide mutual feedback and give closure to the relationship.

Monitoring and evaluation will also be helped if there is commitment from Fellows at the outset to being part of the Programme's informal and formal evaluation processes. While we heard that Fellows were the subject of considerable demand and interest, and were pleased to have a 77 per cent response rate to the questionnaire, we were unsure why this response rate wasn't higher. This would have contributed to enhancing the knowledge base about this innovative approach to clinical leadership development and ensured that all Fellows' perspectives were taken into account. It is hoped that the second cohort of Fellows will engage with any official external evaluation.

It was also suggested that Trusts should be assessed on quality of support provided to a Fellow and that this should be taken into account in judgements about awarding future Fellowships.

Recommendation: Provide Trusts with ongoing feedback on Fellows' progress.

9.1.5   *Refining Fellows' job specification*

Although expectations of Fellows, MD, and stakeholders were exceeded, the first cohort's experience offers useful messages for the job description and person specification for future Fellows.

The key message was identifying the 'right' people. Despite short notice, many stakeholders and MDs were impressed with the calibre of their Fellows. Nonetheless, trainees who demonstrated certain attributes seemed more amenable to the role's demands. As well as good communication skills, these include: humility, strong interpersonal/relational skills, as demonstrated in being personable, approachable, supportive, attentive to others, good listeners, inclusive, and involving colleagues by giving them as much exposure as possible. Other assets appear to be showing negotiation skills, being politically astute, resilient and well-organised. Use of behavioural interviewing techniques might help identify some of these qualities.

While hard to ascertain, several interviewees felt that that it was important that the applicant didn't just want the programme to add to their CV but demonstrated commitment and passion.

> They need something about whether they can demonstrate personal motivation in areas eg sitting in on board meetings. (Fellow)

> The organisation needs to be open minded about the kind of individuals they are looking for, and the difference between those that need suggesting it is good for them and those that will seek this out. There's no perfect answer for that . . . this is designed to foster those who want to develop and those who already have a feather in their bow. (Fellow)

Recommendation: Seek to identify the 'right' people

9.1.6   *Maintaining the diversity of specialist interests while ensuring sufficient numbers within a specialism*

Fellows found it a real asset to their overall experience to learn with peers from different specialist areas, enriching their knowledge and understanding. In addition, it is important to ensure there are sufficient people from different kind of Trusts in the Programme. For example, the nine Mental Health Fellows experienced significant support and encouragement from each other, with concern

expressed that having only two in the next cohort would reduce the potential of this collegial support. MDs of PCTs also thought there should be a more equal split between hospitals and primary care. Several interviewees also noted the benefits of having more than one Fellow in a Trust, and thought was also given to synchronised recruitment, whereby cohorts to overlap with earlier cohorts supporting and getting to know new ones.

Recommendation: In planning the overall cohort, balance diverse specialist interests with ensuring adequate collegial support and potential for networking within broad specialist areas.

9.1.7 *Planning for sustainability*

Sustainability of the Fellowship ideal is dependent on Fellows' ability to continue to put their learning to use and keep the knowledge, understanding and skills fresh. Where many are still completing their training and the obvious next step is to become a consultant or continue as a GP, it would be valuable to find more ways to help Fellows consider a short to medium term plan (over a 3-5 year period), as well as exploring with PCTs how clinical leadership opportunities can be increased.

From other networks' experiences, we know that sustainability requires a common purpose and task, facilitation, infrastructure, face-to-face meetings and a small amount of money to cover these. It may be advantageous to link membership with active contribution to the programmes for current and future cohorts of Fellows and other NHS externally offered clinical leadership programmes. It certainly seemed to be understood that after all of the intense work to bring about change, continuation of commitment and use of ideas is essential.

Discussions have already occurred about means to maintain connections with and between the Fellows. As alumni, they can join the London Deanery's alumni programme and participate in its activities. They have also made their own commitments to stay in touch, and a number have set up leadership capacity building initiatives in their Trusts or across a group of related Trusts. Further ways to help continue the networking are desirable.

The length of time that registrars spend in specialist training posts in any one Trust is a wider issue that needs to be considered in relationship to Fellows' capacity to engage in meaningful projects with short timelines, and Trusts' interest in investing energy in clinical leadership development of trainees that move on quickly. This applies equally to sustainability of Fellows' knowledge, skills and enthusiasm and other clinical leadership development opportunities that take this kind of live project and extra support approach. Extended periods of time in a specialism might alleviate this issue, although as increasing numbers of Fellows and graduates of 'mini Darzis' start moving through the system, capacity will be circulated into different Trusts.

Recommendations: Ensure that Fellows remain connected to the Fellowship knowledge and ideas and have opportunities to share their experience and enthusiasm widely.

9.1.8 *Considering how other professionals might be included*

Partnerships across the public sector are on the increase, as are associated leadership development opportunities. Some interviewees suggested that the Fellowship might be opened up to become a multi-professional experience:

> Having different people from different backgrounds in the leadership programme, you learn outside your immediate confine (MD).

> There's a slight sensitivity around the drive to push doctors into the leadership framework without considering other professionals. It feels embarrassing. I don't want to be considered more important than a Director of Nursing. (MD)

Shadowing a senior leader from another organisation was also proposed.

Recommendation: Explore whether opening up the Fellowship to other professionals could enhance overall experience and impact.

9.2 Recommendations for the learning programme

9.2.1 *Enabling Fellows to 'hit the ground running'*

The Fellowship year starts and is over quickly – one year isn't a long time. Fellows need to be ready to engage quickly in the practicalities of project work. Although over three quarters found the supporting modules very valuable, they didn't provide the practical skills Fellows needed:

> It would have been useful to have some more 'hard skills' - project planning, writing, policy, finance etc. We were extremely well versed in complex systems but rather without the other skills you need to make things happen. (Fellow)

> 'Darzi' Fellows need support with the transition to management including practical things like structuring time and objectives. (Stakeholder)

A related but slightly different point was the length of the education modules. The question was raised as to whether all needed to be as long as they were and whether e-learning might be adopted as an alternative strategy for some modules.

Recommendation: Include practical project management skills up front in the supporting programme.

9.2.2. *Achieving the right balance between demands of accredited study, project work and clinical practice*

Accreditation was appealing to many Fellows but they hadn't anticipated the extra demands in being able to complete their assignments at the same time as delivering their projects. Some of this was due to the close timing of some assignments that left many Fellows reeling and "stressed". Part time study always makes extra demands on people's time – as one of the designers of the learning support programme acknowledged: "The PG Cert is labour intensive" – but the strong message was for ways to be found to pace the accreditation more evenly throughout the Fellowship year.

An overall Programme recommendation is also pertinent here. Closer alignment between the workplace and supporting programme components (see 9.1.3) would make it easier to come up with mutually agreed times for submission of assignments. Exploring other levels of accreditation might be valuable too, given the demands of time and energy devoted to study.

Recommendation: Accredited assignments need to be more evenly paced throughout the year.

9.2.3 *Greater involvement of MDs in the learning support programme*

A clear message from MDs was that they would appreciate greater opportunities to connect with mentoring MD colleagues, hear about the projects in different Trusts and share and discuss experiences, as one described it "with like-minded colleagues". Most of those interviewed had attended at least one network event but, while sometimes enjoyable, generally they did not address MDs' key interests or concerns. Some were pleased to have the opportunity to experience

the educational component through their Fellows, one commenting that she felt like she had been through an MA during the year!

MDs clearly had different backgrounds and their Trusts varied considerably in their learning culture. One respondent wondered whether a change management course for MDs might be a good idea. Another would like to have contributed more to the learning support programme but after the initial application process was not asked again. In the mid-year review CIHM also suggested that MDs and project leaders should attend joint sessions at the onset of the Fellowship to clarify expectations about project outcomes and personal learning for Fellows. This corresponds with our other findings that this very experienced and influential group should be involved more closely in the overall Programme experience, rather than just that in their Trust, which would provide a further means of mutual engagement

Recommendation: Find ways to draw on MDs' expertise in the learning support programme and provide them with opportunities to share Fellowship experiences with peers.

9.3   Recommendations for sponsoring Trusts

9.3.1   *Sponsorship meaning total Trust commitment and organisational support*

Fellows are in Trusts to contribute but, most fundamentally, they are there to learn clinical leadership. As one interviewee said, "they need to ask themselves 'What do you need to do to help your Fellow learn?" Many Fellows greatly valued the involvement of the MD and the opportunities this afforded to them, and some MDs were extremely generous with their time, taking a very hands-on approach, but MDs are extremely busy and the burden of ensuring that the Trust properly supports the Fellow can't rest entirely on their shoulders. When the Trust decides to apply for a Fellowship, the commitment of other senior leaders is necessary, a few of those interviewed even recommending 'buy in' at Board level. This includes thinking through how different people will support the Fellow and how to ensure they are properly integrated into the Trust. Of 14 stakeholders responding to the survey, only five reported they knew a considerable amount about the Fellowship.

Strategic thought also needs to be given to where, physically, the Fellow will be located to ensure that they are not isolated.

> It's terribly damaging to be stuck in a cupboard at end of corridor that nobody goes to. These are inexperienced and potentially vulnerable people who need to be facilitated rather than obstructed. If you are going to be a change agent you need to be at heart of the organisation. (MD)

> They need to make sure you have office space. That wasn't a problem for me but for others it was. I had admin support and access to a Blackberry and a laptop. (Fellow)

> The Trust should have been clearer about what they are offering, and put you in the right direction. (Fellow)

Ensuring that Fellows have access to technology, administrative support, other resources and a proper induction is important, as well as 'opening doors' and giving them access to meetings. Another aspect of this is communicating with colleagues so that they are clear about the purpose of the Fellowship as well as the nature of specific projects.

It is also, one stakeholder argued, about giving the Fellowship its appropriate status:

> It is about influencing people and behind the scenes persuasion and influence. It's a long drawn out process of overarching higher level change...From the Trust and PCT point of

view there needs to be more understanding of Fellowships and they need to carry some professional recognition. I hope it will develop into that. (Stakeholder)

Recommendation: Broad, senior commitment to sponsoring a Fellow is needed, with associated support.

9.3.2 *Ensuring high quality mentoring support*

The Fellows most able to follow through on their project work generally had mentors who were accessible, interested and able to offer the right expertise, support and challenge. Any named mentor needs to be available, particularly in the early stages of the Fellowship while the Fellows are finding their feet, and also build in ongoing feedback session, including a year-end final feedback evaluation review session with the Fellow. Also helpful would be having different people who can support Fellows for diverse project needs, and finding ways to connect these people.

Recommendation: Fellows need to be guaranteed high quality mentoring support.

9.3.3 *Planning suitable projects connected to a theory of change*

Fellows often struggled with projects that were well beyond their means, what one person described as projects that Trusts "have not been able to achieve in the last 50 years". Elsewhere, we recommended providing Fellows with early support for project management, but this issue goes beyond project management. Fellows are aspiring leaders nearing or at the end of their training, not experienced leaders and managers. As one Fellow commented, "The Trust needs to realise it's not just another job." Several MDs we spoke with were in accordance, one explaining:

> For the stage they're at, with a self-contained project they are probably more likely to get most out of it. Some of the things people were doing somebody very senior usually does. With one person I met, nothing was happening after six months. It seemed rather unfair. Select something well thought through that they can achieve. A year is not a long time".

Where there is more than one project, finding appropriate connections between the projects will help with overall coherence. Along with project planning, it would also be helpful for the Trust to support the Fellow in developing a 'theory of change' about any project. Carol Weiss[49] popularised this term, the thinking behind which is now being applied in organisations to help them think more about how they manage change. Weiss used the term as a way to describe the set of assumptions that explain the mini-steps that lead to the long term goal of interest and the connections between activities and outcomes that occur at each step of the way. Having a theory of change is also a way to help guide process and impact evaluation activities.

Recommendation: Projects need to be appropriate to a one-year Fellowship, with a clear theory of how change is expected to happen and its intended impact.

9.3.4 *Thinking strategically about the Fellowship as a means of enhancing leadership capacity building in the Trust and planning accordingly*

One of the Programme's originators spoke of how she hoped that the Fellowship might give Trusts a different idea about junior doctors' potential:

> It is talent spotting. It's only a small number of people. Can we use that to help us develop that for junior doctors as a whole?

Sustainability has implications for investment in clinical leadership development at the local level, with less central support. A few participating Trusts already have very advanced leadership development training opportunities and were planning further developments. Some are getting

involved in regional initiatives or piloting programmes. Others are less far down the path. The 'mini 'Darzi'' leadership capacity building projects initiated by Fellows in some Trusts demonstrated to senior leaders how, with little extra resource, it was possible to engage a number of senior trainees in quality improvement, safety improvement or clinical governance projects that benefitted the Trust, and awoke stakeholders to the energy and potential of this group. These Trusts will have stories to share. One Fellow also talked about the benefits of connecting with 'middle grade' management and that Trusts might want to think about their involvement and development:

> The opportunities to meet and observe leaders and executives of the Trust and NHS London was amazing. However, the experiences of working with some of the 'middle grade' management will probably influence me more in the medium term and there is a missed opportunity to use this network locally.

Team building is also a key organisational development strategy. One stakeholder suggested the idea of a leadership day involving Trust stakeholders and Fellows:

> Developing team ethics more would be helpful. Most [Fellows] will work in a team environment. Team building should happen locally. It would be useful if we were doing team building to include key individuals in the locality . . . if we had a leadership day here, make sure 'Darzi' Fellows were part of it. They would add to it, it would show them in a different light. (Stakeholder)

As more Fellows and other graduates of other clinical leadership programme find training or consultant positions in the Trust, their experience can be harnessed to feed into training programmes.

Recommendation: Use the Fellowship as a strategic opportunity for further development of clinical capacity within the Trust.

10. LESSONS FOR OTHER LEADERSHIP DEVELOPMENT

A research question in this evaluation focused on exploring what can be learnt from the Fellowship Programme to inform embedding leadership development across all training programmes. Here, we have drawn both from the general findings of the evaluation and from the answers to a specific question we asked about this issue.

Many of those we spoke with were very aware that the Fellowship is an expensive programme and conscious, as one MD put it, that it should be:

> . . . spread more, so it mushrooms. We need to broaden general management knowledge so that when changes come on stream there's a willingness to work with NHS to deliver that.

Another MD expressed concern that:

> There is a real gulf, however, between the wonderful experience of the 'Darzi' Fellowship, and the management training given to most SpRs, and I would suggest we need to address that. (MD)

The following sets of recommendations aren't mutually exclusive.

10.1 Enhancing the availability of clinical leadership training throughout the medical career

The 'Darzi' Fellowships in Clinical Leader programme is one of a growing number of efforts around the country to offer clinical leadership development to doctors before they are well established as consultants. A number of interviewees thought that greater clinical leadership development

opportunities were needed at different points a doctor's career. The small number of stakeholders who responded to the survey all felt that those doing specialty training should have access to such opportunities and almost all thought they should be made available to those who were newly qualified (see Table 14).

Table 14: Stakeholders' perceptions of appropriate participants in clinical leadership development opportunities

Do you think clinical leadership development opportunities should be made available to:	*Response count (N=14) (39% of those circulated)*
those doing specialty training?	14
newly qualified consultants, GPs and dentists?	12
established consultants, GPS and dentists?	10
undergraduates?	7
those at the foundation stage?	6

Several Medical Directors also believed that clinical leadership should form part of junior doctors' and undergraduates' curriculum:

> This is core to every doctor's daytime business – management competencies and skills that I have acquire by good fortune and experience. It should be core curriculum as an undergraduate and house physician . . . In the undergraduate curriculum it's easy to introduce a management academic course. (MD)

> SpRs may need, before they get their certificate of training, to have demonstrated they have done something similar – for example six months may be enough as part of their curriculum. If it was part of the MD's remit to fulfil that supervision and mentoring function, the NHS would be a much better place. (MD)

> I wish it could also be done a bit in the medical curriculum. It would be good throughout medical training. . . .They should start earlier. It would help with their special interests when they become registrars. They can then look out for quality improvement projects when they become consultants to run their teams. A year is good but I would rather see this run through the training curriculum. (MD)

One wanted to see "increasing roles and branches of medical leadership – maybe this is a stimulus for such things".

10.2 Combining experiential, project-based learning with theoretical learning and opportunities for reflection and collaboration

Our evaluation findings supports much other research evidence demonstrating that one learning approach doesn't appeal to all people. As the table in Annex 4 shows, when asked to select the two aspects of the Fellowship they most valued, even though networking, mentoring and working on live projects were generally more popular, combinations varied. (It should be noted that several Fellows found it difficult to choose just two elements.) We conclude from this that maintaining a variety of modes of learning is likely to address more learners' needs.

We asked interviewees to make suggestions for ways to offer similar programmes on a smaller scale. All of their responses involved an experiential learning component:

> The real bonus is the experience you get. No leadership course can be complete without this, without people-to-people interactions. You only get leadership development from working in real-life environments that give you exposure to that experience. (Fellow)

Suggestions that were offered included:

- reduce the programme length eg one or two days a week and scale down the scope of project work and theoretical components, although: "you need to have some formal education to accompany it" (Fellow)
- increase the clinical aspect eg three days of clinical job and three days of project work
- a training day once a month, and mentoring by a Medical Director or Clinical Director: "This should be sustainable" (Fellow)
- a work-based project with facilitated learning sets
- "producing an e-module on the core elements on understanding finance, structure etc that we could buy or for free, and have some e-modules for inductions for new doctors to use with new GPs. . . . Some resources will need to be paid for. (MD)
- "a leadership and management website could be developed from the Dragon's Den project" (Mentor)

10.3 Enhancing local leadership development opportunities

Scope also exists for some Trusts to increase local leadership development offerings: "some Trusts have nothing on offer" (Fellow). MDs views on local development possibilities differed. One perception was that, "anything you do in house will keep clashing with service provision and their [Fellows'] role doesn't" (MD), whereas another MD imagined a future where leadership development might be locally driven: "It could all be done within a Trust with a little bit of extra which you could set up". Ideas for local leadership training included:

- local coaching through Trusts
- offering their own Fellowships with mentoring, one day a week project work, one day a week training and clinical work
- shadowing clinical leaders followed by debrief sessions in which the leader talks through what they have said and done: "The opportunity to shadow people is a fantastic thing that is free, so acknowledge that people can do that" (Fellow); spending time at board meetings and meeting the Chief Executive – "it's very easy for all trainees to do that during the 7-8 years they are a trainee" (MD)
- drawing on 'Darzi' Fellows' learning while they are in a Trust
- "external training could be more spaced out, prudently used and more linked into NHS management. People in the post could do half clinical work. There could be a bit more resource from the Trust. I had envisaged ther would be a lot more demanded from us as a Trust, for example a week with the Finance Team
- a change management programme for every registrar, including a theoretical module, mentoring and development of shadowing skills and then an opportunity to spend time with an MD or modern matron: "It needs to be put on the syllabus. In a tight curriculum it needs to be highlighted"
- core competency framework – "it's available free in Trusts – you don't need an expensive course" (MD).

10.4 Developing better networking methodologies

This evaluation has found that young clinical leaders greatly value the mutual learning and support derived from their peers, including those in different specialisms. Networking – developing medical learning communities – isn't an expensive strategy to apply within and across Trusts, but doesn't just happen:

> Network building is very much where you are . . . . I suggest that you train people and help them develop networks and networking skills and how to develop a community within them. (Fellow)

There is a strong knowledge base on professional learning communities within education[50] and the associated evidence on networks is increasing. In the health sector, the potential of networks for leadership development is increasingly being realised.[51] Networks are formed in many ways. Fellowship strategies included module cohorts, action learning sets and Communities of Practice. The former two were viewed as more effective by Fellows, with particular mention that action learning sets helped to build strong networks.

10.5   Supporting multi-professional leadership development and promoting links

A message coming through was that the Fellowship Programme might equally be offered to other health professionals. Twelve of 14 stakeholders who responded to the questionnaire thought that, in general, clinical leadership development opportunities should be available to other health professionals. Concern was expressed that a relationships problem would be created if only doctors are seen as needing to have a voice in healthcare service change:

> If I had one wish, it would be that their relationships could be better, to treat each other with more respect and not work in silos. I'm interested in getting doctors and nurses to work and study together. [Fellow]

In relation to this, there was a plea for more joined up thinking in terms of already available leadership development:

> NHS London have made a curious mistake here; that they have staff on a series of leadership programmes but none of them are tied together. We have the medical 'Darzi' Fellowship which has been a fabulous success. Our Trust has nurses on the Aspiring Nurse Directors programme, an occupational therapist on an equivalent to the 'Darzi' Fellowship, one member of staff on the Breakthrough programme for BME staff. There is nothing for social workers which is unfair, and it's always been unfair. NHS London has commissioned all of these programmes, but none of them meet up. If I had been running it, I would want some cohesion between them. The programmes should be thinking about leadership across the board. (Stakeholder)

One Fellow had raised his sights beyond multi-professional public sector leadership development. He described his own experience that will take him out of London in the short term, but will provide him with the opportunity to apply his 'Darzi' Fellowship experience to third sector challenges:

> I think the role of clinical leader needs to be broadened out to cross boundaries. It is not the only important role in a health context. It [the Fellowship] has challenged me to go in small steps. It has confirmed to me that I am not looking to have a high faculty role but the smaller changes you can address as a leader can be more sustainable than bigger changes. It has help me see what I am about. . . . I'm interested in getting further than just general practice and I will be close to the EDEN project. There is a bit regeneration work going on there. I suppose I want to be more of a social entrepreneur but the term clinical leadership does not click for me, a social health leader. [Fellow]

Although the Fellowship's aim has been the development of clinical leadership, in the same way that partnerships across the public sector are being developed to promote 'healthier' communities, there might be opportunities to create stronger links and engage in joint health promoting projects with the third sector through leadership development.

11.   TRACKING SUSTAINABILITY AND ONGOING IMPACT

The NHS London 'Darzi' Fellowships in Clinical Leadership Programme is an ambitious and innovative programme, with an ultimate aim to affect and spawn clinical leadership throughout the system, thereby influencing both individual professional practice and bringing about system-wide change to address the needs of a rapidly changing health service. At this point, 40 doctors in the first cohort have completed or almost completed their Fellowship and a second cohort, that will have a further 20 participants, is underway. These numbers are small in relation to the overall number of 12,500 trainees, even counting other programmes established or commissioned by NHS London and the London Deanery to address leadership development at this stage of clinicians' training. Financial uncertainty also means that the long-term future of the Programme, itself, may be under threat: "I think NHS London's approach has been correct, but it will be difficult to maintain in the long term, particularly as budget cuts arrive". (Stakeholder) Nonetheless, as we have highlighted, impact on individual Fellows and their Trusts has already been demonstrated in various ways. But what is likely to happen over time? Will this impact be maintained? What will happen to the Fellows over the next few years and beyond? Will seeds sown in Trusts through Fellowship projects grow? Will action plans be implemented? What culture change in Trusts and the system will there be over time? Or will time tell that this is a much appreciated but expensive programme that has little power to affect profound and lasting change? These and other issues need to be addressed through longer-term follow up evaluation.

11.1   Tracking further impact on Fellows

Previously, we described the importance of efforts to help Fellows sustain the impact of their Fellowship year (see sections 9.1.7, 9.3.4). Tracking the sustainability of impact and further application of learning will also be important, as well as looking at career choices over time and the extent to which Fellows continue and use their networks.

11.1.1 *Sustaining personal change and further application of learning*

This demanding programme seeks significant change in personal patterns of thinking, responding and communicating, and Fellows have described the impact on them:

> I have become more acutely aware of my weakness and strengths and I hope that will carry me through further challenges in my career. (Fellow)

At this point, it is hard to tell whether the depth of change experienced by individual Fellows will have a significant effect on ways they approach their work. This would also be hard to track without following a parallel control cohort, which is an option. We have already ascertained that an important influence on impact is the context of the Trust in which Fellows are located. The same is likely to be true in terms of Trusts where Fellows take up subsequent positions.

Follow up of the Fellows needs to include ways of eliciting and exploring the elements of their Fellowship experiences they have applied as well as how this has been helped or hindered by cultural factors within Trusts:

> . . . development of services at different Trusts that I rotate to, impact on me personally and my abilities, which will have a long term impact on wherever I am applying myself . . .
> (Fellow)

> On return to full-time clinical work, I will have a broader perspective of patient care/ safety/ quality and working relationships with colleagues and the organisation, so I think this will make me a better clinician. (Fellow)

I have greater awareness of organisational issues and enthusiasm to participate, feeling like I have a responsibility towards the organisation, not just my profession and the need to communicate with them about strategic matters. (Fellow)

11.1.2 *Career choices*

Many Fellows aim to combine management work with clinical work in the future, perhaps becoming a lead clinician in a sub-specialty area or incorporating projects into their clinical roles.

I never thought that I would say it, but I have realised that I may have a real talent for leadership and management, and I would be keen to develop this interest throughout my future career as a . . . psychiatrist! (Fellow)

Here, future evaluation should track career choices over time and also length of time taken to move into clinical leadership positions.

11.1.3 *Continuation and impact of networking*

Fellows expressed a strong belief in the importance of networking. Many hope to continue their networks with other Fellows and stakeholders. Some are already using those connections in immediate work roles. Maintaining the spirit of the Fellowship may not be easy as people move on in their professional and personal lives. Once out of the Programme, to what extent will the alumni be able to create collegial commitment through alumni activities, their own networks and joint activities they have established eg leadership capacity building initiatives across Trusts? Future evaluation should probe this and could draw on network analysis methodology to examine the nature and range of networks.

11.2   Tracking further impact on Trusts

There was some perception that evaluating the impact of a Fellowship means attributing the impact of the work entirely to the Fellow's contribution. If this was the case, as several MDs and stakeholders commented, it is likely to become harder to determine the individual's contribution as time goes by and more people get involved. What has been clear is that, for the most part, Fellows did not work alone on projects and in some instances, they participated in larger projects that would have been part of Trusts' remits even if Fellows had not been involved. Further impact on Trusts over time can therefore broadly be assessed in terms of the following: implementation of action plans of Fellowship project initiatives, continuation and ongoing development of Fellowship projects, and improvement or further improvement in outcomes. In some ways, tracking ongoing impact and sustainability can be seen as moving from "a good start to core business" (MD) with further evidence of outcomes.

11.2.1 *Implementation of Fellowship project initiative action plans*

Over time, any action plans that have been developed during the Fellowship should have been implemented and successful pilot projects scaled up. This includes, for example, policy implementation, model adoption, processes put into place and first offerings of new leadership programmes. Interviewees and survey respondents were asked what further impact they anticipated. Table 15 includes examples of the range. Other examples exist. All could be tracked.

Table 15   Examples of anticipated project developments over the next year

New policies to improve clinical care (quality and safety)
Out of hours agenda will have changed.
Payment by results - in a year 90 per cent of the process will have been put in place.
Whole raft of junior doctor programmes to support their education in patient safety and leadership, currently being submitted
LeMA project will be introducing leadership and management concepts to junior doctors for the first time
Collaborative care, where carers, service users, primary and secondary care clinicians work together to provide better co-ordinated and more effective services, will be the model adopted, and that carers and service users will be developed to participate as active designers and producers of services.

11.2.2 *Continuation and ongoing development of Fellowship project initiatives*

In many cases, work has been started but there is further work to be done:

> My . . . quality improvement [work] . . . is the project that I am most proud of although the work is ongoing and far from complete. (Fellow)

Here, a myriad of project initiatives had led to collaborative work, leadership capacity programmes, policies, training, tools and processes with further impact being seen in terms of continuation of work already underway, further development of ideas and new people getting engaged in further developments, as illustrated in the examples that follow in Table 16.

Table 16:   Examples of continuing and ongoing development of Fellowship projects that can be tracked over time

Primary and secondary care continuing to work together to address various aspect of healthcare
Synergistic working between paediatric teams in running of paediatrics and management of urgent care
Policies set in place continuing eg the oxygen policy in one Trust that will ensure training continues
The care pathways project might be used as a template for other boroughs to use
A system for assessment and training of trainees on management and leadership that will continue to run through a Trust's training department, facilitated by trainees and consultants.
Further patient pathways that will be developed by other SpRs "who would recognise the need for new ones"
The progression onto the next phase of the clinical documentation project with increased clinical engagement.
Continuing to use tools Fellows have developed and/or trained people in eg the dashboard

11.2.3 *Improvement and further improvement in outcomes*

Implementation, continuation and further development are all aimed towards improvement or transformation that will lead to specific outcomes. Over time, the following improvements in Trusts might be attributable, at least in part, to the Fellowships: improvements in service delivery; quality improvement, safety improvement and clinical governance outcomes; further increases in leadership capacity; and further culture change. For these outcomes, it may take longer to see some of the results, particularly those in the area of culture change.

Table 17:   Examples of expected improvement in outcomes

Quality improvement/safety improvement/clinical governance outcomes
Improved patient outcomes and financial benefits
Further reduction in both stroke mortality and morbidity through changes in the delivery of acute stroke thrombolysis treatments
Service delivery improvement
Improved services as a result of use of information from regular surveys of patients
Improvement in communication at nursing handover and in cases of acute patient deterioration
Increased COPD prevalence resulting in improved patient care, QOF income etc
Leadership capacity outcomes
Increased numbers of SpRs and others involved in clinical leadership projects and training
Culture change
An open, fair patient safety culture where clinicians are more accepting of the fact they cause harm and want to engage in the process of reducing it: "valuing each other and using that as a basis for ideas . . . and learning together" (Fellow)
Overall exposure to change management projects encouraging a different attitude and influencing how senior clinicians see their role in relation to joint accountability for organisational aims and objectives
Increased . . .interest amongst clinicians of management training and the development of clinical leadership programmes
Managers who have better insight into the working life of clinicians and are more perceptive and accepting of clinical engagement
The 'voice' of junior staff across the organisation being used as an engine for change/ innovation
Trainees expecting leadership development as part of their medical training
Trainees expecting to be involved in major service change and improvement projects in Trusts

11.3   Tracking system change – a culture that respects, promotes and develops clinical leadership

Over time, it is hoped that 'critical mass' will be achieved in terms of the development of clinical leadership knowledge, understanding, skills and beliefs and expectations throughout the system that quality improvement/safety improvement is part of the clinician's role and that clinicians and managers need to collaborate to improve the system. A Fellowship available to a small number of junior doctors is not, of course, likely to achieve this on its own. With other related initiatives, indicators can be developed to track the development of critical mass. Some indicators follow; there will be others:

- More people knowing about it: "It takes quite a while. Slowly the astonishment will diminish". (MD)
- More registrars showing an interest in clinical leadership
- More Trusts wanting to set up clinical leadership Fellowships or similar, even when funding is limited or unavailable
- A more inclusive approach to leadership development that is multi-professional

11.4   Timelines

Some changes that NHS London is hoping to see may not be visible for a number of years – "At the end of the year, you can't show this finished project that they are looking for" (Fellow); "You're trying to transform a process of care; it's not about implementing a thing" (MD). Several interviewees felt that follow up evaluation in one year would be adequate time to see further progress, especially in relation to individual Fellows:

> I had a very valuable experience and it made a long term impact on me but it's difficult to say there will be full impact [of our work]. (Fellow)

In the first instance, we would ideally recommend following up after one year, three years and five years and have ideas about methods that might be used to track further impact and sustainability.

12   CONCLUSION: A MODEL FOR A CLINICAL LEADERSHIP PROGRAMME DESIGN ORIENTED TOWARDS IMPACT AND SUSTAINABILITY

In this evaluation, we were asked to consider the NHS London 'Darzi' Fellowships in Clinical Leadership Programme in terms of its impact on Fellows, participating Trusts and other stakeholders. In answering this question and the subsidiary evaluation questions, we have identified a range of impacts and pinpointed a number of factors that appear to be related to the extent of impact. We have articulated what we view as some key successes of the Fellowships Programme and highlighted some issues. Based on these, and further input from Fellows, MDs and other stakeholder, we have come up with recommendations for future iterations of this Fellowships Programme, as well as offering some lessons from the Fellowships Programme for clinical leadership development more generally. Finally, we have made suggestions about tracking the impact of this Fellowship and its sustainability of time – something we believe that it is important to do in order to understand impact more fully.

Considering the findings of this evaluation leads us to propose a model (see Figure 3) of the principles required in successful programme design for clinical leadership development programmes of this nature that contain both work-based and supporting learning programme elements and the short- and longer term impact and sustainability that is likely to ensure.

Figure 3:   *A model of successful programme design, impact and sustainability for clinical leadership development that combines workplace and external learning*
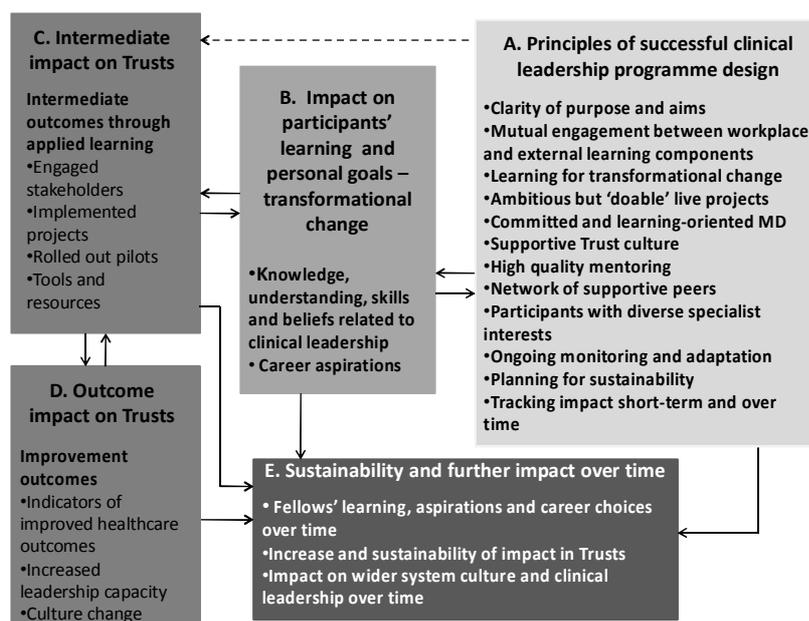
The logic of the model works from right to left (boxes A to E), but the visual representation is intentionally counterintuitive. The eye starts at the left side of the page, thereby seeing impact first: 'starting with the end in mind'.[52]

The model works as follows. Box A contains principles of successful clinical leadership programme design derived from this evaluation research. These principles relate to a clinical leadership programme containing both workplace and external learning elements. Sources for these principles are expanded in earlier sections of the report:

- Clarity of purpose and aims (sections 6.1.2, 8.1 and 9.1.1)

- Mutual engagement between workplace and external learning components (sections 6.6, 8.2, 9.1.3, 9.1.4, 9.2.2 and 9.2.3)
- Learning for transformational change (sections 6.5, 9.2.1 and 9.2.2)
- Ambitious but 'doable' live projects (sections 6.3 and 9.3.3)
- Committed and learning-oriented MD (sections 6.1, 9.2.3)
- Supportive Trust culture (sections 6.2, 8.3, 9.3.1 and 9.3.4)
- High quality mentoring (sections 6.4, 8.4, 9.1.2, 9.3.2)
- Network of supportive peers (sections 6.7, 7.4, 10.4 and 9.1.7)
- Participants with diverse specialist interests (sections 9.1.6, 9.1.8 and 10.5)
- Ongoing monitoring and adaptation (sections 6.8, 9.1.4
- Planning for sustainability (sections 8.5, 9.1.7
- Tracking impact short-term and over time

Anticipated consequences of a programme based on these principles would be a certain amount of impact by the end of the programme at three levels. Sources for potential impact indicators can be found in earlier sections of the report. The three levels of impact are:

- Impact on individual participants in the programme – Box B (sections 5.1 and 7.1)
- Intermediate outcomes for the Trust in which participants were located as participants are designing and implementing projects and processes – Box C (sections 5.2.1 and 7.5)
- Improvement outcomes from the Trust projects in terms of quantitative indicators, increased leadership capacity and the beginnings of culture change – Box D (sections 5.2.2, 7.2 and 7.3).

Two-way arrows between Boxes A and B highlight that ongoing programme monitoring (Box A), including its impact on participants (Box B) would lead to further adaptations (Box A). Two-way arrows between Boxes B and C denote that, through their own learning (Box B), participants have an impact on Trust projects that they lead or support (Box C). Engaging in these projects also has further impact on their learning.

The broken arrow from Box A to Box C suggests that because of mutual engagement and support from Trusts, some impact through projects is attributable to efforts of other stakeholders in Trusts. Two-way arrows between Boxes C and D denote that project work (Box C) has an impact on improvement outcomes (Box D) but achieving these outcomes further energises participants and stakeholders, also giving them ideas for refinement of projects (Box C).

Longer-term impact and sustainability of programme effects is shown in Box E. This focuses on three levels of impact. Sources for potential indicators are in earlier sections of this report. The levels are:

- Sustained impact on Fellows, their learning and their career choices over time (section 11.1)
- Increase and sustainability of impact on intermediate and improvement outcomes in Trusts (section 11.2)
- Impact on the wider system over time in terms of the development of clinical leadership and the culture change to support this (sections 5.3 and 11.3)

Arrows from all of these boxes are directed towards Box E. Programme designers have developed plans for sustainability and are tracking impact over time (Box A), and the nature and extent of earlier impact for individual participants (Box B), of project implementation and successful development of processes (Box B) and of improvement outcomes (Box C) affects what might be sustained over time (Box E).

The model needs testing but may provide a starting point for those interested in designing programmes similar to this Fellowship Programme. Findings of this evaluation suggest that there is much of value that can be learnt about clinical leadership development from the NHS London 'Darzi' Fellowships in Clinical Leadership Programme.

Annex 1

Impact Evaluation Framework
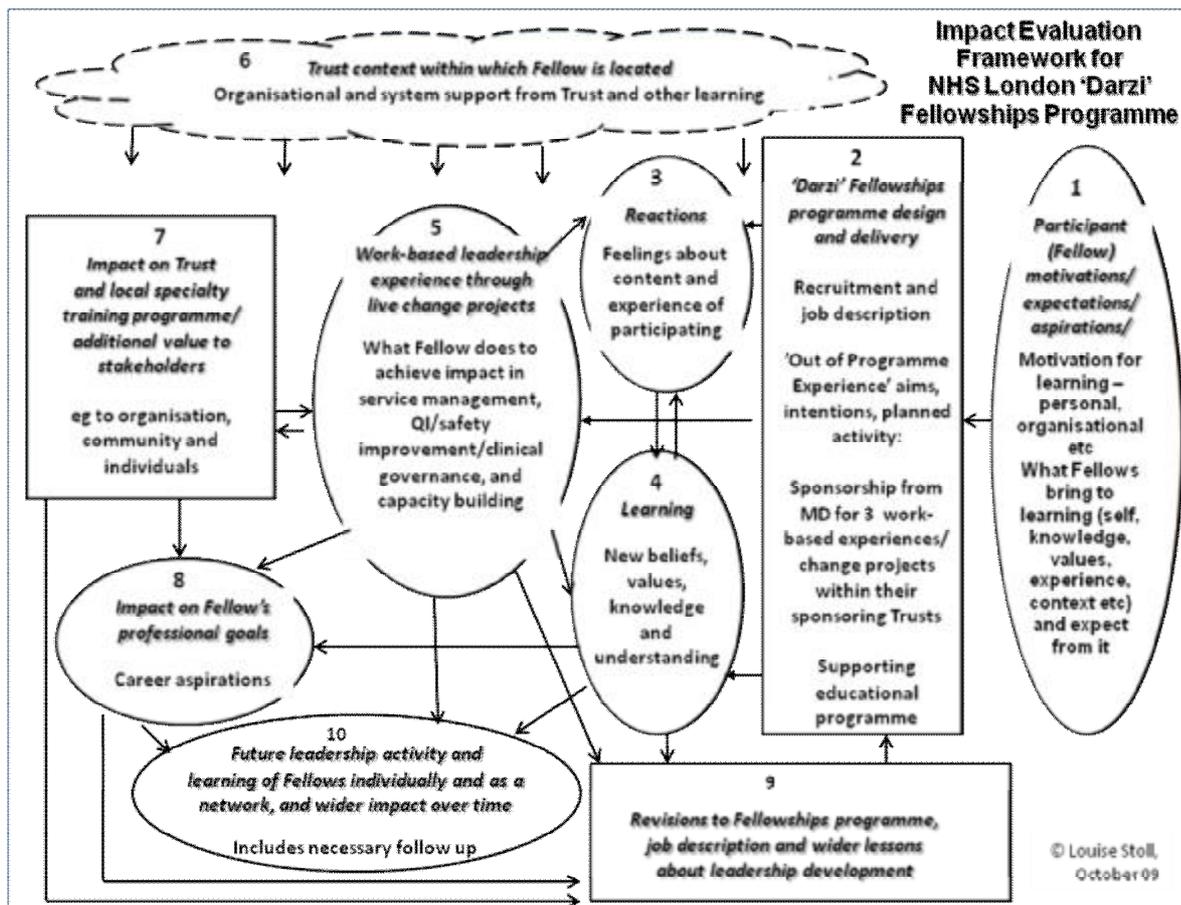
The impact evaluation framework represents a theory of change[53] of how the NHS London "Darzi" Fellowship programme is intended to work, with arrows representing one-or two-way direction of movement and/or impact. The desired impact outcomes (*the primary research question*) are towards the left hand side and the starting point is on the right where baseline evaluation activity usually occurs. This may appear counterintuitive but the intention is to focus attention on 'starting with the end in mind'.[54]

Looking at the beginning of the process, and reading from right to left, the individual Fellows enter the programme with their own motivations, aspirations and expectations (1). They also bring to their learning their background eg previous experiences etc. In this evaluation, information collected was retrospective [*Subsidiary questions no. 1 and 5*].

Fellows enter the Programme (2) through recruitment processes and mechanisms for engaging sponsoring Trusts. Here the focus moves to the Programme's intentions, design and delivery [*Subsidiary questions no. 2 and 8*].

The programme is geared towards impact on Fellows and, through them, impact on their Trusts and stakeholders. Through engaging with the programme, Fellows may experience different levels of impact: reactions (3) to the learning experience and learning they derive from it (4) [*Subsidiary questions no. 1 and 5*]. Another level of impact is when Fellows are engaged in work experience, carrying out live change projects – 'learning as doing' and applying learning from taught modules (5) [*Subsidiary questions nos. 4 and 8*]. This will be affected by contextual conditions and organisational support within sponsoring Trusts that help or hinder Fellows from achieving their Fellowship goals (6) [*Subsidiary question no. 8*].

The next levels of impact are the wider impact of the Fellowship – the extent to which Fellows impact and bring additional value to, their Trust and local specialty programme (7) [*Subsidiary question no. 6*] – and Fellows' own future career aspirations (8) [*Subsidiary question no. 7*].

Knowledge gained from all of these aspects will help to inform future iterations of the Fellowship programme, revisions to job description and person specification for the Fellows and, the potential of embedding leadership development across all training programmes [*Subsidiary questions no. 9, 10 and 11*). Thinking ahead, one would also anticipate that Fellows will continue to use their Fellowship learning experiences to achieve further impact over time, both individually and as a network [*Subsidiary question no.12*].

Annex 2

Methodology

The methodology for the evaluation of the NHS London "Darzi" Fellowships Programme comprised the following elements:

Review of literature – focused on change management, service improvement and capacity building and leadership development, including fellowship models.

Review of background documents – focused on the Programme's establishment, supporting learning programme and practical information about the Programme

Review of data collected prior to the start of the evaluation – including Fellows' perceptions of modules and learning support elements, and a mid-term review consisting of surveys of Fellows (20 responses) and MDs (9 responses) and feedback from the CIHM, the learning support programme provider

Semi-structured face-to-face interviews with the Programme's originators and administrator – focusing on aims, development and expectations (5 interviews)

Semi-structured telephone interviews with the designers of the supporting learning programme and one coach – focusing on aims, development and facilitation of the supporting leadership development programme (3 interviews)

Observation of one supporting module session – to see the learning programme in action

Online questionnaire for Fellows – focused on learning outcomes and perceived impact of different aspects of the Programme (30 of 39 responded = 77%)

Semi structures telephone interviews with a sample of Fellows – focusing on expectations, experience and perceptions of support, challenge and impact. The sample was originally selected to be representative, but amended on the basis of agreement to participate when requested through the questionnaire process (13 interviews)

Semi structured telephone interviews with a representative sample of MDs – focusing on expectations, experience and perceptions of support, challenge and impact (7 interviews)

Online questionnaire for key stakeholders – focusing on perceived impact. The sample was selected by asking Fellows, as part of the questionnaire survey, to identify three stakeholders each (14 of 36 responded = 39%)

Case studies of four individual Fellows – focusing on their expectations, experience, support, challenges and impact. These consisted of semi-structured face-to-face (where possible)

interviews of the Fellow, their MD, the mentor (if different), head of leadership development in the Trust (if available), and up to three stakeholders of the Fellow's choice. The sample was representative, including Fellows from four different types of Trusts: Primary Care Trusts, Mental Health Trusts, Foundation Hospital Trust and Specialist Training Hospital Trust. Other criteria that were taken into account in sampling included: gender, ethnicity, learning support programme cohort and Trust's involvement in the second cohort of 'Darzi' Fellowships (4 Fellows, 4 MDs, 1 mentor, 1 head of leadership development, 9 stakeholders = 19 interviews)

Observation of the Fellows' final poster session – to hear about Fellows' perspectives on impact of their live projects

Annex 3

Case studies

The following pages contain short stories of the experiences of four of the Fellows.

Ed Burns – Camden and Islington Foundation Trust

The Fellow
Ed Burns, a psychiatric registrar trainee with prior experience in other specialities, was in his last clinical post at Camden & Islington Foundation Trust when the opportunity came up to apply for a 'Darzi' Fellowship. Having a better understanding of NHS structures and leadership and management for his future career appealed to him as did working on Trust projects for a year and "leaving something behind that's useful and helpful for clinicians and my colleagues".

Why the Trust wanted a Fellowship
Camden & Islington's MD, Dr Sylvia Tang, was very enthusiastic about having a 'Darzi' Fellow. She thought the Fellowship was a great opportunity to change the system by giving young leaders a head start in dealing with complex issues of leadership, management and governance. As someone who enjoys training, it would also enable her to mentor someone on projects that were part of her own objectives: "My commitment to him and his commitment to the programme was core to the Trust's business". The Trust's lead on human resources and organisational development saw great benefits in the programme's potential to increase the impact of medical leadership on a Trust's goals and enabling trainees to see what goes on in the health service beyond their own specialities.

The Projects
Ed was involved in three main projects.

- *Change across boundaries* – this centred around GP satisfaction with services. Ed worked with the project's manager, focusing specifically on assessment pilots trying to improve the speed of time with which people are seen by mental health teams. The pilot involved four mental health teams trialling different ways of working to improve how they met GPs' targets.
- *Outcome measures* – Ed reviewed methods for electronically gathering information about patient satisfaction (PETs) and co-designed and piloted a questionnaire. He also explored the range of clinical outcome measures, organised a pilot of three different measures, and developed a training package and standard operating procedures for clinicians across the Trust to help them use the Health of the Nation Outcomes Scales (HoNOS).
- *Clinical Leadership Programme for Higher Trainees* (CLP) – Ed set up a "local mini 'Darzi'", to involve other trainees in working on different projects, "designed to be mutually beneficial to the Trust and the registrar". Attending meetings with his MD, he noted issues that needed addressing, turning these into a list of possible projects. Twelve of the Trust's 24 ST4-6s opted in, each choosing a project and receiving individual and group supervision from the MD. Incorporating many features from the 'Darzi' learning support programme and drawing on its ideas, he arranged a training day with senior Trust leaders, "people you don't usually meet", and the STs received project management guidance. Ed was awarded a small amount of funding from the London Deanery for a 'Dragon's Den' proposal for ideas to build leadership capacity. Using this grant, he secured a short course from Middlesex University with accreditation towards a Post Graduate Certificate. A CLP ST helped devise the patient satisfaction questionnaire for another Fellowship project.

Support for the Fellow
The Trust's culture is viewed by senior staff as friendly, welcoming of initiatives, keen to try pilots and committed to carrying out and using research. Team working is also emphasised. The MD ensured that Ed was well supported, with access to people, information and resources. He was intentionally located in the clinical governance team's office – with other supportive colleagues working on similar agendas – "so he could passively absorb what else goes on in the Trust", enabling him to pick up skills from the team members. The Assistant Director of Governance and Assurance, whose office was next door, was available for him to consult informally and regularly, keeping herself informed about his work and progress. He also worked closely with and was

supported by a Borough Director and Assistant Directors managing local mental health teams, and the project manager of the change across boundaries initiative.

The MD, herself, was his main mentor. The relationship was greatly appreciated by both mentor and mentee. As well as the regular list of tasks and troubleshooting occasional problems, mentoring was geared towards allowing Ed space to ask questions, further discuss ideas in the leadership support programme and develop his understanding of the big picture of clinical leadership within the NHS.

In addition to learning and support gained from colleagues across the Trust, Ed participated in the Fellowship's supporting learning programme, which stimulated "a mind shift in thinking about 'clinician versus manager' in the NHS". Learning with and from Fellows in his action learning set who came from completely different disciplines – two from mental health trusts, a GP, an endocrinologist and a surgeon – was a highlight: "We don't mix normally". Networking built into the Fellowship experience also helped develop a bond between the nine participating mental health trust Fellows and was an excellent way of sharing ideas.

Experience and personal impact of being a Fellow
Ed's previous work in the Trust in his most recent registrar position meant that he knew a number of people which was helpful, although he had to weather early mixed reactions to his changed role. Like all Fellows and new leaders, he also had to get used to being perceived as a leader by people who hadn't known him previously. He came up against inevitable challenges faced by all leaders of change, finding the new way of working extremely demanding at times. His conclusion, though, was that he'd learnt a tremendous amount, that the Fellowship's impact on him had been huge, and that if he had his time over, he'd do it again.

Impact of the Fellowship on the Trust
It's hard to judge in advance what might be achieved in one year. Some of the project work involved pilots and was "embryonic" and all of it was very much ongoing, but it was widely agreed that it had been given an excellent start. Stakeholders felt that overall organisation impact was significant at all levels, with "tangible outcomes" in the boroughs.

Referring to the impact of the pilot project capturing service user satisfaction, one senior leader described the success of the business case as "marvellous" while another explained how the new patient tracker methodology would be used immediately on wards and with the care team: "it will be a great improvement, allowing us to gather better information in a more timely way and act on it quickly". The Trust's presentation day of CLP projects went down very well with the directors and consultants who attended, and the head of Human Resources and Organisational Development described her pleasure in seeing "junior staff blossoming and seeing their skills grow", endorsed by a CLP registrar who found that:"it put into context the bigger drivers as to why we provide the service we do in the way that we do . . . It has changed my way of practising. It's really good training for being consultants". The MD was also confident that the Trust would reap benefits of further impact over time.

The future
Ed's view of clinical leadership was already changing before he began the Fellowship, although the experience changed his views of the NHS, making him much more passionate about his role in improving it. He is returning to his final year of training and is likely to seek a consultant's post for a number of years, but imagines that there will be management opportunities within this.

While inevitably "more modest" than the 'Darzi' Fellowship, the Trust's local mini fellowship programme has had such a positive impact that the Trust is repeating it next year, with Ed's support one day a week, broadening it to include trainees from other professions and building in accreditation possibilities. Eighteen clinicians have already signed up. Senior colleagues anticipated this with enthusiasm but also awareness of their own roles in ensuring success: "there's enough activity to keep a team going for the next five years, so the important thing is to choose appropriate projects, considering the skills of the individual, with appropriate targets".

<div align="center">

Günen Ucyigit

Bexley Primary Care Trust

</div>

The Fellow

Günen started in 2008 as a GP graduate in Bexley Primary Care Trust, and wanted to integrate management with clinical work for the Graduate GP Scheme. The Fellowship seemed like a great opportunity to continue with both management and clinical work. She also felt that the Fellowship would help inform her to be more active in her community. After a successful interview presentation within the Trust she joined the Fellowship Programme.

Why the Trust wanted a Fellowship

Gunen is one of five Fellows at Bexley PCT. For the last three years, Bexley's Medical Director, Dr Jo Medhurst, had been running a clinical leadership and management development programme for junior doctors, The Graduate GP Scheme. She saw the Fellowship as providing further opportunity for young doctors to experience a quick learning curve: "I think it has condensed everything I have learnt in change management over 10 years as a medical manager". The operational emphasis instead of just theoretical training was particularly appealing: "It's more focused about what you do, not what you can say". Günen and the other Fellows joined both the Fellowship and Bexley's Scheme and became involved in supporting Jo Medhurst's projects.

The Projects

Günen was involved in three main projects.

- Building polysystems – Günen worked with residents, managers, healthcare professionals, and health partners. Presenting to patient forums, GPs, secondary care directors and practice managers, and health Partnership Board, she also communicated with GPs in the community, patients, health partners, the third sector, and wrote the primary care infrastructure strategy and polyclinic strategy for the upcoming five years. She established a poly systems team that met monthly, engaged with all the GPs in the borough, with one locality meeting each week, set up a lead meeting to create the right expertise for innovation, and communicated to other health partners about poly systems. She also carried out other projects within polysystems, such as a patient experience project, a locality project (to drive systems forward), and a backfilling scheme. She was supported in this work by one other Fellows in the Trust.
- Educational project – Günen has helped to secure funding for an online tool to improve communication, beginning to establish a software system to hold information and share it in one central place. The tool includes guidelines and information on where to refer to for a particular ailment, as well as a forum for questions.
- Leadership development - Plans are place to hold a workshop in the Trust about improving collaborative work between clinicians and managers work with managers, a focus in the Trust.

Support for the Fellow

Jo Medhurst provided mentorship for all of the Fellows in the Trust. Her approach was to lead by example as well as "sense checking, reflecting things, mirror them back, and encouraging them when they are stressed and down and frazzled. She also challenged the Fellows. The relationship was informal and supportive. Günen also received help within the Trust from senior leaders and benefitted from the Bexley-based 'Darzi' Fellow peer group who provided emotional support and generated ideas for best steps to take: "we feel we can discuss things together". In the Fellowship's learning support programme, she appreciated the one-to-one coaching where she received feedback to reflect on. She also found learning sets helpful for discussing problems with her projects: "colleagues from different specialties can help create solutions".

Experience and personal impact of being a Fellow

Some of Günen's main learnings from the Fellowship were the importance of sharing knowledge, staying loyal to a network of care even when there has been negative feedback about polyclinics and perceptions that she was 'going over to the dark side', and prioritising other people's

involvement: "If people are involved from the beginning the project will be more sustainable". She has gained more confidence in approaching others and taking a systems perspective on projects, "everyone is an expert in their own right". Günen felt she has gained a lot from her experience: The Fellowship has "given us a stepping stone as effective leaders for the future, a richer systems view. There are different ways of leading and the Fellowship has enabled us to create the right conditions to initiate change in the Trust and enable better engagement between hierarchies".

Impact of the Fellowship on the Trust
Günen worked on encompassing three Polystems in Bexley. She became a member of the Clinical Cabinet, co-chaired Polysystem Lead meetings, and became Locality Lead and Communications Lead for the Clinical Redesign Directorate. In the words of the project manager of the polysystems project, which had a chequered history over 15 months before she became involved, Günen had "taken real responsibility" and that they were now moving towards implementing strategic plans. She had taken part in redesign, given various presentations about what polyclinics are, as they became polysystems. She was able to manage stakeholders' expectations. One stakeholder noted: "She is about communication. If you have a good doctor talking about it, it's better than having a manager who is not a doctor". Jo Medhurst noted Günen's growth and development change over the Fellowship period: "I watched her coping and coping and then managing and now she does all the face-to-face meetings with the public and she's a great young person to lead". Stakeholders described her strengths in showing empathy and being a very good team player which enabled her to negotiate the challenges of this project.

The future
Bexley Trust will carry on the projects that Günen and the other Fellows have started. The leadership development will continue to be a main focus within the Trust, perhaps also extending to nurses. Günen and others have set up a study group session to carry on the professional development amongst the doctors which might feed into incoming junior doctors in the Trust.

Noshaba Khiljee
Epsom & St. Helier NHS Trust

The Fellow
Noshaba Khiljee was on maternity leave and had completed a year as a renal registrar before starting as a 'Darzi' Fellow. The Fellowship seemed to her a great opportunity to take part in understanding the NHS system and interact more with management level work. She saw the experience as a chance to bridge the gap between clinical work and management.

Why the Trust wanted a Fellowship
Epsom & St. Helier NHS Trust and its Medial Director Dr Jonathan Kwan were keen to have a Fellow to support their ongoing projects. Dr Kwan saw it as: "a duty to train the new generation of medical managers . . . . If you get them early they may learn faster and come out as future medical leaders who have insight and understanding enough to hit the ground running to get to medical management positions".

The Projects
Over time, Noshaba became involved in three main projects:

- *Urgent Care Centre (UCC)* – in this project, Noshaba provided input into the South West Sector re-design of the unscheduled care pathways group, developing a co-terminus with extended GP hours to provide an alternative to the existing A&E. Through this work, she also became involved in the redesign of the unscheduled care pathway group in the South West Sector, an initiative that is bringing together representatives from the four acute hospitals and local GPs.
- *Patient Reported Outcome Measures (PROMs)* – here, Noshaba helped establish a robust response rate proforma to comply with the national response rate. She sat in out-patient settings to get better insight about the issues and found out what the stumbling blocks were.
- Leadership capacity of Specialty and Associate Specialist Grade (SASG) doctors. Working with an audit team in the Trust, a questionnaire was designed to identify SASG doctors' needs in developing their management and leadership roles in the Trust. Noshaba also secured some funding from within the Trust to take forward the outcomes of the questionnaire.

Support for the Fellow
As Noshaba's mentor; the MD provided Noshaba with many opportunities to observe him in action, as well as meeting once or twice a week in the first six months, regular email contact and a willingness to explain anything. The clinical pathway group also invited her to join their meetings, and she received support from an MD leading the South West Sector initiative. Other support from the Trust included a mobile phone, internet access and shared desk space with two secretaries.

Noshaba found coaching extremely beneficial, describing her coach as "a driving force" in supporting her. She enjoyed networking with other Fellows, especially learning from them in design surgeries. Overall, she felt she was able to access support she needed when she wanted it and was given the autonomy and trust she needed to carry out her work.

Experience and personal impact of being a Fellow
Noshaba's Fellowship experience included access to committees and the Executive Director, as well as meetings closed to others. In addition, she was invited to attend strategic discussions to which she wouldn't otherwise have been exposed. Being an invited speaker at a clinical summit meeting with over 60 senior delegates was another feature of her experience.

The year wasn't without its challenges. Noshaba was "exposed to politics in the raw", and found that she had to negotiate her role among different stakeholders in one of her projects. Deadlines for assignments were, at times, fast and furious. She also realised that sometimes it can take a long time to get things going. This and other experiences, however, increased her self-confidence. At the end of her year, she concluded that the Fellowship Programme had exceeded her expectations and had "sowed seeds that make us think in different ways. It has opened my eyes".

Impact of the Fellowship on the Trust

Although it is difficult to assess the long term impact of the Fellowship, over the year the Trust had a better response with the PROMS questionnaires and financial rewards, and the profile of leadership qualities for associate specialists had been raised. The directorate of inpatients and out-patients appreciated having someone that brought a neutral perspective to the project, a senior leader in this directorate viewing Noshaba as "very good in assisting areas of improvement to capture the PROM data" and "instrumental" in moving the PROMS project along. Described by one stakeholder as "fantastic", she had been a fresh pair of eyes who also encouraged others to be open to wider changes.

The future

The Trust has another Fellow next year. The work she was involved in will carry on. Noshaba's view of clinical leadership has been influenced by the hands-on experience of the Fellowship and she plans to make sure that her skills are retained.

Julian de Silva

Moorfields Eye Hospital Foundation Trust

The Fellow
Julian de Silva was already at Moorfields when he heard about the Fellowship Programme. He saw it as an opportunity to enhance his career, by learning leadership and management skills and felt it was important to experience real leadership first hand, with financial resources and support. Having carried out many audits before, he had seen opportunities to change things, and his interest in improving systems was further motivation to undertake the Fellowship: "It is clear that certain clinicians are engaging with managers to take things forward. I wanted to put myself forwards and take those steps. We need clinicians to make 'correct' decisions in management". He also spotted an opportunity to meet senior people and network with medical directors, other consultants, training directors, and others who he might not otherwise have met at his stage of career.

Why the Trust wanted a Fellowship
The Trust and its Medial Director, Declan Flanagan, were very positive about registrars having access to management training and hands-on experience of project development. The MD reflected on his own experience: "I have done an awful lot myself over 25 years. I learned as I went along. I could have gone faster and done more with such a programme". As there were many areas to develop, the Trust was interested in being able to delegate tasks to good people. A consultant ophthalmic surgeon also saw it as critical to "get some more leadership and management training into trainees before they become consultants". With little training available, when they become consultants, they have to deal with all the issues and "it becomes a shock, an unpleasant and steep learning curve". She was clear about the importance of getting experience well beforehand and embedding this in training. The aims were to give registrars exposure on how hospitals are run and how healthcare is provided in the current health economy.

The Projects
Julian became involved in a number of projects. These are three examples:

1. *Developing a community clinic in Watford* – The aim was to improve the efficiency, effectiveness and safety of the general retina and medical service in the locality by bringing together and supporting collaborative working between staff from the GP consortium, who offered information on what was needed; Boots who provided the premises, technical staff, and optometrists and Moorfields, whose contribution was to co-ordinate the project and provide specialist input and training. Julian's role was to work closely with a senior Moorfields colleague and partners within the GP consortium and Boots to design and set up this new form of clinic: "Developing community clinics is a priority for the Trust as we want to make things easier for patients, part of what 'Darzi' wanted. These are the first of their kind for ophthalmology".

2. *Leadership and Management Training for Ophthalmic Trainees* – Seed funding for this project was allocated via a competitive bidding process known as the 'Darzi' Den. The timelines for proposals and delivery were tight and success in the biding process required Julian to work closely with his project partner, another 'Darzi' Fellow based in the Trust and to access support of the Medical Director and a number of enthusiastic and committed senior colleagues. Prior to delivering the programme, Julian evaluated current levels of management and leadership training and experience of trainees. Evaluation was undertaken in five areas: NHS structure, clinical governance, financial planning, people management and service development. Results highlighted inadequate exposure for management and leadership and a management training programme was created using workshop teaching sessions and practical involvement in trust management projects. An important aspect of this programme was that it was multi disciplinary and Julian found relying on, trusting, supporting and then sharing success with his multidisciplinary colleagues to be a vital part of this training programme.

3. *Development of advance practice roles for nurse practitioners* – This enabled patients to be seen quicker, not having to wait. Working with a nursing colleague, Julian's key role was in identifying how practice could be changed and in teaching over a 6-7 month period. This project services the priorities of the Trust in terms of improving patient experience, improving patient flow and has the potential to be rolled out into the community. Julian's nursing colleague stated: "We have already identified recommendations and are starting to work out how we can improve discharge planning. It is really good to have multi disciplinary support. Julian thinks of things and I think of things; we bounce ideas off each other. We are generating the way to get best care for the patients".

Support for the Fellow

Julian benefitted from having two senior colleagues offering mentor support, the Medical Director and a consultant with whom Julian has had some involvement around service development.

The Medical Director saw his role as providing supervision, guidance and support – encouraging Julian to grow in confidence and deal with a range of practical aspects from leading within the complexities of organisational politics to time management and prioritisation. Julian's consultant colleague believed in the need for Fellows to be able to access a range of people for their support and that mentoring should focus not only on the Fellow's projects, but on their longer term development. Helping Fellows make a positive contribution to the Trust and to future leadership development was also of key importance.

Further support, mainly brokered through the Medical Director, was provided by a range of high level organisational players including the Chief Executive, Chairman, Finance and other Directors, IT and project managers, who not only provided valuable information but also helped Julian navigate through the workings of the organisation and provided crucial 'backing' for action needing to be taken in order for project work to proceed.

Experience and personal impact of being a Fellow
Project work taught Julian the challenges of bringing everyone on board and of getting decisions made and followed through. Julian thought he gained experience in managing conflict, diffusing tensions between stakeholders, learning to say 'no' to work and managing his time to what he can deliver. This programme has changed his views of leadership and management: "It is a challenging role, conflict is certain, you learn how to manage people, manage yourself, you learn to keep personal emotions out of decision making process. I learned how long it takes to do management – you can invest a lot of time into an objective that is relatively short lived."

Impact of the Fellowship on the Trust
Julian was delighted with early outcome data from the leadership development programme he designed from scratch. He hoped this will have recognisable long term impact on the Trust. This management training programme was stimulated by the Dragons Den process, and stakeholders viewed it as a great success. The management training scheme is now incorporated into doctors' formal training. The MD noted that: "The feedback is that this is much better than other standard management courses . . . The challenge will be maintaining it, and keeping up the quality of input".

Julian felt that his biggest impact was on developing the Watford service: "It took a lot to get it going. I was given a lot of autonomy". Both mentors agreed that this was a particularly valuable achievement, which, if successful during the pilot period has the potential to be rolled out across London.

The future
Julian's career aspirations have not changed. He wants to be consultant in a London teaching hospital but now feels he is far better placed to lead change processes than he was six months ago.

Annex 4

Fellows' Survey Responses on the 2 Most Valued Aspects of the Fellowship

Respondent	Valued aspect 1	Valued aspect 2
1.	Networking	Support modules
2.	Networking	Coaching
3.	Mentoring	Networking
4.	Mentoring	Live projects
5.	Mentoring	Networking
6.	Mentoring	Networking
7.	Mentoring	Access to significant health sector leaders
8.	Mentoring	Networking
9.	Mentoring	Action learning sets
10.	Networking	Coaching
11.	Networking	Live projects
12.	Networking	Live projects
13.	Networking	Live projects
14.	Mentoring	Support modules
15.	Mentoring	Live projects
16.	Mentoring	Design surgeries
17.	Networking	Live projects
18.	Networking	Accreditation – PGCert
19.	Networking	Live projects
20.	Action learning sets	Accreditation – PGCert
21.	Coaching	Accreditation – PGCert
22.	Networking	Action learning sets
23.	Networking	Live projects
24.	Mentoring	Networking
25.	Networking	Live projects
26.	Live projects	Support modules
27.	Networking	Live projects
28.	Action learning sets	Design surgeries
29.	Communities of Practice	Design surgeries
30.	Live projects	Communities of Practice

REFERENCES

[1] Department of Health (2008) *High Quality Care for All: NHS Next Stage Review Final Report [The 'Darzi' Report].* Norwich: The Stationery Office.

[2] Connell, J. P. and Kubisch, J. C. (1998) Applying a theory of change approach to the evaluation of comprehensive community initiatives, in K. Anderson et al (Eds) *New Approaches to Evaluating Community Initiatives*, Volume 2. Washington, DC: The Aspen Institute.

[3] Ham, C. and Dickenson, H. (2008) Engaging Doctors in Leadership: what can we learn from international experience and research evidence? Coventry: NHSII, AMRC and the University of Birmingham.

[4] Kotter, J. P. (1996) *Leading Change*. Boston, Mass.: Harvard Business School Press; Heifetz, R. A. and Linsky, M. (2002) *Leadership on the Line: Staying Alive Through the Dangers of Leading*. Boston, Mass.: Harvard Business School Press.

[5] Mountford, J. and Webb, C. (2009) When clinicians lead, *The McKinsey Quarterly*, February, 108.

[6] Department of Health (2008) *High Quality Care for All: NHS Next Stage Review Final Report [The 'Darzi' Report].* Norwich: The Stationery Office.

[7] NHS Confederation (2009) *Future of Leadership*, Paper 1 March. London: NHS Confederation.

[8] Ham, C. and Dickenson, H. (2008) op cit.

[9] NHS Confederation (2009) op cit

[10] Ham, C. and Dickenson, H. (2008) op cit

[11] Ham, C. and Dickinson (2007) *The Challenges of Leadership Development in the NHS*. London. NHS Confederation; Gill, R. (2001) *Can you Teach Leadership?* Paper for presentation to the Best Conference. Business, Management and Accountancy Education: April.

[12] Riggio, R. E. and Smith Orr, S. (2004) *Improving Leadership in Nonprofit Organizations*. San Francisco: Jossey-Bass.

[13] Gill, R (2001) op cit

[14] Anderson, L., Malby, B., Mervyn, K. and Thorpe, R. (2009) *The Health Foundation's Position Statement on Effective Leadership Development, Research Report*. September. Health Foundation and CIHM.

[15] The NHS Confederation (2007) op cit.

[16] NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges (2009). *Medical Leadership Competency Framework 2nd edition*. Retrieved from www.institute.nhs.uk/medicalleadership

[17] Bolden, R (2010) Leadership, management and organisational development in: Gold, J., Thorpe, R. and Mumford, A. (eds) *Gower Handbook of Leadership and Management Development*, Farnham. Gower.

[18] Willcocks, S. (2005) Doctors and leadership in the UK National Health Service, *Clinician in Management.* 13:11-21

[19] Black, G. and MacDonald, L. (2000) Practice-based learning: an alternative approach to continuing medical education in primary care, *Education for General Practice,* 11: 397-404; Kennard, J. (2002) Illuminating the relationship between shared learning and the workplace, *Medical Teacher,* 24 (4): 379-384.

[20] http://www.health.org.uk/current_work/leadership_schemes/qifs.html; http://www.ihi.org/IHI/Programs/ProfessionalDevelopment/FellowshipPrograms.htm

[21] http://www.nhmrc.gov.au/nics/programs/leadership/index.htm#fel

[22] eg http://www.health.org.uk/current_work/leadership_schemes/harknesshealth.html

[23] eg see reference 21

[24] Hartley, J and Hinksman, B (2003) *Leadership Development: A Systematic Review of the Literature: A Report for the NHS Leadership Centre*. Coventry: Warwick Institute of Governance and Public Management; Gill, R (2001) op cit; Willcocks, S. (2005) op cit; Bolden, R. (2010) op cit.

[25] Hartley, J and Hinksman, B (2003) op cit.

[26] Henochowicz, S and Hetherington D (2006) Leadership coaching in health care, *Leadership and Organisation Development Journal*, 27 (3): 183-189; Hartley, J and Hinksman, B (2003) op cit.

[27] Gill, R (2001) op cit; Humphries, D., Connell, C and Meyer, E (2004) *Leadership Evaluation: an impact evaluation of a leadership programme*. Project report University of Southampton.

[28] Humphries, D., Connell, C. and Meyer, E. (2004) op cit.

[29] NHS Confederation (2009) *Future of Leadership*, Paper 1 March. London: NHS Confederation.

[30] McAlearney A. S. (2008) Using leadership programs to improve quality and efficiency in healthcare, *Journal of Healthcare Management*, 53(5):319-31

[31] Mountford, J. and Webb, C. (2009) op cit.

[32] McAlearney A. S. (2006) Leadership development in healthcare: a qualitative study. *Journal of Organisation Behaviour*. 27,967-982.

[33] Bolden, R (2010) op cit

[34] egs Stoll, L. (2009) Capacity building for school improvement or creating capacity for learning? A changing landscape. *Journal of Educational Change*, 10 (2): 115-127; OECD (Ed) *Networks of Innovation: Towards New Models for Managing Schools and Systems*. Paris: OECD.

[35] Hartley, J and Hinksman, B. (2003) op cit.

[36] The NHS Confederation (2007) op cit

[37] Walmsley, J. and Miller, K. (2008) *A Review of The Health Foundation's Leadership Programme 2003–07*. The Health Foundation.

[38] Kirkpatrick, D. (1960) Techniques for evaluating training programs, *Journal of American Society of Training Directors*, 13 and 14; Kirkpatrick, D. L. and Kirkpatrick, J. D. (1998) *Evaluating Training Programs: The Four Levels.* 3rd edition. San Francisco: McGraw Hill.

[39] Guskey, T. (2000) *Evaluating Professional Development*. Thousand Oaks, CA: Corwin.

[40] Stufflebeam, D. L. (2000) The CIPP model for evaluation. In D. L. Stufflebeam, G. F. Madaus and T. Kellaghan (Eds) *Evaluation Models*. 2nd edition. Boston: Kluwer.

[41] Willcocks, S. (2005) Doctors and leadership in the UK National Health Service. *Clinician in Management*, 13:11-21.

[42] Hartley, J. and Hinksman, B. (2003) *op cit.*

[43] Schön D, A. (1983) *The Reflective Practitioner*. London: Temple Smith.

[44] Rooke, D. and Torbert, W. R. (2005) Seven transformations of leadership, *Harvard Business Review*, April.

[45] Graham, C. R. (2005) Blended learning systems: definition, current trends and future directions, in C. J. Bonk and C. R. Graham (eds) *Handbook of Blended Learning: Global Perspectives, Local Designs*. San Francisco, CA: Pfeiffer Publishers.

[46] Hartley, J. and Hinksman, B. (2003) op cit

[47] Anderson, B. (2004) Dimensions of learning and support in an online community, *Open Learning*, 19 (20): 183-190.

[48] Hawkins, P. and Smith, N. (2006) *Coaching, Mentoring and Organisational Consultancy: Supervision and Development*. Maidenhead: Open University Press.

[49] Weiss C (1995) Nothing so practical as a good theory: exploring theory-based evaluation for comprehensive community initiatives for children and families, in P. Connell (Ed) *New Approaches to Evaluating Community Initiatives: Concepts, Methods and Contexts*. Washington DC: Aspen Institute.

[50] See, for example, Stoll, L. and Louis, K. S. (2007) *Professional Learning Communities: Divergence, Depth, Dilemmas*. Maidenhead: Open University Press.

[51] Hartley, J. and Hinksman, B. (2003) *op cit.*

[52] This is based on a model developed by Earl, L. and Katz, S. (2006) as a result of their evaluation of the Networked Learning Communities initiative of the National College for School Leadership. See Earl, L. and Katz, S. (2006) *How Networked Learning Communities Work.* Centre for Strategic Education Seminar Series Paper No. 155. Jolimont, Victoria: CSE.

[53] Connell, J. P. and Kubisch, J. C. (1998) Applying a theory of change approach to the evaluation of comprehensive community initiatives, in K. Anderson et al (Eds) *New Approaches to Evaluating Community Initiatives*, Volume 2. Washington, DC: The Aspen Institute.

[54] See note 52.