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Multi-professional clinical leadership training in healthcare: A peer-led evaluation of the experience and benefits of the "Darzi Fellowship"

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Multi-professional clinical leadership training in healthcare: A peer-led evaluation of the experience and benefits of the "Darzi Fellowship"

"The creation of training programmes, open to all across the health and care sector would have a significant impact on leadership, in particular on the promotion of good practice and of positive collaboration throughout the system" (Rose, 2015, p.27)

Abstract:

Purpose

This paper examines the impact of a structured clinical leadership programme on healthcare professionals working within the British National Health Service (NHS). Clinical leadership is now regarded as essential in addressing the complex challenges in the NHS, yet few trainees of any healthcare discipline receive formal training. The study describes a peer-led evaluation of a year-long, multidisciplinary, experiential programme, the 'Darzi Fellowship', based in London.

Design

An anonymous survey was analysed using a mixed-methods approach. Individual and collective experiences of fellows were evaluated, in particular the perceived impact the fellowship had on:

1) the fellows themselves,
2) their 'host' organisation, and
3) the NHS as a whole

Findings

A 90% return rate was achieved. 94% reported that the experience had been valuable to them, 85% feeling more empowered to effect change in healthcare systems. Crucial mechanisms to achieve this included increased self-awareness, personal reflection and the freedom to gain a greater understanding of organisations. Particular emphasis was placed on the value of developing clinical networks which promote collaboration across boundaries. Fellows emerged as more reflexive, critical and strategic thinkers.

Practical implications

This paper demonstrates the positive impact that clinical leadership training can have on participants, and the mechanisms by which future leaders can be created.

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Value

Our novel, non-commissioned, peer-initiated and peer-led evaluation describes the personal experiences of Fellows in a unique, multidisciplinary clinical leadership programme. We hope this will inform the development of future schemes in the NHS and provide learning for an international healthcare audience.

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Introduction

No longer considered the preserve of a select few, leadership in healthcare, or 'clinical leadership' has come to be regarded as essential in addressing current challenges within the British National Health Service (NHS). The NHS Next Stage Review (DoH, 2008) placed renewed emphasis on clinical leadership, sparking a paradigm shift from an historical and well-documented divide between Healthcare Professionals and general managers (Nichol, 2011) to a state where clinical leadership was emphasised in several subsequent high-profile reports for clinical staff across the health service (Francis, 2013; Berwick, 2013). In line with this change, healthcare professionals' cynicism about the role of 'management' is subsiding, being replaced with an increasingly clinically-led leadership focus.

Yet, despite this highlighted importance, few trainees of any healthcare discipline receive formal leadership training. Clinical leadership appears to emerge from individuals rather than being taught and trainees tend to observe rather than participate in leadership and management decisions. The Rose Report (2015) highlights the NHS's "limited investment in systematic leadership" and links this strongly with poorer patient outcomes; in other words, there is a distinct need for high quality leadership training, which benefits both those who work within the system and those who use it.

Although remaining few and far between, formal clinical leadership programmes are expanding in number and size and are being accessed by increasing numbers of Healthcare Professionals (HCPs). Whilst this can mean a secondment from an organisation, or taking a year out of training, these primarily non-clinical programmes are viewed as inherently positive and ultimately valuable to patient care. Multiple studies have demonstrated that effective, joint working between HCPs and general managers is associated with improved outcomes in efficiency, safety and – importantly – quality (Aggarwal & Swanwick, 2015).

There is increasing evidence that developing clinical leaders who possess skills and abilities across these hitherto separate domains of management and clinical care can have added benefits (Stoll et al, 2011). However, there has only been limited research as to the effectiveness of the schemes themselves (Swanwick & McKimm, 2011).

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In this paper we present the results of a peer led evaluation of a year-long, clinical leadership programme.

What is the Darzi Fellowship?

The Darzi Fellowship (named after Professor Lord Ara Darzi, an internationally-renowned surgeon and former Government minister) is a dynamic leadership and management programme, acting across multiple health organisations. It aims to produce a *"cadre of clinicians who are confident and competent to lead improvement and manage change across the health and social care system in London and beyond" (*CIHM, 2014*).* NHS organisations including Trusts, Clinical Commissioning Groups and Local Education and Training Boards (LETBs) apply to be host organisations for one or more Darzi fellows, overseen by the London Leadership Academy (LLA). Despite the focus and positioning within London, applications are accepted from HCPs based anywhere in the UK.

The Darzi programme supports clinical staff from a variety of backgrounds to undertake project-based leadership attachments. Through this innovative approach, fellows acquire critical thinking skills and begin to understand how to lead and sustain effective change. By facing authentic challenges within a 'live' organisation, working with established organisational culture(s), the fellows develop a greater understanding of change management, cultural shifts and Whole System views (Pratt et al, 2005).

Fellows are supported by sponsors; typically these are leaders within the fellow's professional group. This proximity to leadership in action provides an exceptional opportunity to make tangible and significant improvements, whilst also growing as leaders in their own right.

Although a resource-intensive programme, the Darzi Fellowship is intended to be a global investment for the NHS. Funding for each fellow derives from the LLA, sometimes in combination with a contribution from the host organisation. For this reason, fellows are employed in addition to each organisation's operational workforce. Host organisations report benefits in terms of service improvement, the development of networks and increased capability resulting from fellows' projects (Swanwick & McKimm, 2011).

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Multi-professional Leadership Learning

Initially offered solely to medical trainees in 2008, the programme has since widened its focus to incorporate multi-professional participants. In 2014-2015, fifty-eight fellows participated, including general practitioners, hospital doctors, nurses, paramedics, pharmacists and allied health professionals. Such inclusiveness counters traditional healthcare hierarchies and power dynamics, permitting collective leadership learning across boundaries. Participants are intended to develop an insight into the inherent complex differences of a variety of health professions and the impact of these differences on patient care.

The programme has adapted through iterative change, based on the feedback from consecutive cohorts. There is increasing focus on group-based learning; Action Learning Groups (Atherton, 2013), for example, were introduced in the fifth cohort with great success.

Taught Course

The taught element of the fellowship is currently provided by the Centre for Innovation in Health Management (CIHM) at the University of Leeds. The programme's design outline describes the intended learning for fellows:

> *"to lead local systems innovation and change; generate clinical leadership capacity; train others in organizational skills, and build effective relationships for improvement within and across organisations and sectors in service to patients"* (CIHM, 2014)

The programme emphasises the development of adult learning strategies. It comprises a multitude of teaching methods (figure 1), including: site visits, structured conversations with invited healthcare leaders and dialogue with 'expert patient' volunteers.

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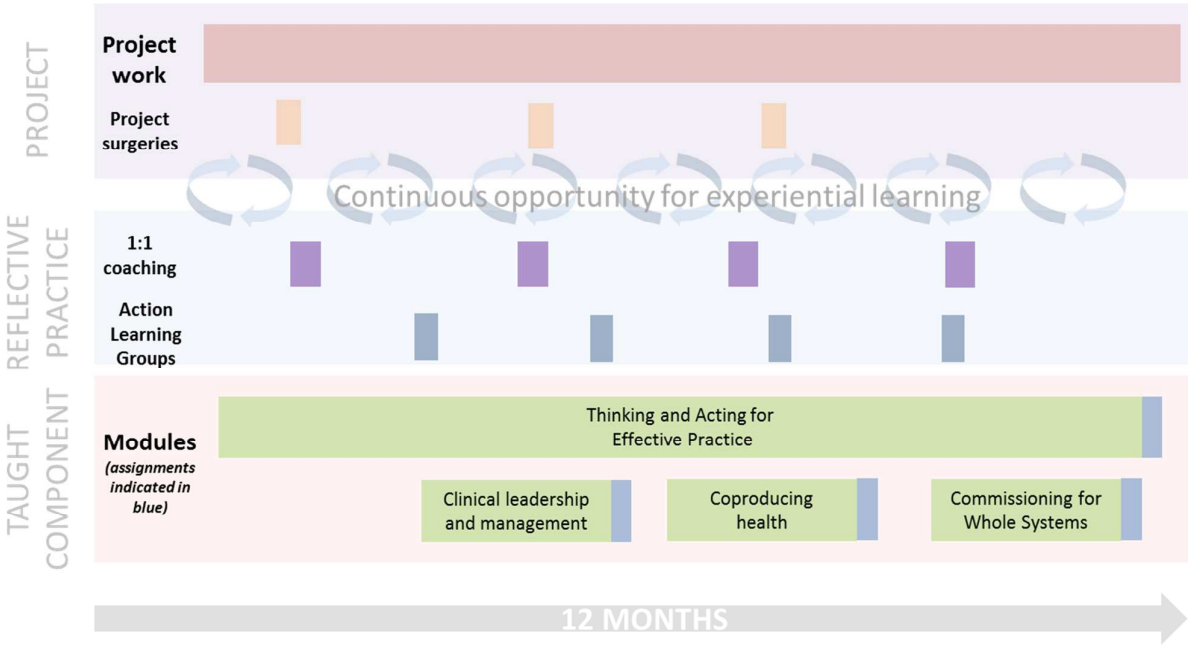
Figure 1. Course Structure



What constitutes a "Darzi Project"?

Whilst host organisations propose project topics when applying to the LLA, these are rarely prescriptive. Fellows soon discover that they have to take responsibility for defining scope and delivery strategy; this active project ownership itself develops their leadership skills.

Examples:

Schwartz Rounds®

Schwartz rounds are a systemic narrative-based intervention to help healthcare organisations deliver compassionate care to both patients and also their own staff (Conn, 2015). The guiding principle is that high quality care can only be delivered if staff are mindful of their own, and one another's emotional and cognitive experiences. This project showed the value of the Darzi fellowship in improving patient experience through increased staff resilience and organisational culture change, as per the Francis Report (Francis, 2013).

This fellow was tasked with introducing Schwartz Rounds (identifying funding, executive buy-in, project leadership) in a specialist children's hospital.

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Improving Epilepsy Care for Children and Young People (CYP)

This fellow's work addressed previously demonstrated poor outcomes by involving CYP and parents, and stakeholders across health, education and social care. A report was published by the team using the barriers, enablers and solutions identified (Young Epilepsy, 2015). The innovative approach it recommended (to achieve integrated, person-centred care) is influencing policy at local, regional and national levels. The fellow is continuing the work beyond the initial year, with current projects aiming to establish a national registry, co-create young people's networks and commission a health economic analysis.

Interprofessional Education (IPE)

This exploratory research study generated insight into the understanding and perceptions of children's nursing students, lecturers and clinically based children's nurses in relation to IPE and its potential impact on the care delivered to children, young people and families. The key findings indicated that students value IPE, in particular role-play and simulated education. Additionally, students identified adaptations to their clinical practice as a result of their increased understanding of other professional groups within the healthcare setting.

Why Evaluate the Darzi Fellowship Programme?

Stoll et al's (2011) retrospective evaluation of the first Darzi cohort, commissioned by the LLA, remains the only published review of the programme. No published work has evaluated subsequent significant changes in course structure, particularly in light of the programme having become multi-professional. Importantly, little has been described formally of fellows' personal experiences.

Methodology:

We wished to understand the 2014-2015 cohort's individual and collective experiences, in particular the perceived impact of the fellowship on:

1) the fellows themselves

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2) their host organisation
3) the NHS as a whole

Our blended, mixed-methods approach enriches findings, preventing the limitations posed by quantitative or qualitative data used in isolation (Polit et al, 2001).

Data Collection:

An anonymous online questionnaire was circulated to all fellows via email, following the penultimate learning set of the taught programme (ten months into the fellowship). Three subsections (as above) included Likert scale (Polit et al, 2001) alongside free-text responses. The survey was open for one month with only one submission per fellow permitted. The authors themselves contributed responses.

Ethical Approval:

This work was not commissioned and was instead a peer-initiated evaluation. Participation was voluntary, therefore ethical approval was not sought (MRC, 2015).

Data Analysis:

Quantitative The questionnaire platform collated Likert responses, providing proportions or average rankings, as appropriate and allowing response breakdown based on professional groups.

Qualitative We collated all free text responses and utilised a thematic analysis approach, allowing structured interpretation and identification of emerging themes (Alhojailan, 2012; Polit et al, 2001). Initially, the authors independently coded free-text responses to detect overarching topics. Next, these were reviewed collectively and triangulated, with consensus sought to classify key categories to then be analysed in depth.

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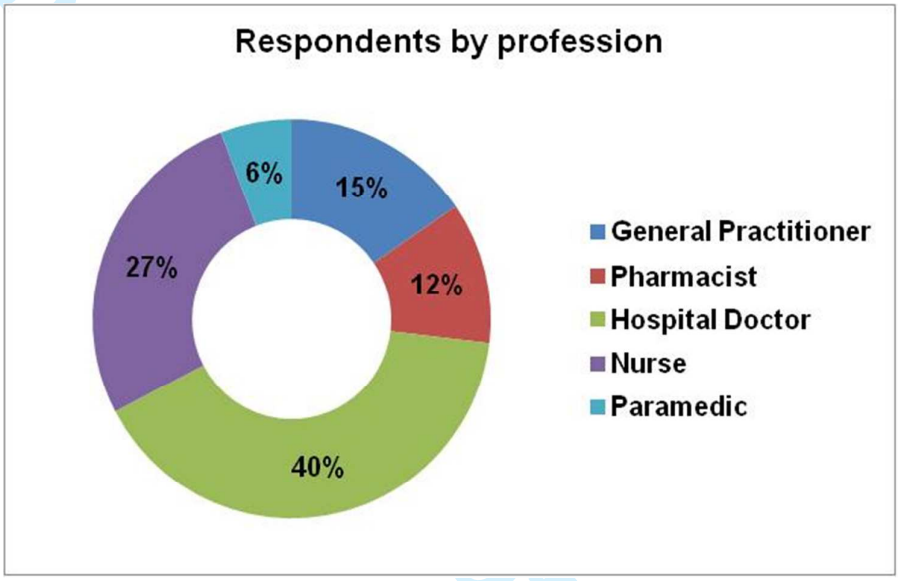
Results:

Quantitative:

Responses were received from 52 of 58 fellows (90% return). Numbers across the professional groups were proportionately representative (figure 2).

Figure 2: Respondents by profession



Gender	
Male	31%
Female	66%
Prefer not to say	3%

Ethnicity	
Asian	14%
Mixed-race	5%
White	48%
Other	2%
Prefer not to say	31%

With regards the taught course element, the authors asked fellows to rank learning components on a scale of 1-6, according to their perception of relative worth (1 being the least and 6 being the most useful for their leadership development). A combined mean score was established (figure 3).

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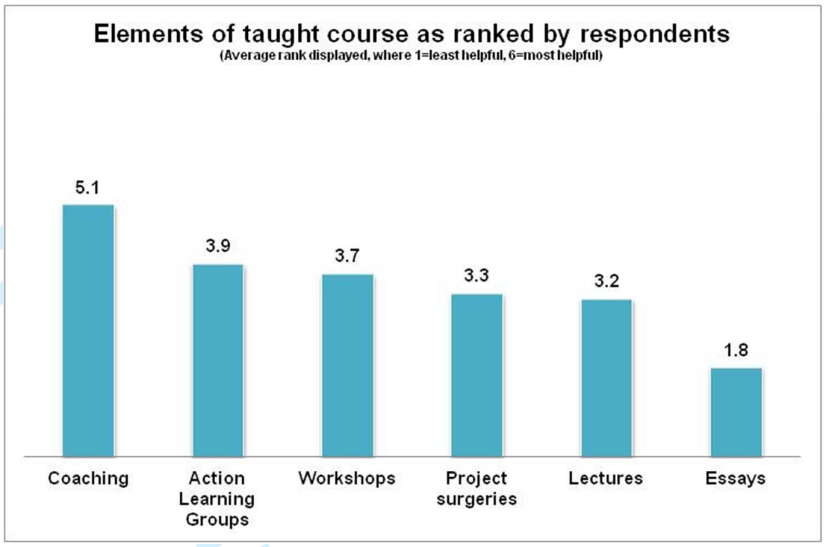
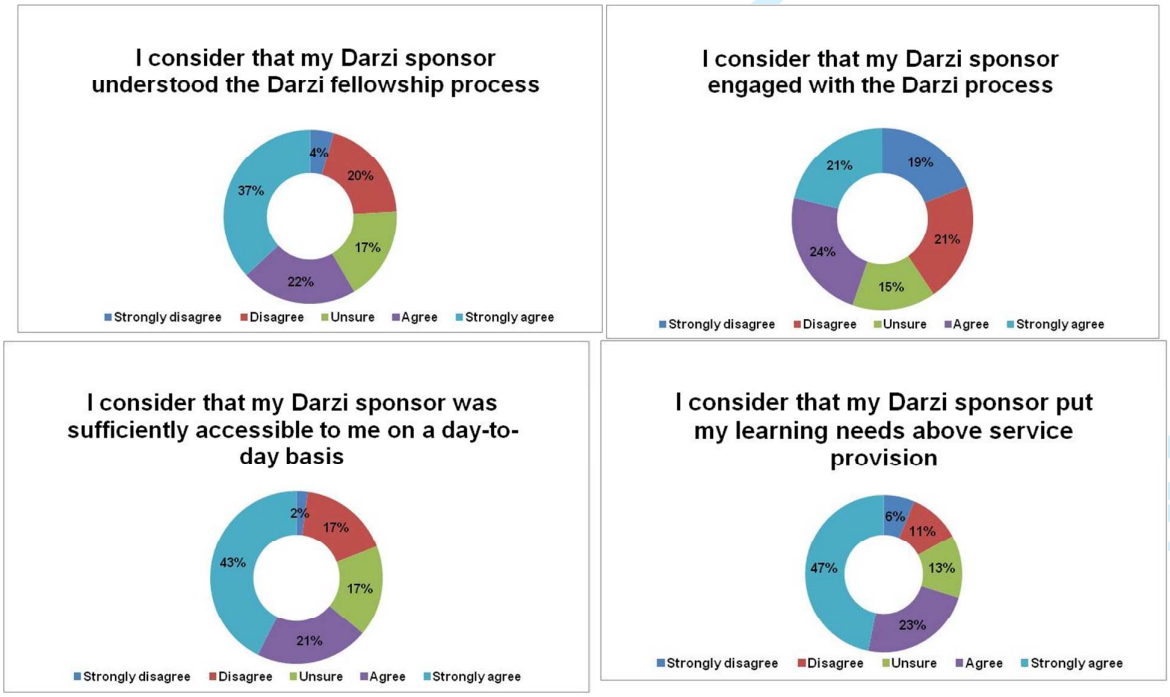
Figure 3: Elements of taught course, as ranked by respondents



We evaluated fellows' perceived quality of the sponsorship they had received, to include the degree to which their sponsor appeared to understand the Darzi 'process', their sponsors degree of engagement with the taught component (e.g. attending sessions), their level of day-to-day accessibility, and the extent to which fellows' development was prioritised above service provision (figure 4).

Figure 4: The role of sponsors



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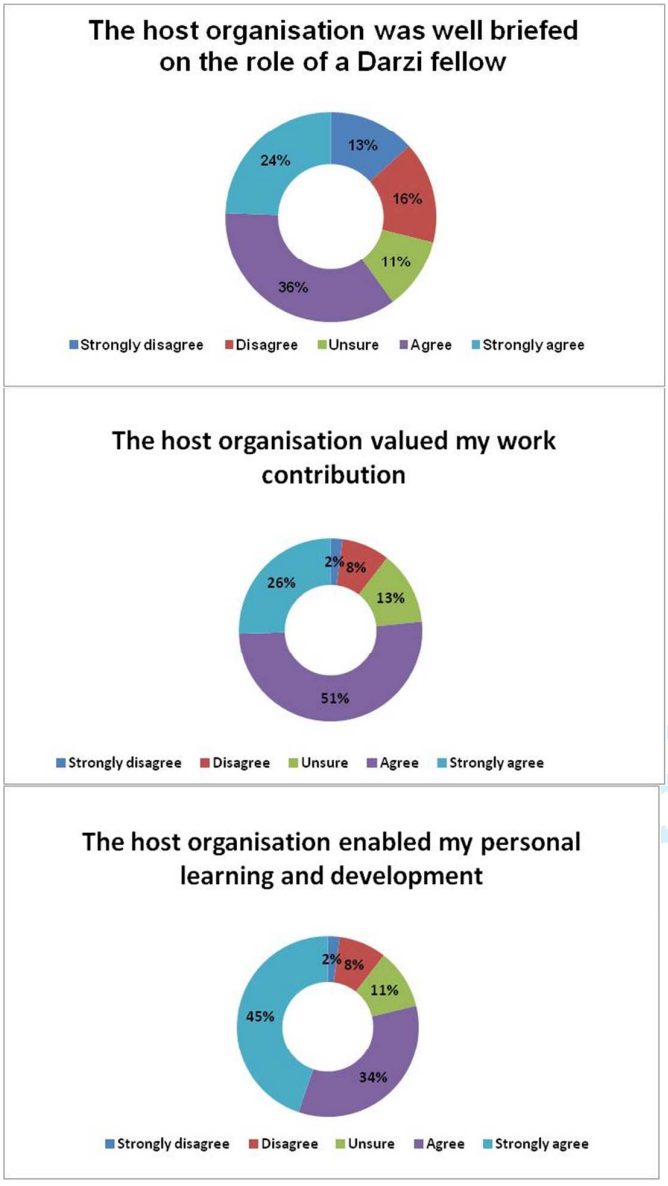
We asked fellows to rate the suitability of their host placement according to: a) how well briefed the fellow considered the organisation to have been about the purpose of their role; b) how valued the fellow felt within the organisation; and c) to what degree the organisation enabled learning and development (figure 5).

Figure 5: The role of host organisations



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We assessed the overall experience for fellows of their Darzi year, asking: a) how transformative fellows found the experience; b) whether they would recommend the Darzi fellowship to peers (figure 6).

Finally, we evaluated the potential capability built through the Darzi fellowship process, specifically: a) whether fellows felt more empowered individually as agents of change; b) what proportion of fellows would consider continued involvement in leadership at senior levels (figure 6).

Figure 6: Personal reflections on the fellowship year

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Qualitative:

Six themes emerged from free text responses:

1. **New Opportunities**

Fellows consistently reported the perceived benefit of taking time away from training, variously described as "*coming off the treadmill*" or "*a year away to think*". This was identified as a luxury of time and space, not otherwise afforded them in their generic healthcare training. The fellowship provided a novel form of job satisfaction, unrelated to specific clinical outcomes, described as a self-affirming chance "*to be recognised…for more than my clinical skills*".

The value of being "*parachuted*" into an organisation, with approval to simply observe complex processes in action was described. Many fellows left the relative comfort of their training schemes and organisations to work in unfamiliar environments. This challenged them to critically evaluate new and old working cultures and informally benchmark standards of care. A number of sponsors expressly highlighted to their fellow the importance of 'pushing beyond' established theoretical paradigms.

Fellows were, for the first time, encouraged to approach and establish dialogue with experienced leaders including medical and nursing directors, non-executive directors and chief executives. This level of access to senior members of organisations was generally viewed in a positive sense, one fellow summarising this as "*a chance to see 'the other side'*". Access to senior individuals gave fellows opportunity to understand and sometimes question the validity of these positions. Senior leaders were observed to be "*very inspirational, some the reverse*". Fellows thus sought out leadership role models suited to their own styles.

A particularly novel and rewarding aspect was having been given *permission* to be innovative. Project work provided fertile ground for the testing of ideas – a safer space to 'fail' than within fellows' more familiar clinical environments.

It is acknowledged by fellows that additional postgraduate qualifications can positively influence future employability, providing objective proof of academic development and, by

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association, of the ability to apply this knowledge in the clinical realm. Many described how the highly prestigious 'label' of the Darzi Fellowship itself opened up conversations and opportunities.

2. **Personal Reflection**

For many, the Fellowship represented a change of pace and focus. An emphasis on increased self-awareness in the moment, and in retrospect ('in-action' and 'on-action': Schon, 1983) generated possibilities; many commenting on the chance they had been given to reassess professional goals and change their own practice. Instead of applying previously gained knowledge from their usual roles, fellows interpreted and digested their novel experiences, in part through formal 360degree feedback, but also unconsciously. A deeper knowledge-of-self prompted, for some, a "*renewed passion for making a difference*". One respondent described the fellowship having "*led to me taking a new role …which is a far cry from my assumed career pathway*". A common theme was a revealed sense of greater purpose and self-belief, through personal appreciative enquiry: *"I discovered the leader in myself".*

The "*invaluable*" sense of perspective achieved through strategic consideration of interpersonal strengths and weaknesses, helped fellows surface their personal assumptions. Fellows observed consequent changes in their own beliefs, values and behaviours (*"I have a more mature and deeper understanding of my own capabilities"; "It has made me aware of personal shortcomings, and strategies to address them").*

A primary catalyst of self-reflection was coaching. Personalised, safely challenging conversations with experienced coaches allowed fellows to explore personal and professional narratives, to "*let go of unhelpful hang-ups*" and challenge their prejudices. An understanding of each fellow's interconnected identity emerges: fellows were encouraged to be mindful of how they are positioned within teams or organisations, which was "*eye-opening*". For some, the process involved an in-depth analysis of their interpersonal styles. Fellows were challenged to address their 'task vs relationship' orientation and a narrative 360degree (Thach, 2002; Lepsinger & Lucia, 1997) assessment enabled fellows to consider the value of softer skills such as emotional intelligence, authenticity and humility.

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An identified effect of the programme was to clarify and reinforce existing, perhaps vaguely defined, principles, for example: *"I have more confidence in what I have always strongly believed in and now recognise as 'distributed leadership'"*.

3. **Personal Development**

Despite a notional focus on the goals of a specified 'Darzi Project', the culture of the Fellowship encourages investment in the fellows' own growth as future leaders: *"I realised with time that I was the project".* Learning outcomes were primary, with project outcomes considered secondary. Virtually universal was a description of "*an opportunity to develop and grow as a person and leader*".

Fellows remarked on the benefits of managing their own diary and the freedom given them to attend conferences and meetings, broadening their portfolios. The possibility of moving between environments and professional groups to influence people on multiple levels gave a sense of agency and greater internal locus of control. Fellows felt empowered to take initiative in change, asking for forgiveness rather than permission; this was a validating process.

The acquisition of "*leadership skills*" was almost universally noted. Fellows reflected that at times the experience had felt "*traumatic*" but that they had learned from this, emerging more resilient with knowledge of "*how to handle negative experiences*". This was a mentally challenging but rewarding experience. Many commented on the process of "*toughening up*" to "*navigate conflict*" and have "*difficult conversations*". These conversations often began with newly strengthened active listening skills: *"I am more aware of the value of silence…"*

The length of the Darzi programme allows the fellow to understand and strengthen their personal style. Fellows learnt to engage in debate objectively and productively, becoming stronger advocates for colleagues and patients. An enhanced natural inquisitiveness was highlighted: "*the programme has taught me that being sceptical is good, questioning the status quo…Asking 'why' and seeking out a range of opinions….*"

Fellows had opportunities to chair meetings and shape agendas. Strengthened communication styles now include better presentation and negotiation skills. An enhanced

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ability to predict the behaviours of others is apparent: "*I am more skilled in understanding the motivations of others and making these explicit*".

For many this was their first formal experience of leadership and management. Fellows expressed a healthy caution: this was the start of a process of learning, rather than its completion. They are aware that their personal growth does not yet equate with mastery: *"I feel as if I have increased my personal utility and moved from a position of unconscious incompetence to conscious incompetence",* reflecting Howell (1982).

4. Organisational knowledge

Fellows overwhelmingly reported they had developed their knowledge about the structure and function of the NHS and healthcare organisations therein. A particular sub-theme was a better understanding of operational practices, one respondent stating that they discovered "*why things happen the way they do*". An associated advantage was exposure to what was termed "*the business side*" of healthcare organisations, with specific references to financial, budgetary and commissioning expertise gained ("*I understand better the structure of healthcare organisations. I am aware of how commissioning and evaluation occurs*").

A common related benefit was a heightened appreciation of wider context ("*A new perspective on my place in the organisation and the wider NHS*"). Some specifically remarked on the sense-making which came with a greater understanding of prioritisation, advocacy, policy and the "*wider political sphere*".

Within organisations, fellows were exposed to power, authority and influence with regard to leadership practices – and developed an appreciation of the impact of these traits on clinical practice. Fellows emerge increasingly cognisant of the multiple contexts in which leaders must operate. Values and culture became more meaningful concepts.

The great majority of fellows described a better comprehension of how they should operate as leaders within systems, including the leadership and management of resources and performance ("*Most importantly I've learnt…how to manage people and teams*"). Importantly, such reflexivity, applied within a team environment, has been positively linked to better effectiveness and innovation (West, 2000).

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Having had the chance to "*work alongside those at the top of the NHS*" it felt to some that "*doors were simply opened*" to learn more about national structures and policy.

5. Theories and frameworks

Despite some criticism of the taught component of the Post-Graduate Certificate, overall the language used to describe the academic process is broadly indicative of synthesis and productive application.

Fellows learnt new strategic methods and leadership models, reflecting in their feedback on previous somewhat naïve preconceptions. The theories and frameworks provided crucial "mental maps"; tools with which they could approach difficult challenges throughout their project work. A few fellows reflected that they had previously conflated clinical leadership with management, and felt they had benefitted from being disavowed of this conception, a key process described by the seminal Kings Fund Paper 'No More Heroes' (The King's Fund, 2011).

Commonly-mentioned concepts, introduced through the teaching programme, were those of 'wicked' problems (Briggs, 2012) and of Whole Systems Approaches (Pratt et al, 2005). Fellows were encouraged to move from 'thin' to 'thick' descriptions, acknowledging levels of complexity. They spoke of a new "*….platform for approaching problems, rather than assuming that someone somewhere has all the answers*".

Participants commented on particular techniques they had found useful in making complex interventions. Leadership and change theories were paramount, with many using tools on this topic to drive forward projects in their home organisations. Frequently referenced were skills in negotiation ("*I am better able to lead difficult conversations and navigate conflict within and between teams*"). Importantly, fellows mentioned how utilising these aforementioned frameworks had improved their capability to lead teams and projects ("*I have learnt how to bring people together and build on key relationships to keep momentum*").

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There was widespread mention of engagement practices, with many revealing increased appreciation of patient involvement. The model of Co-Production (Nesta, 2012) - the subject of an entire taught module - was particularly well received ("*I have realised the value of people and relationships, in particular the value of the service user and the relationship with them*"). Patients were increasingly understood to be expert resources in the management of their own care. The concept of 'public value' was introduced.

Many found opportunity through Project Management and Quality Improvement methodologies; previously unknown concepts for most. The science of Quality Improvement in particular opened up conceptual possibilities, for example the use of stakeholder analysis and process mapping. More than simply teaching the common 'language' of change in healthcare, these constructs provided tools for fellows to analyse problems within their healthcare environment, and to develop practicable solutions to improve clinical care.

6. Networking

A consistent theme involved fellows' learning about the power of professional networks; described to have developed at multiple levels. Primarily, there was the valuable cohesion of a group of motivated peers within the Darzi programme itself. The simple statement that the Darzi programme "*symbolises collaboration*" binds much of what is written within the evaluations about group working, described as "*a great opportunity to network with like-minded people*". [This paper itself represents a positive leadership collaboration made possible by the programme].

Action Learning Groups provided a high-trust, confidential space in which peers could help shape one another's personal understanding. It was within these spaces that fellows were encouraged to consider developing tactics and strategies for disrupting norms and entrenched practices in others, the 'gaming' of how to influence and negotiate successfully and with integrity.

Many fellows developed working relationships with their Darzi predecessors and have begun offering formal and informal support to their successors. Plans are in process to develop a network of Darzi Fellows, past and present, as a means of expediting adjustment

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to the Darzi programme and to rapidly expand existing networks associated with individual projects.

Within host organisations, fellows gained from networking with clinical and non-clinical staff, including project managers and administrators. It was acknowledged that these opportunities of multi-professional engagement had been previously neglected in their training. Fellows described feeling more open to multiple perspectives, embracing diversity of background and knowledge base.

Partnership working occurred for many beyond their Darzi cohort and host organisation. Time spent in Royal Colleges, educational institutions and even political spheres was valuable. Some discovered clinically based national networks of which they had been unaware. The taught content of the programme emphasised the value and meaning of networking and evaluation suggests that influence and collaboration in change processes became clear to Fellows.

Whilst the opportunities presented by networking were generally positive, one Fellow observed the restrictions which occur when networks become too insular, describing how "*pre-existing networks within a host organisation make implementing projects challenging*". Some, on reflection, demonstrated frustration that their networking opportunities were limited by time or practical constraints, recognising that networks are essential to ensuring the longevity of projects and change, engaging "*wider stakeholders and establish(ing) relationships… creating a momentum*".

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Discussion

The Darzi fellowship could be summarised as an initiative 'to create better prepared future clinical leaders'. This paper identifies just how influential the year has been for participants. In collecting data at the point of near-completion of the fellowship, it is clear that respondents are already able to envisage long-term benefits.

The mixed-methods approach used, deliberately chosen by the authors to augment the quality and depth of the responses, surfaces not just *what* the perceived impacts were but,

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more importantly, *why* these have been formative. Overwhelmingly, the collective experience of the programme has been a positive one, described at its most effusive as *"a golden opportunity" …"the best year of my career to date".*

- 94% agreed or strongly agreed that the experience had been valuable to them
- 87% would recommend the opportunity to peers
- 85% now feel more empowered to effect change in healthcare systems, whereas just 9% felt uncertain and 6% felt the opposite.
- Just over half of respondents 'strongly agreed' that they would be more likely to take on a senior leadership role, and a further third 'agreed' with the statement. 4% were 'unsure' and 8% 'disagreed' or 'strongly disagreed'. For this significant minority, this demonstrates the advantage of "try-before-you-buy" exposure to leadership.

Significantly, analysis of individual responses showed no particular patterns with regards differential experiences between professional groups. This suggests that the programme was appropriately balanced and delivered in a manner which was accessible regardless of professional background.

Reflection

Our results suggest that the programme design, developed over time by the faculty, undoubtedly contributes to the quality of fellows' experiences. Two of our identified themes relate directly to the personal journey fellows went through during the fellowship, with the opportunity for personal reflection explicitly recognised by the majority. Reflection was felt most keenly in fellows whose project work lay outside their typical professional spheres. The positive manner in which all fellows discussed reflective practice suggests the importance given to this aspect by the faculty was well-founded, with the acquisition of these abilities having a profound effect on individuals' experiences of the year.

Moreover, attaining reflective skills enabled fellows to ascertain the personal qualities that make them effective leaders. The origins of this approach lie in the notions of authenticity (Avolio, 2005) and in wider emotional intelligence; the latter having been associated with improved performance (Goleman, 2004). A transformational leader must display these

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qualities (e.g. empathy, motivational skills) in order to properly engage team members; the process of reflection, encouraged as part of the Darzi fellowship, provided a clear road map towards this.

Systems thinking

The development of reflective qualities will enable fellows to avoid the trap of old-style 'heroic' leadership and move towards the model of shared leadership that is encouraged increasingly within the NHS (The King's Fund, 2011). The merits of distributed leadership were promoted elsewhere in the fellowship, with further linkage between the concepts of personal development, reflection and wider team learning detectable in the prominence of systems thinking in the taught programme. Such a combination, as outlined in work on learning organisations (Senge, 1990), provided a crucial model by which fellows could approach and appraise transformation and change, both personally and within their organisation(s). It is imperative for healthcare professionals, so used to concentrating on technical-based tasks in their clinical roles, to develop such a framework on their journey towards becoming successful clinical leaders.

'Learning to learn'

One of the fellowship's learning methods found especially useful was that of *experiential learning* - attaining the skills to meaningfully use experience to inform one's progress – or 'learning to learn' (Argyris, 1997). Quinn & Hughes (2007) cite Jasper's (2003) assertion that reflective practice allows students to actively engage in learning through linking theory and practice. The link between project work and the taught course, facilitated by the reflective practice element of the fellowship, was a central component of the programme. Enabling continuous, loop-learning from experiences allowed fellows to further their personal development (Hinchcliff, 2009).

In terms of 'tangible measures', several fellows have suggested a second 360degree appraisal may have provided external affirmation of personal development.

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A deliberate device, employed at regular intervals through the year, were *Communities of Practice* (Lave & Wenger, 1991). These facilitated collective reflective practice, allowing fellows to learn from their peers and practice healthy scepticism. Such interactions are a crucial counterbalance to the isolation that may be experienced in leading an individual project.

The use of essays for Masters level academic assessment encouraged *critical analysis* of the course content. There was for some a tension between the academic rigour of these essays and the relative freedom of thought and debate within the 'classroom'. The assessment component was hence not rated highly by fellows.

Multi-professional networks

The Darzi fellowship differs from other NHS clinical leadership programmes in that it now includes participants from all healthcare professions. The creation of networks that cross traditional professional hierarchies is a distinctive programme output, deliberately running counter to the historical, chain of command model of the NHS, and is designed to address silo-style working.

Yet such a novel set-up was not without its difficulties, with the rewards of multi-professional learning accompanied – at least initially – by the challenges of conflict derived from tribalism. For some fellows, perceived power dynamic issues persisted throughout the year. This was despite pointed efforts by the faculty – and fellow participants – to resolve disputes when they arose. We suggest that such issues around hierarchy and power which remained for a minority, derived principally from individuals' own belief systems rather than the fellowship itself. Removing such long-held 'tribal' beliefs is perhaps beyond the scope of such a programme. However, the creativity resulting from the varying perspectives of different disciplines provided an enriched experience for the overwhelming majority of participants, and positively shifted attitudes for many.

Whilst content was taught using a *multi*professional model- many professionals in a room, being taught the same thing, all internalising and sense making their own way (McKimm, 2010), the benefits of *inter*professional education were a vital secondary outcome. CAIPE

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(2002) describe the benefits of interprofessional education being in terms of learning derived 'from, with and about each other'. This reflects the experience of fellows, even those unable to move beyond the constraints of professional title. All participants were able to test out new ways of responding to and dealing with allied professionals, within the safety of the 'learning community'. One fellow described the experience as 'unlocking so many small details about other professions, despite having worked closely together for decades.'

The taught course was delivered at sites separate from fellows' usual clinical settings. A choice of venue may appear superficial, yet the 'neutral' location produced an apolitical and level 'playing field', which was considered vital in facilitating open discussions and developing peer-to-peer networks.

Importance of Sponsorship

Positive working relationships with sponsors and host organisations, directly correlated with and amplified the new opportunities offered to fellows. A minority found their sponsor was not as engaged or accessible as they hoped, impacting on their satisfaction levels and perceived learning. This is likely not the fault of individuals, but instead a reflection of incomplete feedback systems between fellows and sponsors. Anecdotally, coaching and project surgeries helped bridge such gaps in practical and pastoral support and, in a few cases, kept placements from being untenable.

What has the fellowship offered the organisation/NHS?

The wider future impact of such a fellowship is hard to predict, context dependent and widely spaced in time. Within our study, fellows found it easiest to describe the benefits the year had for them personally. Many were less clear in quantifying how their time had benefitted their host organisation (only 59% considering that they had "delivered" on the project expected of them), and many suggested that they could only speculate about the wider implications

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of their leadership training for the NHS as a whole. This pattern is expected, since such wider benefits are likely to take time to emerge.

Yet the corollary of the individual benefits, particularly the greater understanding of NHS structures and processes, implies a resultant cumulative advantage. This closely relates to the concept of expansive apprenticeships, with commonalities in the development of rounded individuals who subsequently enhance the workforce as a whole (Fuller & Unwin, 2008). Added to the identified gains in thinking and acting, along with the potential of novel networks, it is surely not too bold to suggest an effect that is greater than the sum of its parts.

Limitations of study

Our peer-led study evaluates the extent to which the 2014-15 fellowship impacted participants' subjective development as leaders. There are limitations to this type of evaluation (Lambert, 2012); however, given the vacuum of evidence to date, the authors felt this study would act as an appropriate addition to the evidence base of such programmes in healthcare. The data does not allow for analysis of which professional groups benefitted "most" or "least" from the process. A more qualitative approach in a future cohort might wish to focus on these differential outcomes, although the authors would warn against the potentially divisive nature of asking participants feedback on this subject, which could be counterproductive.

Future iterations of the course could include explicit "learning contracts" drawn up by fellows at the outset of their year. Such Personal Development Plans could be used as reference points throughout the experience to track learning progression as it occurs.

Whilst 59% of fellows thought that they had delivered on the "project expected of me", 17% did not feel they had. This study was not designed to interrogate the reasons underlying the perception of this minority, but significant group. Further work is necessary to uncover these, and so add to understanding of the impact of the Darzi fellowship with regard to projects undertaken. Any such work could perhaps include a return on investment analysis, in order to inform future fellows, potential sponsors and commissioners.

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Our survey was undertaken with eight weeks remaining of the programme and we acknowledge the potential reporting bias inherent in such recency. Conversely, it is possible that some fellows may not have felt the benefits of their time were realised before its later conclusion (e.g. exit interviews). The design of this study enabled an insightful 'snapshot' in time, albeit a rich and informative one. It is probable that even greater depth may have been uncovered with the use of tools such as a peer-initiated 360^{o} feedback. In an effort to gain further insight, the authors recommend a further, longitudinal study follow-up of this cohort, utilising such tools. 360^{o} feedback tools already form part of medical revalidation exercises.

The evaluation of results was performed by current Darzi fellows, and therefore was not independent. However, the peer-led element may be construed as an advantage, with no role for bias from a commissioning organisation, and the added advantage that respondents may have felt more able to express their true perspectives to their contemporaries. Fellows were not party to how their responses were to be used. This may have encouraged a 'freedom to speak'; equally, this may have restricted comments on participation.

Given investment in fellows is significant and NHS resources are increasingly stretched, how can the financial value of this scheme be demonstrated? We see this as a future direction for research in such clinical leadership schemes.

Conclusion:

This study primarily describes the personal value, as evaluated by recent fellows, of a bespoke clinical leadership programme. The great strength of its group-learning design confers myriad benefits simultaneously to participants from multiple professional groups. The fellowship's immersive structure offers participants a longitudinal view of their strengths and areas for improvement within the context of complex healthcare organisations. Fellows appear to emerge as more reflexive, critical and strategic thinkers.

Schyns and Schesny (2010) describe the attributes of leadership and self-efficacy, in particular on mastery, self-reliance, and achievement. They describe self-efficacy as being

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associated with improved organisational performance, greater persistence in a task, and in the approach to a new and challenging task. Through the experiential processes within the fellowship, fellows describe increasing confidence, a new way of thinking and increased adaptability; similar attributes to those described by Schyns and Schesny (2010).

The authors hope our findings will inform the experiences of future potential applicants, as well as commissioners and providers of leadership programmes in healthcare and beyond.

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