Improving Global Health: a win-win for leadership development and a fairer world?

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Abstract

Purpose – Improving Global Health is a one year leadership scheme which places trainee doctors and more experienced nurses, midwives and AHPs in a developing country (Cambodia or Tanzania) to develop leadership and quality improvement skills while contributing to Millennium goals in the developing countries. The purpose of this paper is to report on an independent evaluation of the programme, with the purpose of highlighting lessons learned to inform other leadership development initiatives, and in particular to highlight the vital importance of a receptive NHS environment if maximum value is to be gained from investment in clinical leadership.

Design/methodology/approach – The evaluation methodology comprised literature review; review of documentation, including online questionnaires to Fellows; interviews with stakeholders and attendance at key scheme events in July-September 2011. Fellows who had completed an overseas placement in either Cambodia or Tanzania during 2009-2010 were interviewed using a semi structured questionnaire. Mentors and Steering Group members were interviewed using an amended version of the Fellows’ questionnaire.

Findings – Impact was found at the level of personal development; working collaboratively; and understanding the value of audit, teaching and quality improvement. There was some impact on the NHS, however, the majority of Fellows struggled to find opportunities to apply their learning immediately on return from their overseas placement.

Research limitations/implications – Resource and time constraints meant that achievements in meeting Millennium goals were excluded from the evaluation; the authors’ working assumption is that only Fellows who enjoyed the Fellowship responded to the invitation to take part; judging the extent to which the Fellowship meets its goal of creating a cadre of improvement champions in the NHS will require time to elapse.

Practical implications – Lessons from implementation of this Fellowship scheme are transferable to the wider NHS.

Originality/value – The paper provides lessons on the design of leadership schemes intended to develop quality improvement skills, particularly for clinicians at an early career stage, illustrates the potential of a placement in a developing country to achieve this, and highlights the importance of a receptive NHS environment to realise maximum benefit from investment in leadership development.

Keywords Leadership development, Clinical leadership, Overseas development, Talent management, Quality improvement, Developing countries, Placement, Leadership, Doctors, Nurses

Paper type Research paper

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Introduction

Making change actually happen takes leadership. It is central to our expectations of the healthcare professionals of tomorrow (NHS Next Stage Review, 2008).

This paper discusses the results of an independent evaluation[1] of Improving Global Health (IGH), a leadership development programme which seeks to fulfill Lord Darzi’s vision for the health professionals of tomorrow (2008). It then reviews the implications of these findings for developing clinical leaders, and for the NHS.

IGH differs from most existing leadership schemes in that its area of practice is a placement in a developing country. As the focus of a one year fellowship, clinicians from NHS South (Central) spend three to six months on a placement in a developing country. This aims to enable fellows both to develop individually as a leader, and to contribute to achieving the in-country Millennium Development Goals. The scheme’s development coincided with the publication of the Global Health Partnerships Report by Lord Crisp (Crisp, 2007), which received support in 2008 from the UK Government. The scheme works in partnership with non-government organisations (NGOs) in-country and fellows work in partnership with the local health teams, to contribute to development of effective and sustainable systems to reduce poverty and ill health. Both main in-country partners use the philosophy of integrated development, as outlined by the global Millennium Villages project, led by the Earth Institute of Columbia University, New York, they each work in areas of high rural poverty, aiming to achieve the eight Millennium Development Goals agreed in 2000 by the United Nations development group. These goals set time-bound and measurable targets for halving extreme poverty by 2015.

The fellowship simultaneously seeks to address a key domestic goal of developing clinicians with both the motivation and the skills to lead quality improvement, – “ordinary leaders for improvement” as Ovretveit (2008, p. 98) terms them. Clinical leadership, including full engagement with quality improvement as a core professional responsibility is seen as vital to the transformation of health care (Department of Health, 2008; Hockey and Bates, 2010; Stoll et al., 2011). However, there is wide recognition that pre-registration training ill prepares young clinicians to become proficient at more than one-to-one relationships with patients, and in particular equips them poorly to lead quality improvement. In a review of leadership education in undergraduate nursing curricula the authors noted that “The importance of leadership to the effective provision of health care is unquestionable” (Curtis et al., 2011, p. 309), but that it is taught largely as an add-on rather than integrated into the curriculum. The same has been said of medical training (Stoll et al., 2011).

As a result of the recognition of the need to encourage young clinicians to develop skills more traditionally associated with management (Stoll et al., 2011), there have been a number of initiatives in the UK and beyond to develop leaders of quality improvement (Hardacre et al., 2010), and competence frameworks which seek to define what is required (NHS Institute, 2011).

Traditional classroom based leadership development has been widely criticized as based on a flawed theory of change, more likely to lead to self-aggrandizement than to quality improvement (Ferlie and Shortell, 2001; Walmsley and Miller, 2007), hence there have been recent moves to situate leadership development in the context of “real world” challenges, requiring a shared or distributed approach to leadership (Burgoyne et al., 2009):
A modern conceptualization sees leadership as something to be used by all but at different levels. The model of leadership is often described as shared or distributed, leadership and is especially appropriate where tasks are more complex and highly interdependent – as in healthcare (NHS Leadership Framework, 2011, June).

IGH sits within this tradition of developing leadership. Of the management education models quoted in Stoll et al. evaluation of “Darzi” fellowships, it can best be termed: A more reflexive approach aiming for a higher order of criticality resulting in a practitioner able to challenge established forms of action (Holman (2000) quoted in Stoll et al. (2011, p. 275).

The paper describes the fellowship, draws on the results of the independent evaluation to assess its effectiveness in developing leadership skills transferable to the NHS, and discusses the implications of experience on this programme for developing NHS clinical leaders.

The IGH fellowship
The IGH fellowship has been in existence since 2007. It has three major objectives:

1. to support the delivery of sustainable improvement in health and healthcare in developing countries;
2. to provide an unparalleled personal and leadership development experience for staff from NHS South Central; and
3. to create a cadre of skilled clinical leaders with quality improvement skills to make a real difference to the NHS.

It is a one year fellowship structured in four phases:

1. Selection.
2. Pre-placement, including induction, meeting with educational supervisor/mentor to agree learning objectives drawn from NHS Leadership Qualities Framework (LQF).
3. Placement – in Cambodia, Tanzania or Kenya (normally three or six months), during which time fellows undertake quality improvement projects negotiated with local partners. They also maintain a leadership learning log to encourage reflection. Educational supervision is provided for fellows in the developing country.
4. Post-placement/re-entry into NHS – includes interview with mentor on return, sign off of learning log, presentation of achievements within three months of return.

The target audience is professionals with expertise in maternity services, child health and generalist healthcare. The fellows’ role in the developing country is explicitly NOT to deliver clinical care directly, rather to support the capacity of local agencies and individuals to develop and deliver effective services.

Fellows negotiate their own project focus in the developing country with the local in-country partner. This is intended to ensure that work undertaken fits with the existing local annual work plan, and to facilitate fellows being able to match their professional interests and identified learning needs with existing needs on the ground.
Examples include conducting an audit of current health care provision, exploring workforce development needs, developing clinical service-systems, developing educational programmes and teaching relating to health care, supervising and supporting health care workers[2].

At the date of the evaluation (July 2011), 47 individuals had undertaken the fellowship, of whom 23 were doctors, the rest being nurses, midwives, allied health professionals, public health practitioners or managers.

**Educational model**

The underpinning educational model for the programme is Kolb’s (1984) experiential learning cycle.

Concrete experience is followed by reflection, then the derivation of general rules to describe the experience, and hence to modification at the active experimentation stage, leading in turn to the next concrete experience. Through immersion in the developing country project, fellows are expected to learn from experience, modify their work after reflection, and return to the NHS day job with a range of new models to apply.

The fellowship is an example of a “whole systems approach” in which “The individual leader enables the energy of others to be channelled into improvement work” (Hardacre *et al.*, 2010, p. 30), in other words “those ordinary leaders for improvement” identified by Ovretveit (2008).

This resonates with the shift from the concept of the heroic and talented individual leader to one where the task is to embed a culture of improvement in the team which is sustainable when the individual leaves (Ovretveit, 2008; Burgoyne *et al.*, 2009; Boaden, 2011).

Table I shows how the fellowship’s educational model is intended to translate to the key features of a “whole systems approach” to leadership.

The fellowship is competence focused, drawing on the NHS LQF five domains:

1. personal qualities;
2. working with others;
3. managing services;
4. improving services; and
5. setting direction.

The scheme design anticipates that the fellowship will develop competence in all five domains. Fellows keep a learning log detailing their achievement of these competences.

Kate Lees is a dietitian, currently working as a Public Health Specialty Registrar. In her Cambodia placement she lead on maternal health: improving access to family planning; workforce training; support and planning to ensure midwifery skills meet the needs of the local area; working through the local community workers such as traditional birth attendants to encourage women to deliver at the Health Centre and attend ante and post-natal appointments; and using a “serious incident review” type process to learn from child and maternal deaths and deliveries at home. She carried out a scoping exercise into the incidence of abortion in the area; started a sex education programme in the secondary school; and audited the ante-natal, post-natal and delivery notes against governmental guidelines.
while on placement. On their return to the UK mentors discuss and subsequently sign off these learning logs, and these also form part of the formal training curricula for medical staff which are assessed annually.

**The evaluation aims and methodology**

The evaluation was commissioned in May 2011 and reported in October 2011. Its aims were to review the extent to which it meets the two of the three scheme objectives:

1. to provide an unparalleled personal and leadership development experience for staff from NHS South Central; and
2. to create a cadre of skilled clinical leaders with quality improvement skills to make a real difference to the NHS.

The extent to which it meets its millennium goals objective was excluded, as the involvement of fellows in these achievements is part of a larger contribution, hence it would be difficult to isolate the fellows’ contribution from that of others.

The methodology was:

- review of documentation including e-mail survey evidence from returned fellows collected early in 2011;
- review of research literature into leadership development for clinicians;
- telephone interviews using a semi-structured questionnaire, circulated in advance with fellows who had completed their fellowship between September 2009 and December 2010[3];
- telephone interviews with mentors, using a semi-structured questionnaire;
- face-to-face or telephone interviews with scheme organisers and sponsors; and
- observation at UK programme related events during 2011.

### Table I.

<table>
<thead>
<tr>
<th>Application</th>
<th>IGH application</th>
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<tbody>
<tr>
<td>Focus of attention</td>
<td>Fellows negotiate their own focus of attention in facilitating improvement with local workforce</td>
</tr>
<tr>
<td>Starting point</td>
<td>Fellows identify though audit and/or negotiation the particular problem they will work on</td>
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<tr>
<td>Method of working</td>
<td>Critical to success is demonstrating their added value to ongoing work in the developing country, depends on valuing other cultures and practices, effective communication. Learning log promotes a habit of reflection</td>
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<tr>
<td>Result</td>
<td>Increase in human and social capital</td>
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<td></td>
<td>Increase in human capital – more confident leaders of improvement. No independent evidence on in country social capital</td>
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*Source: Adapted by the author; based on the “Warwick Model” quoted in Alban Metcalfe and Alban Metcalfe (2010)*
The data were analysed using the question headings in the interview schedule (Appendix), and themes were identified.

Preliminary evaluation results were discussed with returned fellows and mentors in July 2011, and results of the discussions were incorporated in the evaluation report.

Limitations of methodology
The methodology had limitations, and the findings should be read with this in mind.

Possible sample bias
All 29 fellows who met the criteria of a completed placement in Cambodia or Tanzania in 2009 and 2010 were approached for an interview. 19 responded, and no more were forthcoming after second and third reminders. Anecdotal evidence suggests that a minority of fellows did not flourish in the developing country. However, they did not respond to the invitation to interview. Therefore, it is possible to infer that the sample was biased towards those who felt they had benefitted.

Self-report
The evaluation depended to a considerable extent on self report. This has value in enabling people to reflect and self assess, but has limitations from a research perspective. There was only limited independent evidence of the Fellows’ development and in-country achievements. Some triangulation was attempted through interviewing mentors; however they relied upon their mentee’s reports of their achievements in the placement, and were unable to provide independent verification. The evaluation would have been stronger had there been observation of Fellows in their placements, this would have added considerably to the expense impact in the developing country.

Evidence of impact in the developing country was not part of this evaluation. Nevertheless, there is evidence from NGO partners and the fellows’ own post-fellowship reports that there has been an impact. The challenges of making objective judgment on such issues in a post-colonial environment are considerable, and would require a separate evaluation with a different methodology.

Selection and motivations to apply
One identifiable benefit of a fellowship which places overseas experience at the heart of the development opportunity was that it attracted clinicians who otherwise might have avoided anything badged as “leadership development”.

For all the fellows interviewed, the decision to apply was an individual one, often requiring considerable persistence to persuade employers or trainers to allow them time out. Although the application requires sign off by manager or educational supervisor, no one reported that IGH had been suggested by an employer or appraiser as a career development strategy.

The majority of fellows recall being attracted only by the opportunity to spend time in a developing country. Frequently this was combined with a sense of being stifled in career terms or the attraction of having the space in a training programme to do something different. For most, “leadership development” was either secondary or unnoticed. Typical responses were:

Motivation was desire to work abroad; I love health care, want to make a contribution, and was at the time frustrated in opportunities for career advancement.
I had been to Cambodia, wanting to do something useful and was despondent about job prospects as female GP in crowded market.

For some the leadership/quality improvement focus was initially perceived as a disadvantage or irrelevant. One doctor reported:

When they told me at the interview about service improvement my heart sank because I had in mind a clinical role.

However, this individual reported that the fellowship had changed her views:

I am now a complete convert; leadership and service improvement are the way forward, unexpected benefit, amazing.

There are advantages in the twin aspirations of IGH, to contribute to Millennium Development Goals while at the same time developing leaders. The overseas opportunity made the scheme attractive to clinicians who might otherwise have avoided “leadership development”. On the other hand, it meant that for some the learning journey was exceptionally steep, young doctors in particular had to grasp not only the challenge of making a difference in an alien culture, they also had a whole new set of concepts to learn.

**Induction**

There is an ambitious agenda for induction. Not only must it introduce leadership concepts, it must also prepare people for living and working in a developing country.

At the time of the evaluation, induction pivoted on a full day course run by NHSSC and a pre-departure meeting with a mentor to agree leadership learning objectives. Not only did these two encounters need to introduce significant content, such as the LQF and quality improvement knowledge and tools, they also sought to prepare fellows for the culture shock of living and working in a developing country. The evaluation results indicated that fellows required more pre-departure support in both areas.

In response to this finding a requirement to attend two additional preparatory days have been added to the fellowship:

1. attendance at a recognised introductory leadership course; and
2. attendance at a bespoke one day training event on quality improvement techniques.

In addition, mentors have been briefed to take on the task of setting objectives associated with the NHS LQF at their pre-departure meeting with the fellow. This enables a focus on the immediate requirements of the in-country placement at the fellowship induction.

**Impact of fellowship on personal development: “life changing experience”**

The fellowship aims to “provide an unparalleled personal and leadership development experience” through being placed in a role which requires fellows to develop services by working with and through local staff, rather than to deliver clinical care directly. The evaluation sought to measure whether and how it achieved this objective.

The impact of the fellowship was most obvious in the area of personal development. Every single interviewee commented positively on this. Most fellows echoed the views
of the scheme’s sponsors that this was an unprecedented opportunity to lead quality improvement, opportunities that were not available to them in NHS roles.

Fellows used terms such as “life changing”, “best thing I have ever done”. The greatest impacts were in improved self-knowledge, greater confidence and a renewed sense of enthusiasm and vocation. Fellows reported that they discovered they could make a difference, as well as finding out more about their own communication style.

This personal development was apparently achieved by two elements of the fellowship.

Most obviously, it was the result of moving young clinicians out of their comfort zone, not only in terms of culture, but also giving them responsibility they simply do not experience within the NHS in training or early career. This was particularly the case for GPs:

For the first time I had to take initiative and responsibility, in the UK always someone to check back with, here no-one to lean on . . . In medical training you are molly-coddled, never on your own. Here the buck stops with you, never before been in that situation.

Benefits the NHS by developing skills that are difficult to get over here, recognising you will make mistakes and take the consequences. Makes you grow up.

People who had been accustomed only to being a junior member of a hierarchical team found themselves leading teams and initiating change. Personal development was also in part attributable to the support fellows were able to offer one another while in their overseas placement. Although not formalised as part of the scheme’s educational model, in practice some fellows formed an *ad hoc* action learning group with others on the IGH fellowship. This was reported to lead to some valuable learning – and to enhance appreciation of the contribution of different disciplines to health care.

**Attitude change: “more prepared to get into management”**

There was clear evidence of attitudinal change. The fellowship had, for most, met its intended objective to broaden people’s thinking of what it means to be a clinician, from hands on care to appreciation of the value of non-clinical skills – audit, management, teaching and teamwork. These quotations indicate just how narrow were the views of some prior to the fellowship, and the extent to which they reported that the experience had changed them:

I’m not alone in feeling negative towards managers with whom we have no contact in training except for targets and demands. You feel they have no idea what you are doing as doctors, their work has no relevance to us. IGH participation changed that perception.

In training you do an audit, but it is an ordeal, you never see the benefit. In Tanzania you can see it working.

I am a different person, better clinician, more rounded, more prepared to get into management.

Finally, and equally important, the experience of working in countries where nutrition, transport, housing and environment are so obviously determinants of health and well being, enabled people to grasp the notion of holistic approaches to health, and the importance of relying on the patient to take some responsibility:
Has made me a better doctor seeing things more laterally, leaving the patient with more responsibility rather than thinking I must do it all.

It gave me an appreciation of the wider determinants of health, especially the links between democracy, freedom and health.

One fellow, a GP placed in Tanzania, gave this vivid example of his learning about the value of holistic approaches to health care:

Increasing female literacy is seen as a lynchpin for improving healthcare in Africa as it is linked to, amongst other things, a reduction in family sizes. A project was set up in one village distributing free sanitary towels to the schoolgirls. This resulted in increased attendance at school of young girls by 1 week every month, as they could now attend even when they were menstruating – female student attendance increased by 25%.[4]

Several fellows pointed to a change in career aspirations or trajectory as a result of participation:

- I have taken on more teaching, presenting and mentoring roles which previously had been avoided.
- I would be interested in getting involved in commissioning, and know I have a lot to offer, I would never have got involved before.
- Never had been in leadership position before, had been purely clinical, now in a completely different job for which Fellowship was good preparation.

The evaluation gave clear evidence that IGH does offer the personal development experience that it sets out to do. Results indicate that it also changes people’s views on what being a professional clinician entails, from solely delivering hands on clinical care to recognition of the value of standing back and taking stock of how the wider system works – and just where a quality improvement intervention can be valuable. In that sense it is a vindication of the “whole systems” approach to leadership development. And yet there was ambiguity in the extent to which fellows regarded themselves as having developed as “leaders”.

Developing leadership? “It’s about managing people and leading change”
Most fellows were uncertain whether they had learnt about leadership. Although leadership qualities could be inferred from their response to evaluation questions, and observations from mentors, most lacked the language or conceptual framework to know whether they had developed leadership.

A minority answered the question “How far has taking part enhanced your understanding and practice of leadership?” with some confidence:

- I now recognise it’s about managing people and leading change.
- I had always thought leadership meant you were the boss, now I know better.
- A good leader listens to all, takes on views, works with team as part of it, gets best out of everyone.

More fellows reported a lack of clarity about leadership. There was a sense that what learning fellows got about leadership, other than experiential, was somewhat haphazard.

- Comments include:
I think it did. Not the most confident of people, am now more confident and willing to set direction.

Very little formal input. Learnt on the job.

I do not think my understanding is any clearer of the definition – I can appreciate leadership types and qualities better.

As well as learning by doing on their placement, some recognised that they had had the opportunity to observe others in leadership positions, and learn what to do, or, more frequently, what not to do:

Main leadership learning was watching others, how not to do it. A more experienced Fellow was able to support my observations.

I never got to see one right way.

Ambiguity about leadership learning could be attributable to relatively light touch formal learning about leadership in the fellowship, the type of learning that is more readily achieved in a classroom than in the “real world” of whole systems approaches to leadership. As one fellow observed:

You don’t know what you don’t know. You need a little bit of leadership to develop leadership.

Whether it matters that fellows were not able readily to describe themselves and their competences in the language of leadership competencies is a moot point. It was possible to infer that, even if they did not evidence developed competences in every domain of the NHS LQF, in terms of personal development and working with others there was significant learning, sufficient to position people with skills and attitudes to contribute to quality improvements in NHS roles.

The drawback of lacking a language of leadership is perhaps most significant in achieving the second of the fellowship objectives:

To create a cadre of skilled clinical leaders with quality improvement skills to make a real difference to the NHS.

The IGH team responded to this evaluation finding by adding a requirement to attend a recognised leadership development course to the pre-departure programme.

Transferability of learning to the NHS: “We’ll be very valuable, it’s whether we will get valued”

It is an explicit IGH objective to enable the NHS to benefit from the learning and competence IGH fellows develop. It is in this area that the evaluation indicates a major challenge for sponsors of leadership development – enabling the service to benefit.

A minority of the doctors were able to practice quality improvement on return. These include two GPs who had been inspired to join their clinical commissioning groups by their experience on the fellowship; and a paediatrician who had undertaken a quality improvement project:

I have been reviewing the paediatric day ward at the hospital which is always working at maximum capacity and only gets by by skin of its teeth. I have interviewed/listened to all who work there from Surgeon to manager to Band 7, and have been able to make small
changes, e.g. wording of letter to parents re what to expect timewise. The RAID teaching I had in IGH has been quite invaluable for this. Others in the NHS rush to the “implement” stage. I learnt in Cambodia how important it is that people feel listened to.

Probably a majority, however, felt that they were not able to use their new skills. In part this was because of time constraints, also because many GPs were at the end of training and returning to locum jobs which do not lend themselves to quality improvement or leadership. The majority of fellows believed that their skills and capabilities were not recognised by colleagues or managers on their return. Some expected that this would come in time:

As a locum hard to put learning about Quality improvement into practice, I have not used this learning at all, but I know the learning will stay with me so there is no great hurry.

For others, it was a source of considerable frustration that the enthusiasm with which they had returned to NHS roles had been blunted by experience:

You’ve got this amazing portfolio and no one looks at it.

Learnt all these skills and now I cannot do anything with them.

Professionally one of the worst things I ever did because I am so frustrated at not being able to use what I learnt.

Others were more phlegmatic, nevertheless the sense of wasted talent was palpable:

Rather frustrated that locum GP role does not enable me to have a role in significant service change, though aware that the skills and perspectives I have developed will be valuable if I get involved in commissioning. Found myself enthusing others at a recent event about commissioning, but I am skeptical that young GPs like me will be allowed into Consortia. We’ll be very valuable; it’s whether we will get valued.

Mentors with considerable experience of the NHS were of a similar view, that most fellows were too junior to be able to influence much more than their own practice. GPs were in a particularly difficult position as most were not in established posts, and would be looking for (at best) salaried roles if not locum.

Overall, the ambition to “create a cadre of skilled clinical leaders with quality improvement skills to make a real difference to the NHS” had not been fully achieved, fellows believed that they had developed the skills, and most were highly motivated to do this, but the lack of readiness of the environment back in the UK makes it difficult for many to implement these new skills directly as circumstances get in the way. This state of affairs appears to be attributable to a number of factors:

1. timing;
2. selection;
3. design of the fellowship programme; and
4. NHS culture.

With regard to timing, given that IGH attracted a significant number of doctors in early career it may just be too early to make a judgment. There is also a methodological issue. Seeking to evaluate the impact of leadership development shortly after the
intervention is notoriously difficult. Assessment of impact is ideally attempted at least five years after scheme participation (Walmsley and Miller, 2008).

Selection may have played a part. Participants were not selected for their explicit potential to contribute to quality improvement in the short-medium term. GPs were the largest single group, but are unlikely to be in a position to influence quality improvement in any significant respect until they are established in either a salaried post or a partnership. The advent of GP commissioning already appeared to be altering this at the time of the evaluation (2011), however respondents were of the view that currently only senior partners were able to get involved. For other doctors, time in busy clinical roles seemed to get in the way of implementing quality improvement. This was less true for the nurses, midwives, AHPs and others, many of whom attributed significant career progress to the fellowship.

The design of the fellowship programme may in part be a factor. According to the IGH team, the expectation has been that fellows will forge their own pathway into quality improvement roles, and that this is part of their leadership learning, hence no specific assistance is offered post-placement. Fellows are told that they can call on the IGH team to assist with re-entry; none interviewed for the evaluation has taken up this offer.

Cultural barriers in the NHS were widely cited. There was a view that in the NHS there are few opportunities to innovate, and that managers are unlikely to value junior staff who have undertaken significant leadership development. This finding has previously been reported in a large survey of medical trainees in the NHS who reported that they did not feel valued or "heard" by NHS leaders, despite having skills and ideas for the advancement of patient care (Gilbert, Hockey, Vaithianathan, Curzen and Lees). In addition, fellows reported that a climate in which budgets are strictly limited does not create the ideal conditions for innovation:

Philosophy [in Cambodia] very different to staid NHS, they want you to change but not if it means either cutting services or spending money. You can come with lots of ideas – invest to save – but they go nowhere.

A mentor, himself a senior GP, commented on the slow pay back time for his GP mentee:

She will struggle as going into salaried GP post which will leave few opportunities to suggest how they might improve their systems. This would not be welcomed from a new colleague. For GPs pay back time will be slower than with a consultant.

Clearly it is beyond the scope of a single fellowship to change the culture of the NHS; however, the failure to manage talent proactively appears to fly in the face of exhortations in policy to develop “clinical leadership” (Department of Health, 2008). Schemes like this are able to do this in relatively cost effective ways, but the NHS needs to be able to use the talent awakened.

These findings underline the importance of aligning Ferlie and Shortell’s four levels of change – whole health system, organisation, team and individual (2002). In isolation, even with the support of change exhortations at the whole health system level, individuals will struggle to find purchase in hierarchical organisations which do not readily embrace “ordinary leaders for improvement”.

Conclusion
The evaluation indicated that IGH’s “whole systems approach” to developing leaders met the challenge of developing clinicians who appreciate the value of management, audit,
quality improvement and holistic approaches to health and well being, all qualities
which are widely regarded as desirable if health care is to improve (The Health
Foundation, 2008; Stoll et al., 2011). It appears to be particularly effective in supporting
personal development, team working/communication skills, which can cross cultural and
linguistic differences, and motivating people to use quality improvement tools such as
RAID.

If, as is asserted by NGO partners in Cambodia and Tanzania, fellows make
a contribution to the achievement of Millennium Development Goals, then it is indeed
a win-win for leadership development.

The evaluation indicated that the “whole systems approach” requires some
augmentation from more traditional approaches to management education in terms of
teaching theory and new language codes if fellows are to be able to communicate their
learning in language readily appreciated by senior managers. Hence attendance at a
recognised leadership course and an introduction to quality improvement have been
added to the IGH induction programme. However, without a more receptive environment
in the UK, it is possible that Darzi’s vision of clinical leadership will not be realised –
programmes like this can sow the seed, but fertile ground and nurturing are required for
those seeds to mature into quality improvement.

If cultural barriers can be overcome, the developing recognition of the importance of
active talent management in the NHS represented in innovations such as
Darzi Fellowships (Stoll et al., 2011) should assist in ensuring that the investment in
IGH fellows is repaid through the creation of a cadre of health professionals, who are
aware of the importance of systemic improvement, skilled and motivated to lead it
thus making that real contribution to the NHS that the fellowship seeks to make
possible.

Notes
1. The evaluation was conducted by Jan Walmsley, Jan Walmsley Associates Ltd.
2. IGH Educational Plan for fellows 2010.
3. Excludes fellows who went to Kenya, none of whom had completed by end 2010.
4. Extract from post-fellowship report.

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Further reading


Appendix. Interview schedule for fellows

Introductions

The evaluation: the purpose of the evaluation is to consider the extent to which it has met the following objectives:

- **Objective 2.** To provide an unparalleled personal and leadership development experience for staff from NHS South Central.

- **Objective 3.** To create a cadre of skilled clinical leaders with quality improvement skills to make a real difference to the NHS.
Any questions about the evaluation:

Q1. Tell me a bit about yourself, and why you applied for the programme?
Q2. Review your contribution to Global Health in Tanzania or Cambodia?
Q3. Reflect upon the impact of participation in terms of personal and professional development on your work in the UK NHS?
Q4. How far has taking part enhanced your understanding and practice of leadership?
Q5. How far can quality improvement and leadership knowledge and skill gained in a developing country can transfer to the UK, and what supports, or hinders, the transfer?
Q6. Are there ways in which the IGH programme could be made more effective in meeting the two objectives?
  * Objective 2. To provide an unparalleled personal and leadership development experience for staff from NHS South Central.
  * Objective 3. To create a cadre of skilled clinical leaders with quality improvement skills to make a real difference to the NHS.

How would you justify investment in the fellowship, and in you, at a time of resource constraint?

About the authors

Jan Walmsley is an independent teacher and researcher whose company, Jan Walmsley Associates, specialises in leadership in the health sector. She is Visiting Professor in Leadership and Workforce Development at London South Bank University where she teaches Strategic Leadership to health professionals. Her interest in clinical leadership was fostered when she directed The Health Foundation’s investment in leadership. Her “holy grail” has been to find ways of independently testing the value of investment in leadership development, and she continues to seek his elusive creature. She is co-editor of Better Health in Harder Times published by Policy Press in 2013, which explores what kind of leadership is required if we are to achieve genuine partnership with patients and service users, all the more painfully urgent in the light of the Francis Inquiry into Mid Staffs NHS Foundation Trust, published in 2013. Jan Walmsley is the corresponding author and can be contacted at: janwalmsleyassociates@gmail.com

Peter Hockey is Deputy Postgraduate Dean at the Wessex Deanery and a GMC Associate where he works as part of the Responding to Concerns Action Team. He is also a Consultant Physician in Respiratory and General Internal Medicine and practises at Lymington New Forest Hospital in Hampshire. He was previously Deputy Medical Director at NHS South Central and a 2007/2008 Harkness Fellow in Health Care Policy & Practice at Harvard Medical School.

Fleur Kitsell qualified as a Physiotherapist in 1982. She worked clinically for six years, in the University sector for 13 years; and since 2004 has been in the NHS in Workforce Development. Experienced in working with teams of people from all backgrounds, she believes strongly that learning and working in this way is both more effective and more interesting. She has also maintained regular clinical practice throughout her career and PhD studies. In 2008 a clinical team piloted a programme in which Fellowships were offered to individuals from the NHS, during which they would work with a partner organisation in a country without a fully functioning structured health system, using Quality Improvement, project management and
system development to help build local capacity; rather than delivering clinical care. Here the individuals each receive coaching support and get the opportunity to develop leadership skills in a unique and effective way.

Amanda Sewell, BM (Hons) FRCA MRCGP, graduated from the University of Southampton Medical School. In 2008 she spent six months as a fellow on the Improving Global Health through Leadership Development programme in Cambodia. She now splits her time between General Practice in Hampshire and providing project management support to the Improving Global Health Programme.