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Evaluating the Impact of a National Clinical Leadership Fellow Scheme

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JM led the evaluation and drafted the paper. JM and DH are responsible for the overall content of the paper. KA and PL contributed to the paper.

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Abstract

The drive towards engaging UK doctors in clinical leadership and management has involved a number of initiatives at various levels, including specific Fellowships for doctors in training which enable them to take a year out of programme to work with senior leaders on service improvement or policy development projects. This paper reports on the findings of an impact evaluation of a national Fellowship scheme involving six cohorts of Fellows and key stakeholders. The evaluation has clearly demonstrated the impact of this long-standing national Fellowship Scheme and the huge benefits for the individuals and organisations involved. For the Fellows, a national Scheme such as this provides a unique experience, allowing them to learn first-hand from a range of senior decision-makers and engage in policy and strategic developments and processes. However, it has also highlighted that more evaluations are needed of the wide range of Fellowship schemes on offer to evidence broader impact, and raised issues around some of the difficulties these Fellows encounter on their return to practice in using their new skills to engage in service and healthcare improvement initiatives.

Keywords: leadership development; doctors in training; fellowship scheme; evaluation

INTRODUCTION

In most countries, an increased acknowledgement of the pivotal role of doctors in healthcare leadership and management has led to different initiatives to support and promote medical leadership development[1,2,3]. The UK is no exception and, particularly over the last decade, the provision of training opportunities for medical students, doctors in training and fully qualified clinicians to 'learn leadership and management' has been growing rapidly[4,5]. For doctors in training, a number of medical/clinical leadership and management Fellowship schemes have been established, at national, regional, organizational and specialty levels. These Fellowships aim to provide experiential opportunities (sometimes combined with a formal education or training programme) for Fellows to work with senior healthcare leaders and undertake projects, typically around service or healthcare improvement[6]. Many schemes involve taking a year, sometimes two, out of a training programme to focus on the project and experiential learning.

This paper reports on the findings of an impact evaluation of the longest-established UK Fellowship Scheme focused on leadership and management, the National Medical Director's Clinical Fellow Scheme. The evaluation studied the first six cohorts of Fellows recruited under the Scheme during 2011 – 2017 and key stakeholders. The key questions the evaluation aimed to answer were:

- What were the key success factors and areas for improvement of the Scheme?
- How did the Fellows experience the Scheme and how has this influenced their subsequent engagement, behaviours and thinking about healthcare leadership and management?
- What was the perceived impact of the Scheme on the Fellows themselves, the host organisations and on the wider NHS organisations involved?

BACKGROUND

The National Medical Director's Clinical Fellow Scheme was originally established in 2005 by the then Chief Medical Officer for England, and known as the Chief Medical Officer's Clinical Advisor Scheme. In 2011, the current Scheme was established, sponsored by the NHS England Medical Director and managed by the Faculty of Medical Leadership and Management (FMLM). Subsequently, the number of Fellows has expanded from 11 in 2011 to 35 in 2018. The Scheme now includes an intensive six day induction programme, developmental seminars throughout the year and a closing celebratory event.

The Scheme's development and implementation reflects the need to develop future medical leaders, and the significant demand from doctors in training. The Scheme has expanded to include host

organisations in both the North and South of England, and has close links to similar Fellowship arrangements in Wales, Northern Ireland and Scotland[7,8]. At the time of writing, more than 200 doctors in training are alumni of the English Scheme.

AIMS AND STRUCTURE OF THE SCHEME

The Scheme was designed to select both specialty and GP doctors in training, who demonstrate significant potential to develop into senior leaders and managers within the NHS. It gives the Fellows a dedicated year out of their training programme, providing experience, education and training aimed at developing the personal and professional skills required to be an effective leader and manager within a healthcare system. Fellows are recruited against defined criteria, through an application and interview process involving former Fellows, host organisation representatives and FMLM staff.

The Fellows work in an immersive, internship, 'vertical leadership'[9] model with the most senior personnel in national NHS and healthcare-related non-NHS organisations and also engage in activities, including visits to other host organisations and Parliament, teaching on leadership and management, and action learning sets (facilitated by FMLM staff). A key feature of the Scheme is its national perspective, intentionally providing participants with an intimate understanding of health policy, the relationship of the health service with the political system, and first-hand experience of high level strategic thinking and decision making. Fellows develop a range of skills including policy development, project management, research and analysis, writing and publishing, and are actively encouraged to develop and utilize professional networking skills.

Host organisations

The 'host' organisations are fundamental and, in providing salary costs plus a small FMLM management cost, fund the entire Scheme. They primarily offer Fellows the opportunity to work on various projects and activities in many different areas and sectors, always at national level and with senior people. Different types of host organisation are involved to reflect the shifting landscape of healthcare, including: the Department of Health, NHS England Commissioning Board Authority, NHS Improvement, General Medical Council, BUPA, BMJ, the Health Foundation, the National Institute for Health and Clinical Excellence, Health Education England and the National Patient Safety Agency.

EVALUATION METHODOLOGY

The project was independently evaluated by an external expert (JM) using both qualitative and quantitative methods which generated consistent, standardized feedback from alumni of the first five cohorts, the then current Fellows (Cohort 6), and host organisations. Formal ethics approval was not required for the evaluation, however participants were fully informed about the evaluation process and outputs, involvement in the evaluation was optional (including Cohort 6 who were undertaking the Scheme when the evaluation was being carried out), all identifying information relating to the Fellows was removed, and anonymity was assured through a randomised coding of respondents. Groups and individuals were geographically spread, therefore a combination of online survey questionnaires and telephone interviews was used. The questionnaires included a mix of open and closed questions, based on the stated learning outcomes of the Scheme and the FMLM Leadership and Management Standards for Medical Professionals[10]. Cohorts 1-5 were surveyed between December 2016 and April 2017. Cohort 6 Fellows, who had just commenced the Scheme when the evaluation began, were surveyed and interviewed at three points between September 2016 and July 2017. Whilst the interviews and survey questionnaires were structured around key questions aimed to elicit responses to the evaluation questions, thematic analysis of the data was carried out to identify key themes emerging from the responses. These are reported below.

FELLOWS' AND STAKEHOLDERS' PROFILE

When the evaluation was carried out, a total of 145 Fellows in six cohorts had been through the Scheme. Fellows from cohorts 1-6 were distributed evenly by gender, just over half were white identifying, with the remainder identifying as primarily British Asian, spread across training levels (from Foundation year 2 to Specialty Training 7) and specialties, with the vast majority from internal medicine and general practice, rather than surgical specialties. Over 60% of these Fellows were from the London region and South of England. The demographics have remained largely static, other than a slight increase in women, with 59% of clinical fellows in 2018/19 being female. General Practice trainees remain the highest represented specialty on the Scheme. Other stakeholders included representatives from FMLM and the NHS England Medical Director's office as well as leads in each of the host organisations

RESULTS

Respondents

66% of Fellows responded to the online survey (95/145): a representative sample in terms of the demographics outlined above. In addition, ten Fellows from Cohort 6 were interviewed at the end of their Fellowship. Twenty stakeholders from the host and other organisations involved in the Scheme in 2017/18 were interviewed on the telephone (14) or provided written responses to the interview questions (6).

FELLOWS' AND STAKEHOLDERS' VIEWS OF THE SCHEME

Endorsement of the Scheme

The Fellows overwhelmingly endorse the Scheme and would recommend it to other trainees, e.g. *'it has changed my outlook on medicine and healthcare in the UK. It has had a tremendous impact on me as an individual - I could not recommend it more strongly'* (R15). It was described as a unique and transformative experience, a positive opportunity for personal and professional development, and *'life-changing'*.

The stakeholders' view is also overwhelmingly positive. 'Hosts' describe a range of benefits and examples of the impact of Fellows' work on their organisations, including financial impact (e.g. income generation, cost savings) and a range of deliverables (e.g. reports, publications, research studies). That the stakeholders see the Scheme as so positive is exemplified by their continued engagement and investment in the Scheme.

Reasons for participating in the Scheme

The opportunity to work with national bodies and senior leaders and gain unique experiences is the main motivator cited by Fellows for applying for this Scheme over other specialty or regional Fellowship Schemes. Fellows wanted to learn new skills in leadership and management so that they could effect change, 'make a difference' to patient care, and enhance their CVs and employability.

For hosts, a key theme was around gaining knowledge and perspective from enthusiastic and intelligent 'frontline' clinicians, providing an up-to-date perspective of realities in the NHS. Arms-length bodies, not for profit organisations, third sector and commercial organisations were keen to promote their sectors as alternative places for doctors to develop their skills and *'seed insight and understanding that will counter some of the myths and assumptions about the nature and purpose of private sector healthcare organisations'* (S2). Many cited the benefits of being part of a national, prestigious Scheme. Other hosts (e.g. from Parliament or government departments) were keen to

increase Fellows' knowledge and understanding of policy-making and developing guidance within complex systems.

Structure and approach of the Scheme

Many aspects of the approach and structure of the Scheme are highly valued by Fellows, particularly access to significant health leaders; networking with other Fellows and diverse health leaders, and working in the host organisation. Fellows highly value the experiential approach, having 'headspace' to think about their careers, feeling valued as a professional and as part of a team, and having the chance to participate in activities that they do not have the opportunity to in clinical training. The most successful aspects were working on national projects and with senior leaders, such as *'shadowing a health minister in parliament, spending time with the National Medical Director and Editor-in-Chief of the BMJ'* (R21) and *'high level exposure to health care and decision making that offers legitimacy and confidence in other situations'* (R38).

Whilst the Scheme is clearly highly valued, some Fellows highlighted a lack of structure and direction by the Scheme and the host organization and a feeling that they were *'not being utilised to (their) full potential - I struggled for purpose at times'* (R11). Differences emerged about the need for a more theoretical focus and qualification versus the experiential approach which is a key feature of the Scheme. 77% of respondents responded that a theoretical component (e.g. leadership and management theory, postgraduate certificate etc.) would have been useful, some Fellows felt they didn't have anything to "show" for the year, for example *'formal recognition of the skills gained within this Scheme would be much more beneficial for our CVs'* (R20). However other Fellows said that the great value of the Scheme came from the experiential, *"on the job"* learning. One respondent said, *'making it compulsory would have frustrated me - I suspect many of those you recruit would feel the same'* (R11).

Both hosts and Fellows noted that it cannot be assumed that Fellows will have a good understanding of the many health service management aspects required. They identified key topics for Fellows to be informed about on commencement to the Scheme so they could better contribute to the host organization and feel less out of their depth (mentioned by all Fellows), see Table 1.

Table 1 Useful skills and knowledge for Fellows

- | |
|--|
| <ul style="list-style-type: none">• project management |
|--|

- understanding what a project initiation document is
- NHS structure and organisation
- policy awareness
- programme management
- coaching skills
- leadership skills
- negotiation skills
- communication skills
- presentation skills

Host organisations

Host organisations are central to the experience and development of the Fellows and many have been engaged in the Scheme for years. They identified some of the attributes of a successful Fellow, summed in terms of *‘enthusiasm, agility, flexibility, willingness to get involved in other areas outside medicine’* and *‘work with people at all levels in the organisation’* (S4). The Fellows need to have a good mix of personal qualities and skills in dealing with complexity, ambiguity and change and *‘an open mind ... not too wedded to the idea of producing a ‘shiny report’ at the end of the year ... interested, innovative and resilient ... focused on achieving benefits for patients and understand the impact of small changes* (S7). They also mentioned the benefits of having *‘some understanding of the nature of evidence and how evidence changes practice, so if they have done something like audit work that’s really helpful’* (S15). Because *‘they might be working with a president of the College or ministers of state, they have to be personable and able to work with all sorts of people at different levels’* (S16) and *‘be natural networkers who can work across organisations and systems. They need to be flexible, be able to take stock of complex information quickly... be a completer-finisher’* (S1), and *‘be aware of the wider outside world and have thought about issues around government and health services’* (S19).

Fellows and stakeholders identified elements of the ‘ideal’ host organisation (Table 2).

Table 2 The ‘ideal’ host organization

The ‘ideal’ host organization:

- Attends to practical aspects to provide a welcoming environment and give a sense of belonging
- Provides a tailored induction to the organisation
- Defines and negotiates meaningful projects and activities which stretch the Fellow and can be completed within the year
- Sets clear boundaries and defines expectations
- Provides active and meaningful involvement in daily activities, meetings and discussions
- Provides ongoing support, clinical mentoring and project supervision
- Enables the fellow to have access to and work with senior people so they can see their day to day struggles and coping strategies

Provides support and time for the Fellow to engage in a range of activities and reflection

Opportunities to work in different sectors, e.g.

- access to national agenda, policies and interests
- understanding Parliament's working and interests
- sitting on panels or inquiries
- attending committees
- working across health, public health and social care
- political understanding and contexts
- service development
- health policy, evaluation and economics
- media and communications
- working with non-doctors

Analysis and review, e.g.

- policy analysis
- data analysis, research and writing up
- engaging in Cochrane reviews
- developing evidence base for services/care
- inspections
- regulation of healthcare providers
- improving the patient experience
- working with digital online providers
- programme development, evaluation

Skills development, e.g.

- developing influencing skills

Writing and publication, e.g.

- producing policy and guidance

<ul style="list-style-type: none"> • presentations • facilitation • project management • professional education • customer engagement • engagement with external stakeholders 	<ul style="list-style-type: none"> documents • audit reports • articles • project and visit reports • presentations to committees, etc.
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Impact of the Scheme

On the Fellows themselves

The Scheme has reported impact at individual level for the Fellows and at higher levels for the NHS and host organisations. It develops Fellows' self-confidence as a leader (87% of respondents); willingness to speak up and take action if standards, quality or safety are threatened (84%); understanding of complex health/care systems (91%); understanding of policy development and implementation (80%); teamworking skills with diverse groups (84%), and the ability to engage and network with a range of colleagues and stakeholders (82%). 84% also gained awareness of the responsibility, accountability and pressures (economic, political) that clinical leaders are under, for example, *'I learnt what a hard job it is to do, that you are never truly offline, and that you need to have a very thick skin'* (R18).

With increased self-confidence comes increased inspiration, empowerment and ambition, with many respondents saying it has allowed them to *'aim high'* (e.g. R25, R22). *'It has only increased my drive to be involved in medical leadership in the future and has helped with my belief that I am able to do that'* (R9) and *'it has changed me as a person and as a doctor. I feel more confident in myself and my abilities. I feel happier to speak truth to power and to have self-belief'* (R23). 76% of respondents indicated that the Scheme had helped them understand what they wanted from their career, including wanting and feeling able to pursue senior leadership roles, e.g. *'it made senior leadership roles seem more accessible and the path towards them clearer'* (R41). All respondents mentioned their clinical practice, such as, *'I realised that clinically I'm replaceable, but when it comes to leadership, management and being entrepreneurial, I can make an extremely valuable contribution outside clinical medicine'* (R11). 63% of Fellows have gone on to undertake further leadership/management development as a result of the Scheme, including seven further fellowships

and various award bearing qualifications, including MBAs. However for some, it had changed their minds about leadership, for example *'I've decided to delay any move towards NHS leadership for the next few years as I think the environment is too adverse to make this rewarding'* (R15).

Impact on organisations and the wider NHS

The reported high level impact of the Scheme on the NHS is about inspiring and nurturing a generation of clinicians who are interested in and informed about policy change at a national level. At organizational or regional levels, the biggest impact is evidenced by Fellows' subsequent engagement with service delivery improvement, with 60% of respondents describing active involvement in service improvements. Their increased confidence, motivation and understanding of the structures of organisations and how decisions are made led to ongoing project work for many. Explanations for this increased engagement are summed up in this quote: *'I feel more confident that I understand the structure of the organisation and how to impact on service delivery, for example being able to write a business case for more funding of staffing'* (R16). 57% of respondents had also been actively involved with QI initiatives, one had established a QI academy (R1) and another reported their increased *'confidence to mentor others in their own QI projects and deliver teaching on this topic'* (R17).

52% of respondents had been involved in culture change, based on increased understanding in *"how cultures develop in organisations"* (R6). R1 described a large piece of work on culture change for NHSI, and that *'frankly, I didn't really know what it meant before the Scheme.'* 86% of respondents reported changes in attitude, such as being, *'less collaborative in negative thinking'* (R19) and *'willing to challenge examples of bad practice'* (R16). 40% of respondents are actively involved in developing other clinical leaders, through training, mentoring and role modelling, e.g. *'I am even more enthusiastic about the benefits of clinical leadership to the NHS and most importantly to the patients we care for'* (R5).

The impact on the host organisations is perceived as very positive, through tangible outputs and softer outcomes, in particular having access to practising clinicians who can advise and contribute from a fresh and front-line clinical perspective. Access to the wider host organisation and stakeholder national network also allows 'hosts' to tap into shared intelligence and *'build connections with other organisations and their projects'* (S14). Some Fellows formed their own network, worked collaboratively on projects and provided support for one another to the mutual benefit of different organisations. Some hosts reported financial impact through income generation

or cost or efficiency savings: *'they add a significant amount of value... one developed a new service, another identified major cost savings in the millions of pounds (£10).*

Challenges

Some Fellows identified challenges relating to the host organization, primarily related to how out of their depth they felt at the start of the internship: many compared themselves unfavourably to other Fellows and felt like *'imposters'*, and some supervisors did not have dedicated time for or clear expectations of their Fellow.

For host organisations, the high cost of a Fellow can make it difficult to justify the costs to their organisation, and, because the Fellows are appointed and allocated centrally, the specific grade, specialty, skills and expertise the Fellow will bring is unclear. Although all stakeholders support the principles of the Scheme, some have reduced the number of Fellows they host or stopped hosting Fellows because of cost. Some organisations (e.g. the Royal Colleges) now have their own Fellows who they select themselves, partly because they value the additional input of a clinician from their own specialty and also find it easier to justify the costs internally.

TRANSITION OUT OF AND BACK INTO TRAINING

One of the major challenges highlighted by all respondents was managing the transition in and out training. This arose as a key theme in the Cohort 1-5 survey and stakeholder interviews and was specifically followed up with interviews with Cohort 6 on their return to clinical training. 40% (45) of the respondents from Cohorts 1-5 had some problems returning to clinical practice, describing very mixed experiences in the way others perceived them, ranging from the positive, to indifferent, to negative or hostile e.g. *'It is a big culture shock and an adjustment to how much less people are interested in your non-clinical/management contributions than when on the fellowship'* (R12) and *'since returning, I have been told by my supervisor "We're not training you to be a leader, we're training you to be a clinical doctor". I feel like there is no appetite at all to allow me to use the skills and knowledge I learnt on the fellowship. I have actively been stopped from participating in opportunities, even when I suggested doing it during annual leave.'* (R21).

Hosts became increasingly aware of these difficulties and tried to provide Fellows with support to help them make the transition back into clinical training, including a clinical mentor, making sure Fellows are up-to-date with administrative aspects such as appraisals, and encouraging them to keep in touch with work. Hosts have to deal with employers and training bodies about contractual and employment issues regarding their Fellow's contract and out of programme time. This can

sometimes prove problematic. Hosts also noted that Fellows need to make a mind-set shift, for example, *'it can be quite heady working at top level with access to ministers, presidents of colleges and working in London, so it is difficult to adjust, though hopefully the skills we have given them will help them make the transition'* (S19).

95% of Cohort 6 Fellows had felt anxious about returning, particularly those who had been out of clinical work for the whole year, but looked forward to working with patients again: their *'real work'*. Fellows also felt a loss on leaving the Scheme and their peers and valued being able to get together before they returned to practice. Many found the return physically tough and demanding (e.g. nights, on calls), some would have welcomed more supervision so they felt they were safe clinically. All Fellows welcomed support and information from hosts and FMLM about returning to clinical practice, because they were prepared for the transition to be tough, and that their clinical skills and knowledge had degraded. Some Fellows had organised their own return to work through contacting the Trust/practice or locuming. Those who had locumed, done revision before returning, had passed College exams or were further on in their training were much less worried about losing their skills and returning to work. This echoed what hosts suggested, i.e. that *'the more senior ones are at a level to make a difference, but the junior ones get frustrated as they are plunged straight back into clinical work and people don't understand what they've been doing'* (S10).

Fellows need to be proactive when they are allocated to the Scheme and set things up for their return, including obtaining a letter of support from their MD/CEO as this adds weight to having protected time or other needs when they return. FMLM also now sends a detailed letter and individualised 'transcript' to the CEO/MD to provide information for the Fellow's return. Supervisors or doctors who understood the Fellowship and potential of the Fellow were much more positive, encouraging Fellows to undertake new projects, with some being given protected time to do so. Other Fellows kept quiet about having been a Fellow for fear of negative reactions, some experienced very negative responses which made them feel like an *'alien'* or a *'spy'*. Many expressed frustration about the lack of knowledge and appreciation from colleagues of their new skills and understanding and felt they were *'put in a box'* with other trainees whereas they had gained huge experience that they wanted to use.

DISCUSSION

In response to this evaluation's findings and recommendations, the issues described above relating to the Scheme's structure and support and the matching of Fellows to host organisations have been

addressed. For example, the expectations of and requirements from the hosts have been clarified and strengthened and there is now a closer matching of Fellows to organisations. The Scheme continues to be regarded nationally as highly prestigious and *'word on the street'* (promulgated by previous Fellows) is that the Scheme is hugely transformative, albeit viewed as slightly *'elitist'* as it involves working with national bodies and very senior leaders. However, this is also the strength of the Scheme and is highly valued by the Fellows once they have settled in to their roles.

Since this Scheme was established, the number of out-of-programme Fellowships for doctors in training in clinical leadership and management and quality/service improvement (plus education and research) has significantly increased, including specialty specific Fellowships, and national and regional Fellowships across all four UK nations. The evaluation of this Scheme reflects other evaluations[6,7], reporting clear impact, at individual level, for host organisations and through the Fellows adding value to the NHS organisations to which they return, through their more informed engagement with quality and service improvements and shift in career aspirations towards taking on leadership roles. Whilst this dedicated time out of training is beneficial, it raises potential workforce planning issues around *'justifying stepping out of training when there are huge workforce gaps in some specialties and regions'* (S19). S19, one of the stakeholders, suggested that at all levels, work is needed to build leadership and management development *'into the workforce structure and show its impact'*. Whilst it is clear that the vast majority of Fellows on the various schemes gain huge benefit and learning for themselves, as Edmonstone[11] also noted, more systematic measurement and evaluation is needed of all schemes to help demonstrate their wider impact, potential cost savings, and healthcare and service improvements. If impact can be clearly evidenced and demonstrated, then Fellowships (and Fellows) are much more likely to be seen positively rather than as a drain on the NHS.

Potential future Fellows and the wider NHS require commissioning or supporting organisations to be very clear about the specific opportunities, projects and experiences they can offer, training in management skills, and high level support and supervision for their Fellows (see also Bagnall[12]) so that both the Fellows and the organisations funding these (relatively) expensive schemes optimise the benefits. Supporting a doctor in training to take one or two years out of full-time training is a big investment, and was a big issue for some host organisations. Doctors in training will not necessarily have the understanding or skills to work in management or policy contexts and at a level that might be required, therefore provision needs to be made to facilitate this learning, either through signposting to online resources or through specific training. Whilst this does not necessarily have to be a formal or award bearing programme, Fellows are increasingly looking to obtain *'value-added'*

from their Fellowship year through a masters' or other qualification to enhance their CVs and demonstrate achievement, and many of the regional and specialty schemes offer these. However, this needs to be balanced with the intended immersive experience offered by such a national Scheme, exposing Fellows to uncomfortable 'heat' experiences which provide 'colliding perspectives' and new insights into healthcare and policy[9].

The final issue that came through very strongly from all respondents concerns the transition back into clinical training. 48% of the Fellows experienced some difficulties with making the shift back into clinical training, despite support from FMLM and host organisations. Part of this is a mind-set adjustment after working out of programme often with senior leaders in non-clinical environments, and then going back to being simply 'one of many' trainees. Despite the evidence that medical leadership and engagement improves outcomes and performance[13], many Fellows and hosts reported that, often senior, clinicians did not understand what they had been doing on their fellowship and how they could subsequently use their new skills to engage in service and quality improvements. This is not unique to this Scheme[14] and may reflect the relatively recent emphasis in the UK on leadership development for doctors, as opposed to the more traditional areas of clinical medicine, research and education. This was both frustrating and diminishing, and in some cases, people were actively hostile to the Fellow. It is hoped that, as doctors' engagement in clinical leadership and management activities becomes more mainstream, such behaviours decrease, but in the meantime wider communications and dissemination of the benefits and value that these Fellows can bring is essential.

Both Fellows and hosts also reported that those who were further on with training or had passed College examinations felt better-placed to contribute to leadership and quality improvement activities on their return. Anxiety about eroded clinical performance appeared less in those Fellows who had kept in touch with work and worked locum shifts and therefore those funding and setting up Fellowships should consider developing, possibly longer, posts that combine clinical work with a Fellowship. This would dovetail into the increasing shift of doctors towards portfolio careers and might ultimately help recruitment and retention.

Limitations

FMLM staff (including the co-authors) were closely involved with the Fellows, some hosted Fellows and others provided teaching and support. This may have influenced Fellows' willingness to engage in the evaluation, also respondents were self-selecting, so may have had specific concerns to share. The time point when Fellows were on the Scheme and when stakeholders were involved also varied and many of the issues identified had been subsequently addressed by FMLM.

CONCLUSION

This evaluation has explored the impact of a national Fellowship scheme on six cohorts of Fellows and the stakeholders involved. The evaluation has clearly demonstrated the perceived impact of a long-standing national Fellowship Scheme for doctors in training on the Fellows themselves, on participating organisations and on the wider NHS. A national Scheme such as this provides a unique experience for the Fellows, allowing them to learn first-hand from a range of senior decision-makers and engaging them in policy and strategic developments and processes.

Since the Scheme began, the clinical and medical leadership landscape has changed immensely, and now many out-of-programme Fellowship schemes are available in all four UK nations (and internationally), for different medical specialties, and at organizational, regional and national levels. Despite the number of Fellowship schemes, little systematic evaluation of the wider impact of these schemes on organisations, service and patient care has been undertaken and this is essential in order to provide robust evidence of their impact and success. In addition, whilst the individual Fellows themselves clearly develop hugely professionally and personally throughout their fellowship, for some, their potential value when they return to training is massively under-utilised, even ignored. Such toxic cultures urgently need addressing so that the potential and enthusiasm of these doctors continues to be nurtured, and the skills they have learned are capitalized upon to the benefit of patients and services.

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Competing Interests

DH, KA and PL are intimately involved with the management of the Scheme and have been responsible for its development since its inception.

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