SECTION 1 - EVALUATION PLANNING PRO FORMA

Development Intervention	*Back to the Future: A Development Programme for GP Practice Managers as Community Change-Makers and Social Leaders*
Sponsor/Lead	Anonymised
Context	The world in which the NHS operates has changed significantly since its inception in 1948. The NHS now needs to shift its focus in order to adapt to the new challenges associated with the changing profile of our population - people are living longer, but often with multiple and complex long term conditions, some of which might be preventable. There is a need to take advantage of the opportunities that advancements in science and technology bring and also to develop more engaged relationships with patients, carers and citizens, as well as building new partnerships with local communities and neighbourhoods. People's expectations are also changing, as patients want to be more actively involved in their own care. Alongside this, the concept of patient leadership is emerging as an important way of working collaboratively with patients, carers and communities. Patient Leaders can bring a credible voice and can work with system leaders in making the case for change. Their focus on the experience of care can also ensure that health care services remain focused on the right priorities. G.P practices are at the heart of our communities and never more so, as there is a growing expectation that people should be treated more locally. This is further reinforced by the emergence of sustainability and transformation plans (STPs), emphasising the need for providers of services to work together locally, in order to improve the health and care of the people they serve. Practice managers play a key role as change agents - leading and supporting the delivery of improvements to services, via the work they do within their own practices; their relationships across the system, with patients, carers, communities and neighbourhoods, commissioners, voluntary and community organisations. Similarly, the emergence of patient leaders requires a change in focus and the development of new relationships and partnerships in order to deliver improvements and develop a local focus that allows people, where possible, to be treated closer to home and to have a more active relationship with their practice and within their own care. Patient leadership and community engagement are therefore key components of the underlying programme structure and concepts around working collaboratively with patient leaders will be applied through the application of a work based improvement project that will be integral to the development outcomes for practice managers who undertake the course.

SECTION 1 - EVALUATION PLANNING PRO FORMA

Intervention	The programme outline includes: • 4 formal days of class room based learning • Attendance at 3 Action learning sets • Completion of an independent service improvement project with a patient leadership and community engagement focus • All participants will be expected to identify and work with a community mentor who will support and guide them with their project work • Access to YHLA coaching and other resources for professional development Location: **Leeds** This pilot programme was developed for a total of 20 Practice Managers in the Yorkshire and Humber region. Rollout of the programme is to be determined by the evaluation of the pilot.
Theory of change	YHLA have committed, in consultation with stakeholders, to the following core principles that need to underpin the overall ethos, the content and the delivery of the programme: • A dialogic peer based learning approach - supporting participants to share their existing knowledge, understanding, experience and perspectives • Facilitated in a way that enables core 'theoretical elements' to be introduced and woven into the sessions and that helps participants to understand that they are active learners and have expertise and experiences of value to share with others • Focus on practical work based application, and action learning by participants of which patient leadership and community engagement is at the core • Connective leadership, authenticity and shared humanity as leadership approaches and the importance of building relational capital in how we lead and enable change • An asset-based model throughout – in relation to participants identifying and harnessing their own power, fulfilling their potential and identifying/enabling this in others • Direct experience/exposure to the impact of patient and citizen action to improve health and care services along with the principles of co-production; recognising the power of a Social Movement approach to the transformation of health and care services • Use of coaching approaches within the programme and in encouraging participants to use/develop coaching approaches in their role as change agents

SECTION 1 - EVALUATION PLANNING PRO FORMA

Expected measurable outcomes	To pilot a development programme for Practice Managers in Primary Care which will: • Understand the local, regional and national context in which they operate and their influence in their role as change agents within their practices and communities • Build effective, authentic partnerships for wellness and self-care with citizens and across communities - enabling people to improve their own lives and to influence development of health and care services locally • Support practice managers to discover their gifts and potential for growth and development • Successfully harness the knowledge, experience and commitment of others, within the practice and local system to bring about improvements in health and wellbeing • Identify their location in present systems and roads to possible re-alignment • Supporting the emergence of effective prevention and self care for people and communities • To create alliances of care and change, with patients and carers as partners • To promote one's own resilience, energy and self care and that of their communities • Developing an innovation mindset and spirit of intrapreneuralism, in order that practice managers can identify and initiate innovation and improvement that will enable their practice to respond to and flourish in a changing environment • Build effective support networks to help sustain their courage, resilience and energy levels through the challenge and complexity of leading change
Evidence	See separate Evidence Gathering template
Reporting and Dissemination	See separate Evaluation Report. This report is circulated to the HRD community, available online and lodged in the Leadership Community's Evaluation Repository.

SECTION 1 - EVIDENCE GATHERING PRO FORMA

Development Intervention	*Back to the Future: A Development Programme for GP Practice Managers as Community Change-Makers and Social Leaders*
Sponsor/Lead	Anonymised

	Before	**During**	**After**
Individual	Programme eligibility defined as being for Practice Managers working within the NHS, in the Yorkshire and Humber region. Invitation for expressions of interest sent out across various networks within Yorkshire and Humber outlining content, approach and purpose of the programme to ensure that candidates understand the programme's core vision, and that this fits with their learning needs. Application process agreed as follows: Candidates must submit documents which demonstrate reasons for applying for course that meet with the course aims/objectives and outcomes; include an up to date CV in order to assess for relevant knowledge, skills and experience; as well as demonstrate general aptitude Confirmation from Practice Line Manager confirming commitment to course. Authorisation of study leave for all elements of the course must be secured. Opportunity will be provided here for candidates to discuss purpose, aims and objectives and method of course delivery to ensure that they are satisfied that it meets their learning needs and style, and to provide further assurance of candidate suitability for programme	Attendance and active participation in all sessions including Action Learning Sets (ALS) Identification of peer mentor 'buddy' within group to provide support and critical challenge Identification of a current issue/project to which to apply their learning/development. Identification of someone within their practice who represents patient leadership to work alongside a service improvement project. Evidence via ALS of practical application and of new ways of working and behaviours by participants. It is expected that due to the protected space within ALS sessions, this evidence will be experiential and sought through feedback from participants. Completion of reflective account – which demonstrates development in participants' self-assessed level of confidence and competence in their change agent role	Continued engagement of participants with each other as part of an ongoing network Interest in further study day post programme to discuss application of learning and promote ongoing engagement with peer network of participants. Feedback from participants in relation to their development should be collected including: • Personal learning and development outcomes • Reflections about how they might apply their learning within their role • Reflections about how they might work together collaboratively in future as a peer group • Constructive feedback on how the programme can be further improved and developed

SECTION 1 - EVIDENCE GATHERING PRO FORMA

Organisational	Agreement of employing organisation to study leave for all elements of programme (via application process). Document (flyer) produced clearly stating: • The context in which the programme has been developed (the 'why') • Aims and benefits of the programme • Who it is aimed towards • What is expected of employing organisations • Effective communication/promotion of programme to GP Practices and Practice Managers via GP & Practice Manager networks, CCGs to their member practices & Practice Manager 'talent pool' • Also via LWABs, Primary Care Workforce Groups and STPs	Evidence of learning being applied in practice, including changes in thinking, behaviour and style, as well as new ways of working and any examples of how this is being employed within the organisation.	Feedback from individual and their employing practice on impact of programme – benefits seen, practical improvements delivered. To collect evidence of this at follow up day.

SECTION 1 - EVIDENCE GATHERING PRO FORMA

Provider	Development of programme undertaken with input from various stakeholders to ensure it is relevant to participants and organisational need and that it is complementary to, rather than duplicating of other programmes. Document (flyer) produced clearly stating: • Who the programme is aimed at • The context in which it has been developed (the 'why') • What we are hoping to achieve • Approach and guiding principles • Aims and benefits of the programme Providers sought will be suitable for the programme, with the right mix of skills/experience and a track record delivering programmes with a theme of patient leadership to ensure core focus is retained	Evidence collected via ALS and throughout formal learning days to demonstrate practical application of learning and any evidence of change relating to thinking, behaviours, as well as new ways of working and emerging styles. Ongoing feedback collected throughout the programme regarding course relevance, including theory and the practical application of learning from the formal learning days as well as the ALS. Consistent attendance by participants should be seen, as well as high completion rate. Level of take-up by participants of access to other provision via YHLA or other linked provision should be monitored e.g: • Individual coaching • Systems Leadership Labs • RADAR & effective networking • HLM & 360 feedback • Co-creation network	Continued engagement/contact with participants as alumni and/or active network/community of practice. Active involvement of alumni in development of others within future programmes. Longer-term feedback via alumni /network of impact of programme on participants' role development and achievement as change agents.

SECTION 2 – EVIDENCE GATHERING PRO FORMA

Development Intervention	*Back to the Future: A Development Programme for GP Practice Managers as Community Change-Makers and Social Leaders*
Sponsor/Lead	Anonymised

Date	16/10/2017	Author(s)	Anonymised

1. Executive Summary

The *Back to the Future Programme* was commissioned in Winter 2016 in order to address an increased local need for GP practices to work more closely with Patient Leaders, who provide a credible voice in making the case for change. The programme was based on the core vision that patient leaders' experiences of care can help to ensure healthcare services are focusing on the right priorities, strengthening relationships with patients, carers, communities, neighbourhoods, commissioners, and voluntary/community organisations.

The YHLA Head of Leadership commissioned the programme. Initially, two Leadership Associates, based within the Yorkshire and Humber Region were seconded to Yorkshire and Humber Leadership Academy on a part time basis to lead the design and development of the programme. These had a background in Practice Management. During the design phase, one Associate left the programme team in order to take up new employment and another joined the team as an Associate. A series of discovery meetings with patient, community and system leaders from voluntary and community organisations within the region were conducted to inform and shape the core vision of the programme and this was an iterative process that continued to evolve as the programme design started to take shape.

The programme initially offered 20 places to GP Practice Managers based in Sheffield and Leeds. This decision was made initially as the two programme leads were based in these areas for their substantive roles and therefore understood the landscape in which practice managers operated within these CCG areas. This was initially thought to be important in order that the programme could be tested out as a pilot for practice managers operating in these areas. However, once the programme was advertised, it generated interest across the Yorkshire and Humber region and the geographical criteria was reviewed to enable all practice managers working across Yorkshire and Humber to be eligible to apply for a place on the programme. 21 participants were ultimately offered places. A chart demonstrating the breadth of organisation demographics geographically can be found in Appendix 1 below.

The programme comprised 4 formal days of classroom based learning, plus attendance at least 3 facilitated Action Learning Sets (ALS) and completion of any set work between face-to-face sessions. The programme was modular in approach, with each day focusing on a different topic. All participants were initially expected to identify and complete an independent service improvement project with a patient leadership and community engagement focus, whilst working with a community mentor who would support and guide them with their project work. However, this was later adapted to align with the level that participants were working at, in order to ensure the programme's aims remained relevant and appropriate to the participant and their workplace's learning and development needs (further discussion of this is provided in Section 6).

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All participants were provided with access to YHLA coaching and other resources for professional development. The programme was based in Leeds, due to the central and accessible location for programme participants and stakeholders across Yorkshire and the Humber region. This was discussed again with participants during the programme and the consensus was that Leeds was the most central location for participants working across the geographical footprint.

2. Introduction

G.P practices are at the heart of our communities, and never more so as there is a growing expectation that people should be treated more locally. Furthermore, at a population level, the profile of health care need has changed dramatically since the inception of the NHS in 1948, with management of long term conditions now accounting for the most significant proportion of the NHS budget. People are living longer, but often with multiple long term conditions. It is widely acknowledged that services need to be delivered differently and that people now need and often want a more engaged relationship with their general practice. Self-care and peer support now feature strongly in the way that many people manage their long term condition. Community rather than hospital based treatment is now the usual approach to care and treatment for the general population, with hospital based care being more focused on care of the most acute and/or complex end of the pathway. The use of digital technology is becoming increasingly prominent in facilitating support, care and treatment that enables people to live more independently and autonomously within their own homes and communities, with varying levels of support from health care practitioners during a person's life span.

This is all set in the context of the NHS England Five Year Forward View and associated new models of care, as well as the emergence of Sustainability and Transformation Plans (STPs), emphasising the need for providers of services to work together locally, in order to improve the health and care of the people they serve.

Practice managers play an important role in this as change agents - leading and supporting the delivery of

improvements to services, via the work they do within their own practices.

Many of our citizens are seeking to be more actively involved in their care and to have a more active involvement in the development of services and new ways of working, both within their local area and nationally. Patient Leaders are emerging as a crucial voice within the current and future NHS landscape and are shining a light on the NHS and the ways in which we need to adapt to ensure that services are fit for purpose in today's world.

Patient leadership requires a shift in the locus of control away from historical, paternalistic models of care that placed little emphasis on citizen and patient involvement. Instead, it emphasises the need for more collaborative and transparent relationships with patients, carers, families, citizens and their communities and neighbourhood's , whereby improvement is co-produced with the people who services are intended for.

Patient Leadership and community engagement is therefore a key component of the underlying programme concept and structure, with a particular emphasis around supporting practice managers to develop new and more engaged relationships with patient leaders and their community, in order to bring about sustained change in how health care services are led and delivered.

SECTION 2 – EVIDENCE GATHERING PRO FORMA

3. Method

The design of the programme was influenced by a number of underlying theories of change. Firstly, Carl Rogers' work built upon the assumptions of Maslow's 'Hierarchy of Needs' in relation to the process of self-actualisation. Maslow suggested that one's potential can only be reached once all other needs are met.[1] This is defined as a hierarchical process, starting with the most basic physiological needs through to eventual self-actualisation, concerned with fulfilment of potential. This is illustrated below (Fig. 1).

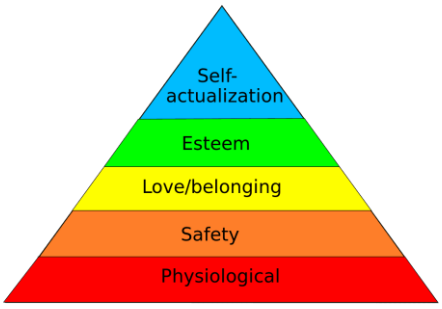

Fig 1. Maslow's Hierarchy of Needs

In order to self-actualise, Rogers believed that we need to explore our thoughts and feelings at each level and to be grounded in the 'here' and 'now'. For a person to grow, Rogers emphasised that the conditions of the individual's environment need to be genuine, allowing for openness and self-disclosure. He also emphasised the importance of acceptance and displaying unconditional positive regard and empathy for one another.[2] These conditions were considered to be inherent to the delivery of the programme, as a developmental process for each individual and the group as a whole. This was particularly important as this was a pilot programme and therefore there was no existing benchmark in relation to the participant's level of learning and development.

The programme leads therefore developed a core outline for the programme in order to provide definition and purpose, but also ensured that the actual content of each session was fluid and to some extent participant-driven. It was identified early on that the group facilitator needed to be able to adapt the learning environment and content to the individual learning needs within the group.

The Programme Leads were therefore keen to ensure that the participants individual development needs were met as this was thought to be fundamental in supporting them to develop new relationships within their practices and communities. However, in addition, the Programme leads thought that it was essential to shape the programme in a way that encouraged Practice Managers to look outwards to the communities in which they operate, understanding the context of the communities in which they are based, as well as being able to develop new and more engaged relationships within their local area in order that they can unlock the potential gifts that exist within their communities. Asset-based Community development offers a useful framework within this context.

Asset based community development is a methodology for the sustainable development of communities based on strengths and potential. It involves assessing resources, skills and experience available in a community; organising the community around issues that move its members into action; and then determining and taking appropriate action. This approach emphasises the need to use the communities' own assets and resources as the basis for development.[3] This is set against the background of the current direction of travel for the NHS, as detailed in the 5 Year Forward View.[4]

[1] A. Maslow, 'A Theory of Human Motivation', *Psychological Review* (American Psychological Association: Washington D.C., 1943)

[2] C. Rogers, *Client Centred Therapy* (The Riverside Press: Cambridge M.A., 1951)

[3] *Asset Based Community Development* (Nurture Development)
[http://www.nurturedevelopment.org/asset-based-community-development/]

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Local health and care providers are facing increasing constraints and challenges in relation to budgets and resources. This context along with the challenges posed by widening health inequalities appears to be driving a shift towards more asset-based approaches in health, care and wellbeing.[5] The premise of Asset Based Community Development is that communities themselves can drive the development process. Asset based approaches build on assets found in the community and mobilise individuals, associations and institutions to come together to realise and develop their strengths. Shifting the conversation with people accessing primary care services from "I" to "we' reframes the situation, offering a shift from a passive patient response to a citizen response.[6] In order to develop an asset-based approach, programme leads considered principles of co-production as key to the design of the programme.

Co-production is defined by Nesta as 'delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change'.[7] From the programme design team's discovery work, during which they engaged with a variety of stakeholders, it was apparent that many Practice Managers had an operational mind-set, focused upon the needs of the practice, rather than locating themselves within the community the practice operates in. The programme was developed with the aim of helping to create a shift towards working more closely with patients, carers and citizens within their communities, utilising principles of an asset-based model of community development as outlined above, whilst also acknowledging and working with what the participants consider to be their leadership development needs, which are likely to be characterised by demands occurring from existing cultures and practices.

From the team's initial engagement work, a working hypothesis was developed: that concepts of patient leadership and principles of co-production would not be part of the existing leadership and improvement model within GP Practices. Following this, consideration was given to how this approach would be introduced to the group, emphasising the benefits for Practice Managers and their practice environment. It was also hoped that the programme would create opportunities for the practice managers to test out collaborative working partnerships within their own practices and communities, whilst within the safe and reflective learning environment that the programme aimed to offer.

Based on these core concepts, a modular programme was developed comprising 4 days of semi-structured facilitated sessions including theoretical inputs and group work; 1 day per month over a 16 week period, covering the following themes:

Day 1 – **Keeping it Real**

The local health and care landscape and the bigger picture; understanding where Practice Managers fit and what their role is in shaping the future; assets and deficits; developing a collaborative approach and setting the scene for partnership working with patient leaders; setting the scene for peer learning; NHS and core professional values

Day 2 - **Presence, Impact & Influence**

Sharpening your change 'tools'; harnessing your own and others' potential, skills & commitment; creating spaces and conversations for others to identify their potential, skills and contributions; new thinking-new partners; setting the scene re patient leadership-story telling by patient leaders and other community leaders; developing a project brief for a service improvement project that involves patients, carers and communities; exploring ideas around community mentorship and local resources

Day 3 - **Keeping it going**

System leadership and system change; finding connections, tools and networks

Day 4 – **Where Now - Where Next**

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[4] *Five Year Forward View* (NHS England)

[https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf]

[5] *Head, hands and heart: asset-based approaches in health care* (Health Foundation, 2015)

[http://www.health.org.uk/sites/health/files/HeadHandsAndHeartAssetBasedApproachesInHealthCare_InBrief.pdf]

[6] *A Question for Community Wellbeing* (Nurture Development, 2017)

[http://www.nurturedevelopment.org/blog/abcd-practice/question-community-wellbeing/]

[7] *The Challenge of Co-Production* (Nesta, 2009)

[http://www.nesta.org.uk/publications/challenge-co-production]

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Hearing the story; evaluating progress and journey - next steps; resilience and sustained change; mapping the future

Format

- 4 formally delivered learning days, as above
- Monthly Action Learning Sets (3 in total)
- Putting learning into practice through an identified service improvement project (this was later adapted: see Section 6 below)
- Completion of reflective account

Participants will also have access to a variety of Yorkshire and Humber Leadership Academy development resources.

5. Costings					
Staff Costs:	Third Party Costs:	Venue related (accommodation, room hire, AV, catering)	Materials:	No. of Participants:	Total Cost:

SECTION 2 – EVIDENCE GATHERING PRO FORMA

6. Findings, Analysis, Discussion, Recommendations for the future and lessons learned

Patient leadership and community engagement were intended to be key components of the underlying programme structure, with concepts based around collaborative working with patient leaders applied through work-based improvement projects that was intended to be integral to the development outcomes for the practice managers undertaking the course. However, as the development of the programme progressed, it moved further away from this focus and closer towards a practice manager-centric leadership development programme. The team involved with the design of the programme considered this to be as a result of several factors:

1. Participant level of working

Prospective applicants for the programme were required to submit documents which would be assessed against a strict set of selection criteria to ensure their suitability for the programme, including a statement from the individual which gave evidence of how they would work with their local community and patient leaders, a statement of organisational support from the individual's line manager, and a current CV. Despite this, it became apparent once the programme had launched that participants were operating at a basic level in relation to their development as leaders and that concepts around co production and community development were new concepts, and therefore some formal learning and reflection on these would be required before progressing towards implementation of these concepts within an improvement context. Furthermore, initially the programme did not appear to be what the participants were expecting. Despite the background literature provided during the application process, as well as them evidencing their expectations and learning needs in relation to being 'community change makers' working with patient leaders, it appeared that the majority of participants saw this as an opportunity to develop their own leadership abilities and presence within their local practice, rather than this being a development programme that might support them in developing engaged relationships with patient leaders and within their own communities.

This was especially apparent in the first session, 'Keeping it Real' as concepts around patient involvement and leadership appeared to be novel to the group, who could not see the relevance, in terms of their development or that of the practices. Participants had also been asked to draw a map of their world within a work context and to bring this to the first session and share it with the group. It was apparent from the maps that the participants saw their world as existing within the confines of the medicalised, operational aspects of the practice. There were very few examples of how the wider community looked and where there were examples, these were minimally described and often linked to a medical service that operated in that part of the neighbourhood.

For homework from the first session, the participants were required to have a conversation with a patient registered with their practice, but not necessarily within the practice environment. It was apparent that many of the participants were uncomfortable about this and were also very outcome focused, expressing uncertainty about what outcomes this would achieve. One of the participants said that he already had an established patient forum in the practice, but it was apparent that whilst this was held at the practice, staff from the practice were not involved and it was unclear about how this forum influenced service developments in any way because of this disconnection. However, once the participants returned on Day 2, feedback was generally positive and the participant who had expressed concern about the relevance given that he had an existing patient forum in place, had gone out into his local community and had a conversation with a patient that he had found enlightening. He was therefore able to articulate and understand why this was beneficial to his development as well as for the development of the practice.

In all, programme leads recommended that for future cohorts, the application and assessment process for prospective participants should incorporate a compulsory screening interview/discussion, in order to ensure the individuals are the right people for the programme, that they are already fully receptive and committed to the programme's core vision, or otherwise that we signpost them to a more suitable offer which meets their expressed learning needs. Whilst programme leads did attempt to make contact with prospective applicants prior to the programme commencing, due to the restricted timescales, getting through to practice managers in a timely manner was a challenge. This report would therefore recommend that application guidance/expression of interest documents for future cohorts should make it clear that applicants will be

expected to arrange direct contact with the programme leads before a place will be offered.

2. Lead time

An additional element that affected the recruitment/selection process of this pilot programme was the limited turnaround time available in which to recruit suitable participants to the programme. As a workaround, the programme leads implemented a process whereby the participants were required to provide an up to date CV, expression of interest and formal study leave approval document within a short time scale. It was thought that this would ensure that the most motivated candidates would be likely to submit their applications within the time scales available. The disadvantage was that both the programme leads and candidates did not have much scope to engage in pre application screening or discussion, ahead of the formal application process.

3. Length/structure of programme

Based on the observations of the programme design and delivery team involved and feedback from the participants, this report would recommend that future iterations of this programme should either run for a slightly longer duration, or to be run as two separate but linked programmes – one being at an introductory foundation level, and another for those who have mastered the concepts and are ready to embed this learning by implementing service improvement plans.

It was identified that the participant group as a whole only began to fully 'buy in' to the programme's vision during Day 3. This appeared to be following a session where a number of patient and community leader speakers delivered talks to smaller groups of 6 participants at a time in a carousel format. The powerful and moving stories from the speakers appeared to inspire and motivate individuals, by enabling them to hear different voices and stories about real change where patients and communities have been key aspects of the transformation.

In support of the above relating to recommendations about programme length, further feedback from the ALS Facilitator suggested that more ALS meetings would have been very beneficial for many individuals in the group, as they had just begun to cement their learning by time the programme ended.

4. Patient Leadership focus within delivery

On reflection, it was thought that the programme did not fully reflect its original aims and vision around patient leadership and community development. These concepts were introduced at a basic level and there was evidence of reflective learning amongst the participants, who by the end of the programme were articulating the benefits of more engaged relationships with their patients and communities. However, by the end of the programme, participants were at the level of thinking and understanding that had been predicted as being their development level at the beginning of the programme. The programme was therefore largely focused on supporting them with their development needs as leaders and concepts of patient leadership and community development were delivered at a basic level, rather than being the main focus of the programme and its outcomes.

In relation to this, the programme initially intended to have participants identify and develop a service improvement project whereby they were required to work collaboratively with a patient leader, who they self-selected from within their community. The original intention was that the improvement journey would be presented to the group at the end of the programme and delivered as a partnership approach by the Practice Manager and Patient Leader. However, this appeared to be too advanced in terms of the level of capability, knowledge and skills of the participants in the group. The service improvement project proposal was discontinued, and instead the outcomes were seen as more developmentally focused around introducing the key concepts and then supporting them as a group and individuals in developing relational skills linked to their leadership approach.

It was noted however, that significant learning appeared to occur as a result of the session whereby various speakers gave talks to the group from either a patient or community development perspective and that this appeared to illustrate for them 'the art of the possible'. It is recommended that for future iterations, patient and community voices are more strongly featured in the programme delivery. In addition, it is recommended

that a stronger emphasis on social media should be built into the design of the future programme structure, in order to encourage participants to think more diversely, to hear different voices and to encourage wider networking and learning from beyond their organisational and geographical boundaries. Introducing the participants to various thought leaders on social media who represent patients and communities may also have been beneficial to their development. The use of digital tools for protected networking to occur between the participants within the group may have also helped facilitate further learning and peer support once the programme had finished. Indeed, the participants reported that the networking aspect of the programme had been one of the most valuable aspects of learning for them.

5. Evaluative Data Gathering

Via informal mid-programme verbal feedback collected through programme leads and facilitators and a final 'review' session with participants, the programme was considered to broadly be a success and received generally positive comments from the participant group who thought that they had developed their leadership skills through their learning within the programme. The opportunity to network with other practice managers from across the Y&H region was considered particularly valuable by participants.

In terms of patient leadership, the sessional speakers who delivered talks on Day 3 about patient and community leadership were also considered to be a powerful component in inspiring participants and cementing their understanding of programme concepts, creating a shift in perspective by demonstrating to participants that things can be done differently and that transformational change is possible.

Two participants withdrew on the first day of the programme: the two individuals had applied for the programme after the application deadline had passed, so it is possible that they did not have the same preparation time or understanding of the programme's aims prior to commencing on it. It would have been valuable to have a conversation with these individuals following the programme to ascertain their reasons for withdrawing – however this is not always possible. An additional participant also withdrew during the programme, citing conflicting organisational pressures as reasons for failing to attend multiple sessions. This was noted by the programme leads/facilitators as an area for learning in relation to both the organisation's commitment to support the participant in attending all programme days, and the individual's possible resistance to accessing deeper learning as the programme progressed – this report considers the focus on the individual and attention to detail demonstrated by the providers here a very positive indicator of the quality of support and investment in the participants' success.
However, there is limited written evidence of mid- or post-programme feedback, as typical evaluation forms/surveys were not conducted within each session. The facilitator had been cautious about using these formal tools, preferring to provide opportunities for group discussion as a development process for the group. Themes identified from these discussions are reflected within the report. The final session of the programme also provided an opportunity for more focused reflection on the entirety of the programme and notes from this feedback are transcribed in the Appendices.

To strengthen, the evaluation aspect of future programmes, it would be useful to re consider how more individualised feedback might be captured throughout the programme.

Furthermore, the report authors did not have access to direct feedback relating to the ALS aspect of the programme. This was partly due to the confidential nature of the ALS component of the programme. There was the potential for disconnect with these two elements. However, feedback from the ALS facilitator at the end of the programme was wholly consistent with the rest of the findings detailed in this report.

6. Potential for replication

Whilst this programme was initially aimed towards GP Practice Managers, there is clear potential for it to be developed and replicated for other professionals working in primary care: for example, practice nurses, who may experience significant benefits from the programme's goal to help them work more closely with their communities, or those working within hospice care, due to the changing focus around hospices supporting people with end of life care in their own homes and communities.

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7. Access to other development

Reflecting on the programme, leads identified that it would have been valuable to have linked up the programme with other existing networks/YHLA offers, such as the OD Network and the Co-Creation Network. Future participant groups should be encouraged to develop a Community of Practice within the participant group, which could help them to maintain their learning and access to peer support, as well as increasing the sustainability of learning into practice as an outcome of the programme. All participants were provided with access to the online YHLA coaching/mentoring offer, My eCoach. A key discussion point towards the end of the programme was whether enough work had been done to enable participants to begin influencing culture change once they returned to their organisations and it is thought that a network such as a Community of Practice, alongside continued ALS sessions and mentoring/coaching support, might provide an opportunity to continue monitoring the participants' progress, and in turn, measure the long-term impact of the programme.

8. Equal Opportunities Monitoring

This pilot programme collected anonymised Equal Opportunities forms from 19 out of 21 participants. A break down of this data can be found in Appendix 4. It appears that a majority of participants were female, and the vast majority were of a White British ethnicity. A focus on encouraging diversity of the ethnic background and faith of participants would be a further consideration during recruitment for future cohorts to better reflect representation at this level of the workforce in the Yorkshire and Humber region.

Conclusion and final comments

It is clear from the evidence gathered that this pilot programme was successful in addressing some of its initial key aims, and that participants experienced a number of benefits from attending. The recommendations described above provide significant learning which will be helpful in developing the programme further to ensure it meets all of the expected outcomes and that its impact is measured in a robust and reliable manner. This report would conclude that the programme was an overall success, and that it should be considered for re commissioning for future cohorts, where it can continue its positive impact on patient leaders and their communities through potential replication with not only GP Practice Managers but also with other professional groups in primary care.

SECTION 2 – EVIDENCE GATHERING PRO FORMA

EVIDENCE GATHERED	BEFORE	DURING	AFTER
Individual	This programme was initially aimed at supporting the development needs of patient leaders. In order to achieve meaningful culture change around patient leadership, it was decided that the programme should be aimed at Practice Managers within primary care, as it was thought that developing their abilities to be community change makers and social leaders would foster a more collaborative approach, where co production is likely to flourish, leading to more sustained change and the development of new relationships between practice managers and with the citizens and communities in which their practices operate. Patient leadership would remain at the heart of the programme design and delivery, but with the emphasis being on supporting the development of collaborative relationships between patient leaders and practice managers. The aim of the programme would be that Practice Managers are supported to develop new relationships with patient leaders and within their communities. Participants were expected to be receptive to learning to work with patient leaders as a core element of the programme, with a view to embed this and influence culture change within their own organisation. To demonstrate this, participants were required to submit individual statements, line manager statements, and a CV in order to evidence their suitability for the programme. Programme leads measured evidence from these documents against a set of internally agreed selection criteria in order to ensure the right people for the programme were secured. Participants were required to complete Equal Opportunities Monitoring forms. Anonymised information from this collected data can be found in the Appendices.	Full attendance and engagement with all face-to-face days, Action Learning Sets (ALS), and 'homework/pre-work' between sessions was expected from participants. Some set tasks did not produce tangible evidence (such as having a conversation with a patient leader), so in order to provide challenge and promote personal accountability, participants were asked to identify a peer mentor from within the group. Their mentor would then check in with them to ensure that they had completed the task and to provide a space for reflection at the beginning of each session, where they could discuss any challenges and successes One participant withdrew from the programme due to other organisational pressures. This was identified as a key area of learning for the providers in terms of ensuring organisations and individuals are fully committed to the protected time of each face-to-face study days. Due to the nature of the ALS sessions, commitment to the basic rules of Action Learning were also expected (e.g coming along with a real issue to discuss, maintaining the protected and confidential space within the session, and taking action between each session) As discussed in Section 6 above, it was identified once the programme had commenced that the practice managers were not at the development level that had been expected, and that concepts introduced, as part of the programme were novel to them and therefore a developmental focus was required, enabling them to move away from a more operational mindset, where they could embrace new opportunities, relationships and possibilities. However, during the programme, leads identified a moment when the concepts seemed to ‘click’ with	Following completion of the programme, the expectation would be for participants to bring the learning, attitudes and behaviours developed from each session back into their GP practice, and use these to influence organisational culture change and create an environment with a stronger focus on their relationships with patient leaders and the wider community. Participants may choose to continue to meet with their ALS group indefinitely, without additional facilitation. There is still the possibility for a future follow-up session to take place for this pilot cohort, which would be an opportunity for further feedback to be collected, and monitor any progress that has been made by each individual as a change-maker within their organisations.

	20 places were initially offered and following expanding the offer to the wider Y&H region 21 participants were ultimately agreed in December 2016.	the participants – Day 3, where a number of speakers (patient leaders and leaders from voluntary and community organisations) delivered talks in a 'carousel' format, so small groups of 6 participants had the opportunity to listen to each talk in a smaller and more intimate space. The powerful and moving talks delivered by these speakers appeared to have a significant impact on the shift in the practice manager's perspectives. The ALS Facilitator also noted that participants appeared to be understanding and committing to the programme's core concepts towards their final ALS sessions. One of the recommendations above therefore suggests that future iterations of the programme should be longer, or be comprised of a 'foundation' component and a then a more 'advanced' element, which would be more likely to deliver the full benefits of the programme's original intentions.	

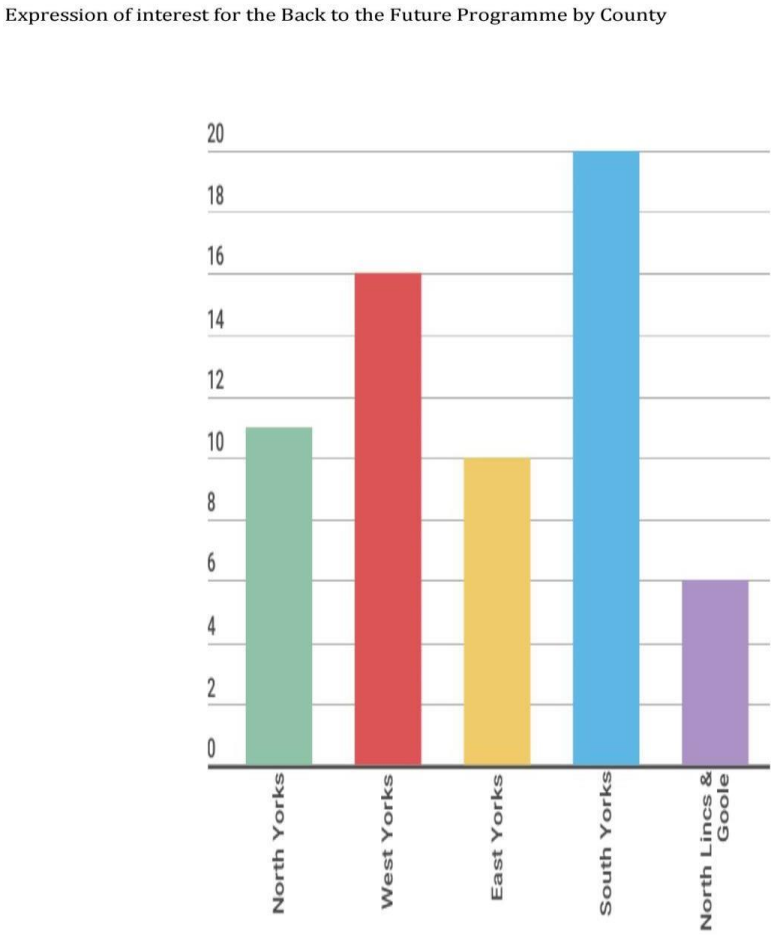
SECTION 2 – EVIDENCE GATHERING PRO FORMA

EVIDENCE GATHERED	BEFORE	DURING	AFTER
Organisational	The organisations were expected to provide full support for the participants, including authorising any dates that the participant would need to be away from the practice, as well as agreeing to be receptive to the learning that the participant would bring back to the organisation and committing to the long-term vision of the programme. Initially, organisations were to be selected from the Leeds and Sheffield areas. However, due to the scale of demand demonstrated through a large number expressions of interest, the offer was widened to include the Yorkshire and Humber region (please see Appendix 1 below)	Organisations were expected to continue to provide support for participants, allowing any protected face-to-face days away from the practice and supporting participants with any set tasks between sessions where possible.	As before, the organisation would be expected to continue to support the participant's long-term service improvement plans informed by patient leaders, and would be expected to continue to provide an environment which fostered the individual's capacity as a change-maker and social leader.

SECTION 2 – EVIDENCE GATHERING PRO FORMA

EVIDENCE GATHERED	BEFORE	DURING	AFTER
Provider	For this programme, three associates were sought who would develop a strong vision for the core principles, methodology, expected outcomes and long-term impact of the programme. These people were agreed as leads to develop the programme in Winter 2016. Following discovery and engagement work within the region conducted by these leads, it was decided that a credible facilitator with a proven track record of delivering programmes within this field would be sought, who would be able to align the programme design and delivery to ensure the core theme of patient leadership was maintained. Following an invitation to quote, a number of providers submitted proposals/delivery plans to articulate their suitability, credibility and experience within the programme topic. Following assessment of the proposals, it was agreed that another training provider would be the most suitable for this programme, having extensive experience and a proven track record working with the Leadership Academy and its associated organisations. They therefore led on the design and delivery of the programme, bringing in an associate within this organisation to facilitate the majority of ALS sessions. This report would recommend this provider as a highly credible and valuable provider for future programmes. To complement this, it is also recommended that patient leadership and community development concepts might be strengthened either by including a patient leader as a co facilitator or strengthening the patient voice by increasing input from patient and community leaders within each delivered session.	The providers ensured ongoing support was offered to programme participants. Whilst significant data was collected around the programme design/planning phase, which is useful in considering the initial planned learning outcomes and expected impact, minimal individualized mid/post-programme evaluative feedback was gathered. The focus was around the gathering of group based feedback as this was thought to align more with the spirit of the programme delivery. It would be beneficial however to re consider including more individualized methods of feedback for both the formal study days and ALS sessions. Nevertheless, is apparent from the evaluative source data provided that based on observation and informal qualitative feedback from participants, as well as flipchart notes from the 'review' session during the final day, the programme leads were receptive to the current working level of participants, and adapted the programme accordingly to ensure they would still achieve some of the expected outcomes, despite not being ready for some of the core aims of the programme – such as working alongside a patient mentor on a service improvement plan. As this is a pilot programme, it is understood that some adjustments to the programme structure like this must be anticipated, with the learning from this being carried forwards to future interventions.	At time of writing, it is possible that the participants will be invited to one further follow-up session, which would be a valuable opportunity to measure the long-term impact and sustainability of the programme. Any collected evaluative data/feedback was collated for the purposes of evaluation (which has subsequently formed the basis of this report), in order to assess the programme's impact compared to its initial aims. As discussed previously, further feedback from participants (and, possibly, their organisations) should be sought during the mid- and post-programme phases of future cohorts.

APPENDIX 1. Geographical demographics of EOIs received



SECTION 2 – EVIDENCE GATHERING PRO FORMA

APPENDIX 2. Flipchart notes (Hopes and Fears) transcribed from Day 1

HOPES

- To go away with something tangible and pragmatic
- To be able to make a difference
- Hearing and learning from others – different CCGs, practices, and communities
- Having the opportunity to meet neighbours and build networks
- Primary care can be insular – hope to meet likeminded people
- Learn from others' experiences and to do better
- Good to learn from people fairly new to primary care and its culture
- Working together
- Learning from practices beyond own neighbourhood boundaries
- Mentoring – helping day-to-day work

FEARS

- Let's not waste this space
- Not taking shared experience and knowledge away
- Not having the energy or time to put this into practice
- To what extent does my experience resonate with others?
- Primary care can be insular: resistance from people, including patients
- Limited experience – what can I offer?
- Competitiveness of different practices
- Lack of knowledge
- Practice may be resistant to change
- Pace/scale of patient leaders and changing patient behaviour

SECTION 2 – EVIDENCE GATHERING PRO FORMA

APPENDIX 3. Flipchart notes (reflections and thoughts) transcribed from Day 3

- Putting things into practice
- Time to think and dream
- Time for reflection
- Bouncing ideas
- New perspectives
- Practice Manager – isolated role – partners not understanding business world, need to take time to be strategic
- Not about money
- Networking with people from other areas
- Time to work on ideas
- Building momentum
- Struggled in first day
- Patient leaders – changed perspective
- PL – surprised didn't understand system/CCG etc.
- Time of course – year end (3 days over March – too much)
- ALS – extra days

APPENDIX 4. Equal Opportunities Monitoring information