Centre for Strategy & Evaluation Services

# Evaluation of the Primary Care Development Programme

## Final Report

## NHS Southwark and NHS Lambeth Clinical Commissioning Groups (CCGs)

28th July 2016

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# Executive Summary

This report by the Centre for Strategy and Evaluation Services LLP (CSES), supported by Optimity Advisors, sets out the findings of the evaluation the Primary Care Development (PCD) programme commissioned by NHS Southwark and Lambeth CCGs.

## Objectives

The *overall objective* of the programme was to build capability to enable general practice across both boroughs to:

- Shape new ways of working in primary care through the development of a cadre of 'emerging leaders' and a shared vision for the future of primary care, and by creating wider momentum for change across primary care through peer-to-peer engagement
- Engage with and shape wider system transformation in recognition that strong primary care will provide the groundwork and building blocks for integration.

A core founding principle of this overarching objective was that these models were generalist-led, bottom-up and clinically driven.

*Specific objectives* of the programme to support the overall objective were to bring about, within primary care:

- Increased understanding of strategic objectives in relation to primary care development
- Increased capability and leadership within general practice to enable local providers to appropriately respond to the agenda for change
- Enhanced peer support through the identification and development of local clinical champions
- Practices starting to organise themselves in geographically coherent groups that have the ability to deliver consistent and high quality services on a population health basis
- Continuing momentum to build capability for population based service delivery within neighbourhoods/localities, and to test new ways of working with health and social care partners
- Resourcing general practice capability and development for a collective leadership and engagement infrastructure
- Support for general practice to effectively engage in the co-development of new models of integrated care and shape the leadership role primary care plays within these
- Movement towards a state of readiness for the implementation of new primary care models by that will ultimately deliver better patient outcomes on a population health basis.

## Timing and phases of the programme

The PCD ran from January 2014 to April 2016. There were three phases: "Leadership Development" from March to September 2014; "New Ways of Working and Organisational Development" from November 2014 to June 2015; and, "Transition to New Models of Care" from October 2015 to April 2016. There were 26 participants ("Emerging Leaders") who went through the programme (see Annex 1 for the list of names).

## Assessment criteria

The effectiveness of the programme was assessed in terms of impacts on *individuals,* impacts on *organisations* and impacts on the *system* of health and care delivery.

*Individuals:* As far as individuals are concerned, both external stakeholders and programme participants indicated that the impacts had been substantial. As a group participants developed a confident and articulate voice for general practice, and displayed a wide range of behaviours evidencing leadership capabilities that had not existed previously. Stakeholders mentioned their roles in taking command of difficult situations and turning them around to produce target outcomes, for example through their interventions with the Southwark and Lambeth Integrated Care (SLIC) provider engagement, Local Care Networks (LCNs) CQC accreditation, federation development and commissioning of healthcare delivery.

Participants provided examples of personal development that included leadership skills, working in teams, negotiation, influencing, collaboration and awareness of the health economy outside the silos of general practice.

*Organisations*: Turning to impacts on organisations, in particular general practice and federations, there is also wide ranging agreement among external stakeholders and participants that there has been a significant impact through the development of a collective voice and implementation of new models of care and working, which is gradually bringing about cultural change in primary care. Examples across both boroughs, include the formation/development of federations and their internal structures which is widely attributed to the role played by the Emerging Leaders group, the success of Prime Minister's Challenge Fund bids for the setup and delivery of Extended Primary Care Access Hubs, and the contribution of programme members to the SLIC recovery plan for holistic assessments and integrated case management after a slow start.

*The system*: At systemic level, the view expressed by stakeholders and course participants was that the PCD programme developed the capabilities in individuals and gave them the necessary head space to look outside individual practices to engage more widely at the health and care system level with other providers through the SLIC programme and led to the development of the LCNs, which operate as multi-speciality community provider networks for wide ranging systemic engagement, service design and delivery.

## Overall conclusion

Overall the view is that the programme has met its objectives. Compared to the situation at the beginning of 2014 there has been a quantum change - a new way of doing things - has emerged, driven by primary care. A new model of healthcare delivery has emerged, and is continuing to evolve as more participants are being drawn into the process through, for example, the LCNs.

However, external stakeholders and PCD programme participants are under no illusions. This is seen as just the beginning and a great deal more still needs to be done to develop cross-organisation working to support new models of integrated care, and improve the readiness of general practice to implement these new models of care. General practice remains under significant pressure and the performance of the federations in coming years will be crucial in improving the sustainability of general practice.

## The future

With a view to the future, the strengths of and challenges faced by the programme were identified. Strengths included the provision of "head space" for thinking as well as a "safe space" for trying out those ideas in a non-challenging, collaborative and supportive environment. The different phases, the variety of channels, and the flexibility of delivery were also seen as major strengths. The main challenges were to find the necessary time (and resources) to participate fully, balancing the demands of the practice, the programme and family/ private lives. Backfill did mitigate the demands of resources to an extent; however, the pace of change and demands on leaders as a result of the programme's success was significant.

For the future, respondents emphasised the importance of building on the investment made in the PCD programme and also the need for a succession programme to ensure a future supply of those with the required skills, capabilities, and readiness to work across the system as a whole. It was stressed that for the future the net would have to be cast wider than general practice (as has already partly been done). For scalability and replicability, future programmes should include participants from others in the evolving LCNs and federations as well.

There is certainly a need for continuing support for the future transformation of health and social care in Lambeth and Southwark. Such initiatives should be of three kinds: those aimed at individuals in the system to develop their personal capabilities to initiate and deal with change, those aimed at supporting the growth and development of specific institutions such as the relatively new federations, and those aimed at developing the system as a whole through for example the LCNs. And while a great deal remains to be done, the experience of the PCD programme shows that a good support programme can go a long way to moving things in the right direction.

# 1. Introduction

This is the final report submitted by Centre for Strategy and Evaluation Services LLP (CSES), supported by Optimity Advisors who acted as subject matter experts, for the *Evaluation of the Primary Care Development* (PCD) *Programme*. This evaluation was commissioned by NHS Southwark and NHS Lambeth Clinical Commissioning Groups (CCGs), with the support of funding secured through Guy's and St Thomas' Charity (GSTTC) who invested £1.2 million in the development and delivery of the PCD programme as part of their commitment to innovation in local healthcare (Health Innovation Fund).

The first two phases of this three phase programme were evaluated by the Learning Partners (providers) responsible for supporting the organisational development aspects of programme. This evaluation builds on earlier findings, and assesses the achievements of the programme as a whole.

*The study team wishes to expresses its thanks to programme participants and stakeholders who contributed to the Evaluation. Their inputs have provided very useful feedback on and insights into the various aspects of the different phases of the programme we investigated. As such they have also contributed to the further development of health and social care provision in Lambeth, Southwark and further afield.*

# 2. Context

## 2.1 The challenges facing delivery of health and social care

For some decades the delivery of health and social care in the UK has been under pressure due to trends such as: demographic change – in particular the changing needs of an ageing population, the prevalence of long term conditions, lifestyle risks, service user preferences in terms of how healthcare is delivered and, advances in treatment. Against this source of increasing demand there is set the reality of financial constraints and scarce resources.

At regional level, the reaction to these trends in London led to the publication *of Transforming Primary Care in London: General Practice a Call to Action* (October 2013), which examined the challenges facing primary care and outlined the case for action. This called for general practice to play an even stronger role at the heart of more integrated out-of-hospital service that delivers better health outcomes, more personalised care, excellent patient experience and the most efficient use of resources.

## 2.2 The response from NHS Lambeth and Southwark

In response to the challenges facing primary care, NHS Lambeth and Southwark CCGs in partnership with Local Medical Committees (LMCs) and Guy's and St Thomas' Charity, (GSTC) have led an innovative PCD programme across the two boroughs. The aim has been to build leadership capability within general practice, broadly speaking, to drive development and implementation of models of primary care that can become building blocks for wider system integration through Local Care Networks (emergent multi-specialty community provider networks as envisaged in the NHS Five Year Forward View).

The programme was launched in January 2014 and has been delivered in three phases: Phase 1 from March 2014 to September 2015, Phase from 2 November 2014 to June 2015, and Phase 3 from October 2015 to April 2016. Initially intended to run for a 6 month period, the programme aimed to create protected time and headspace for the development of a cohort of 18 'Emerging Leaders' (GP's and practice managers) within the 92 practices in Lambeth (n48) and Southwark (n44). The programme has evolved to provide organisational development support for GP federations alongside leadership development for a wider set of general practice provider leads to engage in both primary and integrated care development.

Evaluations of the first two phases found that they had significant impacts in terms of achieving programme objectives and in driving other transformational programmes. As a result of this, and in recognition of the need for further engagement to shape wider system partnership arrangements, the Charity made additional funds available to extend the programme into a third phase, bringing the total investment from the Charity to £1.2m.

As a result of the investment in this programme, alongside other CCG transformation funding, there are now 5 GP federations across Lambeth and Southwark covering each locality area:

- Quay Health Solutions (QHS) – north Southwark
- Improving Health Limited (IHL) – south Southwark
- North Lambeth Practices Limited (NLP)
- South West Lambeth Healthcare (SWLH)
- South East Lambeth Health Partnership (SELHP)

# 3. Aim of the Evaluation

The aim of the project is to evaluate the Primary Care Development (PCD) Programme commissioned by NHS Southwark and Lambeth CCGs. The programme is assessed in terms of the evaluation criteria of *relevance*, *efficiency*, *effectiveness* and *sustainability*, and recommendations are made as regards to future developments.

## 3.1 Objectives of the Primary Care Development (PCD) programme

The *overall objective* of the programme was to build capability to enable general practice across both boroughs to:

- Shape new ways of working in primary care through the development of a cadre of 'emerging leaders' and a shared vision for the future of primary care, and by creating wider momentum for change across primary care through peer-to-peer engagement
- Engage with and shape wider system transformation in recognition that strong primary care will provide the groundwork and building blocks for integration.

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*Specific objectives* of the programme to support the overall objective were to bring about, within primary care:

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- Enhanced peer support through the identification and development of local clinical champions
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## 3.2 Key evaluation issues

The terms of reference for this evaluation emphasised the need to explore:

1. Issues around process and success of implementation, to inform future development of new models of care.
2. Whether and how the programme has contributed to primary care development locally, and the impact of the programme on overall aims and objectives including:
    a. whether the programme has enabled general practice readiness to deliver new models of care
    b. strengths and weaknesses of the programme

c. any gaps in terms of requirements/needs for general practice in relation to their 'readiness' to lead and deliver change
d. the impact on cross organisational working and partnerships, and
e. the impact on sustainability of general practice.

# 4. Methodology

## 4.1 Phases of the project

The evaluation project methodology consisted of three phases:

1. An *inception or preparatory phase* during which an initial kick-off meeting took place; and, an evaluation framework was developed and agreed on the basis of discussions with key stakeholder organisations.
2. The main *research and fieldwork* phase during which interviews, surveys and additional desk research was carried out.
3. A *reporting* phase which consisted of preparation and submission of a draft final report, a review meeting and preparation of the final report.

The *evaluation framework* identified that the key questions the evaluation needs to answer are:

a) What has been the impact of the PCD Programme on new models of care within the wider health and care system?

b) What has been the impact of the PCD Programme on a sustainable model for general practice (practice level and federation level) in Southwark and Lambeth?

c) What have been the strengths and weaknesses in the delivery of the programme?

d) Where are there gaps?

e) How could the gaps be addressed by the future development of the programme and what would that look like (what would the future impact be)?

## 4.2 Fieldwork

The field research consisted of:

- an on-line survey targeting programme beneficiaries, general practice peers, and nominated leads to provide feedback on programme beneficiaries; and,
- an interview programme conducted with external stakeholders and programme beneficiaries.

The following results were achieved with the field research.

**Table 4.1 Number of survey and interview responses**

| | Beneficiaries | General Practice | Nominated leads |
|---|---|---|---|
| On-line survey responses | 13 | 4 | 4 |
| | **Beneficiaries** | **Stakeholders** | **Phase 1 & 2 providers** |
| Telephone interviews | 9 | 10 | 2 |

As set out in more detail in Section 6.2, 26 people participated in and completed the programme. Interviews were carried out with 7 of the 12 beneficiaries (58%) that participated in all three phases of the programme. In addition, 3 of the beneficiaries that went through all three stages completed the on-line survey.

Although the percentage of beneficiary interviews (35%) does not seem very high, we do think we obtained feedback from most of those that were in by far the best position to provide a high quality response. 50% of beneficiaries responded to the on-line survey. In our view this constitutes a sufficiently large population for us to consider that the findings are representative of the group as a whole.

Interview responses were written up in or transferred to spreadsheets and analysed in terms the responses to specific questions.

# 5. Programme Relevance

The first stage of the evaluation consists of assessing the *relevance* of the programme: to what extent is the programme relevant to the needs of its target groups, and how the needs of the target groups were assessed. The GSTTC bid documents set out clearly the context of, and need for, the programme. The programme was initiated by Local Medical Committee (LMC) representatives and CCG clinical leads and managers who identified the need for bottom-up and clinically-driven change.

## 5.1 The visioning workshops

A series of visioning workshops were held with participants and external stakeholders to help visualise what primary care could look like in the future; how it could better support health and service improvement in the two boroughs, reflect the likely changes in commissioning and in particular the move towards integrated care.

**In March 2014, 50 local leaders representing primary care from Southwark and Lambeth CCGs came together for the first of three visioning workshops focusing on creating a shared vision for primary care.**

## 5.2 The programme rationale

The rationale for the programme emerged from the visioning exercise: *to deliver the vision of a system of primary care* that:

- is better configured to deliver an increased range of services to patients and integrate with other services on a population health basis,
- reduces variation in access and quality for local populations,
- delivers demonstrable benefits in terms of quality and value for money,
- makes primary care a more attractive place to work, and reinvigorates existing staff, and
- drives innovation and achieves both local and national strategic objectives.

**"They have really developed and articulated a vision for the future of primary care in the locality"**
**(Stakeholder feedback Phase 2)**

It was recognised that general practice providers need the time to think and capacity to develop leadership capability and drive the pace and scale of change within primary care locally to deliver on the programme objectives. A significant portion of funding was allocated to financing backfilled time to support GPs and practice managers to participate in the programme, and act as 'change catalysts/ leaders' to drive and realise systemic change. These leaders spearheaded change to general practice locally and influenced other major health and care programmes; bringing the perspective and views of primary care to the forefront.

The importance of capability building is recognised in primary care policy documents such as the *General Practice Forward View*, which highlights the need for investment and practical support to build change leadership capabilities in practices and federations; enabling providers to improve quality, introduce care innovations, and establish new arrangements for the future.

**"Teams need support and space if they are to adopt new ways of working"**
**(General Practice Forward View, April 2016)**

# 6. Programme Delivery

This section asks how *efficiently* the programme has been delivered. It considers feedback about the structure and organisation of the programme, feedback on previous phases, participant numbers and programme costs. Strengths and weaknesses and lessons that can be learnt for the future are dealt with in Section 8.

## 6.1 Structure and organisation

The programme commenced in January 2014 and was intended to run for 6 months. However, both the size of the task to develop 'at scale' models of primary care and the programme's initial success meant it was necessary and possible to secure further funding to enable it to run over a two year period. There were three phases of delivery to participants: from March to September 2014; from November 2014 to June 2015; and from October 2015 to April 2016. The first phase was very much focused on personal development, developing leadership skills and preparing the course participants for leadership roles. The second phase was more directed towards applying their skills acquired in an organisational context and developing new ways of working. The third phase was largely directed at supporting the development and establishment of GP federations (recognising that the federations in the two boroughs were at very different stages of development), and establishing the relationships between the federations and other providers through LCNs, so as to move towards new models of care.

Concise summaries of each phase of the programme are provided below.

**Phase 1 Leadership development -** March to September 2014

The first phase aimed to address the immediate priorities of supporting local general practice leaders to understand the changing primary care landscape, to facilitate groups of practices to develop locality groupings, and to begin to shape the role of primary care providers within integrated service models.

Funding in this phase was deployed in three key areas:

- Leadership and capability development for a cohort of 'Emerging Leaders' (clinical and non-clinical)
- Backfill to release time for Emerging Leaders to participate in the programme and fulfil leadership roles within their localities/neighbourhoods
- Facilitation and support for general practice localities/neighbourhoods.

The delivery of phase 1 was supported by a Learning Partner (Impower and Healthskills) who facilitated a series of diagnostic interviews and visioning summits in March and April 2014. Focused development workshops were delivered between May and September, which covered topics such as:

- New models of primary care – drivers and national policy
- Understanding your leadership style
- Exploring creativity and innovation
- Influencing and impact (negotiation, political impact, personal authority and storytelling)
- System engagement
- Change management
- Building high performing teams and motivating others
- Managing conflict
- Showcasing outcomes, celebrating success and moving forward.

Beneficiaries also participated in mixed action learning sets and had access to individual coaching.

Following this development:

- Lambeth emerging leaders had facilitated conversations within their respective localities to consider options for working at scale, and had developed plans to take these options forward.
- Southwark emerging leaders had utilised their leadership skills to take forward collaborative working with the established federations.

The findings of the evaluation of phase 1 identified that the Programme largely fulfilled the aim of providing Emerging Leaders with the knowledge, skills and capability to shape and develop new models of primary care and further the quest for more coordinated and integrated health and car provision. However, the evaluation highlighted that there were still questions as to whether the Emerging Leaders would have the necessary capacity to lead and implement change. This helped inform the approach to Phase 2 of the Programme, which was aimed at maintaining momentum by giving Emerging Leader's the time and space to plan and implement change in a deliberate fashion. This would require the actual development of new models of care, the practical scoping and deployment of new roles and the embedding of efficiency and productivity processes.

**Phase 2** **New ways of working and organisational development** - November 2014 to June 2015

The second phase focused on continuing the momentum of the programme to build capability for population based service delivery, and enabling general practice to move from exploration/considerations of new ways of working to implementing new models of care.

It was recognised that the Emerging Leaders had made considerable progress in Phase 1. However, the multiplicity of practice voices and the lack of connecting infrastructure were a limiting factor in terms of the impact general practice could have as a force for primary care and wider health system improvement. In response to this, phase 2 also focused on resourcing general practice capability to build a collective leadership and engagement infrastructure to enable:

- formal decision making and engagement with the wider general practice workforce
- engagement with wider locality/neighbourhood leadership teams to progress partnership working, co-develop new provider models, and understand the leadership role general practice plays within these
- development of the infrastructure and mode of delivery to support general practice to transition to new models of integrated care across Lambeth and Southwark.

Similarly to Phase 2, a learning partner (Different Development) was engaged to support the delivery of the organisational development aspects of the programme. This focused on the delivery of a series of development workshops and master-classes focused on a range of topics, with some examples below:

- Leadership communication skills
- Making difficult decisions
- Local Care Networks – the Federation Role
- Good practice governance and decision making
- Practice staff and service user engagement
- Developing a unified voice
- Contracts and financial negotiation
- Conflict resolution
- Networking and influencing/managing across boundaries.

During Phase 2, local GP federations were established (in Lambeth) or were further developed to formally take on contractual responsibilities (in Southwark). The programme participants were instrumental in these developments, and many of the Emerging Leaders transitioned into formal Federation leadership roles. In addition, beneficiaries were able to access group and individual coaching sessions, and facilitation support (both at a Federation level, cross-borough, and with local health and social care partners).

**Phase 3 Transition to new models of care** – October 2015 to April 2016

Following Phase 2 of the programme, it was recognised that further work was required to continue the momentum of the PCD programme in the context of wider Lambeth and Southwark partnership discussions across health and social care providers and commissioners. Continued investment in general practice provider leaders was integral to both enabling primary care to take an active role in these discussions, and to ensure that GP federations would be fit for purpose to deliver the vision for primary care and wider system integration.

Phase 3 saw a continuation of leadership development, individual and group coaching, as well as a stronger focus on applied learning (rather than knowledge and theory), which was delivered by a Learning Partner (Healthskills). This aspect of the programme also focused on federations as providers to ensure they were fit for purpose to deliver population based care and participate as active partners in emerging LCNs. To support this, development sessions consisted of masterclasses and workshops, as well as call off consultancy support available to federations to support board and organisational development. The programme was informed by a needs assessment undertaken at the outset of phase 3, which took into account the different levels of organisational maturity across the federations and enabled both shared learning and bespoke support. Topics canvased included:

- Local Care Networks – implementation and sharing best practice
- Managing change
- Position and politics
- Workforce challenges
- Whole system leadership
- Building collaborative relationships

## 6.2 Programme beneficiaries

Potential programme participants from general practice were invited to express an interest in participating in the programme and selected following an interview. In Lambeth, some (for example those with an established reputation among the GP community) were contacted directly and asked if they would like to participate. Efforts were made to obtain a mixed group that included both GPs and practice managers (PMs) and appropriate geographical coverage.

**"It was really good that it was renamed Federation Development and widened out to all Federation teams – this made a big difference – gave us more opportunity to work in teams, have head space, explore new ideas together, etc."**
**(Phase 3 course participant)**

In all, 33 people participated in the programme (across various phases). Of these, 7 withdrew during the course of the programme for the reasons set out below in table 6.1.

**Table 6.1 Withdrawals from the programme**

| Number | Reason or withdrawal | Phases participated in |
|---|---|---|
| 4 | Moved to an out of borough practice | 1,2,3 |
| 1 | Lack of capacity | 1 |
| 1 | Retired/ capacity | 1,2 |
| 1 | Moved into CCG Governing Body role | 1 |

While some "leakage" in a programme such as this is inevitable, one respondent said that if the level of commitments expected had been made clearer up front, there might have been fewer departures. Another respondent said that on the other hand, there may also have been less volunteers in the beginning as some very good candidates may have been put off, whereas once they were immersed in the programme, they were more reluctant to leave despite the level of commitment required. This is a matter to be born in mind when considering similar development programmes, as the initial scope likely underestimated the intensity and length of development required to support new models of care. .

The remaining 26 beneficiaries participated in the phases as set out below in table 6.2.

**Table 6.2 Participation in phases of the programme**

| Number | Phase |
|---|---|
| 12 | 1,2,3 |
| 3 | 2,3 |
| 11 | 3 |

The table makes clear that there was a substantial new intake with the beginning of the third phase as the development of the federations gained momentum, and other federation leads joined who had not been part of the 'Emerging Leaders' cohort. One interviewee who had been through all three phases pointed out that the large intake for phase 3 did not have the benefit of attending the first two phases that, in their view, very much paved the way for success in the third phase.

## 6.3 Programme costs

Detailed programme expenditure and progress reports were submitted on a regular basis to GSTC. Headline programme costs are set out in the table below.

**Table 6.3 Programme costs**

| | Phase 1 (£) | | Phase 2 (£) | | Phase 3 (£) | |
|---|---|---|---|---|---|---|
| | Grant Allocation | Expenditure | Grant Allocation | Expenditure | Grant Allocation | Expenditure |
| | 250,000 | 251,461 | 478,000 | 474,471 | 475,000 | 474,998 |
| **Breakdown of spend:** | | **Expenditure** | | **Expenditure** | | **Expenditure** |
| Organisational Development | | 138,838 | | 77,460 | | 60,180 |
| Backfill to release time for beneficiaries | | 84,103 | | 255,903 | | 360,000 |
| Programme costs (incl. project management, communications, venue & facilitation, and evaluation) | | 28,520 | | 36,108 | | 54,818 |
| Service Pilots (testing new ways of working) | | 0 | | 105,000 | | 0 |
| **TOTAL:** | | **251,461** | | **474,471** | | **474,998** |

# 7. Effectiveness of the programme

The *effectiveness* of the programme is assessed in terms the impacts on individuals, organisations, the system of healthcare delivery, sustainability and the overall objectives.

## 7.1 Impacts on individuals

Both external stakeholders and programme participants indicated that the impact on individuals had been substantial. Stakeholders including the CCGs, the LMCs, GSTC, the Citizen's Board, South London and Maudsley Mental Health Trust (SLAM) and the Learning Partner providers (both Different Development and Health Skills) all agreed that they had witnessed the development of a group of leaders and opinion formers who had become a voice for general practice that had not been there before the programme started. An articulate and confident voice of general practice has emerged which has been heard at federation and system leadership forums and in the negotiation of primary care contracts. This has been accompanied by a change in mind-set, thinking beyond the individual practice and developing a willingness to talk on behalf of, and build consensus across, the system. While there are of course personal differences, the programme participants had developed a reputation for challenging the status quo, facilitating discussion, seeking consensus, collaborative working, and understanding and dealing with diversity.

**"At the beginning, I didn't know what I didn't know. Through the course I opened up to learning."**
**(Course participant)**

**"We have seen a change in mind set as programme participants are thinking more broadly rather than at an individual practice level. Previously general practice had been more protectionist."**
**(External stakeholder).**

**"We have seen a greater sense of curiosity, ability to challenge (the status quo), be insightful at a system level (among PCD programme participants). They are better at holding each other to account."**
**(External stakeholder)**

A wide range of examples were mentioned by external stakeholders providing instances where participants had displayed individual attributes that led to highly significant or breakthrough contributions, including: performance at the Southwark and Lambeth Integrated Care (SLIC) Provider Board, LCN development, dealing with Extended Primary Care Access governance and practice engagement, CQC accreditation, and federation development – all of which require a specific set of skills to have successful impact.

**"I was at a Federation meeting five minutes ago where negotiations were taking place and there were discussions around "savings" which included inputs from programme participants. They were very able in participation - articulate, had confidence, skills, were proactive as leaders and opinion formers, etc. The whole Lambeth cohort seems to have ended up as Federation Directors - a very powerful group with a great deal of expertise now".**
**(Senior CCG manager)**

Participants in the programme held similar views to those of external stakeholders stating that their levels of confidence had grown and giving examples of step changes in their ability to influence, network, negotiate, have difficult conversations and drive forward new initiatives. This was possible due to the increased personal confidence and resilience they had gained from participating in the personal development programme. Useful skills they felt they had acquired included leadership skills, reflective skills, self-awareness skills, carrying out difficult conversations, political awareness, reading others, negotiating in complex environments, how to be a team player, a collaborative approach, and understanding the dynamics of

**"I have only been in the third part of the programme and have found it useful"**
**(Course participant)**

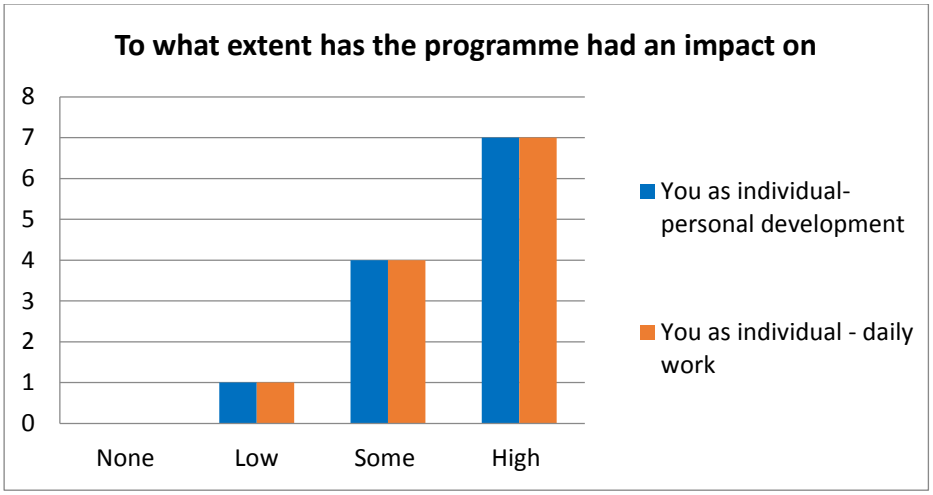
the health economy outside the individual practice. Figure 7.1 illustrates their view that personal impacts of the programme on beneficiaries tended to be high.

**"I think I'm more patient and respectful of the opinions of others. I'm perhaps more pragmatic in assessing whether I am able to have an impact in certain situations"**
**(Course participant)**

All the respondents to the survey that answered the questions "What was your role (in the practice/ GP Federation) when you first entered the programme?" and "Did your role change during the course of the programme or soon afterwards?" indicated that it had. Wherever they were at the beginning of the process (GPs – salaried and partners, PMs, associate directors), many progressed to being federation directors (sometimes in addition to other roles). However, as indicated in Section 7.2 (where we assess the strengths and challenges of the programme), this often came at a significant personal input/ cost.

**"I am tailoring my approach according to the audience I am trying to address thanks to better awareness of MBTI profiling"**
**(Course participant)**

**Figure 7.1 Impact of the programme: individual participants**




Source: On-line Emerging Leaders survey (n=12)

**"My personal growth in skills and understanding of management, project design and evaluation, case for change, ways to lead, stakeholder and practice engagement has been huge."**
**(Course participant)**

A few participants talked about having experienced "imposter syndrome" in the initial stages due to the great expectations placed on them, and feeling that at some point they would be "exposed", whilst going on to say that they would have never stood up in a room full of people when they embarked on this journey and now 18 months on "here I am standing in front of you telling you my story". There were often great expectations placed on them that they felt initially unsure that they would be able to live up to.

Another made the direct connection between the programme and career progression. Participation in the programme had provided the skills and the confidence to apply for senior positions requiring their newly-acquired capabilities.

**"I wouldn't have dreamed of applying for the role of Federation Director before participating in the programme".**
**(Course participant)**

## 7.2 Impacts on organisations

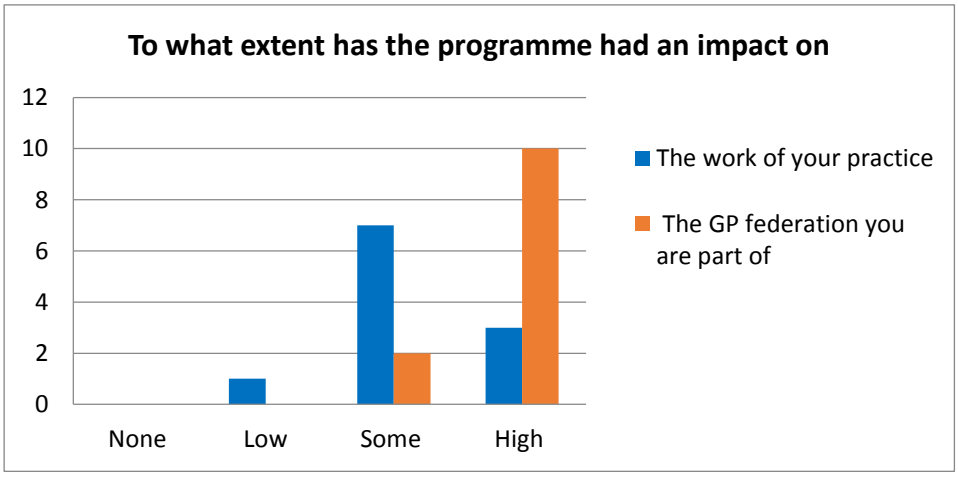
This sub-section asks to what extent there were impacts on organisations – in particular general practice and federations – as a result of the programme. There is wide-ranging agreement among participants and the wider stakeholder group consulted that the programme enabled individual participants to develop their own voice, and general practice to develop a collective voice and narrative through the development of the federations and implementation of new models of care and ways of working.

As a result of this, respondents highlighted the beginnings of a cultural change leading to more collaboration between practices, the federations and the wider system.

**"18 months ago, if I walked into any of the 20 practices in my area, I would not have been able to talk to anyone. Now they know who I am and what I/we stand for and what the discussion will be about – I will be able to have a conversation with them".**
**(Course participant)**

The bar chart below suggests that programme impacts on federations were more significant than on the practices that the participants were part of.

**Figure 7.2 Impact of the programme: participant practices and federations**




Source: On-line Emerging Leaders survey (n=12)

**"Whatever the objectives of the programme might have been, the outcomes were exactly what was required!"**
**(External stakeholder)**

Emerging Leaders have represented general practice across a variety of primary care and system integration groups, across both Lambeth and Southwark, and South East London.

When considering examples of individual practice and federation initiatives that would not have happened had it not been for their participation in the programme, respondents mentioned the following examples from Lambeth, Southwark and across the two boroughs.

### Lambeth

In Lambeth, there was broad agreement that the three GP federations would not have formed in 18 months had it not been for the programme, nor would the process have been so robust.

The Prime Minister's Challenge Fund bid for the GP Access Hub was also highlighted by many Lambeth participants as being successful largely as a result of the impact of the programme and that ownership taken by the federation positively impacted on uptake.

Other examples included the Safe and Independent Living (SAIL) initiative with Age UK Lambeth, and the success of the GP Delivery Framework in developing work with the CCG on mental health, children's asthma and long term conditions.

### Southwark

In Southwark, a federation was already setup when the programme started, however it was recognised that the programme had an impact on internal board development, the development of key relationships with system wide stakeholders, and in enabling the federations to sustain pace and mobilise their members and to contract with the CCG.

**The effect (of the PCD programme) on general practice and primary care was beyond expectations – it empowered them and gave them the understanding to lead change in primary care. Influence extended to wider and systemic change, well beyond primary care, for example with the LCNs. (External stakeholder)**

In Southwark, the federations were successful in their bid to the Prime Minister's Challenge Fund for the Extended Primary Care Access service which saw practice engagement in the co-design of pathways, enabling the CCG to effectively commission the service from each Federation for a three year period. Respondents expressed the view that this would not have been the case without the input from the course participants. Other examples were given of Southwark practices actively getting more involved in pilot projects around Dementia, Age UK Southwark and Lewisham Safe and Independent Living (SAIL) Care Navigation, and Primary Care Navigators.

**"Primary care has an equal seat at the table with other larger organisations, such as the acutes & has a 'provider' voice." (Feedback during Phase 2 evaluation)**

Through the contracting process, trust was built between the CCG and general practice (as providers of services) which enabled more open contracting conversations around population health management contracts and more collaborative models of working. From the federation's perspective, they had firmly established their position as clinical leaders sat at the same table as the commissioner and able to offer constructive challenge. Southwark CCG recognised that through this contracting process, there had been a step change in how general practice operated and role modelled leadership behaviours. The professional way in which discussions with large organisations such as Guy's and St Thomas' (GSTT) and SLAM were conducted by participants within LCNs was also noted by external stakeholders.

### Cross-borough

Another example mentioned was the contribution of programme participants to the successful roll-out of the SLIC programme after an initial slow and difficult start, which led to successful uptake and meeting of holistic assessment and case management activity and quality targets for frail elderly patients.

**Clusters of practices are now having conversations about performance - as a result conversations are more constructive. The starting point for conversations is different - it starts with "how do we serve our populations but protect our viability?" (External stakeholder)**

### Practice-level

**"Practices no longer necessarily think about referring to "the surgery down the road" but to the best provider in a Federation context." (External stakeholder)**

There was also some development in collaborative working across practices. Instances mentioned included sharing of nurses and the Ambulatory Blood Monitoring Service. Through the federations there has also been sharing of experience between practices as regards for example practice management and CQC Accreditation. However, the general view was that while there has been a start in change at practice level, a good deal remains to be done.

## 7.3 The system of healthcare delivery

Turning to the system of healthcare delivery as a whole, the programme enabled individuals to develop relationships on behalf of their practices and federations, and engage system-wide on more complex issues. This was seen through general practice's engagement with patient representative groups, SLIC and LCNs as they started to develop across Southwark and Lambeth, bringing together all health and social care providers to transform services for their local populations. Conversations that were not taking place previously are also taking place with groups such as the Evelina Children's Programme and Health Watch. Federations are now routinely meeting through the LCNs whilst 18 months ago it was noted that in some cases there was an unwillingness to connect across the system with their counterparts in secondary and community care.

**General practice needed to engage in the relationships with the LCN and the Emerging Leaders provided the leadership and understanding of the challenges. (External stakeholder)**

External stakeholders also noted an increased willingness to engage with other participants, an appreciation of long term benefits of engagement, not just at a formal level, but also through informal conversations. There is an increased respect for the general practice leaders, their skills and what they can do from other participants in the system, although the nature of the GP business model and the limitations that poses is not always appreciated.

**"The emerging leaders have used leadership to shape new models of primary care in a tough environment. They have been able to play a strong role in local discussions on system change and GP practices are reshaping themselves quite radically. Something that is possible because it is truly led by GPs". (Stakeholder feedback Phase 2) evaluation)**

One of the elements of the overarching vision of the programme was that it would support the development of new models of primary care that are better configured to deliver an increased range of services to patients and integrate with other services on a population basis. The feedback from course participants on the extent to which this has been achieved suggests that this is "beginning to happen", and that this "would not have happened without the programme". The mandate for such development now exists, where it did not exist previously, and the vehicles to bring this about have been created. However, it is realised that there is still a good way to go, and progress has not been as fast as had been hoped. But sometimes the first steps are the hardest to take.

**"North and South LCNs have monthly meetings - Federations are fully engaged with and sit around the table with their counterparts in secondary and community care (with PM support from the CCG) - they have since moved to weekly co-located working which has enabled them to work on more complex issues." (External stakeholder)**

For other elements of the vision, feedback is as follows:

- Reduction in variation in access and quality for the local population: this is seen as being in its first stages, for example with the setting up of access hubs, but the question of quality is seen as complex.
- Benefits in terms of quality and value or money: this has started (e.g. sharing of good practice) but a great deal still remains to be done.
- Making primary care a more attractive place to work and reinvigorating existing staff: this does not seem to have resulted as yet, except in the case of maybe of a few individuals, although some respondents suggested it may come about the course of the next few years as federations work on the issue.

Overall, while a start has certainly been made, much remains to be done and system-wide working seems more complex than had been initially thought.

## 7.4 Did the programme meet its objectives?

As indicated in Section 1.1, the programme's overall objective was to build capability to enable general practice across both boroughs to:

- Shape new ways of working in primary care through the development of a cadre of 'emerging leaders' and a shared vision for the future of primary care, and by creating wider momentum for change across primary care through peer-to-peer engagement
- Engage with and shape wider system transformation in recognition that strong primary care will provide the groundwork and building blocks for integration.

A key facet of this objective was that these models were generalist-led, bottom-up and clinically driven.

The starting hypothesis had been that by investing in individuals and building capability, those individuals in turn would be enabled to change ways of working across the system in which they worked. The programme supported this through a variety of learning opportunities which allowed participants to develop new skills and to self-identify as leaders and develop a 'voice' for general practice. This was facilitated by the back-filled time that enabled participants to engage above and beyond day-to-day general practice business.

### The PCD programme has met its objectives

All respondents were in broad agreement that the programme had met its objectives. There was consensus that the programme had been a journey, and that the route had been informed by, and responded to, the development of the federations across Southwark and Lambeth and a greater emphasis on system wide working.

External stakeholders consulted were generally of the view that the programme did meet its overall objectives, largely by providing headspace and a safe space in which to think, try out ideas and plan. A voice for general practice emerged as it took a seat at several fora where it had not been previously presented. One external stakeholder said that even though she was unsure what the objectives of the programme were, the programme's outcomes certainly were what was required. Others said that the results of the programme exceeded expectations.

Some interviewees who had been deeply involved in setting up the programme did make the point that the initial objective of the programme when set up was to improve the sustainability of general practice which had become very challenging. However, when federation development came on the horizon, the focus of the programme, understandably, shifted toward that. While federations have now been set up, they now have to deliver an improved operating environment for general practice. The point was made by respondents that during the initial "honeymoon period" of federations, general practice will be supportive. But general practice has adopted a "wait and see" approach as to whether federations really will deliver value, before committing further and fully to develop and support change in the wider primary care and healthcare system. What happens will depend very much on the performance of the federations.

From the interviews with participants it appeared that they saw the objectives of the programme as multi-layered: providing both headspace and a safe space for developing leadership capability within primary care; galvanising general practice and developing federations, ensuring better representation and a unified voice for general practice across the integrated care arena, increasing collaboration between practices, and encouraging thinking outside their silos. Even if sometimes initially unclear at the outset, respondents felt that objectives emerged that were achieved in the end.

### There is still a great deal to do

On-line survey responses relating to specific objectives are set out in table 7.1.

**Table 7.1 To what extent do you think the programme has met the following objectives?**

| Objective | Fully | Somewhat | Not at all |
|---|---|---|---|
| Impact on cross-organisational working to support the development of new models of integrated care and shape the role primary care plays within this | 2 | 10 | 0 |
| Capability and readiness for general practice leaders to lead and deliver change | 7 | 5 | 0 |
| Developing a 'unified' voice across GP Federations and the LMC to ensure the collective views of general practice are represented when engaging with key partners | 6 | 6 | 0 |
| The state of readiness for general practice to implement new primary care models that will ultimately deliver better patient outcomes on a population health basis e.g. Extended Access | 2 | 9 | 1 |

Source: On-line beneficiary survey

The responses indicated that all respondents thought that the programme had met its objectives to a "yes, somewhat" or "fully" extent except for one that thought it was "not at all" in the case "readiness for change of general practice". The reasons for indicating "somewhat" are largely because they think that even if there has been a huge change compared to the situation 18 months ago there is still a long way to go and they have a very challenging task to complete. This challenge cannot be underestimated and there are some real barriers as well (see section 8.3).

It was also pointed out that general practice in Southwark and Lambeth had started on their transformation journey from slightly different places. A few respondents were of the view that the programme was directed at federation development, and that other organisations might have emerged if a fully bottom-up process had been adopted. However, it should be noted that other models are emerging locally (e.g. Super-partnerships) and the programme did include facilitated workshops canvassing various primary care models. There is still some uncertainty about the exact nature of integrated care models among some respondents, and it was pointed out that it is sometimes difficult to work with other organisations that might have different agendas.

*Overall, there was consensus that the programme had created a strong foundation and readiness for change but that it was still a work in progress.*

Over the course of the programme, there is evidence of individual career progression into leadership roles, greater collaboration across practices, and the development of federations. A number of respondents directly attributed the development of the federations in Lambeth to the programme (Southwark federations had been in existence when the programme started) and many were of the view that general practice was better represented at the table in both boroughs as an equal partner sitting alongside other system leaders.

The key challenge highlighted in meeting the programme objectives was the size of the cohort that directly benefited, and the capacity of individual participants to mobilise their peers and their practices into new ways of working beyond working through the federations.

There is no doubt that general practice remains under significant pressure as is recognised most recently in the *General Practice Forward View* (April 2016) and at this stage in the journey it is not possible to claim that the general practice in Southwark and Lambeth is in a more sustainable place as a result of the programme. However, there is evidence to suggest that the programme has impacted positively on general practice's resilience and its readiness for change now and in the future.

# 8. Strengths and contextual challenges of the programme

A programme such as this presents a very challenging environment for both the participants and stakeholders involved – like "changing horses in mid-stream" during a journey - a perilous undertaking. This section sets out the strengths and contextual challenges faced in programme delivery, building also on details of programme delivery set out in section 6. In section 9, the future development of the programme is considered.

## 8.1 Strengths

**"The way in which sessions encouraged joint working, joint thinking and opportunity to challenge each other as well as the systems we work in." (Course Participant)**

The availability of quality 'protected time' was a consistent theme when talking to participants about how the programme was delivered. The programme took people out of their day jobs albeit briefly and allowed them the opportunity to work collaboratively with peers, share ideas and learn outside the normal silos of their individual practices. This supported the development of relationships between the participants by creating a mutually supportive learning context, where ideas could be floated out, tested, and discussed in a non-threatening environment. Working in a more collaborative way also equipped participants to make connections across both the wider general practice community and health and care system that would not otherwise have happened. For some these relationships were the starting point for the development of their own personal networks and career progression.

That the programme was delivered through a variety of different channels over the 3 phases was also seen as a key strength. This included the delivery of theoretical learning, practical workshops and masterclasses, action learning sets, networking opportunities and coaching. Coaching was highlighted by many as having had the greatest personal impact.

A further key strength of the programme was its flexibility. This meant that the actual workshops, or training events, could be based on issues and challenges that the participants were experiencing at the time. This made it very current and practical, and added value for many participants. Although individual participants had preferences as to the different providers based on their own personal predispositions, several indicated that having a mix of providers added value to the programme delivery overall.

**Table 8.1 What was your view about the delivery format of the programme (e.g. locations, timing, structure, content, etc.)?**

| | Phase 1 | Phase 2 | Phase 3 |
|---|---|---|---|
| Completely appropriate | 6 | 8 | 7 |
| Partly appropriate | 2 | 2 | 5 |
| Not involved | 4 | 2 | |

Source: Online beneficiary survey

Participants were asked their views about the delivery format of the programme. Responses are set out in table 8.1 above. While the sample and response numbers are not very large, the feedback suggests a relatively high share of "completely satisfactory" responses for phases 1 and 2, and that the share of "partly" to "completely satisfactory" responses rose with the third phase. The reasons for the findings about phase 3 are not clear, but it may have been related to some of the initial expectations about phase 3 not being fully met, or the larger group, or due to the increasing difference between the situations in Lambeth and Southwark, or because some of the course

participants in phase three did not have the background context that those who had been through phases 1 and 2 had..

## 8.2 Challenges

Creating time to think and learn was a great strength of the programme but availability of time was also the greatest challenge for the participants of the programme: balancing the demands of personal life, their practice, their federation (in many cases) and the programme itself. This had two aspects: both the length of the programme which evolved to exceed the initial 6 month window (running for 2 years) and the intensity of the programme demands.

One respondent suggested that "For the future, it may be worth considering if there might not be some modularisation or more flexibility in a successor programme."

**"I have never worked so hard in my life over a sustained period" - (Course participant)**

This high demand on time was mitigated somewhat by backfill and some examples were given of how practices had reflected on different ways of working internally to free up time. However, programme participants often mentioned that backfill was not enough to compensate for absence from the practice. Replacements were not always possible and even when they were it could hardly make up for the role of someone that was an integral part of the practice and had been for years.

Several respondents mentioned that as a result of the programme and subsequent Federation leadership roles they could not keep up with or stay on top of practice work commitments. This meant that some reduced days at the practice where possible and others ended up leaving the practice completely and concentrating on their role at the relevant federation and/or other bodies.

Attending the programme involved a high personal cost in terms of relationships at the practice and the work-life balance overall. It is understood that locums or replacements were not available for practice managers participating in the programme, as their work tends to be very context specific (as opposed to that of clinicians), so it is not always easy or useful to obtain useful short-term replacements. This is also something that would have to be looked at in the future if a similar programme is rolled out more widely to other professions in primary care.

It has emerged that in Lambeth there are some unresolved issues related to compensation for attending the programme, which may be attributed to inter-related programmes funded separately (e.g. Challenge Fund). It seems participants had thought some costs that would be claimable that appear not to be. In the future, it should be made much clearer what can and what can't be claimed right from the beginning of the programme so that such situations cannot arise.

Some respondents indicated that the programme objectives had not always been clear at the start – both in terms of expectations for them as individuals and on the future of general practice. Subsequent phases of the programme saw a shift in focus from personal development and individual leadership to leadership and new ways of working within the federations. Once this shift occurred the focus of the programme became clearer. This shift in focus was in direct response to a change in the external environment and the need to build capability of general practice to work at scale and system wide through federations and LCNs.

There was also feedback from participants that some of the aspirations set at the outset of the third phase were not fully realised, in particular expectations that the learning partners would bring in people in primary care from other parts of the UK or other walks of life that could provide useful insights locally.

A further point that was brought up by several participants is that the differences between Lambeth and Southwark, which were already present at the beginning of the programme, appear to have increased as time progressed and there is a question whether it is still valid to have a joint programme, or if so, how? Some occasions were noted when time was taken up by dealing with

issues in one borough this meant that participants present from the other questioned the value of their presence at the workshops. However, others stated there was value in the shared learning across geographies.

## 8.3 Barriers to change

In addition to the challenges already identified, some wider external barriers to change were mentioned by respondents, and will need to be dealt with in order for general practice to work towards system wide collaboration. These include:

- The financial model of general practice makes it difficult to extend outside the conventional GP silos, and other participants in the healthcare (e.g. salaried hospital staff) are not always aware of this constraint.
- Some GPs prefer a small-scale, personalised service, and are put off by talk of delivering at large scale.
- There is much conservatism and traditional thinking in general practice, especially as the new models of integrated care are often not yet fully developed or validated – which can create significant risks for general practice.
- The complexity of setting up arrangements between different organisations can put general practice off such initiatives.

# 9. Future development

This section considers the potential future of the programme in terms of *sustainability, scalability* and *replicability*. The findings of the previous sections indicate that the programme has had a substantial impact on the development of new models of care in the wider healthcare system, and that although a start has been made as regards developing a sustainable model for general practice in Lambeth and Southwark, a great deal remains to be done. This suggests that there is a need for developing a programme to support and drive change in the future - as one respondent put it there is a "need to invest in people to continue this journey". This programme should also bear in mind the strengths and weaknesses of the one that has just concluded, as well as gaps that were not filled.

The programme has focused on providing individuals with the skills and the time required to build capability within general practice at both a practice and federation level. However, it is recognised that this is only the start of the transformation journey. To continue the journey successfully, the nature of the terrain requires use of two "vehicles": one is the existing model - a tough vehicle used to explore the unknown terrain - of the programme alive which must be kept going to continue to bear more fruit in the future. The other is a new model which needs to be able to accommodate more passengers following in the path of the pioneers.

## 9.1 Benefitting from the legacy of the programme

Programme participants and external stakeholders often stressed that they are concerned about what is to become of those that participated in the recently completed programme. They are concerned that the cohort that has learnt so much, provided so much mutual support, and been through so much together might disband completely, dissipate and fritter away. This would be a significant loss to the system as a whole.

It has been suggested that to sustain the advances made something should be done to continue to obtain a return on the investment in the programme participants by, for example, involving them as mentors to future candidates, or as people who could be shadowed to learn how they operate. They could be used to support the development of a next generation of leaders, or in succession planning, as many of the current cohort seems to have reduced their operational involvement in general practice, and there is still a considerable amount of system transformation to be undertaken that requires strong primary care leadership at all levels.

**"We need to grow our own leaders. Each leader is to mentor others for sustainability – do not want to re-start from scratch. For LCNs to succeed we need a mixed group of people – GPs, PMs, practice nurses, community nurses, etc. Much more learning needs to be shared between them".**
**(Course participant)**

## 9.2 A new model for the future

In order to continue with the transformation to sustainable models of delivery, external stakeholders and programme participants have expressed the view that, as far as scalability and replication are concerned, the next stage of development needs to broaden its focus to encompass the development of leadership skills and behaviours across general practice (e.g. receptionists, HCAs, nurses and practice managers), and system leadership capabilities for health and care providers through the LCNs, including practice nurses, district nurses, pharmacists, the voluntary sector social services, and the wider community, etc.

**"The cohesive multi-partner multi-stakeholder group envisaged for phase 3 of the programme has not materialised. We can move towards that now."**
**(Course participant)**

As well as broadening the scope beyond general practice to consider system-wide participation in change leadership, there may also need to be a shift of focus beyond the formation of federations to new ways of working across a multi-provider network rather than a fragmented hierarchical system. Having said that, it was recognised by all we spoke to that there was still a need for an investment of time and resource into the on-going organisational development of the federations (e.g. in business development skills, human resources management and financial management) which are still in their infancy and creating the conditions in which the federations are sustainable and ready to operate system wide.

**"For LCNs to succeed we need a mixed group of people – GPs, PMs, practice nurses, community nurses, etc. Much more learning needs to be shared between them".**
**(Course participant)**

The key point is that even though the PCD programme has now been completed, this does not mean that system development should stop. The programme has started the process and identified the way ahead. Stakeholders and participants in health and social care delivery need to continue with the process of change. This will require commissioners and providers to determine how best to support further team and leadership development within LCNs, recognising that these are multi-speciality groups of health and care providers with different organisational and business models.

The following are key elements to ensure sustainability, replicability and scaling up the roll-out of a future programme.

*Encourage and support distributed leadership across the wider general practice community (across professional groups)*

**"More capability must built across the system to engage at a system level, focusing on collaborative and collective leadership – brining on board other system players and developing relationships at a system level"**

**(Course participant)**

A key challenge made to the programme was that it focused on a small cohort of largely GPs and practice managers and that whilst the federations grew, it was often difficult to mobilise individual practices and their staff. One way to create a critical mass of change champions who are equipped to work at scale, is to open up opportunities to others working in general practice, both in terms of numbers of people and different professional groups. This is obviously easy to say but in reality there are significant constraints in terms of time and funding. However, future support programmes could consider less intensive interventions that create maximum impact. By taking this approach, respondents felt that future support would be responding to the need for succession planning in identifying a new generation of leaders.

*Continue to develop skills to support new ways of working: the development and implementation of new services and new models.*

Both programme participants and external stakeholders have recognised the impact the programme has had on the development of new initiatives and new ways of working across general practice, and with the CCG and other health system participants. It was also recognised that general practice had started the process of developing stronger relationships with providers through the LCN model. The next phase needs to focus on translating these relationships, trust and commitment into new ways of working which could include releasing general practice to work differently in a community setting to enable opportunities for championing skills exchange across professional groups in primary, secondary, and community care. The outcome of developing new ways of working collaboratively – itself a change in working culture - will be a continued change to working culture and the creation of a collective sense of leadership across the system.

**"GPs' core role will be … to act as leaders within larger multi-disciplinary teams with greater links to hospital, community and social care specialists".**
**(General Practice Forward View, April 2016)**

*Create readiness to work across networks rather than hierarchies*

Where this programme has been about getting general practice ready to work at scale, any future programme will need to consider what skills and behaviours are needed by providers of health and care within LCNs to work collaboratively across multi-provider networks rather than traditional organisational hierarchies. Many respondents cited the softer skills and behaviours that were needed system-wide to collaborate across more informal networks. These included: influencing; peer accountability; collaboration; dealing with relationships; co-design; and, taking collective responsibility for delivering local population health outcomes.

**"There is still a lot of uncertainty around models of integrated care. It is far more complex than we ever imagined and difficult to effect change across organisations. The programme has supported general practice to consolidate and unify but it hasn't yet had much impact on the integrated models. That work is just starting." (Course participant)**

The challenges to delivering cross-network working models should not be underestimated as business models, operational performance, and financial flows tend still to follow the fragmented hierarchical pattern. Readiness through soft skills and mind-set will not be enough as they will have to be informed by understanding of financial models, cost structures, and risk assessments.

*Collective system leadership across LCNs – equip all providers to work more closely together towards new ways of working across primary and secondary care*

The next part of the transformation journey needs to focus on supporting the development of a 'collective narrative' for the LCNs as networks of providers of which the federations are a core part. The next phase will need to create the 'headspace' for providers across the networks to explore what each brings to the table, where their strengths and weaknesses lie, where there would be opportunities to work differently with other parts of the system that haven't traditionally worked closely together for the benefit of the local population.

**"The next phase has to be about providing leadership development. No one provider has the resources to deliver alone. They need to work collaboratively across primary and secondary care at a system level through LCNs". (Stakeholder)**

For LCNs to succeed there needs to be a sense of collective leadership from across the health and social, the voluntary sector and the broader community. The LCNs will need leaders that are GPs and practice managers but also practice nurses, community pharmacists, patient representatives, voluntary sector representatives, etc.

*General practice*

While the programme's focus has, in response to external developments, shifted to developing the links between the many participants in providing health and care in Lambeth and Southwark, it should not lose sight of the fact that the initial impetus for this programme came from an identified need to support and transform general practice. This has not gone away with the development of individual leaders, federations, and the focus on working across LCNs, and the surveys and interviews confirm that there is still a great deal to be done as regards general practice. The recently published *General Practice Forward View* has also focused renewed attention on the matter.

# 10. Conclusions

Our evaluation's conclusions - taking into account the objectives set as out in the terms of reference and the evaluation framework - can be summarised as follows:

- The PCD was a highly innovative programme that has been considered by a wide range of external stakeholders and programme participants to have made a substantial positive impact on the development and implementation of new models of care in the wider health care system across the two boroughs. It is continuing to do so with these new models of care as the vehicles for transformation locally.
- The PCD was based on the hypothesis that concentrating on the nurturing, development and empowerment of a cohort of 'change leaders' working towards a shared vision of the future of primary care, would benefit the health care delivery system by initiating and bringing about change for the system as a whole, and this is happening.
- The PCD has enabled primary care to more effectively provide the groundwork and building blocks for system integration and change, to speak with a unified voice, and engage with the health and care system as a whole.
- Primary care is leading the way through its increased understanding of the strategic environment which has resulted from Emerging Leaders' participation in the PCD programme, and the capabilities they acquired to articulate and implement the strategic objectives developed in the course thereof.
- General practice in the two boroughs has organised geographically through GP Federations that have started to deliver population based services and collaborate with other health and care providers.
- There is also continued momentum for developing new ways of working with health and social care partners to co-develop new models of integrated care through LCNs (e.g. the development of a shared operating model for to deliver person-centred and coordinated care to a cohort of people with 3+ long term conditions).

Overall, the position that general practice is today in a very different position from what it was in at the beginning of 2014. General practice has a voice, it can present itself as a participant in discussions with other participants in the health care system; there is ample evidence of collaborative approaches in support of new models of service delivery including geographically based organisations; and, overall a readiness to move to new primary care models to deliver better patient outcomes. Many examples of the impacts at individual, organisational and system-wide level are provided in the report.

However, the investment cost and the demands on the people involved have been substantial – a huge effort was required by programme participants. And while there has been a major shift, respondents stressed that there was still a great deal to do. These were first, albeit critically important, steps on the journey. General practice is poised for change, but needs to become sustainable in order to deliver on the vision for integrated health and care in the two boroughs. At this stage, the operating conditions within general practice have not been significantly changed beyond what the Federations can provide. There are some important structural issues relating to business models and financial flows that inhibit change, as well as preferences as to how GPs think they should interact with patients. These factors together mean that the challenge should not be underestimated, as is evidenced by the attention given to primary care through the recent *General Practice Forward View* (April 2016).

There is a need for continued support to enable further evolution of the health and care landscape locally. Some guidelines in this respect are provided in the recommendations that follow.

# 11. Recommendations

Looking to the future, and bearing in mind the conclusions drawn in the preceding section, there is certainly a need for the continued and on-going transformation of the health and social care system in Lambeth and Southwark in order to meet the challenges being faced. Recommendations are set out below.

### Recommendation 1 - identify and audit existing development/ transformation programmes currently under way or contemplated in each borough.

Just the exercise of carrying out such a review should bear fruit in terms of identifying gaps in provision, overlaps and possible joint working opportunities. In doing so, it would be useful to distinguish between initiatives that target the development of individuals that could lead change, those that target a specific group of providers or institutions, and those that are focused on overall systemic change.

**"Leadership is an art that can be learnt, grown and nurtured. I think on-going training and support and skills must be continued to be sought and developed. Just because we are now 'Emerged' does not mean the learning ends here" (Course participant)**

### Recommendation 2 – Continue to involve and engage PCD programme participants to support sustainable change.

The skills and experience this cohort of general practice leaders have acquired in the course of completing the programme are invaluable for the boroughs and need to be further used to drive on-going change both in primary care and more broadly. In particular, Federations need to continue to build their capacity to ensure that they are sustainable in their own right, are able to support resilient primary care, and engage with health and care partners through LCNs.

Further, these leaders should be looked to in terms of mentoring new leaders to support succession planning.

### Recommendation 3 – Develop system leadership capability and capacity through LCNs

There is also a wide ranging view from external stakeholders and programme participants that, more people must be supported to take up leadership roles to ensure continued and large scale change for the future, and that these individuals should come from a wide range of backgrounds and professions, reflecting the composition of those involved in community care more closely.

**"The biggest priority is to identify and support the next generation, the new wave that will take over" (Course participant)**

At the same time, there is a need for on-going development of how the parts interrelate, creation of new relationships and new institutions to drive change in the healthcare system as a whole. Both commissioners and providers need to determine how best to support further development and transformation efforts within LCNs taking into account the development and learning through the PCD programme, and the complexity of the LCN landscape (e.g. different organisational and business models).

# Annex 1 Primary Care Development programme participants

| Primary Care Development programme participants | |
|---|---|
| Abdul Mukadam | Lambeth |
| Ademola Salau | Southwark |
| Adenike Williams | Southwark |
| Anna Kedian | Southwark |
| Carol McPaul | Southwark |
| Catherine Arden | Southwark |
| Catherine Otty | Southwark |
| Di Aitken | Lambeth |
| Elaine Richmond | Lambeth |
| Jacques Mizan | Southwark |
| Jonathan Mortimer | Southwark |
| Justin Hayes | Lambeth |
| Kenny Chan | Southwark |
| Lauren Parry | Southwark |
| Lin Clarke | Southwark |
| Louisa Dove | Southwark |
| Mark Chamley | Lambeth |
| Martin Block | Lambeth |
| Martin Iu | Southwark |
| Michele Izzo | Lambeth |
| Nigel Smith | Southwark |
| Rachna Chowla | Southwark |
| Rebecca Dallmeyer | Southwark |
| Ross Dyer-Smith | Lambeth |
| Saadi Doha | Southwark |
| Sandra Connolly | Lambeth |
| Sonia Hall | Southwark |
| Stephanie May | Lambeth |
| Tarek Radwan | Lambeth |
| Therese Fletcher | Lambeth |
| Tilly Wright | Lambeth |
| Tyrrell Evans | Lambeth |
| Wande Fafunso | Southwark |

# Annex 2 Online survey template for programme participants

## Emerging Leaders/Federation Development Programme evaluation

An independent evaluation of the Emerging Leaders/ Federation Development Programme has been commissioned which will assess the impact of the programme on individuals, the development of new models of care (at a practice, Federation and Local Care Network level), and the sustainability of general practice across Southwark and Lambeth. The evaluation will identify strengths that can be built on and make recommendations for how we build on this programme as we move into this next phase of development focused around Local Care Networks.

You are being asked to complete this survey as a participant of the programme. It aims to ascertain your views

- of the programme
- impact on
- you individually and your career trajectory,
- your practice/ federation
- at a system level

In addition to this online survey we will also conducting more in depth telephone interviews with a sample group to drill down into more detail.

This survey should take no more than 10 – 15 minutes to complete. You can choose to make your responses anonymous. All mandatory questions are multiple choice and open questions with free text are optional.

The survey will close at 10.00 am on Monday 25th April 2016.

Thank you for your time in supporting this work.

Please click 'next' to begin the survey.

| Participant information (for analytical purposes only - not for identification) | |
|---|---|
| 1. Name (optional) | Free text |
| 2. Practice/ Federation (optional) | Free text |
| 3. Role | Free text |
| 4. Size of practice (patient list) | Free text |
| 5. Borough | Southwark<br>Lambeth |
| 6. In which of the phases of the programme did you participate (or are you participating in)? (Tick all those that apply). | 1 – Emerging Leaders Programme (Phase 1)<br>2 – Emerging Leaders Programme (Phase 2)<br>3 – Federation Development Programme (Phase 3) |

## Programme objectives

| No | Question | Response format |
|---|---|---|
| 7. | The programme's overall objective was to build capability to enable general practice across Lambeth and Southwark to shape and develop integrated models of primary care that are generalist –led, bottom-up and clinically driven.<br><br>In your view has the programme met its objectives to date? If only partially or not at all, please explain. | Yes, fully<br>Yes, somewhat<br>No, not at all<br><br>Free text |
| 8. | To what extent do you think the programme has met the following objectives:<br><br>a) Impact on cross-organisational working to support the development of new models of integrated care and shape the role primary care plays within this<br>b) Capability and readiness for general practice leaders to lead and deliver change<br>c) Developing a 'unified' voice across GP Federations and the LMC to ensure the collective views of general practice are represented when engaging with key partners<br>d) The state of readiness for general practice to implement new primary care models that will ultimately deliver better patient outcomes on a population health basis e.g. Extended Access<br><br>If only partially or not at all, please explain any gaps/developmental requirements as regards (a) – (d) above that need to be addressed in order to ensure sustainable impact? | <br><br>Yes, fully<br>Yes, somewhat<br>No, not at all<br><br>Yes, fully<br>Yes, somewhat<br>No, not at all<br>Yes, fully<br>Yes, somewhat<br>No, not at all<br><br>Yes, fully<br>Yes, somewhat<br>No, not at all<br><br>Free text |

## Delivery of the programme

| No | Question | Response format |
|---|---|---|
| 9. | What was your view about the delivery format of the programme (e.g. locations, timing, structure, content etc.)? | Phase 1<br>completely appropriate;<br>partially appropriate;<br>not appropriate at all<br>Free text to elaborate<br>Phase 2<br>completely appropriate;<br>partially appropriate;<br>not appropriate at all<br>Free text to elaborate<br>Phase 3<br>completely appropriate;<br>partially appropriate;<br>not appropriate at all<br>Free text to elaborate |

| No | Question | Response format |
|---|---|---|
| 10. | What was the greatest strength in delivery of the programme? i.e. what worked well? | Free text |
| 11. | What was the greatest weakness in the delivery of the programme? i.e. what could have been improved and made this more effective? | Free text |
| 12. | What (if any) were the barriers/ constraints to your active participation in the programme? | Free text |

## Impact of the programme

| No | Question | Response format |
|---|---|---|
| 13. | To what extent has the programme had an impact on<br>a) You as an individual<br>a. Personal development<br>b. the work that you do day-to-day?<br>b) The work of your practice<br>c) the GP federation you are part of<br>In each case, can you provide any examples of things you, your practice or your GP Federation would not have done had it not been for your participation in the programme? E.g. mobilisation of service contracts | High impact<br>Some impact<br>Low impact<br>No impact<br>Don't know<br>Free text to elaborate |
| 14. | What was your role (in the practice and GP Federation) when you first entered the programme? | Free text |
| 15. | Did your role change during the course of the programme or soon afterwards? (for example, new job, new responsibilities…) | Yes<br>No (- question 17) |
| 16. | If yes, please can you describe how? | Free text |
| 17. | To what extent were you able to develop new knowledge and/or skills as a result of participating in the programme? | I developed a lot of new knowledge and/or skills<br>I developed some new knowledge and/or skills<br>I did not learn any new knowledge and/or skills |
| 18. | What skills and knowledge were the most useful? | Free text |
| 19. | Can you describe a change to your leadership style or leadership behaviours as a result of your participation in the programme? | Free text |
| 20. | Can you describe how you utilised the backfilled 'time and headspace' that was provided as part of the programme, and whether you found this useful? | Free text |
| 21. | Do you have any other comments relating to the programme that you would like to share: | Free text |

### Future sustainability and scalability of the programme

| No | Question | Response format |
|---|---|---|
| 22. | Given your experience in the programme to date, what do you think is one key learning point that should be taken forward in the next phase of development? | Free text |
| 23. | If you would like to provide more detailed feedback on the programme or contribute to a more detailed case study, please provide your name and contact details. | Free text |

# Annex 3 Primary Care Development programme evaluation – semi-structured interview guides

### Stakeholder interview discussion topics

An independent evaluation of the Emerging Leaders/ Federation Development Programme has been commissioned to assess the impact of the programme on individuals, the development of new models of care (at a practice, Federation and Local Care Network level), and the sustainability of general practices across Southwark and Lambeth. The evaluation will identify strengths that can be built on and make recommendations for how we build on this programme as we move into this next phase of development focused around Local Care Networks.

### Personal details

1. What is your role in Lambeth &/or Southwark?
2. What has been the nature of your involvement with the Emerging Leaders/ Federation Development Programme?

### Shared understanding of the programme's objectives

3. The programme's overall objective was to build capability to enable general practice across Lambeth and Southwark to shape and develop integrated models of primary care that are generalist –led, bottom-up and clinically driven.

In your view has the programme met its objectives to date? If not, what do you think the barriers to this have been and what would have made this more achievable?

Have the objectives of the programme changed as the world has changed? And if so how?

What do you base your view on?

### Individual impacts:

4. Thinking about the individuals who were involved in the programme, could you provide examples of where you have seen participants develop as leaders at a practice, federation and/or Local Care Network level? Think about it in terms of:

- Skills, knowledge, learning embedded through experience
- Resulting behaviour change
- Change in mind-set; resilience/ adapting to change
- Changes in relationships
- Changes in career paths

What if anything have been barriers/ constraints to this happening?

### Organisational/ system wide impacts

5. What has been the impact of the programme on general practice's capability/ capacity to deliver at scale? (at a practice and federation level)
   Please give examples
6. What has been the impact on the capability/ capacity of general practice (at practice and federation level) to deliver initiatives that wouldn't have otherwise happened e.g. extended access service?

   Are there other examples?

7. The overarching vision of the programme was that it was able to support the development of new models of primary care that:
    a) Are better configured to deliver an increased range of services to patients and integrate with other services on a population health basis
    b) Reduce variation in access and quality for local populations
    c) Deliver benefits in terms of quality and value for money
    d) Make primary care a more attractive place to work and reinvigorates existing staff.

Do you feel that the Federated models developed locally deliver on this vision?

8. What changes in relationships have you witnessed at a system level e.g. through SLIC or LCNs?

### Future sustainability and scalability

9. Thinking about the programme strengths and the impact it has had, what should the programme be prioritising/ building on as it moves into the next phase of development focused around Local Care Networks?
10. Do you think there are any barriers to the readiness of general practice to implement new models of care both in primary care and through local care networks? How do you think we can best support these to be addressed?

### Transferable and replicable

11. In your view are their opportunities to replicate this model across other parts of the system?

Thank you and anything else to add

## Participant interview discussion topics

An independent evaluation of the Emerging Leaders/ Federation Development Programme has been commissioned which will to assess the impact of the programme on individuals, the development of new models of care (at a practice, Federation and Local Care Network level), and the sustainability of general practice across Southwark and Lambeth. The evaluation will identify strengths and make recommendations for how we build on this programme as we move into this next phase of development focused around Local Care Networks.

You have already been asked to complete an online survey as a participant of the programme and in addition you are part of a sample group of telephone interviews where we want to drill down in more detail about the impact of the programme.

The objective is to evidence the impact of the programme on your practice, Federation and Local Care Network and demonstrate the impact the programme has had on you individually.

We would like to use quotes in both the final evaluation report and external communications materials (e.g. GSTC Annual Report). Please let us know if you are happy for us to do so and if you would prefer for your name/position not to be used.

### Personal details

1. What is your role in Lambeth &/or Southwark?
2. What practice/ Federation are you part of?
3. In which of the phases of the programme did you participate (or are you participating in)?
4. How did you come to be involved in the programme?

### Shared understanding of the programme's objectives

5. What in your view were the objectives of the programme and has the programme met its objectives to date?
6. What do you base your view on?

### Individual impacts:

7. What was your role (in the practice and GP Federation) when you first entered the programme?
8. Did your role/ career path change during the course of the programme or soon afterwards? (for example, new job, new responsibilities…)
9. Do you think your experience on the programme contributed to that change in role/ career path? Think about it in terms of:

- New skills, knowledge, learning embedded through experience
- Resulting behaviour change
- Change in mind-set; resilience/ adapting to change
- Changes in relationships
- Can you provide any examples of change to your leadership style or leadership behaviours as a result of your participation in the programme?

12. Were there any barriers/ constraints to this change?
13. Were there any other positive or negative impacts that the programme has had on you as an individual?

### Organisational/ system wide impacts

14. Can you make a connection between your participation in the programme and the work of your practice/ federation you are part of?

    Can you provide any examples of things you, your practice or your GP Federation would not have done had it not been for your participation in the programme? E.g. mobilisation of service contracts, development of your Federation

15. The overarching vision of the programme was that it was able to support the development of new models of primary care that:

    e) Are better configured to deliver an increased range of services to patients and integrate with other services on a population health basis

    f) Reduce variation in access and quality for local populations

    g) Deliver benefits in terms of quality and value for money

    h) Make primary care a more attractive place to work and reinvigorates existing staff.

Do you feel that the Federated models developed locally deliver on this vision?

16. What impact do you think the programme has had at a system level e.g. through SLIC or LCNs?

### Future sustainability and scalability

17. Thinking about the programme strengths and the impact it has had, what should the programme be prioritising/ building on as it moves into the next phase of development focused around Local Care Networks?

18. Do you think there are any barriers to the readiness of general practice to implement new models of care both in primary care and through local care networks? How do you think we can best support these to be addressed?

### Transferable and replicable

19. In your view are there opportunities to replicate this model across other parts of the system?

Thank you and anything else to add.