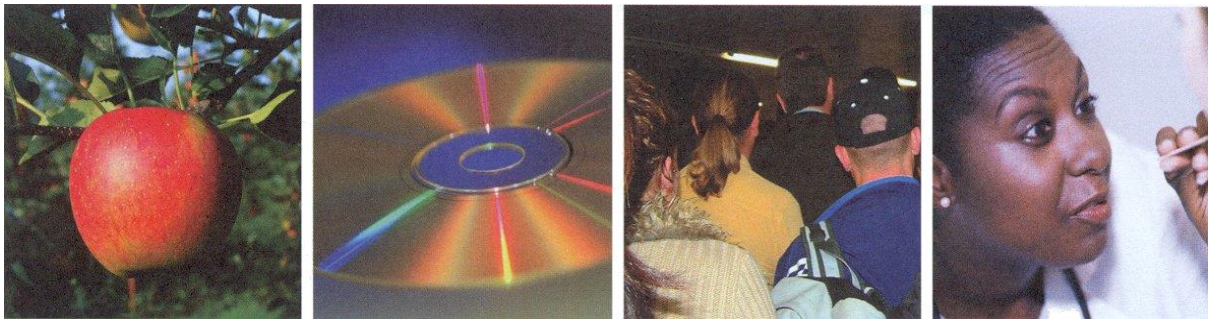
CHSS
University of Kent
Centre for Health Services Studies

Proof of concept evaluation of a project using 'conversations inviting change' methodology to support the development of in-place systems leadership in local care hubs.

Jenny Billings, Professor of Applied Health Research & Director, Integrated Care Research Unit and Dr Vanessa Abrahamson, Research Associate, Centre for Health Services Studies, University of Kent.

September 2018

Commissioned by the NHS Leadership Academy on behalf of Kent and Medway Sustainability and Transformation Plan and delivered by East Kent Community Education Provider Network.



www.kent.ac.uk/chss

Executive summary

This evaluation took place between March and August 2018 and was commissioned by the NHS Leadership Academy on behalf of Kent and Medway Sustainability and Transformation Plan (STP) and delivered by East Kent Community Education Provider Network (EK CEPN). The programme consisted of three development sessions carried out over two sites, or multi-professional teams known as hubs, clusters or primary care networks by an experienced facilitator using the model 'conversations inviting change'. This model embodies a narrative approach that recognises the domains identified by the National Leadership Academy of individual effectiveness, relationships and connectivity, innovation and improvement, learning and capacity building (NHS Leadership Academy, 2017).

Aim of the evaluation

The evaluation aimed to investigate the impact of embedding the function of an educational facilitator within the multi-professional primary care hub. The objectives were to:

1. Explore participants' perceptions of professional development as experienced through the hub support.
2. Explore participants' perceptions of the method of facilitation.
3. Explore perceptions of how (or if) the course should be scaled-up, how it could achieve impact in team work and the wider system.

Method

A qualitative approach, using a combination of interviews and focus groups, was selected given the natural fit with formative evaluation. Both hubs were invited to take part by the course facilitator and those who agreed were contacted by the researcher. Each hub has 20-25 members but not all attended the training sessions; of those who did, eight agreed to participate from site 1 and seven from site 2. Interviews/focus groups were carried out between July and August 2018. The interview schedule was designed to reflect the evaluation's objectives and the facilitators were also interviewed using an adapted version of the schedule.

The interviews/focus groups were recorded, transcribed and anonymised to protect participant's identity. The data was analysed using Flick's (1998) pre-determined template method of content analysis. Once all data had been sifted, a narrative was developed within the themes using selected quotes to support interpretation.

The main study limitation was the small sample size, as is common with small scale process evaluations.

Summary of findings

These are summarised in three areas that relate to the evaluation's focus:

1. Perceptions of professional development as experienced through the hub support

Many participants talked about their learning as part of the hub which everyone viewed positively. It was more difficult to identify what they had learnt specifically from the 'conversations in change' versus the hub overall. Time to reflect on their own role within the team, their colleagues' roles and the development of the team since its inception were the key benefits identified.

2. Participants' perceptions of the method of facilitation

Some participants were unclear about the programme's remit, were unclear how the suggestion of providing GP trainee placements fitted with the programme and did not recognise the exemplar of a critical friend. Even within hubs, opinions were mixed concerning the number of sessions, their timing and duration. Their suggestions for improvement were grounded in practicalities and included more preparation, clearer aims and a tighter structure for each session. Participants recognised that the facilitators came from an educational background and were highly skilled facilitators but found the terminology confusing.

3. Views on rolling out the programme, its impact on team work and the wider system

The main tangible outcome across both hubs was the decision to build in a regular opportunity to reflect as a team. No barriers were identified with regards to implementing what had been learnt and opinions were divided as to the value of further sessions with an external facilitator. Participants did not express strong views about rolling out the programme but thought that other hubs might benefit depending on contextual issues including how established the team was and its culture.

4. The facilitators' perspective

The facilitators had a clear view of the programme's purpose set within the current policy landscape and higher education agenda. They intended the hubs to use the reflective space however they found beneficial but the hubs did so in a way that was not as envisioned, resulting in an underlying tension, or mismatch of agendas. From the facilitators' perspective, there was insufficient time at the outset to explain the programme's purpose and further sessions would have been beneficial. While sessions were initially facilitated by one coach, they were later facilitated by both, which was not favourably evaluated by participants. The facilitators acknowledged a cultural gap between their educational background and that of clinicians.

Conclusion and recommendations

This evaluation investigated the impact of embedding the function of an educational facilitator within the primary care hub. Participants identified the key benefit as having the opportunity to reflect on their professional development, both individually and as a team. Participants did not perceive the relevance of policy to their daily work but this is in the context of competing priorities and perhaps indicates that the policy agenda may not always be tuned to the direct needs of frontline staff. To counter this, a systems approach would help develop strategies at the organisation level in order to enable grassroots change and lead to better alignment between policy, team and individual priorities. Co-creation is one approach that could help redress the disconnect between staff and organisational priorities because it has the potential to facilitate staff involvement and improve efficiency (Voorberg et al., 2015).

Recommendations are as follows:

- Prior to making any decision to roll out the programme, other options or approaches should be explored, taking into account evidence of feasibility, sustainability, (cost-) effectiveness and added value. Such approaches should embrace the concept of reflective practice and co-production/co-creation. Sustainability is likely to be undermined by staff turnover and organisational change both of which need consideration.
- In order to sustain the spirit of CIC, and embed the notion of reflective practice as an ongoing and dynamic process, hubs that have already participated should be offered follow-up sessions once or twice yearly, depending on their preference.
- If the decision is made to roll out the approach, the practical recommendations volunteered by participants, particularly around preparation and implementation would ameliorate some of the issues identified. It would also be worth reassessing some features of the training such as 'critical friend' and integration with GP training.
- Co-creation of a common language that spans individuals, teams and the organisation would help improve understanding of priorities across the micro-, meso- and macro-level. This would help make policy accessible to practitioners and enable them to assess the relevance of policy changes to their context, reflect on potential impact and act accordingly.
- The hubs would appreciate meaningful feedback based on data that is already collected. This would provide evidence of clinical outcomes and could be used to inform development.

September 2018

Acknowledgements

With many thanks to the members of staff who kindly gave their valuable time to inform this evaluation. Sincere thanks to the facilitators who were so generous with their time and explanations.

Abbreviations

CCG	Clinical Commissioning Group
CHOC	Community Hub Operating Centres
CIC	Conversations Inviting Change
EK CEPN	East Kent Community Education Provider Network
GP	General Practice
PPI	Patient and Public Engagement
STP	Sustainability and Transformation Plan

Contents

1 Introduction

CHSS were commissioned by the NHS Leadership Academy on behalf of Kent and Medway Sustainability and Transformation Plan (STP) to evaluate a methodological approach for a 'proof of concept' in-place leadership facilitation course which took place between March to August 2018. The programme was delivered by East Kent CEPN consisted of three development sessions carried out over two sites by an experienced facilitator with the role of 'critical friend' and leader of learners' inter-professional development.

This formative evaluation aimed to identify what worked, and how efficiently, in order to determine how improvements could be made (WHO 2013). 'Proof of concept' refers to the assessment of a certain method or idea in order to demonstrate it is feasible, effective, and provides added value over existing approaches (Rabinowitz et al 2013). The advantage is that it shifts decisions for continuing development to early stages of development, thereby reducing the likelihood, and cost, of failures at a later stage (Schmidt 2006).

1.1 Background

In East Kent there are currently 16 hubs, or groupings, (also called primary care networks or clusters) of primary care practices at various stages of development with a need to deliver integrated health and social care closer to home more effectively and efficiently across a population of 695,000 (EKHUFT, 2018). Each clinical unit is working towards a single Kent and Medway Sustainability and Transformation Plan (STP) and faces varying degrees of recruitment and retention challenge, yet all aspire to deliver quality care through developing the current and growing the future workforce (NHS Leadership Academy, 2017).

The number of general practices (GPs) in England has dropped by more than 650 in the past four years and average list sizes have increased by around 900 patients (Bostock 2017). For East Kent with a coastal boundary on three sides the national picture is intensified, thus moving to hub working is not necessarily a happy marriage of organisations but one of necessity. However, this is a unique opportunity to align workforce training and professional development to service delivery across the multi-professional workforce, both at scale and across systems.

Evidence for successful multi-professional working leading to better patient outcomes is variable but certain themes emerge as important for positive impact, with emphasis on particular aspects of multi-professional education and training. Specifically this relates to *how* to build effective health and social care teams within our cultural and system norms, whilst tackling recognised barriers which often reflect lack of trust and values-based tensions (Raines, et al. 2014).

Whilst calls for place-based attention to service delivery (Ham 2015) and the case for workplace-education (Manley et al. 2011, 2015, 2016; Manley and Titchen 2016; Manley, Titchen and Hardy 2009; Martin and Manley 2017) are well articulated and evidenced, the UK has no mandate for the role of critical friend in ongoing professional development in primary care. Supportive facilitation, leadership activity, mentoring, coaching for example are all adjuncts, often viewed negatively or as unaffordable, either in time or financially. Other professions mandate 'clinical supervision' in varying guises but there is no embodied organisational role that embeds this remit as a matter of course leaving the role to chance. However, a series of development sessions guided by a coach or critical friend may help professionals to reflect on their own approaches and the resources that they can employ to manage conflict and achieve mutually beneficial solutions (Fillingham and Weir 2014).

1.2 Conversations inviting change (CIC)

In the context of public services (including primary care), boundaries between organisations and between the roles of professionals at all levels are becoming more fluid as jobs and teams that were once separate are merged. Professionals have to navigate increasing complexity and unpredictability alongside growing patient expectations, coupled with decreasing resources and capacity (Ghate et al. 2013). Systems leadership is an approach that intends to deliver positive change across multiple and intersecting systems. It has been defined as leadership 'across organisational and geopolitical boundaries, beyond individual professional disciplines, within a range of organisational and stakeholder cultures, often without direct managerial control' (Ghate et al. 2013, p13). The key difference to a traditional unilateral model is the focus on participatory leadership, or the joint effort of professionals working together across systems and at different levels (Ghate et al. 2013). This requires leadership which fosters 'connectivity', or builds relationships with partners and communities, and values learning and a culture of 'transparency and sharing' (NHS Leadership Academy 2017, p3).

Tapping into a common vision that transcends organisational attachments can facilitate the development of a set of common goals 'anchored' in what is beneficial for the community (Fillingham and Weir 2014, p34), or in this case users of primary care. A collective approach has the potential to avoid dissonance in stakeholder and organisational values which may compromise effective multi-professional working. However, it is inevitable that conflict will emerge, whether individual, inter-professional or inter-organisational, and there needs to be a means of airing and resolving such conflict (Fillingham and Weir 2014). Roebuck (2011) also emphasises the need for clinicians to understand the whole system so that they appreciate how the overall process works to deliver care,

not just their own job, with the implication that this would support multi-professional systems based working.

The model for 'conversations inviting change' has been developed over many years by Dr John Launer and has been shown to improve professionals' resilience and decrease negative behavioural patterns such as bullying in NHS organisations (Launer 2018). It embodies a narrative approach that identifies with core personal values, and the place of the individual within complex systems. The model uses expert facilitation to enable individuals within a small group setting to reflect, explore and rehearse highly challenging conversations that invite personal change in attitudinal perspectives and behaviours (Launer, 2018). The approach has the potential to support emergent leaders as 'facilitators' as well as to support a wider pool of 'followers'. In this way the methodology recognises the domains identified by the National Leadership Academy of individual effectiveness, relationships and connectivity, innovation and improvement, learning and capacity building (NHS Leadership Academy, 2017).

1.3 The hub development programme

The programme consisted of three sessions with two hubs of geographically aligned GP practices in East Kent and took place between March-August 2018. A further session in site 1 was carried out in September 2018. Sessions were initially led by one expert facilitator but later sessions were led by two facilitators. The initial session explored current ideas, concerns and expectations from the perspectives of individuals and the organisations they represented in the context of the multi-disciplinary team and aimed to ascertain:

i. What can you and your organisation bring to the hub?
ii. What obstacles do you anticipate to delivering the objectives and what will be needed to overcome them?

The two sites were:

a) **Site 1** as part of the Primary Care Home model of new ways of working developed by the National association of Primary care (NAPC). This is an approach to integrated community and acute care systems based around local populations of 30 to 50,000.

b) **Site 2** practices as part of the Encompass Vanguard. This is one of five Community Hub Operating Centres (CHOCs), now called hubs (or hubs). The aim of a hub is to provide a community based model of integrated service delivery, reaching across health and social care to deliver seamless care. Hubs represent a fully integrated multi-disciplinary health and social care team, offering services inclusive of primary, community and social care provision.

1.4 Aims of the evaluation

The evaluation aimed to investigate the impact of embedding the function of an educational facilitator within the multi-professional primary care hub. The objectives were to:

i. Explore participants' perceptions of professional development as experienced through the hub support.
ii. Explore participants' perceptions of the method of facilitation.
iii. Explore perceptions of how/if the course should be scaled-up and how it could achieve impact in team work and the wider system.

2 Method

2.1 Study design

A qualitative approach was selected given the 'natural fit with formative evaluation' and the aim of identifying elements of the programme that might have hindered its effectiveness (Padgett 2012, p17). Qualitative research favours an inductive approach whereby observations generate theory which helps understand the phenomenon and (arguably) is best suited to unpack the 'black box' of complex interventions (Robson 2011). The approach acknowledges multiple perspectives and that understanding requires appreciation of contextual issues.

A combination of focus groups and interviews were used. Focus groups were an appropriate choice for a process evaluation aiming to explore ideas and gain consensus on what actions have worked, what have not, with what effects and why (Robson 2011). We took a pragmatic approach to the size of the focus group and limited the time to one hour. Those who could not attend the focus group were offered interviews which took no more than 30 minutes.

A semi-structured focus group schedule was developed (appendix 1) to explore participants' perceptions of professional development as experienced through the hub support and what they had learnt about their own development. It was designed to elicit their views about the process and content of the programme; facilitators or barriers to implementing what they had learnt individually and as a team; and how the programme could be improved and scaled-up. The schedule was adapted for individual interviews (appendix 2). A separate interview schedule (appendix 3) was designed for the facilitators which covered the same areas but was re-phrased to suit their role.

2.2 Sample

Each hub has 20-25 members but not all attended the sessions and a register of attendees per session was not available. Both teams were invited to take part by the course facilitator and were provided with verbal explanation and an information sheet (appendix 4), with the researcher's contact details, as to the purpose of the evaluation.

The focus group in Site 1 consisted of eight people and that in Site 2 of four. Three individual interviews were carried out and a fourth was terminated early, and the data discounted, when it transpired that the participant had not attended the sessions. Three people initially agreed to interview but were lost to follow-up. For both sites, there was a representative mix of health and social care professionals (including doctors, nurses, therapists and care co-ordinators), administrative and voluntary sector staff.

Table 1 summarises the interviewees per site:

Table 1: Number of people interviewed per site

	Site 1	**Site 2**
Focus group	8	4
Interviews	0	3
Total:	**8**	**7**

2.3 Data collection

The researcher contacted the team co-ordinator and arranged a focus group for each site, carried out at a time and location of their choice. In site 1, the focus group was carried out at the end of the three sessions while for site 2, it was carried out between the second and third session for pragmatic reasons. Consent was taken at the start of each focus group (appendix 5). The focus groups lasted approximately one hour.

For those who could not attend the focus group, or preferred individual interview, this was carried out either in person or by telephone and took up to 30 minutes. A separate information sheet and consent form were used (appendix 6-7).

The facilitators were interviewed jointly, on two occasions. The first interview was carried out before the sessions had finished and the second interview after the last session had taken place. This allowed time to discuss the final session and issues stemming from the first interview. The individual information sheet and consent form were used (appendix 6-7).

All data was collected between July and August 2018.

2.4 Data analysis

The interviews/focus groups were recorded, transcribed and anonymised to protect participant's identity. The data was analysed using Flick's (1998) pre-determined template method of content analysis. This entails constructing an analytical template from the interview/focus group schedule themes and filtering coded transcribed data into the template appropriately. We were careful not to force data into categories and used a blank category for information that did not fit with the predetermined themes. Once all data had been sifted, a narrative was developed within the themes using selected and coded quotes to support interpretation.

2.5 Ethical issues

As the evaluation is focused on 'proof of concept' and is focused on a small pilot with health care professionals, it did not need formal ethical approval. However, ethical principles of informed consent, beneficence, confidentiality and 'do no harm' were adhered to, as were aspects relating to data storage and transfer. Interview/focus group transcripts were anonymised before analysis and only one researcher (VA) was able to link transcripts back to personal details.

Given the small sample size, participants have not been identified by their profession as this might render them identifiable. However, there is the potential that the teams may be identifiable to local staff working in the community, Encompass and the Clinical Commissioning Group. This risk was explained to the professionals prior to obtaining consent.

3 Findings

The findings are structured into three sections that explore participants' views related to the research questions: their experience of professional development through the programme; their views on its delivery; and whether or how it should be rolled out. The fourth section presents the facilitators' perspective.

Participants are not identified by their job titles or site as this could compromise anonymity. However, they have been divided into three groups reflecting their profession or training. Firstly, 'doctors' which included those with a medical background; secondly, 'clinicians' which comprised those with nursing or allied health training; and thirdly, 'non-clinicians' or those who worked in the voluntary sector, were care co-ordinators and/or had an administrative role.

3.1 Perceptions of professional development as experienced through the hub support

This section summarises participants' perceptions about their professional development over the duration of the programme. Three broad questions explored their views about individual professional development, learning as a team and how or if this had made a difference to their practice.

3.1.1 Individual learning

Many participants started by talking about their learning as part of the hub and everyone viewed this positively. For example, one participant commented on feeling more comfortable to ask questions while another felt she had a better understanding of her colleagues' roles:

> *I've learnt a lot I think... when I first started going to the CHOCs I really didn't have a clue about a lot of things that were being spoken about… if you don't know something you don't feel embarrassed to ask...* (administrative role)

> *I have learnt quite a lot from going to the CHOC about different people's roles, who does what, and when* (clinician)

Participants found it difficult to identify what they had learnt specifically from the 'conversations in change' versus the overall process of hub working. None had apparently researched the approach and few had considered its theoretical underpinning. Two doctors were unable to identify learning specific to the programme, or on an individual basis, but did identify learning as part of the team:

> *The outcomes I would say have been more around us developing the CHOC as a service than it has been for ourselves… We haven't come out of it thinking we all need to do this to develop ourselves* (doctor)

However, participants did appear to reflect on what they valued about each other, as this exchange between two respondents demonstrates:

> *Yeah… I look forward to seeing my colleagues…, you know?*
> *I think it's improved the trust between us all hasn't it, because…*
> *Yeah.*
> *…then we know that we've asked somebody to do it, invariably it gets done, and we can sort of rely on each other to if we asked for something we're going to get an answer.*

Respondents also reflected on their own role within the team and their colleagues' roles, which they felt was positive. As one doctor commented:

> *I would think that it would be good for the development of any project to reflect on the roles that people have in them and what's going well for them. You know, just as an aside… the administrators are given the job of working the mouse on the computer [in meetings]… when they were asked how they felt they said they don't like using the computer, it never works… and doctors are always saying, "Just get on with it." So, you know, we fall into our stereotypes… it was useful for everyone to have a voice* (doctor)

Participants had also reflected on the experience of visitors to the team meetings which they did both individually and collectively, for example one of the clinicians commented:

> *For me what [facilitator] made us do, made me reflect was also just stepping back, but also looking at how do we allow other people to come into the group, how do we present ourselves when other people attend… because we're just, we're so gelled, we're just kind of we're going ahead*

3.1.2 Learning as part of a team

Participants differentiated between individual reflections and reflecting as part of the team. Time to reflect as a team appeared to be the key benefit identified by almost everyone:

> *I think we might have all done our own, kind of our own personal reflection during the meeting, or we asked questions… but I think what [facilitator] done was made it more of a collective group as a reflector, you know, as almost like a think tank as a group* (clinician)

Participants also differentiated between reflecting on patient care and reflecting on process:

> *We're not just talking about the reflection about what we could have done better for the patients, that we're now shifting that to what could we do better as a group* (clinician)

Stemming from this, the main tangible outcome across both hubs was that they decided to build in a regular opportunity to reflect as a group, in addition to their usual patient related meetings:

> *There's no time, so that was really useful to have that time… … we're going to have a longer CHOC, a longer meeting once a month where we are going to talk about the process in more detail* (doctor)

Secondly, as a result of reflecting on each other's roles, participants in site 1 took a more proactive approach to managing referrals which benefited their care co-ordinator:

> *I think now that the onus is not just put on me, for referrals, that everybody takes a referral, and we do try and make that referral happen… I do think that's much better… it's a better understanding of the importance of the referral, and how quickly the actions need to be put in place…*

Thirdly, reflecting on roles encouraged clinicians to opt for joint visits with a potential benefit for patients:

> *Initially I think [the facilitator] felt perhaps we weren't really certain of each other's roles, perhaps to start with a bit uncomfortable to say 'is it alright if we go and do a joint visit'… that's another thing that's come out of it, we're quite happy to go and do joint visits after the meeting*

However, while clinicians in site 2 agreed that it had allowed them time to reflect on each other's roles, and that the process of working in a hub had broken down inter-professional barriers, they were still frustrated by barriers beyond the hubs and doubted the programme (at least in its current format) could remediate this. One clinical manager remarked:

> *It's in-ground into me that you work inter-professionally, whereas there's still pockets out there that still have them barriers… so I get quite frustrated… I think there's still quite a large cultural change that needs to happen… I don't think it [the programme] would change the way… it's about experience and working in these hubs*

3.1.3 Changes in confidence about service delivery

All participants in both hubs regarded themselves as strong teams that communicated effectively and achieved what they needed to do. There were a couple of comments that indicated team meetings had the potential to improve and could on occasion stagnate but most participants thought the meetings worked well. As they already worked together efficiently, this limited what the programme could add and as one clinician pointed out:

> *I think that we're quite a forward thinking team anyway, so I think that the ideas, we would have had them anyway*

However, other participants stated that the programme had boosted their confidence (individually and as a team) and/or enabled them to try new ideas or develop their team working:

> *I think he gave us confidence, because we were trying new things, and inviting different people to come along* (clinician)

> *I think, as I said, putting it into some context to look at the journey and where we'd come from and why and appreciate each other and verbalise the fact that we are working in different ways, but all working well together. So, it is a bit of an affirmation really* (doctor)

Comments were mixed as to whether they would have achieved the same level of function without the programme, albeit more slowly. Only one participant was definite that the programme made no difference to the team. As the focus group in site 1 noted:

> *I don't know if we would have got there to the point that we would have said, right, let's have protected time* (clinician)
>
> *I don't know if that would have evolved into what we are now, without [facilitator]… I think [facilitator] got us there quicker* (non-clinician)

In terms of service delivery, no one identified any barriers to implementing what had been learnt. The new monthly reflective space appeared to prompt clinicians to discuss problems, listen to each other's ideas and then make a decision and as two of the doctors commented:

> *Those meetings [with the facilitator] made us realise that… it's going to be of great value, having that time out rather than bumbling along… Having that time out to think about the process is something valuable in the long run, to ensure it continues*.
>
> *We always listen to the ideas everybody else had around the table but now with this session we're doing each month we're actually using that to properly discuss them and look at whether they're possible or not, whereas before we'd sort of mention ideas but then perhaps didn't actually move them forward… this period of reflection once a month gives us more of an overview.*

In summary, the programme appears to have encouraged clinicians to reflect on their own role within the team, their colleagues' roles and the development of the team since its inception. The key outcome, of putting aside time to reflect on process, has had positive outcomes in terms of providing the space to discuss process related issues and find ways of addressing them.

3.2 Participants' perceptions of the method of facilitation

This section covers views about the programme's delivery and method of facilitation. Most prevalent were comments concerning preparation and purpose as well as views on the delivery and contents of each session.

3.2.1 Aims, expectations and preparation

Many participants were unclear about the programme's purpose and some complained that they had received sufficient information in advance. Some participants had a 'vague' idea what to expect and assumed that there must be some element of service improvement:

We were just told they were going to come and talk to us about the process and whether there's anything we can learn… we were told that they'd got a background in working in multidisciplinary or collaborative ways and maybe they'll have something that will help us. That sort of vague (doctor)

I wasn't quite sure what it would gain or achieve… it was really just hoping it might help us have a little bit of time to take stock and look at the future… because we all just carry on doing what we're doing and we don't really have a chance to think about it (doctor)

Mm, [xxx] said that he could come and help us really to put more structure into the meetings, and to also to try and invite others to come to the meeting (clinician)

However a range of participants from all backgrounds came with no preconceptions or expressed uncertainty:

I didn't have any expectations, I didn't really quite understand what it was all about (doctor)

We didn't really know what we were sort of signing ourselves up to (administrator)

We was all a little bit confused as to what… what it's all about (clinician)

The first session clarified the purpose for many participants, who related it to team building and developing the hub. However, participants in both hubs remained unclear where the idea of taking on trainee GPs fitted in:

I think there was two threads, there was this kind of thread around education, but not sure what area of education was this, was it particularly just for GPs or was this open to any other health professional, but there was this main emphasis there's going to be an element of education, and there was also an element of kind of self-reflection and review… (clinical manager)

It's difficult to know what their aim and expectations was, because then [facilitator] came back in the end and was saying all about medical students and want to place medical students in the CHOCs, you know, that never came out in the beginning… I think there was a lot of confusion, we really didn't know what the aim was (doctor)

Most participants felt clearer about the purpose after the first session but others expressed ongoing confusion or uncertainty about the aims of the programme which appeared unrelated to the number of sessions they had attended, which hub they worked with or their profession. For example, these clinicians commented:

We don't want to come across as negative, but there were a lot of uncertainties throughout the three sessions (FG2)

What were the aims… what our expectations were regarding what we wanted to get out of the three sessions… that was made obvious at the first session

After the first session I was very confused… I didn't know really what the aim was

Many participants preferred a more structured approach and commented that they preferred the second session because it had specific questions and set tasks:

> *I think after the second session… because we were in our groups by then and we'd chosen our own subject areas, so I think the second session I felt I knew what we were doing by then* (clinician)

Participants commented on the facilitator observing their patient-specific team meetings and while some appreciated the feedback others appeared to expect recommendations, reflecting a mismatch in expectations:

> *The good thing was that he actually came to the meeting… he sat and witnessed the meeting, and so he could then tell us what he'd observed*…
>
> *The first time they were sitting in the background on the first CHOC so they listened… and then we almost pounced on them… [to] give us some feedback… but they wasn't going to give us feedback… that [was] frustrating straightaway, you sat there for the whole CHOC and… we thought it was to give us some feedback, but really it wasn't, it was them that we had to give the feedback [to]*…

3.2.2 Practicalities: timing, format and approach

There were several comments about not being given enough notice of the meeting dates in advance and this had prohibited some people from attending sessions. Even within hubs, opinions were mixed concerning the number of sessions, their timing and the duration of each session. While some participants wanted more regular sessions, with less time in between, others thought two sessions would have sufficed. This clinician remarked:

> *I don't think we need three sessions… the first one we were floundering, I think we didn't know what was going on… I wasn't privy to the second one… and the third was kind of almost pulling everything together that we did on the first one, and even though I missed the second one I don't feel I missed anything*

One of the doctors commented that taking time out put pressure on their colleagues and made their own day longer because the work still had to be completed:

> *I really felt I should be working and I really didn't have the time. It didn't feel like protected learning time… so I just felt like I should be getting back… I found it a bit stressful that I was being taken out of what I would normally be doing… I see one [patient] every ten minutes, so six people who haven't been seen, who I have to see… at another part of the day*

This pressure on time was reflected by other participants who acknowledged that the facilitator had to contend with truncated sessions when the prior meeting overran, different staff at each session and pressure to finish on time:

But then it must be difficult for him because… he's got a different group now compared to the first meeting (clinician)

We put quite a lot of pressure on him… about how long we were going to be there… I felt sorry for him because as soon as he was getting somewhere… people… just went, that's it, I'm off (non-clinician)

Some people wouldn't stay because it was not funded, and that was a shame… (doctor)

This led to comments around the style of facilitation and the amount of time spent discussing in small groups, for example this exchange between clinicians and non-clinicians:

He had us in groups, then when we first went in we were in groups talking about, you know… bear in mind this time is quite protected, he then had each group going around talking about it, and it just felt [taps table].

Yeah, move it on.

Move it on, move it on, just, you know... and then that was the first session done.

Mm.

The thing is, what was really interesting… every one of us gave exactly the same answers didn't we?

Yeah, because I think we're gelled, we're a gelled group aren't we?

Yeah, everyone's ideas was more or less the same, when we had to write it down… there wasn't really much to write… it was near enough the same for every person, so that was… interesting.

While this overlaps with the comments above concerning professional learning, participants understood that they needed time to reflect but there was also a certain amount of impatience. Similar to the above exchange, a range of participants from the focus group at site 2 explained:

Everyone's ideas was more or less the same… there's a lot of time wasting about a lot of nothingness, you know? … it was a bit repetitive, I agree that at times… he allowed you to stop and think… we noticed that we needed that, but I do think there was some repetitiveness...

And to be fair you could see people's frustration as well… You could see people getting a bit fidgety…

There's kind of this very nebulous type of conversation…

Overall, most participants understood that the method of facilitation was intended to be non-directive and to encourage them to identify issues to work on for themselves. However, there did appear to be a certain disconnect, either because people had missed sessions or simply because they were tired and had not had a lunch break. These clinicians' comments reflect the views of both focus groups:

It gave us an opportunity for us to reflect… but… because we haven't been able to attend all the sessions, I think it feels a bit disconnected

We're not having a lunch break, so that's really quite important … but if you haven't got the time after to sort stuff out, that's when it just drags isn't it?

A few participants, mainly doctors and non-clinical staff, commented on the language used. They recognised that the facilitators came from an educational background but found the terminology confusing, especially in sessions with two coaches:

> *Well, they need to be much more direct, you know, we're healthcare professionals, we don't talk around things to patients* (doctor)

> *There was a huge emphasis on [xxx] also facilitating some of that session as well, there's a lot of conversation between [the two facilitators]… I found [that] even more confusing*

Participants recognised that it was a non-directive approach and commented on the facilitator's skilled approach but many still found this disconcerting, as this exchange in site 2 exemplifies:

> *It's interesting to see [the facilitator's] different way of… doing it… he's making you go on the journey, he's not directing, he's kind of facilitating, he's not directing you.*
>
> *That's true, yeah.*
>
> *And it's a very different, it's a very clever approach to be fair. But actually where we're so kind of concrete in maybe our thinking as a group, he exposed us… he didn't give us a set of parameters, he didn't give us right this is what we're doing to do, this is where I want to get to.*
>
> *Mm.*
>
> *He kind of left us feeling almost floundering to the point, well I don't know what he wants.*
>
> *Yeah, don't know what he wants, yeah.*

And similarly, site 1 could not initially see where the conversation was leading:

> *We were a bit like, what is this about [all laugh]… because it's like it's not really useful, it didn't seem useful to us… it's like well… what we are doing sitting here listening to this sort of thing.*
>
> *Yes, it wasn't never tangible wasn't it, there wasn't…*
>
> *No.*
>
> *And it was really just looking at it now, because it wasn't until we thought oh actually the review, that could be really useful, till we felt there was something we could implement that was useful…*

Most participants valued written feedback after each session although some could not remember receiving it. Several wanted a more structured approach with tangible outcomes, for example, focus group 1 suggested that analysis of patient data would give them a better idea about the hub's impact on patient care:

> *For me the approach was too nebulous, I would have preferred there to have more evidence of what we're doing… I don't know if they [patients] stay on longer or shorter, I have a kind of feeling but no-one ever gives us that information*

In summary, many participants were unclear in advance what was involved, expected clearer aims and wanted to know the session dates well in advance. Some found the approach too intangible, perhaps in contrast to their patient focused discussions which appeared to be much more 'concrete' and task orientated. There were also different experiences between those participants having one facilitator, and those having two at the sessions. However, nearly all participants valued the time to reflect and appreciated how skilled the facilitators were.

3.3 Views on rolling out the programme, its impact on team work and the wider system.

This section summarises participants' views concerning the added value of the programme, whether it should be rolled out, what support might be needed to do so and what the impact might be beyond an individual team.

3.3.1 Impact on service delivery and outcomes

Participants found it difficult to add to earlier comments on professional learning, given that the main benefit had been the opportunity to reflect on the team's processes and overall development:

> *It's the discipline around having somebody there to support you to actually be the different perspective and I think without somebody there you don't do it, even if you're given the time I think you've got to be quite disciplined to actually ask the right questions…* (doctor)

> *I think he just sort of said reflection on, you know, have you ever reflected on what you've done and what you've achieved, and it was kind of like a lightbulb moment, actually no, we haven't had time to sit back and think what we've done* (clinician)

Participants did not identify any direct impact for patients and/or carers, or new ways of working, beyond what has already been discussed. When asked about the sustainability of what they had learnt, opinions were limited to whether or not they would benefit from further sessions with an external facilitator:

> *Do we actually need him, maybe you'd only need the input of somebody like him once a year, whereas we will do self-reflection every two months* (clinician)

3.3.2 Perspectives on the benefits for other teams

Participants largely reverted to talking about the benefits of hub working rather than the programme and found it hard to identify what support might be needed to roll out the programme and what the benefits might be. Contextual factors included how established other teams were, how they functioned and their culture, as participants in site 2 suggested:

> *Do you think it still might be beneficial for groups that… aren't as formed as ours, I do think there might be a benefit.*

Maybe, I don't know…

Yeah, because we've been through a lot, right from the beginning, we've basically formed it ourselves, and run it how we want to run it, maybe if someone's there a bit earlier…

The programme was regarded as potentially beneficial for teams that were less cohesive, as this exchange from site 1 demonstrates:

I think it depends what their problems are with the way they work, I think definitely out in [xxx] where they're all conflictful and they don't even believe the whole thing [hub working] is worth doing, they would be really beneficial from having that gentle…

Persuasion [laughs].

…just trust building…

Encouragement.

…and kind of cultural changing type approach

Finally, both focus groups briefly alluded to the wider system in which they worked. The NHS and wider policy context was regarded as peripheral, or even hindering their front-line work:

If I'm honest with this whole CHOC thing I don't even get half of what's going on a lot of the time because there's so many people in there [the hub meeting]… my main objective, and I think most of our objectives, is the patients we've got on the bit of the paper are the important thing… (clinician)

All these politics outside it, even when we went to that big consortium, they didn't even know what the CHOC was, did they?… and they're the people that are up there, so I do question sometimes exactly what… is all this stuff going on, behind the scenes, I don't know… (clinician)

The NHS is a very clunky machine isn't it, but I think the things that are always going to hold us up are well outside our control, because decisions are made way up about changing things without any sort of negotiation with the people on the ground floor… the NHS just doesn't keep up with the change in society… you know, more people with dementia living alone in their home… I think as far as we're concerned I think we're doing as much as we can do, and I don't think [facilitator's] approach is going to change any of that. (clinician)

In summary, participants thought that other hubs could benefit from the programme depending on contextual issues such as the team's approach and outlook. They struggled to comment on the logistics of upscaling the approach and what support might be required for this to succeed.

3.4 The facilitators' perspective

This section focuses on the facilitators' perspective concerning the aims of the sessions using 'conversations in change', its delivery, outcomes and opportunities to offer it more widely.

3.4.1 Aims and expectations

The facilitators clearly articulated the approach, their rationale for selecting it and its theoretical underpinning, set within the current policy agenda:

> *The systems side leads us to believe that everything has to be understood within its context and the context with the Five Year Forward View and so on is increasingly multi-professional, it's to do with dialogue, it's to do with mutual understanding of people's constructions of the world, which obviously are different between doctors and other professions. And the narrative side leads us to believe that all of this is constructed and enacted through the evolution of stories so that you're essentially working with people describing their realities and creating a space in which those descriptions can evolve in, as people have a dialogue with each other.* (Facilitator 1, F1)

As a bottom-up approach, starting with front-line clinicians at a local level, the facilitators felt it should be possible to make incremental changes that reach the managerial level and indirectly lead to better team working:

> *I was very keen to adopt this approach because I've thought for a long time that having a much more bottom-up, based in reality, based in the messy world of day-to-day practice, which is orientated more towards that socially constructed model, was what we needed and also it was the way… to perhaps influence some of those above me. I think as time has gone on I have found that because we've now gathered a bit of traction with this type of approach, by having the same conversation in lots of different circles it's starting to feed back up through the food chain to some of the people who are in those managerial positions.* (F2)

However, both facilitators were aware that the narrative element was somewhat at odds with most managers' discourse and that this could cause confusion:

> *It can be quite hard to get managers who understand it because it's so counter-cultural… you get some people who look perplexed because it is so, the language is so alien…* (F1)

The approach was described as taking place within a regulatory, legal, organisational and policy context but is not driven by these aspects and is a dynamic process that facilitates change through discussion:

> *The philosophy of conversation inviting change is essentially that change happens incrementally from moment to moment in dialogue between people… part of that dialogue is introducing contexts… but it's saying that those contexts should not drive the conversation, those contexts should be introduced and absorbed into the conversation so that people are cognisant of them… but within those constraints or influences they evolve their own view of what should happen and how things should happen…* (F1)

The approach in itself was felt to be non-directive and neutral:

> *The core linguistic process is essentially firstly curiosity and questioning, secondly that everything follows on from something that has emerged from the people you are listening to…* (F1)

Conversely, the facilitators remarked that teams were presented with the opportunity to use the reflective space however they wanted, and to set their own goals, but they did not use the space as envisioned:

> *When we went into the first meeting of each hub I basically presented it as this is an opportunity for you to have a reflective space… to set their own objectives… what we'd not fully articulated in our own minds or to each other was that that was in retrospect a little disingenuous because [F2] was kind of thinking "I do hope they come up with a, b and c as objectives"… it became apparent, especially with the first hub that that was simply not part of their mind-set, the first hub is very target-driven…* (F1)

From the facilitators' viewpoints, both hubs took a somewhat 'concrete' approach (one more than the other) and chose tasks with specific goals and outcomes, perhaps demonstrating the gap that the approach intended to address - the need to reflect on a 'higher conceptual level' (F1). This seemed to be compounded by different underlying agendas: the need to increase the availability of placements for GP trainees in a multi-professional setting and the policy agenda around STPs:

> *One of the perhaps tensions that we've come across is the purity of the conversations inviting change model… and the fact that I actually come with certain goals in mind, goals that… are most definitely open to shaping… but obviously I am to some degree tasked with… what other parts of the system or other individuals might want.* (F2)

> *In terms of their [the hubs] collective goal, it's prescribed by an agenda that comes from the CCG [clinical commissioning groups]/STP and their focus is around the frailty agenda. So they are meeting specifically as an MDT to put in place local care, however you would define local care, with a specific initial focus on the frailty agenda*. (F2)

However, the facilitators noted that the hubs did not seem to fully comprehend these agendas which added to the lack of clarity around the programme's purpose and the facilitators' remit:

> *They [hubs] don't necessarily understand the higher structures which we're aware of, they understand the local structures, … the steer they're being given by the CCG etc., but most of the people round the table don't understand the wider context of for example the STP or the potential involvement of Health Education England… but also our own authority to give them a steer is quite unclear because it is guided by our knowledge of the general direction of travel of documents like the Five Year Forward View… we're in a position to inform them of those things but we're not in a position… to direct them… nor is it very clear that we've got many incentives to offer them… we need to steer a very careful line between not trying to push them in a direction simply because we think it's a good idea but influencing them to see that it is in their own best interest… because then they will be more fit for purpose as things change. (F1)*

The facilitators remarked on the level of appreciation of the wider context within the team meetings. One hub, which they felt appeared more medically orientated, less patient-centred and to a certain extent less democratic than the other, seemed to use a discourse that distanced patients, particularly those who were difficult to engage:

> *They'll talk about, "I talked to the husband" … It's very medical, it's very distancing… we hear narratives like "I went in and they didn't want input from our service so I left", … very thin narratives… … There's no sense of… how much ought we to do in this context to make sure this person who actually has quite complex needs gets them addressed and doesn't take a hostile attitude towards [clinicians]…* (F1)

This hubs' medical discourse seemed to be in contrast to the other hub which appeared more reflective in their approach and more receptive to the programme:

> *They seemed to have a much more collegial and much more compassionate, a community-oriented view of what their task was. So the conversations were much softer* (F1)

From the facilitators' perspective, three sessions were perhaps over-ambitious to gain trust, develop understanding of the approach, set and deliver goals, and support the team in taking on an expert/educational role.

3.4.2 Format and delivery

There were not many issues raised by the facilitators around delivery but two key constraints were articulated, perhaps underpinning the confusion that some participant expressed. Firstly, there was insufficient time at the outset to explain the programme's purpose and the different agendas:

> *On both occasions… we put it in very general terms… I don't think we were nearly transparent enough about that there was a list of other agenda that we had in our minds to do with the needs of STPs and HE and so on*. (F1)

While sessions were initially facilitated by one coach, they were later facilitated by both, which reflected their different remits but perhaps added to the confusion:

> *I think things evolved, the assumption at the beginning was that I would facilitate the meetings and [F2] would be there as a resource. I think as time went on and we realised that [F2]'s hopes for the group were a very important part of the dialogue we brought [F2] in more and more but I think that was an appropriate thing to do…* (F1)

However, this put one of the facilitators in a difficult position:

> *It started to make me feel slightly ethically challenged…* i*t puts me in a position of wanting to be true to the CIC methodology but also needing to deliver a particular output*. (F2)

Secondly, there was a cultural gap between the facilitators' educational background and that of clinicians and this was apparent in the terminology both parties used:

> *I think [I and F2] have both been on a typical educationalist's journey where possibly we lose touch a bit with what it's like… to be a clinician.* (F1)

> *That language belongs to the world of educationalists… these are jobbing clinicians and so I think we are learning how to translate our language into their terms.* (F1)

For the more medically oriented hub, this gap seemed particularly difficult to bridge. In addition, the facilitators did not have sufficient information in advance to gauge the team's level of inter-professional cohesion nor had they expected such a difference between both hubs:

> *I prefer to go in fairly cold and just work with what I find in the room so I wouldn't have regarded that as a particular obstacle… … We had no idea how very different the two cultures were - the very slick operational culture in [one site] … [compared to] a much more sociable and mutually supportive culture of [the other site]*… (F1)

This also touched on the timing of the programme in terms of the team's development. Similar to the hubs, the facilitators had mixed views about the most opportune time to intervene:

> *In theory, I can see more advantages to working with a group at very early stages of forming, they're less likely to have fallen into a ritualised way of working. And if you find that they're already working in a very ritualised fashion then it's still possible to do a different type of work with them.* (F1)

However, the facilitators understood that it was important to have an alliance with key people within the hub, including the chair who had the potential to promote or block progress. Both facilitators were aware that certain individuals were sceptical of the approach:

> *And there are… people here whose alliance we need…[X], who I think was quite sceptical, you know, like "who are these sort of wishy-washy, you know, therapy types coming to psychoanalyse us?" you know, that was what I picked up from..[X's] body language. But I think [X] has gradually come on-board and it was quite clear we needed… them to believe in what we were doing.*

Finally, it is worth noting that both hubs received written feedback after each session which the facilitators felt was positively responded to by participants:

> *After each meeting we sent them minutes of what they thought [were] the important points were to work at and we invited them to focus on those so they can report back to us at the next meeting what they thought they'd achieved… We were quite surprised at how seriously they'd taken that.* (F1)

3.4.3 Outcomes and opportunities

As identified by clinicians, the main tangible outcome was deciding to hold a reflective space in addition to the usual patient related meetings. This indicates that the hubs understood the programme intended to develop their team work with an indirect impact on patient care:

> *I think we were quite clear that we wanted them to be able to work together to be the best that they can*. (F2)

However, the facilitators questioned how reflective the hubs would be without a coach or critical friend:

> *What they call a reflective space may be in a far more concrete way than in a way you and I would prefer… And in a sense that's their prerogative but that doesn't necessarily mean that they've got the concept that you were trying to convey…* (F1)

The second tangible outcome, if arrangements were made, was considered to be supporting the hubs to take on trainee GPs:

> *In terms of Health Education England we need more training placements and we need those to be multi-professional and we need education to be delivered in an interdisciplinary, inter-professional fashion. These are looser aspirations I suppose but that's what we want, and locally we also want them to take medical students.* (F2)

However, there were other wider aspirations, including developing the role of a critical friend within the hub, which both facilitators did not think had been achieved:

> *I wanted them to take on-board this notion of a critical friend to see what we were doing and to be able to have the opportunity…*
>
> *I don't think we got that.*
>
> *And I don't think that came through at all.*

Again, this appeared to stem from lack of clarity at the outset, although this could have been counterproductive (in that hubs may have rejected the agenda):

> *I think we helped them achieve the objectives that we had explicitly set for them… in those terms they achieved what we'd offered them. I think what they didn't do is, to put it bluntly, to guess where we wanted them to go*. (F1)

While the hubs only identified tangible outcomes, the facilitators could see opportunities to develop their role. For example, the hubs could increase their involvement with patient and public engagement (PPI) as well as sharing their expertise within primary care, not just with medics but across health, social care and the voluntary sector.

In terms of the hubs, the facilitators were keen to have further input with them and to role the programme out to other teams. They were clear that there is no obvious 'endpoint' and that teams have to continually adapt and would therefore benefit from further support:

> *I think a lot of leadership models are explicitly or implicitly based on the idea that you get somewhere, there is an end point when things work. I actually don't believe that… we're dealing here with constant flux of resources coming, resources going, structures coming, structures going… we're working with a system, everything in that system and everything around that system is changing, so that the best favour we can do anybody is to help them move into a different way of thinking that accepts that and accepts there are constantly going to be buffets, constantly going to be insults to their way of working, there's going to be constant adaptation needed, that's never going to stop* (F1)

4 Summary of the findings

This summary considers whether the programme was feasible, effective and provided added value to the hubs' prior approach to professional development. The section is structured according to the evaluation's objectives and aims to synthesis the perspectives of all stakeholders.

4.1 Perceptions of professional development as experienced through the hub support

Participants valued the opportunity to take time out from the pressure of their daily schedule to reflect on their professional development, both individually and as a team. There was little evidence of any significant changes in individual outlook, team approach or service delivery. While it might be overly ambitious to expect that there would be, given the intervention's short duration, facilitators appeared to have anticipated wider changes than participants identified.

The main outcome was that both hubs decided to initiate a monthly space for reflecting on process, in addition to their regular meetings, and regarded this as a positive outcome. Both hubs presented as cohesive teams that worked well together and had common goals anchored in what was beneficial for their patients. Therefore, from their perspective there were limits to the programme's potential added value.

The facilitators endorsed the main outcome but envisioned a wider remit for the programme than the hubs. For example, they could see opportunities to take on trainee GPs; enable the hubs to share their expertise; and develop PPI involvement. The facilitators had a clear view of the programme's aims which reflected the wider policy agenda but participants did not regard this as relevant to their daily working lives. The facilitators intended the hubs to use the reflective space however they wanted but the hubs did so in a way that was not quite as envisioned, resulting in an underlying tension, or mismatch of agendas. Consequently, an underlying dissonance manifested in the confusion expressed by some participants.

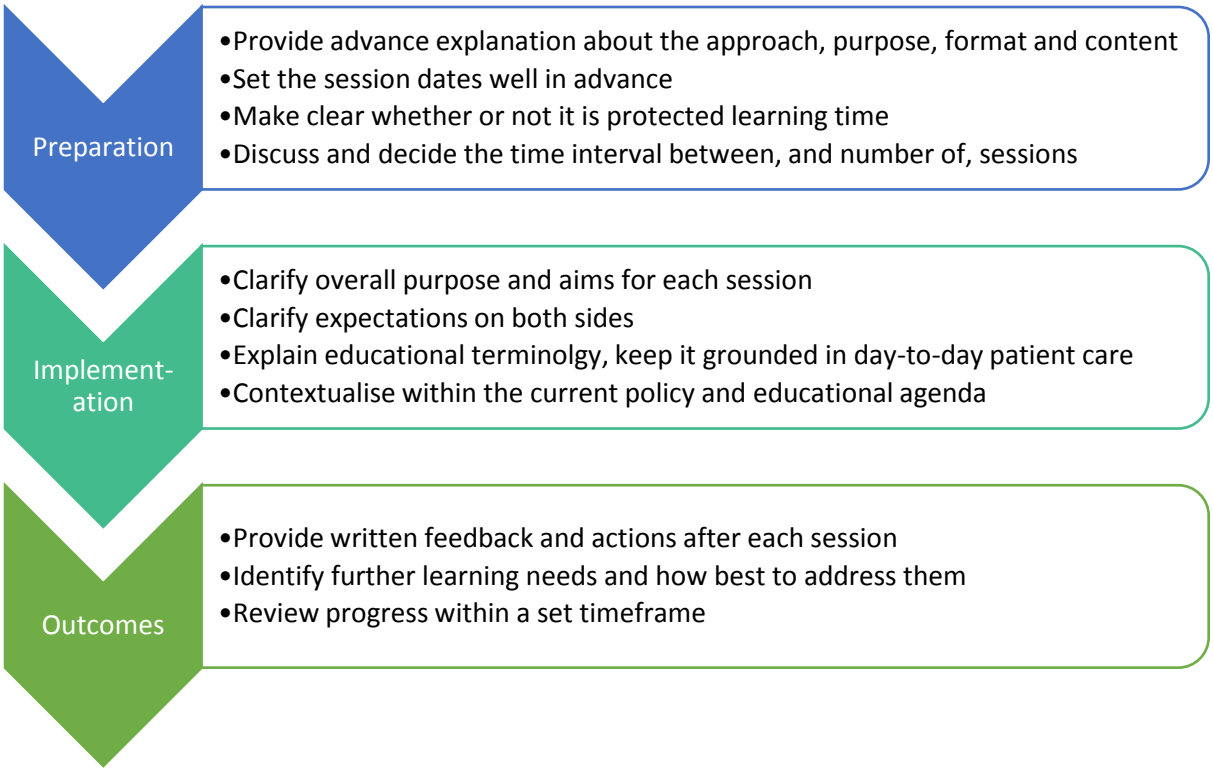
4.2 Perceptions of the method of facilitation

The lack of clarity around the aims permeated the interviews and focus groups. Alongside uncertainty of purpose, participants struggled with an educational approach (and terminology) which they found, to varying degrees, somewhat intangible. While facilitators regarded the sessions as an open forum that participants could mould to suit their needs, they also acknowledged that they had their own underlying agenda which the hubs had sensed. The facilitators suggested that this stemmed from insufficient time at the start such that they had to present the programme in general terms; further time would have allowed them to be more explicit. Similarly, having just three sessions was perhaps overly ambitious to achieve their aims.

While sessions were initially facilitated by one coach, they were later facilitated by both, which reflected their different remits and provided an exemplar of the critical friend approach but participants did not appreciate this. The facilitators acknowledged a cultural gap between their educational background and that of clinicians which was reflected in the hubs' more pragmatic approach.

Participants' suggestions to improve delivery focused on more preparation, clearer aims and a tighter structure for each session (Figure 1):

Figure 1: Practical recommendations



4.3 Perceptions of how/if the programme should be scaled-up

Participants did not have strong views about rolling out the programme and were tentative about the benefits beyond giving them time to reflect. They suggested that other hubs might benefit, depending on contextual issues including how established the team was and its culture. Participants struggled to comment on the logistics of upscaling the approach and what support might be required for this to succeed.

There appeared to be two underlying tensions that underpinned this response and reflected the dissonance between facilitators' aspirations and participants' response. Firstly, although participants were comfortable with the notion of reflective practice, the course appeared to be pitched at a level

that they found hard to relate to, mostly reflected in comments around the use of language. Secondly, a policy agenda reflecting the needs of higher education, GP leadership and GP training appeared contrary to the spirit of CIC and the aim of facilitating hubs to identify their own goals. Alongside both these strands, participants did not recognise the notion of a critical friend, exemplared by joint coaching, but not explicitly so.

In relation to the policy agenda, Roebuck (2011) emphasised that clinicians need to understand the whole system so that they appreciate how the overall process works to deliver care, not just their own job, with the implication that this would support multi-professional systems based working. However, participants focused on their everyday work and found the programme's approach to wider systemic issues and higher education initiatives somewhat confusing and/or irrelevant. Whether, or how much, these issues are pertinent to front-line staff is arguable, but the mismatch of agendas remained unresolved.

Views were mixed with regards the usefulness of further sessions, how sustainable the outcomes might be, and whether or not other hubs would benefit. This suggests that the concept has not been embedded within the hubs, but given its short duration this is unsurprising. However, it is notable that both groups absorbed and incorporated the notion of regular reflection into the team.

4.4 Study limitations

The main limitation was the small sample size, as is common with small scale process evaluations. To protect confidentiality quotes are not married with the participant's profession, or role within the hub, which reduces transparency but was necessary to protect confidentiality.

5 Commentary and Conclusion

This evaluation aimed to investigate the impact of embedding the function of an educational facilitator within the multi-professional primary care hub and to explore perceptions of professional development as experienced through hub support. Participants identified the key benefit as having the opportunity to take time out from the pressure of their daily schedule to reflect on their professional development, both individually and as a team. However, if the initial explanation had been more explicit, the hubs are likely to have had a better understanding of the agenda which may have altered their overall perceptions of the programme and enabled them to link these goals to the wider policy landscape.

Participants did not perceive the relevance of policy to their daily work, particularly the need to create GP trainee placements in primary care. However, this is in the context of competing priorities across individual, team and organisational boundaries and perhaps indicates that the (continually changing) policy agenda may not always be tuned to the direct needs of frontline staff. To counter this, a systems approach would help develop strategies at the organisation level in order to enable grassroots change, such as negotiating protected time, and lead to better alignment between policy, team and individual priorities. Co-creation is one approach that could help redress the disconnect between staff and organisational priorities because it has the potential to facilitate staff involvement and improve overall efficiency (Voorberg et al., 2015). This could be supported by feedback to the hubs, using data that is already collected, to demonstrate evidence of outcomes which could be used to reflect on and contribute to ongoing development.

6 Recommendations

The recommendations are as follows:

- Prior to making any decision to roll out the programme, other options or approaches should be explored, taking into account evidence of feasibility, sustainability, (cost-) effectiveness and added value. Such approaches should embrace the concept of reflective practice and co-production/co-creation. Sustainability is likely to be undermined by staff turnover and organisational change both of which need consideration.
- In order to sustain the spirit of CIC, and embed the notion of reflective practice as an ongoing and dynamic process, hubs that have already participated should be offered follow-up sessions once or twice yearly, depending on their preference.
- If the decision is made to roll out the approach, the practical recommendations volunteered by participants, particularly around preparation and implementation (Figure 1), would ameliorate some of the issues identified. It would also be worth reassessing some features of the training such as 'critical friend' and integration with GP training.
- Co-creation of a common language that spans individuals, teams and the organisation would help improve understanding of priorities across the micro-, meso- and macro-level. This would help make policy accessible to practitioners and enable them to assess the relevance of policy changes to their context, reflect on potential impact and act accordingly.
- The hubs would appreciate meaningful feedback based on data that is already collected, for example readmission rates. The data would provide evidence of clinical outcomes and could be used to inform development.

7 References

Bostock, N. (2017) *Number of GP practices drops by more than 650 in four years*. https://www.gponline.com/number-gp-practices-drops-650-four-years/article/1436925

East Kent Hospitals University NHS Foundation Trust (EKHUFT) (2018) *About us* https://www.ekhuft.nhs.uk/patients-and-visitors/about-us/

Fillingham, D. and Weir, B. (2014) *System leadership Lessons and learning from AQuA's Integrated Care Discovery Communities*. https://www.aquanw.nhs.uk/resources/publications/system-leadership-october-2014.pdf.

Flick, U. (1998) *An introduction to quality research*. London: SAGE Publications.

Ghate, D., Lewis, J. and Welbourn, D. (2013) *Systems Leadership: Exceptional leadership for exceptional times: Synthesis Paper* http://www.cevi.org.uk/docs/Systems_Leadership_Synthesis_Paper.pdf

Ham, C. and Alderwick, H. (2015) *Place-based systems of care. A way forward for the NHS in England*. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Place-based-systems-of-care-Kings-Fund-Nov-2015_0.pdf

Launer, J. (2018) *Narrative-Based Practice in Health and Social Care: Conversations Inviting Change.* Second Ed. London: Routledge.

NHS Leadership Academy (2017) *Developing systems leadership. Interventions, options and opportunities*. http://www.londonleadershipacademy.nhs.uk/sites/default/files/SL_Brochure_FINAL_Web%20version.pdf.

Manley, K., Martin, A., Jackson, C. and Wright, T. (2016) Using systems thinking to identify workforce enablers for a whole systems approach to urgent and emergency care delivery: a multiple case study. *BMC health services research*, 16(1): 368.

Manley, K; Martin, A; Jackson, C; Wright T (2015) *Developing Standards for Integrated Facilitation in and About the Workplace. Phase 2 Report: Transforming Urgent & Emergency Care Together*. England Centre for Practice Development, Canterbury Christ Church University. ISBN: 978-1-909067-54-7.

Manley, K., Sanders, K., Cardiff, S. and Webster, J., (2011). Effective workplace culture: the attributes, enabling factors and consequences of a new concept. *International Practice Development Journal*, 1(2); https://www.fons.org/library/journal/volume1-issue2/article1

Manley, K. and Titchen, A. (2016) Facilitation Skills. The Catalyst For Increased Effectiveness In Consultant Practice And Clinical Systems Leadership. *Educational Action Research* 24(2): 1-24.

Manley, K., Titchen, A. and Hardy, S. (2009). Work-based learning in the context of contemporary health care education and practice: A concept analysis. *Practice Development in Health Care*, 8(2): 87-127.

Martin, A. & Manley K. (2017). Developing standards for an integrated approach to workplace facilitation for interprofessional teams in health and social care contexts: a Delphi study. *Journal of Interprofessional Care* 32(1): 41-51. doi: 10.1080/13561820.2017.1373080.

Morgan, D. (1993) *Successful Focus Groups*. Sage Publications: Thousand Oaks, CA.

Padgett, D. K. (2012) *Qualitative and mixed methods in public health*. SAGE Publications: London.

Pope, C. and Mays, N. (2006) *Qualitative Research in Health* Care. Third Ed. Blackwell Publishing Ltd: London.

Rabinowitz, P.M., Kock, R., Kachani, M., Kunkel, R., Thomas, J., Gilbert, J., Wallace, R., Blackmore, C., Wong, D., Karesh, W. and Natterson, B. (2013). Toward proof of concept of a one health approach to disease prediction and control. *Emerging Infectious Diseases*, 19(12): e130265.

Raine, R., a'Bháird, C.N., Xanthopoulou, P., Wallace, I., Ardron, D., Harris, M., Barber, J., Prentice, A., Gibbs, S., King, M. and Blazeby, J.M. (2015). Use of a formal consensus development technique to produce recommendations for improving the effectiveness of adult mental health multidisciplinary team meetings. *BMC psychiatry*, 15(1): 143.

Roebuck, C. (2011) *Developing effective leadership in the NHS to maximise the quality of patient care The need for urgent action*. https://www.kingsfund.org.uk/sites/default/files/developing-effective-leadership-in-nhs-maximise-the-quality-patient-care-chris-roebuck-kings-fund-may-2011.pdf.

Robson, C. (2011) *Real world research: A resource for users of social research methods in applied settings*. 3rd Ed. Blackwell Publishing: Oxford.

Schmidt, B. (2006) Proof of principle studies. *Epilepsy research*, 68(1): 48-52.

Voorberg, W.H., Bekkers, V. J. J. M. and Tummers, L. G. (2015) A systematic review of co-creation and co-production: Embarking on the social innovation journey 17(9): 1333-1357.

World Health Organisation (2013) *Evaluation practice handbook*. http://apps.who.int/iris/bitstream/10665/96311/1/9789241548687_eng.pdf.

Appendices

Appendix 1: Focus group schedule

Appendix 2: Interview schedule

Appendix 3: Dyad interview schedule for coaches

Appendix 4: Information sheet for focus group

Appendix 5: Focus group consent form

Appendix 6: Information sheet for interview

Appendix 7: Consent form for interview

Appendix 1: Focus Group Schedule

1. **To explore participants' perceptions of professional development as experienced through the hub support.**

1a) Can you tell me what you have learned about your professional development over the past few months. Prompts:

- What have you learned about yourselves as professional beings?
- Have you felt inspired to learn more about the approach?
- Has it changed how you feel about yourself, or your role, within the team?
- Have you changed your approach to anything as a result?

1b) Can you tell me something about what you have learned as a team? For example:

- Have you discovered things about each other that you weren't expecting?
- Or about how you work together?
- Or each other's approach?
- Has it helped you develop priorities as a team in how you move forward?

1c) Has what you've learnt made a difference to your professional practice? For example:

- Are you more effective in anyway?
- Have relationships with your colleagues in this or other teams changed?
- Or how you work with patients & carers?
- Have there been any barriers to implementing what you've learnt?
- How have you addressed them?
- Has it affected confidence about service delivery and transformation?

2. To explore participants' perceptions of the method of facilitation

2a) How did you find the course in terms of its delivery?

- Did you feel adequately prepared?
- Was it what were you expecting?
- What about the practicalities, for example the timing & length of sessions?
- Do you have any comments about the course materials?
- Was it at the right level to meet your professional development needs?
- Do you have any suggestions for improving how the course is delivered?

2b) What did you think about the course content and method of facilitation?

- Was there anything you found particularly helpful? Or that you disliked?
- Was there anything that you hoped would be covered but wasn't?
- Was it challenging enough?
- Did you get sufficient feedback? Was it helpful?
- What suggestions do you have for improving the course

3. **To explore perceptions of how (or if) the course should be scaled-up, how it could achieve impact in team work and the wider system.**

3a) What impact do you think the course has had on your work?

- *If 'none', ask to expand on the reasons – barriers may have been covered in Qu1*
- Has it helped you create new ways of interprofessional working?
- Has it had an impact on the quality of care for patients and/or carers?
- *For all impacts*: Do you think these changes are sustainable? If not, what are the reasons?
- Have you felt supported to use what you have learned by your managers? If not, how could you gain support?

3b) Do you think other teams would benefit from the course?

- What sort of benefits can you envision?
- How would you describe the value of this course?
- Could the learning from the course be transferred to other teams?
- Would the transfer of benefits/learning depend on the type of team or setting?
- What would help support transferring benefits/learning to another team?
- Do you think it is worth rolling out the project to other teams?
- What would be needed to support rolling out the project?

Final question: Is there anything else you would like to add?

Thank you for your time

Appendix 2: Interview Schedule

1. **To explore participants' perceptions of professional development as experienced through the hub support.**

1a) Can you tell me what you have learned about your professional development over the past few months. Prompts:

- What have you learned about yourself as professional being?
- Have you felt inspired to learn more about the approach?
- Has it changed how you feel about yourself, or your role, within the team?
- Have you changed your approach to anything as a result?

1b) Can you tell me something about what you have learned as part of the team? For example:

- Have you discovered things about your colleagues that you weren't expecting?
- Or about how you work together?
- Or your colleagues' approach?
- Has it helped you develop priorities as a team in how you move forward?

1c) Has what you've learnt made a difference to your professional practice? For example:

- Are you more effective in anyway?
- Have relationships with your colleagues in this or other teams changed?
- Or how you work with patients & carers?
- Have there been any barriers to implementing what you've learnt?
- How have you addressed them?
- Has it affected confidence about service delivery and transformation?

2. To explore participants' perceptions of the method of facilitation

2a) How did you find the course in terms of its delivery?

- Did you feel adequately prepared?
- Was it what were you expecting?
- What about the practicalities, for example the timing & length of sessions?
- Do you have any comments about the course materials?

- Was it at the right level to meet your professional development needs?
- Do you have any suggestions for improving how the course is delivered?

2b) What did you think about the course content and method of facilitation?

- Was there anything you found particularly helpful? Or that you disliked?
- Was there anything that you hoped would be covered but wasn't?
- Was it challenging enough?
- Did you get sufficient feedback? Was it helpful?
- What suggestions do you have for improving the course

3. **To explore perceptions of how (or if) the course should be scaled-up, how it could achieve impact in team work and the wider system.**

3a) What impact do you think the course has had on your work?

- *If 'none', ask to expand on the reasons – barriers may have been covered in Qu1*
- Has it helped you create new ways of interprofessional working?
- Has it had an impact on the quality of care for patients and/or carers?
- *For all impacts*: Do you think these changes are sustainable? If not, what are the reasons?
- Have you felt supported to use what you have learned by your managers? If not, how could you gain support?

3b) Do you think other teams would benefit from the course?

- What sort of benefits can you envision?
- How would you describe the value of this course?
- Could the learning from the course be transferred to other teams?
- Would the transfer of benefits/learning depend on the type of team or setting?
- What would help support transferring benefits/learning to another team?
- Do you think it is worth rolling out the project to other teams?
- What would be needed to support rolling out the project?

Final question: Is there anything else you would like to add?

Thank you for your time

Appendix 3: Schedule for coaches

1. To explore participants' perceptions of professional development as experienced through the hub support.

Facilitators questions	**Clinicians questions**
Can you tell me a little about the **approach** and its philosophy? Ask re ***conversations inviting change***. What is the main **purpose** of the hub support? How does it **add value** to their work? What **differentiates** it from **other approaches** to coaching or mentoring? How is it **best suited to primary care** and the hubs/Vanguard sites? How does the hub support **enhance prof**essional **dev**elopment? How do you ensure clinicians **understand:** - the purpose - how it can contribute to prof dev (indiv) - What the process requires of them - The added value to their work (indiv/ team) What **barriers** have you encountered so far? (what's worked well)	**1a) Can you tell me what you have learned about your professional development over the past few months.** • What have you learned about yourselves as professional beings? • Have you felt inspired to learn more about the approach? • Has it changed how you feel about yourself, or your role, within the team? • Have you changed your approach to anything as a result? **1b) Can you tell me something about what you have learned as a team?** For example: • Have you discovered things about each other that you weren't expecting? • Or about how you work together? • Or each other's approach? • Has it helped you develop priorities as a team in how you move forward? **1c) Has what you've learnt made a difference to your professional practice?** For example: • Are you more effective in anyway? • Have relationships with your colleagues in this or other teams changed? • Or how you work with patients & carers? • Have there been any barriers to implementing what you've learnt? • How have you addressed them?

	• Has it affected confidence about service delivery and transformation?

2. To explore participants' perceptions of the method of facilitation

Can you tell me about **implementation** – what's involved, the three sessions, your approach to delivery? One versus two coaches? Any **barriers**… What worked/works well? Do you need at least **one key person** to drive it forward and/or maintain motivation? What about clinicians **buy-in**? Did clinicians carry out **activities** required of them in-between sessions?	**2a) How did you find the course in terms of its delivery?** • Did you feel adequately prepared? • Was it what were you expecting? • What about the practicalities, for example the timing & length of sessions? • Do you have any comments about the course materials? • Was it at the right level to meet your professional development needs? • Do you have any suggestions for improving how the course is delivered?
	2b) What did you think about the course content and method of facilitation? • Was there anything you found particularly helpful? Or that you disliked? • Was there anything that you hoped would be covered but wasn't? • Was it challenging enough? • Did you get sufficient feedback? Was it helpful? • What suggestions do you have for improving the course

3. To explore perceptions of how (or if) the course should be scaled-up, how it could achieve impact in team work and the wider system.

What are your thoughts about how **effective** the process has been so far? And how **feasible**?	**3a) What impact do you think the course has had on your work?** • *If 'none', ask to expand on the reasons – barriers may have been covered in Qu1*

<table>
<tr>
<td rowspan="2">What about in terms of scaling up?

How do you evaluate outcomes or impact, particularly longer-term? Prompt:

- on team relationships
- effective working
- patients/carers' care
- overall service delivery

Does it provide added value over other approaches? (Implication: do clinicians regard it as worthwhile?)

What are your thoughts about sustainability and embedding the approach in practice?</td>
<td>• Has it helped you create new ways of interprofessional working?
• Has it had an impact on the quality of care for patients and/or carers?
• For all impacts: Do you think these changes are sustainable? If not, what are the reasons?
• Have you felt supported to use what you have learned by your managers? If not, how could you gain support?</td>
</tr>
<tr>
<td>3b) Do you think other teams would benefit from the course?

• What sort of benefits can you envision?
• How would you describe the value of this course?
• Could the learning from the course be transferred to other teams?
• Would the transfer of benefits/learning depend on the type of team or setting?
• What would help support transferring benefits/learning to another team?
• Do you think it is worth rolling out the project to other teams?
• What would be needed to support rolling out the project?</td>
</tr>
</table>

Appendix 4: Information sheet for focus group

Study Title: Evaluation of a 'conversations inviting change' approach to supporting leadership development in local care hubs.

Invitation to participate in the evaluation

We are researchers at the University of Kent and are evaluating an approach to support leadership development in local care hubs, on behalf of Encompass. The approach, conversations inviting change, is designed to support the development of systems leadership and team working 'in-place'.

The information sheet explains the purpose of the evaluation and we are inviting you to take part because you have attended the programme.

Purpose of the study

The evaluation intends to find out your perceptions of the programme and how (or if) it has influenced your professional development. We would like to find out what you found helpful, what could be improved and how (or if) you think the course should be scaled-up.

What will happen?

We are seeking your permission to take part in a face-to-face focus group, with your team members, to explore your thoughts about the programme. The focus group will take approximately one hour and we would like to record it, with your permission.

Do I have to take part?

It is entirely up to you whether or not you take part in the focus group. If you prefer, you can opt for an individual interview, in person or by telephone, at a time that suits. If you decide to take part, but change your mind, you are free to do so and you can stop at any time. Taking part in the evaluation will have no effect on you as a member of your team.

Will my taking part in this study be kept confidential?

We would like to reassure you that any information collected about you will be strictly confidential and we will protect your identity. It will be coded and stored on a password protected network at the university and will only ever be accessed by the evaluation team.
Once the project is finished, we will immediately destroy any personal data collected about you and coded data will be destroyed after five years. You will not be identifiable in any written reports. Things you say during the interview may be directly quoted in written reports and publications, but your name or anything else that could make you identifiable will be removed. There is a possibility your team may be identifiable to local staff, but we will make

every effort for this to be minimised. If you like, we can give you a draft of the report to read through before it is made public to make sure you are satisfied with the level of anonymity.

Benefits and risks of taking part

We will ensure that there are no risks to you by taking part in the evaluation. Any sensitive information regarding yourself, other professionals or service users and carers will not be shared with anyone. Your participation will contribute to improving the programme's delivery and help us decide how to use it in the future.

What will happen to the results of the study?

Any information you give us will be made completely confidential and anonymous. The findings may be published in a journal or presented at a conference.

Who can I contact if I have any further questions?

If you have any further questions or concerns about the study, please contact:

Vanessa Abrahamson
Research Associate
Centre for Health Service Studies
Tel: 01227 826506
Email: v.j.abrahamson@kent.ac.uk

Who can I contact if I want to make a complaint about the study?

If you are unhappy about any aspects of the study and wish to make a formal complaint, you can do this through contacting

Professor Jenny Billings
Phone: 01227 823052
Email: j.r.billings@kent.ac.uk.

Thank you for your time

Appendix 5: Focus group consent form

Project Title:

Participant ID:
Please initial if you agree:

❑ I have read the attached information sheet and have been given the opportunity to ask questions.

❑ I understand that my participation is voluntary and that I can stop taking part in this project at any time. Any information I have offered up to this point will not be included in the project.

❑ I understand that I do not have to answer any question(s) that I do not feel comfortable with.

❑ I understand that by participating in a focus group that I am consenting to have my comments recorded.

❑ I understand that any comments I make may be reported but I will not be identifiable in any report. Although the team will not be named, it may be potentially identifiable.

❑ I understand that all information gathered during the interview will be kept confidential and will be safely stored on a password protected network with restricted access and in the offices of the Centre for Health Services Studies (CHSS) at the University of Kent.

❑ I understand that my signature below means I have given permission to participate in this project.

Name ……Signature ……..Date ……

Researcher's Name…….Signature ……..Date ……

Appendix 6: Information sheet for interview

Study Title: Evaluation of a 'conversations inviting change' approach to supporting leadership development in local care hubs.

Invitation to Participate in the Service Evaluation

We are researchers at the University of Kent and are evaluating an approach to support leadership development in local care hubs, on behalf of Encompass. The approach, conversations inviting change is designed to support the development of systems leadership and team working 'in-place'.

The information sheet explains the purpose of the evaluation and we are inviting you to take part because you have attended the programme.

Purpose of the study

The evaluation intends to find out your perceptions of the programme and how (or if) it has influenced your professional development. We would like to find out what you found helpful, what could be improved and how (or if) you think the course should be scaled-up.

What will happen?

We are seeking your permission to take part in an interview, either face-to-face or by telephone, at a time that suits. The interview will explore your thoughts about the programme and take approximately forty-five minutes. We would like to record it, with your permission.

Do I have to take part?

It is entirely up to you whether you take part in the interview. If you decide to take part, but change your mind, you are free to do so and you can stop at any time. Taking part in the evaluation will have no effect on you as a member of your team.

Will my taking part in this study be kept confidential?

We would like to reassure you that any information collected about you will be strictly confidential and we will protect your identity. It will be coded and stored on a password protected network at the university and will only ever be accessed by the evaluation team.
Once the project is finished, we will immediately destroy any personal data collected about you and coded data will be destroyed after five years. You will not be identifiable in any written reports. Things you say during the interview may be directly quoted in written reports and publications, but your name or anything else that could make you identifiable will be removed. Although we will not name the team you are working in, there is a possibility that it may be identifiable to local staff, but we will make every effort for this to be minimised. If you like, we can give you a draft of the report to read through before it is made public to make sure you are satisfied with the level of anonymity.

Benefits and risks of taking part

We will ensure that there are no risks to you by taking part in the evaluation. Any sensitive information regarding yourself, other professionals or service users and carers will not be shared with anyone. Your participation will contribute to improving the programme's delivery and help us decide how to use it in the future.

What will happen to the results of the study?

Any information you give us will be made completely confidential and anonymous. The findings may be published in a journal or presented at a conference.

Who can I contact if I have any further questions?

If you have any further questions or concerns about the study, please contact:

Vanessa Abrahamson
Research Associate
Centre for Health Service Studies
Tel: 01227 826506
Email: v.j.abrahamson@kent.ac.uk

Who can I contact if I want to make a complaint about the study?

If you are unhappy about any aspects of the study and wish to make a formal complaint, you can do this through contacting

Professor Jenny Billings
Phone: 01227 823052
Email: j.r.billings@kent.ac.uk

Thank you for your time

Appendix 7: Consent form for interview

Project Title:
Participant ID:

Please initial if you agree:

❑ I have read the attached information sheet and have been given the opportunity to ask questions.

❑ I understand that my participation in an interview is voluntary and that I can stop taking part in this project at any time. Any information I have offered up to this point will not be included in the project.

❑ I understand that I do not have to answer any question(s) that I do not feel comfortable with.

❑ I understand that by participating in an interview that I am consenting to have my comments recorded.

❑ I understand that any comments I make may be reported but I will not be identifiable in any report. Although the team will not be named, it may be potentially identifiable.

❑ I understand that all information gathered during the interview will be kept confidential and will be safely stored on a password protected network with restricted access and in the offices of the Centre for Health Services Studies (CHSS) at the University of Kent.

❑ I understand that my signature below means I have given permission to participate in this project.

Name ……Signature ……..Date ……

Researcher's Name…….Signature ……..Date ……