



NAPC | National Association
of Primary Care

Primary Care Home: population health-based workforce redesign



A brief guide
[#primarycarehome](#)

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Foreword

Welcome to this short practical guide to developing a primary care home (PCH) workforce for your locality.

The PCH community of practice has been rapidly expanding. As part of our commitment to support PCH sites and share their learning, we've been working with sites to produce this guide. It looks at how to design and develop a PCH workforce through population health-based workforce redesign and team-based working.

We hope you will find this guide an informative quick and easy read, whatever your experience or expertise in workforce design and development.

The guide does not attempt to answer every workforce challenge or question but it includes signposts to additional resources, including case studies and tools. More can be found on the workforce page of the primary care home workspace on the futureNHS collaborative platform or by contacting NAPC's workforce team.

A handwritten signature in black ink, appearing to read 'Nav Chana', with a horizontal line underneath it.

Dr Nav Chana
NAPC Chair

Introduction

The primary care home model aims to enable better and more sustainable services for local populations to address the quadruple aims of health care¹. The model is a proactive approach to managing the health and well-being of a local population, incorporating the total care needs, costs and outcomes of that population.

It involves segmenting the population into groups of people with similar characteristics to enable targeted interventions for both those population groups and the individuals within them. It means looking at health management, not just from the perspective of trying to make existing services more efficient and effective, but stepping back to consider the needs of the population and being prepared to organise services around them.

Learning from our community of practice shows that any effective health and care system has an engaged and capable workforce. Developed and led by the National Association of Primary Care (NAPC), the PCH model provides an approach to enable local leaders and clinicians to engage and empower their workforce to design, develop and embed a new model of care which they 'own'. Our experience has shown with the primary care home rapid test sites that staff being part of the redesign improves their experience and joy of being at work.

Moving to this model involves a shift from traditional organisational and professional boundaries to establish place-based 'systems of care'. This is where healthcare, social care, voluntary and charitable sectors work with each other to address the challenges and improve the health of the populations they serve.

Redesigning your workforce across organisational and professional boundaries will help resolve long-term tensions and deliver the care you want and which your population needs. It also gives staff more opportunities to develop, use the skills they were trained for and improve morale.

“ **Redesigning your workforce
across organisational and
professional boundaries will help
resolve long-term tensions** ”

1. Improved health and wellbeing, transformed quality of care delivery, sustainable finances and improved staff satisfaction and reduce burnout.

Three key actions

There are three areas to workforce redesign that you need to focus on.



How to design workforce change

Evidence from sites demonstrates that the following questions are critical to consider.

QUESTION ONE

Designing a workforce around population health needs

What are the needs of the local population? Are you clear about your local population health challenges?

- Think about what **data** might be available that could help you begin to profile the local population
- Focus on a **few key priorities** that will have the greatest impact on your locality
- Think about the **health and care outcomes** you want or need to deliver for these population groups and the individuals within them
- Keep it **simple** – use the information to guide discussions and agree common aims
- **What services have you already** and how are they working to meet the needs of your priority groups?

QUESTION TWO

Designing a workforce around population health needs

Having determined local needs, what care does the population group require?

- Are you clear about **which services will be necessary** to support the health and care needs of the identified population group?
 - Will these **deliver the shared outcomes** you agreed for the locality?
-

Useful resources

- Public Health and NHS RightCare data
- Primary Care WebTool
- Quality and Outcomes Framework (QOF) data
- Clinical commissioning group (CCG) 'dashboards'
- Information from your practice's clinical system
- Local intelligence from other organisations and stakeholders
- Patient feedback
- NAPC's population health enabler information

QUESTION THREE

Designing a workforce around population health needs

Thinking about your current and future workforce, have you looked beyond the traditional organisations to identify and engage all the people delivering health and care services? Who will you need to deliver the required service changes?

- **Do you know who** you've already got?
 - Who they are and where?
 - What skills and qualifications do they have?
 - How many are there?
 - Who employs them?
- Focus on **making the most of your current workforce**. Make them feel valued by involving them in thinking about the future, the co-design of new services and what needs to change.

Think **outside the traditional view of workforce** to draw on people and employees from across health and social care, the voluntary sector and the local community, including patients, carers, volunteers.



QUESTION FOUR

Are you clear about what you want your future transformed workforce to look like, their capability and the services they will be providing?

- Always **do your thinking with your current workforce**. They will know better than you what needs to change and are more likely to own and make the changes happen in practice if they've contributed to their design.
- The care activities you've identified will help you work out what you need in terms of:
 - skills / capability mix (general and specialist)
 - behaviours
 - roles (numbers and types)
 - structures (squads and teams, reporting and supervision) to deliver them.
- Know your real **resource gaps** by checking out what you've already got and identifying how you can make the most of your current workforce and their skills.

Useful resources

- Talk to your Local Workforce Action Board (LWAB) about existing workforce data
- Use your local networks (including your own organisation's workforce) and their knowledge of people across the locality
- NAPC's workforce resources
- Existing competency frameworks, such as health and social care coordinators and care navigators
- PCH case studies, available on the NAPC website



QUESTION FIVE

Have you done enough to understand the current and future demands on your existing workforce as well as where you are going to source them in the future?

- Concentrate on **understanding and managing patient demand** as well as addressing existing workforce recruitment issues.
- Make sure you identify a clear and robust understanding of the **impact of the demand** on your current workforce.

Useful resources

- There are a number of tools that can be used to understand demand, capacity and activity as it relates specifically to patient populations. For more information contact NAPC's workforce team.

QUESTION SIX

Are you clear about the challenges and means of overcoming them when you bring teams of people together from across different employing organisations, including the benefits the changes will bring to individuals, teams and local population health outcomes?

- While employment contracts and arrangements need to be clarified and managed, most effective integrated teams enable **staff to work ‘where needed’** rather than constraining them by their employment arrangements².
- At the moment most PCHs have **‘virtual’³ employment contracts** supported by practical arrangements to develop their integrated team structures. However, we are looking at alternative models.
- Establishing **effective partnership working** arrangements from the beginning is critical to retaining good staff relationships and support throughout the change process.
- Sites could consider setting out funding and employment liability arrangements in a shared **Memorandum of Understanding (MoU)**.

“

**Establishing effective
partnership working
from the beginning
is critical**

”

2. The Health Foundation’s ‘Staffing matters; funding counts’ (July 2016) contrasts the short term pressing need to address current and looming skills shortages with the longer-term need for a fully aligned and co-ordinated national approach to workforce policy and planning. 3. Virtual integration – where staff remain employed in their current organisations, but work together in integrated teams.

QUESTION SEVEN

How will you measure the success of the changes?

- It's important **to keep all your partner organisations** and people engaged and committed to your PCH model to make it sustainable over time.
- Identify and agree **a shared vision and outcomes** with your locality and agree the things you need to measure to assess the successful delivery of these outcomes over time.
- Establish a baseline by which to measure progress and success.

Useful resources

- NAPC's PCH evidence and evaluation enabler information



QUESTION EIGHT

How will you lead your team and across the locality?

- Leaders will need to **role model** and encourage working across organisational and professional boundaries.
- **Shared ownership** for designing and delivering the PCH is critical.
- Keep it simple. Find a shared challenge or opportunity to work differently and **just get started**.
- Find the person with the right **energy and ability to influence** and bring others together around a common goal to deliver the PCH.
- Focus on **bringing clinicians on board** by involving them in defining the shared challenges and designing the PCH model.
- **Allow for flexibility** of the workforce to deliver care across primary, community and social care regardless of the employing organisation.
- **Devolve leadership responsibility** to the appropriate level and role.
- Put appropriate **governance and programme management structures** in place ensuring it brings together a mix of strategic, operational and clinical leaders.
- Keep bringing people back to the shared goals.

Useful resources

- PCH case studies, available on the NAPC website
- Bodenheimer's 10 Building Blocks of High Performing Primary Care – www.napc.co.uk/bodenheimer
- Systems Leadership: Exceptional leadership for exceptional times, Virtual Staff College 2013
- Examples of good governance structures

QUESTION NINE

What principles should you apply to workforce redesign?

Bodenheimer's 10 Building Blocks of High Performing Primary Care (www.napc.co.uk/bodenheimer) offer some key components for transforming primary care.

- 'Share the care' – **multidisciplinary teams** working across organisational and professional boundaries to deliver population health outcomes for groups and people.
- Trained and engaged leaders – develop and support **collaborative system leaders** from across your locality.
- **Stable squads** – create a group of multidisciplinary “players” from which teams can be assembled. Change your thinking from role and rank to skills and competence and focus on enhancing job satisfaction for existing staff through breadth of opportunity and personal development.
- **Co-locate teams** wherever possible – enable team-based working through shared office or meeting space. Allow team members to get to know one another well and build trust across traditional system boundaries.
- Sufficient staffing ratios – ensure you have **enough people** to deliver the care you have agreed for the locality and to the appropriate standards and quality.

Useful resources

- NAPC's PCH evidence and evaluation enabler

QUESTION TEN**What tools will you need to make the redesign work in practice?**

These include:

- Memorandums of Understanding (MoUs) and protocols
- Defined workflows
- Specific roles with training and skills checks
- Ground rules (behaviours)
- Communication – huddles, social media

Useful resources

- MoUs and protocols
- New job role descriptors



**Build trust across traditional
system boundaries**







Designing a workforce around population health needs

Designing a workforce around population health needs

Once you know the health needs of your population and have agreed your shared goals across the locality, you can start to design your workforce. The guiding principle is to shift your thinking:

FROM ROLES...



FUNCTIONS...



TEAMS

ROLES

Much of the focus to date has been on organisations, professions and roles (GPs, nurses, physician associates, clinical pharmacists, physiotherapists, etc). This approach inevitably leaves perceived resource gaps and misses opportunities to address cross-organisational and professional tensions.

To increase capacity, successful sites are looking beyond the traditional workforce to identify and **engage all the people needed to deliver the required service changes** drawing on people and employees from across healthcare, social care and the local community, including patients, carers and volunteers.

FUNCTIONS

Once you've mapped out the population health group, you should work with all the people involved in delivering care to decide exactly what is needed e.g. diagnosis, assessment, treatment and medicines management.

The people delivering the care know the people they're supporting and understand the issues and challenges better than anyone, so who better to ask. If you involve them in designing the changes needed, they will accept them more readily as you start to implement them.

NAPC can link you with primary care home sites that have used different approaches e.g. surveys, patient groups, staff forums to engage the widest possible workforce across their locality in this analysis.

TEAMS

'Form follows function' and now you understand the care activities that are needed you can start to work out the skills (general and specialist), behaviours, roles (numbers and types) and structure (reporting and supervision).

Baselining your existing workforce, e.g. finding out who is doing what across the locality and with what skills, qualifications, capability, and who employs them, will be critical for helping you identify the 'real' gaps.

When you are pulling together employees from different organisations, volunteers and people from the local community to deliver integrated services, you are forming **'networks' or 'squads'** – i.e. a workforce group from across health and social care and the voluntary sector from which teams will be assembled.

They may perform tasks together, but these tasks do not define the network. It is the ongoing learning and delivery of place-based population health outcomes that sustains their mutual commitment. The team members' development is based on their ability **to learn together**, care about the population group they are providing care for, respect each other as practitioners, expose their questions and challenges, and provide responses that reflect practical experience.

It is particularly important that the focus is on **generating creative tension** by bringing the different professions together in integrated teams, rather than forcing compliance and generic ways of thinking and working.

SIZE MATTERS

The population served by the PCH, 30 to 50,000, is small enough for the workforce to retain the **in-depth knowledge of their patients and communities** that enables them to deliver the most appropriate, personalised care to individuals.

This **sense of belonging** and ability to see the difference they're each personally making is key to everyone working in the local health and care system. They should have a sense of accomplishment and feeling of satisfaction that results from delivering meaningful work.

WORKFORCE MODELLING

There are several workforce modelling tools which help to identify the workforce requirements for current and future population health needs. For more information, contact NAPC's workforce team.





Leading change

We are not planning to write a new comprehensive guide to leadership and change management. There are plenty of development programmes and papers on system leadership and change management. We aim to capture some of the lessons that local leaders have so far drawn from their experience in making change happen.

We would recommend you look at *Systems Leadership: Exceptional leadership for exceptional times*, Virtual Staff College, 2013, which says: "The art of change-makers are not described in terms of charismatic heroes or divas, but as thoughtful, calm personalities who are as confident working in the background, supporting and enabling others, as they are in the limelight, leading from the front".

LESSONS IN LEADING CHANGE

A few lessons from PCH sites.

- **Leaders will need to role model** and encourage working across organisational and professional boundaries. Don't be distracted by organisational risk and who's responsible for what, but focus on the shared population health and organisational challenges and how much more can be achieved collectively.
- **Shared ownership** and leadership for designing and delivering the PCH is critical. This is a model designed and owned by staff for the local population.
- **Keep it simple** and just get started. Allow ideas and ways of working to emerge through experience of what's possible. Staff and leaders should feel engaged and involved by 'doing' and can spot the things that need to change for themselves.
- Find the **person with the right energy** and ability to influence and bring others together around a common goal to deliver a PCH.
- Focus on **getting clinicians on board** by involving them in defining the shared challenges and designing the model. The most successful PCHs tend to be GP-led with support from the CCG. Peer-to-peer influence is often easier and more effective.

- Allow for **flexibility of the workforce** to deliver care across primary, community and social care regardless of the employing organisation.
- **Devolve leadership** responsibility to the appropriate level and role, e.g. whole workforce approach rather than formal leaders.
- It is complicated so you will need to create **governance and programme management** around what you're doing.
- Keep bringing people back to the shared goal - excellent **population health management** across the locality.

MEMORANDUM OF UNDERSTANDING AND PROTOCOLS

PCH teams might be considered more difficult to build because of their multiple employer and professional makeup.

Integrated working can broadly be achieved through two forms of employment models:

- **actual integration** – where an integrated team is established within a single employing organisation or a new organisation created for the purpose of delivering the integrated services and
- **virtual integration** – where staff remain employed in their current organisations but work together in integrated teams.

While employment contracts and arrangements have to be clarified and managed, most effective integrated teams enable **staff to work 'where needed'** rather than by constraining them by their employment arrangements.

Some PCH's have adopted practical arrangements to support integrated working, including signing a **Memorandum of Understanding** with different organisations or shared protocols setting out funding and employment liability arrangements.

You should still engage with each organisation to agree ways of working together effectively to enable the PCH to flourish.

MEASURING SUCCESS

Clarity about **shared goals and outcomes** between your partner organisations and leaders is critical to ensure they remain engaged and committed to your PCH model.

We recommend that you identify and agree what and **how you will measure the delivery** of your shared goals and outcomes over time.

Consider the evidence you'll need to collect, from where and how you will gather, analyse and report on it.

Having these success measures, along with the relevant data, will also be helpful when it comes to reporting to national bodies and regulators about what you're doing and why. Please refer to the NAPC's PCH evidence and evaluation enabler.





Workforce
redesign –
making it
happen in
practice

Workforce redesign – making it happen in practice

This section is about how you put your designs into practice to develop and embed new ways of integrated working across your PCH.

We've talked about designing teams, here we look at how to build an effective multi-disciplinary team (MDT).

BUILDING EFFECTIVE TEAMS

NAPC can provide expert advice and support to sites looking for ways to develop their MDTs.

Useful factors to consider are:

- Staff who work in teams report **higher levels of involvement and commitment** and less stress.
- **Co-locate** PCH teams, wherever possible, or use shared meeting space.
- We describe the PCH workforce as **'squads'** from which smaller teams can be formed.
- Where teams work effectively together with other teams within the squad, there is **more sharing of good practice**, more integration of differing perspectives and more holistic understanding of team and local system-wide tasks.
- Create a **culture where people are free to design and implement change** so that the changes made are more likely to become part of normal practice⁴.
- Undertake a **continual review of staff ratios** to ensure you have enough people to deliver the care you have agreed for the locality to the appropriate standards and quality.
- **Link your teams in with senior leaders** to align strategic and operational decision-making, for example, make them a part of the governance and programme management structures.

4. Defining and Building A Culture of Sustainability – an overview of the determinants and enablers of a culture of sustainability and how to identify and develop them'. Tim Cotter Organisational and Environmental Psychologist, 2013.

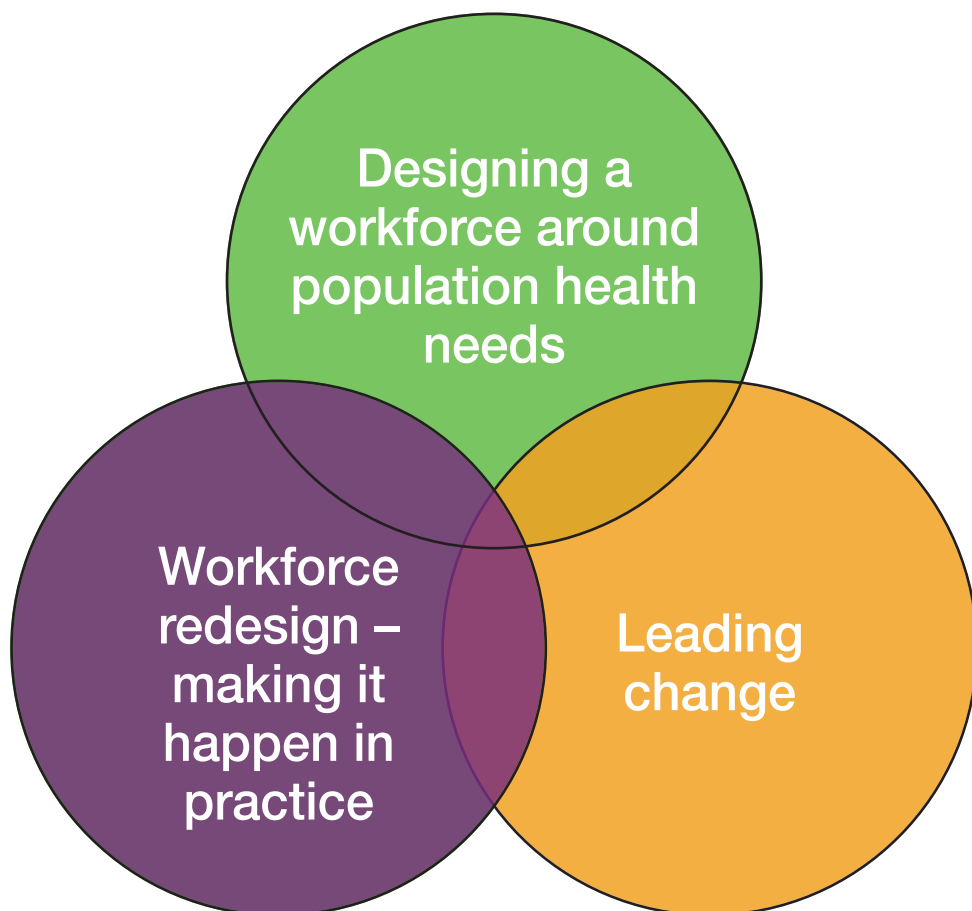
- Consider using team **communication techniques**, including huddles (a team gathering to strategise, motivate or celebrate) or a cascade approach to regular team briefings and social media options to enable minute-by-minute interactions.
- Teams are generally more able to be creative when they are **clear about the basics** such as the vision, their overall purpose, role and ways of working together (values and behaviours).
- PCH squads and teams also need to be able to define and articulate their **shared work objectives**, understand the way work will flow around the team and, importantly, they must have the necessary authority, autonomy and resources to achieve their objectives.
- Retain and **develop people** through visible support, mentorship and upskilling to increase the scope of existing jobs and careers.
- **Create new roles** to free up your current workforce to concentrate on the areas of work most appropriate for them to deliver and do the jobs they love and were trained to do.

EDUCATION AND TRAINING

Education and training can provide the glue to hold together your PCH workforce.

- **Health Education England's Community Education Provider Networks (CEPNs)** bring together the workforce required to improve population health, from the early years of professional training, through to new ways of established clinicians training together around the needs of specific patient groups. These education networks provide the opportunity for clinicians to share ideas, learning, skills and experience across professions and settings, to give them the full range of perspectives that need to come together to enable integrated care. They provide the backbone for the delivery of local care networks, where clinicians can come together to redesign patient care, based on the needs of patients, and aimed at delivering the highest quality care.

- **Develop new routes into education** and agree arrangements for the employment of all those in training - recruit all your graduates from pre-registration education.
- **Identify competencies** to support integrated working to enable the commissioning of training and education.
- **Close working between health, social care and the voluntary sector** will help address workforce skills and training gaps to deliver integrated care.



More information

If you have any questions relating to this guide or would like more information on workforce redesign, please contact NAPC's workforce team either by phone on: **020 7636 7228** or by email: **napc@napc.co.uk**.





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