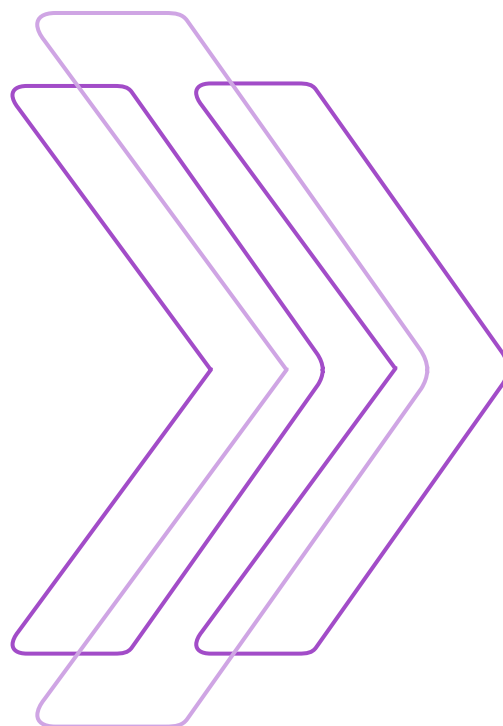# The King's Fund>

Ideas that change
health care

Insights from the spread of the primary care home

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This independent report was commissioned by the National Association of Primary Care. The views in the report are those of the authors and all conclusions are the authors' own.

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Key messages

- As the health and care system in England evolves, facing challenges and opportunities on its way, the need for transformation becomes increasingly evident (Murray 2019b). Particularly clear is the need for a more joined-up health and care approach with focus at its heart on population health (Buck *et al* 2018). Numerous examples of innovative practice exist, but challenges are faced when spreading this practice more widely (Dougall *et al* 2018).

- In this report we look at factors that contributed to the spread of the 'primary care home', a type of primary care network, from concept to more than 200 sites in a few years. We draw on a series of interviews with staff from the National Association of Primary Care (NAPC, who curated the primary care home concept for use in England in 2015), NHS England (who supported the work) and local sites (who delivered changes on the ground).

- We identify seven factors that enabled the spread:
    o recognition that change should start with an understanding of the local context and pre-existing conditions
    o a combination of skills to turn motivation into action: the ability to create a compelling case for change and to use influence to make this heard by people who can support next steps
    o hard work, to build and sustain local relations
    o the ability to persevere through challenges, accepting that this is part of moving forwards in the change process
    o recognition that staff need adequate time and resources to deliver change
    o a new form of leadership that is capable of supporting spread
    o data and analytic capabilities to enable transformation.

- We also identify four factors that made the spread harder:
    o Structural barriers to delivering transformation.
    o Severe workforce challenges exist. 'Without the ability to focus properly on the 'now', it is impossible to contemplate the future.'
    o There are challenges in terms of communication and understanding.

- o   The reach of many transformation efforts is limited and needs to be increased.

- Our work shows that a dual focus is needed. It is essential to address these barriers, as well as support enablers, in order to deliver meaningful change.

- The primary care home concept provided a means for local areas to articulate aspirations for a new way of working. As well are curating this concept, NAPC helped to foster national recognition for these new ways of working, provided support for local sites to use the concept to develop their own solutions, and facilitated local connections between sites to share learning and support.

- In delivering the next stages of their work, NAPC and others should consider using the insights from this work to:

  - o   support local efforts to spread primary care transformation efforts further into and across their health and care economy, and to help demonstrate the impacts of their work for local people and staff.

  - o   work with partners to articulate the primary care contribution for delivering population health and focus on the practical approaches for realising this.

  - o   encourage the development of leadership capabilities necessary for system transformation at a local, regional and national level. This includes fostering locally-led nationally-enabled transformation practice, creating a common leadership narrative, strengthening clinical leadership for whole-systems working, and nurture leadership for population health.

  - o   help create the right conditions for the spread of good practice to transform the health and care effort in a way that benefits patients, staff and the public. This includes championing existing good practice, addressing areas for further development, engaging with a wide range of partners to connect this to other population health efforts, and build further based on the insights from this work.

1 The purpose of this report

The National Association of Primary Care (NAPC) commissioned this work to better understand the factors that contributed to the spread of its initial primary care home concept in 2015 to more than 200 sites in England by 2018. It sought the work as a follow-up piece to our 2018 report on transformational change in health and care (Dougall *et al* 2018) as it had become interested in the challenges that stakeholders had experienced when trying to spread transformation initiatives from one site to others, and which we identified in our report. The purpose of this report is to inform the next stages of the NAPC's work and to support others in their health and care transformation efforts.

2 Methodology

For this study we used a mixed-methods approach across three phases. First, we carried out a brief literature review and quantitative analysis of the spread of the primary care home. Second, we carried out qualitative interviews with 20 people during the period November 2018 to February 2019: 10 from the NAPC and 10 from partner organisations (of the latter, eight were from local adopters of the primary care home model – 'rapid test sites' and members of the 'community of practice' – and two were senior commissioners at NHS England). Additional interviews were conducted with three local sites to develop case studies. Third, we tested findings with internal and external stakeholders and collated high-level reflections from the work.

3 Limitations

This report is not an evaluation of the primary care home model. Rather, it is a brief study of the factors that contributed to its spread. What motivated people to take up a different way of working? What enabled or hindered their efforts? What was the experience of those trying to spread the new approach? What insights can be gleaned from this for others wishing to spread transformation efforts?

Due to budgetary constraints, this study is based on a relatively small number of interviews with limited reach. It is important to interpret our findings in this context, particularly when considering additional factors such as time lag since events, individual recollections, and the evolution of the health and care landscape since we carried out the research, which could impact on the relevance of the contributions in this report to the current context.

Despite these limitations, we have taken every step to ensure quality and independence in the production of this report. We hope that the findings will be used to enhance approaches to spreading change in a health and care context where there is currently a lot of interest in doing this. It is not intended that this work will present a model to replicate – previous work shows that 'drag and drop' approaches are unlikely to work for transformation (Ham 2014). Instead, it is hoped that the insights will be used to highlight areas for further consideration and thus strengthen more locally led, centrally supported approaches to transformation.

4 The primary care home story

What is a primary care home?

The NAPC developed the primary care home concept in 2015 in collaboration with NHS England as 'an innovative approach to strengthening and redesigning primary care' (NHS England undated). It was one of several models at the time focusing on the primary care element of wider efforts to transform health and care (National Association of Primary Care undated a). It provides an interesting area for study because of its spread and due to its seeming influence on the wider primary care landscape in England. For example, primary care homes have been recognised as a type of primary care network (PCN) and helped to inform the development of PCN policy (NHS England 2019, National Association of Primary Care undated a).

A primary care home aims to create cohesive teams that share resources and expertise to cater to local population needs and provide personalised, pro-active and preventive care. The four key characteristics that make up a primary care home are (National Association of Primary Care 2015):

• an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care

• a combined focus on the personalisation of care and improvements in population health outcomes

• aligned clinical and financial drivers

• provision of care to a defined, registered population of between 30,000 and 50,000 people.

Why was the primary care home formed?

We heard from those we interviewed that the creation of the primary care home predominantly resulted from various challenges faced within primary care. For example, funding challenges in primary care meant that some interviewees felt that innovation was needed to 'drive efficiency to expand services within the community'. Others felt that insufficient time and 'space' had been given to allow previous transformation ideas to flourish and have long enough to see results. We also heard from leaders at all levels (local, national and NAPC) that primary care needed to be at the forefront of the reform of the NHS, particularly to find new ways of working to bring about a stronger and more sustainable future.

At the local level, workforce issues were a major factor in the development of the primary care home concept. Interviewees said that as demand outstripped supply in primary care, particularly within a financially challenged health economy, the inability to increase staff capacity in line with demand meant that pressures on a number of practices became unsustainable – leading to further fragmentation of the local health system.

Furthermore, local leaders in primary care in the areas we spoke to reported a growing recognition that a '*multi-agency approach and better team-based care approaches, integrating colleagues from different sectors*' was fundamental to meeting rising demand.

Some local leaders reported that, despite working in primary care for many years, they felt that little lasting impact on the health of their community was being made. This was because the social determinants of health (social issues that individuals and their communities face that do not fall within the traditional remit of general practice) were not being addressed.

> *I've been a GP [general practitioner] for more than 20 years. We've made no impact in that career on improving population health outcomes. It was a sense that if we didn't have a better multi-agency approach and better team-based care which incorporated colleagues from different sectors working in a more joined-up way, all our frustrations would just continue.*

Although the narrative for a more joined-up approach to health and care already existed, many NAPC staff we spoke to felt that it needed a catalyst or spark to put it into action.

Development and spread of the primary care home

In the summer of 2015, senior policy-makers in NHS England invited the NAPC to develop a model that promoted a more integrated approach in general practice at the community level and would be accepted and spread by those working in primary care.

> *That led to a key moment when [NAPC] met with a senior team in NHS England to articulate [NAPC's] thoughts on engaging primary care in the shaping and design of the new care models programme as a component of the multi-specialty community provider [MCP] process that they were developing at the time.*

Interviewees explained this request from NHS England came from three bases:

- pre-existing relationships and trust between the individuals in NHS England and those in the NAPC

- seeing the need for a different way of working for primary care

- a growing recognition of the need for a different way of working for NHS England and the NAPC, as national bodies, that was more enabling of local efforts rather than about top-down control or performance management, and with distance from the political landscape in order to do this.

For NAPC interviewees this acted as a catalyst for them to bring together their thinking on and formulate the primary care home model. The NAPC developed a proposal built on learning and thought for more than 25 years, setting out principles and constructs leading to the four key characteristics of the primary care home outlined earlier (National Association of Primary Care 2015). This gained the endorsement of NHS England's Chief Executive and NAPC was given some funding to develop a programme of work to start to deliver the model with 15 local areas, called 'rapid test sites'.

To develop the work, NHS England staff provided support to NAPC leaders through coaching-style conversations, seeking to allow the NAPC to lead efforts (that is, a more 'bottom-up approach'). NHS England relied on NAPC to bring its understanding about local needs and clinical challenges, its ideas about reforms needed and its ability to connect with the clinical community at frontline and senior levels. NHS England provided technical support to fill skills gaps such as project management, communications support, networking opportunities and critical-friend challenge to support the NAPC to develop and deliver their plans.

Through this process of joint working, led by the NAPC and enabled by NHS England, 15 rapid test sites were advertised for and successfully recruited to

become early adopters of the primary care home model. The rapid test sites were provided with funding of £40,000 each as well as support from the NAPC to develop their own local model based on the four key characteristics of the primary care home.

The NAPC team supported the rapid test sites by acting as enablers, motivators and 'un-blockers', and used a similar approach to the one NHS England used to support the team. The NAPC team spent time with each site to understand local aspirations and challenges and used coaching approaches to help them plan practically how best to move forwards.

While much of this was locally led and actioned, NAPC provided help to connect areas with each other, enabled them to share learning, provided practical support and tailored information to help local leaders overcome local issues, for example by sharing how others approached similar problems to the ones they were facing. The NAPC also helped to promote local efforts at a national level. This included giving prominence to local leaders, presenting their work at conferences and events, publishing case studies and reports, and publicising local work through other forms of media. The NAPC worked to create a wider national environment where these efforts were accepted, valued and welcomed, through its own ability to influence senior policy-makers and commissioners and make the case for change.

On a more practical level, the NAPC created a series of guidelines and tools, a common language, support for evaluation and data analysis, and a connected learning community, which enabled practices to share progress and ideas about what works and what does not, using the common language. Leaders in local sites described this as a big draw of the model.

> *You become part of a community that shares that aspiration and celebrates success and is also very open to sharing learnings, success and failure, with others in a non-judgemental way. I think that's why it's really worked well.*

Successes of the rapid test sites meant that sites acted as agents for the spread of the primary care home to other sites, both intentionally by the NAPC sharing insights, and organically through local sites sharing their learning, energy and positivity. Other practices or areas with similar challenges were drawn to become primary care homes as a result. By December 2016, a further 77 sites had joined the programme of work, making a total of 92 sites. Most of the sites beyond the first wave of rapid test sites received no financial support (only practical support), and despite this they joined and remained part of the work.

The number of primary care home sites continued to grow, and in October 2018 there were more than 200, with a number of those being within integrated care systems as well as more traditional areas of general practice, covering more than 16 per cent of the population (National Association of Primary Care undated). The growth in the number of sites and geographical coverage is shown in Figures 1 and 2 respectively. It is possible that the primary care home model may have spread in other ways as well, for example by influencing practice in areas that are not formally registered with the NAPC as primary care homes by encouraging a greater focus on the four key characteristics of the primary care home or learning from insights shared. We have only included sites that are formally registered as primary care homes in this work.

Figure 1 **Growth in the number of primary care home sites**
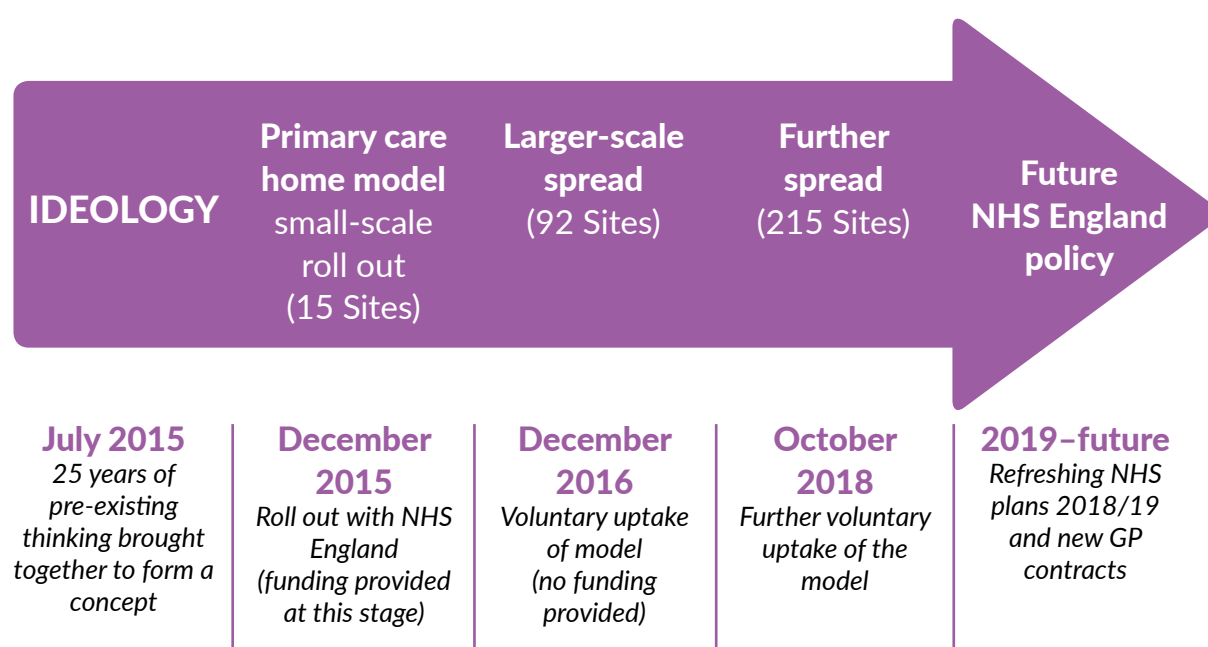
Source: National Association of Primary Care (undated c, p 8)

Figure 2 Growth in the geographical spread of primary care home sites ⟨K⟩
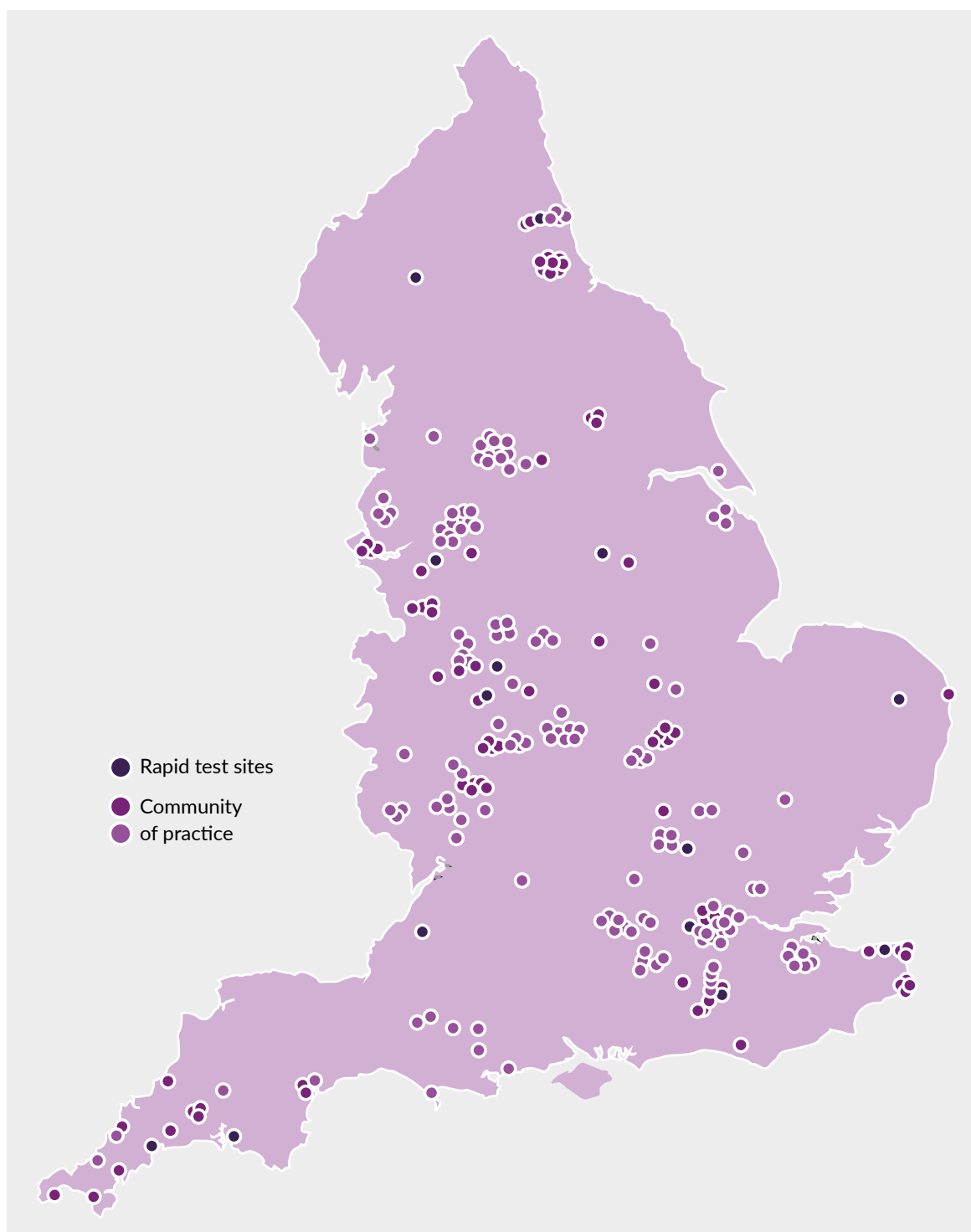
Source: National Association of Primary Care (undated c, p 8)

Local experiences of being a part of this spread

To better understand why local sites chose to join the primary care home programme, and thus contribute to the spread of the concept, we interviewed local leaders to find out about their perspectives. In this subsection we present three local stories – St Austell Healthcare, Granta Medical Practices, and Newport Pagnell and Newport Pagnell Medical Centre at Willen (NPMC@Willen) – outlining the reasons for, experiences of and aspirations for their primary care home work. These stories are based on in-depth interviews with different leaders (between four and six) in each site, which we combined to form a story that as accurately as possible reflects their joint inputs and the language they used.

Local perspective 1: the St Austell Healthcare story

Local context

St Austell is a market town in Cornwall with a high incidence of socioeconomic deprivation a history of struggling primary care: 'struggling to recruit, struggling to retain, struggling with workloads, struggling with premises'. A large practice in the town, which had about 9,000 patients, had to hand back his contract with no GPs, so in 2014 the three remaining practices came together and ran that as an Alternative Provider Medical Services (APMS). Its journey has been about survival from the start – how to create something that is sustainable. One interviewee said: 'We are only too aware of watching a practice fold and the effect that that has on the staff, the patients and the partners who were declared bankrupt. We set out to create a sustainable model of primary care from the outset.'

Motivation to become a primary care home

Through their experiences of working together, local GPs decided to merge practices. They saw it as an opportunity to set about redesigning what primary care should look like in the town, based on the challenges and opportunities at the time and hopefully opportunities in the future. They sat down and talked. 'We talked a lot about integration, workforce, addressing wider determinants, poor health and essentially population health.'

This coincided with the opportunity to become a primary care home rapid test site. The primary care home principles chimed with their strategic vision. Additionally, some of their partners were in their early 30s and had no leadership experience. They felt that it was an important opportunity to get support not only for the delivery of their local vision but also for new leaders at this critical time. 'General practice can be quite an isolating environment so it was great to join something national bringing together a lot of like-minded practices to share information and have some guiding principles and to cross-reference and ratify the kind of things we were trying to do.'

Local approach: a focus on the workforce and social prescribing
A key focus for staff working in the St Austell primary care home has been the workforce: improving staff working lives, developing multidisciplinary teams, and ensuring that patients see the most appropriate person in the team, in the most appropriate timescale. These efforts are underpinned by aspirations for financial and clinical sustainability, as well as quality improvement. An example of this is their work on social prescribing.

In 2015, when local leaders considered how to shape services to be fit for the future, one of the main things that they realised was that they were seeing many lifestyle and social problems in the surgery that they did not feel well equipped to deal with. The demand was overwhelming so they wanted to find a way to manage that. As a rapid test site, they had a small amount of 'seed funding'. With it they employed a social prescribing navigator. This was based on work by the Bromley by Bow Centre in London and initiatives from elsewhere. Interviewees described their efforts:

> *We decided to start by concentrating on physical activity because we knew there was a lot of evidence behind that, so would be an easy sell for us or partners and local NHS colleagues.*

> *We wanted to have a mantra that we could find physical activity for anybody, no matter what their physical or mental health needs were, so a lot is incredibly low-intensity like chair yoga or very light walking groups or pool sessions. We also tried to keep prices down. Most of it is free, for some there's a small charge.*

> *Once it began, and having seen some positive results, other charitable sector colleagues became interested. Now we have another one-and-a-half whole-time equivalent social prescribing navigators funded by other organisations.*

More than 600 people have been referred to the service. The capacity has since increased due to further funds being sourced from new local partnerships (for example, local business). The service now has a community matron who works alongside the social prescribing navigator and health promotion staff to meet the demands of and provide support to local people. It has branched out beyond physical activity to arts and horticulture courses, work to move people closer to employment, and efforts to connect people. The leaders are hopeful that they can connect even more people with things that will help prevent them from becoming unwell, improve their health and wellbeing and help them connect with other people in the community. The leaders also hope that the service will improve the vibrancy and cohesion of the community.

Measuring success

Interviewees felt that being part of the primary care home programme has been helpful in supporting them to make progress. They report that it was feeling supported and confident to work in this different way, to be able to focus on their local population's wellbeing, rather than solely focusing on ill health or the medical conditions that people have, that really helped.

> *You could ask: 'How much of it is because of the primary care home? Wouldn't we have done this anyway?' That's impossible to know. Practices elsewhere doing similar things. For us the two have gone hand in hand. It's been an overwhelmingly positive experience. It's shaped our direction of travel, and gives national permission to say: 'You're on the right track' even if doesn't all fit what's going on locally. It gives us confidence to say it is broadly in line with what others are doing in the rest of the country.*

Local perspective 2: the Granta Medical Practices story

Local context

Granta Medical is a single General Medical Services (GMS) practice in Cambridge serving around 44,000 patients. It was formed by the merger of four general practices over the past four years into one single practice. It is one of the NAPC primary care home sites that are part of the NAPC community of practice. It was on a journey of development and found that it was aligned with the NAPC vision of the primary care home so became part of the community of practice about three or four years ago. One interviewee described the journey as follows:

> *About 10 years ago we did scenario building as a practice and came to the conclusion that our future was only going to be sustainable by achieving a high level of scale. We set about moving to scale by merger with like-minded adjacent practices. That's been a journey over a decade. We are now a more stable, mature general practice that combines advantages of scale with sensitivity and responsibility of a community-based organisation. We serve a defined population. We have a team delivering the service, driven by their social interactions with each other. It remains human sized but with some of the benefits of scale.*

Motivation to join the NAPC community of practice

 GPs in Granta Medical had known NAPC leaders for a long time and talked over the years about general practice, its future, and primary care structures. At a Nuffield Trust event, one GP partner was talking to a NAPC leader about the NAPC's work and plans. Granta Medical arranged for a member of the NAPC

team to visit the practice to talk to all the staff and explain the concept. This proved to be an important encounter.

> *'Our staff felt it aligned completely with their vision for the future. It was very powerful for our practice staff to hear someone from outside the practice, come and endorse our vision for the future as being aligned with innovative thinking, and other practices across the country. It was very powerful for us to have someone saying: 'You're not doing this alone.'*

Granta Medical did not get any of the early vanguard investments, but was motivated by the knowledge that other people were being supported in going on this journey and this felt sufficient for it to join the community of practice. It formally applied, was accepted and, since then, has done a lot with the NAPC and primary care home network, including hosting visits from the Minister for Public Health and Primary Care and the Secretary of State for Health.

The experience of being in the NAPC community of practice
Staff at Granta Medical who we interviewed said that being in the NAPC community of practice has been a useful experience. They have valued the information and shared resources. They have found meeting like-minded GPs, managers and practitioners from different community practices across England a particularly helpful experience.

> *Largely we share the same issues and a similar analysis of what needs to be done. We are coming through convergent evolution to very similar conclusions about what practices can do to improve their sustainability and improve the lot for their practice and members. That's been the most powerful utility for us.*

They describe three aspects of this work that have been particularly helpful. First, interviewees reported that 'the belief that the solution for the future of a publicly funded health service needs primary care at its heart' is a powerful means for connecting widely to deliver improvements:

> *In the face of what has been a very uncertain and, at times, hostile environment for primary care: to know that there are others who share optimism and a belief in a vibrant, sustainable primary care future, where staff are rewarded and supported, where practice patients get great service is invaluable.*

Second, the value of the enabling rather than directing approaches used:

> *'being a grassroots, organic movement; it's not been imposed from on top; it's been sold on a message of hope and volition over imposition. So, those have been the key features: it's enabling, rather than controlling; it's positive, rather than coercive; it's about aspiration, rather than desperation.'*

Finally, local leaders reported the value of the practical support from the NAPC (in the ways outlined already in the primary care home story). '*It hasn't been intrusive but of high quality when given*.' In particular, the efforts by NAPC leaders to promote local work and foster wider recognition of its importance:

> *The leadership and inspiration from people like [NAPC leaders] has been great. They have moved us up the national agenda by organising visits from Central, NHS England, DH [Department of Health] and politicians. That helped us achieve greater credibility within our local health economy, as well as national, agenda.*

Measuring success

Granta Medical's national general practice profile of patient satisfaction has risen year on year over the past seven or eight years. Currently it has 96 per cent patient satisfaction with the practice, which compares with England's average of 77 per cent. Additionally, it reports that this is improving, against a background of decline for many parts of England. One interviewee said:

> *Whether or not that's because we're a primary care home, it's difficult to tell. At the heart of our vision is a sense of self-determination, self-control - probably the most important thing for primary care. It's when people feel there's no point trying that things begin to fail. For us, the primary care home's model is a credible, supportable, invigorating, energising narrative for practices who want to get involved. If it supports the belief that practices and GPs have got a future where they can help shape it and determine it, then it's got enormous value.*

Local perspective 3: the Newport Pagnell and NPMC@Willen story

Local context

Newport Pagnell Medical Centre is a large practice employing around 130 people. It serves a growing population of approximately 22,000 people. It is located in Newport Pagnell, which is a small market town on the outskirts of Milton Keynes. The practice has an older population demographic compared with the rest of Milton Keynes, with 8.5 per cent of the local population over the age of 75 (National Association of Primary Care undated b). Several staff retirements have resulted in the partnership now being the smallest it has been, consisting of six partners and a managing partner.

The practice has a long history of developing more integrated ways of working. For example, in 2000 it created its own integrated nursing team, led by a lead nurse and consisting of district nurses, practice nurses, health visitors (now no longer part of the team) and community matrons, who are employed directly by the practice.

Motivation to become a primary care home
Newport Pagnell Medical Centre's efforts to work in this more integrated way meant that staff were already presenting at conferences and in contact with NAPC leaders comparing ideas. Following the first wave of the primary care home rapid test sites, NAPC leaders talked to local leaders about becoming a second-wave primary care home. Local leaders thought they would be able to contribute as well as learn from the NAPC and other rapid test sites. They wanted to learn more about population segmentation to supplement their existing work. The data element particularly appealed to local clinicians. So they joined the primary care home programme as a second-wave rapid test site.

Local approach: population segmentation and tailored support
The Newport Pagnell primary care home focuses on using population segmentation techniques to better understand the needs of groups of local people, and then works with a wide group of stakeholders to tailor approaches to meet those needs.

One of the priority areas for Newport Pagnell is young people and mental health. At the home's initial meetings with local stakeholders, a picture emerged of a strong mental health challenge for young people in their area.

> *Our local town council has a huge amount of knowledge about the town. They run the local youth clubs. They talked to us about mental health need among young people. We thought who else might be of help. Drug and alcohol teams for instance. The CCG [clinical commissioning group] commissioner for young people, and so on. It grew it from there really.*

Working together with its local gym – Places Leisure – and its local school, it created a course called 'Talk for Sport' for young people struggling with anxiety and other low-grade mental health issues. Data from the course shows that, before the course, 46 per cent had visited their GP within the previous six months for depression and 72 per cent had accessed child and adolescent mental health services (CAMHS); after the course, 69 per cent reported improved wellbeing and 83 per cent said that they would choose a 'Talk for Sport' option before seeing a health professional.

Another area of interest has been catering better for local people who are housebound. District nurses in Newport Pagnell are part of the integrated nursing team who cares for housebound patients. They work jointly with the practice nurses and together have developed a community leg club where people with leg ulcers go to have their legs dressed in a more relaxed and social environment. As a result, staff in Newport Pagnell have noticed higher healing rates as well as improved working practices and staff wellbeing.

> *There's been huge positivity about working together. The meetings are exciting and buzzy and that's quite a rare thing. We're coming up with ideas that I think we wouldn't have come up if we'd just carried on working of just working with other health care providers and using information we've always had.*

Measuring success

Staff in Newport Pagnell report challenges in demonstrating impact due to the limited data systems and processes in place, which do not always collect the information needed to support their transformation efforts. Capacity issues pose an additional challenge for them, but they report using any extra capacity when they can to conduct evaluations. They recall that their data challenges are not unusual.

> *I remember at the NAPC 2018 conference the NHS England lead for data said it takes three years for a new programme to start having an effect on population health. I think the NHS forgets that all the time by using one-year targets, but we are already seeing positive effects from programmes.*

Despite not being able to fully quantify the benefits of their work, those we interviewed were proud of the benefits they were seeing in practice.

> *I saw a patient this week whose life had been fine until a few years ago when he got into all kinds of problems and ended up alcoholic. I thought I'm never going to be able to do anything to help him. But by talking to him in a very different way I was able to pick up that there had been trauma in his childhood that was affecting his life choices. He really felt isolated. He'd been a successful working man with a family and now had no home of his own or money. He became keen to volunteer with [one of our new programmes] and reverse that negative self-esteem cycle that so often results in ill-health. Having relationships across our area that we never had before is fantastic. It's a completely different way of working and patients really do benefit.*

Factors that made the spread of the concept easier

Drawing on what we heard from our interviewees, in this subsection we describe seven factors for the NAPC and others to consider as enablers for the spread of the primary care home concept:

- pre-existing conditions for change

- sparking action

- building system-wide relationships

- a continued focus on the new ways of working

- providing staff with adequate time and resources

- a new approach to leadership

- data and analytic capabilities.

Individually, these factors may seem like common-sense approaches (Hulks *et al* 2017) and indeed they resonate with existing literature on good practice (NHS England 2018). They are also not radically new things. But interviewees cited them as being critical for the spread of the primary care home concept.

Pre-existing conditions for change

Many pre-existing conditions enabled the primary care home concept to come into being. The landscape that contributed to has already been described.

- There were pressures of meeting increasing service demands (in terms of both complexity and caseload), along with financial and workforce challenges, and fears about service sustainability as a result.

- There was a wish to avoid what did not work based on experience of previous changes such as GP fundholding, total purchasing and practice-based commissioning in the context of the emerging policy direction and patterns.

- There was frustration with health and care structures in England not being able to meet the 'real' health needs of people being cared for. Wider circumstances impact heavily on people's health and require general practice to work jointly with councils, community organisations, national agencies and others. But, with no obvious means of doing this in place and limited capacity, clinical efforts felt like they were 'skimming the surface' rather than addressing 'real' health issues.

- There was a growing body of literature outlining the need for change (Welbourn *et al* 2012) and there were opportunities to learn from existing approaches and international models. NAPC leaders were interested in these,

in particular the patient-centred medical home model in the United States (Epperly 2011), as well as the thinking from industry, human resources and organisational development (Lewis and Chana 2018).

Thus, conditions for change existed. NAPC leaders say that by understanding and addressing these, they were able to create a primary care home concept that could generate interest and be spread. The temptation (and risk) is to overlook this step, and instead start change efforts by focusing on practical change(s) to deliver (Weberg 2012). Our work suggests it is important for NAPC and others to continue to start change efforts by asking the following questions.

- What are the biggest challenges that staff and the public locally are facing? **(needs)**

- What approaches are already under way to address these? **(green shoots)**

- What are the opportunities to build on these? **(assets-based focus)**

- What lessons should we heed from the evidence and our experience about what works and what doesn't? **(informed by insights)**

Sparking action

The three stories related in this report show that local actions to start working in a different way had begun even before the primary care home work in England was under way. However, the formal beginning of the primary care home model and its subsequent spread required a spark to bring it about. We found that this spark consisted of three components, all of which were needed:

- a motivation to act

- a compelling case for change

- an ability to act.

NAPC leaders were senior clinicians and had established networks in the health and care system, including with senior policy-makers. We have already described their motivation to act. When the opportunity presented itself, they were able to articulate the opportunities and challenges faced ('burning platform') through a compelling narrative and, through their connections, make this heard by those with the power to act at local and national levels. This case for change was augmented by a proposal for delivering the primary care home concept that seemed practically achievable, was supported by evidence and was championed by respected clinicians in the field, and thus NAPC leaders felt able to engage others at a more local level to deliver change. The primary care home concept received the necessary support to proceed.

This sparking of action was probably assisted by a shift in the wider 'mindset' of national and local leaders at the time (Buck *et al* 2018). There was a growing understanding about the need to focus on populations rather than individuals to meet people's health needs and to achieve a more sustainable health and care model. While this is more widely accepted now, it was not the prevailing paradigm at the time or commonplace in practice. This mindset shift is likely to have primed the grounds for a more population-focused primary care concept like the primary care home, influenced its design and bolstered support for it.

Building system-wide relationships

Interviewees commonly stated that building system-side relationships was a key enabler of the spread of the primary care home model. An important factor even in traditional primary care practice, we heard that the shift towards population health necessitates an even greater focus on this. However, the practice of building such relationships appears to be challenging and requires further attention.

The first challenge that interviewees faced was identifying partners to involve in new ways of working, and where best to start. The thought of 'system-wide' working can feel daunting given its more abstract nature as a concept and due to the vast number of partners who it suggests need to be involved. In terms of local inputs, the advice from interviewees seemed to be: pick a focus, start locally from where you are at, connect meaningfully from there and grow outwards. Interviewees reflected that every area will be different, each with a different starting point. There is no 'drag and drop' solution for who to include when. Small steps helped those involved in the primary care home work.

Some areas started this by broadening representation at pre-existing meetings to include non-traditional partners. Others arranged bespoke multi-agency conversations for the purpose of exploring possibilities. We heard about efforts to recruit a social prescriber to map local opportunities by having lots of conversations with community organisations. Other areas started with more individual-level conversations. There was a diverse range of approaches. But the consistent theme was the need to widen representation beyond the NHS and traditional health community, and forge connections more widely with the police, the education system, business, charities, councils and other partners for health.

The next challenge that the interviewees faced was how best to handle these diverse groups and the numerous perspectives they were encountering. They suggested: 'Start by understanding the different challenges and where they're coming from … you can't start to move forward without this. It is absolutely an ongoing thing.'

This meant being aware of assumptions and fears in themselves and others, and being willing to understand and address these in order to move forwards. 'Initially they [community partner] were sceptical because they thought we were just going to move a shedload of work on to their shoulders. When they realised this wasn't about that, it changed relationships.'

Through exploring a shared understanding of local needs, interests and possibilities, joint approaches were often identified, with mutual gains for the organisations involved (for example, reducing the duplication of work and increasing their reach), as well as having considerable potential benefit for the public by improving the care offer. Additionally, efforts to deliver the initiatives in themselves, as well as subsequent results, generated further interest and spread. 'Once people have seen the results … the managers and other stakeholders start to take notice … and also think about spreading it.'

So at a local level, as seen in the stories related in this report, this resulted in more people and organisations being willing or wanting to get involved, more funding sources, more capacity and even further growth. At the level of the primary care home model nationally, it resulted in increasing interest in the programme and the number of sites involved.

A continued focus on the new ways of working

It would be easy to conclude from the last subsection that the process of relationship building is a simple challenge of logistics and minor mindset change. But the academic literature in this area, let alone the practical insights from our interviewees, demonstrate with conviction that this is not the case. Models of change show that resistance is experienced in the process of moving forwards with change (Fisher 1999). This resistance is a normal part of the process of change and to be embraced as such. Interviewees reflected that a mental reframing is needed. 'Don't expect that people will readily engage in new ways of working. See it as a leadership challenge, not a barrier.'

Even when people did agree to conversations about possibilities for working together, interviewees experienced considerable mistrust about and an unwillingness to support new ways of working. Working through this took time, patience and resilience on the part of interviewees – sometimes over years – in order to make progress.

As well as mistrust, there were a lot of personalities and perspectives to work through. Interviewees often found themselves being challenged.

> *GPs are a difficult lot! We're used to making decisions in 10 minutes, the decisions have to be decisive, and we have to stick to them. That means we're often quite stubborn in what we think is right and don't understand why other people don't see that I'm right. We are part of the problem in that way.*

> *When we started out, people were wondering 'Why?', and whether it would make any difference or just take us away from looking after people with personal care. Like: 'Why are carers working with us? What will they bring to the team?'*

Some interviewees felt that the history of changes in the health and care landscape contributed to some of this mistrust. However, their message again is that negativity is a normal part of change, and their recommendation is one of perseverance. Many people we spoke to reframed the challenges as opportunities to find ways forward. For example:

> *… a number of practices were starting to close due to retirement. We had one contract handed back. In the space of four years we've lost seven of our practices – basically a third. Conversations started to happen with the remaining practices about how to sustain their ability to care for the patients. We started to see how they can work in a more efficient and effective way through collaborating with each other.*

Interviewees also highlighted the need to view this work to build relationships as a continual process and not 'something you just do once for whatever piece of project work you're working on – it's important to maintain all of that as well'.

We heard about the need to repeatedly encourage others to stay focused, keep up morale and continue with efforts – basically to provide ongoing focus and support for those already engaged with the new ways of working so that they continue to stick with it.

> *People have lots of vested interests. If you try to get them from step one to ten, the first thing is to get from one to two. If you move too far ahead, you lose them. It's been quite a challenge to stay close to where people are to help move them forwards.*

Often, face-to-face interactions worked best. This required staff travelling out to where people were working, and supporting them in their environment, as well as in more central or virtual ways. This was of particular importance given the cross-system nature of this work and numerous partners being offsite, as it was not possible or practical to locate people in the same place. Interviewees

reported an added benefit of this in terms of enriching their sense of 'community' and connecting them to their working geography better.

It seems that efforts become easier over time when more mature relationships and more established working practices have developed. 'A lot of reassurance had to be provided, and then again, once people became a bit more comfortable with it, it became a lot easier.'

These insights should help the NAPC and wider partners with their support plans. They need to recognise the scale of the challenges that local areas face in creating new ways of working and to consider particularly the expectations placed on them (for example, in terms of timeframes and scale), as well as the support they need. While they have achieved much, local sites face ongoing challenges to reach out in more depth as well as breadth in order to deliver the next phases of their work.

Providing staff with adequate time and resources

In order for people to deliver new ways of working, interviewees told us that adequate time and resources need to be available to support this, for example:

- backfill for clinical involvement

- practical and timely support to overcome technical issues

- staff time to fill skills gaps

- affordable facilities for whole-system working where partners have access to less resources (for example, the charity sector).

A number of sites mentioned the importance of 'seed funding' from NHS England via NAPC to help develop the local model through engagement meetings and workshops. In one site this funding was used to develop a training and education service to bring staff from different organisations to learn about the new ways of working being developed in the area and to enable teams to work as multidisciplinary teams while maintaining core services. But interviewees also noted that this is not achieved easily or quickly. 'It takes such a long time. We co-located our district nurses in our acute hub and for six months barely nothing changed. By the time we got to nine months and we'd all had a Christmas party together, we started to know each other's names.'

There was a sense that a lack of understanding at both local and national levels exists about:

- the resources needed to support this way of working – financially but also more widely in terms of capacity, capability and confidence

- the time needed to deliver this properly.

As well as the time required to build relationships and embrace new ways of working, staff also valued the time and support to visit and build connections with other sites, to learn from them. One interviewee noted: 'It's inspiring to get a bit of headspace outside of the surgery and go to London or Birmingham and just meet other inspirational colleagues, or colleagues who are going through similar things as you are, and to take that back to the practice.' For them, it enhanced the quality of their local efforts and helped to renew energy and sustain momentum towards delivering their efforts. For others with insufficient time to visit other sites, they valued the insights that the NAPC brought to them. 'Being able to draw on the expertise and support from NAPC has been valuable … we've been lucky enough that we've had people come down to us to share their insights.'

We heard similar comments about the primary care home community of practice in enabling quicker access to learning and reducing the time needed for individual research into how other areas are developing new ways of working.

These insights signal again a need within the health and care system to:

- better understand the practical time and resource challenges that sites face when trying to deliver new ways of working

- recognise the value of support to connect local areas that are trying to work in new ways and help them to share learning.

Particularly in the context of insufficient capacity (and possibly limited capability) to look further afield to learn about other sites, this support becomes critical, especially if it is provided in a time-efficient way and it is of maximum practical relevance.

A new approach to leadership

A recurrent theme throughout our work was the enabling contribution of leadership in driving the spread of the primary care home. This had several key features.

Organic
Leaders at all levels who were successful in driving the spread of the primary care home seemed to have more organic processes, where plans emerged through a process of engagement with others rather than being enforced from the top down. One interviewee said that:

> *… those that are doing really well haven't got this formulaic synthesised approach. They've just done it naturally. They create empowered teams. It's that simple: practical leadership that makes the difference between a successful primary care home and a maturing primary care home and those that don't get off the ground.*

Permissive

Interviewees noted that the permissive nature of developing the primary care home model locally had further enabled partners to work together. An interviewee described this as follows.

> *Really important is that different professionals from different organisations can look at each other and say: 'Maybe GPs aren't best placed to do this.' 'Public Health, do you want to lead on this aspect - we'd love to learn from you in that process?' and asking: 'What can we learn from each other?' That collective effort to create a psychologically safe environment is fundamentally important if you're going to create the right conditions for a primary care home.*

Locally led

Whether by NHS England (allowing the NAPC to lead efforts) or the NAPC (being led by local sites), interviewees noted the benefits of a more locally led approach. One interviewee recalled that:

> *… when we launched the first rapid test site element of the programme, beyond just the very crude descriptors as they were at the time, we actually didn't shape that any more than that and we just said: 'There's a bit of cash coming from NHS England to give a bit of headroom, but really we need your help in thinking through the detail behind these characteristics.'*

Able to resist the urge to mandate

A key attribute of the form of leadership that enabled the spread of the primary care home was described as the ability to resist the 'temptation to mandate' and instead focus on creating a culture of compassion and valuing staff. Staff reported feeling more likely to share their own thoughts and ideas when they felt they were being listened to and felt they had the power to effect change. This requires being open and having honest conversations with staff about the strategy and deliverables, but also taking the time to listen to their inputs and valuing their contributions.

Informed by leadership theories

Some interviewees referenced specific leadership theories or styles that they had found especially important in underpinning their primary care home efforts. Two examples are as follows.

> *I have always particularly been an advocate of Lencioni [Lencioni 2002] and the servant leadership style of approach … teams empowering colleagues, listening rather than talking.*

> *From Michael West's work on pseudo teams [West 2015], there's a lot of that culture going on where people pretend they've got a team, it's just completely dysfunctional, it doesn't do anything … when I talk about a team I'm talking about a group of people who know each other, they trust each other, they have mutual interdependencies, they hang out together, they socialise together, they have fun together.*

There might be a tendency to think that leadership models are academic and can disengage people or be too hard work. However, from the insights of our interviewees it would seem that they can actually provide structure and a way of thinking that have a very practical use. It may be helpful for the NAPC and others to develop a consistent leadership narrative and local practical capability to supplement efforts to spread the primary care home.

Able to create a learning and supportive culture

Interviewees noted that peer-to-peer learning and learning from other sites was also a key enabler for spread. This was both from the perspective of connecting peers for support at an individual and a geographical level, and also from the perspective of local leaders being invited to speak and promote their efforts more widely by sharing learning with their peers.

Able to instil confidence and self-belief in others

The national framework of the NAPC model gave some interviewees extra confidence that sticking to their 'principles' was the right thing to do. 'So it just gives you that sort of confidence to stick to your principles and say this is the right thing to do and this is the way that we want to go and this is somehow in line with what a lot of other people are doing in the rest of the country as well.'

Data and analytic capabilities

Interviewees highlighted data and analytic capabilities as both a key enabler for spread but also an area needing further focus to maximise this potential. They seemed to agree that data has many uses and is an essential part of the work described in this report, for example it can be used in population health management (Dougall *et al* 2019) to segment patients and tailor approaches for local groups. '*Our insights around our population, how we shape things differently, our data – it's a real powerful driver*.'

But one of the biggest challenges that local sites face also relates to data. Many interviewees found getting data to understand the relationship between changes and outcomes very challenging. This was due to both data collection limitations and the time lag between changes and their impact on outcomes. Others felt that more data to help benchmark their own efforts would be helpful.

Interviewees also highlighted another aspect of data as being an issue – the measures of success that are in use. They suggested that information sets were often set up to collect information that was not always helpful for transformation efforts. It was only by modifying what data was collected that they were able to progress their local efforts.

> *Two aspects are vital for spread. Number one: patient experience and acceptance – that was key to not only implementing but [also] measuring. The second: the experience of the people delivering care at a time when we were going into a very difficult environment. So, making sure that we built in and measured those two aspects first were some of the earlier successes.*

Another interviewee reiterated this need to include an additional tranche of staff-related metrics that are often overlooked.

> *We've got dashboards in place that measure things for the primary care home. We don't need to worry about the system measures because they're already measured. But, what we needed to measure was self-morale, satisfaction, how well people know and trust each other. Those sorts of things you can measure and they are really important.*

Hence, the challenge for those involved in further stages of work on the primary care home model is to find ways to demonstrate impact despite the challenges of current datasets, limited data access and availability, different information technology systems often operating across the different partner organisations involved and different metrics in place.

Local staff are working to include additional measures where they can, but it would be valuable to have additional input from the NAPC and others to develop ways to:

- benchmark performance in key areas against peers

- connect partner systems in a local area to support a more whole-system working practice

- develop staff-related metrics as well as existing system measures

- help local areas to demonstrate measurable impact on patient outcomes.

This would help in the next phase of the development of the primary care home.

Factors that made the spread of the concept harder

In this subsection we set out four key factors that we heard from interviewees acted to make the spread of the primary care home concept harder:

- structural barriers to transformation

- workforce challenges and operational pressures

- insufficient understanding, enquiry or dialogue

- challenges in reaching and engaging sufficiently with local people.

Interviewees suggested the need to be aware of these factors and to find ways to work around them in the short term. This requires resilience and flexibility. They stated that in the longer term, it would be helpful to review existing structures, and create new ways of working across national, regional and local organisations that enable rather than hinder transformation efforts and ensure an optimal provision of care by staff to patients.

Structural barriers to transformation

Interviewees reported that the single biggest factor hindering transformation are the structural challenges that can impede 'new' ways of working. These are explored further in this section.

Unrecognised activity
Due to limited time and pressurised workloads, lack of understanding from commissioners and others about the level of staffing time and work needed for transformation efforts, and a lack of capacity in the system to accommodate for additional work, people report that supporting new ways of working at a local level often came at a great personal cost. Many interviewees reported this to be the most impactful factor in their efforts to foster new ways of working:

> *That's felt very much as if we've been fighting the system rather than working with the system to get to this point.*

This implies a need for greater understanding about transformation across all parts of the health and care system to inform funding and contracting practices as well as by those practically delivering change on the ground. For example, by recognising the time, capacity and support needed for this.

Commissioning challenges

Interviewees described local commissioning challenges that sometimes hinder their efforts to bring about new ways of working. For example, use of data and metrics that do not help transformation efforts or create additional bureaucracy that detract from this. We heard about challenges caused by excess bureaucracy or over focus on structures rather than on quality and purpose of efforts.

We also heard about a disconnect between local and national commissioners in their communications. For example, contradicting advice from local and national commissioners about what is possible and how, or a sense of unease for some local commissioners about local sites being directly in communication with national teams. This would benefit from further work by the NAPC and others to look into the issues and support better alignment of efforts at a local, regional and national level.

Contractual challenges

Interviewees said that they were facing challenges with new ways of working that are also proving complicated to work through. For example:

> *There are some really technical issues, like CQC [Care Quality Commission] registration – how do you register across a network of providers? We know CQC are wrestling with that one at the moment. Also things like employment issues, Agenda for Change, and [the] NHS pension. Those sort of issues rear their ugly heads for practices who [want to work more in this way].'*

While such organisations clarify their processes and create more guidelines, uncertainties remain for those working at a local level who need to plan their approaches. NAPC could consider working with partner organisations to support local sites with these emerging issues in their future work.

Competing interests

There was a generally positive relationship between organisations in the local areas. But working across a system also included addressing the tricky issue of 'which organisation wins?', particularly when trying to work more collaboratively across a wide range of organisations for population health. '*It's like a tug of war,*

[one provider] wants more resource saying: "If you only gave me this and took this out of the acute sector, I could do it better." I'm thinking – it's not about where resources fit, it's about how we use the resource effectively.' The next phase of support work by NAPC and others could include focus on connections across primary care and other sectors to help overcome some of these issues.

Workforce challenges and operational pressures

Interviewees describe impactful workforce and operational pressures that hinder efforts to spread the primary care home concept. These included convincing people to work differently when they are already working at capacity.

> *Getting people to understand that we needed to work at scale was challenging because people thought: 'Why are we doing this?' Everybody was so snowed under, we all have got that bunker mentality at that time, we don't want to see beyond the challenges we are facing.*

An inability to secure extra workforce, even in a locum or well-supported capacity, exacerbated the problem. This lack of time and headspace, or an ability to secure additional staffing capacity to break out of that cycle, came up repeatedly as a major issue.

> *Personal challenges in terms of time management. Developing something of this scale, doing it and managing the job of a full-time GP was challenging.*

> *I don't have time to think. I don't want to feel how the future will be when I can't see what the present is.*

This is complicated by further fears among interviewees about the future.

> *We can't attract partners because people don't want to take that risk on of being a partner, so that is going to hamper practices over the next few years.*

> *I'm now thinking about my own personal retirement in a year's time or so, probably March 2020, so the GP partners are now quite anxious about how they will replace me.*

> *We've probably lost 25 per cent of our staff because they didn't like working at scale.*

This paints a challenging landscape in which primary care is endeavouring to develop new ways of working. NAPC and others could consider how best to use

their national influence and skills to help generate solutions to these issues as these are likely to be critical for the ongoing delivery of new ways of working.

Insufficient understanding, enquiry or dialogue

Communication issues came up as a barrier, particularly in relation to:

- a difference in meaning and varied use of some terms and concepts, resulting in confusion

- varied skill in understanding situations and perspectives, leading to the use of assumptions or formation of conclusions that may not help change efforts.

An example of this is as follows.

> *We were talking to the community trust and they said they can't help because the CCG won't let them as it's under contract. So we did the simple thing of saying: 'Why don't we get the three of us in a room and have that conversation?' Guess what happened. The CCG said: 'We support that. It is perfectly logical, so why wouldn't we? People were making assumptions that weren't true.*

It is important to recognise the many factors described already that are also likely to be also contributing – for example, lack of time, staff workload, system fragmentation, contractual limits, natural resistance to change and the need for different skills. In this example, it was the skill to bring people together and enable the dialogue to explore perspectives that helped everyone move forward. These skills should be nurtured and supported more consistently through the health and care transformation efforts of the NAPC and others.

Clarity of language was another factor that was important for some interviewees, who reported encountering terms such as 'population health management' with differing meanings. Similarly, the notions of a '100 to 150 workforce size' and a '30,000 to 50,000 population size' (defined by NAPC leaders based on the evidence as part of their work on the primary care home) came up as a common area of interest. NAPC leaders described the concepts in terms of being in a small-enough workforce so that staff retain the sense of being in a 'team', and having a manageable population size so that the needs of local people can be met. Hence, they said, there is some level of flexibility.

> *So, the 100 to 150 workforce size will work, but if you're a bit over or a bit under that's fine too because you can grow into it.*
>
> *Thirty thousand might not be the right number, it might be 25,000, it doesn't matter, it's what works.*

However, local interviewees were finding that practice staff and commissioners did not always recognise this flexibility and that this in itself was hindering progress.

> *People are getting very obsessed about the size of the population*
> *– the 30,000 minimum. My sense is that people in leadership like*
> *to see scale, particularly CCGs and GP federations. So, trying to*
> *get them to understand [the realities and the need for more*
> *flexibility] has been a bit of a barrier.*

Interviewees raised additional points about communication for the NAPC to consider in its future efforts. First was the impact of the rapid spread itself and the need now to consolidate the support for local connections. This is not dissimilar to reports we hear from more advanced integrated care systems (Charles *et al* 2018), where the course of the work maturing is the need to focus on more local connections within primary care as well as wider connections through system-wide efforts.

Additionally, the use of the words 'primary care' in the term 'primary care home' – a model that is more system focused. One interviewee reflected on this: 'One of the problems is that people get quite precious about whether it is primary care home or primary care network; whether because it's called primary care does that mean that secondary care can't; which misses the point really.' This is an area for the NAPC and others to work together to consider further. This report shows that, particularly given the earlier insights about importance of clarity, the terminology used does matter.

Whilst important in themselves, these insights also signal a wider issue about system readiness to embrace the ambiguity and 'chaos' involved in dealing with complexity and change like this. Interviewees' expressed wish for clarity and accounts of discomfort with complexity could also indicate that the NAPC and others now need to focus their support more on system leadership capabilities and development support. This is something that will become critical as local partners move more deeply into system-wide and population-focused working.

Challenges in reaching and engaging sufficiently with local people

Another area that interviewees highlighted was the current challenges in getting a representative view of the needs of local people, particularly those who are most vulnerable and disadvantaged.

> *It's always difficult getting representative patients' involvement*
> *in design. Patient involvement can be powerful, but those who*
> *are disadvantaged in our communities – the very elderly, the*

> *frail, those not on social media, those with mental health problems, the homeless, children too – these are all groups of people whose voices are rarely heard within the system.*

Interviewees recognised that engagement is a critical component of new ways of working but reported a lack of ability to do it properly as yet. They gave the following examples of guidance they would find valuable:

- best practice about mobilising local communities

- how best to gather insights and use this to supplement existing data

- methods of creating solutions jointly with communities

- ways to engage with the most vulnerable people in their communities and help meet their specific needs.

For some interviewees, a question was surfacing about their role in this as clinicians, now that the focus is shifting from individual health and ill health to population-level and wellbeing-centred approaches. They report that there is much that they could contribute (for example, insights or opportunities from their clinical care) but had questions about how best to do this. There was a sense that they would value more support.

Thus, a potential area needing focus from the NAPC and others as part of the next phase of work on the primary care home model is the collation of examples of good practice in terms of engaging communities and the role of clinical leadership (for example, from this work and others such as integrated care or population health efforts) and the translation of this into practical support for action at the local level.

Views about the future

The GP Contract (Baird and Charles 2019; BMA and NHS England 2019) and *The NHS long term plan* (Murray 2019b; NHS England 2019) have been published since we carried out the interviews and inevitably these will have an impact on the future of the primary care home. Given that the primary care home is a type of primary care network and has influenced the development of the policy in this area it has already been shaping further spread in this way (Murray 2019a). However, interviewees were unclear as to what will happen to the spread of the primary care home as a concept in the future. There was a sense of both optimism and concern about this among local, NAPC and national interviewees.

The sense of optimism related to the opportunity afforded by the emergence of primary care networks to spread the learning from work on the primary care

home even further. Interviewees' insights will be helpful in aiding others with primary care network efforts.

But the concern we encountered related to not heeding some of the lessons outlined in this report. The main question about the future was related to this: '*Will policy-makers let go of top-down "command and control" ways to embrace the more hands-off, enabling and empowering leadership style of those involved in the spread of the primary care home?*'

Interviewees reminded us of the importance of central bodies in their own primary care home journey to this point and the great value that national leadership brought for enabling further steps. *"I think NHS England is still very instrumental in the spread because they've now taken arguably elements, if not all of the policy, and they've now made it a national imperative.'* However, they also stressed the approach used at that time for supporting the primary care home, which was valued, and the need to remember the key elements of this in the future.

> *When you say: 'Everyone needs to have a defined network', then there's a real danger you miss the point. The point is to get a group of willing people who come together, who believe that by collaborating together at a local level, we can make a real difference to health and population. It's a transformational change as opposed to a transactional change. A social movement, not a project.*

Thus, the journey of the spread of the primary care home is fascinating. The primary care home has evolved and grown over a relatively short period of time, from concept, to more than 200 sites, sparking momentum and debate. It has come to stand on the edge of an exciting period of uncertainty and potential, with a future story that could be as much if not more interesting than the sections in this report just gone. It seems that much now rests on emerging decisions about the 'how' and the lessons contained in this report.

5 Overall reflections

In this section we explore briefly some of the dilemmas that this research has raised and summarise our thoughts about the implications for the future work of the NAPC and others in their health and care transformation efforts.

The new future – this needs focusing on now

This research has revealed many insights about the spread of the primary care home concept. Of all the findings, possibly the most striking is the disconnect that exists between evidence about transformation and the realities of delivering this in practice. It was evident that transformation in this case was brought about by a handful of insightful leaders in NHS England, the NAPC and locally who 'fought' against constraints such as fragmented structures, limiting practices, overwhelming workloads and severe workforce challenges (Beech *et al* 2018), to generate opportunities and momentum for a new way of working, often despite 'personal impact' (Anandaciva *et al* 2018).

The primary care home concept has provided a loose model to articulate local aspirations for a new way of working. The NAPC has helped to foster national recognition of and support for this, and facilitated local connections to share learning. While this concept is to be recognised and celebrated for its strengths, it also signals a major gap in the current health and care system. There is clearly an interest among staff to work differently, and a recognition that this is part of the way forward for a sustainable future. But without the ability to even cope with 'now', thinking about the future becomes a near impossibility. This tension exists unhelpfully to compound transformation efforts, and warrants further focus by the NAPC and others working to transform health and care in the future. Additional funding is helpful, but this alone is insufficient (Collins 2018).

In supporting clinical leaders to transform services, more is needed to understand and address the issues of 'now', as well as inviting and supporting leaders to create a new future (reform from within – a 'bottom-up approach').

Enabling further spread

When considering **positive approaches** to spread, a number of facets have been described (Horton *et al* 2018). In our research we heard from interviewees that the NAPC used several features successfully to help spread the primary care home concept (McCanon *et al* 2007) including:

- The communications team in NHS England and the NAPC carried out awareness-raising.

- NAPC leaders visited sites or used opportunities at other events to share stories and experiences.

- Behaviour change was enabled through the community of practice within the conditions of a safe environment and a network of peers.

- The primary care home model had a flexible design, used a variety of methods and the NAPC supported local leaders to develop the concept at the local level.

Our work suggests that these are features that the NAPC should continue to champion in its work.

The NAPC and others should consider a number of additional areas further in the next stages of its work. For example, the more open nature of the primary care home concept has enabled many areas to buy in to the concept and start creating local solutions. This has resulted in a variety of models as teams work to use local assets and design ways to meet needs locally. There is thus a need to build more sophisticated information and insight systems in terms of the **impacts being delivered** across England – rather than activity per se, which will be varied due to the variation in the models used in local areas. Especially helpful would be a focus on the impact on population-level outcomes, particularly as this is a powerful driver for further spread.

We have already outlined the need to support local areas to **address barriers**. The national-level influence of the NAPC in this work, which we have detailed in this report, has been a big asset in helping to do this. Finally, there needs to be a shift from a predominant focus on primary care to leadership practices that **enable wider cross-system working**. This requires a greater focus on nurturing necessary skills and practices, explored more in the next subsection.

Supporting a new leadership approach

Throughout this research, it was clear that the leadership approach used at local, regional and national levels was a key enabler for the spread of the primary care home. There are four lessons from the research to note.

First, there is a need for **practical support for leaders** at all levels to bring about new ways of working. Our work shows the importance of three components of support for spread:

- national efforts to enable local working

- practical support to create local solutions

- an enabler function to connect efforts and foster learning.

Second, the role of **clinical leadership** is important in the spread of the primary care home – in terms of both leadership from respected individuals and also leadership that enables peer-to-peer spread. This seemed to be a key factor in enabling others to connect with the work and take up or spread it further. However, we found a need to build on this and now support clinicians to develop their clinical leadership in the context of more system-wide working for population health. There is interest in and great potential for this, but as of yet there is a gap in helping to contextualise opportunities and approaches for working in new ways (Timmins 2015).

Third, there is a need to create a **shared language of leadership** to help support the spread of transformative practice. We were interested that some interviewees referenced specific leadership theories, suggesting that an awareness and understanding of these theories was helpful, enhanced by skills and conscious practice, to strengthen the spread of transformational change.

And fourth, in the current constraints of a pressured system, we noted the importance of **giving people a sense of hope and optimism**, connecting with their existing aspirations and making change feel achievable (while also acknowledging and helping to address some of the major challenges they face). We heard from interviewees that a clear shared sense of purpose exists across the system, particularly in frontline and clinical-facing roles, which shows a sign of dedication to the public. Work on the primary care home model has tapped into this in order to engage people, and it has then supported them to progress local efforts by building positive energy, while taking steps to remove obstacles to progress where possible.

Considering next steps

The findings of this research coincide with an important stage in the development of the primary care home model and wider primary care. It is hoped that insights from this report will aid both given the involvement of the NAPC and partners in wider efforts to transform health and care.

We recommend that attention is now given to the strengths of the primary care home model and areas for further work, and that these are used to **support ongoing practice**. Given that the broader policy agenda has moved on with integrated care, primary care networks and population health approaches, the NAPC needs to set out how the insights from the primary care home model can

contribute to these developments, and what the NAPC itself can offer to support them.

A particular focus is needed not on the case for working on population health more collaboratively across health and care partners, but on the **practicalities** of how this can be achieved, for example:

- how to define the fit of the 'primary care' component of the primary care home in the context of a wider population system

- how to connect with other contributors of a population health system

- how to describe the potential impact of the primary care home particularly on population health outcomes

Additionally, we recommend that the NAPC shares its knowledge about and approach to leadership practices for the spread of the work on the primary care home model. In working to support NHS England, the NAPC should continue to include the insights from the variety of people who contributed to this research into the discussion. It should not only focus on guiding the development of technical strategies but also help to highlight what is missing and what is needed to support leadership development. Importantly, it should help to create the **right conditions** for the spread of good practice to transform the health and care effort in a way that benefits patients, staff and the public.

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7   Acknowledgements

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Among her consulting skills she has specialist skills in the design and facilitation of dialogue processes for resolving organisational issues. These skills are best employed where there is a need for open conversation about complex issues, usually helping stakeholders to find a collective way through the issues. Collaborative leadership is a particular area of interest and current research.

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