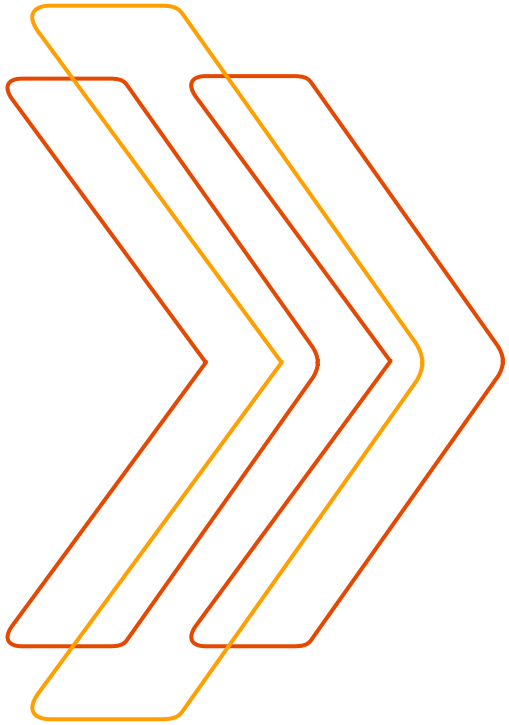
The Kings Fund

Ideas that change health and care

How to make change happen in general practice



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Introduction

Change can be difficult in any organisation and general practices are no different in that respect. But general practices are funded and run in a different way to most of the NHS and need to approach change in a way that that reflects that difference.

The growing crisis facing general practice, where demand is outstripping available workforce, means that, as integrated care systems (ICSs) take on responsibility for NHS resources, understanding how to make change happen and happen well in general practice is vital.

ICSs will need to make sure any changes are based on what has been shown to work and given the best possible chance of succeeding.

In the report *Levers for change in primary care*, we outlined the findings from the published evidence on how change happen. That report was commissioned by NHS England and published alongside the Fuller stocktake on primary care.

In this document we set out four principles drawn from this evidence to highlight how to make change happen. For each principle we describe why it matters, and what it might mean for those working in general practices and in ICSs. However, it is worth noting that these ideas would equally apply at a national or place level.

We hope you find these principles helpful – they are not new but leaders in both general practice and ICSs will need to demonstrate they truly understand them and implement them in order to see successful and effective changes in general practice.

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1

Changes work best when they're driven from the bottom up

What does the evidence say?

For people to deliver change in their places of work, they need to be involved and engaged in the process (**Brooke-Sumner *et al* 2019**). If this doesn't happen and changes are simply imposed, the evidence suggests that there's a real risk that efforts to bring about change and improvement fail, and could even make things worse by causing staff to feel disenfranchised, alienated and ignored (**Gosling *et al* 2019**; **Pettigrew *et al* 2018**; **Madavia *et al* 2017**).

There is also a risk if processes of change are too top down that they are designed in a way that is unintelligible to staff, whose ability to improve things is then compromised by a lack of understanding (**Gray *et al* 2018**).

Bottom–up approaches help avoid these risks – and also allow local knowledge (**Levesque *et al* 2015**) and professional expertise to be fed into processes, making them more likely to succeed.

Why does it matter?

Change in general practice, such as improving access, will mean changes to how clinicians and practices work. There is no shortage of initiatives and ideas of what those changes could or should be, and many case studies that show how particular changes have been implemented to great success. The evidence is clear that for any change to be effective it must have the buy-in of those who are directly affected by it. Without that, even initiatives with the most compelling cost-benefit analyses will not result in positive change.

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What does it mean for me?

For general practice teams

- Don't rely on others to create change – take ownership of improvement efforts by recognising the team's role in bringing about positive change.
- Decide how you measure your improvements based on your own priorities.
- Use patient and staff surveys to inform processes of change.
- Take a continuous approach to improvement, consistently checking and questioning.

For ICSs

- Use a 'with' not 'to' approach when you are working with practices, even though that approach might take more time.
- Support teams to develop their own metrics.
- Facilitate the use of local knowledge.
- Offer/provide access to a range of support and expertise that practices can draw on, including data analytics, organisational development and estates expertise.
- Value and support practices in their improvement efforts.

2

Financial incentives and targets can change activities, but that's not the same as improving outcomes

What does the evidence say?

Evidence shows financial incentives and targets can be effective at shifting where clinicians spend their time and focus (**NHS England 2018**), and increase certain types of activity, so long as targets are set appropriately.

However, increases in activity are not the same as improving quality of care or outcomes for patients. Indeed, evidence does not suggest that incentivised areas of care improve at a faster rate than other areas. Beyond this, there is a risk highlighted in the literature (**Doran *et al* 2011**) that by focusing on the actions that are incentivised, others fall by the wayside. There is also some evidence that the use of pay for performance can increase health disparities, as those organisations in more affluent areas find it easier to achieve targets.

Why does it matter?

Financial incentives are tempting for policy-makers and commissioners to use, particularly for 'contractor' professions such as general practice or dentistry, as even small changes in cash flow can have an impact on small businesses. However, the English NHS is an international outlier in the extent to which it has, over its history, used financial incentives to drive improvements in general practice. The danger of this approach is that there is a significant risk of perverse incentives. By using financial incentives and targets, particularly at national or regional levels, it's possible to distort priorities and hinder practices from addressing the priorities that staff and patients feel are most important.

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What does it mean for me?

For general practices

- Having a well-chosen locally owned set of metrics can be an effective way of focusing activity.
- Once a target is set in one area, consider which other areas may now get less attention.

For ICSs

- Set up high-level targets carefully and sparingly; consider complexity and the potential for unintended consequences.
- Be aware that financial incentives to create new services (**Tan and Mays 2014**) risk creating confusion and making things worse.
- Know that incentivising increases in scale might not lead to improvements in cost-effectiveness or quality (**Pettigrew *et al* 2018**).
- Continuously evaluate the effect of targets, including the possibility of worse outcomes in a different area.

3 The ‘soft’ stuff is important

What does the evidence say?

Cultural factors are enormously important for the success of improvement initiatives in general practice. At ICS level, recognising this means ensuring that different levels (from neighbourhoods to systems) within the NHS agree on goals and act in a co-ordinated and unified way (**Tan and Mays 2014**). It also means taking informal networks (**Stokes *et al* 2014**) and peer support across the system just as seriously as hierarchical relationships and formal systems and processes.

Studies of high-performing organisations that have successfully implemented change programmes show that they value and invest in local leadership (**Crabtree *et al* 2020**), are clear with people about their role within processes of change (**Allan *et al* 2014**), and free people up from pressure and bureaucracy that can make people feel uncomfortable trying out new ways of working (**Gosling *et al* 2019**).

Why does it matter?

Practice-level leadership is crucial to the success of any change programme. If staff become stressed or frustrated or feel like they are being bombarded with impossible demands, it will affect their ability to deliver change and improve ment. For people to perform at their best they need to feel that they have the safety to test and to fail; to work across traditional boundaries and to build trust. Local leaders will also need to feel that they have similar trust and support from the wider system.

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What does it mean for me?

For general practices

- It takes time to make change: staff need to be involved throughout the duration of the journey, and space needs to be created for conversation and discussion.
- There are no 'perfect' processes. That's okay – incremental progress can still create positive momentum.
- This momentum can be built by celebrating successes and creating a sense of shared achievement.
- Be open to, and prepared to endure, the discomfort that can come from trying new things.

For ICSs

- Be careful not to bombard frontline staff with too many messages or obligations.
- Support practices to build relationships and trust with each other.
- Provide access and support for training in the leadership skills needed for change.
- Create and use comparative data to facilitate learning and engagement.

4

People need capacity and capability to make change happen

What does the evidence say?

There is strong evidence showing that facilitating processes of change, and ensuring they have the best chance of being successful, requires both financial support, and serious preparation and planning (**Solyu *et al* 2020**). At all levels, there needs to be a process of 'readying' and of getting buy-in from all stakeholders – a process that relies on strong, effective, and purposeful leadership to overcome levels of change resistance that are natural in most working environments.

Success is also affected by factors including leadership skills, HR and data skills within practices (**Smith *et al* 2020**), and by the extent and provision of external support.

Why does it matter?

Workloads in general practice are already extremely challenging. Even though change might potentially free up time in the long run, in the short term finding the headspace and skills to design and implement changes is very difficult. Many practices, in common with other small organisations, are unlikely to have ready access to the full range of skills needed to implement changes, for example, data analytics, organisational development, HR or digital skills.

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What does it mean for me?

For general practices

- Build internal capacity for change and make everyone part of the process; don't just spring initiatives on staff from nowhere.
- Consider what information and resources can be shared and ask the integrated care board (and other local networks) for support.
- Build clinical and managerial partnerships across practices – practices can help each other through processes of change.

For ICSs

- Provide a range of flexible support to respond to differing needs across general practice teams.
- Keep in mind that change and improvement initiatives work best if the capacity is built within the team.
- Clinicians often respond better to their peers than to hierarchical systems and bureaucracies. This should be reflected in where capacities sit.

Conclusion and additional resources

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In this resource, we have condensed the key messages from our review of how to make change and improvement happen in primary care. We found that traditional 'hard' levers for change, such as financial incentives and targets, are perhaps more limited in their efficacy than one might expect. Conversely, we found that 'soft' factors are crucial – and how it is important to build change and improvement initiatives in a more organic and bottom-up way.

If you want to read more detailed findings from our literature review, you can see the full write up of our findings **here**. These findings have big implications both for ICSs and for individual practices. Much closer attention needs to be paid to the cultural factors that surround change and improvement initiatives, and real consideration needs to be paid to the potential negative consequences that can come from top-down, hierarchical approaches.

If you are interested in this research and want to find out more, please contact Beccy Baird, **b.baird@kingsfund.org.uk**.

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