Kent Surrey Sussex Academic Health Science Network

Unity Insights

Foundry Healthcare Lewes PCN

Thought leadership piece

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Executive summary

Purpose of the report

Over the last 5 years, the Foundry Healthcare Lewes PCN has implemented transformational changes based on a population health management approach, utilising a population segmentation method to better serve its population based. Less than one year after the publication of the Fuller Stocktake report, this thought leadership piece explores whether the Foundry model of care constitutes a local reply to the ambitions of the Fuller Stocktake report. It is produced by Unity Insights and commissioned by Kent Surrey Sussex Academic Health Science Network (KSS AHSN), in addition to a retrospective evaluation.

Key discussion points

- **Building integrated teams:** the Foundry was able to build integrated teams through the merger of its three practices into one, which provided the framework to pool resource and reorganise the workforce to better align with clinical priorities and better serve their population's needs (via the continuing care teams and Green Hub). The establishment of the Urgent Treatment Care (UTC) is a further illustration of building teams across organisational boundaries to provide enhanced services and improve the system resilience.

- **Working with people and communities:** was in part achieved through the public engagement initiatives conducted during the merger and the reorganisation of the Patient Participation Group (PPG). More efforts are needed to embed patient representation at the inception of a project to co-design the solution.

- **Improving access:** is a key aim of the Foundry model, enabled by the population segmentation and the capacity planning tool. This is supported by the findings of the evaluation report, although patient feedback underlined the continued challenges to curb the bottleneck observed in primary care.

- **National environment supporting locally driven change:** the Foundry model was able to capitalise on the national and regional funding opportunities thanks to its proactive strategic vision. It also utilised the support offered by High Weald Lewes Havens CCG on three key transformation levers: its workforce model, its estates, and its use of data.

Conclusion

The interventions implemented by the Foundry echo and answer many of the ambitions presented in the Fuller Stocktake report. Its journey presents a roadmap for delivering integrated services using population health management and a dynamic workforce model to tackle the challenges of providing timely, appropriate and personalised care. Whilst the model has the potential to benefit many PCNs, tailoring of the interventions and bottom-up leadership will be pivotal for its successful adoption.

1. Acknowledgment

The authors would like to thank a number of people who have provided helpful insights and engaged in the evaluation activities during the production of this report. We are deeply grateful to the Foundry patients and staff members who partook in the interviews for the testimonies and their suggestions. It also includes partners from other NHS organisations who generously offered some of their time to provide accounts on the Foundry model of care or to support the data collection, these are, namely: Elizabeth Tinley (Senior Manager, Primary Care Contracts, NHS Sussex), Hugo Luck (Associate Director of Primary Care, NHS Sussex), Dr Nayan Patel (GP Principal, Blackheath Standard Surgery; Clinical Director; Blackheath and Charlton PCN) and Richard Titheradge (Lead Performance Business Partner - Adult Services, Sussex Community NHS Foundation Trust).

2. Note to the reader

Please note that this report can be read in conjunction with the Foundry PCN evaluation report produced by Unity Insights. Throughout the report, the use of jargon will be avoided to allow clarity of understanding across a wide range of stakeholders. To this effect, please note the following considerations with regards to vocabulary:

- **Primary care network (PCN):** A network made up of local GP practices that work together with their communities, pharmacies, social care, mental health, hospital, and voluntary services. A PCN typically serves a community of 30-50,000 patients, they provide personal care and utilise collaboration to benefit from economies of scale.
- **Clinical commissioning groups (CCG):** Membership bodies made up of general practices and led by an elective governing body comprised of GP's and clinicians. They began in 2013 and their role was to manage the NHS budget and commission healthcare. From July 2022 they were dissolved and replaced by integrated care systems**Invalid source specified.**.
- **Integrated Care Systems (ICS):** A partnership of organisations that plan and deliver collaborative healthcare services established in July 2022 following the implementation of the Health and Care Act (2022). They are made up of integrated care partnerships (ICPs), integrated care boards (ICBs), local authorities, place-based partnerships, and provider collaboratives (NHS England, n.d.a.).
- **Additional roles reimbursement scheme (ARRS):** A scheme introduced in 2019 to provide funding for an additional 26,000 roles across general practice to help create multi-disciplinary teams within PCNs (NHS England, n.d.b.).

3. Introduction

3.1. Context

Primary care services provide care and support to over a million people daily and often act as the first point of contact for people accessing NHS services (Fuller, 2022). However, both the public and the staff within the NHS are showing increased signs of discontent with primary care. In 2021, the overall patient satisfaction decreased from 53% in 2020 to 36%, making it the lowest satisfaction score since 1997 (Wellings, et al., 2022). The waiting time for GP and hospital appointments was one of the main sources of public frustration, along with staff shortages, and the perceived lack of government investment in the NHS. Similarly, both clinical and non-clinical staff are expressing their concern on increasingly difficult working conditions and the impact it has on patients. GPs for instance are highlighting the double threat of an increasing workload and the dwindling number of fully qualified GPs: the average number of patients assigned to a GP has increased by nearly 17% since 2015 (The British Medical Association, 2023). There are now just 0.44 fully qualified GPs per 1,000 patients in England – down from 0.52 in 2015 (The British Medical Association, 2023). Fewer GPs providing care for more patients increases the risk of harm and suboptimal care through decision fatigue. this also risks GPs becoming burned out. The annual leavers rate for NHS staff supporting GPs, nurses and midwives was increasing in 2021 and in a survey of 70 receptionists, 44.3% reported that they were highly unsatisfied with their role with many reporting a lack of recognition of the value of their work (Litchfield, I., Burrows, M., Gale, N., & Greenfield, S., 2022)

The pressure faced by primary care services was compounded by the pandemic both in terms of the impact on capacity and demand. Indeed, whilst practices were adapting to provide remote care and drive the vaccination efforts, there was a spike in early retirements in the first financial year of the pandemic (Beech, Fraser, Fisher, & Vestesson, 2022). The authors also note that November 2021 had highest number of appointments on record until that date, both including COVID vaccinations (34.8 million appointments) and excluding COVID vaccinations (30.5 million appointments). Moreover, there has been a steady increase in the number of people with two or more long term health conditions between 2004 and 2019, with an even greater increase amongst individuals in the most deprived areas of England (Head, et al., 2021). This capacity decline combined with an increase in demand has led to backlogs, with health professionals unable to provide the full care they believe their patients need. These issues are also more pronounced in deprived areas leading to increased health inequalities.

To overcome the pressure, exacerbated but not created by the pandemic, the NHS has set out ambitions of transforming the provision of primary care services in several policy documents such as the Five-Year Forward view (n.d.), the NHS Long Term Plan (2019) and the Health and Social Care Act (2022). The creation of PCNs and the establishment of ICSs are two of the levers introduced to support collaborative working between local authorities, voluntary sector, arm's length bodies (ALBs) and healthcare providers. PCNs support the creation of multidisciplinary teams in GP practices by funding additional roles such as social prescribers, clinical pharmacists, first contact community paramedics, and first contact physiotherapists are made available (NHS England and BMA, 2019). ICSs, through the Integrated Care Partnerships (ICPs) and the Integrated Care Boards (ICBs), provide the statutory framework to pursue this vision of joined up health and care services delivering better care for people in their area (NHS England, n.d.a.). Together, partnerships of organisations focus on developing a local strategy and commissioning the appropriate services to cover their population health and social needs. They also strive to include wider health determinants such as housing, unemployment, financial stress, domestic abuse, poverty, and lifestyle choices. Providing this holistic care can be done through various means such as utilising population health management (PHM) principles to identify specific population and prioritise particular services according to their needs (The King's Fund, n.d.).

3.2. The Fuller Stocktake Report

The 'Fuller Stocktake' report reviews how PCNs can best be supported within the emergent ICSs and presents numerous innovative projects looking to address current challenges. This is with the aim to ensure primary care remains the lynchpin of community-facing healthcare while also meeting the needs of people in their local area. Additionally, the report sets out a limited number of recommendations for NHS England, the Department of Health and Social Care, and other national bodies that will enable local systems to drive change in their communities and neighbourhoods. The report is a collaborative piece involving nine workstreams and four task and finish groups. It was commissioned by NHSE and published in May 2022. Dimensions developed in the report include:

- Building integrated teams in every neighbourhood
- Working with people and communities
- Improving same-day access for urgent care
- National environment supporting locally driven change
- Workforce model
- New approach to primary care estates
- Data, data, data

3.3. Purpose of this report

The thought leadership piece was developed in parallel to the Foundry evaluation report, and both produced by Unity Insights. It utilised the quantitative and qualitative findings, referenced the economic impact of the Foundry model but also drew insights from the stakeholder engagement conducted with the NHS Sussex ICB (Hugo Luck, Associate Director of Primary Care; Elizabeth Tinley, Senior Manager of Primary Care Contacting) and with the Blackheath and Charlton PCN (Dr Nayan Patel, GP partner and PCN Clinical Director). More information about the interviews conducted can be found in Appendix A: Interview methodology.

The report aims to answer the question, **“The Foundry model: a local answer to the Fuller Stocktake ambitions?”**. Firstly, it presents the main interventions constituting the make up of the Foundry model (and their associated timeline). Secondly, it explores to what extent it fulfils the ambitions of the Fuller Stocktake report, highlighting the objectives that were not met, and areas where the Foundry model goes further than the Fuller report. Finally, it addresses the question of the replicability of the Foundry model by describing the conditions and principles needed for adoption and potential impact if rolled out in contrasting areas.

4. The Foundry model of care

Foundry Healthcare Lewes Primary Care Network ('Foundry' or 'FHL PCN') is a single GP practice and PCN that formed following the merger of three GP practices (School Hill, St. Andrews and River Lodge) in 2019 with the goal of building a more resilient model of primary care based on population health management principles. It serves a total population of 28,219 (NHS Digital, 2022). The Figure 1 and Figure 2 present an overview of the interventions implemented and their associated timeline, a more detailed description of the interventions can be found the Foundry evaluation report.

Interventions map

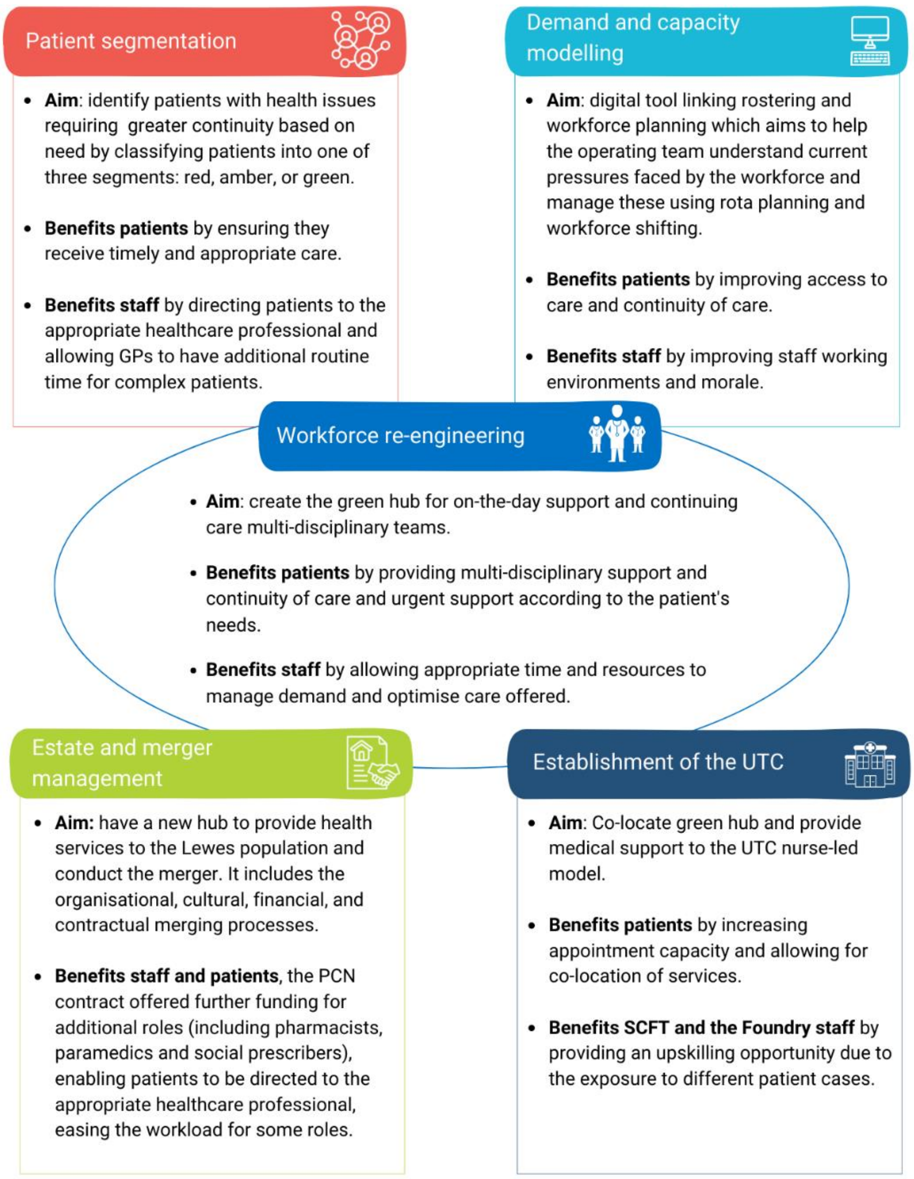

Figure 1: Summary of the interventions implemented at the Foundry (with beneficiaries).

Timeline of the different interventions

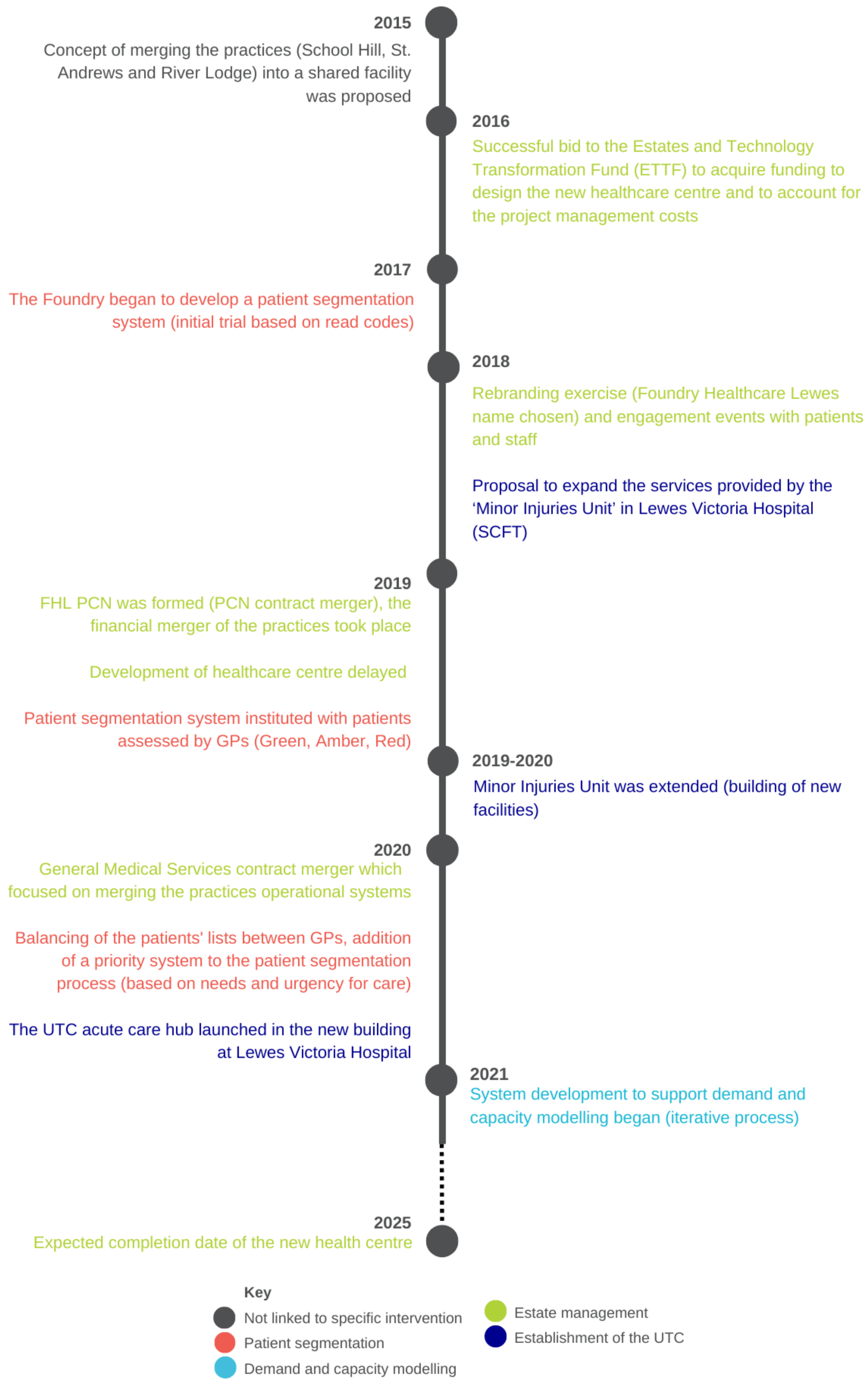

Figure 2: Implementation timeline of the interventions at the Foundry (the colour of the text corresponds to the specific intervention).

5. Does the Foundry model answer the Fuller Stocktake ambitions?

This section explores whether the key dimensions presented in the Fuller Stocktake report are realised in the Foundry, it also highlights challenges and enablers.

5.1. Building integrated teams in every neighbourhood

The practice merger

In the Fuller Stocktake, building integrated teams is described as “bringing together previously siloed teams and professionals to improve patient care” (Fuller, 2022). Through the practice merge, the Foundry was able to pool resources and to reorganise its workforce to ensure it aligns with the clinical priorities identified and serves the population’s needs better. The workforce also encompasses roles such as social prescriber, dementia care coordinator and clinical pharmacist echoing the psychosocial model of care encouraged by the review.

Enabling collaborative working internally

The Foundry was able to build strong relationships across the workforce thanks to the work conducted by the practices prior to applying for the merge. Notably, this included the practices adopting the primary care home model – an innovative approach to strengthening and redesigning primary care (NHS England » Primary care home model). This was a precursor to the PCN model which introduced focusing of the role of the collaborative working between healthcare professionals to provide enhanced care for the community (NHS England » Primary care home model). This benefitted the merge by integrating aspects including the teams (for example, the three GP teams, the three nurse teams, etc), policies, and computer systems – putting the practices in a better position to successfully merge. Further, it helped to create common ground between the practices team and avoid an “us versus them” divide prior to the merger.

Bringing together individuals from different teams and organisations can be challenging. Although this was done successfully for the Foundry overall, there was still tensions between some staff members and the loss of some individuals. Often this is the result of differences between practice approaches, policies, and procedures and whether some members of staff disagree or feel short-changed by process changes after the merger.

The establishment of the UTC

The establishment of the UTC, in the collaboration between the Victoria Lewes Hospital and the Foundry is another example of creating an integrated teams working together across organisations. The provision of medical oversight and the co-location of services to funnel some of the appointments for Foundry patients at the Green Hub benefits both organisations. It benefits patients by on the one hand providing enhanced services (via the UTC) and on the other hand offering more flexibility for Foundry patients (via the Green Hub).

One should note that setting up the UTC, an innovative model to jointly delivery care pushing the boundaries of commissioning, was a challenging endeavour which required time (2018-2020), resources and commitment from various organisations (Sussex Community Foundation Trust, FHL PCN, Friends of Lewes Victoria Hospital, High Weald Lewes Havens CCG). It also required the definition of local agreements between clinicians to determine clinical responsibility, e.g., what was appropriate for an advanced nurse practitioner consultation compared to what required GP involvement, in addition to agreeing on patient flow between Foundry and out-of-area patients visiting the UTC.

Support from the system to encourage the redesign of Minor Injuries Units and UTCs was important, so that when operated collaboratively with primary care, this could help to tackle gridlocked GP practices and A&E services. Levin, Fleming & Crighton (2020) identified convenience and short wait times as factors for people attending emergency departments, with less than one third of patients considering they had a medical emergency. Gatfield, et. al. (2021) noted that active consultant presence in minor injury care provided for early and definitive plans based on orthopaedic surgeons supporting minor injury units. This could also ensure that the UTC utilisation as envisaged in the Foundry model can be replicated in other areas.

At present, the Foundry has integrated care with some mental health and third-sector services but there is still ongoing work to improve the integration with other health services such as the community nursing team.

5.2. Working with people and communities

Public engagement during the merger

Looking back at the merger, an enabler mentioned during the interviewees with the Sussex ICB was that the Foundry recognised the importance of public engagement. Indeed, they held a number of public events which were widely advertised and attended (by Foundry patients and non-Foundry patients alike). The events provided detailed information about the merger such as plans, proposals and what these meant for the local population, as well as an opportunity for the public to ask questions.

“I would say they stepped far beyond what they had to do in terms of consultation and engagement with their patients and public.”

- *Sussex ICB interviewee*

Nevertheless, it was reported in the patient interviews that there was confusion about the what the Foundry represented, suggesting that more needed to be done to continue to establish the organisation's identity.

Patient representation

The appointment of a communication and engagement officer and the reorganisation of the Patient Participation Group (PPG) demonstrates the Foundry's efforts to better work with people and communities. Galvanised by the wave of volunteering witnessed in Lewes during the pandemic and by the push for more patient representation in co-designed initiatives, the Foundry decided to take stock of how their PPG was operating and whether it fulfilled its role effectively. Since the merger, the PPG was inherited from the three practices, each chair was still attached to their practice's identify making it more a juxtaposition of the three groups rather than one cohesive entity. Although the Foundry engaged regularly with the PPGs it may have felt more like a tick box exercise, they were unable to effectively channel the patients' knowledge to inform the improvement projects. For instance, the meetings often lacked direction or were centred around topics GP practices or PCNs cannot influence, such as fracking or NHS price code. Additionally, the PPG lacked flexibility in the type of participation, which was offered to patients, with bimonthly face-to-face PPG meetings only, which in turn limited how representative of the Lewes population it was. To address these elements, the Foundry put together a new proposal for how the patient group could be organised: the core principle was to reach out to all patients to widen participation, and to group patients interested in getting involved based on pre-determined topics. This form of participation was diversified to include a mix of online and on-site projects. Some examples of ongoing engagement projects include:

- The establishment of an expert patient panel on improving access composed of 20 patients invited to a variety of meetings to speak with Partners and Managers on their experience of accessing the Practice and to co-design priority areas for improvement.
- Site Improvement Plans to upgrade the appearance of each of the surgeries developed in partnership with patient representatives.
- Introduction of a digital ambassador to support patients with new digital initiatives and to help reduce digital exclusion.
- Patients testing a mobile application to support self-management of Chronic Obstructive Pulmonary Disease (COPD).

Despite patient representation in quality improvement projects increasing, the Foundry recognises that it can still be reactive at times, e.g., utilising patients' inputs to test a solution rather than to have patient representation at the inception of a project to co-design the solution.

5.3. Improving same-day access for urgent care

Access and continuity of care

As presented in the intervention map in Section 4, access to care and continuity of care were two key priority areas for the improvement work that the Foundry has conducted. The evaluation findings suggest that the Foundry model has successfully improved in each, however, further improvement is possible despite being five years into the implementation of the new model.

Key to the observed improvement was the development of Green Hub and Continuing Care Teams to provide appropriate care according to the patient's need, with the workforce redesign being critical to enable these changes. Access to care can be complicated to measure objectively. In the Fuller Stocktake report, access is defined as improving access to the community "when they need it" (Fuller, 2022). The Foundry utilises their segmentation-prioritisation approach to define this demand from their population. Foundry has made substantial progress towards delivering the model as they have designed it, which generates improvements to access for the urgent needs of their 'Green' patients and for their high priority 'Red' and 'Amber' patients. Despite this, aggregated measures such as "the percentage of appointments booked on the day", have remained stable and broadly similar to the regional and national averages (as shown in the *Results* section of the evaluation report).

Set against this, patient insights gathered through the evaluation indicated challenges and frustration amongst patients regarding access to care at the Foundry and responses from patient interviews regarding continuity of care were mixed. Whilst these findings must be contextualised within the national picture of increased demand and strained workforce in primary care, it remains a limitation in the reception of the Foundry model by patients.

Impact on other services

The Fuller Stocktake report highlights that one of the "three essential offers" of integrated primary care is "helping people to stay well for longer" (Fuller, 2022). This is evidenced in the short term through a reduced flow of patients into more acute healthcare services, as analysed in the evaluation report, with 12,480 fewer bed days and 170 fewer ambulance conveyances estimated since over the 5-year evaluation period.

5.4. National environment supporting locally driven change

A strength of the Foundry model was the long-term financial strategy put in place by the practice and how it utilised different funding streams made available for primary care transformation every year. Whether the funding opportunity is linked to the GP Forward View (2016), the PCN maturity matrix (2019) or the Investment and Impact Fund (2021), some funding is allocated for primary care transformation and can be applied for every year. The Foundry was able to proactively plan how the funding could be used to support multi-year development projects, including recruitment. This is not possible if practices or PCNs develop their business cases once a “new” funding pot is made available, indeed decisions about a change in the workforce, for instance, have to be budgeted for at the start of the financial year. This forward planning meant that the Foundry was willing to support in-house some of its improvement project costs, knowing that funding from national partners would consistently be awarded and would cover them.

Another key piece of the supportive environment was the role played by High Weald Lewes Havens CCG in facilitating local leadership by back-filling time for clinicians to attend training so they can develop the skills needed. They also supported the practices merger, providing expertise for the contractual, financial, and organisational transformations.

The open and regular communication between the CCG and the Foundry about the General Medical Services (GMS) throughout the merger was helped by the fact that the commissioners and practices all had offices located in Lewes. Therefore, they were able to avoid the “red tape”, convey face-to-face meetings to solve problems collectively and engage senior-level management more effectively.

The role of national partners to create an environment conducive to integrated care is presented throughout the Fuller Stocktake. It highlights that whilst financial support is needed, more is required to enable local teams to adopt innovative models of care. Workforce, estates and data are the three major levers where appropriate support can drive the changes needed to realise the integrated care services vision.

5.5. Workforce model

The ambition to build a sustainable workforce was one of the main drivers of the transformations conducted at the Foundry and is a key expected benefit for Blackheath and Charlton PCN. Indeed, as documented in the Fuller Stocktake report the challenges posed by the workforce gaps are complex and require a profound redesign as well as investment to be addressed. The interview participants agreed and declared “at this moment in time, people can throw money at us, but we haven't got the human resource”.

Recruitment, upskilling of the existing clinical and non-clinical roles, and the creation of teams with varied expertise organised around a clinical priority are part of the workforce strategy implemented at the Foundry as demonstrated by the following elements:

- The increase in salaried and partnered GP’s, with 8 GP’s recruited in 2012/22 alone, and 12 recruited overall l between 2018/19 and 2022/23.
- The change in locum staff utilisation with 720 sessions saved between 2018/19 and 2022/23.
- The utilisation of ARRS roles since the introduction of the scheme (just two FTE in 2019/20 for clinical pharmacist and social prescribing link work, rising to 16 FTE in

2022/23). The majority of roles (7.2 FTE) are care coordinators, but also include Pharmacy technicians (2 FTE), Community paramedics (1.25 FTE), Physiotherapists, mental health practitioners, and advanced practitioners (1 FTE each) and digital transformation lead (0.64 FTE).

Improving the supervision, development, and career progression in order to retain and realise the potential of clinical and non-clinical staff is a priority shared by the Fuller report and the Foundry. Indeed, this is evidenced by initiatives such as the creation of “Silver Teams” to drive quality improvement, the guaranteed protected time for leadership across a variety of roles and the training and mentorship opportunities offered to the Foundry staff. Another initiative to note is the year-long Leadership Development Programme offered to all managers and team leaders in the Foundry (13 people in total). Starting in 2022, the programme focuses on developing the skills of non-clinicians in managing and leading a large and complex organisation by providing a mix of internally and externally sourced training.

Another benefit of the Foundry model is the increased resilience of its workforce thanks to the Green Hub team as well as the operational tools implemented. As the Green Hub was the ability to absorb additional activities from Green and Amber patients, it enables the Foundry to be more resilient to system perturbations such as surges in demand or staff sickness.

5.6. New approach to primary care estates

The estate management journey of the Foundry PCN portrays well the challenges and opportunities described in the Fuller Stocktake report. The idea of collaborating under one roof was prompted by the inadequacies of the practice premises and the need to scale primary care to adapt to the increasing demand.

“The two clinical rooms yesterday and the day before were flooded […] we’ve been on a red list for new premises for School Hill for over 15 years.”

- *Foundry interviewee*

Despite a successful bid to the Estates and Technology Transformation Fund (ETTF), and the collaboration with the local authorities and a private developer to design the new healthcare centre, the construction of the new building was delayed and is now due for completion in 2025. Whilst a lot has been achieved by adopting a different clinical model and by working across multiple sites coordinated digitally, the example of the Foundry underlines the challenges of estate management in primary care.

The establishment of the UTC, on the other hand, illustrates how innovative building management and service provision can benefit neighbourhoods. Indeed, it was the drive for a better utilisation of the Minor Injuries Unit combined with the Foundry’s need to reduce pressure on the practice whilst still providing urgent care for patients who do not require continuity of care which made the establishment of the UTC worthwhile. In 2020, the UTC launched in the new building at Lewes Victoria Hospital. SCFT receives funding for the UTC and the Foundry is subcontracted by the SCFT to provide medical supervision. The UTC benefits both SCFT and Foundry staff thanks to the upskilling opportunity and the exposure to different patient cases respectively. It also benefits patients thanks to the larger and more resilient team.

5.7. Data, data, data

Data utilisation is the spearhead of the Foundry model as exemplified by Tempo, their in-house demand and capacity modelling tool which links rostering, workforce planning and patients' demand metrics. This allows the operating team to use real-time information to plan resources allocation effectively. The system development which began in 2021, has been an iterative process, with the collaboration with GP Networks enabling the integration of flexible staff pools in the software. The PHM approach taken with the patient segmentation is another example of the PCN's willingness to have a data-centric perspective. The crucial role of data in the Foundry model was echoed in the interviews with the Sussex ICB:

"This is the bit I think the Foundry really got right, is focus on the data […] They use that to predict not just their patients' footfall but their workflow, their rotas, their recruitment, they really get the data."

- *Sussex ICB interviewee*

To support with the ambition to create a data-driven system, the Foundry recruited a digital transformation lead and a software developer but also protected time for the GPs and the Chief Clinical Information Officer to take part in the modelling tool development.

The data-centric approach of the Foundry is also a powerful argument to convince other PCNs to adopt their model as it provides a clear roadmap of what existing systems can be utilised and it is a transparent way to present the concepts at play. This view was relayed by Dr Patel from Blackheath and Charlton PCN:

"It works, it is a very logical way of designing a system."

- *Interviewee*

Although the Foundry has strived to put data at the heart of their patient segmentation and capacity planning interventions, more support, time, and concerted efforts between organisations are needed for them to embody the Fuller vision of linked datasets driving the provision of integrated care. Indeed, the data collected by the Foundry is in the main operational and does not yet encompass outcome data. Similarly, the digital infrastructure to share data with community and secondary care is lacking, even for the care delivered jointly at the UTC.

6. How can this model of care be replicated in other PCNs?

This section examines the replicability of the Foundry model by considering the factors at play at the Foundry which influenced the deployment of this model of care, as well as the conditions and principles needed for its adoption by another PCN. Finally, it considers the estimated impact of the Foundry model and its potential variability in other areas. The interview with the Blackheath and Charlton PCN is referenced throughout this section, as it provides an example of a PCN which recognises the benefits of the Foundry model and on its journey to implement it. In addition, it is an interesting case study as the practices are looking to achieve collaborative and integrated working without merging their organisations.

6.1. What made it possible?

The elements listed below summarise the factors which influenced the success of the Foundry model.

- **Local leadership (bottom-up change):** in each practice various leads were selected to drive the change, this was agreed to ensure collaborative leadership and a balanced sense of ownership.
- **Strong shared vision embodied by practice staff:** from clinical and reception staff to board level engagement. GPs and clinicians were able to communicate their vision to other NHS organisations and local authorities.
- **Strategic long-term planning:** utilising the recurring funding made available for practices and PCNs in a proactive way and working closely with the ICB to benefit from their support (bottom-up change facilitated by the ICS).
- **Data-centric approach** to track and plan effectively.

A number of Lewes specific factors should also be noted:

- **Geographic proximity between the practices:** they were contained in a relatively small area and gathered a homogenous population.
- **Proximity with the CCG:** as they were a small team located in Lewes (at the time) it enabled them to gather relevant actors to propose and enact changes faster. This is likely to be difficult under the new system of ICSs and ICBs due to the geographical spread of the teams, and the added challenge of building or maintaining relationships remotely.
- **Practices willing to merge:** being a one-practice PCN presented some unique advantages, such as having a shared budget which enabled allocating the workforce across all patients based on needs and clinical priorities rather than on a per practice basis.

6.2. Adoption of the model - conditions and principles

Conditions

Building relationships

Throughout the interviews conducted for the evaluation and for this piece, a recurring element mentioned by stakeholders was the importance of building relationships and trust between practices, as a prerequisite for collaborative working. The role of PCNs in aiding and nurturing these interorganisational relationships was also highlighted. Indeed, although PCNs have existed since 2019, many of them lack a clear purpose and shared vision (McEvoy, 2022). According to Dr Patel, the COVID-19 pandemic was a game changer in this quest for identity of PCNs as "the COVID vaccination program gave a perfect opportunity to show what collaborative working looks like". If PCN establishment have facilitated creating these working relationships, it still takes time:

"The Foundry's journey started years before PCNs, it takes that long to build those relationships".

- *Interviewee*

Local ownership of the model

Testimonies from various stakeholders highlighted that local ownership of the model was a key element of success for the Foundry model. It was not a top-down approach, imposed by the CCG, but as a group of three practices coming together with a strong strategic vision, they believed in the benefits of working together and they designed the premises to fit with the processes (not the other way around).

"They need to want to change, it is not something we can impose."

"This cannot be a shotgun marriage […] because it will fall apart afterwards."

- *Interviewees*

Staff buy-in in the model

In order to operate changes at scale in primary care, agreement from all professional groups represented in the practices is needed. It cannot be limited to board members' buy-in and must involve clinical and non-clinical staff members at different levels of seniority. Some of the conditions described in this section (local ownership, clear objectives, and national narrative) will contribute to convincing staff members to adopt the model, as will presenting some of the long-term benefits only achievable after the system transformation. For example, many GPs advocate for the introduction of 15-minute-long appointments (instead of the current 10-minute target) to reduce the risk of harm and suboptimal care through decision fatigue (The British Medical Association, 2023) Patient segmentation and improved triage has the potential to release GP time by ensuring that patients are seen by the right healthcare professionals and by enabling better demand and capacity planning. Presenting this long-term favourable objective is a good way to incentivise clinical staff to engage in transformation changes.

Clear objectives

Closely linked to creating shared vision and fostering local leadership, establishing clear objective is a sine qua non condition to redesign the model of care. Some of the objectives mentioned by Blackheath and Charlton PCN were:

- Maintaining a good standard of medical care
- Ensuring general practices are sustainable
- Creating an environment conducive to recruitment and retention

National narrative

When asked what support from the healthcare system was required, interviewees emphasised the need for a concerted communication strategy and a strong national narrative. These would promote collaborative models of care such as the Foundry model and help reduce the resistance to change experienced currently.

"Where we are going, and why doing nothing is not an option."

- *Interviewee*

Shaping the national conversation about what primary care services can offer, how they are changing to accommodate current pressures and how these innovative models of care benefit patients was presented as key role for NHS England but also for public health authorities.

"If they hear the message enough, they will realise the change is inevitable."

- *Interviewee*

Support needed from national partners

Whilst financial support was deemed paramount to supporting PCNs implementing innovative model of care, the stakeholders interviewed also noted that access to the right expertise to accompany them in their transformation journey was lacking. Change management, leadership, pathway redesign, and data analytics were some of the capabilities mentioned. They stated that having a directorate of people with experience in system transformation, who would be able to provide peer-to-peer support to guide PCNs looking to implement the Foundry model would be very valuable. Similarly, establishing a community of practice to gather standard operating procedures, to share funding opportunities for PCNs and to spread learnings about enablers and blockers was another concrete step to support emerging PCNs.

"It is about utilising existing resources to bring about the transformational change."

- *Interviewee*

One should note that the expertise needed to support new PCNs adopting the Foundry model cannot be solely funded by clinical and operational NHS staff volunteering their time in additional to their daily responsibilities. Indeed, relying on busy and pressured healthcare professionals to support other PCNs will impact how quickly these transformational changes can occur.

"If you want transformation, you have got to be prepared to invest in it […] It's not a free good […] or otherwise your pace of change is much slower."

- *Interviewee*

Training opportunities or the ability to back-fill roles so that designated individuals can have protected time to implement or guide the implementation are potential ways to organise this support. This could ensure that PCN team have the skills needed to develop a long-term strategy and to move away from reactive management.

Another key role of ICBs mentioned during the interviews was to facilitate collaboration between secondary care providers and GP practices, indeed they pointed out that the difference in size of the organisations meant that it is was not a level-playing field for discussions or negotiations.

"Our role is to broker these decisions and to bring acute and mental health trusts around the table."

- *Interviewee*

They noted that the assumption that ICBs have a statutory mandate on providers needed to be tempered. Whilst they can help bridge the gap between services, the remit of what they can dictate to providers is very limited.

Where to get started?

This section presents a checklist of the activities to conduct first for a PCN looking to adopt the Foundry model. It is based on the insights provided through the stakeholder engagement.

- **Assessment of local needs**: tailoring of the model according the PCN-specific characteristics. This includes population demographics and wider determinants of health but also workforce review, and taking stock of the ongoing collaborative initiatives intra and inter practices as well as with other organisations (secondary care, community care, local authorities, tertiary sector, etc.).

- **Initiating the relationship building journey:** by encouraging partners to be honest and transparent about what they want. Define clear objectives and identify the interests rather than the positions will help to create a common vision and set realistic expectations.

- **Start small to create a pipeline of successful collaboration:** for instance, practices could start by implementing extended access and utilising ARRS roles. This would enable them to gain experience in managing a rota staffed by existing resources at PCN level. A further step in this roadmap could be the sharing multidisciplinary staff around specific clinical priorities such as medicines optimisation or musculoskeletal (MSK) health.

- **Embedding collaborative working by standardising clinical and operational practices:** For instance, standardising repeat prescribing across practices to promote collaboration between pharmacists and ARRS roles.

- **Staged changes:** implement the changes progressively, both the Foundry and Blackheath and Charlton PCNs adopted a modular approach to system transformation. This phased-up change could be structured as follows:

  - Phase 1: patient segmentation by rating patients Green (G), Amber (A) or Red (R) based on their clinical needs. Clinical templates compatible with SystmOne and EMIS and the software developed by the Foundry are available to support with this task.
  - Phase 2: practice appointment data audit to understand how many appointments can be offered by each practice based on the level of G, A, R patients in the population. At this stage the capacity planning is likely to still be conducted at a practice level, pooling of resources will take place in subsequent phases.
  - Phase 3: sharing of part of the clinical and non-clinical workforce, this could include pharmacists, physiotherapists, reception staff. Creation of joined rota to pool resources across practices.
  - Phase 4: sharing of the rest of the workforce (nurses and GPs) to manage acute on the day demand.

6.3. Potential impact

The conclusions of the evaluation report, which looked to identify the costs and benefits, are that the Foundry model is estimated to deliver tangible value in the order of £1.50 of benefit within the healthcare system for every £1 invested in the project. This is based on cautious and prudent adjustments for optimism bias applied to both the benefits and the costs.

The Foundry did not receive additional funding in comparison to that is received (or what is available upon application) by other GP practices and PCNs. The costs modelled in this evaluation are representing time allocated by the Foundry team to support with the system transformation changes and not additional money which would need to be secure to implement the model. This follows the cost benefit analysis methodology, as presented in The Green Book (HM Treasury, 2022).

Overall, the greatest estimated saving was in the reduction of 12,480 non-elective bed days representing 87% of monetary benefit. Further estimated savings include 751 fewer A&E visits and 170 ambulance conveyances, as well as 720 fewer locum GP sessions. It was not possible to discern a notable positive impact on primary care activity numbers as a whole.

Whilst it is reasonable to expect similar benefits should this model be adopted in other PCNs, one should note that the anticipated impact is likely to be influenced by a variety of factors including social-demographic patterns, population morbidity, practice list size and proximity to a GP practice. Further data collection and analysis are needed to robustly determine how differences in PCNs will shape the outcomes of the model. Nevertheless, the examples below aim to illustrate how differences in settings between PCNs could determine how impactful the model is (both by presenting a bigger opportunity or an increased challenge). Although, there are multiple benefits evidenced, the examples focus on the impact on secondary care activities as it is a well-researched area.

Population demographics

As deprivation negatively impacts the rate of admissions, readmissions and A&E attendances (Johnson et al, 2019: Scantlebury et al, 2015), implementing the principles of the Foundry model in a more deprived population could wield a greater benefit. Indeed, there were more than twice as many attendances to A&E departments in England for the 10% of the population living in the most deprived areas (3.1 million), compared with the least deprived 10% (1.5 million) in 2018-19 (NHS Digital, 2019). Similarly, controlling for demographic and health factors, not being in employment and living in poor quality housing increased the likelihood of attending an A&E service (Giebel et al, 2019). Williamson, et. al (2019) identified repeated non-attendance at primary care consultations as a predictor of patients being at risk of suffering from health inequalities. Therefore, a model of care looking to provide better continuity of care and to facilitate access to appropriate care could positively impact patients experiencing health inequalities.

Practice characteristics

Practice list size, average distance to a GP practice, inability to speak to a GP/nurse within two working days are all predictors of hospital attendances and admissions (Giebel et al, 2019; Scantlebury et al, 2015; Tammes et al 2016). The focus of the Foundry on improving access and pooling resources to create a more resilient workforce has the potential to impact some of these factors. The time needed to change the practice characteristics should not be underestimated.

7. Conclusion

As explored in this piece, the principles and interventions implemented by the Foundry echo and answer many of the ambitions presented in the Fuller Stocktake report. The FHL PCN journey presents a roadmap to delivering integrated services using population health management and a dynamic workforce model to tackle the challenges of providing timely, appropriate, and personalised care. Whilst some dimensions of the integrated care agenda (such as collaborative working with secondary care) are yet to be delivered at the Foundry, the drivers for changes and the enablers listed mirror closely the recommendations of the Fuller report. These include the need for local leadership, widely spread buy-in from staff members, long-term strategic planning supported by regional and national partners as well as the systematic use of data.

The model has the potential to benefit many other PCNs, but tailoring of the interventions and local sense of ownership will be pivotal to successful adopt the Foundry principles. Special attention and support should be given to the activities conducted at the Blackheath and Charlton PCN as they will address some of the unknowns of the model of care. Namely, it will provide an answer to the following questions:

- Can the model be as impactful without the practice merger?
- Can the model be successful in a different setting (population demographics and geographical assets)?

Although these questions remain unanswered, the quote from one of the stakeholders interviewed highlights the potential of the Foundry.

“We can always have conversations about populations being different […] But if you take all of that away and just look at the underlying approach, it is perfect for how to run a business and deliver a public service.”

- *Interviewee*

Finally, a key takeaway of this piece and the Fuller report is the role of the system to support the emergence and spread of innovative models of care. Setting the strategic vision, shaping a positive narrative around the transformation in primary care and providing clarity and (where possible) long-term stability about funding opportunities were the main asks for NHSE and other national partners. The role of ICSs, on the other hand, was centred around brokering relationships between providers and practices to enable cross-organisation collaboration, as well as supporting the rise of local leadership via expert assistance and training programmes.

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Appendix A: Interview methodology

Two interviews were conducted with members of the NHS Sussex Integrated Care Board. The first interview took place on November 28th 2022 with Hugo Luck, the Associate Director of Primary Care. The interview with the Senior Manager of Primary Care Contacting, Elizabeth Tinley, took place on December 7th 2022. The purpose of the interviews with the mentioned stakeholders was to gain better understanding of how the organisational change was managed at the Foundry, how local leadership was fostered and the role of CCG in the interventions.

An additional interview was conducted with Dr Nayan Patel during two meetings which took place on December 21st 2022 and January 19th 2023. Dr Patel is a GP partner at Blackheath Standard Surgery and the Clinical Director at Blackheath and Charlton PCN. The aim of the interview was to gather the views of different PCN looking to adapt the Foundry model and implement it. Similarly to the interviews with Sussex ICB, the discussion explored the challenges in implementing the Foundry model in a different PCN, such as drivers and barriers to implementation. The discussion also included the steps to implementation, the perceived impact of the model, communication strategy to relay the changes to the patients, the importance of local ownership and the support needed from the system.