Primary Care Pilot for NHS Prevention Pledge:

Process Evaluation Report

Executive Summary

This report presents the findings of a process evaluation of a pilot programme testing the implementation of the NHS Prevention Pledge in primary care settings across Cheshire and Merseyside delivered between mid-2024 and early 2025.

Background and Purpose

The NHS Prevention Pledge framework is designed to embed preventative healthcare into routine practice across the NHS. In recognition of primary care's central role in prevention and tackling health inequalities, HEG developed a tailored six-commitment framework for primary care drawing on many of the themes covered by the commitments in the version of the Pledge adopted by NHS trusts.

The pilot aimed to test the feasibility of this adapted framework in practice, tracking preventative actions across five participating pilot sites: three PCNs (two in Liverpool, one in Wirral) and two GP practices (both in Cheshire East).

Pilot Implementation and Support

Pilot sites were asked to identify and implement two actions under each of the six core commitments with accompanying KPIs to track change. Actions were developed following mapping sessions to establish current practices and were then guided via a support pack and individual guidance from HEG staff, plus quarterly Community of Practice meetings.

Key Actions and Outcomes

Examples of impactful pilot actions included:

- Staff wellbeing: A PCN launched a staff health checks programme and tracked improvements in engagement and absenteeism.
- Patient empowerment: One PCN developed a new multi-disciplinary education programme for COPD patients.
- Addressing inequalities: A GP practice appointed a health inequalities lead and implemented a digital exclusion strategy.

- Prevention promotion: Installation of a weight management kiosk in a GP reception area led to a 33% increase in referrals to support programmes.

Findings and Conclusions

The evaluation, based on qualitative interviews with four of the five pilots, found:

- High levels of engagement, with the Pledge seen as both feasible and beneficial
- Sites had overcome significant local challenges around capacity, staffing and organisational changes to deliver the pilot successfully
- Value added to existing prevention work, particularly in areas such as health inequalities, Making Every Contact Count (MECC), and workforce wellbeing
- Strong support for the Community of Practice meetings and the opportunities for collaboration that these generated
- A desire from all pilot sites to continue using the Prevention Pledge framework beyond the pilot phase

Recommendations for Future Delivery

Feedback from pilot sites informed several recommendations to enhance future rollout:

- Extend and refocus Community of Practice meetings to allow more strategic discussion.
- Clarify overlaps in commitment areas and allow flexibility in PCN vs. GP-level action planning.
- Update and align support resources, including the support pack and action tracker.
- Strengthen initial onboarding by offering clearer guidance on action planning and the use of mapping findings.
- Promote long-term integration of the Prevention Pledge into PCN governance and planning structures.

Conclusion

The pilot demonstrated that the NHS Prevention Pledge for Primary Care is a viable and valuable framework for embedding preventative health into primary care settings. The pilot sites reported strengthened commitment to prevention, better alignment with system-wide priorities, and improved staff and patient outcomes. With refinements, the model holds significant potential for wider adoption across the NHS primary care landscape.

1. Introduction

This report describes the findings from the process evaluation of a pilot programme testing implementation of the NHS Prevention Pledge for primary care organisations that was developed and coordinated by public health charity, Health Equalities Group, over 2024-25. The report offers background information on pilot process, with the main findings drawn from qualitative interviews conducted with pilot sites at the end of the pilot process. The report also offers an overview of the actions developed by pilot sites aligned to the six core commitments that underpin the NHS Prevention Pledge framework for use by primary care network (PCNs) and individual GP practices.

2. Background to Programme

Across Cheshire and Merseyside, there is a strong commitment to enhancing population-level prevention efforts which are primarily supported through the ICB's Population Health Programme, which includes the sub-region's health inequalities programme All Together Fairer, plus sub-regional programmes on physical activity (All Together Active), All Together Smokefree, and programmes promoting social value and wider Anchor Institution principles.

In supporting NHS provider Trusts to take a place-based approach to prevention, the ICB's Population Health Programme is supporting work carried out by public health charity Health Equalities Group (HEG) to develop and roll out an NHS Prevention Pledge for the sub-region's provider Trusts. This programme started initial work in 2019 and has now engaged all 17 Trusts across the sub-region using a framework underpinned by 14 'core commitments' that NHS providers are expected to work towards as a means of formally adopting the Pledge over a 24-month period.

In addition to work with Provider Trusts in the sub-region, it is recognised that primary care settings play a pivotal role in the prevention of ill-health and reduction of health inequalities, and there is an opportunity to take a system-wide approach to prevention across the NHS. As such, Health Equalities Group worked with colleagues from primary care in Cheshire and Merseyside to develop a version of the Prevention Pledge for use in primary care settings over 2023-24, with a specific focus on GP surgeries and Primary Care Networks (PCNs).

3. Pilot Implementation

The primary aim of the NHS Prevention Pledge for Primary Care is for PCNs and GP practices to make a strategic commitment to prevention priorities through both governance and operational structures to improve health outcomes, in particular for those facing the highest levels of health inequalities. For the pilot study, the Pledge was

underpinned by six core commitments (see Annex 1) focused on improving population health through preventative actions for staff, patients, and local communities. Developed through stakeholder consensus and an evidence review, the commitments sought to align with the NHS Long-Term Plan and regional priorities. Pilot sites were recruited through an expression of interest process in the first quarter of 2024-25, with three PCNs recruited to the pilot (two in Liverpool, one in Wirral), and two GP practices based in Cheshire East. A 'mapping session' was carried out with each of the pilot sites early in the process to understand current policies and practices covering prevention, health inequalities and anchor institution practices. Findings from the mapping process were fed back to pilot sites by HEG, including how current practices map onto the six core commitments for primary care.

For the pilot, sites were asked to demonstrate the following over a six-month period through an agreed action developed with support from HEG:

- Evidence of at least two actions aligned to each of the six core commitments (i.e. a minimum of 12 actions in total)
- One of these actions could be associated with a current policy or initiative that was recognised through the mapping process conducted with HEG in June/July 2024
- The second action for each of the Commitments would either need to be a new policy or initiative, or would need to have a specific 'stretch target' that would differentiate it from work that is already in process.
- Each of the actions would need to have an associated KPI (preferably a metric) to measure any changes from a baseline KPI recorded in September 2024, to an end of pilot KPI recorded in early March 2025.

Development of key actions was supported by staff from HEG, with finalised action trackers needing to be submitted by the start of September 2024. Pilot sites were offered guidance through a bespoke 'support pack' developed for the pilot, plus 1-2-1 drop-in meetings with HEG, and online quarterly community of practice meetings which all pilot sites participated in to share current practice, overcome any barriers, and foster collaboration.

4. Key actions developed by pilot sites

Action trackers developed by pilot sites were structured by the six core commitments developed for primary care. Please refer to Annex 1 for a summary of the main policies and actions developed under each of the commitment headings by the five pilot sites. Pilot sites were required to submit quarterly updates on the progress of their actions in December 2024 and again in March 2025 to understand changes to KPIs.

Below we have included examples of how actions from pilot sites were able to mature over the pilot period and outcomes associated with these actions:

- A PCN pilot site set an action to develop and expand the Freedom To Speak Up Guardian Programme with an ambition to set up a network across practices > By March 2025 the PCN had identified a champion in every GP Practice and had developed a new training package with the new Network launching in April 25.

- Another PCN pilot site recognised they had no current provision of long-term condition education programmes, and set an action to develop a programme to provide holistic support for managing COPD, reducing exacerbations, physical activity & nutrition, and emotional support > By March 2025, a new education programme covering key aspects of COPD features, management and support was developed and was starting to be delivered by an MDT including GP, respiratory nurses, health coach, social prescriber and smoking cessation service.

- One PCN pilot site recognised that they could be taking a more strategic approach to staff health and wellbeing, and set an action of developing a staff health checks programme > Building upon initial work with staff participating in Know Your Numbers week, a health checks programme was developed for all staff to undertake, with KPI's set for employee engagement and participation, health outcomes data, identified health risks and reduction in absenteeism. Staff are due to undertake checks every six months.

- A pilot GP practice recognised that they wanted to take more of a strategic approach to addressing health inequalities and embedding this within their governance structures and across all of their workforce, and wanted to address this by appointing a health inequalities lead > By the end of the pilot period a health inequalities lead was appointed at the practice with a health inequalities strategy in development. An initial output from needs assessment work was creation and implementation of a digital exclusion strategy for the local population.

- One pilot GP practice wanted to increase uptake of weight management checks with their nursing team and promote greater awareness of healthy BMI amongst their patient population and installed automated weight management machine in the reception area of the surgery > The weight management machine is able to send patients a link to join the practice weight management programme, and by

the end of the pilot period the GP practice had increased their weight management referrals by 33% on the previous year.

5. Qualitative interviews with pilot sites

5.1 Background and method

The formal pilot period for testing a primary care model for the Prevention Pledge finished in March 2025, and this included a final submission of action tracker documents by all five of the pilot sites. At the end of the pilot period, in April 2025, five semi-structured interviews were conducted with representatives from four of the participating sites (three PCNs and one GP surgery) as part of the process evaluation of the initial phase of developing the Prevention Pledge in primary care. One GP surgery pilot is not covered by these interviews as the key member of staff for the project left the organisation at very short notice in late February 2025, although feedback from the site's action tracker is included elsewhere in this report.

The interviews were carried out via Teams, primarily with the main contact from each of the pilot sites, with additional input from other colleagues within their organisation. The sessions were recorded with participant agreement and were fully transcribed to for the purposes of this report.

There was a common structure to the interviews, with scope for participants to discuss any other issues they felt were relevant to the process. The findings reported below follow much of the same structure as the interview questions, covering a range of subjects including the initial mapping process, governance, the nature and extent of the support provided by HEG, the individual Pledge core commitments, barriers and enablers and any additionality associated with the project. An analysis of key themes and findings are presented below, whilst quotes are included to illustrate the feedback from respondents, these are anonymised.

5.2 Summary of progress to date over pilot period (September 2024-March 2025)

Some of the sites had to deal with unexpected challenges that made it more difficult to make progress during the six-month pilot, including changes of personnel, a sabbatical, illness and a PCN splitting into two different Networks. Despite this, pilot sites were able to maintain momentum and embedded the Pledge into their local processes.

Feedback from the interviews was largely positive - there were also constructive criticisms but, perhaps most importantly, each of the four sites interviewed made clear that they want to continue with the implementation of the Prevention Pledge in 2025-26. These pilots felt that the experience to date had been positive, giving impetus to the wider prevention agenda and introducing new thinking into these primary care settings.

At the start of the interview, respondents were asked to summarise their experience in a couple of sentences.

> *"It's gone really well. We've had a huge degree of engagement from every level of the practice from partners, upper management, all the way to our healthcare navigators." (Pilot 1)*
>
> *"I think we've done some really interesting things being part of the project… it has allowed us to give time, effort and focus to this area of work and it's going to give us hopefully a platform to build on." (Pilot 2)*
>
> *"Some of the things we were already thinking of doing, so the likes of our cancer stuff, our big strategic things we were already planning on starting. The good thing with this is that it probably gave us a little bit of a kick on the backside and helped us to give more focus on staff health and well-being, engagement and local procurement policies". (Pilot 3)*
>
> *"The timing was the worst for this piece of work, but it has absolutely helped us to focus our intentions and our vision for our new PCN from this month. I'm still full of optimism". (Pilot 4)*

5.3 Mapping sessions

Following the same approach as used with implementation of the Prevention Pledge with Provider Trusts, the formal start to the project with each of the sites began with a mapping session to identify current actions (policies, practices, governance) addressing prevention and health inequalities, along with possible ideas for future work. The approach involved gathering staff members working in a variety of roles and then aligning current actions to the broad themes covered by the six core commitments. At one of the sites, there had been a complete change in personnel since the mapping, so the issue was not addressed directly in the interview.

The mapping sessions and subsequent outputs were generally well-received and the value of having this sort of baseline was widely recognised.

"It was a really good starting point for us. Things later came to mind that maybe we hadn't included in the mapping session so I think it's just accepting that this is always going to be a work in progress" (Pilot 4)

"It was it was really helpful and opened our eyes up to a lot of different pathways and avenues that we could explore. I found it very useful." (Pilot 1)

"I think the mapping process for us was more of a reflection in the way of in which primary care moves. Things move quickly and you can lose track of where you've got to. I think with a mapping set session. it's actually good to look at how far you've come." (Pilot 3)

Interestingly, there was useful discussion about the need to keep the output as more of a 'live' document, not least with the potential to substitute actions selected for the Pledge that were not making the expected progress.

"Substitution could be a good idea. Take the idea of healthy food options at sites, that was something of a non-starter and it was hard to put time into it. I think with hindsight that it would have been better to update and then substitute another action. I think that's probably a key thing for people to understand that the actions can be changed." (Pilot 3)

Another site – where there was significant change in personnel over the duration of the pilot – actually went back to the mapping content as a reference point to inform changes to some of their original actions for their participation in the pilot. Returning to mapping data on a regular basis could be a helpful approach for future sites going forward, although the bulk of the selected actions will need to be consistent across time especially when linked to KPIs to help demonstrate impact.

5.4 Governance, organisation and leadership

When implementing the Prevention Pledge with Provider Trusts, this model generally involves appointment of an exec-level sponsor, although with varying levels of active involvement in the project. Much the same approach was adopted by two of the PCNs and one of the GP surgeries involved in the primary care pilot. In general there were positive reports from these sites about governance arrangements, with significant learning to take from this approach:

"That has gone very well for us. We actually have a couple of senior people really embedded and involved in this work – a GP and our sustainability lead, who was working on this stuff before I came along. That was a really positive development in terms of our relationship. So, I think we have always had buy-in from the top. We had a meeting just this week around our away-day plans because we're going

to make the Prevention Pledge and the anchor institution framework work our focal points." (Pilot 4)

"I'd say there has been support from all of the practice partners, all of the other management team. There has been engagement in every role, whether that's clinical or non-clinical and we also have quite a strong breadth of actions across our commitments which helped. All of the doctors have been involved in some way". (Pilot 1)

"Within the PCN itself, the governance has gone very well – ours is a very proactive Network. We are looking at any sort of pilots that come out. So, we're very proactive and we do have a buy-in from our clinical directors and Managing Director. So, getting those things done is ideal, I think. We definitely get the right people involved. Someone with a good eye for health inequalities is probably the best person to engage with." (Pilot 3)

There was also recognition that input from senior leaders could be limited because of other demands on their time.

"What I would raise is that one of the issues for me personally is that buy-in with clinical people is time-constrained. Clearly their number one job is to be active clinically and sometimes I found that a little bit frustrating, having to remind myself that that this isn't their main priority. But we are very lucky in our PCN that all of this work is supported and actually encouraged by all of our clinical leads." (Pilot 4)

The fourth pilot site had a different model with a group of three active hands-on leads who were empowered to create time to focus on the project, with little involvement from senior leaders. While this approach has worked well to date, there will be a challenge to embed the process in the PCN via a new board and clinical director.

"We have not had as much senior GP involvement as we would have liked. If we could have pinned a GP down it would have helped because they have got so many connections. We have weekly catch up with our delivery group, we aren't micromanaged, so we can manage our time and say, 'Okay, this is how long it needs'. I know that GP involvement would be really difficult, but it would have been nice. It would have been helpful to have had more of a clinical presence when we did our own PCN workshop for this project - there was a nurse, a paramedic and a pharmacist but no GP involvement. If it's going to be successful, it obviously needs that involvement." (Pilot 2)

5.5 The six core commitments for primary care

The core commitments for primary care were developed in consultation with a small task and finish group of clinical directors in the latter half of 2023, taking inspiration from the themes covered by the 14 core commitments underpinning the framework for Provider Trusts. Further consultation with primary care stakeholders across the sub-region was carried out between January-March 2024 which further distilled the commitments for primary care to just six core commitments. The general reaction to the range and coverage of the core commitments was positive, although one respondent noted that, "*The commitments could be slightly simpler, the language and wording might be made more succinct." (Pilot 2)*

> *"They are not complex by any stretch of the imagination. I did look and think, 'Oh good, this has got someone's name written all over it'. But the bigger the team and the more kinds of perspectives you're looking at it from, the easier it is to make sense of them" (Pilot 2)*
>
> *"The commitments are good. I like the fact there are 6, not 14! There's enough crossover in the commitments to make them link, but equally they have their own distinct areas and I'm able to understand them." (Pilot 2)*
>
> *"I think it really it was nice to have those different commitments. Often you just focus on one or two things, so it was nice that we were forced to think elsewhere, about your recruitment policy or your health and well-being strategy" (Pilot 3)*

There was recognition that the number of commitments had a ceiling - *"I think six was probably the most we could have handled, any more would have been really difficult." (Pilot 1)*

There were also comments in relation to individual commitments.

> *"I think the one which stands out as being a little more complicated is the commitment around anchor institution principles. I had to go away and do quite a lot of reading about that. I'm not in a leadership position, somebody in that position is going to be much more knowledgeable about anchor institution principles and things like paying wage."* (Pilot 2)

Another PCN noted the difficulties in addressing Commitment 5 in relation to healthy primary care environments because of not being in control of the premises:

> *"We rent within a building, so we're governed by that. So, any screens that are not under our control, nor vending machines. That's why I think it's hard at a PCN level because more than likely we're not going to be in our own building. At practice level, it might be a bit different because then it's up to you what you*

provide for patients or staff like water machines or you've got the screens that you can put health information on." (Pilot 3)

5.6 Support from and contact with HEG project team

Interviews addressed the nature and extent of the contact between the pilot sites and HEG. This aspect of the project was especially well-received by the pilots with widespread agreement that the balance of contact was both appropriate and supportive, without being too burdensome.

> *"I think it's been a really good mixture. We've had our regular meetings, but equally you've always been at the end of an email or call which was really valuable, especially when we first picked this up because we did need all the guidance we could get!".* (Pilot 2)

The pilot in primary care was designed to be lighter touch than the process adopted for Provider Trusts, reflecting the reduced capacity of PCNs and surgeries. Again, this was reflected in the feedback from the interviews.

> *"Not any point during this have I been like, 'Oh my God, are we meeting again?' It's not been too heavy at all. I think every time we've probably needed a bit of support and a bit of a lift then you know the next meeting with you guys has been there. Equally, we've been able to get on and go away and just do the work"* Pilot 2)

> *"I think it was totally appropriate for me. I'm also on the side of just wanting to get on with it and not engage too much. So, for me it was perfect. My only negative feedback would be I would have preferred to have more face to face, but I understand that that's not the preferred method that other sites wanted or could do."* Pilot 4)

> *"I think the support has been, overall, positive. I don't think it was all that frequent, I thought it was quite timely. I think there was enough breathing room for us".* (Pilot 1)

> *"I think it's been great because obviously it could have easily been contact every month - we're going to be on top of you and we're going to keep hammering you and all that type of stuff. I think it's just been a nice time frame to get enough work done."* (Pilot 3)

5.7 Support pack

Alongside the mapping session, all sites were supplied with a support pack. The support pack provided pilot sites with: the background and context to the project; an overview of how the pilot would run and required outputs; an overview of the six core commitments and examples of actions that could align to each of the commitments; an example action tracker; and, case studies and data sources to inspire potential actions that sites could use as part of the project. Again, overall feedback was quite positive, certainly in respect of initial use and sharing with colleagues.

> *"It was important for me to be able to explain what the Prevention Pledge is, so the pack was ideal because it was able to improve my own understanding of how I might explain it to others. And then it was very much used in the formation of the actions."* (Pilot 2)

> *"I went through the support pack quite closely. What I did find was that it didn't exactly mirror the action tracker that was first put out which led to confusion at my end, and I needed clarification around a couple of points"* (Pilot 1)

However, not all site leads made much use of the document, although it still had some value at local level.

> *"At the start-up, it was obviously good to understand the commitments, then after that it just dropped off in my mind because we had what we were focused on doing."* (Pilot 3)

> *"If I'm being dead honest, I'd probably glanced at it. What I have used it for is sending to other people who aren't involved in the work, so it's been really useful from that point of view... obviously for people that know nothing, you know it's a great tool to say, well, this is what it is, this is what we're doing."* (Pilot 4)

5.8 Action trackers

A key tool to help with implementation and monitoring of the Prevention Pledge for both primary care and Provider Trusts is an 'action tracker' dashboard which was made available to pilot sites in the form of an Excel template. The template helped sites shape an action plan for the pilot demonstrating the progress of two actions for each of the six core commitments (i.e. 12 in total) with aligned information on anticipated outcomes, ownership of each action, key dates associated with each action, and KPIs that can be used to measure progress.

Respondents acknowledged that it is necessary to have a standardised form of monitoring output for all sites and saw the value of a template action tracker, but some

of them struggled with certain aspects of the template. To some extent, this was mitigated by creating parallel internal documents.

One way of addressing these concerns would be to spend more time with sites to support a first draft of their action tracker, whilst it might be that further instructions on this process could be developed as part of the support pack. Consideration also needs to be given to how the current tracker would work if actions extend from the central PCN to local GP practices.

> *"Yeah, I enjoyed it. I slightly amended the layout just so it was all on one sheet. It was clear and concise. Easy to just kind of skim over, see where you are. You know you had your key dates, you had the ownership it."* (Pilot 1)

> *"It's quite wordy, a very detailed tracker, and it's quite a lot to look at, but I equally I accept that that my initial impression of it is probably mainly down to the fact that we weren't involved from the beginning, which is where you would no doubt have gone through that in detail. A light bulb moment was when we were told that the action tracker is a guide, if you need to adapt that it to suit your needs, do it. We haven't been using the tracker really to work from as we have an internal log to focus on the action and its progress rather than the broad overview of the tracker gives us".* (Pilot 2)

> *"I just can't think of a better way to do it if I'm honest. So, it doesn't work great for me, but I can't think of a better way to do it. I've been sharing that with our leads, so when I do a report, I just embed the tracker and say, 'This is where we're up to'. So, I have to step back on my criticism of it and say, actually, it's quite useful".* (Pilot 4)

> *"I think for me the issue is in some of the language you're using kind of high level strategic professional language, which is fine and we all understand it, but I feel like some of the wording could be made more plain English."* (Pilot 4)

> *"It feels like an overwhelming document at the beginning but as you begin to use it and as you populate it, then it was okay."* (Pilot 4)

> *"It's been fine for me although it could be changed to show more update columns in a single document rather than saving them as separate ones like December or March."* (Pilot 3)

5.9 Community of Practice meetings and collaborations

One of the most successful aspects of Provider Trusts adopting the Prevention Pledge has been the regular Community of Practice (CoP) events when sites come together to

discuss progress, often with a focus on a specific commitment, and hear from guest speakers. The same approach was adopted for the primary care pilot and was met with considerable enthusiasm, with strong support for these sessions and the benefit of CoP meetings leading to further collaboration between pilot sites.

> *"I think the meeting that we had with the other pilot sites was really useful, just to see what they were doing and the type of organisations that they were involved with because we never really look outside what we're doing internally. Just knowing what others are doing in that space, and being a little bit further along maybe, is inspiring and it gives you confidence about what might be possible." (Pilot 2)*
>
> *"I thought it was really positive. I think it makes you think the other pilot sites were really positively engaging which made it all the better because we were able to take bits and pieces from that and look and see how we could do X, Y and Z"* (Pilot 1)
>
> *"I've had a really good chat with other PCNs. Another reason for reaching out is because I'm aware that they have quite a lot of experience in building and managing teams – social prescribing, communities, etc. You can go to your leadership team and say okay this PCN is doing XYZ, but that's because they've got XY and Z in place"* (Pilot 2)
>
> *"We are actually talking lots to the other PCNs - it's been really interesting, and that relationship never would have developed without the Community of Practice."* (Pilot 4)
>
> *"I think I think lots of positives have come out, in terms of working jointly on areas and sharing good practice."* (Pilot 4)

There were comments and learning to be taken about the format of the CoPs and, moving forward, these sessions will be revamped as the primary care cohort expands in size and will include a focus on a specific issue, such as how to move some actions into surgery settings.

> *"It just becomes a little bit rushed at the end. I was the last one in, and it was a bit short, we we've only got an hour and a half. But it was really good".* (Pilot 1)
>
> "*What I don't like about them and this isn't criticism of just this, it's all the time I say this. I feel like we spent too much time showing and telling. I'm more interested in the gritty reality of stuff Bring us your best or your worst! Or maybe both. Only in the last 15 minutes, you end up talking about difficulties and how can we work on this together"* (Pilot 4)

"I hate doing presentations where you just talk on for half an hour and people just listen to you. I'd rather have to talk about something." (Pilot 3)

The different pilot sites engaged well with each other, and this led to some direct contact and then an event to promote MECC that involved all three PCNs meeting in person to discuss ways in which these types of brief interventions could be extended.

"We are doing a piece of work with the other two PCNs around MECC training that would never have come about if that was just me looking for information. And then suddenly that's borne out a little bit from the Community of Practice. So that was great." (Pilot 3)

5.10 Barriers

A key focus of the interviews was on barriers to implementation for pilot sites. A variety of issues were identified, sometimes site-specific but also reflecting the general challenges faced by primary care organisations, notably in relation to time pressures.

"The key barriers are time and capacity, access to the people I need to work with because of their clinical commitments. The other one was [the PCN] splitting in two." (Pilot 4)

"There were no real barriers, other than time. But you know that's par for the course, isn't it? You know, you're just adding another ball into the mix." (Pilot 1)

"I'm trying to think if there were barriers as such. I just think that there is a lot of other stuff going on within primary care. I've got about five different hats on. I manage different teams as well as the recruitment and then the Pledge. If I could take my other hats off and be totally dedicated, we probably would have done a lot better than we have done." (Pilot 3)

"For us it was PCN staffing and leadership transition. The main barrier is getting PCN ownership but we've made a nice start with the Pledge workshop for practices. We had issues with practices because of the way things are in primary care. They want the basics sorting before we start preaching to them about this amazing idea of prevention" (Pilot 2)

5.11 Enablers

From considering barriers the interview moved on to enablers, focusing on the ways in which challenges had been successfully addressed and what had helped internally in the implementation of the Prevention Pledge at each site.

Two of the pilots emphasised the importance of support from the organisation's leadership to embed the work and empower the project leads to focus on delivery.

> *"For us, an enabler is that this work is valued and understood by our leads. It's forming part of our overarching plan moving forward. It's forming part of our PCN away day. Other enablers have been the realisation that this isn't standalone work. All of this is laying a foundation for us, for all that we need to be doing anyway. An enabler is understanding the Pledge as integral to the work we're doing, not as additional."* (Pilot 4)

> *"The support came, heavily, from the top down and as a consequence there was there was never any issue in getting things that relate to the Pledge over the line. It is a piece of the puzzle for the Anchor Institute scheme, which is something that we want to try and get involved with. I had the support from the higher-ups so it made things easier."* (Pilot 1)

The communications between the pilot sites, at the Community of Practice meetings and offline was cited as a real positive in terms of making progress with the Pledge.

> *"It is really nice to have these offers from key partners such as HEG and other sites in the background so I could say, well, you don't have to hear it from me. Hear it from someone else who knows and does it. It's easy to just drop each other an e-mail or use Teams chat. So, the fact that we can be more informal with it and kind of more frequent in our communication has definitely been helpful."* (Pilot 2)

There was also a specific mention of using the action tracker as a vehicle to make progress by knowing what to focus on and how to move an action to the next level.

> *"The action tracker and our internal action plan have been helpful because they do break it down literally step by step and it's like, this is what we need from you, XXX. This is what we need from you, ZZZ. Not so much now, but when we were at an earlier stage, we were looking at it and it was full of ambers and reds. When you've got that document to go along with it, where it breaks it down, we can work to change things to green."* (Pilot 2)

> *"I think it's been good to share the load and the communications and documents which are used by different people so that we can all see where the project is up to. That's been a real enabler for the for the project. I think we want more support and more guidance from our leadership. On the other hand, the lack of that gave us autonomy".* (Pilot 2)

5.12 Additionality

All of the pilot sites were confident that working on the Prevention Pledge had furthered their existing work on prevention, health inequalities and social value and acted to galvanise actions in this broad area. The extra impetus was apparent in a number of respects including health inequalities, MECC and staff well-being as well as thinking about prevention in different ways.

> *"100% because I think we've chosen some actions which we can achieve or have achieved quite easily for the purposes of making it a success and building momentum being able to show something that has been successful and has worked. However, I think every single action has a stretch point or a next step section to it."* (Pilot 2)

> *"I think it's allowed us to think differently moving forward about the direction of our work, particularly with communities, particularly around the tackling health inequalities. I think this programme has given us a way to think about things in a kind of positive, proactive way. And I know that this now this way of thinking is embedded in what we do."* Pilot 4)

> *"So, for example, the MECC approach was something that we never would have otherwise incorporated. And we are now looking more closely at our procurement strategy. I'm now established as the health inequalities lead and we came up with the digital inclusion strategy looking at the high proportion of our patients who are over-60. So, it has helped us do things that we otherwise wouldn't do. Simply put, it's just a good thing to be involved in it. You know it does good things for the practice and patients."* (Pilot 1)

> *"I think it's added in two ways. One, it helps strengthen what we were planning on doing. It's given us a really good drive for our two strategic aims around cancer screening and CVD prevention. Two, I do think It's given a nice focus around staff health and well-being which has then improved morale and the atmosphere."* (Pilot 3)

5.13 What is in it for the PCN?

The pilot PCNs were very much part of a coalition of the willing – other PCNs might be less enthusiastic about adopting the Pledge, so it is important to identify ways in which the benefits of the programme can be promoted to primary care. During the evaluation interviews, respondents were asked about how this might be done. The quotes below

include the challenge of prioritising prevention when faced with cost pressure, the value of collaboration and innovation and providing a focus.

> *"How does it impact our finances and investment and resources? I'm happy to talk about why it's the right thing to do to invest in prevention and proactive care. The trouble is that you might not see any actual impact in terms of whatever you're measuring for a decade. Is it a reduction in CVD? Is it reduction in obesity, is it even savings? Wow, imagine that in healthcare! So that's just the question I've been asking. You know, we have no money and we are actually cutting costs rather than investing."* (Pilot 2)

> *"Creating the Prevention Pledge workshop in particular is an opportunity to galvanise and get people together and co-design a service. How could we do this better? And how could we build all this based on your feedback and your thoughts? It's a vehicle to help, to encourage collaboration and teamwork within your PCN around a common issue. So, the issue links GPs, it links receptionists, it links everybody."* (Pilot 2)

> *"It does give a really good opportunity to collaborate with people. We will be taking the collaboration forward even though it's not necessarily now 100% focused on this project. It does give you the freedom to mould it how you want to."* (Pilot 3)

> *"I think it can open your eyes to other things that potentially that you've not thought of, bringing relevance and value to the PCN. I think the collaboration and the support from other member sites is a big help to think outside the box. I think the drive from HEG really helps sharpen time frames - setting up a strategic arm could drag that on for three years but we've turned it around now in probably what is four to six months."* (Pilot 3)

5.14 Challenges – expansion at practice level

Most of the work in the pilot phase was at PCN level, although there was also a strong performance from an individual GP surgery that was one of the pilot sites which demonstrated that the Prevention Pledge can operate at a practice level where ownership and resourcing is available. However, with over 350 practices and only c55 PCNs in the Cheshire & Merseyside sub-region, the focus for the Prevention Pledge will need to remain at a PCN level moving forwards. While some actions can work well for a PCN, there are others that might be at least as effective at practice level (e.g. the commitment around healthy environments). There is hence a challenge to see how parts of the Pledge might work at GP surgeries.

"The key thing for us looking at the next stage is the buy-in from the member practices. What we utilise is then fed out to member practices so it's across the Network and I think that's where potentially we struggle. A lot of our commitments have been around about PCN staff and around our governance rather than the member practices." (Pilot 3)

"An honest point of view is we have practices that don't really engage. They are part of our Network and we're trying to get them on board with help and support but they just run basically solo sites. Yet we have as many practices that are fully engaged, so I know I could roll this out to a couple of practices tomorrow and they will buy into it." (Pilot 3)

"What we are doing at the moment with the funding is trying to get practices on board for help and support as a Network. Some practices are resistant because they don't want to be told by the PCN what they should be doing. It's about trying to roll stuff out – we are trying to dangle little carrots like we employ a pharmacy team which the PCN runs but they do work for practices. I'm hoping some of the things that we do can show that we've tried it, it works and we are rolling it out, perhaps by the new workflow coordinator." (Pilot 3)

Another PCN organised an event for their GP surgeries and this was well-received – feedback from this event will be a focus at a future Community of Practice meeting.

"We had a meeting about the Pledge with most of our practices. It did go really well. I think the idea that you had to do the questionnaire at the start and the questionnaire at the end really did prove that people were open to it. Even I was shocked that social factors contribute to X percent. I think that kind of grabbed their attention a bit and they did come up with some great ideas, like their visions and things like that." (Pilot 2)

"It is easier to gain engagement from some people than others, but everybody had a go, everybody got involved and it was about making people aware of it, with some of the admin staff who came along getting people in their practice talking about it". (Pilot 2)

"I don't want it to go stale now. I think we had a really good initial session. I think it'll be a real shame if we did nothing else with it in terms of a follow up workshop. It would also be a bit of a shame if we left it another 3-4 months before we did anything with it because we've got some momentum now which we are in danger of losing." (Pilot 2)

6. Limitations

The interviews included constructive feedback from four of the five pilot sites but there were no formal interviews with GPs, despite a number of them being actively involved in three of the five pilot sites. There is, however, no reason to believe that senior leaders locally were anything other than supportive of the work as this was something that was fed back during 1-2-1 meetings with pilot sites, and when GPs attended Community of Practice meetings.

The other limitation is the relatively modest pilot period with necessarily only 5-6 months of real activity for some sites, some of whom had additional local challenges to overcome.

7. Conclusions and recommendations

Findings from the interviews suggest that this has been successful pilot, certainly from the perspective of the four sites who took part in the interviews. Engagement was good and the constructive relationships that developed during the pilot brought additional benefits. All sites were positive about the Prevention Pledge process and felt that it had added value to their existing work on prevention and acted as a catalyst in areas such as MECC, addressing health inequalities and staff well-being.

A key finding is that all of these pilots want to continue with the implementation of the Prevention Pledge going forward, despite a variety of local challenges.

Feedback supported the continuation of the same broad approach, with a mixture of 1-2-1 site meetings and the wider Community of Practice events. Beyond that, the interviews generated a number of recommendations to fine tune the ongoing delivery of the Prevention Pledge in primary care.

- Extend Community of Practice meetings to two hours, with less focus on individual progress and more on specific commitments or issues and challenges (e.g. engagement with practices, how to get PCN leadership on board with the initiative).
- Consider clarifying any overlaps between Commitments 5 and 6 and suggest that PCNs are able to choose one action for Commitment 5 that is PCN-wide in scope, and one action that can be adopted across their members GP practices.
- Update the support pack with content from the pilot, ensure alignment between information in the support pack and the action tracker template, and encourage ongoing use of the support pack through the adoption process.
- Encourage sites to make greater and ongoing use of the findings from mapping sessions; this is likely to assist PCNs develop ‘substitute’ actions if they are

facing difficulties in progressing any of the original actions they have committed to delivering.

- Invest more time in an explanation of the action tracker so that sites 'hit the ground running' more quickly with a stronger first draft.
- Consider evidence about how best to embed the Prevention Pledge within PCNs so that it is seen as a being a long-term vehicle supporting prevention as everyone's business.
- Reassess the Prevention Pledge support documents to simplify wordings where appropriate.

Annex 1: Summary of key action developed by pilot sites under the six core commitments

Commitment 1: Prioritise a long-term focus on prevention, wellbeing and early intervention by embedding prevention within governance structures and making prevention 'everybody's business' across the primary care workforce.

Long-Term Conditions – Health Checks, Screening & Group Support

- Establish a new project team to assess implementation of CLEAR project and recommendations
- Design and pilot a COPD group support and education programme (6 workshops)

Health Inequalities

- Appoint a Health Inequalities Lead for the PCN and develop health inequalities strategy

Digital Exclusion / Inclusion

- Develop a plan to reduce health inequalities resulting from digitalisation of healthcare
- Implement changes within MMC to align with its digital exclusion reduction strategy

Cancer Screening

- Support the Bits and Boobs Strategic Cancer Screening Programme to improve screening uptake.

CVD Prevention

- Launch the ABCD – CVD Prevention Project to deliver community-based health checks and preventative care to underserved patients.

NHS Health Checks & **Specialist Health Checks**

- Contact patients aged 40–74 for free NHS health checks to assess risk of heart disease, diabetes, and stroke.
- Conduct full reviews (including medication) for patients with conditions like hypertension, heart/kidney disease, asthma, and COPD to support management and prevent hospital admissions.

Commitment 2: Work with social prescribing teams and partners 'at place' to address health inequalities & deliver local priorities through clinical and non-clinical support.

Radway Green Estate Project:

- Collaborative work with local partners to improve resident wellbeing and living conditions.

Hygiene Project:

- Discreet distribution of hygiene packs via Cedars Medical Centre in partnership with schools and businesses.

Expand Social Prescribing Team:

- 9 link workers (including 7 with specialisms) delivering clinics, education, and weight management.

VCFSE Partnerships:

- Active collaboration with 3 TAN groups and 9 community organisations.

Internal Development:

- Formation of a Social Prescription team and creation of a resource library with evidence-based activities.

Community Mapping:

- Identification and outreach to local organisations for future collaboration.

Impact Monitoring:

- Collection of patient case studies to showcase service outcomes.

Commitment 3: Establish key anchor institution practices that positively impact on the wider determinants of health when making decisions on procurement, purchasing, enhancing local employment or training and ensuring real living wage for all full and part-time employees.

Fair Pay and Employment Practices:

- Become a Real Living Wage employer across all practices; standardise this through the CLPCN legal entity and TUPE process if not already achieved.
- Pay all staff above the Real Living Wage and introduce regular salary reviews and pay increases.
- Increase the number of apprenticeships in the organisation at Levels 2–5.
- Develop an apprenticeship programme aimed at boosting local employment and generating social value.

Education and Workforce Development

- Partner with local schools, colleges, and universities to create shared working and learning opportunities.

Sustainability and Green Initiatives

- Declare a climate emergency, following the guidance in the Cheshire & Merseyside 10-Point Plan for Primary Care.
- Join the Cheshire & Merseyside Greener Practice Group.
- Form a Green Plan working group across the PCN to coordinate sustainability efforts.

Local Procurement and Economic Support

- Appoint a lead within the admin team to develop a procurement strategy that supports local businesses.
- Develop and implement a local procurement and purchasing policy for the PCN.
- Reorient procurement of surgery supplies towards local organisations.
- Move to bulk ordering of supplies to achieve cost efficiencies.

Commitment 4: Embed a 'MECC approach' through provision of training and/or resources across the workforce to offer brief advice and/or referral in supporting patients (diet, P/A, tobacco dependency, alcohol, mental health)

Making Every Contact Count (MECC) Initiatives

- **Training for Reception Staff:**
  - Provide MECC training to all reception staff.
  - Evaluate the impact of this training on patient interactions.
- **NHS Health Checks Staff Training:**
  - Deliver training focused on MECC principles.
  - Improve the quality and accuracy of health information given.
  - Encourage personalised, supportive conversations for behaviour change.
- **MECC Leadership and Coordination:**
  - Appoint a MECC lead to oversee implementation and ongoing support.
- **Ongoing MECC Training:**
  - Deliver quarterly MECC training and refresher sessions for all network staff.
  - Aim to embed MECC into the culture of the practice.
- **Workforce-Wide MECC Embedding:**
  - Provide training and/or resources across the workforce.
  - Enable brief advice and referrals related to diet, physical activity, tobacco, alcohol, and mental health.

Health Education and Patient Engagement

- **Menopause Support:**
  - Promote a virtual menopause engagement event to all relevant PCN patients.
  - Deliver a virtual group consultation session.
  - Conduct post-event evaluation to guide future group consultation formats.
- **Patient Signposting:**
  - Support patients by directing them to relevant health services:
    - Smoking cessation (Pharmacy, LSSS).
    - Musculoskeletal issues (Physiotherapy).
    - Support groups (Dementia, carers, stroke survivors).

Quality Improvement and Clinical Standards

- **Daffodil Standards Implementation:**
  - Progress made by the Daffodil Standards lead in embedding end-of-life care standards within the GP practice.

Commitment 5: Develop health promoting primary care environments: a comprehensive smokefree site policy; promotion and facilities to assist active travel; provision of healthier food & drink choices where applicable (e.g. vending machines)

Healthy Eating and Nutrition

- Develop guidance on healthy food choices for meetings, staff rooms, and events.
- Include advice on growing food in GP practice gardens.

Physical Activity and Active Lifestyle Promotion

- Further develop **Active Practice** initiatives:
  - Establish a running group.
  - Participate in the **ParkRun Practice** programme.
- Implement a patient survey to:
  - Identify the most inactive patients.
  - Understand barriers to physical activity.
  - Gather suggestions on how primary care can better promote activity.

Active Travel and Sustainable Transport

- Ensure site plans include active travel facilities (e.g., bike racks, shelters).
- Encourage improvements at sites lacking active travel support.
- Implement incentives for alternative travel to work:
  - Cycle-to-work scheme.
  - Electric vehicle (EV) charging.
  - Salary sacrifice schemes for eco-friendly transport options.

Community and Green Space Initiatives

- Formally create a **community garden initiative**:
  - Provide access to the Serenity Garden for individuals and groups.
  - Offer opportunities to participate in gardening and landscaping activities.

Health Promotion and Monitoring

- Encourage all staff to take part in the **Know Your Numbers** campaign (BP awareness).
- Install **blood pressure and weight management machines** in GP practice reception areas.
- Display **health promotion videos** on TV screens in reception areas to raise awareness and encourage healthier behaviours.

Commitment 6: Provide workplace health and wellbeing programmes for staff and foster an organisational culture that promotes workplace resilience and positive mental health (e.g. mental health first aid training).

Workplace Health & Wellbeing Programmes

- **Develop a comprehensive Workplace Wellbeing Programme**:
  - Include initiatives, events, training, and challenges.
  - Design based on feedback from a staff wellbeing survey.
- **Monthly Health and Wellbeing Drop-ins**:
  - Held across Practices and the PCN Hub.
  - Topics include *Menopause in the Workplace*, delivered in collaboration with Women's Health Hub and WHaM Lead (Cheshire & Merseyside).
- **Quarterly Away Days**:
  - Professional development and wellbeing sessions.
  - Designed to support change management, team bonding, and staff morale.
- **PCN Wellbeing Policy**:
  - Workplace wellbeing policy implemented for the new PCN structure.
  - New initiatives include:
    - Access to the NHS Fleet Car Scheme.
    - Reimbursement for eye tests.
- **Regular Engagement and Communication**:
  - Health & wellbeing notice board regularly updated.
  - Ongoing team building events throughout the year.

Champions & Leadership Networks

- **Freedom to Speak Up Guardian Programme**:
  - Expanded to include a network of Champions.
  - Aim for at least one Champion in every GP practice.
- **Health & Wellbeing Champions Team**:
  - Established across the PCN.
  - Champions will collaboratively lead on events, initiatives, and staff engagement.

Mental Health and Resilience Support

- **Appoint a Mental Health Lead**:
  - Assess workforce mental health and resilience.
  - Develop and implement a plan for ongoing support and interventions.
- **Mental Health First Aid Training**:
  - Deliver training to all staff.
  - Continue to train additional staff as mental health first aiders.
- **Cultural Development**:

- Foster a workplace culture that supports and promotes mental health.

Staff Health Monitoring and Screening

- **Health Screening Policy Development**:
  - Engage staff in designing and implementing a PCN-wide health screening policy.
  - Plan to offer regular health screening assessments.