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Reimagining General Practice for the NHS 10-Year Plan: Organisational Culture as the Social Determinant of Team Health

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Abstract

General Practice in the UK faces acute pressure from rising demand, workforce shortages, and policy changes. Traditional NHS reforms, focused on financial incentives and activity targets, often overlook the human-centred complexity of primary care. This commentary presents a five-year cultural transformation at Birley Health Centre in northern England, centred on the 'social determinants of team health'.

Drawing on organisational psychology, leadership theory, and staff experience, we outline practical strategies to build psychological safety, communication, autonomy, and inclusive leadership. Key changes included redefining non-clinical roles, improving recruitment, fostering everyday trust, and embedding leadership based on empowerment and humility. These shifts led to lasting gains in staff morale, patient satisfaction, and care quality.

We argue that, in this organisational setting, a deliberately nurtured culture of psychological safety and relational trust became a core driver of systemic improvement, particularly vital in the post-pandemic context of recovery and workforce fatigue. Birley's experience offers a replicable model for GP practices and policymakers seeking to revitalise primary care. As the NHS implements its 10-Year Plan, we advocate for prioritising leadership development, healthy team dynamics, and patient engagement as essential to sustainable reform.

Key Words

Primary Health Care, Leadership, Organisational Culture, Quality Improvement, Psychological Safety, Workforce.

Introduction and Background

General Practice in the NHS faces growing demand, workforce shortages, and policy shifts that intensify strain [1], [2]. Initiatives to shift care into the community risk compounding pressures [3]. The period following COVID-19 brought accumulated fatigue, rising public expectations and significant leadership turnover across many practices [4], [5]. While funding and workforce expansion are vital, reforms based solely

on financial incentives and activity targets have had limited success in such a complex, human-centred system [6], [7]. These pressures exposed longstanding issues: fragmented teams, widening role boundaries and uncertainty. Against this backdrop, the approach described in this commentary emerged organically from the need to stabilise the workforce, rebuild trust and reconnect people to a shared purpose.

In recent years, substantial scholarly attention has been directed toward understanding and improving teamworking in General Practice. Several NIHR studies, for example, have been funded to examine the impact of workforce redesign and skill-mix change [8], the conditions under which women GPs thrive [9], understanding and improving compound pressures [10], and understanding how the composition of the workforce and team climate affect job satisfaction, quality of care and burn-out in primary care [11]. These projects contribute valuable evidence on the structural and organisational determinants of effective primary care teams. However, despite this growing research base, many practices continue to report challenges in applying such insights in the flow of day-to-day work. Our experience suggests that while the evidence is expanding, its translation into routine organisational practice remains uneven, particularly around the interpersonal and cultural aspects of team functioning.

While attention has increasingly been paid to strengthening existing teams, our experience suggests that embedding these insights into routine organisational practice remains challenging. Studies of implementation in primary care highlight the organisational and contextual factors shaping how new approaches take hold [12]. Sustainable improvement in General Practice depends on building high-performing, resilient teams by focusing on organisational culture. We propose to call this ‘The Social Determinants of Team Health’, which we define as the relational, cultural, and environmental factors that release potential in teams and enable excellence to emerge from a complex organisation.

This commentary presents a case study from Birley Health Centre, a GP practice in northern England serving 9,400 patients with average deprivation and age profiles. In 2018, it faced high staff turnover, low morale, and poor patient satisfaction [13]. There was an established ethos of care for staff and patients. However, this truly played out as intended after the leadership grasped and implemented principles rooted in organisational psychology and high-performing sectors [14], [15], [16], [17].

Early efforts produced only temporary fixes. True change began with small but powerful actions: listening and questioning. Staff from all roles engaged in open, informal conversations, guided by humble inquiry [14] and purpose-driven leadership [18]. Many felt unheard and disengaged, despite leaders' best intentions.

The lessons learnt from Birley have informed the development of a framework grounded in empowerment, trust, and inclusive leadership. Throughout this paper, we use the language of organisational culture, as this remains the dominant term within General Practice and wider NHS discourse. However, we recognise the important distinction highlighted in the evidence base between organisational culture and organisational climate [19]. Organisational climate refers to employees' shared perceptions of “how

things are done around here", the policies, practices and everyday behaviours that shape experience, and is more tractable and measurable than deeper cultural assumptions [19]. Much of what we describe, particularly in relation to team communication, psychological safety, leadership behaviours and everyday interactions, aligns more closely with climate. Our aim, therefore, is to illuminate how climate changes can reinforce and shape organisational culture over time.

This model focuses on culture over technical fixes. Though progress was slow, early wins-built momentum, echoing Kotter and Rathberger's short-term gains [20], Lewin's change model [21], and Hirt's path-goal theory [22]. We share seven key domains underpinning the Social Determinants of Team Health and offer a practical framework to support transformation across primary care.

Psychological Safety and Trust

We began building trust using principles from *The Fearless Organisation [17]*, introducing activities to foster psychological safety. Team members shared personal stories, explored their personalities, and joined collaborative exercises to break down silos. Relationships and trust are foundational to high-performing teams [16] yet often neglected in busy GP settings [4]. We prioritised creating a space where staff could voice concerns without fear [23] knowing that feeling heard increases innovation and collaboration.

Leaders modelled vulnerability and humility, for example, by sharing their weakness, mistakes and their dependency on the team. They developed collaboration [24] through one-on-one listening and team-building. As psychological safety developed, team members spoke up more, especially when supported by facilitation and improvement tools [25]. This flow of diverse ideas enabled productive disagreement and better decision-making [26], [27], [28]. As staff felt genuinely heard, decisions gained stronger commitment. Trust-building took time and consistent effort [24], [29] but significantly improved collaboration and healthcare delivery.

Distributed Decision-Making and Engagement

Partners in General Practice are typically all GPs, leading to one-team dominance in decision-making. This narrowed perspective and hampered the cascade. We instead scheduled monthly meetings with departmental leads, ensuring cross-team views were included. These collaborative sessions became a problem-solving engine and freed partners from decisions.

One of the principles adopted was shared accountability and decision-making. Staff were involved in shaping decisions and direction using quality improvement tools [25] and facilitating tools. Space was created for idea generation, inclusive decision-making and collaboration, which reduced backsliding and strengthened change adoption. Echoing Lewin's model [21] and Kotter's emphasis on embedding new behaviours, team members who were able to contribute to decisions made, had a voice at the table and could influence change [20]. Lencioni argues that teams often confuse consensus

with commitment [16]. True commitment doesn't mean everyone agrees; it means that everyone has been heard and is willing to support the decision, even if it wasn't their preferred choice [23], [28]. One example was the smooth transition to new IT software, following an inclusive debate. Rich discussion led to a strong consensus, and minimal disruption with adoption.

Purposeful Communication

We use "purposeful communication" to refer to structured, intentional information-sharing that supports coordination, clarity, and day-to-day functioning. Regular, transparent and multidirectional communication practices, both formal and informal, were built through daily 10-minute huddles, shared lunches, brief exercise sessions, and social chats via WhatsApp. Informal activities like Friday lunches and post-work socials developed over time. This fostered purposeful communication, empathy, and boosted morale, ultimately saving time and fostering resilience. Our experience aligns with West and colleagues [30] whose NHS data analysis linked leadership support with empowered decision-making and staff satisfaction. These regular touch points also served as an everyday routine, reinforcing changes.

Relational Connection and Empathy

In contrast, relational connection and empathy describe the informal, human interactions that build trust, belonging, and emotional resilience within the team. Quality communication in many forms is vital for a healthy team [23] from keeping everyone informed about changes and decisions, to addressing daily operational challenges, connecting personally, and enabling deeper engagement and strategic input [24]. Although related, purposeful communication and relational connection serve different functions: the former aligns teams around shared work, while the latter strengthens the emotional foundations that allow that work to happen well.

In response to the instability and fatigue the practice was experiencing, we began by introducing simple low-burden routines that strengthened communication and connection. We implemented 10-minute daily huddles, bringing one representative from each team together to surface pressures, clarify priorities and resolve operational issues before they escalated. Alongside this, we created informal touchpoints, including team lunches and coffee breaks, team-building, and occasional celebratory meals, which helped to build trust and strengthen cohesion. Birthdays were marked with cake, poems and socials, reinforcing that people were seen and valued. These small, infrequent interactions reflected the work of Schien [14] and Lencioni [23] who emphasise that culture is built through everyday interactions, rather than formal boardroom strategy. Although some might assume General Practice is too overwhelmed for this approach, none of these activities exceeded 30 minutes. The mindset shift was recognising that practices cannot afford 'not to' invest in team health. Staff survey results demonstrated that strengthening the Social Determinants of Team Health in these types of activities did not take time away from work; conversely, it prevented waste, duplication, conflict and improved staff morale.

Previously, information updates dominated team meetings, which are rare and valuable moments in pressured settings. We redesigned these sessions to prioritise relational connection, empathy, engagement, and trust-building, rather than transactional updates. Routine information updates were moved to digital channels, with staff selecting their preferred collaboration tools (social media apps and email).

Inclusive Empowering Leadership

Leadership roles can gravitate to people who are clinically senior or who demonstrate charisma, authority, certainty, self-promotion, and confidence. Collins [31] found that 'the greatest leaders display a powerful mixture of personal humility and indomitable will.' High performance in a fast-paced, complex world requires us to harness the views of all the staff to build a confident, autonomous workforce [24]. For this, we need leaders who are great at listening, bringing out the best in others and who can create a safe, inclusive culture, and epitomise the values of the organisation. In our experience, we needed those who were admired, respected and showed honesty, bravery, vulnerability, service, kindness, and who empowered others, leading by example. We found in facilitated conversation that these people did not self-identify as leaders.

We hypothesised, if each team (nursing, reception, admin, medical) had a leader like this, we could give them the trust and autonomy to lead. These leaders became the mechanism for ensuring that we brought out the best in our staff. One of their roles was to ensure that everyone on the team was deeply known and understood, both personally and professionally, and they were committed to bringing out the best in individuals. This approach aligns with Daniel Pink's theory of motivation and nurturing mastery [32], based in psychology and behaviour science, it argues that intrinsic motivation is more effective than traditional reward-based (extrinsic) motivation. Organisations that apply this theory allow employees autonomy, nurture technical ability and connect work to a greater mission, which leads to higher employee engagement and innovation [32].

Few would argue with the role of regular, positive, and specific feedback. However, managing deficient performance can be uncomfortable and even seen as 'unkind.' Conversely, managing performance is an act of kindness, both to colleagues and to patients. It supports those who want to improve, who may benefit from additional guidance, or who might thrive in a different role or even a different organisation that better suits their strengths. We found that most colleagues value this kind of feedback. It is also a kindness to patients, who rightly expect and deserve high standards of care. The importance of addressing performance issues constructively is clearly outlined in the NHS Human Resources and Organisational Development report [33], which emphasises the need for compassionate leadership, timely feedback, and supportive interventions to foster both staff wellbeing and high-quality patient care.

This process of empowerment began with asking some simple questions in a facilitated conversation: Do you enjoy your role? If not, why not? Is it too simple or too complex? Do you have the right skills and knowledge to master it? Do you know how your role fits

in the team? Do you understand how your efforts make a difference? Do you feel valued? The outcomes of these conversations led to offers of support, coaching or a change of role. On occasion, we found kind ways to establish that the practice was not a good fit for them and supported them to move on.

Values-Based Recruitment and Role Design

At Birley Health Centre, we reimagined recruitment by focusing on values, character, and potential, prioritising cultural fit over immediate Primary Care experience. Drawing on recruitment theory, we developed principles that reshaped job adverts, candidate selection, and role design.

Adverts were crafted to reflect our team's values, purpose, and the behaviours we valued in daily practice. Shared widely across diverse platforms, this approach attracted candidates from beyond traditional NHS pools. While Primary Care experience was welcome, we often prioritised transferable skills and fresh perspectives, believing technical knowledge could be learned.

Recognising that conventional interviews often miss future performance indicators, we explored candidates' personal journeys, motivations, and growth potential. This approach brought in people aligned with our ethos and enabled us to shape roles around individual strengths.

A key cultural shift involved redefining traditional hierarchies, especially for non-clinical roles [2], [34]. By valuing all team contributions, we unlocked efficiency and improved patient care [24]. Reception staff, often overlooked, became central to our transformation.

Receptionists, many from outside the NHS, were selected for adaptability and a patient-centred mindset. With strong training, they improved workflow, supported demand management, and set the tone for patient interactions. Their work contributed to the continuity of care and significantly boosted patient satisfaction scores.

Empowering non-clinical staff to redesign processes not only improved efficiency but also increased job satisfaction and team cohesion. By recruiting for potential and aligning roles with individual strengths, we built a more motivated workforce capable of delivering high-quality care [32].

Wholehearted Patient Engagement

Patient engagement is a cornerstone of effective healthcare [35] yet often remains peripheral to operational and cultural decisions. At Birley Health Centre, we aimed to move beyond tokenism by embedding patient perspectives into our improvement efforts.

Alongside a structured patient and public involvement group of 20 members, we launched a Facebook group, now with over 1,300 followers. This informal platform

became a powerful channel for real-time dialogue, enabling patients to share concerns and suggestions and breaking down traditional barriers between service users and providers. It fostered trust, empathy, and shared ownership over care quality.

Importantly, this engagement was integrated with our internal culture. The same values, openness, humility, and responsiveness, guided our approach to both staff and patients. When patients raised concerns about the booking process, clinical, admin, and reception teams collaborated to co-design improvements. This enhanced clarity, reduced bottlenecks, and better reflected patient needs.

Such feedback loops reinforced staff purpose. Seeing their impact on patients boosted morale and reaffirmed their roles. Over time, this created a virtuous cycle: a climate of internal listening enabled external listening, benefiting both staff and patients. By embedding patient feedback into team activities, not just governance, we achieved meaningful, sustained change. True engagement, we found, strengthens not only patient experience but also positive organisational health.

Results: Measuring outcomes

Over a five-year period, Birley Health Centre demonstrated significant and sustained improvement in patient-reported outcomes, consistently outperforming national benchmarks across a range of quality metrics. Initially, patient satisfaction scores at Birley trailed national averages in areas such as appointment availability, continuity of care, and ease of accessing services. However, Birley saw marked improvements across the board. Patient satisfaction scores improved in every measured domain, continuity of care increased, and the patient list size grew by 15%, reflecting both improved service quality and local trust in the practice. By 2023, satisfaction with the helpfulness of reception and administrative staff had reached 89% points above the national average and overall patient experience was rated at 85%, outperforming the national average by 11% [13].

Outcomes were monitored through routinely collected NHS GP Patient Survey data, annual internal staff surveys, and qualitative feedback gathered through ongoing quality-improvement sessions. These mixed methods provided continuous insight into both patient-facing impact and internal team climate, allowing the practice to adapt actions iteratively.

These improvements were mirrored internally, with staff engagement and morale seeing a significant uplift. The 2024 staff survey revealed that 9.4 out of 10 staff would recommend Birley as a place to work, and 9.7 out of 10 would recommend the practice to friends or family. Staff who had once been disengaged were now enthusiastic, proud, and invested in the team's success

> Staff member 1 said *'I actually feel so lucky to work with amazing people that, without seeing it in themselves, have reached somewhere they never thought they*

would. It's so good and I hope you are able to share this with other practices. I feel we've absolutely nailed it and can't wait to see where we go.'

Staff member 2 said *'I feel so proud to work for such a lovely surgery, we have old staff wanting to come back, that's the progress we have made. It's a privilege working for Birley, I couldn't say that 3 years ago'.*

These improvements are consistent with, and likely linked to, the deliberate actions taken to strengthen communication, psychological safety, leadership behaviours, and distributed decision-making. This cultural shift directly aligns with findings by West et al [30] who explored the relationship between leader support, staff influence over decision making, work pressure and patient satisfaction, concluding that workplace culture significantly influences patient outcomes. This also mirrors Braithwaite and colleagues [29] who found that constructive environments in healthcare settings positively correlate with patient satisfaction and well-being.

The Birley experience illustrates that improvement in General Practice is possible not through crisis-driven responses, but by embedding a culture that prioritises psychological safety, nurtures leadership, and aligns team health with patient outcomes. We propose that this climate-focused approach appears to play an important role in sustaining improvement within primary care settings.

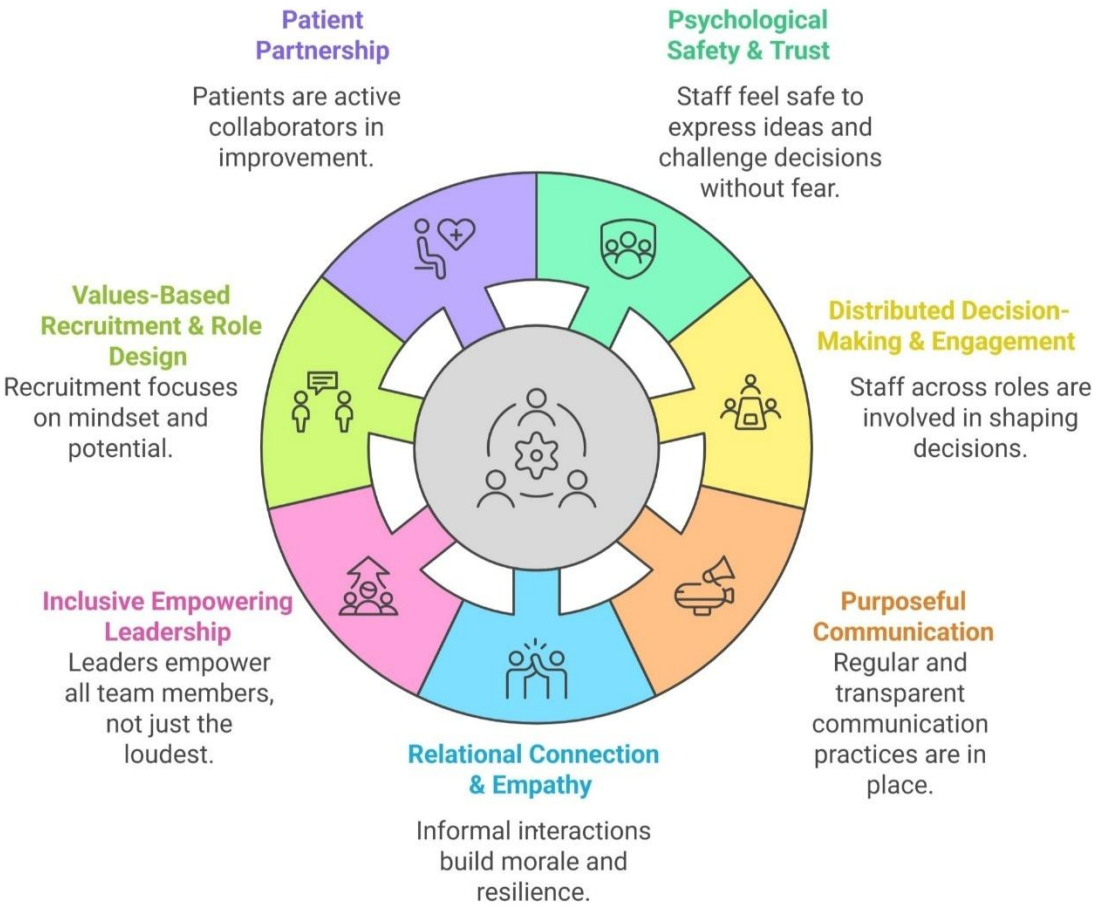
Discussion

The Social Determinants of Team Health Framework (Figure 1) outlines seven interdependent factors that could support thriving, high-performing teams in General Practice. At its foundation is psychological safety and trust, where individuals feel safe to speak up, challenge decisions, and contribute without fear of blame or exclusion. Our approach draws explicitly on well-evidenced constructs from organisational and occupational psychology, including psychological safety [36], leadership climate [37] and organisational team learning [38] all of which have robust empirical foundations and are consistent with the organisational climate framework identified in the CIPD evidence review [19]. Our focus on the Social Determinants of Team Health aligns with well-established research showing that team-level climate, particularly psychological safety, interpersonal trust, and leadership behaviours, shapes whether teams reflect, learn, and enact change. The theoretical concepts and practical insights informing framework development are illustrated in the supplementary information.

Edmondson's group-level analyses demonstrate that organisational learning is inherently local and contingent on team climate rather than on broader organisational culture alone [38]. In our experience, this is reinforced through distributed decision-making and active engagement, ensuring that staff across roles contribute to shaping priorities through quality-improvement and facilitation tools. Purposeful communication, regular, transparent, and multidirectional, helps sustain the clarity, responsiveness, and cohesion required for teams to adapt, learn, and perform effectively [38].

These efforts are grounded in relational connection and empathy, cultivated through everyday interactions, build morale and interpersonal resilience. Driving these dynamics is inclusive, empowering leadership that prioritises humility, service, and the development of others over hierarchy or charisma. Complementing this is a commitment to values-based recruitment and role design, where individuals are chosen for mindset and potential, and roles, especially non-clinical, are reimagined to maximise autonomy, contribution, and impact. Finally, wholehearted patient partnership ensures that patients are not passive recipients of care, but active collaborators in shaping services, with their feedback meaningfully integrated into improvement work. Together, these seven determinants form a replicable and practical blueprint for cultivating a healthier team climate and delivering more compassionate, effective primary care (Figure 1 represents the seven social determinants of team health).

Figure 1: Social Determinants of Team Health



Reimagining leadership in primary care: Investing in the social determinants of team health

Reversing the decline in Primary Care needs more resources, but also smarter use of what we have. At Birley Health Centre, progress came not from targets but from empowering staff through partnership and distributed leadership. Prioritising the social determinants of team health created a compassionate workplace, unlocking staff potential and productivity.

Leaders need to shift from reactive to proactive development, embracing incremental, sustained change. Systems could support this with funded development time, recognition of non-NHS experience, professionalising reception roles, and better training in facilitation and recruitment. Communities of practice and workforce development are key.

Birley's story shows that team culture drives patient satisfaction and staff morale. Culture is essential, not optional and leadership means consistent empowerment over heroism. We propose a practical, people-focused approach with seven steps to embed a strong organisational culture (Figure 2). At its heart: psychological safety and trust, enabling open dialogue, collaboration, and innovation.

Sustained, open communication, both formal and informal, is vital. Leadership must go beyond hierarchy to elevate those who empower others, model inclusion, and lead by example. Non-clinical staff need more training, recognition, and autonomy. Recruitment needs to focus on values, behaviour, and potential, embracing diverse experience. Patient engagement, built on listening and adapting, keeps culture aligned with care.

The NHS 10-Year Plan [39] recognises that patient care quality is tied to team wellbeing. We argue that organisational culture is a core driver of effectiveness, not an afterthought. Just as social conditions shape personal health, team culture and conditions shape clinical performance.

Figure 2. Practical actions to cultivate the social determinants of team health.

Figure 1 outlines the seven Social Determinants of Team Health, which are best understood as features of organisational climate, the shared perceptions of trust, communication, leadership, and relational connection within the practice. Figure 2 presents seven practical actions that help cultivate these determinants. Each 'plant pot' represents an actionable way to nurture the corresponding domain in Figure 1, illustrating how climate is shaped through everyday behaviours and routines. To make this relationship explicit, Table 1 maps each action to its associated domain and provides brief examples of how these were implemented in practice. Thus demonstrating how climate-focused behaviours were operationalised in day-to-day work.

Table 1: Synthesis of Social Determinants of Team Health and Practical Actions.

Practical Action (Figure 2)	Corresponding Domain (Figure 1)	Example in Practice
Build Safety & Trust	Psychological Safety & Trust	Daily huddles, modelling humility, thanking staff for speaking up.
Engage Teams	Distributed Decision-Making & Engagement	Whole-team priority-setting, small-group facilitation, voting on solutions.
Foster Communication	Purposeful Communication	Transparent updates (WhatsApp/email), structured feedback loops.
Support Leaders	Inclusive Empowering Leadership	Identifying quiet leaders, providing leadership development opportunities.
Rethink Roles	Values-Based Recruitment & Role Design	Recruiting for mindset and emotional intelligence, not only technical skills.
Recruit to Values	Relational Connection & Empathy	Team social interactions, informal connections to build trust and morale.
Embrace Feedback	Patient Partnership	Using patient experience data to co-design improvements.

Overall, the Birley experience shows that sustained improvements arise not from isolated interventions, but from consistent attention to the relational and organisational climate that shapes everyday team practice.

Conclusion

Birley Health Centre's transformation shows how investing in the workplace can contribute to lasting improvements, even with limited resources. Our findings suggest that addressing the Social Determinants of Team Health could spark systemic change in primary care. By focusing on leadership, trust, and patient engagement, NHS leaders can foster environments where staff and patients thrive.

This challenges the notion that resource constraints are insurmountable, urging a shift toward cultural change. While resources matter, strengthening team dynamics appears to play an important role in unlocking team potential. As General Practice reaches a critical point, building resilient, thriving teams is essential. Prioritising team health has the potential to make the NHS more effective, compassionate, and fulfilling for patients and providers. Supporting and scaling cultural work across teams may contribute meaningfully to long-term sustainability.

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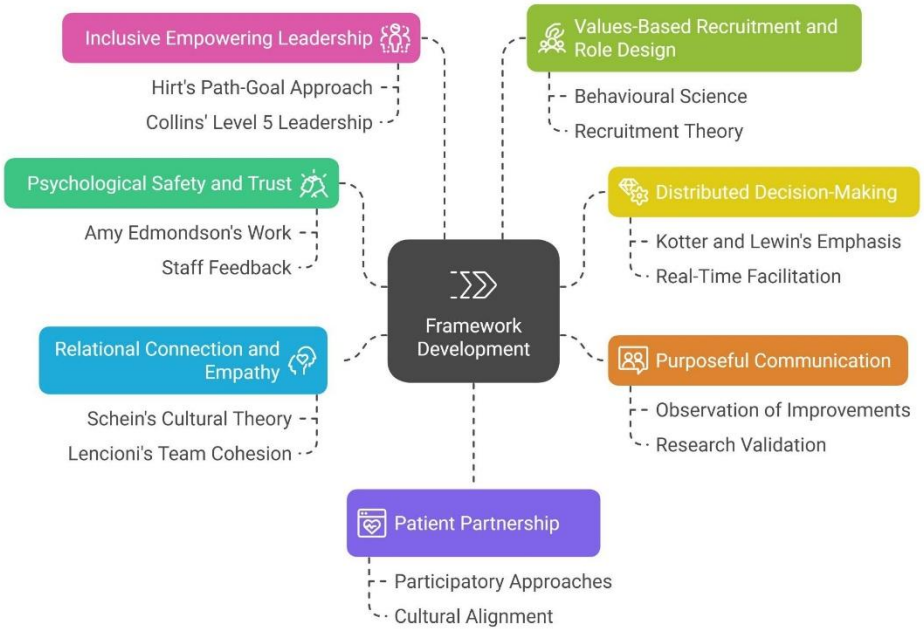
Figure Legends
Figure 1: Social Determinants of Team Health
Figure 2. Seven ways to embed an effective organisational culture in primary care

Supplementary Information

Theoretical concepts and practical insights informing framework development.



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