

Is bigger better? Lessons for large-scale general practice

Research report

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Traditional general practice is changing. Three-quarters of practices are now working collaboratively in larger-scale organisations – albeit with varying degrees of ambition. Policy-makers and practitioners have high hopes for these organisations and their potential to transform services both within primary care and beyond. But can we be confident that they can live up to these expectations? This study examines the factors affecting the evolution and impact of large-scale general practice on staff, patients, the wider health economy and the quality of care. The study combines an extensive literature review and national surveys with an in-depth mixed-methods evaluation of contrasting, large-scale general practice organisations that includes detailed case studies.

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Traditional general practice is changing. Three-quarters of practices are now working collaboratively in larger-scale organisations – albeit with varying degrees of ambition. Policy-makers and practitioners have high hopes for these organisations and their potential to transform services both within primary care and beyond. But can we be confident that they can live up to these expectations?

The following key points are drawn from a 15-month study of large-scale general practice organisations in England. This study examined the factors affecting their evolution and their impact on staff, patients, the wider health economy and the quality of care. The study combined an extensive literature review and national surveys with an in-depth mixed-methods evaluation of contrasting, large-scale general practice organisations, which included case studies.

Key findings

- **Rate of formation.** Almost three-quarters of general practices are in some form of collaboration with other practices, around half of which formed during 2014/15. The two commonest reasons for forming were to ‘achieve efficiencies’ and ‘offer extended services in primary care’.
- **Sustainability.** The case studies demonstrated how larger scale can help to improve sustainability in core general practice through operational efficiency and standardised processes, maximising income, enhancing the workforce and deploying technology. However, the resources needed to develop and maintain the large-scale organisation and introduce these approaches are significant.
- **Quality of care and patient satisfaction.** The case study sites routinely used quality improvement methods such as peer review, electronic clinical templates and standardised coding. However, analysis of 15 quality indicators in eight organisations was unable to detect marked differences in quality of care compared to the national average; nor reductions in variation within the organisations. While three of the case study organisations performed significantly better than the national average on over half of the measures, particularly in prescribing, no single large-scale organisation consistently outperformed or underperformed the others on all indicators.
- **Patient involvement and experience.** Patients had mixed views about large-scale general practice, identifying more with their own practice than with the overarching organisation. Some patients valued new forms of access offered by the larger organisation but others voiced concerns about losing the ongoing, trusted relationship with their own general practitioner (GP) and their own practice. Emerging organisations must find ways to harness the benefits of larger scale while preserving the localism and ‘expert generalism’ of general practice.
- **Staff experience.** Staff were broadly positive about working in a large-scale organisation, with administrators and receptionists reporting the highest overall satisfaction scores and salaried GPs reporting the lowest. Staff particularly valued education and training opportunities and peer support arrangements across practice boundaries, which provided rapid access to clinical advice, offered support with day-to-day operational problems and reduced professional isolation.

- **Extending the range of services offered in general practice.** The case studies had established high-quality community specialist services that were popular with patients. However, they were mainly small scale and none of the case study organisations had yet tried to redesign care delivery across a whole speciality. Furthermore, the case study organisations had not yet operated at the scale envisaged for new models of care and only one of them was embarking on this process.
- **Working with the local health economy.** The quality of relationships with commissioners and specialists shaped the ability of large-scale general practice organisations to develop extend services. Relationships with CCGs changed over time and could help or hinder progress with developing extended services. It was harder for organisations that worked in multiple CCGs to build strong relationships with commissioners, which could make it harder for multi-site providers to win contracts for extended services.
- CCGs had to manage the paradox of supporting large-scale groups to develop so they could contribute to commissioning plans while also managing conflicts of interest. These arose because GPs were both CCG members and owners of these private provider organisations. However, while some were for-profit, others were community interest companies and so far, all had reinvested savings back into their organisations.
- **Realistic expectations.** National and local policy-makers and commissioners need to have realistic expectations of large-scale primary care organisations. The case study organisations had been operating for many years and newer groups may struggle to establish the systems needed to deliver efficient, high-quality services if too much is asked of them too quickly.

Practical insights for emerging groups

The case studies also offer practical insights for those who are leading the establishment of large-scale GP organisations – particularly in relation to the governance and leadership arrangements needed for success, opportunities to strengthen the workforce and the potential for technology to contribute to sustainable general practice.

- **Clarity about goals and values.** Each organisation had agreed its core values and developed and refined its goals over time. We observed three broad, overlapping goals pursued by large-scale organisations:
 - **sustaining and improving core** general practice services
 - **delivering extended services** in community settings
 - leading **whole-system change** as a multi-speciality community provider.

These were not mutually exclusive and evolved as new opportunities arose and external policy changed. They offer a framework around which emerging organisations can develop their future plans.

- **Governance.** There is no ‘off the shelf’ governance plan that can be applied in all organisations and governance arrangements must be designed to support organisational goals and values. An important difference between the case study sites was whether member practices or the central organisation held the contracts for core services as this influenced how the board and executive team were able to work with individual practices.

- **Leadership.** Inspiring clinical leaders played an essential part in engaging staff and supporting them to change. However, leaders worked long hours, stepping in at short notice to fill staffing gaps and address operational problems, and the case study sites sought ways to disperse leadership roles across a wider group. Emerging organisations should develop a broad leadership group to avoid dependence on ‘heroic’ leaders.
- **Models of change.** We observed a more directive model of change where the central organisation held member practices’ General Medical Services (GMS)/Personal Medical Services (PMS) contracts as the executive team appeared to have authority to direct day-to-day operations, allocating additional resources and offering leadership support where needed. However, this authority was not used if imposing change risked reducing professional engagement. Where practices retained their core contracts and the executive team had no formal authority to direct staff in practices, a model of ‘concertive’ change was used, which involved member practices and was implemented through peer review, peer pressure and outreach support from the central team.
- **Economies of scale.** While few of the initiatives introduced to improve efficiency were groundbreaking, there appeared to be added value from implementing them at scale using standardised systems and processes that could be extended into weaker practices that would not otherwise use them. The economies of scale available to larger organisations allowed investment in staff, technology and support that would be unaffordable in smaller practices.
- **Workforce.** Large-scale general practice creates new opportunities to strengthen and diversify the workforce. Investment in training, skills development and peer support seemed to improve job satisfaction at the same time as helping to achieve strategic goals. Formal and informal support networks for different staff groups were relatively low cost to organise, highly valued by most interviewees and helped to reduce the sense of isolation felt by many staff in small practices. However, senior staff support for these initiatives was at times ‘heroic’ and staff burnout was described.

Expectations of large-scale general practice organisations are high and there is a **risk that these organisations will become overwhelmed by opportunities** available to them. Emerging organisations will need **sufficient time to develop** the necessary skills, knowledge and working relationships. They will also need excellent **leadership and organisational development support** if they are to undertake the work needed to establish themselves and build capacity to deliver new services. This report provides recommendations and practical lessons for the leaders of emerging large-scale provider organisations and recommendations for commissioners and policy-makers to enable them to create a receptive context in which emerging organisations can thrive.

Recommendations to large-scale general practice organisations

- Invest the time needed to **agree the purpose, values and short- to medium-term goals** of the organisation. This should include agreeing the extent to which the organisation wants to take on the delivery of extended services (this may be a phased process).
- Consider including **specific and measurable quality improvement goals** that are consistent with local commissioning priorities in order to improve care, build

relationships with the local CCG and create a rationale for CCG investment in the organisation.

- **Invest time and resources to develop staff roles** across practice boundaries and to create peer support and peer learning opportunities.
- Design the **simplest governance arrangements possible** to deliver agreed goals and be prepared for them to evolve and become more complex as the organisation's objectives develop. Also agree the level of decision-making authority to be ceded by member practices to the board that will best balance the pace of change with ongoing engagement of member clinicians.
- Ensure that **resources are available to achieve agreed goals and be clear about the level of risk** (in terms of investing money and/or resources) that members are willing to take to attain these.
- Engage with patients to **design services that address diverse needs** and preferences, including rapid access to and continuity of relationships with clinicians.
- Where member practices are seeking to establish **extended services, ensure that these are underpinned by positive, collaborative relationships** and shared goals with specialists.

Recommendations to clinical commissioning groups

- Have **realistic expectations about the capacity of large-scale general practice organisations to take on extended roles**, their ability to develop specialist skills and their capacity to set up new services. Involve large-scale organisations, therefore, at a pace that allows them to bid for and, if successful, establish new services without becoming overwhelmed.
- **Facilitate local debate between patients, the public and other stakeholders** about how best large-scale general practice organisations can contribute to population health improvement and what other part they might play in the local health economy.
- Follow **guidance on conflicts of interest, but avoid excluding GPs** with an expert knowledge of a specific area of care from service redesign work.

Recommendations to national policy-making and research bodies

- Ensure that there is a **phased introduction of the alternative contract for large-scale** general practice organisations and multi-speciality community providers, as there is currently insufficient evidence that large-scale general practice will deliver high-quality, cost-effective care that is valued by patients.
- Acknowledge the **time needed** for large-scale general practice organisations to develop into reliable, high-quality providers.
- Commission research on the impact of larger-scale general practice organisations on the quality of core services; the extent to which they deliver the 'expert generalism' and continuity of relationship that is valued by patients; and their impact on use of other services.

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Glossary

Advanced nurse practitioner (ANP)	An experienced and autonomous registered nurse who has developed and extended their practice and skills beyond their previous professional boundaries.
Alternative Provider Medical Services (APMS)	A contract type that allows NHS England to contract with ‘any person’ under local commissioning arrangements.
Calculating Quality Reporting Service (CQRS)	A national electronic system used by general practices to record practice participation in service delivery (for example, enhanced services).
Care Quality Commission (CQC)	The independent regulator of health and social care providers in England.
Charitable incorporated organisation	A new form of legal entity available for charities or charitable groups that would like to be incorporated.
Clinical commissioning group (CCG)	A statutory organisation, of which GPs are members, responsible for commissioning the majority of health and care services for patients.
Commissioning for Quality and Innovation (CQUIN)	A national payment framework that enables commissioners to reward excellence by linking a proportion of English health care providers’ income to the achievement of local quality improvement goals.
Community interest company (CIC)	A business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community.
Continuing professional development (CPD)	The learning activities that professionals engage in to develop and enhance their skills and abilities.
EMIS Health	Supplies electronic patient record systems and software used in primary care in England.

General Medical Services (GMS) contract	A nationally directed contract between NHS England and a general practice, introduced in April 2004. Currently, about 60 per cent of general practices are on GMS contracts.
GP Patient Survey	An independent survey run by Ipsos MORI on behalf of NHS England, sent out each year to over a million people across the UK.
Health care assistant	A member of the GP practice team, providing support to nurses and doctors and undertaking basic clinical tasks.
Key Performance Indicator (KPI)	A type of performance measurement tool used to define and monitor progress towards organisational goals, which in turn calculates the performance and success of activities and the organisation.
Limited company	An organisation that is responsible in its own right for everything it does and its finances are separate from the owners' personal finances. Any profit it makes is owned by the company, after it pays Corporation Tax.
Limited liability partnership (LLP)	An agreement in which partners in a business are not personally liable for debts that the business cannot pay. Partners' responsibilities and share of the profits are set out in an LLP agreement.
Patient and public involvement (PPI)	Active participation of citizens, service users and carers and their representatives in the development of health care services and as partners in their own health care.
Patient participation group (PPG)	A group of volunteer patients and general practice staff who communicate at regular intervals to review the services and facilities offered by their general practice.
Personal Medical Services (PMS) contract	A local contract agreed between NHS England and the general practice, together with its funding arrangements. In England, approximately 40 per cent of practices are on PMS contracts.
Plan, Do, Study, Act (PDSA) cycles	A change management tool used to test an idea by temporarily trialling a change and assessing its impact. The four stages are: Plan (the change to be tested or implemented); Do (carry out the test or change), Study

	(data before and after the change and reflect on what was learned); Act (plan the next change cycle or full implementation).
Primary care trust (PCT)	An administrative body responsible for commissioning primary, community and secondary health services from providers between 2001 and 2013, when they were abolished. Their work has been taken over by clinical commissioning groups.
Prime Minister's GP Access Fund	A national incentive scheme to improve access to primary care (2013, wave 1 funding) and also improvements in information technology and premises (2014, wave 2 funding).
Quality and Outcomes Framework (QOF)	A financial incentive scheme available to all general practices tied to a range of quality standards. It measures practice achievement against evidence-based clinical, public health, quality, productivity and patient experience indicators. Although voluntary, most practices participate.
Significant event audit	A way of formally analysing incidents that may have implications for patient care. Learning from what went wrong or right should help to improve practice.
Sustainability and Transformation Plan (STP)	Strategic plans for 44 geographic areas in England showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

1. Introduction

General practice remains the bedrock of the National Health Service (NHS) in England, carrying out an estimated 340 million consultations each year, of which over 95 per cent are completed without referral to other services (Foot and others, 2010). It is still seen as an international exemplar of what good, local, family-centred primary care should be.

But general practice has also played a central role in increasingly ambitious plans by policy-makers to transform and modernise the NHS over the past two decades. It has almost become a truism that future ambitions for general practice will require a shift away from the ‘corner shop’ autonomous business model that has dominated the sector since 1948, towards a sector that combines the benefits of local access with those of large scale. Indeed, the latest vision for the future of the sector – the *General Practice Forward View* (NHS England, 2016a) – appears to take large-scale general practice as a given.

Yet the paradox of the past two decades is that, just as the vision for what general practice can and should do has become increasingly ambitious, the pressure on general practitioners (GPs) to do their basic job has increased dramatically. A combination of reduced funding, an ageing population, rising patient expectations, a declining workforce and other factors are all adding to the difficulty of delivering high-quality, sustainable services. GPs regularly bemoan the stresses of their working lives and question how they can find the time to participate in the development of larger-scale organisations.

A few entrepreneurial GPs and clusters of other organisations have established larger-scale general practice groups around England, despite the pressures on the sector (Smith and others, 2013). The founding aims of these initial groups varied, with some focused on commissioning and others established to deliver community clinics in response to competitive tenders. In subsequent years, other groups were set up and over 250 now exist (Renaud-Komiya, 2016). Mirroring their predecessors, newer organisations have formed with a variety of motives, some stimulated by experienced clinical leaders who have practical knowledge of service redesign and clear plans for what they want to achieve, and others by leaders with less clarity of purpose.

This report captures the experience of organisations at the forefront of ‘scaling up’ general practice in order to help leaders of newer general practice organisations to make sense of the world into which they are emerging. It aims to:

- describe the effects of scaling up on the organisation and quality of general practice
- clarify the decisions that emerging groups will have to make if they are to establish themselves effectively
- examine emerging roles for large-scale general practice in a fast-changing health system.

The report also aims to inform policy-makers and commissioners about what these organisations might realistically achieve and about how to create a receptive and supportive context in which large-scale general practice organisations can thrive.

The following section briefly reviews the policy, financial and regulatory factors that have shaped the formation of general practice organisations in recent years, as a backdrop to the research.

A changing policy, financial and regulatory context

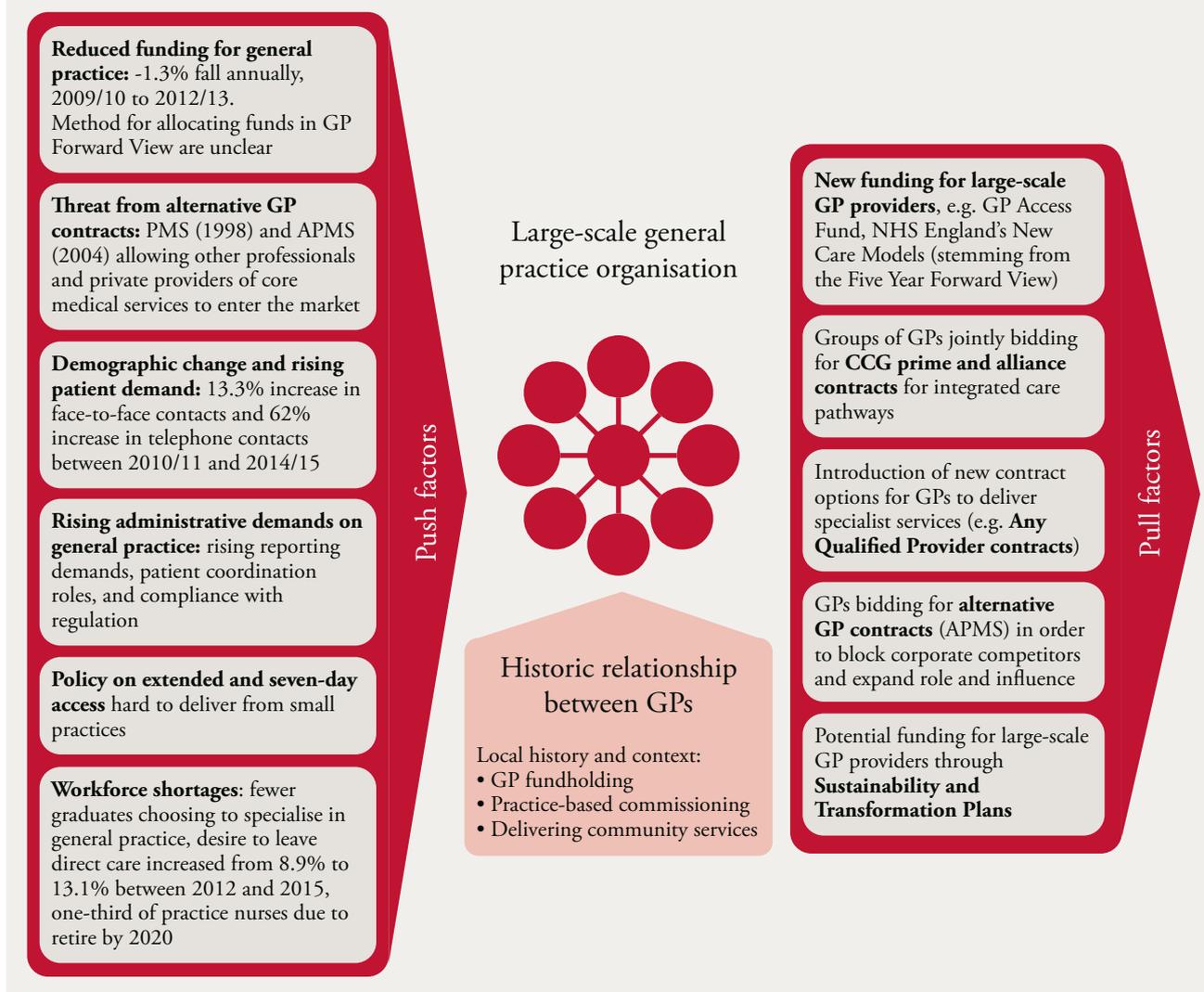
The traditional small business model of general practice has been struggling to deal with growing financial pressures, increased administrative burden and the significant costs of regulatory compliance that have been described elsewhere (Smith and others, 2013; Roland and Everington, 2016). With increasing patient expectations, the growing health needs of an ageing population and workforce shortages, many smaller practices that have struggled to survive for some time have closed in recent years (Dayan and others, 2014). Others are feeling pushed to look for new ways of working in order to survive.

Added to this, there has been a steady stream of policy over the past decade, which has encouraged GPs to play a greater role in care coordination for patients with complex needs (see, for example, *Our Health, Our Care, Our Say* – Department of Health, 2006) and to expand their services to deliver elements of specialist care in community settings. More recently, the government's pledge to deliver a seven-day NHS has included weekend access to routine general practice appointments. Funded through the Prime Minister's GP Access Fund, almost a third of the population now has access to such services – delivered not from their own practice, but from central 'access hubs'. With small practices unable to provide specialist clinics or seven-day access, many GPs in these practices have been pulled into collaborative arrangements to deliver new services across clusters of practices.

Significantly, policies promoting competition between providers – which have pulled many GPs into larger organisations to bid for contracts – are changing. The *Five Year Forward View* (NHS England, 2014) signalled a return to collaboration between local providers; and the forthcoming Sustainability and Transformation Plans (STPs) – aiming to stabilise the finances and services of regional clusters of NHS providers – are likely to extend this approach. This has important implications for large-scale general practice organisations. For while they are essential to both competitive markets and collaboration, emerging organisations will need to be clear about the different opportunities they could pursue and the operational and governance challenges that each will present. Above all, they will need clarity about their strategy and purpose.

The major contextual factors 'pushing' and 'pulling' practices towards operating at large scale are described in Figure 1.1.

Figure 1.1: Push and pull factors driving collaboration in general practice



What is already known about large-scale general practice?

Limited research currently exists on new forms of large-scale general practice organisations in England. However, there are opportunities to learn from previous initiatives that encouraged GPs to work as groups, such as GP-led commissioning, out-of-hours GP cooperatives, integrated care initiatives and clinical networks. Likewise, there are opportunities to gain insights, albeit with greater limitations for transferability, from experiences of large-scale primary care organisations in other countries. A summary of the findings from a review of the literature is presented below. The full version is published as a supplementary report (Pettigrew and others, 2016).

Development

Collaborations among health care providers can emerge voluntarily from the 'bottom up', or be mandated from the 'top down'. While this distinction is not always clear cut, evidence suggests that mandated collaborations can offer legitimacy and stimulate new relationships, but are more likely to result in clinician disengagement and dampen innovation than those that emerge organically (Erens and others, 2015; Goodwin and others, 2004; Guthrie and others, 2010; Smith and Mays, 2012). Likewise,

involvement in previous collaboration initiatives can leave legacy relationships that facilitate or hinder local relationships in new large-scale organisations, and influence their ability to establish and evolve to achieve their goals (or not) (Checkland and others, 2012; Zachariadis, 2013). If there are discrepancies between members on levels of trust, degrees of consensus on goals and interdependency to achieve their goals, the collaboration risks being ineffective or dissolving altogether (Provan and Kenis, 2008).

Researchers also suggest that there are trade-offs between:

- small and large organisations
- loose networks of providers and tightly run single organisations
- flat and hierarchical governance structures
- different ownership models.

For example, sufficient size is needed to take on financial risks and to generate economies of scale; however, if partnerships become too large, diseconomies of scale can emerge, as the increase in size may attenuate the effects of external productivity incentives and the ability to coordinate decisions (Sheaff and others, 2012). Furthermore, smaller practices are typically better able to deliver relational continuity of care, which is more closely linked with better patient satisfaction and fewer unscheduled admissions to hospital than larger practices (Casalino and others, 2014; Huntley and others, 2014; Ng and Ng, 2013). There is some evidence that single organisations may be preferable to networks for the delivery of coordinated care, because networks' looser governance structures are more likely to result in weaker information flows and organisational links, less-aligned financial incentives and targets, and less power to generate accountability (Sheaff and others, 2015).

Impact

Research evaluating the impact of new forms of GP collaborations is limited. Most publications on the subject are descriptive (see, for example, Addicott and Ham, 2014; Baker and others, 2013; Imison and others, 2010; Smith and others, 2013). Only four studies, all in the same locality, were identified that measured the impact of a large-scale general practice organisation implementing complex interventions to improve care and outcomes (Cockman and others, 2011; Hull and others, 2013; 2014; Robson and others, 2014). All the studies found improvements in quality indicator scores; however, contextual differences in implementation limit the transferability of findings to other large-scale organisations.

Research on domain-specific clinical networks (for example, in cancer or palliative care) spanning primary and secondary care have similarly found that networks can be effective vehicles for improving the delivery of health care and clinical outcomes. However, like large-scale general practice organisations, improvement is contingent on numerous variables – both internal and external to the evolving organisation – such as leadership, culture, resourcing available and the power over their local health economy (Brown and others, 2016; Ferlie, 2010; Goodwin and others, 2004; Guthrie and others, 2010).

No known studies have measured the impact of GP collaboration on patient experience. However, researchers have suggested that inadequate patient and public involvement in the creation of integrated care organisations was a cause of mismatches

between patient-reported experience and the perceptions of improvements by the professionals involved (RAND Europe and Ernst & Young LLP, 2012). This provides a warning to practices joining larger organisations that they need to engage their patient participation groups (PPGs) along the journey.

Importantly, studies to date have not provided detailed economic analysis, therefore the cost-effectiveness of developing large-scale GP collaborations remains unknown. Similarly, the evidence base on the cost-effectiveness of the integration of care initiatives, including evaluations of collaborations between GPs and other community services, is small (but see, for example, Erens and others, 2015; Nolte and Pitchforth, 2014; RAND Europe and Ernst & Young LLP, 2012).

Overall, most research suggests that the theoretical benefits of new large-scale collaborations between health care providers are not always realised as expected. Time and costs required are often underestimated, as are personal efforts needed to build relationships and the role of clinical leadership, as well as the disruptive effects of organisational change on clinical care and workforce morale (Edwards, 2010; Fulop and others, 2002; Thomas and others, 2005). The measurement of impact and attributing causality to complex organisational changes are also challenging. Therefore, while the theory on how and why large-scale general practice organisations will deliver on the anticipated expectations is substantial, rigorous empirical evidence that they will ultimately improve patient outcomes and experience and/or control costs, to date is limited.

Who should read this report?

The report is aimed at two main audiences.

First, it is aimed at the leaders (and members) of recently formed large-scale general practice organisations who are trying to decide how best to develop them. To this audience, the report offers insights and practical suggestions on how larger organisations can improve care for patients, support and sustain member practices, and avoid common pitfalls.

Second, it is aimed at commissioning and policy leads in NHS England and clinical commissioning groups (CCGs), who are counting on the emergence of high-performing large-scale general practice organisations to contribute to their transformation plans. This report offers insights into how they can create a receptive context in which emerging organisations can form effectively and develop.

Structure of the report

In Chapter 2, we describe our research questions and methods.

In Chapter 3, we summarise findings from a survey that the Nuffield Trust conducted in partnership with the Royal College of General Practitioners (RCGP) on collaboration between general practices. In doing so we describe the national landscape of new large-scale providers and present the context for the analysis of our findings, discussion and recommendations.

Chapter 4 is deliberately detailed and is written for leaders of emerging general practice organisations so that they can learn from the experience of mature organisations. In this chapter we first describe four case study site organisations, drawn from the Nuffield

Trust's General Practice Learning Network, and then explore seven analytic themes:

- organisational structure and governance arrangements
- leadership and culture: managing and supporting change
- financial and organisational sustainability
- clinical quality
- staff experience, training and education
- patient experience and involvement
- relationships with CCGs and providers across the system.

We draw out a summary of findings and practical lessons at the start of each themed section, intended to support the leaders to make progress with organisational development.

In Chapter 5, we present quantitative data on the impact of the three case study sites delivering core general practice services and five other members of the Learning Network on 15 publicly reported measures that describe different aspects of quality in primary care services.

In Chapter 6, we discuss the implications of our findings for practitioners, commissioners and policy-makers who are expecting large-scale general practice organisations to address a wide range of aims.

In Chapter 7, we identify policy and regulatory challenges that will need to be addressed if large-scale general practice organisations are to make rapid progress towards their chosen goals. We set out recommendations to large-scale general practice organisations, clinical commissioning groups and national policy-making and research bodies.

2. Research questions and methods

Following on from its work on *Securing the future of general practice* (Smith and others, 2013), which was carried out in association with The King's Fund, the Nuffield Trust funded a 15-month project to investigate the evolution and goals of both new and mature large-scale general practice organisations. The research combined two national surveys, an analysis of quality indicators and an in-depth mixed-methods evaluation of a sample of four large-scale general practice organisations. The research protocol was developed in collaboration with the Nuffield Trust's General Practice Learning Network of 13 mature organisations (see the Appendix), which were not only study participants, but also provided feedback on the research methods and interim findings between October 2014 and April 2016.

Research questions

We set out to answer the following research questions:

1. How is the landscape of general practice changing? How quickly, and in what form, are new large-scale general practice organisations emerging? What are the factors driving the formation of these new organisations? (See Chapter 3.)
2. For a small sample of mature large-scale general practice organisations, how have they emerged and evolved over time? (See Chapter 4.)
3. How have organisational, local, national and other contextual factors affected the abilities of mature large-scale general practice organisations to achieve their goals over time? (See Chapter 4.)
4. What impacts are the organisations having on their patients, staff and the local health economy? (See Chapter 4.)
5. What impacts on quality of care can we measure? (See Chapter 5.)

National surveys

To address our first research question, we designed surveys for commissioners and providers in partnership with the RCGP. We sent one survey to leaders of CCGs and the other to RCGP members in England.¹

¹ The surveys were the only element of the study conducted in partnership with the RCGP and funded by NHS England (as part of the Supporting Federations programme). The Nuffield Trust independently funded and conducted all other study elements.

Case study analysis of four large-scale general practice organisations

We addressed research questions 2 to 4 through case studies of four contrasting, large-scale general practice organisations, drawn from the Learning Network. The organisations were mature (the oldest was formed over 10 years ago), ensuring that each site encapsulated many years of experience of working at scale. The four case study organisations were:

- **AT Medics** – a multi-site provider of general practice services focused on improving quality and developing educational support within practices
- **GP Care** – a limited company owned by 100 general practice shareholders providing community-based diagnostic services and collaborating in an extended GP Access Fund initiative
- **Harness Healthcare** – a federation and community services provider rooted in its local community, formed to improve quality of care, reduce health inequalities and ensure sustainability of general practice
- **Modality Partnership** – a GP super-partnership rooted in its local community and formed to improve general practice and extend the scope of services provided, and now embracing the *Five Year Forward View* (NHS England, 2014) challenge of leading whole-system change.

Data collection methods with the case study sites comprised:

- observations of four board meetings (one at each organisation)
- reviews of 41 internal documents from the case study sites (approximately 10 per organisation)
- 100 interviews across all four organisations with senior clinicians and managers, salaried staff, consultants working with case study sites, local CCG staff and PPG members
- a staff satisfaction survey that received 198 responses from the three organisations delivering core general practice services (AT Medics, Harness and Modality).

All data fed into an analysis of how each case study organisation had formed and of the part they played in their local health system. The analysis framework was based around seven themes that emerged from the data, but were also evident in literature:

- organisational structure and governance arrangements
- leadership and culture: managing and supporting change
- organisational and financial sustainability
- clinical quality
- staff experience, training and education
- patient experience and involvement
- relationships with CCGs and providers across the system.

Quantitative evaluation of trends in 15 quality indicators for general practice

The final part of our analysis aimed to determine whether large-scale general practice organisations were having measurable impacts on quality. Drawing on the sample of 13 member organisations of the Learning Network, four were excluded from the analysis because they did not have sufficient data or their members had not been actively collaborating during the analysis timeframe: 2009/10 to 2014/15. One further organisation – one of our four case studies: GP Care – was excluded because it did not provide core general practice services, which many of the indicators assessed.

For each of the remaining eight, we mapped their performance across 15 indicators spanning four domains:

- prescribing behaviour (4 indicators)
- registered patient use of hospital services (4 indicators)
- patient satisfaction (4 indicators)
- performance on the Quality and Outcomes Framework (QOF) (3 indicators).

Detailed descriptions of the sampling, recruitment, data collection and analysis methods for each study component are provided in the Appendix.

The study was approved by the East of Scotland Research Ethics Service REC 1 NHS Research Ethics Committee and the governance committees of participating CCGs.

3. The extent of collaboration in general practice in England

With most organisations forming through local initiatives, little is known about the number, form or aspirations of emerging large-scale general practice organisations in England. In collaboration with the RCGP and funded by NHS England, we conducted two surveys from July to November 2015. We wanted to obtain a national cross-sectional snapshot of the pace and scale of collaboration in general practice.

We sent a survey to all CCG chief executives (with a request to forward it to the most appropriate respondent) and received responses from 94 CCGs (45 per cent of all CCGs). We also sent a similar survey intended for providers to all 50,000 RCGP members in England, and received responses from 982 GPs and practice representatives to whom they had delegated the survey completion (representing 184 CCGs; 87 per cent of all CCGs), who identified their affiliations with about 210 large-scale collaborations. Full results are available in Kumpunen and others (2015) and a summary is set out below (including in Figure 3.1).

Figure 3.1: What do large-scale general practice collaborations look like?

Most general practices are now collaborating:

73% of practice-based respondents reported that their practices worked in collaboration with other practices



2012/13



2013/14



2014/15

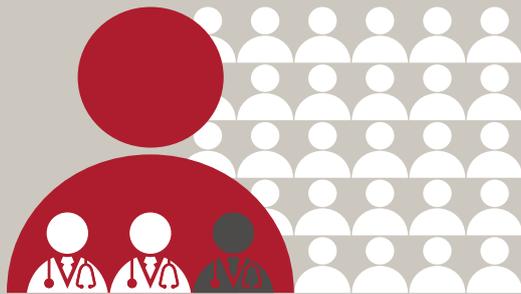


Most collaborations formed recently:

44% of respondents said that their main collaboration formed during 2014/15

Most collaborate locally:

84% of respondents said their collaboration was with practices in the same CCG area

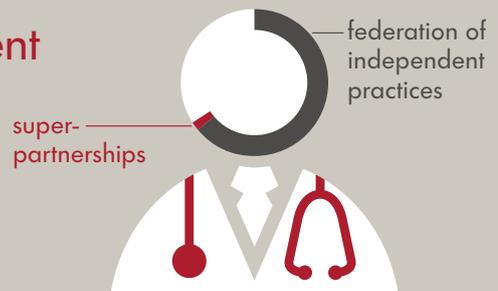


Most collaborations care for large numbers of people:

Two-thirds of those in collaborations provided care for 50,000 or more patients

Most collaborations remain independent within their organisation:

64% of practice-based respondents described their status as a federation of independent practices – only 2% were super-partnerships



What do large-scale general practice collaborations look like?

The surveys revealed that almost three-quarters of respondents' practices worked in collaboration with others. Larger-scale working has expanded rapidly since 2013/14 when the British Medical Association reported that 22 per cent of English GPs were part of an existing large-scale organisation and a further 35 per cent were considering it. Most of our respondents said that their collaboration was located in a single CCG area. However, approximately 7 per cent of collaborations covered two or more CCGs, which can complicate organisational governance processes and/or cause members to be a part of two organisations competing for contracts. Of those who were in formal collaborations (with a legal agreement between member practices), the majority had chosen to retain their individual practice contracts by creating federations of independent practices, which can create risk and reward sharing, rather than merging into a single super-partnership. The survey also revealed that collaborations had formed for many different reasons (see below).

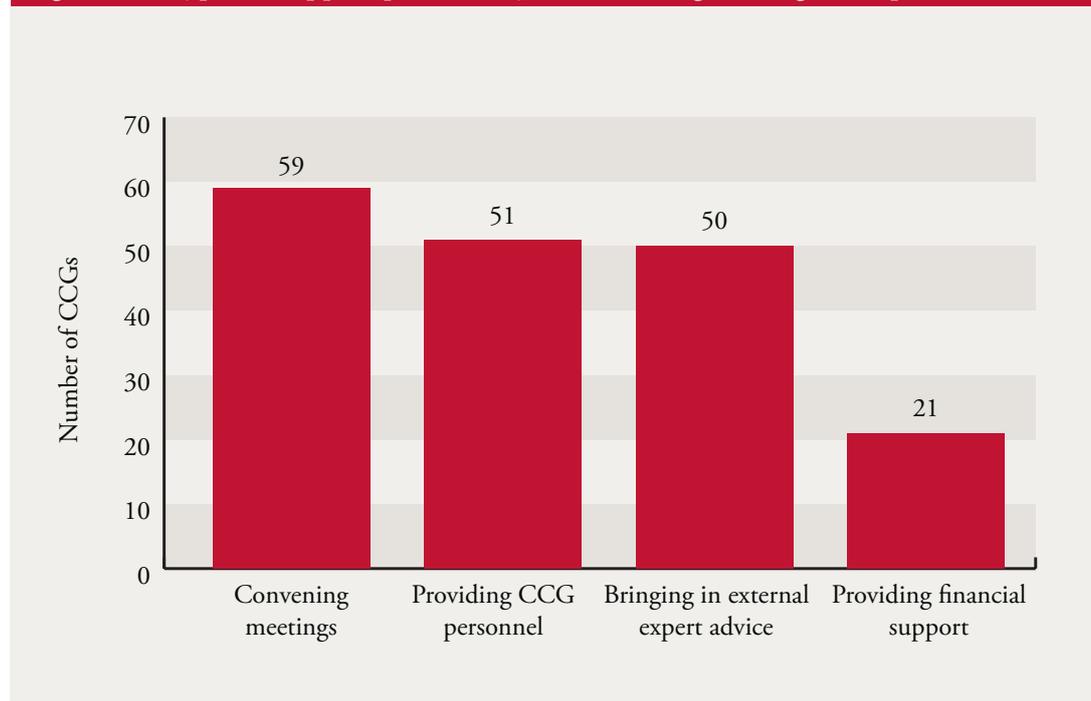
What do large-scale collaborations aim to achieve?

Practice-based respondents described a wide range of motivations to collaborate. From a list of 12 possible motivations, no single response had more than 11 per cent of positive responses, but the top two were to 'achieve efficiencies' and 'offer extended services in primary care'. The third most common motivation was that their 'CCG had encouraged' them to work at scale. A small number of respondents suggested that they had collaborated because they felt national and CCG pressure to do so, or were coming together proactively only to avoid being left out of large-scale contract tendering.

CCG respondents agreed that practices were motivated to collaborate to achieve efficiencies and extend services. Around half of CCGs viewed their influence as essential to the shift. Seventy-three out of the 94 CCGs reported that they had 'actively encouraged' provider collaboration, and had done so by:

- convening meetings (n=59)
- providing CCG personnel (n=51)
- bringing in external expert advice (n=50)
- providing financial support (n=21) (see Figure 3.2).

It was difficult to determine what impact CCGs' interventions had made on providers, but it seemed that both commissioners and providers agreed that most collaborations prioritised maximising income and cost savings opportunities.

Figure 3.2: Types of support provided by CCGs to large-scale general practice

To measure what providers had achieved since founding, we provided a list of 11 options and analysed their reported achievements against the length of time since their collaboration had been launched. In Table 3.1 we report the most common activities achieved by at least a quarter of respondents in each maturity band (0–12 months, 13–24 months and 25+ months). The analyses reveal two particularly interesting findings:

- Around a quarter of respondents reported that within their first 24 months they had agreed an organisational plan, attempted to extend the range of services available in primary care settings and invested in staff training and development. These steps are sequentially logical: organisations need to agree a focus and then gain income to fund collaborative working; however, in the meantime, sharing human resources to deliver training is an inexpensive first step (which can also allow member practices to begin forming relationships).
- The likelihood of having extended services increased as the collaboration matured, but none had achieved this in year one. If extended services are a potential source of income to ensure the survival of collaborations, then such income is unlikely to be available (assuming extended services are profitable) for a year or two. Furthermore, the process of bidding is resource intensive, and, if resources are limited, there may be opportunity costs in terms of other collaborative activities that can benefit member practices (for example, developing shared back-office functions or peer review).

Table 3.1: Achievements of existing large-scale general practice organisations (2015)		
0–12 months (n=151 collaborations)	13–24 months (n=100 collaborations)	25+ months (n=97 collaborations)
<ul style="list-style-type: none"> • Developed an organisational strategy or plan (n=38) 	<ul style="list-style-type: none"> • Extended the range of services available in primary care settings (n=34) • Invested in staff training and development (n=29) 	<ul style="list-style-type: none"> • Extended the range of services available in primary care (n=43) • Aligned clinical pathways (n=37) • Developed new ways for patients to access services (n=37) • Pooled human resources (n=36) • Invested in staff training and development (n=34) • Introduced more flexible opening hours (n=33) • Developed an organisational strategy or plan (n=30) • Introduced new clinics (n=29) • Developed back-office functions/processes (n=29) • Brought in new workforce from community and social care (n=28) • Collectively invested in information technology (n=25) • Carried out peer review (n=24)

Note: Activities are reported here if cited by at least a quarter of respondents in each maturity grouping. We asked GP respondents to list all of the collaborations their practice was involved in. Most reported one collaboration (that is, their main organisation), but some reported up to five collaborations. This table reports the results of their main collaboration, of which there were 355, but only 348 provided the length of maturity of the collaboration.

Source: Kumpunen and others (2015)

What support is needed?

Practice-based and CCG respondents agreed that the main challenges faced when forming a collaboration were:

- building trust between practices
- convincing all members of the benefits
- finding time to develop collaborations.

These findings confirm headline findings from the British Medical Association's 2014 GP Practice Collaboration Survey, which found that the majority of respondents described workload pressures (69 per cent) and a lack of time (67 per cent) as barriers to collaboration; meanwhile, around a half of respondents (45 per cent) reported a lack of evidence about the benefits as a barrier (British Medical Association, 2014). Our practice-based respondents suggested that, to overcome some of these challenges, they needed help with managing demand for GP services (potentially to free up time to participate in network development). They also wanted support with organisational development and legal advice. For CCG respondents, the main priority was for emerging organisations to develop new leaders.

Overall, the challenges faced by these large-scale collaborations are both practical – such as finding time to develop leaders and engage members – and conceptual, in terms of agreeing the purpose of the collaboration and setting realistic objectives.

Drawing on case study evidence, this report will now highlight how four contrasting mature collaborations, which mirror the diversity of the organisations described in these surveys, have responded to these challenges. It will also describe the varied ways in which GPs are currently working at large scale and explore the implications of different approaches to governance, leadership and operational management for the achievement of goals and objectives.

4. Learning from established organisations

This chapter presents data from the four case study sites, grouped into seven analytic themes:

- organisational structure and governance arrangements
- leadership and culture: managing and supporting change
- financial and organisational sustainability
- clinical quality
- staff experience, training and education
- patient experience and involvement
- relationships with CCGs and providers across the system.

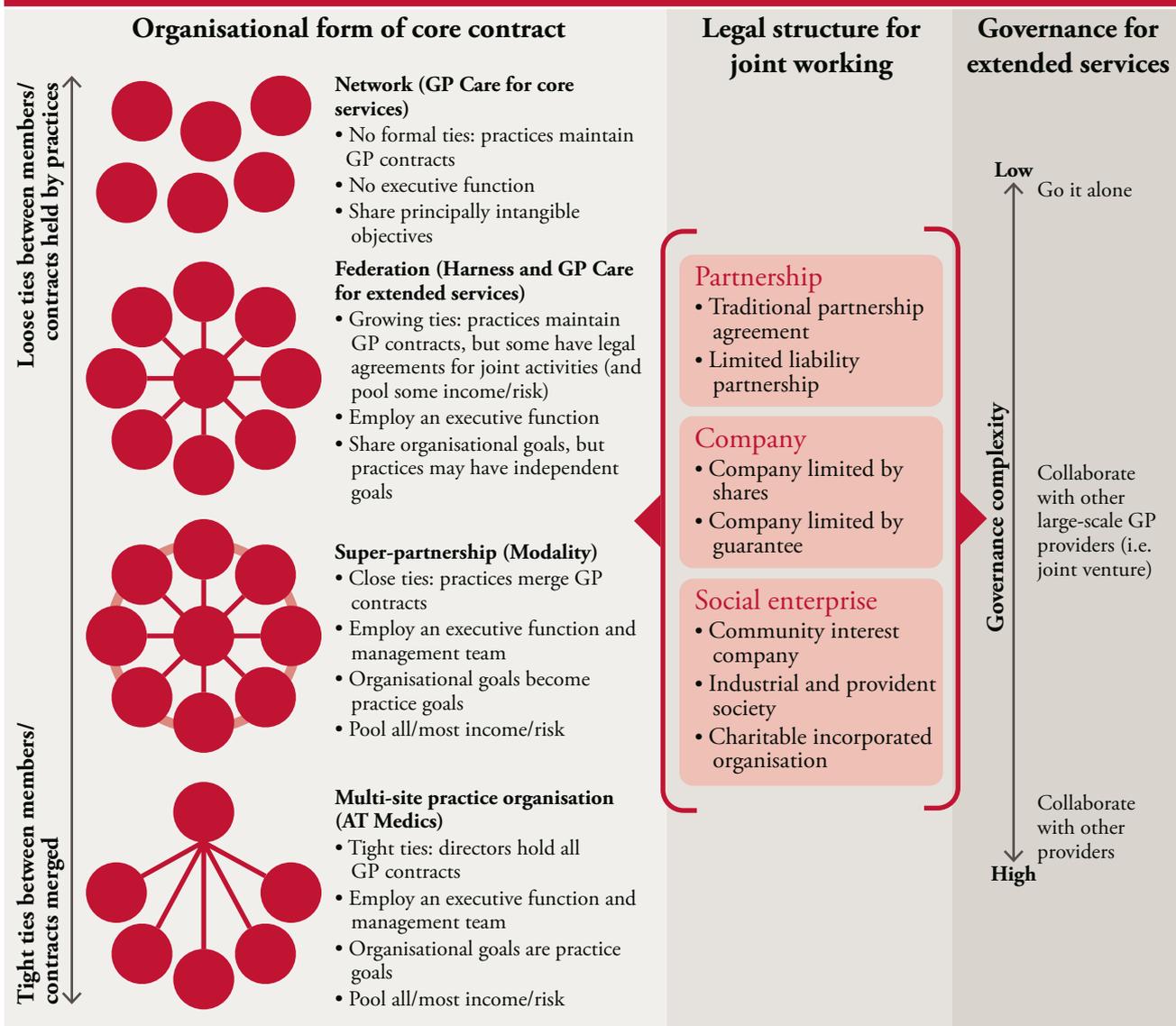
The detailed descriptions included in this chapter are intended for leaders who are setting up large-scale general practice organisations. Key findings from the case studies and practical lessons are highlighted at the beginning of each themed section. The broader implications of the findings for policy-makers and practitioners are explored in the discussion in Chapter 6.

Description of the case study organisations

Many terms have been used to describe the organisational forms of collaboration among GPs in the NHS, including GP groups, clusters, consortia, networks, federations, alliances, joint ventures, super-partnerships, multi-practice organisations and community health organisations (British Medical Association, 2015; Care Quality Commission, 2015; Curry and Kumpunen, 2015; Imison and others, 2010; Smith and others, 2013).

The organisations vary in terms of the financial and administrative interdependency between collaboration members (see Figure 4.1). The variation can be best understood along a spectrum from 'loose' to 'tight' ties between members. At one end, there are loosely associated networks of GP practices with principally intangible objectives such as information sharing (for example, GP Care for core general practice services). Moving towards formalisation, federations or alliances (for example, Harness and GP Care [for extended services]) typically have growing ties and legal agreements for joint activities, including pooling part of their existing income in order to support back-office functions, or setting up a new legal entity in order to tender for community services.

Figure 4.1: Organisational forms of large-scale general practice organisations



Moving further along the spectrum, collaborations, often referred to as super-partnerships (for example, Modality), begin to resemble a single organisation, and for some, if not all, activities, risk and reward may become inseparable between member practices. In super-partnerships, a new partnership agreement is put in place between partners of existing member practices. Their GP contracts may continue to be managed on trust by each practice, or may be handed over to a designated executive with agreement regarding how the funds will be redistributed.

At the end of the spectrum, multi-practice organisations (for example, AT Medics) often grow through ‘taking over’ practices, often where partners are retiring or former General Medical Services (GMS) or Personal Medical Services (PMS) contracts have been put out to tender as time-limited Alternative Provider Medical Services (APMS) contracts. In this case, the partnership or parent company holds more GP contracts than would traditionally have been the case, with there probably being more contracts than GP partners.

Four case study sites were selected from the Nuffield Trust’s General Practice Learning Network (see the Appendix) using a theoretical sampling technique to ensure a contrast

in organisational form along the spectrum (as well as variation in activities and aims), and invited to become case study sites. Each case study was unique; Table 4.1 describes each case study organisation's size, location, funding sources, aims and priorities. It should be noted that, unlike AT Medics, Harness and Modality, which delivered core general practice services among a number of member practices, GP Care delivered specialist and diagnostic services in general practice settings and employed only allied health professionals – not GPs – to deliver services. GP Care was, however, led by GPs and delivered services in general practice settings.

The four case study organisations represent archetypes of the collaborations of general practices that have formed, and are well placed to provide lessons based on approximately 10 years of experience. Their contrasting organisational forms highlight the varied ways in which practices can work at scale, and each has spent many years introducing systems and processes to improve care. They are led by experienced leaders who are well known in their local communities and formed through initiatives led by colleagues with a shared vision for the future of general practice. In many ways, they are the showcases of large-scale general practice, but their stories indicate what might be possible for new collaborations, and the possible variation in form, aims and evolution.

Table 4.1: Overview of the case study organisations

	AT Medics	GP Care	Harness Healthcare	Modality Partnership (formerly Vitality Partnership)
Founding aims	<ul style="list-style-type: none"> • To run general practices in ways that improve quality, efficiency and access for patients • To focus mainly on practices in deprived areas • To be a teaching organisation 	<ul style="list-style-type: none"> • To deliver community-based specialist services through a network of GPs in a geographic area • To protect local community services offered for tender from being taken over by private providers 	<ul style="list-style-type: none"> • To create a support network among local practices to improve local health outcomes and reduce inequalities • To protect local general practice from take-over by private companies 	<ul style="list-style-type: none"> • To create a large partnership to provide sustainable and high-quality integrated services • To improve patient experience and be the preferred provider of primary care services in the region • To improve consistency of quality
Year founded	<ul style="list-style-type: none"> • 2004 	<ul style="list-style-type: none"> • 2006 	<ul style="list-style-type: none"> • Harness GP 2006 • Harness Care 2008 • Harness Health 2014 	<ul style="list-style-type: none"> • 2009
Location	<ul style="list-style-type: none"> • London (working in 12 CCGs) 	<ul style="list-style-type: none"> • Membership includes all practices in Bristol, North Somerset and South Gloucestershire (three CCG areas) • Delivers services in five CCGs 	<ul style="list-style-type: none"> • Started in practices in Harlesden and Neasden localities in Brent Primary Care Trust; now 'Harness' locality in Brent CCG 	<ul style="list-style-type: none"> • Greater Birmingham (coterminous with 3 CCGs)

	AT Medics	GP Care	Harness Group	Modality Partnership (formerly Vitality Partnership)
Legal status, organisational form and structure	<ul style="list-style-type: none"> • A limited for-profit company • A multi-practice organisation with six founding GP directors who sit with the chief executive officer on the company board • A single-parent company, running 20 general practices across London through time-limited contracts 	<ul style="list-style-type: none"> • A for-profit company limited by shares (changed from a limited liability partnership in 2008) • An executive team of a chief executive officer and directors of finance, operations and business development, with a GP chair of the governing board and additional GP and practice manager acting as non-executive directors – all accountable to shareholders • Also participating in a joint venture with the BrisDoc out-of-hours service called ‘One Care’, to deliver Prime Minister’s GP Access Fund services 	<ul style="list-style-type: none"> • A group of companies (best described as a federation) to suit the legal needs and values of members, formed of: <ul style="list-style-type: none"> • 1 GP cooperative of 19 independent practices with lifelong contracts linked together by articles of association and constitution • 1 limited not-for-profit company (holding 2 APMS contracts and walk-in services – delivered in 5 CCG areas) • 1 limited for-profit company (not currently trading) • A 6-member executive management team carries the day-to-day business across the group of companies, reporting to the board and membership council 	<ul style="list-style-type: none"> • A super-partnership, whereby all partners have put their lifelong contracts into a limited liability partnership • Has a number of sub-organisations including property, community interest and private organisations • Some companies are for profit; community interest company is not for profit • Day-to-day operations are run by an executive board with support from a senior management team on behalf of the GP partners
Number of practices	<ul style="list-style-type: none"> • 1 (2004) • 18 (2014) • 20 (April 2016) 	<ul style="list-style-type: none"> • 80 (2008) • 100 (April 2016) 	<ul style="list-style-type: none"> • 12 (2006) • 16 (2008) • 21 (2014 and April 2016) 	<ul style="list-style-type: none"> • 2 (2008) • 9 (2014) • 16 (April 2016)
Registered list size April 2016	<ul style="list-style-type: none"> • 135,000 patients 	<ul style="list-style-type: none"> • Shareholders have a combined list size of 800,000 patients 	<ul style="list-style-type: none"> • 120,000 patients 	<ul style="list-style-type: none"> • 87,556 patients
Contract types	<ul style="list-style-type: none"> • APMS • NHS standard contracts for unscheduled care services 	<ul style="list-style-type: none"> • 3-month rolling community-based specialist and diagnostic services, mainly in the Bristol area but some are in more distant CCG areas • 1-year NHS contract for the Prime Minister’s GP Access Fund 	<ul style="list-style-type: none"> • Cooperative arm: GMS, PMS • Provider arm: APMS • NHS standard contract for walk-in services • Local authority contract for public health services 	<ul style="list-style-type: none"> • GMS, PMS, PMS+

	AT Medics	GP Care	Harness Group	Modality Partnership (formerly Vitality Partnership)
Services offered during 2014/15	<ul style="list-style-type: none"> • Core general practice • Enhanced services • Unplanned care (2 minor injuries units, 1 extended hours hub, 1 walk-in centre) 	<ul style="list-style-type: none"> • Urology • Deep vein thrombosis service • Ultrasound • Audiology • Musculoskeletal triage • Access to consultant telephone advice 	<ul style="list-style-type: none"> • Core general practice • Enhanced services • Community-based specialist services (e.g. gynaecology) • Public health services • Referral facilitation services • Training and development • Extended hours hubs • Nursing home and housebound care • Whole-system integrated care of complex patients • Management and back-office support 	<ul style="list-style-type: none"> • Core general practice • Enhanced services • Community-based specialist services (e.g. dermatology, gynaecology and rheumatology)
National funding for transformation	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Co-funded with local out-of-hours service to receive the Prime Minister's GP Access Fund (£1 million) 	<ul style="list-style-type: none"> • Co-funded with North West London CCGs to receive the Prime Minister's GP Access Fund (£257,000) • Prime Minister's GP Access Fund (£990,000) 	<ul style="list-style-type: none"> • NHS England's New Models of Care ('vanguard') programme (£2.5 million) (shared with partners)
Main activities across member sites	<ul style="list-style-type: none"> • Quality improvement initiatives (e.g. preparation for Care Quality Commission visits, shared protocols) • Organisational redesign for efficiency, particularly focused around reduction of administration for clinicians • Accredited to train GP registrars 	<ul style="list-style-type: none"> • Provides accommodation from which GP Care services are delivered 	<ul style="list-style-type: none"> • Clinical and non-clinical training • Peer-led support and advice • Shared quality management system and assurance processes and support • Staff bank and access to specialist skills • Central team support for information technology and human resources • Partnership working and capacity building with the third sector and wider community • Research hub of Imperial College London 	<ul style="list-style-type: none"> • Organisational redesign for efficiency • Clinical and non-clinical training • Peer-led support and advice • Shared quality management system and assurance processes and support • Partnership working with wider community

	AT Medics	GP Care	Harness Group	Modality Partnership (formerly Vitality Partnership)
Strategic plans and priorities	<ul style="list-style-type: none"> • Continue to improve quality of care • Integrate with neighbouring practices in geographic networks • Increase number of practices and registered patients • Develop staff training tools and resources into saleable commodities • Transfer selected roles and tasks from directors to other senior staff 	<ul style="list-style-type: none"> • Win additional community contracts • Develop methods to support practices to improve core services • Provide rapid access to community diagnostics and assessment and to consultant telephone advice • Deliver new forms of access through a joint venture with the local out-of-hours cooperative, funded through the Prime Minister's GP Access Fund 	<ul style="list-style-type: none"> • Develop the organisation as a respected provider of integrated 7-days-a-week extended care • Evolve the organisational model to achieve sustainability • Continue to improve the quality and assurance process of care, patient experience and outcomes • Develop education and the workforce to support new models of care • Build community capacity and resilience • Continue to develop partnership working across sectors and organisations 	<ul style="list-style-type: none"> • Create an integrated provider organisation of general practice, community, specialist and social care services (via NHS England's New Models of Care programme) • Partner with a new Midlands Metropolitan Hospital by 2020 to redesign and enhance services • Improve patient experience and access to high-quality services • Develop the organisation to achieve greater service integration • Ensure a business of sustainable high performance and resilience

Organisational structure and governance arrangements

Key findings and practical lessons from the case studies

- Although standard legal structures exist for large-scale organisations, there are no ‘off the shelf’ governance plans that can be applied to large-scale general practice organisations. Emerging organisations must invest the time needed to agree the vision, values and goals of the organisation and then develop the simplest governance arrangements possible to achieve these.
- Governance arrangements changed in response to periods of growth or failure, with new Board members periodically appointed. Appointments were typically made to bring additional skills and experience to the board although criteria for new appointments were not always transparent, which could cause distrust among members.
- The executive’s ability to direct day-to-day operations in the case study sites depended on two factors: whether member practices’ contracts were held by the new organisation (or retained by each practice); and the executive’s desire to direct member practices’ actions. If members retain their own contracts, they will have to agree the extent to which decision-making authority over their day-to-day work will be delegated to the board and executive.
- The board must secure the skills and resources to meet organisational objectives and enable growth.
- Subsidiary companies and/or joint ventures may be needed to take advantage of new opportunities to deliver services, increasing the complexity of governance arrangements.

AT Medics

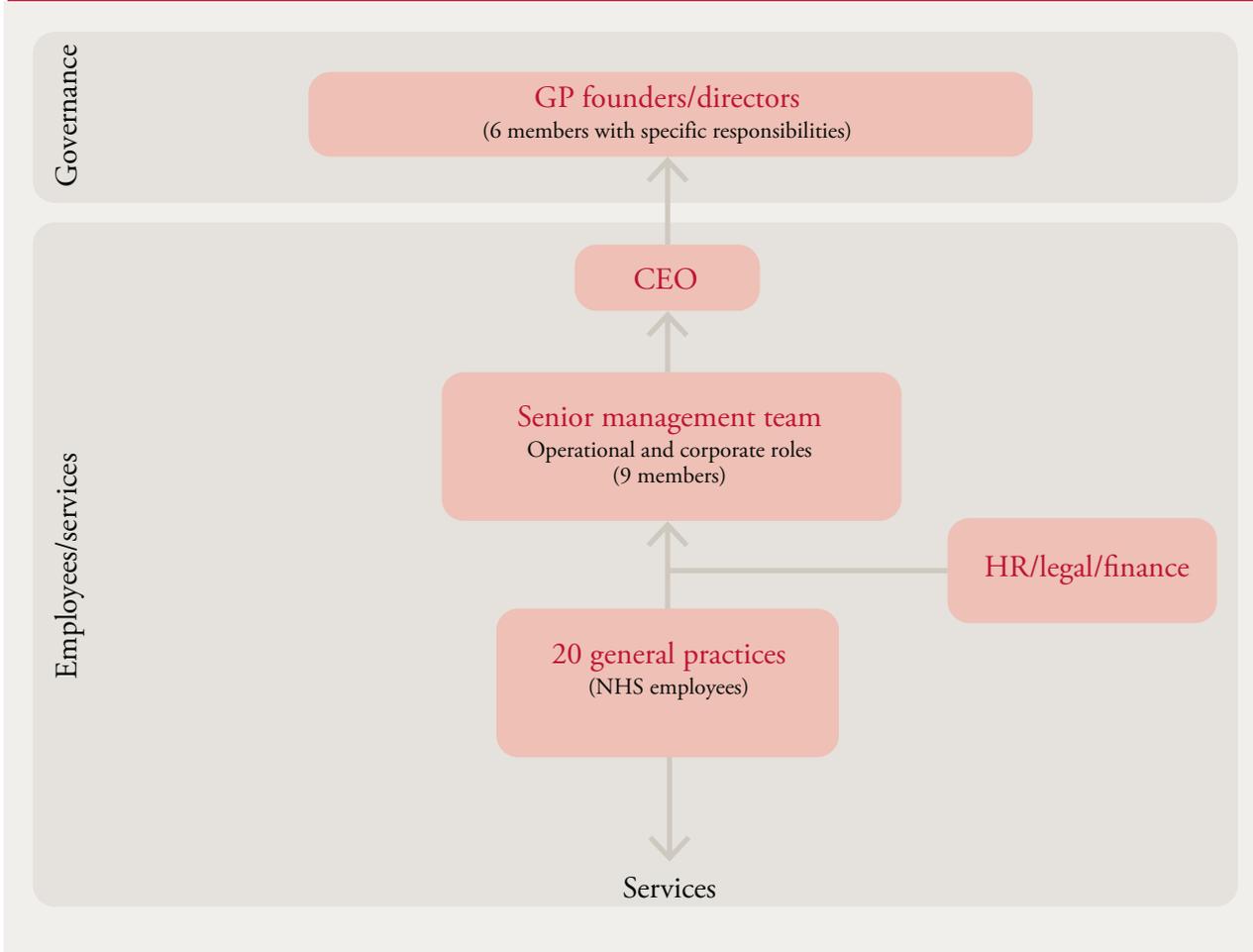
Legal form and organisational structure

AT Medics was founded as a company limited by shares in 2004 to deliver core general practice services. This legal form allowed it to bid for contracts to run practices and has remained suitable for this purpose ever since. So, unlike the other case study sites, AT Medics has not had to change its registered legal status. The organisation has grown through successful bidding for AMPS contracts.

Early governance arrangements were relatively informal, with a weekly board meeting between the six founding members to make strategic and operational decisions and review performance in the practices they ran. Each member had a ‘director’ role for a specific area of organisational work – for example, clinical quality, business development, education and training and service transformation. In 2015, realising that the organisation needed additional skills in strategic development and to support further growth, AT Medics appointed a chief executive officer (CEO).

To support organisational growth and plan for further expansion, AT Medics invested in bringing additional staff into roles that were previously outsourced on a part-time basis (for example, communications and marketing) and created new posts in business development and business intelligence. The current organisational structure of AT Medics is shown in Figure 4.2.

Figure 4.2: AT Medics' organisational structure and governance (2016)



Relationship between the executive, the board and member practices

During the study, the practices for which AT Medics held an APMS contract were clustered into five geographic patches, with day-to-day operational management of each cluster provided by a regional manager who reported to the CEO. Each geographic cluster had a linked GP director who worked closely with the regional manager and undertook clinical practice within their cluster of clinics.

AT Medics was a relatively small organisation during the study, and directors had regular contact with front-line staff and were quickly made aware of the day-to-day operational issues they faced.

Significant turning points in governance arrangements

As already noted, after a decade in operation, the founding directors realised they lacked the strategic management skills for further organisational development. They appointed a CEO and board activities evolved to include more strategic planning.

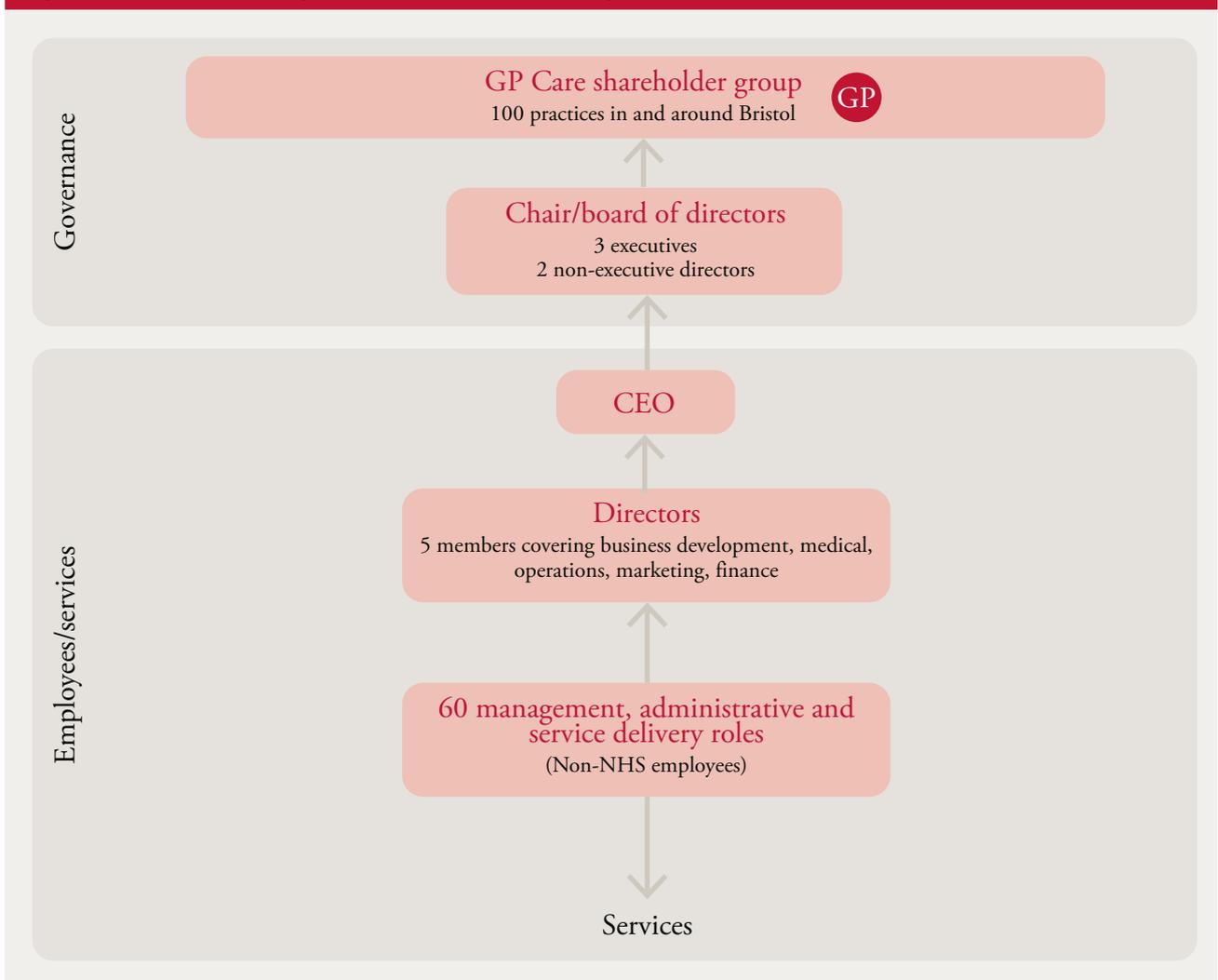
GP Care

Legal form and organisational structure

GP Care was founded as a limited liability partnership (LLP) in 2006 to deliver specialist services in community settings. Each of the founding member practices was a

shareholder that retained their own GMS and PMS contracts. Two years after forming, in 2008, GP Care changed to a company limited by shares because LLP shareholders would have been liable for tax on profits even if no dividends had been distributed. A CEO was appointed in the same year and GP Care's executive team expanded to include directors of finance, business development and operations to run day-to-day business. At the time of the study, the board included two non-executive directors, two GPs (one was chair) and a practice manager (see Figure 4.3).

Figure 4.3: GP Care's organisational structure and governance (2016)



Relationship between the executive, the board and member practices

GP Care was formed and funded by 85 general practices, with an extra 15 practices joining by the time it converted to a limited company.

The day-to-day business of GP Care did not relate to core general practice services. The organisation ran services (e.g. audiology, deep vein thrombosis, urology, ultrasound) across a number of CCGs in Bristol, the Midlands and Essex, with its headquarters based in Bristol. So while the executive team could direct operations in the services for which GP Care held contracts, the shareholding practices in and around Bristol did not delegate decision-making authority for core general practice activities to the organisation, nor did they have significant influence on the leadership, its governance structure or the ways in which services were run by remote teams.

Significant turning points in governance arrangements

Founding GP executives took almost three years to realise that they did not have the skills and resources needed to bid successfully for contracts. For a time, in the words of one interviewee, GP Care was “haemorrhaging money”. Once the skills deficit was recognised, a CEO was appointed with the commercial and bidding skills to enable GP Care to win some competitive tenders. In parallel, the board developed a clinical governance framework for clinical services, and board members gave up any governing body roles in local CCGs to reduce conflicts of interests between the company and its shareholders.

In 2015, a new CEO was appointed who:

- reviewed the organisational strategy
- developed a new business development plan focused on ‘facilitating the shift of simple diagnostic, outpatient and ancillary services out of acute hospitals and into the community’ (www.gpcare.org.uk/site/about/)
- formalised decision-making structures (limiting strategic decisions to the board and offering autonomy to remote services)
- set out clear lines of reporting and expectations of performance.

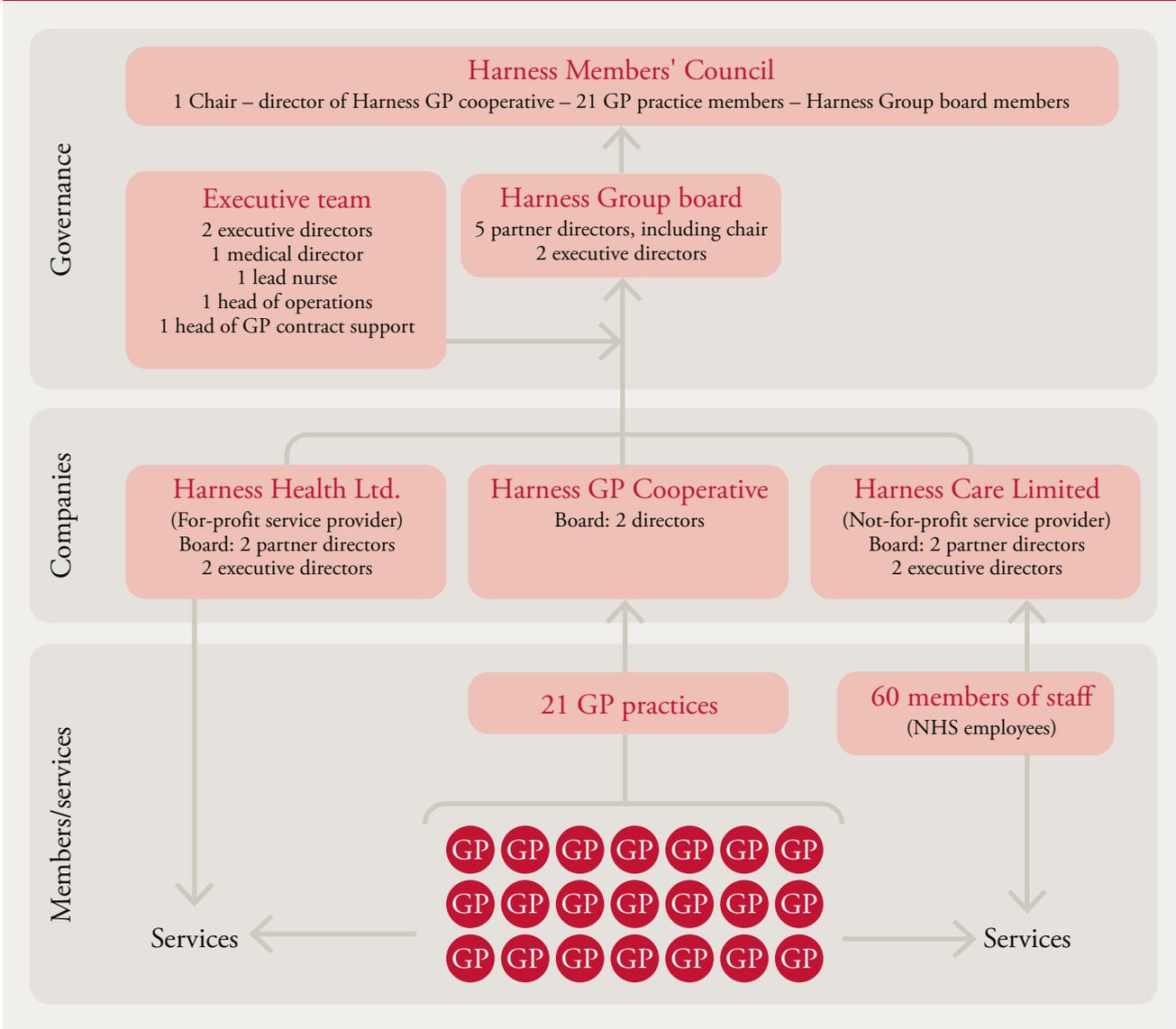
Harness**Legal form and organisational structure**

Harness GP formed as a cooperative member organisation in 2006 and was registered as a company limited by guarantee. Harness Care Limited was launched in 2008 as a not-for-profit company limited by shares, to operate alongside the cooperative, hold contracts with commissioners and employ staff to deliver the services. It carried out the day-to-day work of Harness and organised additional community health activities in accordance with Harness’s overarching vision and values. In 2016, Harness Health Limited was formed as a for-profit company limited by shares, to provide GP services directly delivered by the member practices – most likely in collaboration with other providers through successful competitive tendering. To date, it has not held any contracts.

During the study, an executive group of three directors (director of strategic development and quality, director of finance and a medical director), two senior

managers (head of operations and head of GP contract support) and the lead nurse oversaw day-to-day operational issues and some were members of the Harness Group board along with five additional directors. The board and its subcommittees ensured that regulatory requirements were fulfilled, monitored financial sustainability and performance, and agreed strategic plans. They had decision-making authority for the APMS contracts held by Harness but not for the day-to-day running of member practices. The board reported to the Members' Council, which was the highest governance group in Harness Healthcare (see below). The organisational structure of Harness, presented in Figure 4.4, highlights the complex governance arrangements that have emerged to balance organisational objectives with changes in commissioning methods, regulatory requirements and tax issues.

Figure 4.4: Harness's organisational structure and governance (2016)



Relationship between the executive, the board and member practices

As already noted, the board reported and was accountable to the Members' Council of Harness GP Cooperative. This was made up of the director of the cooperative, a chair, a GP representative from each of the member practices (with one vote per practice) and the board members themselves. Since the formation of Harness, each member practice had retained its GMS or PMS contract and had retained control of the day-to-day running of its own practice. A contrasting view came from an interviewee at a practice that was not a founding member of Harness. They questioned how newer GPs could join the board, specifically whether there were explicit criteria, and raised concerns that board places were reserved for an inner circle of GPs. During the study, the council met twice a year, allowing members to ensure that strategic plans were consistent with the vision and values of the organisation. However, members had additional opportunities to vote on proposals to change services and operational processes at monthly practice development meetings. Membership of the council was dependent on agreeing to abide by the organisation's vision and values and on declaring and managing conflicts of interest with the organisation.

The Members' Council appeared to offer an opportunity – albeit a relatively infrequent one – to influence board decisions through voting processes.

Significant turning points in governance arrangements

Within nine months of forming Harness Care, Harness had won two APMS contracts to provide general practice and 'walk-in centre' services. The newly formed board and executive team had to combine rapid implementation of new services with addressing their core mission of providing practical support to member practices.

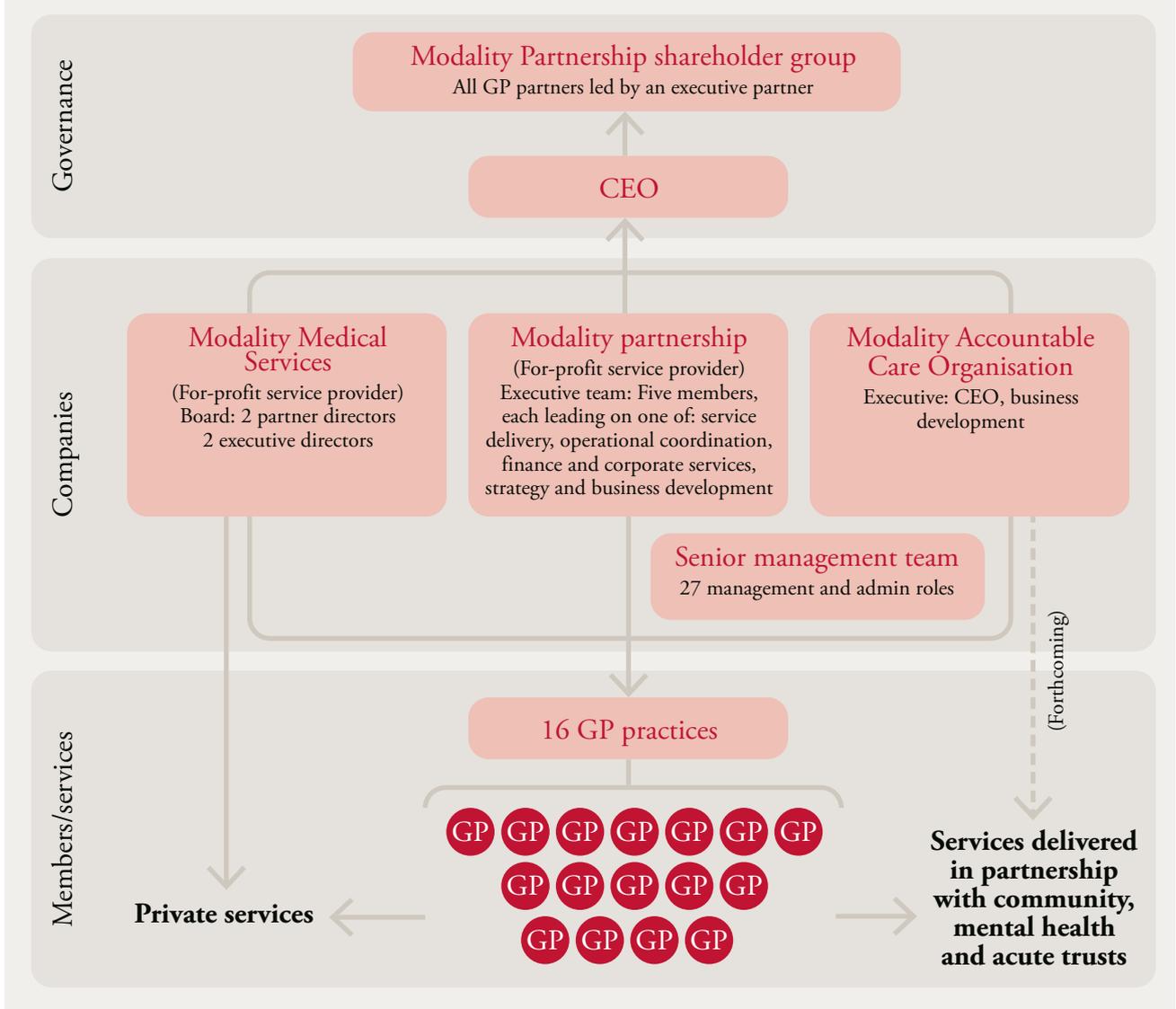
More recently, the external context in which Harness operates has changed. The CCG has encouraged practices to cluster into five broadly geographic locality groups across the borough. The commissioning locality groups in the CCG mirror the GP network provider groups, and Harness is one of the CCG locality networks. Contracts for community-based services are either network-based or borough-based, with the CCG increasingly going for contracts with a single primary care provider or commissioning extended primary care services jointly with neighbouring CCGs. As contract values have increased substantially, Harness has found itself too small to provide the financial assurances needed to qualify for bidding and is forming joint ventures with neighbouring GP networks to deliver borough-wide or multi-borough services.

Modality**Legal form and organisational structure**

Modality Partnership was formed as 'Vitality Partnership' through a merger of general practices and has remained as a limited liability partnership since its formation. It had to change its name to Modality when it was informed that another health care organisation was already registered as 'Vitality'. It was founded through a three-practice merger to improve core services, garner economies of scale and broaden the range of services offered in primary care. It has continued to grow and now encompasses 16 previously independent practices with 85,000 registered patients. All GP partners in practices that merge into Modality become a member of the 'shareholder group' and merge their contracts into the overarching partnership.

During the study, a partnership executive of five GPs met monthly, chaired by a non-executive partner. The executive had delegated authority to take operational decisions about day-to-day work in practices on behalf of the shareholder group. Each executive member had a specific governance role, in one of the following areas: service delivery, operational coordination, finance and corporate services, strategy and business development. Modality's current organisational structure is presented in Figure 4.5, demonstrating how the central workforce grows as the organisation grows.

Figure 4.5: Modality's organisational structure and governance (2016)



An additional governance group to oversee the development of the Modality Accountable Care Organisation (a vanguard site) was created in 2016, reporting to the CEO and accountable to the partnership shareholder group. The partnership also runs a subsidiary company called Modality Medical Services, a limited company registered in 2013 to provide private medical services. All partners are shareholders in this company and entitled to a share of profits.

Relationship between the executive, the board and member practices

The shareholder group met quarterly and aimed to keep the GP executive partners closely linked to practices as new multi-professional care models were developed and

implemented. The executive team was also responsible for oversight as Modality grew in scale nationally and reported to the shareholder group at quarterly meetings. Three operational sub-committees of the executive board – clinical management, operational management, and corporate and specialist services – oversaw the day-to-day workings of member practices. Each member practice was required to report to the finance and governance groups, and processes to ensure this happens were under development.

The executive team reviewed practice-level Key Performance Indicators (KPIs) based on organisational strategy – around patient engagement and involvement, financial management, human resources, communications and marketing – and it also reviewed selected clinical indicators.

Soon after formation, the executive team began acting as the organisation's decision-making authority on operational processes across member practices, albeit with quarterly input from other partners. However, the nature of the relationship between the executive and the wider partnership is shaped by the overall culture of the organisation, which is discussed further in the next main section.

Significant turning points in governance arrangements

Modality has grown steadily since it was founded by merging with smaller practices. Following the introduction of CCGs – with their focus on population health needs – Modality's leadership was considering how to respond to the local CCGs' ambitions to group all GP practices into geographically aligned groups. However, national policy developments intervened and Modality was selected as a vanguard site for multi-speciality community providers. This has resulted in a change in organisational priorities and governance arrangements.

Leadership and culture: managing and supporting change

Key findings and practical lessons from the case studies

- A range of leadership styles can be used to change the day-to-day work of practices. However, change appears to happen faster and more consistently where executives are able to direct staff to change practice and then support them to do so, as this reduces the time needed for consultation and approval in different practices.
- There is a risk that compelling clinicians to change practice will reduce engagement with organisational goals and damage trust in the leadership team. We saw leaders pursuing a different balance in each case study site between directing change and promoting professional autonomy.
- Leaders in the case study organisations worked long hours and fulfilled many roles in their organisations. This kind of 'heroic leadership' appears to be effective at engaging staff and delivering change, but may not be sustainable over time.
- Communication about vision, values and priorities and visible leaders who demonstrate working in line with agreed standards seem to help to embed change and build a staff culture that is receptive to change.
- If rapid change is required in the way services are delivered, then member practices may need to cede control (temporarily or permanently) of day-to-day work processes to the larger-scale organisation.

- Implementing standardised processes and new ways of working requires considerable time from leaders and senior managers as well as other resources. Boards and executive teams must ensure that necessary resources are available if change is to be implemented at pace.
- A small leadership team with clearly defined roles and responsibilities appears to contribute to timely implementation and robust performance management.

AT Medics

The directors at AT Medics explained that over the past decade they had developed a range of standardised methods for improving the quality and efficiency of services when they take over a practice. These methods were refined through repeated Plan, Do, Study, Act (PDSA) cycles, to the point where the directors were confident that the processes they had introduced – such as the use of clinical and administrative protocols, training for all staff and regular review by the clinical director heading the practice – would deliver rapid improvements in performance (see page 47 for an example relating to improving diabetic care). As APMS contract holders, AT Medics had taken over several practices that were considered to be ‘failing’ and needed significant improvement. The directors had authority to direct operations in such practices without the need for approval from incumbent GP partners; this might not have been possible in networked organisations.

The six founding GP leads had a range of roles in practices, including delivering front-line care, leading education sessions, mentoring staff and reviewing staff performance. Staff described them as visible and approachable about opportunities and challenges that arose in clinics. They also said that problems were typically addressed promptly and solutions (developed in collaboration with practice staff) could be rolled out quickly across all sites. The directors also explained that they covered GP staff sickness by physically attending clinics or delivering remote appointments.

However, their relentless focus on standardisation and implementing agreed processes had a mixed reception among staff. One noted that the practice had become a lot better organised after AT Medics took over, while another reported that the atmosphere of the practice had changed: “It’s less of a family now. It’s the fact that if staff leave they can just be replaced.”

Directors and senior managers suggested that AT Medics had acquired new practices in a piecemeal fashion, with decisions driven in part by whether directors ‘wanted to travel there or not’. They had only recently started strategically planning for sustainable future growth. Asked about sustaining the ‘heroic’ input of GP directors into newly acquired practices as the organisation grew, the CEO described work in progress to ensure that ‘turnaround’ processes could, in future, be implemented and monitored by a wider group of people. In the near future, this will be aided by an enhanced practice-level dashboard that will be monitored by a lead clinician in each practice and also reviewed and monitored by the board (who can increase their presence in the practice or allocate other additional resources if necessary).

GP Care

One of the founding aims of GP Care was to use practices' premises and facilities to deliver community-based specialist services. Founded at a time when competitive tendering for clinical services was increasing, along with efforts to develop integrated care pathways, a collaborative relationship between GP Care and local commissioners (initially primary care trusts and later CCGs) was important for its growth. However, one interviewee suggested that there had been a change in the way the CCG perceived the organisation when it changed from an LLP to a limited company:

“ We became a limited company with shares and all the rest of it, and it's hard to know whether that was a success... because somehow with that... we got perceived as money-making GPs. There's always this thing with GPs and commissioners where commissioners think all GPs are interested in is money, and the thing the GPs were very interested in was keeping an un-fractured, joined-up health community and that was really a big part of it.

In addition, the services delivered by GP Care were beyond the scope of core general practice so most front-line practice staff were unaffected by its work – especially newly qualified staff who had not seen the evolution of the organisation from 2008 onwards and GPs outside of the Bristol area who were not eligible to be shareholders. GP shareholders could meet the board at the annual shareholder meeting, but there was not much communication between the leadership and GPs beyond annual meetings. Thus, one GP interviewee who was suspicious about the organisation's motives said: “And nobody really knows what their aims are so we just assume that their aims are competitive to us. Nobody wants to engage with them for fear they are going to use that to their advantage. It's a trust thing.”

The executive team explained that a strategy was under development to combine service delivery with support for practices because resource constraints in the organisation had previously prevented executive staff from visiting practices and engaging with shareholders. Communications to employed staff reportedly became more formalised and regular within the organisation during the study, as well. Despite most GP Care staff having been recruited when their local hospital made cuts, and having reported that they chose the organisation because it “put patients' interests first” and was “not profit-driven”, the comment from the GP above highlights the communications challenge that GP Care will face if it is to develop its supporting role within practices.

Harness

The relationship between Harness and its member practices is different from that in the other case studies. Apart from its two jointly owned and managed APMS practices, Harness practices have not delegated decision-making authority about their day-to-day work to the board or executive team, and each member remains responsible for

decision-making in their practice. Harness is therefore unable to direct changes in day-to-day operations and uses a consensual leadership style and code of conduct, which includes performance and quality expectations related to the Harness Constitution. One interviewee described the results of a consultation exercise with member practices on changing the organisational structure:

“ A number of people, and these were founding GPs, were saying: ‘If we didn’t ever make any money from that I would still be part of it because it’s the first time in my career I’ve had this level of professional support, it’s the first time I’ve had the professional relationship with a big group of GPs where we will debate something, we’ll have different views and then we’ll come to a consensus and we’ll stick to it.’

To achieve improvement, senior staff alert practices with signs of weak performance (based on a review of the organisational dashboard) and, after diagnosing the problems they face, offer practical support through additional staff and resources to address the weak performance. Notional minimum standards exist for entry and membership, but the Harness Cooperative is tolerant of poor performance for time-limited periods. Leaders suggested that members were receptive to change and had a high level of trust in them because they had long working histories in the area and always made themselves available to help underperforming practices. This was evidenced during meeting observations, when members repeatedly looked to the leadership team for guidance on how they should vote or what they would recommend.

Members of the executive team and centrally employed staff regularly spent time in practices, helping them to sort out data problems and advising on how to improve operational processes. As in the previous two case study sites, this work was demanding, time-consuming and at times required heroic levels of leadership effort, which might be unsustainable in the advent of federation growth.

In addition to the relatively short-term, but intense, support from senior staff, Harness staff described a slower form of change that was taking place through its staff networks. One nurse described how participants in the Harness nursing forum were starting to compare practice and agree common protocols to use in their own practices.

Modality

Senior doctors in Modality took an active role in what a clinical executive team member described as the “incredibly demanding work” of turning around underperforming practices when they were merged into the partnership. In the words of the same executive: “You model the culture of high-quality care when you are working in the practice.”

Unlike AT Medics, which typically took over practices that had been offered for tender because they were underperforming, practices joined Modality for many reasons – not all to do with poor performance. Thus, there was no standard

‘implementation process’ for every practice and the executive team and wider partnership board maintained a staged approach to changing service organisation and standards of care in each clinical outlet.

Where necessary (that is, if an underperforming practice joined the partnership), standardised processes were introduced for functions such as coding, record keeping, call and recall, triaging patients and other areas of clinical and operational work. However, if incoming practices were performing well, unlike at AT Medics, they would not be required to change the way they worked in line with organisational norms. The extent of senior clinician/executive leadership presence in each practice varied. As in AT Medics, when a struggling practice was identified, the leadership team spent several months working intensively in the practice if they thought this was needed. Thus, their leadership style sat somewhere between directive and supportive.

More recently, the executive team has focused its efforts on developing as a vanguard site – negotiating with the local acute trust and community providers on the services that might be transferred to the community. It was not possible to assess the impact of this new role on leadership within the core business.

Financial and organisational sustainability

Key findings and practical lessons from the case studies

- Organisational sustainability can be improved through operational and administrative initiatives to increase efficiency and reduce costs. These include:
 - shared back-office functions
 - standardised operating processes
 - joint procurement of equipment and services
 - centralised patient-facing services (for example, call centres).
- In the case study sites, technology was used to increase administrative efficiency through web-based functions, such as new patient registrations, remote data searches and automated performance reporting. Shared clinical information technology (IT) systems were also important to support standardisation of clinical processes and coding, and improve communication among staff.
- Workforce initiatives that improved sustainability aimed to increase role flexibility and develop additional skills in practice staff, enabling them to cover each other across member practices and to deliver additional services that may generate income. Organisations also shared staff employed by the central office across sites, and developed in-house locum capability to reduce agency spend.

It was beyond the scope of the current study to undertake a cost analysis or cost–benefit analysis of initiatives to improve efficiency, control costs and maximise income in each site. The following subsections, therefore, describe these initiatives and report interviewee perceptions of their impact on financial and organisational sustainability.

AT Medics

Interviewees at AT Medics described various cost-saving mechanisms that had been developed and refined over many years. These included:

- controlling management and governance costs
- sharing practice managers across paired small clinics
- requesting group discounts with suppliers for larger-volume procurements
- minimising use of agency staff by moving staff between sites (for either longer-term or shorter-term cover for staff sickness), informed by quarterly monitoring of staffing numbers per 1,000 patients
- using technology to support or improve processes
- reducing the administrative burden on clinicians to improve workplace satisfaction and improve efficiency.

Interviewees reported that another key strategy to ensure financial sustainability was to maximise income from discretionary funding streams, which also improved patient outcomes. This included:

- maximising income from QOF and enhanced services
- achieving required performance outcomes specified in APMS contracts (the organisation is in the top quartile nationally for QOF points among APMS contract holders)
- maximising income from education and teaching.

As one senior manager explained: “They’re very focused on the bottom line as well. So they’ll make sure that they’re delivering maximum quality to get maximum income and it all becomes self-perpetuating.”

Various processes appeared to reduce the time spent by directors and senior staff on management activities. A director and a regional manager jointly managed each group of practices so that operational and clinical meetings could be merged across sites, cutting the number of meetings that directors attended by up to a third.

Additionally, directors developed a handbook of policies and protocols, which could be adapted in response to each APMS contract specification. Interviewees reported that the handbook enabled rapid transition to AT Medics’ ways of working through standardising the mobilisation phase. Furthermore, senior staff reported that they continually adapted protocols to improve processes and protect staff time. The organisation piloted and refined all new initiatives, such as an online triage system, in large founding practices before implementation in smaller sites.

Staff worked flexibly across roles and practices when needed: reception staff who had trained as phlebotomists moved across sites in both roles, nurses often delivered clinics across sites and GPs could offer remote appointments to cover sickness. This prevented the need for locums and allowed staff to exchange knowledge and skills across sites.

Interviewees also reported that technology was a key driver of efficiency. AT Medics used one clinical system, EMIS, and a director said:

“ Most GPs probably use 20 per cent to 30 per cent of their system... in our organisation the directors have to know the clinical system inside out, and the senior managers and doctors... because if you know the limits of your clinical system you can think about a systems approach... there is so much efficiency you can achieve by doing that.

For example, directors could access medical records during remote consultations and draw on clinical information for web-based clinical training sessions. Where necessary, they invested in bespoke modular add-ons where their system underperformed. Patient-facing websites (including GP Access) were adapted for each practice to allow patients to register online as well as book appointments, order repeat prescriptions and access self-care advice.

GP Care

It has not been the aim of GP Care, to date, to improve efficiency in member practices (although its ‘One Care’ joint venture with BrisDoc – see Table 4.1 – is a first step in this direction). However, interviewees described initiatives to improve the efficiency of administrative systems for its community services. For example, it has recently merged appointment-booking teams and retrained staff across all services. Staff now rotate between services every one to three months, creating a flexible bank of workers who can cover staff shortages and sickness absences in different clinics.

One interviewee in a community clinic described the organisation as being “not too focused on money”. Nevertheless, clinics are run by lead clinicians who said they and their teams were aware of the targets for KPIs and the number of referrals they needed to receive to financially ‘break even’.

During the study, GP Care had not yet introduced an integrated IT system for its services. Most were run using speciality-specific IT systems although some were still using paper records backed up by Excel spreadsheets, and none could yet connect to patient records in either of the two major GP clinical records systems. Opportunities for improved data management were being explored.

Harness

Interviewees from the Harness central management team described a policy of, wherever possible, doing something well once in an initial site and then implementing it across all sites. Thus, they had developed a range of initiatives aimed at saving member practices’ staff time, and standardising processes across the federation. These included:

- developing and distributing reporting templates for locally agreed improvement initiatives using the Harness intranet
- developing standard EMIS templates and searches to improve consistency of coding

- centralised data extraction and claims management for local incentive schemes.

The central team provided further support services to reduce the administrative burden on practices, including:

- referral facilitation, including triage, navigation and booking liaison with patients
- communications and administrative support to professional forums, including the clinical multidisciplinary monthly meetings
- quality management systems support, including Care Quality Commission compliance.

The central team also reviewed and summarised communications from external agencies (such as NHS England, CCGs, Public Health England and secondary care providers). This was valued by staff, one of whom commented: “and then say to all the practice managers in Harness, ‘you know that thing that came out last week, don’t worry I’ve read it, I’ve digested it, this is what you need to do’”. The team also shared knowledge and information through the Harness intranet and professional forums.

Workforce initiatives were also reported to improve efficiency. Some staff were trained to do more than one role and could cover absences. Others, such as the immunisation coordinator, were employed centrally and then deployed to practices to ensure that all practices performed above target levels (thus helping to maximise income). It had smoking cessation advisers who ran shared clinics seven days a week across the federation. An immunisation and respiratory nurse was employed centrally and could be hired out to member practices at rates lower than locums to help achieve immunisation targets. Equally, administrators were employed centrally and deployed back to practices that needed support with specific tasks, such as scheduling clinical staff sessions, stock checking and ordering supplies.

All training was provided by the organisation’s not-for-profit arm, which allowed the group to train staff tax-free. Furthermore, the breadth of skills and leadership in Harness staff meant that very little training had to be bought in.

A CCG-mandated single electronic record system across all practices and the extended hours hub meant that operations managers could shift patient flows and clinicians had access to the necessary information for a consultation. However, due to limitations in the clinical software systems, some potential efficiencies could not be achieved. Thus, the administrator responsible for booking appointments at three extended access hub clinics was unable to link the three booking systems and had to work with three different computer screens to book appointments.

Modality

Modality’s efficiency savings were reported to come largely from a centralised administrative team and centralised specialist referral team. Both initiatives aimed to reduce costs through saving staff time (and benefiting from economies of scale), use technology where possible and improve patient experience. Despite initial staff reluctance, the centralised teams, formed in 2013 to cover all member practices, undertook a range of tasks, such as:

- completing registration processes for patients across all sites
- performing centralised searches, data extraction and reporting

- coordinating all enhanced services claims using the electronic Calculating Quality Reporting Service (CQRS)
- introducing systems that automatically enter results into patient records and flag selected abnormal results for clinical teams
- processing referrals to Modality's specialist clinic and managing bookings
- managing hospital referrals.

An internal Modality report stated that the use of technology to centralise information across all sites and better monitoring systems had allowed leaders to hold partners to account for variations in quality and performance. The report also suggested that centralised administration made it easier to roll out the organisation-wide standard operating procedures needed to increase the scale of its services in the future.

During the study, Modality also launched a central clinical contact centre and a universal telephone triage system, with GPs and advanced nurse practitioners phoning patients within a few hours of first contact. Call-back slots could be booked via a central Modality telephone hub, the EMIS Patient Access website or an online Modality application (developed in collaboration with a local IT company).

Interviewees explained that the new approach had initially reduced the morning rush for appointments in practices and that up to 65 per cent of patient contacts were dealt with by telephone. Furthermore, the number of patients who did not attend appointments fell by 72 per cent. However, over time, the demand for face-to-face and remote consultations rose again and Modality leaders are exploring options to manage demand. Leaders told us that the 'jury was still out' as to whether Modality would have made savings on the booking system without the pump-priming funding they had received from the Prime Minister's GP Access Fund.

Using data from the central booking service, a dashboard was developed to support planning, resourcing and management of sites. Daily data feeds allow tracking of practice-level clinical capacity and demand (for example, the number of call-back slots available versus use at each practice) and NHS Friends and Family Test data.² These data are used to plan staffing levels with the aim of creating efficiency savings over time.

Finally, like the other case study organisations, Modality appeared to be working sustainably through experienced senior staff being spread across the organisation, distributing the skills needed to train and mentor junior staff. Large founding practices also piloted service innovation initiatives before expanding to smaller practices.

Clinical quality

Key findings and practical lessons from the case studies

- Monitoring and improving quality was reported as a priority for each central management team, with significant resources allocated to identifying and addressing weak performance in individual practices and services.

² www.england.nhs.uk/ourwork/pe/fft/

- Methods used to improve quality included:
 - education sessions for all role types
 - informal real-time advice from colleagues about managing complex patients (using instant messaging)
 - help from peers to deliver interventions to meet targets (for example, immunisations)
 - sharing data on practice performance among senior staff (to drive friendly competition).
- Organisational systems and processes for quality assurance and improvement included:
 - unified computer systems across sites to support data extraction for comparative audit
 - routine review of quality and KPI dashboards by a senior team
 - use of standardised protocols and reporting templates across all sites.
- Clinical and managerial leaders played an important role in building a culture where quality was considered important, through modelling adherence to clinical guidelines when working in different practices and addressing identified problems promptly.
- It is important for large-scale general practice organisations to set a small number of defined and meaningful quality improvement objectives, and measure progress towards these, to demonstrate their impact as an organisation, for as Chapter 5 shows, impact on quality may be hard to demonstrate using nationally available data.

AT Medics

During the study, the six directors at AT Medics were at the heart of improvements in clinical care at practice and organisational levels. Between them they undertook an average of 21 clinical sessions a week in practices so they were available to answer clinical queries from staff. They were involved in training staff through face-to-face sessions and educational webinars, which all staff groups (for example, health care assistants and receptionists), from all sites, could participate in. These enabled staff to acquire new skills and taught them how to follow protocols and guidelines. The directors provided follow-up sessions to assess adherence to the protocols and address problems that staff were experiencing. They reinforced expected standards of practice by citing and resending policies and protocols to staff.

At the board level, directors continuously reviewed adherence to policies through an organisation-wide dashboard (see Box 4.1). They monitored performance and incidents (for example, issues that had led to poor practice) in practices, developing solutions and allocating extra resources to fix deficits in care. For example, when AT Medics took over a practice with very poor performance in diabetes care, the directors agreed to allocate additional time from administrators, health care assistants, GPs and community-based specialist diabetic nurses in order to improve diabetic control in around 300 poorly controlled patients. They introduced systematic call and recall, virtual reviews by a GP of all off-target diabetic patients, systematic clinical reviews and care planning, which included lifestyle advice. This approach was subsequently rolled out across other practices.

Box 4.1: AT Medics' dashboard

Although the data fields change monthly to inform continuous Plan, Do, Study, Act (PDSA) cycles, the dashboard typically includes around five QOF and KPI measures and a risk register associated with achieving target levels of performance.

Examples of QOF and KPI metrics are:

- flu vaccination rates of people aged under 65
- cervical cytology
- numbers of patients on the child and adult protection registers
- access measures, such as the number of home visits
- the number of GP and nurse appointments per 1,000 patients per week against the national minimum (80 appointments per 1,000 patients per week)
- antibiotic prescribing rates per 1,000 patients
- the number of patients registered for online services.

As part of the safety culture, all significant event audits were reviewed at board meetings, and the review included:

- descriptions of events where risks, near misses or issues had been identified
- actions taken to correct the issues
- improvement actions taken since
- dissemination requirements across the organisation.

Risk register components are:

- practice growth per quarter (which was flagged because of its impact on capacity in premises in terms of patient record storage)
- access issues
- KPI achievement
- finances
- issues that might affect all practices (for example, income via federation gains was found to be non-pensionable).

The directors also worked to address data deficiencies and to develop strategies to improve data across the organisation, for example through standardising coding and sending support staff to low-performing practices. A quarterly face-to-face forum for all practices chaired by the CEO or a regional manager was used to ensure that new policies and protocols were being implemented consistently, mandatory training was flagged, and good practice was being shared from pilot practices to others.

Practice staff reported being motivated to provide good care and adopt the 'AT Medics way' by a range of factors, including the presence of directors in the practices. This was particularly motivating for staff in practices that were newly acquired from other providers that offered less support. GPs reported feeling pressure to perform to high standards, but they also felt supported by senior staff, clear protocols and a relaxed working culture. Senior and regional managers, and directors, who had oversight across the organisation, suggested that competition in relation to performance between AT Medics' practices, as well as in local federations, motivated them.

GP Care

GP Care directors reported that, when developing a new service, clinical leads worked with local specialist and community providers to agree evidence-based pathways. Staff reported that front-line teams conducted audits on a regular basis, and that the internal reporting team produced a weekly dashboard for each service, which detailed the number of patients referred from general practice, the number of patients booked and the number of breaches. All interviewees were aware of expected performance standards for KPIs and one staff reported that the organisation was “very target driven”.

Despite this, front-line staff who worked at remote sites reported mixed perceptions about their responsibilities for reviewing quality. Some thought that responsibility for meeting quality, activity or patient satisfaction targets lay with the central office managers. Other staff kept their own statistics, visited GPs to encourage referrals when low, and worked closely with the central office administrative staff to ensure that everything possible was being done to see patients quickly. Progress towards targets was discussed weekly within teams, and quarterly in face-to-face meetings across all teams delivering the same service in the central office. Competition was not mentioned as a driving force for improvement.

GP Care’s local commissioners used the Commissioning for Quality and Innovation (CQUIN) payment framework to incentivise quality improvement in providers. GP Care participated in CQUIN schemes, organising quarterly meetings between the central management team and practices where GP Care services were delivered to review adherence to protocols and report this to commissioners. CQUIN achievement in 2014/15 linked to indicators such as implementation of the NHS Friends and Family Test across all sites and the release of a discharge summary to a patient’s GP within 24 hours, added 1.5 per cent to their contract value after high achievement on the former measure, but lower achievement on the latter.

Harness

Harness leaders reported that they aimed to improve performance across core and enhanced services through a ‘no blame’ learning culture and by demonstrating and modelling quality improvement work in practices. Harness created a post to work across all sites to monitor targets, to set up searches to identify patients with gaps in care and to establish a text-messaging system to invite patients for tests. Clinical staff also moved across sites to deliver additional clinics to meet national targets (for example, QOF immunisation and smoking cessation). The clinical governance committee created quarterly practice profile report cards to review progress and trigger conversations around referrals, spend and Accident and Emergency (A&E) usage, and provided comparative scores against all other Harness sites using the Primary Care Web Tool.³

Monthly face-to-face educational forums were established for nurse and practice managers, providing an opportunity to discuss new care delivery protocols and implementation plans across Harness sites. The facilitators encouraged members to suggest themes for the meetings and supported online chat forums between meetings to deal with questions in near real-time. These meetings were welcomed by staff. Interviewees said that they helped to standardise care delivery and increased staff

3 www.primarycare.nhs.uk/

confidence. Nurses reported that the sessions improved the care they provided. One nurse said: “So the advantage is that your actual patient care improves, so when I see my patient I know I’m doing it according to the guidelines, rules and policies and everything that a practice nurse should do. It makes me feel like a competent nurse.”

A GP forum was also set up and later extended to other professionals at the request of GPs. Practice forums were popular among GPs and had an average attendance rate of 84 per cent of GPs. A monthly multidisciplinary group meeting also had a high attendance of GP partners; however, salaried staff attended these meetings less often, and tended to send their queries electronically.

A member of the central team also organised quarterly meetings between nurses and practice managers to review QOF data – specifically progress towards targets to date – and to exchange ideas on how to improve performance. There were also frequent telephone calls between directors and struggling practices, and the publication of six-monthly reviews of clinical risks and annual reviews of a variety of targets. Harness also co-created quality targets for Harness sites with the local CCG, which leaders reported meant that practices had more belief in their value and were more engaged in achievement.

Modality

Modality developed its clinical governance framework for GMS contract practices in 2010, modelled on the Care Quality Commission’s inspection standards. Standardised care management plans, templates and operating procedures were made available to staff, with the intention of improving achievement in enhanced and community services.

GP partners attended the monthly clinical management group meeting to review progress against performance measures. They suggested that these meetings encouraged competition between practices, and ensured that they followed up with staff to review coding after the meetings. The central administrative team kept track of searches for prescribing, enhanced services and community-based services to help monitor performance.

Practices also reported relying on CCG locality meetings to review prescribing and other CCG events in which comparative data were presented, to drive improvement through peer review. In a few Modality practices, advanced nurse practitioners and nurses met weekly to review case studies and engage in discussions for continuing professional development purposes, but this practice was not universal. There were aims to expand these meetings and use them for appraisals.

Unlike at other case study sites where practice managers had a lead role in improving practice performance, we heard from some Modality practice managers that they did not feel responsible for the clinical performance of their practices, and at their peer-level meetings they did not discuss clinical quality indicators.

Like at the other sites, we heard that specialist services, run by a small clinical team (including a GP with a Special Interest, a consultant and an administrator) had created their own protocols for care delivery, undertook their own ad-hoc audits and had varied methods for recording and reporting clinical safety and quality to funders. For example, the rheumatology service reported at an annual governance meeting,

Staff experience, training and education

Key findings and practical lessons from the case studies

- In the case study sites, most staff reported that they valued working in large-scale organisations, but they felt more engaged and cared for by the leaders of their own practice than leaders of the larger organisation.
- Salaried GPs were least satisfied of all roles with their overall employment situation, while administrators, receptionists and GP partners were among the most satisfied.
- All staff valued rapid access to peer support with clinical and operational problems through organisation-wide networks, as well as training and career development opportunities offered by the wider organisation. Many reported that these opportunities made them feel less isolated and more confident in their roles.
- The infrastructure, meetings and relationships that enable advice and peer support across practice boundaries take time to build and do not require significant financial investment. Emerging groups should seek to develop these arrangements as quickly as possible, as they are highly valued by staff and were reported to have a positive effect on staff retention.
- Staff valued contact with senior leaders – both through their role in training sessions and through informal day-to-day contact – which helped to build trust in their leadership and engage staff in service changes. Leaders of emerging organisations should spend time in member practices to establish such relationships.

AT Medics

During the study, education and training was a central strand of AT Medics' strategy for quality and growth, with plans to extend its role as a training organisation in London. All directors had postgraduate certificates in education, and staff reported being encouraged by directors to acquire training qualifications early in their careers, funded by AT Medics (to enable AT Medics to train GP trainees across its 12 registered training practices). Newly qualified trainers reported valuing these opportunities and were pleased they had gained the qualifications early on. Interviewees described how a combination of trainers, dedicated support staff for trainers and trainees and technology were used to facilitate education across training sites.

Receptionists and health care assistants also had opportunities to develop new skills, for example receptionists training as phlebotomists and health care assistants carrying out health checks under the supervision of GPs. Two senior managers reported that they joined the organisation as receptionists – illustrating pathways for career development for non-clinical staff. The career development opportunities for all staff groups benefited the organisation by creating a range of in-house capabilities. They also enabled staff to work in extended roles to overcome long-term difficulties in recruiting. Some interviewees reported that career progression created loyalty to the organisation, especially among health care assistants and receptionists. However, we also heard from some salaried GPs running well-established and longstanding practices that they felt isolated and that they had fewer options for career progression because AT Medics did not take on new GP partners. Overall, our survey of 69 staff revealed that 79 per cent agreed that they had good opportunities for training and development (versus a case study average of 65 per cent), and 73 per cent agreed that they had good opportunities to learn new skills and take on new roles in an area of interest (versus a case study average of 61 per cent).

New staff valued the regular presence of directors and the sense of order created by AT Medics' protocols. A practice manager at a newly acquired practice said: "It's a lot more organised. Everyone's not like... They don't get worried or scared or that 'Oh what am I going to do?' or 'What's that supposed to be?' It's a lot more: 'This is this and it should be here and that's like this.'"

The organisational culture was described as one of high expectations, coupled with flexible working schedules and significant support from senior staff. However, a few longstanding staff told us that the culture had changed. For example, one GP said they felt 'less valued' than earlier on in the organisation's journey. Despite this, 81 per cent of staff who responded to our survey agreed that the organisational culture was positive (which was higher than the case study site average of 72 per cent).

GP Care

At the time of the study, GP Care employed a number of audiologists, sonographers and non-clinical service leads, as well as holding contracts with clinical consultants to manage and deliver its services. GP Care worked with a third-party training organisation to train new staff and most training was self-directed (for example, self-organised continual professional development sessions) but funded by GP Care upon application. Directors held monthly coffee sessions to hear feedback from front-line staff about services and executives provided monthly management training on topics such as monitoring budgets and finances. Clinical executives also ran clinical training sessions for non-clinical staff to explain 'the medical side of services'.

Staff described regular opportunities to engage with their peers and leaders and most reported having considerable autonomy about how to run their services. Senior staff at GP Care's headquarters confirmed this view, suggesting that they had opportunities to "influence and negotiate, but not to direct" how their teams delivered at the front line.

When existing services were developed in new geographic areas, service leads provided advice, but there was no formal support structure between teams. Remote teams had little access to training based at headquarters since there was no technology to enable distance learning. Despite this, all interviewees, including those in remote teams, said that they knew who to go to when they needed help or advice.

A small number of interviewees reported that their roles at headquarters had been adapted to their capacities and interests, which had made movement and career progression within the organisation possible. This was not an opportunity available to those in remote sites.

Harness

Training was one of Harness's founding priorities because its local primary care trust had dissolved and training funds held by the trust were lost. Training was offered in clinical tasks (such as phlebotomy) and non-clinical tasks (for example, administration and stock management) for receptionists, and a seven-step management qualification through the Chartered Management Institute for practice managers. There were also opportunities for GPs and nurses to develop areas of clinical special interest. Selected training modules were available online via Harness's intranet and some were offered face-to-face along with mentor support for professional development. Some training was funded by Harness, including core mandatory training, and some by individual member practices.

At odds with these interviewee accounts of career opportunities, among the 39 anonymous staff who responded to our online survey (some of whom may have also been interviewed), only 62 and 50 per cent agreed that they had good opportunities for training and development and upskilling, respectively. This highlights potential barriers to individual training that we were unable to explain.

Organisation-wide peer-to-peer forums for nurses, health care assistants and practice managers, however, were described as very helpful. Many nurses reported that a monthly face-to-face forum – which combined educational sessions, communications about organisational developments, case discussions and peer-to-peer support – improved their confidence as professionals, decreased isolation and led to a sense of belonging. One nurse said that the monthly meeting was “the only time you can get communications and you can share information”. Another nurse reported that between meetings the forum organiser provided support through email exchanges and an online forum “to make sure that everyone is happy in doing their job, like not worried or stuck somewhere”.

Although the monthly meetings were not primarily about retaining staff, several nurses said they were more inclined to plan for a career at Harness because of the support they were offered. One nurse, referring to the lack of support for practice-based nurses generally, said: “It’s really a pity where people have no support they keep leaving” and another said: “Friends in other organisations do not feel nearly so involved.” Finally, the openness in the group meant that nurses had become aware of good and poor employment practice across Harness and this led to some changes in employment terms, with pay and hours harmonised across a group of practices.

A similar forum existed for practice managers to keep them up to date with emerging policy and provide opportunities to discuss problems. A GP partner sceptical of large-scale working said that it was “hard to measure what’s been delivered by being part of Harness”, but they “valued the support provided to the partnership and their practice manager, especially as a small practice with little capacity to build teams”.

Many staff reported a ‘sense of belonging’ and ‘trying to improve things for patients, and for each other’, and 71 per cent agreed that the organisation had a ‘positive culture’. However, this came at a cost to senior managers who faced new and unfamiliar tasks daily and worked more than their contracted hours. We interviewed a senior manager who had just returned from long-term sick leave after agreeing that her levels of commitment would change – both part of a common story across case study sites and reflective of the recognised pressure on general practice.

Modality

Like the other three case study sites, Modality employees were offered skills development opportunities and protected learning time. While a relatively low percentage (57 per cent) of the 90 staff surveyed responded that they had good opportunities for training and development, in interviews, GPs described having good opportunities to develop sub-specialities and learn new skills as the organisation aimed to extend its range of services. They reported enjoying the opportunities that come with working in a larger organisation, and being more likely to stay at Modality because of the training and career development opportunities it offered.

A nurse training programme was also under development to replace a previous small-scale forum that did not include all practices. However, we heard that the nurse

facilitator often had to use the allotted planning sessions to cover the illness or absence of other nurses, and high expectations and delivery delays led to the facilitator taking a period of sick leave. Another practice manager who was moved into a broader role in the wider organisation also took stress-related leave after feeling unprepared to take on the additional responsibilities and tasks. Both returned to adapted roles within a few months. These accounts highlight the high demands of providing development support to staff and practices and the risk of burnout when facilitating growth and development in a larger organisation.

Over two-thirds of the 90 staff surveyed reported that the organisational culture was positive. Interviewees described having independence and autonomy in their practices, but also being able to call on practical support in handling new or challenging issues (for example, responding to difficult patient complaints). However, a small number of interviewees found the autonomy isolating and felt disconnected from other practices.

Staff survey results

We asked all staff in the three case study sites that delivered core general practice services (AT Medics, Harness and Modality) to complete a survey of satisfaction and perceptions of their 'main practice' and the wider organisation. All three sites were in the process of developing staff surveys, but results were not yet available for analysis. Part of our survey was borrowed (with permission) from the 2015 GP Worklife Survey to measure satisfaction across nine areas of the working lives of all staff (not just GPs). Staff at GP Care were not invited to respond to the survey because they do not work in GP practices, and comparison of results would have been difficult.

The three most popular domains of satisfaction and the mean scores reported out of a possible score of 7 (where 4 was the mean) are compared in Table 4.2. Results suggest that respondents' fellow workers were an important influence on satisfaction in the case study sites, as were the amount of variety in their job and freedom to choose their own method of working (that is, not feeling micro-managed). Interestingly, AT Medics staff reported in the survey that they enjoyed the freedom they had to choose their own method of working, but also suggested in the interviews that they followed an 'AT Medics way'.

Table 4.2: Most popular staff satisfaction domains by case study site

	AT Medics (n=69)	Harness (n=39)	Modality (n=90)
1	Amount of variety in your job (5.91)	Your colleagues and fellow workers (5.82)	Your colleagues and fellow workers (5.74)
2	Your colleagues and fellow workers (5.81)	Freedom to choose your own method of working (5.56)	Your hours of work (5.42)
3	Freedom to choose your own method of working (5.70)	Amount of variety in your job (5.47)	Amount of responsibility you are given (5.33)

To determine which role types were most and least satisfied, we pooled results across all three sites and compared within each role type: a self-reported overall satisfaction score within each role type, and the average score across each of the nine satisfaction domains (which we calculated using staff responses) (see Table 4.3). Salaried GPs were the least satisfied overall: they reported the lowest scores of all role types across six of

the nine domains, and tied for lowest on another. Their average score across the nine domains was 4.6 (on a 7-point scale) and their self-reported overall score was even lower at 4.3, making their perceived overall satisfaction the lowest by far among all practice-based roles. Administrators and receptionists reported being most satisfied among all staff types, with an overall score of 5.6 (and an average score of 5.6 and 5.4 respectively). The average score across the nine domains for GP partners was also 5.6, tied with administrators. However, GP partners reported an overall score of 5.5, suggesting – like salaried GPs, advanced nurse practitioners and practice managers – that their overall perception of satisfaction was worse than satisfaction with individual domains (see Table 4.3).

Table 4.3: Total staff satisfaction across all case study sites by role

	Salaried GP	GP partner	Nurse	Advanced nurse practitioner	Health care assistant	Practice manager	Administrator	Receptionist	Other
Physical working conditions	5.0	5.7	4.9	5.4	4.9	5.7	5.5	5.5	5.4
Freedom to choose your own method of working	4.0	5.6	5.3	5.5	5.5	5.9	5.5	5.5	5.8
Your colleagues and fellow workers	5.4	5.9	6.2	6.0	5.4	5.7	5.8	5.9	5.8
Recognition you get for good work	4.1	5.4	4.8	5.3	5.2	5.0	5.2	4.8	5.1
Amount of responsibility you are given	5.0	6.0	5.4	5.6	5.3	5.5	5.6	5.1	5.3
Your remuneration	4.3	5.3	3.8	5.0	4.7	4.5	5.1	4.6	4.5
Opportunity to use your abilities	4.6	6.0	5.6	5.6	5.2	5.5	5.3	5.2	5.8
Your hours of work	4.1	4.8	5.4	5.1	5.9	5.2	6.3	5.8	5.8
Amount of variety in your job	4.7	6.1	5.5	5.4	5.9	5.5	5.8	5.5	5.8
Average across the above 9 domains	4.6	5.6	5.2	5.4	5.3	5.4	5.6	5.4	5.4
Self-reported overall score	4.3	5.5	5.3	5.3	5.4	5.2	5.6	5.6	5.1

Note: Based on responses from 198 participants from AT Medics, Harness and Modality.

All role types, excluding salaried and partner GPs, were least satisfied with their remuneration (across all nine domains), while salaried GPs were least satisfied with their freedom to choose their method of working and GP partners with their hours of work. The domains that gave the highest satisfaction to role types varied. However, ‘your colleagues and fellow workers’ was most common, scoring the highest among salaried GPs, advanced nurse practitioners, nurses and receptionists. Two domains had over 1.8 points of variation between role types – freedom to choose own method of working and hours of work – suggesting a polarisation of experiences among staff groups. Salaried GPs were least satisfied with their freedom to choose their own method of working and practice managers were most satisfied with their freedom, which raises questions that we could not explore further about whether standardisation of work processes affects clinicians more than other staff groups. Salaried GPs were also least satisfied with their hours of work, and administrators were most satisfied, which echoed interviewees’ enthusiasm about the flexible nature of team-based administrative work.

We also asked staff to indicate the strength of their agreement with a number of phrases that compared their feelings of ‘engagement’ and ‘being cared about’ by leaders within their main practice with their feelings of engagement and being care about by leaders across the organisation (see Table 4.4). All staff reported that they were more engaged by leaders of their practice than organisational leaders, and that practice leaders cared more about their wellbeing and career opportunities than organisational leaders. These findings suggest a level of familiarity and trust within practices that is harder to replicate in large-scale general practice organisations.

Table 4.4: Feelings of engagement and being cared about by leaders at both practice and organisational levels

	Practice	Organisation
Engaged by leaders	4.11 (76%A, 6%D)	3.73 (63%A, 15%D)
Able to easily speak to the leader	4.45 (87%A, 4%D)	3.84 (65%A, 14%D)
Leaders care about my wellbeing	4.18 (79%A, 5%D)	3.66 (55%A, 13%D)
Leaders care about my career	3.89 (67%A, 10%D)	3.49 (49%A, 17%D)

Note: A score of 1 represents ‘strongly disagree’ and 5 represents ‘strongly agree’. We have presented mean scores, and summed the percentage who responded ‘agree’ or ‘strongly agree’ (labelled %A), as well as those who reported ‘disagree’ or ‘strongly disagree’ (labelled %D).

Patient experience and involvement

Key findings and practical lessons from the case studies

- There had been little patient involvement in any of the case study sites in the decision to operate at a larger scale. PPGs were typically informed about mergers after the decision had been made and were invited to help to design shared services.
- PPG interviewees suggested that patients were anxious about larger-scale organisations because they feared losing access to their regular GP and not being recognised by staff. While there was no evidence that this had occurred after practices had joined a larger organisation, interviewees were clear that they wanted to preserve a relationship with their usual practice.
- Whole-organisation patient meetings did not seem to have drawn the interviewees into working with other practices. It remains to be seen whether PPGs will prove a good forum for engaging patients in service design or whether other approaches to patient involvement will be needed.

- There appeared to be a continued appetite for PPG meetings based in individual practices and these may be a good place to address patients' anxieties about losing contact with their practice and their usual doctor.
- Links between large-scale general practice organisations and local civic and community groups can create new opportunities for delivering services and promoting health and wellbeing. Three case study organisations were developing innovative links with their local community.

AT Medics

Patient consultation sessions played an important role in redesigning the work of each practice for which AT Medics won a contract. Often the practices had been performing poorly and redesign work included efforts to address the problems that patients had previously experienced with the practice. Early patient engagement was also important because local media often described AT Medics as a private provider, which directors were aware worried patients.

Each practice's PPG operated independently and saw their practice as a "self-contained unit" rather than part of the wider organisation. A PPG member said that the group's remit included providing advice on streamlining services, as opposed to making strategic decisions, and that their group membership needed more NHS experience.

Despite initial worries about losses of relational continuity, one patient vividly recounted how AT Medics' focus on efficiency had improved his experience and he was now more tolerant of seeing different clinicians:

“ There was no IT and it was a one-man band, you went there and queued and there was no appointments... but [now] there's never any shortage of resources or staffing here, you know, you get appointments the next day on the internet, you know, you get pills within a couple of days through the website.

In some of its practices, AT Medics had created links with local health and wellbeing initiatives, supporting patients' campaigns for access to gyms and working with a voluntary sector group in Newham to establish exercise groups in its surgeries.

GP Care

At a practice where GP Care delivered services that had merged with a neighbouring practice (unrelated to GP Care contracts), the PPG chair reported that advising on the merger would have been out of the PPG's remit, but nonetheless they would have wanted to hear about the merger before it happened: "It felt like a *fait accompli*... but I don't think we would have had any influence on the way the merger went; that was out of our remit really... we were kept informed of how it was going."

The PPG was worried about closure of the practice, loss of GP staff and reductions in quality, but the chair reported one year on: "I don't think that's changed really, it's just as efficient." Staff agreed and said the practice's NHS Friends and Family Test scores did not change during the time following the merger.

Patient experience of GP Care services (as opposed to those of the practice where they were registered) was assessed through the NHS Friends and Family Test, with GP Care earning additional (CQUIN) payments (see above) for promoting use of this measure of patient experience. Quarter 1 scores reported to commissioners revealed that 100 per cent of the 132 patients surveyed were very likely or likely to recommend GP Care services.

Harness

Harness staff reported valuing patient feedback, and patients reported that when practices joined Harness, the efforts made to engage patients were refreshing: “this was something very new for the population of this area”. Harness practices each had their own PPG, which ran alongside a Harness-wide PPG and an online patient group. The Harness gynaecology service collected monthly patient satisfaction data, which were reported to be high, with few complaints from patients. The ‘hub’ and walk-in service (which improved access for some patients) were also said to be linked to high satisfaction although two interviewees indicated that they were utilised less than expected.

PPG members explained that their group’s primary focus was on activities within the practice. They were adamant that:

“ All practices should be able to keep their identity because that’s what patients can relate to.

They viewed providing feedback on new service initiatives (for example, a centralised contact number) as a key part of their remit, and reported that their influence did not extend to advising on mergers. Throughout the process of mergers, they reported having been most worried about losing the “personal touch” and “being a little fish in a big pond”, but said that their fears had not been realised during the mergers. Despite this positive realisation, they still only visited their own practice, despite opportunities to use other clinics run by Harness, because they felt “listened to and valued” at their own practice and that “they’ll always find some way to get you seen”. Relational continuity appeared to outweigh fast access for most PPG members.

The chair of one PPG had gone to a Harness-wide PPG meeting but reported that some people had attended to pursue their own special interests as opposed to working together. To encourage joint working, not only among PPGs but also among the community and local providers, Harness ran its first public Health Fair in 2015 in a local park, combining advice on healthy living and wellness checks.⁴

Modality

Modality interviewees reported working to involve patients in service development and redesign since the organisation was founded. Patients were not directly involved in decisions about mergers, but they were informed about them when they took place in several ways, including through verbal information by staff and waiting room posters. The organisation’s commitment to enhancing patient experience was documented in its 2010–15 Business Plan, which included approaches such as:

⁴ www.harnesshealthcare.com/files/2015/03/Harness-Health-Fair.jpg

- developing a consistent brand and layout in all Modality practices
- introducing EMIS Patient Access
- developing a centralised hub for people needing same-day access.

The last of these was most controversial, as about 70 per cent of patients reported to Modality in the first month that the service was better, but a vocal 30 per cent said that the service was poor. As a result, where necessary, practices still accepted appointment requests from patients who directly telephoned or walked in. It is possible that this dissatisfaction is reflected in deteriorating scores for patient satisfaction with access to and ability to see a chosen GP.

PPG members at practices that had recently joined Modality reported that they were not consulted about the process and felt like they were ‘being sold’ the change. They also reported feeling that Modality would benefit from the merger, but that the practice would not, and that partners may lose their ability to decide how to deliver services or work with their PPG. One PPG chair said: “I think we are going to just have to go along with whatever [Modality] wants and we are no longer operating as an individual practice within the group. Now the effects of that are yet to be seen, but I don’t think that we’ll be in a position to introduce new models of service delivery [which we have previously been very good at and won awards for].”

To encourage all PPGs across practices to look to the future collectively, Modality started bringing them together in 2013 at a local community centre. In addition to building relationships with patients, Modality practices were also creating links with the local community. A longstanding and close association between a Modality practice and a local temple led the temple to give a donation towards the cost of a new health centre that worked closely with the temple and its community centre, supporting health and wellbeing and mindfulness events and collaborating on other community projects.

Relationships with CCGs and providers across the system

Key findings and practical lessons from the case studies

- In the case study sites, delivering extended services was easier if the large-scale organisations had developed positive, collaborative relationships with their local CCG and with relevant specialists.

Relationships with CCGs

- Large-scale general practice organisations whose member practices were contained within the boundaries of a CCG had an interdependent relationship with their commissioner. Collaboration through joint planning and service redesign strengthened this relationship in two case study sites.
- Relationships with CCGs developed over time and appeared to be strengthened if the general practice organisation could address population health needs or contribute to commissioning plans. Conversely, it was harder to build good relationships and trust where CCG staff perceived the general practice organisation to be a private company or motivated by profit.
- Where CCG strategies involve developing large-scale general practice organisations, they are likely to need to invest in them to help them become fit for this purpose.

This may cause tensions if the general practice organisations are perceived as private companies. CCGs must be confident that working with general practice organisations will contribute to measurable health gain and commissioning priorities.

- The inherent conflicts of interest between GPs in their provider and CCG roles will require careful management if CCGs are to involve large-scale general practice organisations in their commissioning plans. The case study sites typically handled such conflicts by ensuring that members of large general practice organisations did not hold an executive position in a CCG or *vice versa* and by declaring them where relevant.
- Large-scale organisations that are spread across several CCGs find it harder to have influence over any one CCG, although they may be able to contribute to commissioning plans in some areas. Strong, collaborative relationships were easier to form in the geographically aligned case study sites. Meanwhile, multi-site providers operating over several CCGs thought they were less likely than local groups to win bids to deliver services across a CCG, no matter how good their track record of delivery.

Relationships with providers

- The majority of specialist services delivered in the community by the case study organisations were grounded in strong, trusting relationships with specialists who contributed to service delivery.
- Developing small-scale specialist clinics may be resource intensive and may not help to build the strong relationships with specialists that are needed if whole pathways of care are to be transformed.

AT Medics

AT Medics built its relationships with CCGs and NHS England through reliable delivery of APMS contracts. On some occasions, CCGs had asked AT Medics to take on a practice or walk-in service at short notice if the incumbent provider could no longer deliver it and AT Medics was usually able to do this. Its services were spread across 12 London CCGs at the time of the study, although its patient numbers in any one CCG were too small to gain significant influence over commissioning decisions (beyond working through whatever local governance arrangements existed between the CCG and its members).

Some of the boroughs in which it operated had active provider networks or federations and AT Medics' directors were active participants in these groups. Indeed, in Lambeth an AT Medics director was chairing the local GP care network and participating in discussions with other practices about how to improve services and increase efficiency. They were also engaged with the CCG about delivering extended access services. A respondent from the CCG described AT Medics as "highly involved in pretty much everything that we do".

AT Medics gave two reasons for actively participating in other large-scale general practice collaborations. The first reason was to coordinate with other GP providers' efforts to improve services for patients. As one interviewee outlined: "We don't think it's helpful for patients to carve ourselves out of [a local GP federation]." The caveat

given by one respondent was that the CCG's collaboration's strategic aims would need to align with those of AT Medics. The second reason was to strengthen its influence. "When you're part of a large organisation, if you are talking about commissioning a service... the larger a body you have, the more patients you have, the more of a say you will have in these things." One director described AT Medics' relationships with individual CCGs as supportive and developmental, and underpinned by regular contact with CCGs to address local problems.

However, another director expressed concern that some NHS staff see AT Medics as a private provider. He felt that this reduced their trust in the organisation and made it less likely that AT Medics would be awarded contracts in competitive bidding processes. Moreover, with its services covering only a proportion of the population in any one borough, AT Medics was not eligible to bid for contracts under single-action tenders, no matter how good its track record of delivery.

GP Care

GP Care had worked on relationship building with CCGs and GPs, and at times with specialists and other organisations, but some senior interviewees felt that these relationships were influenced by the perception that GP Care was a private company. Moreover, some of its services were funded through short-term, rolling contracts, making it harder to become an established provider of local services. Furthermore, one interviewee explained that the local commissioning strategy included a commitment to create GP collaborations and GP Care could be seen as an additional provider in this diverse health economy. In practice it was finding it hard to build a strong foothold in the Bristol area and its geographic footprint was broadening as it bid for and won longer-term contracts in CCGs beyond its local area.

In line with its strategy to do more to support practices with core services, GP Care had recently partnered with the Bristol out-of-hours provider BrisDoc in a successful bid for Prime Minister's GP Access Funding. Through a joint venture organisation called 'One Care', it participated in initiatives to extend patient access by providing physiotherapy in general practices.

As with AT Medics, GP Care described the development of its early service portfolio as 'ad hoc' and shaped by the tenders offered by CCGs. Interviewees described challenges in dealing with their local CCGs because GP Care's business was "very poorly understood". However, its new CEO focused the work of the organisation onto community diagnostics so the organisation's purpose and strategy had become clearer and easier to communicate. Furthermore, with some of the CCG board members (but not executive members) being GP Care shareholders, there were conflicts of interest with some CCG decisions. Chapter 6 discusses conflicts of interest in detail.

Harness

Harness interviewees considered it essential to collaborate with CCG initiatives and with other local partners. They were based in an urban environment with a high proportion of patients crossing CCG boundaries. They also had to work with two local commissioning structures – their own CCG, and the North West London Whole Systems Integrated Care initiative covering eight CCGs and all primary, community and secondary care providers. When the CCG was formed, Harness lost some of its most motivated clinical leaders to commissioning and both organisations established explicit arrangements to manage potential conflicts of interest.

Harness executives and members had regular meetings with Brent CCG along with the other three Brent networks to ensure that their activities were aligned and to address concerns about local services (for example, demand management and overspend on the CCG). Some CCG commissioning plans were predicated on having high-quality primary care in Brent so clinical commissioning was creating new opportunities for Harness. Equally, CCG efforts to develop service specifications needed input from GPs with relevant clinical experience. Thus, Harness staff who had worked in the community gynaecology service helped the CCG to understand what should be in a service specification. Strict adherence to guidance on managing conflicts of interest was seen to be very important in these situations.

As an example of collaboration with specialist providers, Harness ran a gynaecology collaborative project with Imperial College Healthcare NHS Trust covering half of Brent's population. The service provided a 'one-stop shop' for patients and included education sessions for GPs and access to secondary care consultants. A respondent explained that one reason behind the success of this collaboration was the synergy of vision and aspiration, the desire for good working relationships and the opportunity for learning between consultants and GPs with a Special Interest by working together. Despite having high patient satisfaction rates, it had been funded as a collaborative project for over five years and a barrier to further development is the likelihood that the service will be re-tendered in the future.

With forthcoming contracts for integrated services across more than one borough, Harness executives were preparing to bid for large-scale contracts covering three boroughs and almost a million people. But such contracts required financial assurances and ability to share business risk that, despite a successful business record, they were too small to provide. Joint bids with other organisations were seen as essential and they were willing to partner with NHS and private sector groups whose values aligned with their own. It was Harness's view that many primary care providers would need to consider how they managed business risk in larger-scale contracts and would need to form alliances and partnerships.

Modality

From its inception, Modality had strong relationships with the local CCG. With a local hospital earmarked for closure and another smaller hospital due to be built, Modality's growth as a potential provider of community-based, specialist care has always been linked to local commissioning plans. It has been in long-term discussions with the CCG and hospital executives about the role it might play in substituting for hospital care and now in relation to vanguard work. Equally, when CCG commissioning plans promoted the introduction of large, geographically defined GP organisations, Modality entered into discussions about extending membership to new practices to create geographic coherence. The opportunity to become a multi-speciality community provider vanguard site has cemented Modality's place in discussions with all local providers as well as the CCG.

Relationship building in Modality has also been important for establishing community-based specialist services. As in the other case study sites, its success was partly attributed to the trust between individuals. Its urology clinic, for example, was borne out of a casual meeting with a urology consultant based at a local hospital. However, these relationships were not always positive and there had been problems recruiting a consultant for a Modality dermatology clinic. One explanation offered

was that the invitation from Modality to participate in the service was interpreted as dealing with the specialists' 'bread and butter' and therefore not desirable. In response, Modality is having to recruit a specialist from further afield. One GP with a Special Interest said: "Well I think there's always been a kind of wariness and almost like we're taking their bread and butter, but then the quality of the referrals that are coming in is really what they want to be dealing with, so it seems a little bit of a misnomer."

As Modality's ambition for extending the range of services it provided grew, collaboration with other providers was described as coming with a clinical and financial risk. One interviewee, for example, mentioned that the organisation had to consider how much risk it wanted to take on from the local acute trust when considering whether to deliver specialist services in the community. Conversely, another interviewee suggested that there could be problems for hospitals if GP federations "cherry-pick" the services they want to provide. The need for a shared strategy across sectors was mentioned by a number of respondents.

The size of Modality, its vanguard status, its contribution to local commissioning plans and its role in delivering Prime Minister's GP Access Fund services were all felt to add to its influence at local and national levels. As one interviewee explained: "Because it's a much bigger organisation there is more clout behind the organisation in achieving or getting services or contracts to improve the patient services."

In the future, Modality has aspirations to run a 'mini-hospital' and to expand its existing services so that patients can experience their whole care pathway in the community. It has been working with an external partner to help decide which services they should start focusing on.

5. Can we detect changes in quality in large-scale general practice organisations?

In the previous chapter, we provided an analysis of qualitative case study data from mature large-scale general practice organisations. In this chapter, we explore whether assumptions that larger scale will deliver higher-quality care is borne out by the available data. We examine changes over time in nationally available indicators of primary care quality in the three case study sites that provided core general practice services plus five other member organisations of the Nuffield Trust's General Practice Learning Network.

The other five members of the network were excluded either because they had only formed as large-scale organisations at the end of the analysis timeframe (2013–14), and so there was limited data available (n=3); or because, after further review from the qualitative work programme, it became clear that their work did not relate to the delivery of core general practice, focusing instead on extended services (n=2).

For this quantitative part of the research, we addressed the following questions:

- How did the organisations perform relative to the national (English) average at one point in time?
- Did the average performance of the organisations improve or deteriorate over time?
- Did variability between member practices within the organisations reduce over time?

The next section describes characteristics of the eight organisations, after which we describe the indicators and the results of the analysis.

Characteristics of the eight member organisations under study

The eight primary care organisations should not be considered as representative of all large-scale organisations as they had generally been established for several years and were organised and motivated to participate in the Learning Network. Overall, the organisations were heterogeneous, with a diverse range of characteristics (see Table 5.1), including the following:

- Founded between 1977 and 2009
- They consisted of four multi-practice organisations, two federations and two super-partnerships
- Five organisations brought together practices within a small geographical area while three were dispersed – two nationally and one across London
- The mean number of registered patients per member general practice ranged from

3,946 to 7,728. One organisation (A) only had one practice code, which meant it was not possible to distinguish member practices; the total registered population for this organisation was 34,476

- Between 2009 and 2013, only one organisation had a stable population with less than a 4 per cent change in patient population size since being established (organisation A)
- There was wide variation in the proportion of patients aged 65 or more (minimum 6.4 per cent, maximum 24.6 per cent)
- There was wide variation in mean deprivation scores (minimum 15.3, maximum 45, based on the 2011 Index of Multiple Deprivation).

Table 5.1: Characteristics of the eight large-scale organisations examined^a

Organisation	A	B	C	D	E	F	G	H
Year founded	1977	2004	2006	2009	2006	2008	2007	2003
Type	Super-partnership	Multi-practice	Federation	Super-partnership	Multi-practice	Federation	Multi-practice	Multi-practice
Location	South East England	London (East, South, West and surrounds)	North West London	West Midlands	South East London	South East England	North England	National
Dispersed practices?	No	Yes	No	No	No	No	Yes	Yes
Number of general practice members (December 2014)	1 ^b	19	21	9	16	44 ^c	8	35
Total patient population (2014)	34,476	97,856	116,881	60,018	91,464	340,047	43,366	142,064
% change in members (2009–13)	0	45.50%	23.10%	33.30%	150.00%	153.30%	75.00%	19.40%
% change in population 2009/10–2013/14	4.60%	82.90%	28.60%	31.60%	123.00%	132.40%	340.00%	78.80%
Mean list size per general practice	–	5,150	5,566	6,669	5,717	7,728	5,421	3,946
% patients aged >65 years	24.60%	7.10%	9.00%	10.30%	6.40%	20.80%	8.20%	8.70%
Mean deprivation score for member practices ^d	15.3	31.5	34.8	45	32.3	20.8	39.4	30.8
Mean WTE GPs ^e per 10,000 patients	5	5	6	9	6	5	5	5
Predominant contract type (APMS/GMS/PMS) ^f	PMS	APMS	GMS/PMS	GMS/PMS	APMS/PMS	GMS/PMS	APMS/PMS	APMS/PMS

Notes: All data were correct at time of collection in 2014.

^a Denominator data corrected for anomalies and missing data; data as at September 2014.

^b Organisation A had three sites that all operated under a single practice code, which meant that it was not possible to examine variation.

^c Excludes student practices.

^d Average of weighted 2010 Indices of Multiple Deprivation score for each member practice, as assigned by Public Health England.

^e WTE (whole-time equivalent) GPs, including GP partners, salaried GPs, registrars and retainers

^f APMS = Alternative Provider Medical Services, GMS = General Medical Services and PMS = Personal Medical Services.

Source: Health and Social Care Information Centre

Selection of quality of care indicators for analysis

We aimed to select a range of indicators of the quality of primary care, including those covering:

- areas of care nominated by Learning Network members as having potential to improve through working at scale
- areas of care identified in the published literature as having potential for improvement in large-scale organisations.

This process included the following steps:

- a literature review on the potential benefits of new models of primary care
- an examination of nationally available quantitative data at general practice level over time
- a review of the services provided by each organisation as stated in their application to join the Learning Network.

Over 400 potential measures were identified and discussed with Learning Network members. With member organisations pursuing varied objectives and focusing on different clinical services, there were no measures that were relevant to the work of all organisations. However, they identified themes they considered particularly relevant to quality improvement in large-scale organisations, such as:

- peer-led quality improvement
- access, waiting times and capacity
- patient experience
- population health.

We examined nationally available quantitative data at general practice level against these themes, and selected 30 to 40 indicators that could be tracked for up to five years. We sought indicators covering different population groups (for example, children, adults and patients with long-term conditions) and different key GP functions (for example, prescribing and referrals). We used the three Darzi (2008) domains of quality – safety, effectiveness and patient experience – as a framework for indicator mapping. We aimed to select indicators that were: reliable; with good construct validity and attributable to care delivered in general practice; with a clear rationale and polarity; and not measuring rare events.

We focused on indicators of quality that were more likely to be in direct control of the general practices (such as prescribing), even though we acknowledge that other factors may influence the trends. For example, two of the four hospital activity indicators selected – ambulatory care sensitive (ACS) admissions and attendance at major A&E settings (type 1 – consultant-led A&E) during core general practice opening hours – are more open to control by general practice than the other two (total admissions and emergency admissions), which are influenced by broader factors than GP care.

The final indicator list monitored the performance of the primary care organisations on 15 indicators as proxies for the quality of care across four domains – prescribing,

hospital activity, the QOF and patient satisfaction (GP Patient Survey). Of interest, the indicators we used are broadly similar to the indicators later identified by the GP Practice Metric Task and Finish Group⁵ for the My NHS website in April 2016 to monitor the quality of general practices.

The list of indicators and time periods covered are summarised in Table 5.2 and described in more detail in the Appendix.

Table 5.2: Quality indicators		
Domain	Comparison over time	Data points
Prescribing		
1. Ibuprofen and naproxen as a percentage of non-steroidal anti-inflammatory drug (NSAID) items	Yes	National average comparison: November 2014 Trends over time: 2010–14
2. Antibiotics (cephalosporins and quinolones as a percentage of antibacterial items)		
3. Hypnotics: average daily quantities per specific therapeutic group age-sex related prescribing units (STAR-PU)	Yes	National average comparison: December 2013 Trends over time: 2010–13
4. Atrial fibrillation: percentage treated with anti-coagulation or anti-platelet drugs		
Hospital activity (rates per 1,000 registered population, standardised for age, sex and deprivation)		
5. Total admissions	Yes	National average comparison: 2013/14 Trends over time: 2009/10–2013/14
6. Emergency admissions		
7. Ambulatory care sensitive admissions		
8. Attendance at major A&E settings during core general practice opening hours (9am to 6pm, Monday to Friday)	Yes	National average comparison: 2013/14 Trends over time: 2011/12–2013/14
Quality and Outcomes Framework (QOF)		
9. QOF organisational domain	No	2013
10. QOF clinical domain	No	2014
11. QOF total		
GP patient satisfaction (GP Patient Survey)		
12. Ease of getting through on the telephone	Yes	National average comparison: 2015 Trends over time: 2012–15
13. Able to get an appointment		
14. Seeing preferred GP		
15. Rating of GP for involvement in own care		

Note: The national averages were composed of all general practices in England at the data point(s) examined. We excluded minor injuries units, walk-in centres and university campus practices from our analysis of Learning Network members, but were not able to correct for this in the national averages (although there are relatively few of them).

5 NHS England agreed with the Department of Health to lead a project to identify an updated dataset of GP practice-level metrics and publish this on the My NHS website in April 2016. This was requested following – and in relation to – the Health Foundation report *Indicators of Quality of Care in General Practices in England* (Dixon and others, 2015), an independent review commissioned by the Secretary of State for Health.

It is important to note that we were not measuring how organisations performed against their own quality improvement goals. This would have required bespoke data collection beyond the scope of this study and would not have been comparable across organisations.

A further consideration is that over the research study period, some organisations had new general practices joining their networks. For example, in organisations E and F, the organisations' patient populations doubled over the period 2009/10 to 2013/14; and in organisation G the patient population tripled (see Table 5.1). This is an important limitation of the analysis, as changes over time in the indicators may reflect changes in the patient population over time for these growing organisations, in particular.

Detailed information about the methods and indicators used is given in the Appendix.

Results by domain

Tables summarising performance for all the organisations across the 15 indicators are available in the Appendix.

Prescribing

Most organisations performed significantly better than the national average in 2013 or 2014 on the four prescribing indicators we analysed. Nationally, as well as in all of the organisations, **there was significant improvement on all four of the prescribing indicators over time (NSAIDs, antibiotics, hypnotics and anti-coagulation/anti-platelet drugs).** Only two organisations deteriorated over time on a single indicator.

Even for the few organisations that performed worse than the national average in the latest year (for example, organisations A and F on three out of the four indicators), we saw (for almost all) improvement in performance over time. Whether or not these trends were due to the particular initiatives within large-scale organisations or a national policy on prescribing was difficult to ascertain without further in-depth analysis.

Hospital activity

We looked at four hospital activity indicators and found no consistent pattern in performance across organisations in 2013/14. **Only one organisation (C) performed significantly better than the national average across the four indicators in the most recent time period,** although the trend from 2013/14 showed deterioration over time. On the other hand, organisation F performed significantly worse than the national average across all four indicators.

Examining national trends over time (between 2009/10 and 2013/14) showed that performance on three out of the four hospital activity indicators (except attendance at major A&E settings during core general practice opening hours) deteriorated, even though none of the deterioration during the period studied was statistically significant. **Thus, the organisations followed the national trends and no organisation achieved significant improvement on any of the four hospital activity indicators.**

Up to five out of the eight organisations managed to reduce variation between practices on total admissions, emergency admissions and ACS admissions. **But, there were trends of deterioration over time nonetheless.**

One potentially positive signal was the improvement over time in six out of the eight organisations for attendance at major A&E settings during core general practice opening hours, and in half of the organisations for emergency admissions, but these trends were not statistically significant.

Quality and Outcomes Framework

We were not able to monitor trends in QOF indicators over time or within-organisation variation, as indicator definitions changed too frequently during the period of analysis (2009–14). We therefore analysed performance in a single year – 2013 – for one indicator and 2014 for the other two. When analysing performance relative to the national average, half of the organisations performed significantly better than the national average on organisational QOF (in 2013), clinical QOF (in 2014) and total QOF (in 2014).

Organisations A and D performed significantly better than the national average across all three QOF indicator groups. Only one organisation (H) performed significantly worse than the national average across all three QOF indicators.

Patient satisfaction

For patient satisfaction we looked at data between 2012 and 2015. **Nationally, performance on the four GP Patient Survey indicators deteriorated and a similar trend was seen in most of the eight organisations we studied. However, the deterioration was statistically significant only for seeing a preferred GP. In 2015, almost all of the organisations performed significantly worse than the national average across all four indicators.**

Although two organisations performed better than the national average on three of the indicators (A and F), no organisation performed significantly better than the national average on all four indicators. Over time, only two organisations achieved a statistically significant improvement over time on ease of getting through on the telephone (G) and ability to get an appointment (D).

One potentially positive signal was that some organisations seemed to be improving over time, even though the trend was not statistically significant. This was seen for two indicators: seeing a preferred GP (six out of the eight organisations) and rating of GP involvement in own care (four out of the eight).

Case study results

The three case study sites that delivered core general practice services – AT Medics, Harness and Modality – from which we analysed data, told us that they were focused on high QOF achievement (and, in AT Medics' case, maximum achievement). During the interviews we heard about a range of activities associated with quality improvement and better QOF performance (for example, peer review of performance data; nurses and practice managers meeting quarterly to review coding; and weekly reviews with directors). Therefore, we expected to see near-maximum performance across all sites; however, our analysis revealed that only Modality was significantly better than the national average across the three QOF domains examined (see Table 5.3). This may reflect differences in 'baseline' QOF performance in practices that joined the larger organisation during the analysis period and the extent to which the need to 'turn around' poor practices affected average performance. It could also reflect differences between their registered populations rather than the quality improvement processes themselves.

Table 5.3: QOF performance by case study site and national average

		Period	England	AT Medics	Harness	Modality
QOF organisational domain	Compared with national average (all practices)	2013	97.4% (97.2%, 97.6%)	Better	Better	Better
QOF clinical domain	Compared with national average (all practices)	2014	92.3% (92.0%, 92.5%)	Better	Worse	Better
QOF total	Compared with national average (all practices)	2014	93.5% (93.3%, 93.7%)	Better	Similar	Better

Note: Dark green indicates statistically significant scores. Numbers in parentheses are 95% confidence intervals.

Modality has gained a strong reputation in Birmingham and for the last few years has attracted high-quality practices, Harness has worked with practices of varying quality and AT Medics has grown from turning around poorly performing practices. In AT Medics, analysis of QOF data for established member practices (defined as those who were a member of the organisation in 2009) suggests that these have achieved more consistent improvements over time; however, the trends are difficult to interpret due to changes in QOF measures over time (Health and Social Care Information Centre, 2015). In Harness, for some of the 12 practices that joined after 2008, the QOF score declined during the year prior to joining the organisation compared with the year of joining but then improved post joining; in others, the QOF score was continuously improving over time. But again, because of the changes in QOF measures over time, it was difficult to ascertain whether these changes were a result of joining the large-scale general practice organisation.

The three case study sites described monitoring and improving patient satisfaction as a high priority but this is a difficult task, as evidenced by the fact that national trends in relation to access to, continuity of and involvement in care have worsened in recent years. Furthermore, all three case study organisations operated in inner-city, ethnically diverse areas. Such areas are known to experience lower patient satisfaction scores compared with the national average. This may go some way to explaining why, between 2012 and 2015, the three case study sites performed worse than the national average on patients being able to get an appointment, patients being able to see their preferred GP and patients' rating of GPs' involvement in their care (see Table 5.4). Only AT Medics performed better than the national average in 2015 on ease of getting through on the telephone, but like the other case study sites (and national trends) their performance deteriorated and variation increased over time.

Table 5.4: Patient satisfaction by case study site and national average						
Indicator		Period	England	AT Medics	Harness	Modality
Ease of getting through on the telephone	Compared with national average	2015	73.3% (73.2%, 73.4%)	Better	Worse	Worse
	Trend	2012–15	Deteriorated	Deteriorated	Deteriorated	Deteriorated
	Within- organisation variation	2012–15	Increased	Increased	Increased	Increased
Able to get an appointment	Compared with national average	2015	73.1% (73%, 73.2%)	Worse	Worse	Worse
	Trend	2012–15	Deteriorated	Deteriorated	Deteriorated	Improved
	Within-organisation variation	2012–15	Increased	Increased	Increased	Decreased
Seeing preferred GP	Compared with national average	2015	36.3% (36.2%, 36.5%)	Worse	Worse	Worse
	Trend	2012–15	Deteriorated	Improved	Improved	Improved
	Within-organisation variation	2012–15	Increased	Decreased	Increased	Decreased
Rating GP for involvement in own care	Compared with national average	2015	74% (73.9%, 74.1%)	Worse	Worse	Worse
	Trend	2012–15	Deteriorated	Improved	Deteriorated	Improved
	Within-organisation variation	2012–15	Increased	Increased	Increased	Increased

Note: Dark red and dark green indicate statistically significant scores. Light green and pink indicate that the scores were not statistically significant. Numbers in parentheses are 95% confidence intervals.

There were some signals of improvement over time across the organisations and indicators. Modality significantly improved on patients' ability to get an appointment and also significantly reduced variation between member practices on this indicator. Meanwhile, all three case study sites improved patients' ability to see their preferred GP, and AT Metrics and Modality reduced variation between practices on this indicator.

In addition to examining trends between 2012 and 2015, we took a specific look at changes between 2014 and 2015. This was because all three case study sites began introducing new methods of managing patient contacts from 2014 onwards, which were in theory meant to improve access. The changes at Modality and Harness were driven by their successful bids to the Prime Minister's GP Access Fund. AT Medics implemented change when its GP Access Fund bid was rejected, but had encouraged innovation. Initiatives included the following:

- AT Medics began undertaking telephone triage and offering same-day remote appointments in 2014. In 2015 it introduced new online services (for example, for new patient registrations, repeat prescriptions and self-management advice).
- Harness began operating two extended access hubs in 2015 and ensuring that patients were offered appointments at hubs when they could not be seen in their registered practice.
- Modality completely redesigned patient access by routing all patient contacts through a triage centre and guaranteeing patients same-day access in 2014.

However, a detailed analysis of trends between 2012–14 and 2012–15, the period during which we may have expected to see the impact of the access initiatives carried

out by the case study sites, revealed few changes in any of the four patient satisfaction indicators. It is possible that it was too early to be able to capture the impact. Therefore, it may still take some time before we begin to see improvement on the four patient satisfaction indicators more widely. Further, in-depth analysis of the case study sites in relation to other patient satisfaction metrics, as well as future updates on the four indicators, may help to reveal the impact of the organisations' quality improvement initiatives.

Summary

Overall, our analysis of 15 quality indicators in eight of the GP Learning Network organisations was **unable to detect marked differences in quality of care compared to the national average**. Nor was there evidence of consistent improvement over time or reductions in organisational variation between member practices across the indicators considered. No single large-scale organisation consistently outperformed or underperformed the others on all indicators; however, **three of the case study organisations performed significantly better than the national average** on over half of the measures.

The most positive results were in the prescribing domain, with most organisations significantly improving over time on all indicators, even where performance was worse than the national average. However, national initiatives to control antibiotic prescribing and other new guidelines may have influenced our findings, which cannot be attributed directly to initiatives carried out by the large-scale general practice organisations. Nevertheless, performance on prescribing indicators probably best reflects areas that are truly in the control of GPs.

Performance on the indicators for hospital activity and patient satisfaction showed clear trends of deterioration over time. These trends mirrored national patterns and were also similar to findings from earlier research into GP fundholding by the Audit Commission (1996), which are considered further in Chapter 6. They may reflect wider challenges in the health and care sectors, and the limited influence of general practice on unscheduled hospital use.

The findings also show deterioration in patient satisfaction based on data from the GP Patient Survey, although it is important to note the limitations of this survey, especially the low response rate (the national response rate in 2014 was 32.5 per cent) (Ipsos MORI, 2015) and bias in the population who responds (for example, more women than men and more older people and a lower response rate in the North East and the North West of England). However, this was the only data available across all sites, and data collection was extended to include 2015 in order to examine patient satisfaction after access initiatives had been implemented. This raises questions about the extent to which larger-scale organisations and initiatives to provide rapid and convenient access address patients' preferences for their encounters with general practice. More in-depth analysis is needed to explore these issues. It may be that benefits will be evident after a longer period of observation.

It is important to remember that we did not measure how organisations performed against their own specific quality improvement goals. This would have required data collection and analysis beyond the scope of this study, and would not have allowed comparison across organisations. If all of the organisations had shared a common improvement goal (for example, diabetic care), we would have included national data

on the clinical domain in question, but this was not the case. In the current analysis, even for the areas that the organisations identified as important (for example, QOF and patient satisfaction), the data only demonstrated patchy improvements.

Regular changes in the membership of large-scale organisations created a methodological challenge. Table 5.1 highlights changes in general practice membership and population size in the eight case study organisations over time. Capturing changes in quality of care over time is therefore complicated, especially when the consistency and representativeness of the indicators are also changing over time (for example, QOF). Finally, we only analysed a sample of eight large-scale organisations – only a fraction of the many heterogeneous, large-scale general practice organisations that now exist.

Therefore, our quantitative findings should be interpreted cautiously when drawing conclusions about the ability of large-scale organisation to improve quality of care.

6. Discussion: what have we learned about the formation and impact of large-scale general practice organisations?

This chapter draws together data from the case studies and accompanying research to examine their implications for the research questions presented in Chapter 2. The research questions are clustered and are explored under the following headings:

- How is the landscape of general practice changing?
- What impact has the local and national context had on large-scale general practice organisations?
- What impact have large-scale general practice organisations had on staff, patient experience and involvement, the wider health economy and quality of care?

How is the landscape of general practice changing?

This section examines the forms in which large-scale general practice organisations are emerging, the factors that are driving their formation, the methods they have used to establish themselves and how they have evolved over time.

The survey data in Chapter 3 highlight the pace at which GPs are forming larger groups, with almost three-quarters of GP respondents currently in large-scale organisations (mainly federations, with only 2 per cent of respondents in super-partnerships). Almost half formed in 2014/15 and around a quarter formed in 2013/14. The proportion of GPs forming collaborations and the rate of formation are higher than was reported by the Audit Commission five years into general practice fundholding, when approximately 50 per cent of practices had taken on some version of this role (Audit Commission, 1996). This recent trend is despite the fact that there is no policy requirement to merge together, which is important, as previous research suggests that mandated networks may suffer from poor engagement by clinicians (Goodwin and others, 2004).

The survey finding that the two most common reasons for forming a large organisation were to achieve efficiencies and deliver extended services was mirrored in the aims of the case study organisations. The third most common motivation – forming because the CCG encouraged them to do so – was not a feature of the case study sites, which all formed well before CCGs came into being. One case study site planned to go beyond improving efficiency and extending services and to lead the development of a population health system through its role as the lead organisation in a multi-speciality community provider.

We observed three broad goals in our case study sites, which are not mutually exclusive:

- **sustaining core general practice services**
- **delivering extended services** in community settings
- **leading whole-system change**, through capitated funding for population health.

These offer a framework around which a large-scale general practice organisation could develop their short-term and strategic plans, the first of which is considered in the next subsection, and the other two are examined below in relation to our research questions on the impact of local and national policy.

Sustaining and improving core general practice services

There was no magic bullet for enhancing the sustainability of general practice.

However, the three case study organisations that delivered core general practice services (AT Medics, Harness and Modality) illustrate the many ways in which larger scale can contribute to more sustainable practices.

Financial and organisational sustainability was improved through a combination of enhanced efficiency, income maximisation and shared resources. Several common approaches were seen in the case study sites to enhance efficiency – not dissimilar to the techniques used in existing improvement programmes such as Productive General Practice (NHS Institute for Innovation and Improvement, 2013), but implemented at larger scale with centralised administrative support. Thus, initiatives that may be too expensive or too difficult to implement in a single practice appeared more achievable across a larger population. A combination of standardisation, automation and centralisation were used to achieve efficiencies, including centralised administration and centrally employed staff to support practices and reduce locum costs.

The case studies demonstrate how sharing the additional resources and infrastructure put in place for extended services can help individual practices, for example by using reporting systems for extended services to collect data on routine care or using additional staff to help practices improve QOF performance. Benefits occur for both the central organisation and the member practices, although the savings made through such initiatives were typically reinvested to fund other developments rather than extracted as additional income.

The case studies also suggest that **investment in technology** could both increase efficiency and improve access to care. While no case study organisation had formally assessed the costs and benefits of various technologies, they were adamant that efficiencies came from:

- using technology to work across multiple sites
- automating administrative processes
- enabling more efficient ways to consult with patients.

Research into various health systems in the United States has highlighted that extensive use of IT and access to real-time data from across multiple providers is a characteristic of all high-performing health organisations (Shih and others, 2008).

Use of technology to improve quality and efficiency is also consistent with some of the ‘design principles’ set out in *Securing the Future of General Practice* (Smith and others, 2013) and with the *General Practice Forward View* (NHS England, 2016a). Equally, the vision for the future workforce set out in *The Future of Primary Care* describes greater use of technology as an important adjunct to workforce development (Primary Care Workforce Commission, 2015). However, the financial and leadership resources needed to install and use these systems are significant. None of the case study sites had undertaken a formal cost–benefit analysis of the technologies they used and the extent to which the efficiencies they claim can be realised in other organisations and result in cost savings remains to be seen.

A third way to improve sustainability was through **enhancing the workforce** by developing new skills and broadening roles. Initiatives to develop additional skills in general practice staff, including GPs with a Special Interest, are now widespread and a well-recognised way to tackle workforce shortages, increase job satisfaction and improve recruitment (Primary Care Workforce Commission, 2015). These outcomes are desirable, but they are not easy or quick to implement. *The Future of Primary Care* (Primary Care Workforce Commission, 2015) emphasises that robust governance arrangements, cultural shifts and innovation are needed to develop the primary care workforce. The case studies in the present research illustrate how much effort is needed from senior clinicians and managers to develop new skills and new roles.

Additional initiatives are also evident:

- peer-to-peer support mechanisms provide staff with rapid access to clinical advice and practical help to solve operational problems
- relatively simple actions such as intranet messaging and peer group meetings provide valuable, low-cost, readily accessible support that is appreciated by staff, with the supplementary effect of reducing professional isolation – this is a valuable spin-off, as evidence to the Health Select Committee in 2015 linked professional isolation in small practices to underperformance (British Medical Association and others, 2015)
- investment in training and development as a source of innovation – seen, for example, in the development of web-based educational resources in AT Medics, which could be delivered across several sites without wasting staff time on travel, and repeated regularly as staff turnover occurs.

While few of the initiatives described above are groundbreaking, there appeared to be added value from implementing them at scale. As noted earlier, this is partly because larger organisations can develop systems and processes that can be extended into weaker practices that would not otherwise use them. It is also because the economies of scale available to larger organisations allow investment in support systems that would be unaffordable in smaller practices.

Lessons from the case studies about providing extended services and leading whole-system change are discussed below in relation to the impact of local and national policy.

How do governance and leadership arrangements shape the ability to improve sustainability in general practice?

The principles of governance set out by the Organisation for Economic Co-operation and Development (2004) are a useful starting point for this question, defining corporate governance as ‘a set of relationships between a company’s management, its board, its shareholders and other stakeholders... [providing] the structure through which the objectives of the company are set, and the means of attaining those objectives and monitoring performance are determined’. The case study sites used diverse approaches to establish these relationships and structures, which varied in terms of:

- the location of decision-making authority and the extent to which this is transferred from member practices to the board (influenced by whether member practices or the central organisation held the contracts for core services)
- the relationship between the governing board, executives and members and the arrangements for interaction and communication between them
- governance processes.

Irrespective of their organisational form (partnership, network or limited company with multi-site practices or services), the ability to achieve objectives was shaped by the interaction between governance arrangements and organisational culture and values. Overall, change seemed to occur faster where the board and the executive team had authority to direct day-to-day operations in practices and this was linked to whether the central organisations or member practices held the contracts for core services. It appeared easier to implement change when the executive team were managing employed staff rather than peers or partners. In the former situation, the board could set strategy and agree objectives, take financial risk over the allocation of resources and direct the executive team to implement change (at pace) in individual practices.

But even where this authority existed, it was not necessarily used – particularly if imposing change in practices risked reducing professional engagement – as seen when the Modality executive team opted not to impose the new access initiatives across all practices. And, in the networked organisation (Harness), where the executive team do not have direct authority over member practices, new initiatives were supported and enabled by the executive team rather than imposed on practices. Thus, implementation of change required a careful balance between maintaining clinician engagement and driving the spread and pace of change.

Harness’s method of prioritising areas for improvement and then supporting practices to deliver better care was consistent with the description by Sheaff and others (2012) of ‘concertive control’ seen in partnership and non-hierarchical organisations. Here, members monitor each other’s work through peer pressure and peer review using a combination of organisational culture and technical knowledge to implement collective decisions. With the majority of emerging large-scale general practice organisations formed as networks, this approach may come into widespread use.

Running alongside observations about governance was **the impact of leadership style**. Direct and regular contact between clinical and managerial leaders and front-line staff

enabled them to spot problems and opportunities associated with delivering services and to address them at an early stage. Staff valued the contact with leaders to highlight and tackle problems in their own practice and this appeared to help to build trust and reinforce a culture of quality improvement. Learning from this kind of engagement was used to design and roll out the solutions across multiple sites. This appeared an important way to improve efficiency across multiple clinical sites, although it became harder as the organisations grew.

In this respect, the case studies are consistent with other case studies of innovation in health care and wider evidence on service redesign, in showing the importance of leaders building trust and engaging front-line clinicians (Baker and Denis, 2011; Goodwin and Smith, 2012). Conversely, the lack of trust reported by member practices in one site, apparently due to weak communication about the organisation's vision and values, flags up potential difficulties if communication is neglected and strong relationships are not forged. Indeed, engagement and trust could not be taken for granted in any of the case study sites, and required continuous effort on the part of leaders.

At times we saw that maintaining these connections required heroic efforts from leaders who were working long, intensive hours, and each organisation was looking for alternative ways to cover some of the leadership functions using other team members. Findings from The King's Fund inquiry into leadership and management in the NHS suggest that the kind of heroic leadership we witnessed should not be widely replicated and models of change are needed that can succeed with less intensive leadership input. Moving beyond heroic leadership will require teams of people – sometimes across organisational boundaries – who can share in the management and governance of an organisation (The King's Fund, 2011).

Best and others (2012) identify five rules for achieving sustainable leadership: distribute leadership (to reduce heroism); establish feedback loops; attend to history (look at why previous interventions have and haven't worked); engage physicians; and involve patients and families. These provide valuable guidance to emerging organisations about how to avoid being dependent on heroic leaders.

The case studies also revealed how each organisation's governance arrangements evolved and became more complex as the goals of the organisation broadened and additional collaborations were developed with other sites. For emerging large-scale groups, the challenges of managing an array of different contracts and organisations, along with maintaining accountability to different governance groups, could be overwhelming. The value of simple, effective governance arrangements in supporting timely decision-making has been highlighted in a series of case studies of integrated care (Rosen and others, 2011).

What impact has the local and national context had on large-scale general practice organisations?

Local context

Changes in the policy and financial context in which the case study sites were operating affected them in various ways. Each of the case study organisations formed without support from clinical commissioners and none was completely dependent on a

single CCG support, but their activities were nevertheless shaped by their relationships with local CCGs and other provider organisations.

Many factors were seen to shape these relationships. For example, they could be helped by clinicians from the general practice provider organisation sitting on a CCG board, and by trust (by a CCG or by member practices) in the motives of the provider organisation to improve population health. On the other hand, they could be hindered by ancient hostilities between CCG members and provider clinicians or by distrust about profit motives, conflicts of interest and being a 'private' provider. These observations mirror findings in other recent case studies in which the complex relationships and the short-term nature of commissioning decisions by CCGs created instability for provider organisations and led them to broaden the geographic base of the services they offer in order to avoid being too financially dependent on a single payer (Rosen and others, 2016).

Where large-scale general practice organisations are owned or run by local GPs who are also members of the local CCG, there are **inevitable conflicts of interest**. Each case study organisation had developed explicit arrangements to manage and minimise conflicts of interest. They did this most typically by ensuring that executive members did not have a formal position in a CCG, or ensuring that CCG executive members relinquished any formal position in the provider organisation. If a GP did sit on both boards, they would be excluded from discussions and decisions about service developments.

However, our survey of CCGs (commissioning leads) highlights that the majority of respondents had encouraged local GPs to form federations and some had provided staff and/or funding to support them. So there is evidence of underlying paradoxes that will need to be addressed as the case study organisations and others develop extended services.

Whatever the underlying aims for primary care development, CCGs need to comply with procurement and competition regulations and with guidance from NHS England (2016b) on conflicts of interest. This and further guidance including detailed worked examples from Monitor (2015) describe processes that must be followed and the assurances needed to minimise conflicts. CCGs need to follow this guidance closely, but, equally, it is important not to 'throw the baby out with the bath water'. The Harness case study illustrated how experience gained from delivering a pilot scheme can be used to shape a service specification for a substantive service within its own CCG and its neighbours.

Delivering extended services and relationships with CCGs and providers

With each of the case study sites delivering extended services beyond core general practice, the **strength of relationships with CCGs and the effectiveness of processes to manage conflicts of interest** were clearly important. Where specialist clinics had been established (such as dermatology or gynaecology clinics) they offered selected elements of clinical specialities that could be delivered in community settings. No case study site had led the redesign of a whole clinical speciality in the way that emerging multi-speciality community providers might start to do in the future.

Their experiences to date highlighted the need within large-scale general practice organisations for **skills in bidding, contract negotiation and operational management**, which take time to develop. With the news stories emerging of bankrupt general practice provider organisations losing money on contracts for extended services (Matthews-King 2016), skills in pricing proposed services will be essential. Data from GP Care show how many months can pass without recognising and filling such skills deficits in the organisation. Investing in the resources needed to bid well and to monitor whether extended services are being delivered to agreed standards and within agreed budgets will be essential for these large-scale organisations.

Another challenge was a trend towards CCGs offering multi-million pound contracts for which the financial assurances required to bid are beyond the scope of smaller organisations – no matter how well run they are. GP Care, Harness and Modality have all entered into joint ventures with other organisations to bid for extended services and, in the case of Modality, to take forward vanguard plans (see below). Leaders in GP Care and Harness acknowledge the complexity of governance arrangements associated with joint ventures. Nevertheless, with contract values rising, emerging federations may need to group together or to enter into joint ventures with other providers to achieve the scale needed to meet bidding requirements.

Equally important for delivering extended services were **collaborative relationships with specialists**. Where present, these resulted in community clinics that were argued to improve patients' access to specialist care and diagnostics. However, no case study organisation had yet collaborated in a whole-speciality service redesign and one consultant who had helped to develop a community service described many of his hospital colleagues as sceptical and reluctant to participate. Prior research on GP specialist services has described the kinds of tensions that can exist with specialists – particularly where GPs have 'salami sliced' clinical specialities to deliver care for simple clinical problems (Rosen and others, 2006). Drawing on learning from medical groups with budgets in the United States, Casalino (2011) emphasises the importance of removing barriers to joint working between GPs and specialists – such as conflicting payment systems – and notes that it is challenging work.

Case studies carried out by Robertson and others (2014) showed the varied achievements of previous initiatives to establish community services linking generalists and specialists. These included employing consultants, jointly staffed outreach clinics, consultant-run education sessions, and consultants supporting staff in extended roles (mainly as GPs with a Special Interest).

These features were evident in some of the extended services we studied, although not all had been developed in each of the case study sites.

As emerging organisations plan to deliver extended services, they will need to find ways to align the goals and incentives of primary and specialist providers and CCGs. Even without capitated budgets, they will have to develop effective payment mechanisms for services. A handful of primary care providers have done this (see, for example, the Pennine MSK Partnership – Corrigan and Nye, 2012), but it is noteworthy that the services seen in the case studies have evolved from smaller origins over a decade or more. These issues will no doubt be on the agenda for Modality in its multi-speciality community provider work if it is to use its planned capitated budget effectively.

National context

Turning to the **impact of national policy**, Modality's emergence as a multi-speciality community provider during the study period followed the launch of the *Five Year Forward View* by NHS England (2014). However, our data collection stopped soon after it formed, so we obtained few insights about its development in this role. The *Five Year Forward View* marks a shift away from many years of policy based on competition towards greater collaboration between geographically aligned provider organisations.

Drawing lessons from US medical groups with budgets, Casalino (2011) argues the need for significant investment in management and infrastructure if these organisations are to succeed. Thorlby and others (2012) describe how New Zealand's independent practice associations invested in support services including IT advice, financial management, contracting expertise, needs assessment and data management. They argue that establishing this infrastructure was central to the success of the organisations. To this end, Modality has entered into a joint venture with a 'risk share partner' that will bring these skills and capabilities to the organisation.

Of wider significance to emerging large scale groups are the proposals and funding streams set out in the *General Practice Forward View* (NHS England 2016a) to bolster core GP services and increase the sustainability of primary care. Many of these are aimed at GPs working at scale and have been designed to address recognised pressure points in general practice including workforce, workload, poor-quality buildings and infrastructure, slow uptake of new technology and pathway redesign. This research presents detailed accounts of how emerging groups can take advantage of these *General Practice Forward View* opportunities. It also highlights the economies of scale and additional opportunities that are available if they respond to the *General Practice Forward View* as a large-scale organisation rather than as individual practices.

Nationally, NHS England's new models of care team are working on an alternative contract for primary care that will enable Modality and other new model organisations to hold a capitated budget for a defined range of services if they choose to adopt the contract. Terms of the contract are still under development, and it remains to be seen how the full Modality partnership – and other GPs in new model organisations – will react to the contract on offer.

This raises questions about how the emergence of multi-speciality community provider models might shape the future of larger-scale general practice organisations. Policy analysis from the Congressional Research Service in the United States about the impact of the US Affordable Care Act 2010 on physician practices (Kirchhoff, 2013) might provide some clues. Drawing first on evidence from the mid-1990s when many US physician practices 'consolidated' into larger groups, the author notes that many eventually de-merged due to public complaints and regulatory changes, with a high proportion declaring bankruptcy. The author also describes a decline in the proportion of physicians in independent practices following the Affordable Care Act, reporting that more physicians are now employed by hospital groups and noting that this may be a way for hospitals to increase revenues and ward off competition.

Evidence from national and international research into medical networks with budgets demonstrates how integrated health systems that include primary care can deliver high-quality care (Shih and others, 2008). However, Robinson's (2014) analysis of vertically

integrated accountable care organisations in California concluded that they increase costs. Meanwhile, Casalino (2014) reported that unscheduled hospital admissions are lower from smaller practices, suggesting that it is hard to predict what will be the overall impact of ever larger general practice organisations.

What has been the impact of the case study organisations on staff, patient experience and involvement, the wider health economy and the quality of care?

This study provides valuable data on staff experience and perceptions, and on selected quality indicators. However, we did not have the time or resources to undertake a survey of patient experience of the organisational changes and specific service developments seen in each case study site. Thus, conclusions about impact on patients are based mainly on interviews, with some insights from the national GP Patient Survey. Findings about impact on the wider health economy are based only on qualitative data from interviews.

Impact on staff

Survey findings that staff, other than salaried doctors, feel more positive than their counterparts across England, suggest that the arrangements we saw to train and develop staff and provide peer support were valued. This was particularly true for reducing the isolation associated with working in small practices and for providing timely advice or support when staff faced clinical, workforce or operational challenges.

The finding that salaried GPs were less positive than other staff is interesting, for each organisation described a range of education and development initiatives aimed at doctors. The interviews suggested that some salaried doctors felt less control over their day-to-day working lives than in other organisations they had worked in, which might explain their lower satisfaction. However, other salaried GPs valued the career development opportunities associated with developing a special clinical interest or taking on a management role.

Overall, the data suggest that the quest for efficiency and sustainability in practices has involved developing skills and providing support for staff groups that have traditionally had little training. This was highly valued, with qualitative evidence that staff were more likely to stay with the organisation and that recruitment was easier as a result.

Impact on patient experience and involvement

For patients there was a mixed picture from the data. Each of the case study organisations had introduced new services to improve access to general practice (GP Care did this through its 'One Care' joint venture) and each argued that patients were benefiting from these initiatives. Yet data from the national GP Patient Survey were patchy, with evidence of improvement in some areas and deterioration in others.

There are important caveats with these findings. The three case study sites improved more than the national average in more than 50 per cent of measures despite being located in inner-city areas. Previous research suggests that ethnically diverse inner-city populations are generally less satisfied with NHS primary care services (Ipsos Mori, 2006). Furthermore, there has been a national decline in satisfaction with access to the NHS, alongside extensive media coverage of problems with access to GPs, which may have affected responses in the case study organisations.

Qualitative data from patients revealed that the majority were loyal to their own practice and concerned that they might lose access to their known and trusted GP. Some interviewees had chosen not to take advantage of rapid access through hub clinics and new technologies but others were enthusiastic about these options, illustrating a well-known tension in general practice between patient preferences for rapid access and continuity. Research suggests that patients in smaller practices have higher patient satisfaction and better access than those in larger practices (Ng and Ng, 2013). Freeman and Hughes (2010) argue that the desire for relational continuity is likely to persist, so larger general practice organisations will need to find a way to deliver this.

The RCGP's vision for the 2022 GP (Royal College of General Practitioners, 2013) recognises the need to deliver varied forms of access and consultation while maintaining the role of an 'expert generalist' and the skills and ethos of generalism in terms of whole-person, coordinated care. It questions whether rapid access to new types of consultation (such as Skype appointments and centralised 'hubs') will disrupt important elements of generalism, such as the ability to develop a holistic understanding of complex patients and the 'holding function' where GPs manage clinical risk in the community without referral to hospital (Royal College of General Practitioners, 2012). Little is yet known about how practice mergers and pooled services to improve access will affect this 'expert generalist' relationship – which was valued by patients in this study – and further research is needed here.

In terms of engagement in organisational and service development, patients had not been involved in decisions to form the large-scale organisations, but some had opportunities to shape future development through PPGs that spanned the whole organisation. With most patients still focused on their own practice's PPG, larger general practice organisations face a challenge in engaging patients in redesigning services that span practice boundaries. However, as organisations grow and seek to deliver both access and continuity, and offer acute and chronic care, they will need to engage representative groups of patients with varied preferences if they are to succeed in addressing diverse needs.

Building relationships between patients and communities

A different dimension of engagement was seen in Harness and Modality, where collaboration with local communities was seen as consistent with organisational values and an important way to fulfil health improvement goals. The initiatives developed between practices, registered patients and local populations were consistent with the aspirations of the *Five Year Forward View* about harnessing community resources and increasing people's ability to improve their own health (Chapter 1 of NHS England, 2014).

Modality exemplified the opportunities that arise from collaboration with local communities through its work with a local temple. While such initiatives are not unique to large organisations, the existence of a larger central administrative team may make it easier to get this kind of initiative off the ground.

Impact on the local and wider health economy

We were unable to quantify impact on the local health economy for several reasons. First, the aims and objectives of each organisation were broad and the main initiatives that might have affected the wider health economy were access initiatives and extended

specialist services. The former were introduced during the study period and were being externally evaluated and the latter were already established at the start of the study. There were few routine data sources to describe impact on the wider system, although the ‘hospital activity’ quality measures in Chapter 5 provide some insights – albeit in an area that is not in the direct control of GPs.

Qualitative data from the case study sites provide additional insights about the relationship between the four case study organisations and their CCGs, highlighting the importance of positive, collaborative engagement between general practice organisations and commissioners. Where there was a weak relationship with the CCG or concern about the general practice provider being a private organisation, the general practice organisation did not play a significant role in shaping commissioning plans. Where there was a stronger and more collaborative relationship, the CCG appeared to influence the development of the general practice organisation – particularly in terms of geographic spread – and the groups were involved in shaping local commissioning plans and services specifications.

With growing interest in place-based systems of care, opportunities for collaborative developments between CCGs and general practice organisations may increase and the case studies offer some insights about how to use local expertise while managing conflicts of interest.

Impact on the quality of care

Findings on quality are varied and hard to interpret. Among the 15 measures of quality assessed in this study, the prescribing and QOF measures were largely under the control of GPs themselves, but hospital utilisation is subject to many other influences that are beyond the control of GPs. Patient satisfaction data covered a period where regular, negative press coverage about access to GPs may have confounded responses.

The mixed impact on quality of the eight organisations for which adequate data were available suggests that larger scale per se does not automatically result in higher-quality care. However, the organisations in which reported measures did improve more than half of the time had all developed systems and processes to address underperformance and had invested resources into improving clinical care. Among the four organisations that did not improve in more than half of the measures, three were multi-site providers that had continued to take over new practices during the period under investigation, and this could have confounded their results if their quality measures at the time of takeover were particularly poor.

That said, a recent analysis of the impact of the QOF concluded that non-QOF-rewarded clinical activities were relatively neglected compared with QOF-incentivised tasks (Ryan and others, 2016). If the organisations focused too much on QOF activities and neglected non-QOF activities, this could explain their relatively poor overall scores. Meanwhile, the extent of GP control over different areas of care varies, with near full control over what they prescribe and much less control over decisions about hospital admissions. This may explain why data on improvements in prescribing suggest some improvement while those on A&E attendance/hospital admission – which are less in their control – do not.

Our quantitative data analysis ended in 2014, before AT Medics and Modality scaled up their online services, so it is not possible to report on the impact of their access

initiatives on another important domain of quality – patient experience. Equally, there are few methodologically rigorous evaluations of technology-enabled access, but a cluster of non-academic published articles suggests relatively high levels of satisfaction. Nevertheless, any improvement will have to take place against a backdrop of steadily declining patient satisfaction with GP access, according to the national GP Patient Survey (Dayan and others, 2014).

7. Conclusions and recommendations

Conclusions and recommendations for large-scale general practice organisations

The case studies suggest that large-scale general practice organisations can improve the sustainability of general practice and provide extended services in community settings. As larger organisations, they can harness some economies of scale and invest in technology and other infrastructure that would be beyond the reach of smaller practices. They can also train and develop their workforce and enable peer support, which is highly valued by staff.

While most of these approaches can be introduced without major financial investment, investment in leadership and the management time needed is substantial. Clarity of purpose is essential as are effective governance arrangements to decide organisational strategy, marshal necessary resources, manage risks and maintain links with members.

The evidence suggests that change can be introduced faster and more systematically in organisations that have ceded their GMS/PMS contracts to the larger group. However, forcing practices into rushed mergers in pursuit of rapid change could lead to failure. Experience from established groups (Rosen and Parker, 2013) highlights the need for careful due diligence, allowing time for collaborative, high-trust relationships to build between potential partners. Federations may be a necessary transitional phase for most practices, and emerging groups will face difficult choices about their governance arrangements and how much decision-making authority to transfer from individual practices to the overarching governance team. Evidence from this study suggests that, in federations, members will need to cede some control to the larger organisation if the large-scale organisation is to work at pace to sustain core general practice and develop extended services.

For patients, the picture was mixed, with some valuing improved access provided through 'hub clinics' and community specialist services. Others worried that it will become harder to access their own practice and that they may lose their highly valued relationship with their usual GP and other practice staff. The characteristics, skills and 'ethos' of 'medical generalism' described by the RCGP include those which patients said they feared losing, and it will be important to assess the impact of large-scale GP services on these factors. There is also challenging work still to be done in terms of involving a diverse range of patients, with varied preferences about the services they want, in the design of scaled-up services.

With mixed results for impact on quality of care – albeit with important caveats about data quality and other factors that might have affected our results – the balance of evidence about the potential contribution of large-scale groups to core general practice services is not straightforward. Further research is needed on how larger scale and

technology-enabled access to GPs affect patient satisfaction and on the impact of larger organisations on referral rates and hospital admissions. Research is also needed on how to ensure that the innovative approaches to education and training, peer support and data monitoring seen in the case study sites are used to deliver consistent and measurable improvements in quality.

Despite these ongoing uncertainties about the scope and impact of larger scale, there are strong signals in the *General Practice Forward View* (NHS England, 2016) that general practice is intended to remain at the heart of the NHS and that the new voluntary contract to be introduced in 2017 will encourage large-scale organisations to form. Meanwhile, the findings of *The Future of Primary Care* (Primary Care Workforce Commission, 2015) highlight the urgent need to strengthen the primary care workforce and to create a different skill mix in general practice, supported by more effective use of technology.

With these observations in mind, we make the following **recommendations to general practice organisations** that are aspiring to sustain and improve core services:

- Invest the time needed to agree the purpose, values and short- to medium-term goals of the organisation. This should include agreeing the extent to which the organisation wants to take on delivery of extended services (this may be a phased process).
- Consider including specific and measurable quality improvement goals that are consistent with local commissioning priorities in order to improve care, build relationships with the local CCG and create a rationale for CCG investment in the organisation.
- Invest time and resources to develop staff roles across practice boundaries and to create peer support and peer learning opportunities.
- Design the simplest governance arrangements possible to deliver agreed goals and be prepared for them to evolve and become more complex as the organisation's objectives develop. Also agree the level of decision-making authority given to the board that will best balance the pace of change with ongoing engagement of member clinicians.
- Ensure that resources are available to achieve agreed goals and be clear about the level of risk that members are willing to take to obtain these.
- Engage with patients to design service delivery that addresses diverse needs and preferences, including rapid access to and continuity of their relationship with clinicians.
- If seeking to establish extended services, ensure that these are underpinned by positive, collaborative relationships and shared goals with specialists.

Conclusions and recommendations for clinical commissioning groups

CCGs will need to address a number of issues when developing their approach to working with emerging large-scale general practice organisations.

Many CCGs are keen to get these organisations up and running in order to deliver more care in community settings and they are likely to feature prominently in

emerging Sustainability and Transformation Plans (STPs). But CCGs may be reluctant to invest money in setting them up due to their current ‘immaturity’ as service delivery organisations, due to conflicts of interest or because some are perceived as private organisations.

Other options for helping the organisations to develop include funding initiatives to improve quality; offering ‘support in kind’ (for example seconding CCG staff to the organisation) and stimulating growth through contracts to deliver services. Each approach will have strengths and weaknesses as a way of encouraging the organisations to develop and if several are undertaken at the same time, local GPs who might be well placed to deliver community clinics in redesigned care pathways, could be overwhelmed.

Explicit principles and processes exist to guide behaviour and CCGs need to follow these closely, but it is also important to avoid ‘throwing the baby out with the bath water’. CCGs will need to find a way to use local expertise (as exemplified in the Harness case study) to inform the development of tenders while separating that work from bidding processes.

The following **recommendations to CCGs** seek to balance support for emerging organisations with caution about minimising conflicts of interest and maximising their contribution to health improvement:

- Have realistic expectations about the capacity of large general practice groups to take on extended roles, their ability to develop specialist skills and their capacity to set up new services. Therefore, involve large-scale organisations at a pace that allows emerging groups to bid for and, if successful, establish new services without becoming overwhelmed.
- Facilitate local debate between patients, the public and other stakeholders about how best large-scale general practice organisations can contribute to population health improvement and what other part they might play in the local health economy.
- Follow guidance on conflicts of interest, but avoid excluding GPs with an expert knowledge of specific areas of care from service redesign work.

Conclusions and recommendations for national policy-makers

We noted in Chapter 1 that it has almost become a truism that bigger is better in general practice. Emerging policy on new models of care and the forthcoming optional contract appear to be nudging general practice in this direction. Moreover, with small numbers of practices being taken over by community or hospital trusts, and evidence from the case studies that the pace of change may be slower in federations than other organisational forms, some may argue that the route to rapid transformation of NHS services is through merging GP groups into other NHS organisations. This would also overcome issues about investing NHS money in private providers.

We highlighted research evidence in Chapter 6 about the risk of clinician disengagement following mandated network formation and the same could be said if GPs are drawn into unwanted mergers with other providers. Too little is currently known about the impact of larger general practice organisations – or general practice practices run by hospital or community trusts – on quality of care; patient experience;

medical generalism and the ability of these organisations to reduce hospital use and costs. More research is needed in these areas.

The research presented here suggests that larger scale can help to sustain core general practice, but we have not been able to provide evidence about improving quality, about the ability of large-scale organisations to manage a capitated budget for a defined population, nor about their ability to redesign services for whole populations or whole pathways of care. We argue that such evidence does not actually exist yet.

The following are **recommendations to national policy-makers**:

- Ensure that there is a phased roll-out of the alternative contract for GP groups and multi-speciality community providers as there is insufficient evidence that introducing a capitated integrated model in England would deliver high-quality, cost-effective care that is valued by patients.
- Commission research on the impact of larger scale on core services and the extent to which larger organisations can still deliver the ‘expert generalism’ that is valued by patients.
- Commission research on what kind of organisational development support will best enable large-scale general practice organisations to become effective, health-improving, self-governing bodies.

Appendix: Research methods in detail

With the aim to better understand the evolution of at-scale organisations, we specifically set out to answer the following research questions:

- How is the landscape of general practice changing? How quickly, and in what form, are new large-scale general practice organisations emerging? What are the factors driving the formation of these new organisations? (See Chapter 3.)
- For a small sample of mature large-scale general practice organisations, how have they emerged and evolved over time? (See Chapter 4.)
- How have organisational, local, national and other contextual factors affected the abilities of mature large-scale general practice organisations to achieve their goals over time? (See Chapter 4.)
- What impacts do organisations perceive they are having on their patients, staff and the local and wider health economy? (See Chapter 4.)
- What impacts on quality of care can we measure? (See Chapter 5.)

The mixed-methods study design involved three main elements:

- surveys to gain a snapshot of the national landscape
- in-depth qualitative analysis of the evolution of four large-scale organisations
- quantitative analysis of quality trends in eight mature large-scale organisations.

This work was informed and complemented by a systematic literature review on networks (see Pettigrew and others, 2016).

National surveys (Chapter 3)

Purpose

In collaboration with the Royal College of General Practitioners (RCGP), we sent surveys to commissioners (senior CCG staff) and providers (represented by RCGP members) to determine the scale of collaborative working between practices at a single time point. The surveys were designed so that similar questions were put to CCGs and GPs to gain two perspectives on the same topic. They were piloted on around 10 GPs employed by the Nuffield Trust and the RCGP.

By surveying commissioners, we were interested in understanding the number of collaborations they could identify in their local areas and the challenges that they faced. By surveying providers, we were particularly interested in understanding how many individuals we could identify who were working collaboratively, as well as their collaboration's aims, achievements and challenges.

Data collection

Commissioners. Invitations to the commissioner survey were sent to a by direct mail to a list of CCG representatives known to the RCGP and Nuffield Trust. The surveys were also publicised via NHS England's and NHS Clinical Commissioners' respective email bulletins. Recipients of invitations were advised to pass on surveys to the most appropriate respondent with the aim of one response per CCG area. We received 126 responses from CCG-based respondents, but 32 were incomplete or duplicates. Data were cleaned so that we had one response per CCG area. We therefore received responses from 94 CCG areas (representing 45% of all CCGs).

Providers. Invitations to the provider survey were sent to over 50,000 RCGP members via the RCGP Chair's Update and through direct mail approaches to about 700 GPs in Nuffield Trust's contact database. There were no sampling restrictions, such as 'only one response per practice or collaboration', which meant that we received 1017 responses from GPs as well as practice-based staff. Data were cleaned to remove respondents who had not submitted completed surveys and anyone who had responded from outside England, which created a total of 982 respondents working within a GP practice in England (representing 184 CCGs and 87% of all CCGs).

Descriptions of the sample are available in Kumpunen and others (2015). Both surveys were open to respondents between July and November 2015.

Data analysis

Commissioners. We received 126 responses from CCG-based respondents, but 32 were incomplete or duplicates. Data were cleaned so that we had one response per CCG area. Where a chief executive responded, we deleted other responses from that area. Where an accountable officer responded, we deleted other responses from that area.

Providers. We received 1,017 responses from practice-based staff. Data were cleaned to remove respondents who had submitted an incomplete survey and anyone who had responded from outside of England.

The provider and commissioner surveys were analysed separately using descriptive statistics and a report of the findings was published in November 2015 (Kumpunen and others, 2015).

Limitations

The survey for providers was sent primarily to RCGP members who then cascaded it down to colleagues – some clinical, others non-clinical. This makes it difficult to quantify an accurate denominator for the provider survey. Furthermore, despite the large number of responses and geographic representation across England, it is unclear whether respondents were representative of the national population of providers.

The commissioner survey was cascaded down to staff within CCGs, so again this recruitment method means that it is difficult to quantify an accurate denominator.

Case study analysis (Chapter 4)

Purpose

The purpose of the case study work was to better understand:

- how mature large-scale general practice organisations have emerged and evolved over time

- how the contexts in which they operate have shaped them
- how patients, staff and the local and wider health economy are impacted by large-scale general practice organisations.

The purpose was not to undertake an economic evaluation of the costs and benefits of large-scale general practice. It was also not to determine whether the policy of large-scale general practice should be implemented nationally.

Data collection

Sampling and recruiting case study sites

The case study selection was drawn from the Nuffield Trust's General Practice Learning Network. The Nuffield Trust received 25 applications to the network, and selected 12 members for their diverse aims, geographies and size (another organisation joined six months in, making the total membership 13). The entire membership was meant to be broadly representative of the types of mature large-scale general practice organisations in operation in 2014.

To ensure that the case studies were heterogeneous, we used theoretical sampling of the characteristics presented in Table A1. Sampling was informed by a review of each organisation's application to the Learning Network, an analysis of their website (primarily used to interpret their ethos and devise follow-up questions for leaders) and a one-hour telephone call with the leader of all potential organisations.

Table A1: Factors considered when selecting the case study sites

Longevity of the organisation	'Middle-aged' organisations (3–5 years), older organisations (5+ years) – avoiding any sites that are too new
List size	Small (<99,999), medium (100,000–349,999), large (>350,000)
Number of practices	Number of general practices (plus walk-in centres, urgent care centres, minor injuries units and so on)
Staff	Clinical staff (GP-led, nurse-led), board and support staff (in-house, external)
Geography	Urban, rural, mixed
Accountability	'Simple': coterminous; 'complex': dispersed across multiple CCGs
Services	Description of service offer: focused or extensive
Motivation	Short-term versus long-term reasons for coming together (for example, resilience, to improve local care, aiming to become a multi-speciality community provider and so on)
Ethos	Ownership, legal status, values (for example, public limited company with shareholders, not-for-profit mutual)
Current research	Projects that might drive/distract from forming organisations (for example, Prime Minister's Challenge Fund, North West London Whole Systems Integrated Care, vanguard programme)
Advantages	Reasons for investigation (for example, IT focus, geographic spread, innovative services)
Disadvantages	Reasons to not involve site (for example, overcommitted to other local research)

Sampling and recruiting practices

Once four organisations had agreed to take part, we selected four practices in each organisation in which to conduct interviews: two larger and two smaller than average practice size (on the basis of numbers of registered patients). Within each category,

we then selected a practice that had been a member of the organisation since its foundation and a newly joined practice. Learning Network members helped to secure agreement of the selected practices.

Sampling and recruiting interviewees

We intended to speak with a number of senior leaders and front-line staff employed by each organisation, affiliated consultants and local commissioners. To recruit senior leaders, affiliated consultants and local commissioners, we asked Learning Network members to contact their colleagues with study information and encourage interested participants to come forward. To recruit front-line staff, organisational leaders provided us with the name of a local collaborator at each practice. The local collaborators both nominated interviewees and accepted volunteers. For the most part, recruitment approaches succeeded. However, because of GP Care's focus on services outside of core general practice, it was difficult to recruit practices willing to take part – the result being that we undertook far fewer interviews at GP Care. The sample of interviewees at each site is described by role in Table A2.

Table A2: Types of interviewees in the case study sites

	AT Medics	Harness	Modality	GP Care
Director/CEO	4	2	1	6
Senior management	1	1	0	2
Finance lead	1	0	0	0
Lead GP/partner	2	6	5	1
Practice manager/deputy	4	4	2	0
Salaried GP	4	3	4	0
Advanced nurse practitioner	0	1	1	0
Practice nurse/health care assistant	4	3	2	1
Practice administrator	2	2	0	0
Other clinician	0	0	0	4
Receptionist	6	2	1	2
PPG member	1	3	4	2
Local partner (CCG/consultant)	1	1	4	
Total (100)	30	28	24	18

Note: Senior members of teams were interviewed on more than one occasion.

Data collection approaches

We intended to bring all data together to provide a holistic view of each organisation, as well as use some data for triangulation. Data collected included:

- an observation of each organisation's board meeting (total=4)
- a review of around 10 internal documents per organisation describing organisational structures, business plans and practice performance monitoring (total=41)
- 100 interviews with organisations' board members, practice-based staff, affiliated consultants and local CCGs
- surveys with staff members (198 respondents from three case study organisations).

Data analysis

We collected qualitative data using realist approaches and had intentions to carry out our analysis based on the principles of realist evaluation (Pawson and Tilley, 2009), which elaborate on how mechanisms (responses to resources) in particular contexts can lead to particular outcomes. While we employed our best efforts to use this approach, we believed that the data we had collected did not robustly create links between the contexts of each organisation, the resources and responses of staff (mechanisms) and outcomes. Instead, a thematic analysis was conducted around broad themes developed from the literature on the theoretical benefits of large-scale collaboration and our scoping interviews with organisational leaders (Fereday and Muir-Cochrane, 2006).

Limitations

Despite our best efforts, we did not manage to recruit a balance of front-line interviewees at each organisation. We also did not receive any responses from the survey sent to GP Care. This means that the perspectives of GP Care's staff and patient populations are under-represented in this report.

At some practices, interviewees were nominated for participation, which meant that they could have been selected to provide a positive perception of the working environment. We did, however, add in a number of unplanned interviews while visiting sites. This meant that we were able to speak with individuals who had not been prompted by the local collaborator.

Despite the various limitations, this study examined large-scale organisations at both national and local levels and provides the most current and comprehensive analysis of their progress to date.

Quality indicators (Chapter 5)

Member practices

Each large-scale organisation provided a list of member general practices from commencement of the organisation to December 2014. They also provided the date each practice joined and left (if appropriate) the organisation. If only the month and year were provided then the joining date was taken as the 1st of the month in the year; if only the year was provided then the joining date was taken as the 1st of January of that year.

Exclusion criteria

Member practices in care settings other than primary care (for example, walk-in centres and minor injuries units) and those with distinct patient populations (for example, student health centres) were excluded from all analyses (n=5). These settings were not excluded from the national datasets as it was not possible to identify them from nationally available datasets.

Data analysis

We obtained data for each measure for each organisation for the years 2009/10 to 2013/14, adding any practice that joined the organisation and adjusting the denominator accordingly. For each measure, we compared organisational performance in 2013/14 to the national average. We also analysed the trend in performance on each measure for the year 2009/10 to 2013/14 – or other periods depending on the data available – to see whether the change within an organisation over time was

significant (e.g. significant improvement or deterioration). Finally, we analysed changes in performance on each measure over time within each organisation to see if there had been a reduction in variation between the member practices.

For the time trend analyses, we plotted the average value for each indicator in each organisation by unit of time (for example, annually or monthly). The unit of time varied depending on the granularity of the indicator. Each organisation's weighted average was calculated using only data from the general practices that were members at each time point – based on the joining/leaving date for member practices provided by each organisation.

Denominators

The practice denominators are listed in Tables B3 to B6 below; however, we provide here a detailed explanation of the denominators used.

The practices' registered populations were extracted from the GP payments system maintained by the Health and Social Care Information Centre (HSCIC) for years 2004 to 2014. We found anomalies where practices had a registered population (denominator data) for one year, but not for the years in between (for example, in 2009 and 2011) despite hospital activity data in Hospital Episode Statistics by patients registered to that practice. We used linear regression methods, based on practice populations by age group and sex, to impute missing practice denominators. The change was minimal (<0.1 per cent change in each year).

Compared with national population estimates for England, the GP-registered population in England was approximately 4 per cent higher. This was comparable to national estimates in 2010, which suggested that the total number of GP registrations exceeded the national population by approximately 5.3 per cent in that year (NHS England, 2013). The reasons for this list inflation include the fact that:

- some patients may have been registered in more than one area
- some patients may have more than one NHS number
- some patients may have remained on a GP's list after having died or having left the country
- GPs have no real incentive to clean patient registers and remove people from lists.

We cannot determine whether the level of list inflation in our sample of organisations was better or worse than the national average.

Denominators for practices are calculated in September of each year, so when calculating rates by financial years, the September 2004 population was used as the denominator for the financial year 2004/05 and so on.

For the purposes of calculating national rates and standardisation, we used the GP-registered population in England in each year as the denominator.

Table A3: Prescribing indicators: definitions and rationale

	Indicator	Definition	Rationale
1.	Ibuprofen and naproxen as a percentage of non-steroidal anti-inflammatory drug (NSAID) items	<ul style="list-style-type: none"> • Number of prescription items for ibuprofen and naproxen as a percentage of the total number of prescription items for all NSAIDs each month • August 2010 to November 2014 inclusive 	<ul style="list-style-type: none"> • Evidence has shown naproxen and low-dose ibuprofen to have the most favourable cardiovascular safety profiles of all NSAIDs. These are therefore the preferred NSAID agents to be prescribed. Concerns were initially raised about the cardiovascular safety of some non-selective NSAIDs in 2006. • www.nice.org.uk/advice/ktt13/chapter/Evidence-context
2.	Cephalosporins and quinolones as a percentage of antibacterial items	<ul style="list-style-type: none"> • Cephalosporins and quinolones as a percentage of prescription items for selected antibacterial drugs each month • August 2010 to November 2014 inclusive 	<ul style="list-style-type: none"> • Use of broad spectrum antibiotics is associated with an increased incidence of Clostridium difficile infection • Cephalosporins and quinolones have been most commonly associated with Clostridium difficile infection and prescribing of these agents has therefore not been encouraged • Over the past 10 years or so, prescribing guidelines have steadily adopted this guidance • www.nice.org.uk/advice/esmpb1
3.	Hypnotics: average daily quantities per specific therapeutic group age-sex related prescribing units (STAR-PU)	<ul style="list-style-type: none"> • Number of average daily quantities (ADQs) for benzodiazepines (indicated for use as hypnotics) and 'Z' drugs per hypnotics (British National Formulary 4.1.1 subset) according to an age-sex-weighted registered population • The quantity is based on ADQ units • The age-sex-weighted registered population is based on ADQ-based STAR-PU • August 2010 to December 2013 inclusive 	<ul style="list-style-type: none"> • Risks associated with the long term use of hypnotic drugs have been recognised since the late 1980s and include falls, accidents, cognitive impairment, dependence and withdrawal symptoms. The lowest dose that controls symptoms should be used for as short a time period as possible • www.nice.org.uk/advice/ktt6/chapter/Evidence-context
4	Atrial fibrillation: percentage treated with anti-coagulation or anti-platelet drug therapy	<ul style="list-style-type: none"> • The percentage of registered patients who are currently treated with anti-coagulation therapy or anti-platelet therapy out of patients with atrial fibrillation and in whom the latest CHADS2* score is 1 • 2010/11 to 2013/14 inclusive 	<ul style="list-style-type: none"> • Since 2012/13 there has been a QOF indicator for the percentage of patients meeting the criteria treated with anti-coagulation drugs, giving two data points at the time of this work. Using the indicator, which is the percentage of patients treated with anti-coagulation or anti-platelet drugs, more data points were available, which allowed assessment of trends over time • www.nice.org.uk/guidance/cg180/chapter/1-recommendations#assessment-of-stroke-and-bleeding-risks-2

* CHADS2 is a scoring system where 1 point is given for each of C (congestive heart failure), H (hypertension), A (age 75 years or over) and D (diabetes mellitus), while S (stroke) receives 2 points.

Table A4: Acute hospital use indicators: definitions and rationale				
5.	Standardised total admission rate per 1,000 population	<ul style="list-style-type: none"> • Numerator: total admissions (only admissions and day cases) • Denominator: total annual registered general practice population from GP payment system (Exeter) reported by Health and Social Care Information Centre (HSCIC) • Standardised for sex, age group and weighted general practice Indices of Multiple Deprivation (IMD) score 	• 2009/10 to 2013/14	<ul style="list-style-type: none"> • Numerator: Hospital Episode Statistics • Denominators: Number of patients registered at a general practice (HSCIC: www.hscic.gov.uk/) • Weighted general practice IMD score (2010)
6.	Standardised emergency admission rate per 1,000 population	<ul style="list-style-type: none"> • Numerator: total admissions (only admissions and day cases) as an emergency • Denominator: total annual registered general practice population from GP payment system (Exeter) reported by HSCIC • Standardised for sex, age group and weighted general practice IMD score 	• 2009/10 to 2013/14	<ul style="list-style-type: none"> • General practice profile (Public Health England): http://fingertips.phe.org.uk/profile/general-practice/data#mod,3,pyr,2014,pat,19,par,E38000003,are,K82079,sid1,2000005,ind1,338-4,sid2,-,ind2,-
7.	Standardised ambulatory care sensitive (ACS) admission rate per 1,000 population	<ul style="list-style-type: none"> • Numerator: admissions for ACS conditions • Denominator: total annual registered general practice population from GP payment system (Exeter) reported by HSCIC • Standardised for sex, age group and weighted general practice IMD score 	• 2009/10 to 2013/14	
8.	Standardised attendance rate at A&E during core general practice opening hours per 1,000 population	<ul style="list-style-type: none"> • Numerator: total number of attendances at major A&E (type 1 – consultant led A&E) during the period 9am to 6pm, Monday to Friday • Denominator: total annual registered general practice population from GP payment system (Exeter) reported by HSCIC • Standardised for sex, age group and weighted general practice IMD score 	• 2010/11 to 2013/14	

Table A5: QOF indicators: definitions and rationale

9.	Case study organisation average total QOF score	Calculated as the average QOF score for member practices in 2014
10.	Case study organisation average QOF score for the clinical domain	Calculated as the average QOF score for member practices in 2014
11.	Case study organisation average QOF score for the organisational domain	Calculated as the average QOF score for member practices in 2013

Table A6: GP Patient Survey: definitions and rationale

	Indicator	Metric	Source	Data availability
12.	Percentage reporting that it is very easy or fairly easy to get through on the telephone	<ul style="list-style-type: none"> • Numerator: total reporting that it is very easy or fairly easy to get through on the telephone • Denominator: total responses minus those who haven't tried or don't know • Practice-level data weighted for non-responses 	<ul style="list-style-type: none"> • GP Patient Survey data, available at https://gp-patient.co.uk/surveys-and-reports 	<ul style="list-style-type: none"> • Annual data available at practice level for June 2012, June 2013, July 2014 and July 2015.
13.	Percentage reporting they were able to get an appointment	<ul style="list-style-type: none"> • Numerator: yes, was able to get an appointment to see or speak to someone (2012–15) • Denominator: total number of responses • Practice-level data weighted for non-response used 		
14.	Percentage rating the GP good or very good at involving them in decisions about their care	<ul style="list-style-type: none"> • Numerator: good or very good rating of GP involving the patient in decisions about their care • Denominator: total number of responses • Practice-level data weighted for non-response used 		
15.	Percentage stating they always or almost always saw their preferred GP	<ul style="list-style-type: none"> • Numerator: Always or almost always saw their preferred GP • Denominator: Total number of responses • Practice-level data weighted for non-response used 		

Detailed results by domain

Acute hospital use indicator dashboard: organisations A to H

Total admissions (age, sex, IMD standardised per 1,000 population)			Attendance at major A&E settings during core GP opening hours			Emergency admissions (age, sex, IMD standardised per 1,000 population)			Ambulatory care-sensitive admissions (age, sex, IMD standardised per 1,000 population)		
Compared to national average	Trend	Within network variation	Compared to national average	Trend	Within network variation	Compared to national average	Trend	Within network variation	Compared to national average	Trend	Within network variation
2013/14	2009/10 to 2013/14	2009/10 to 2013/14	2013/14	2011/12 to 2013/14	2011/12 to 2013/14	2013/14	2009/10 to 2013/14	2009/10 to 2013/14	2013/14	2009/10 to 2013/14	2009/10 to 2013/14
England	276.0 (275.9, 276.2)	Deteriorated	Increase	94.915 (94.833, 94.997)	Improved	Decrease	Deteriorated	Increase	18.2165 (18.1807, 18.2523)	Deteriorated	Decrease
A	Worse	Deteriorated	-	Better	Improved	Decrease	Deteriorated	-	Worse	Deteriorated	-
B	Better	Deteriorated	Increase	Worse	Improved	-	Better	Increase	Better	Deteriorated	Increase
C	Better	Deteriorated	Decrease	Better	Deteriorated	Increase	Better	Decrease	Better	Deteriorated	Decrease
D	Better	Deteriorated	Decrease	Better	Improved	Increase	Worse	Decrease	Worse	Deteriorated	Decrease
E	Better	Deteriorated	Decrease	Worse	Improved	Increase	Better	Decrease	Better	Deteriorated	Decrease
F	Worse	Deteriorated	Decrease	Worse	Deteriorated	Decrease	Worse	Decrease	Worse	Deteriorated	Increase
G	Better	Deteriorated	Decrease	Better	Improved	Increase	Better	Decrease	Worse	Deteriorated	Decrease
H	Better	Deteriorated	Increase	Better	Improved	Increase	Better	Increase	Better	Deteriorated	Increase

Note: Dark red and green indicate statistically significant scores. Light green and pink indicate that the scores were not statistically significant. Numbers in parentheses are 95% confidence intervals. Core opening hours are 9am–6pm, Monday to Friday. IMD = index of multiple deprivation.

		Absolute national average value														
		Ibuprofen and naproxen as percent of NSAID items			Antibiotics (cephalosporins and quinolones as percentage of antibacterial items)			Antibiotics (cephalosporins and quinolones as percentage of antibacterial items)			Hypnotics: average daily quantities per specific therapeutic group, age/sex-related prescribing units			Atrial fibrillation: percent treated with anticoagulation or anti-platelet drug therapy		
		Relative	Trend	Within network variation	Relative	Trend	Within network variation	Relative	Trend	Within network variation	Relative	Trend	Within network variation	Relative	Trend	Within network variation
England		Nov-14	Aug 2010 to Nov 2014	Aug 2010 to Nov 2014	Nov 2014	Aug 2010 to Nov 2014	Aug 2010 to Nov 2014	Dec 2013	Aug 2010 to Dec 2013	Aug 2010 to Dec 2013	2013	2010-2013	2010-2013			
		77.10%	Improved	Decrease	5%	Improved	Decrease	4.20%	Improved	Decrease	98.30%	Improved	Decrease			
A		Worse	Improved	-	Worse	Improved	-	Worse	Improved	no data	Better	Improved	no data	Better	Improved	no data
B		Better	Improved	Decrease	Better	Improved	Decrease	Better	Improved	Decrease	Better	Improved	Decrease	Better	Improved	Decrease
C		Better	Improved	Decrease	Better	Improved	Decrease	Better	Improved	Decrease	Worse	Improved	Decrease	Worse	Improved	Decrease
D		Better	Improved	Decrease	Better	Improved	Increased	Better	Improved	Decrease	Better	Improved	Decrease	Better	Improved	Decrease
E		Better	Improved	Decrease	Worse	Improved	Decrease	Better	Improved	Decrease	Better	Improved	Decrease	Better	Improved	Decrease
F		Worse	Improved	Increased	Worse	Improved	Decrease	Better	Improved	Decrease	Worse	Improved	Decrease	Worse	Improved	Increased
G		Better	Improved	Decrease	Better	Improved	Decrease	Better	Improved	Decrease	Worse	Improved	Decrease	Worse	Deteriorated	Increased
H		Better	Improved	Decrease	Better	Improved	Decrease	Better	Improved	Decrease	Worse	Improved	Decrease	Worse	Improved	Decrease

Note: Dark red and green indicate statistically significant scores. Light green and pink indicate that the scores were not statistically significant. Numbers in parentheses are 95% confidence intervals.

QOF indicator dashboard: organisations A to H			
	QOF organisational domain	QOF clinical domain	QOF
	Compared to national average (all practices)	Compared to national average (all practices)	Compared to national average (all practices)
	2013	2014	2014
England	97.4 (97.2, 97.6)%	92.3 (92.0, 92.5)%	93.5 (93.3, 93.7)%
A	Better	Better	Better
B	Better	Better	Better
C	Better	Worse	Similar
D	Better	Better	Better
E	Worse	Better	Better
F	Better	Better	Better
G	Worse	Worse	Worse
H	Worse	Worse	Worse

Note: Dark red and green indicate statistically significant scores. Light green and pink indicate that the scores were not statistically significant. Numbers in parentheses are 95% confidence intervals.

Patient satisfaction indicator dashboard: organisations A to H																
	Ease of getting through on the phone				Able to get an appointment				Seeing preferred GP				Rating GP for involvement in your care			
	Compared to national average	Trend	Within network variation	Compared to national average	Trend	Within network variation	Compared to national average	Trend	Within network variation	Compared to national average	Trend	Within network variation	Compared to national average	Trend	Within network variation	
England	73.3% (73.2, 73.4)	Deteriorated	Increase	73.1% (73.0, 73.2)	Deteriorated	Increase	36.3% (36.2, 36.5)	Deteriorated	Increase	74.0% (73.9, 74.1)	Deteriorated	Increase	74.0% (73.9, 74.1)	Deteriorated	Increase	
A	Better	Improved	Increase	Worse	Improved	Increase	Better	Improved	Decrease	Better	Improved	Decrease	Better	Improved	Increase	
B	Better	Deteriorated	Increase	Worse	Deteriorated	Increase	Worse	Improved	Decrease	Worse	Improved	Decrease	Worse	Improved	Increase	
C	Worse	Deteriorated	Increase	Worse	Deteriorated	Increase	Worse	Improved	Decrease	Worse	Improved	Decrease	Worse	Deteriorated	Increase	
D	Worse	Deteriorated	Increase	Worse	Improved	Decrease	Worse	Improved	Decrease	Worse	Improved	Decrease	Worse	Improved	Increase	
E	Worse	Deteriorated	Increase	Worse	Deteriorated	Increase	Worse	Deteriorated	Increase	Worse	Deteriorated	Increase	Worse	Deteriorated	Increase	
F	Better	Deteriorated	Increase	Better	Deteriorated	Increase	Better	Deteriorated	Increase	Better	Deteriorated	Increase	Better	Deteriorated	Increase	
G	Worse	Improved	Decrease	Worse	Improved	Decrease	Worse	Improved	Decrease	Worse	Improved	Decrease	Worse	Improved	Decrease	
H	Worse	Deteriorated	Increase	Worse	Deteriorated	Increase	Worse	Deteriorated	Increase	Worse	Deteriorated	Increase	Worse	Deteriorated	Increase	

Note: Dark red and green indicate statistically significant scores. Light green and pink indicate that the scores were not statistically significant. Numbers in parentheses are 95% confidence intervals.

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