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Developing care for a changing population: Learning from GP-led organisations

Discussion paper

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About this report

This report was originally prepared as a working paper for the Nuffield Trust and The Commonwealth Fund's 15th international meeting on improving the quality and efficiency of health care. The meeting, which took place in July 2015, was designed to provoke and inform debate. The Commonwealth Fund is a private, non-partisan foundation that supports independent research on health and social issues. The 2015 meeting reflects a shared commitment to cross-national policy exchange and builds on a collaboration that began in 1999.

The meeting brought together leading medical professionals and senior policy-makers from the United Kingdom and the United States to compare front-line delivery system models and policy approaches aimed at improving care for high-cost and high-need patients. This paper is one of three UK papers commissioned for the meeting and subsequently published by the Nuffield Trust. It explores the issues associated with running large-scale, GP-led organisations, including some of the challenges they face in adapting their services for people with complex needs. It considers how the lessons drawn from two case study organisations can be applied to the new models of care emerging in response to NHS England's *Five Year Forward View*, particularly to multispeciality community providers.

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Key points

This paper explores the issues associated with running large-scale, GP-led organisations that provide services beyond the scope of core general practice. It also examines some of the challenges they face in adapting their services for people with complex needs.

- We present case studies of two such organisations – Fylde Coast Medical Services (FCMS) and Brighton & Hove Integrated Care Service (BICS). We describe the intra-organisational and external factors that have supported and hindered growth in these organisations and examine their experience of integration with other services.
- We consider how the lessons drawn from the case study organisations can be applied to the new models of care emerging in response to NHS England's *Five Year Forward View*, particularly to multispeciality community providers.

  Lessons about the intra-organisational characteristics of the case study organisations that seem to support change include the following:

  - There needs to be **strong links between clinical leaders and GP member practices**.
  - Sophisticated **strategic and operational management support is vital** for GP-led organisations seeking to deliver new forms of care to people living with complex needs.
  - The use of **multiple forms of peer-led improvement is a critical aspect of this support**, as it helps to build and sustain the engagement of clinicians in service change.
  - It is **beneficial if organisations are both entrepreneurial and pragmatic,** using a mix of collaboration with local organisations and competition for national contracts to secure funding for new services.
  - Having linked data between the organisation's own services and other providers is advantageous, but **technical data management issues and incomparable datasets can mean that rich data sources are under-analysed**.

  Lessons about how the external context affected progress made by the two case study organisations include the following:

  - **A 'receptive context for change' is important to enable GP-led organisations to press ahead with service innovations**, reflecting research into health systems change dating back over 20 years.
  - The complex processes of NHS commissioning can slow the growth and financial stabilisation of GP-led organisations as efforts to increase scale by adding new services may be delayed by slow commissioning decisions. **Transferring some of the commissioner role to providers through capitated budgets might facilitate a smoother and more mature approach**.

  - The **slow pace and short-term nature of decision-making** in clinical commissioning groups **may drive emerging organisations to focus on service developments outside of their geographic home** in order to diversify their services, broaden their market and increase financial stability.

- If GP-led organisations are to develop services at the scale and pace envisaged in the *NHS Five Year Forward View*, they will need **'light touch' external governance**.
- Several of the issues identified in the case studies as helping or hindering progress are consistent with those seen in case studies of 'integrated care' and are highly relevant to the emerging NHS 'vanguard' sites.

1. Introduction

General practice in England is facing numerous pressures and challenges, but also opportunities. Many general practitioners (GPs) report feeling overwhelmed by the pressure to meet rising patient demands, and typically lack time to reflect on how they provide and organise care (Dayan and others, 2014). Yet NHS England's *Five Year Forward View* (NHS England, 2014a) envisages general practice as the bedrock of integrated health systems funded with a capitated budget, offering a defined set of services for the registered population, and holding accountability for the quality and cost of care provided. This vision for the future of local health systems is predicated on general practice developing from its current form of numerous small, independent businesses into larger primary care provider organisations, with a more diverse mix of community clinicians and increased capacity to engage with other providers in the local health and care system.

Against this backdrop, the landscape of English general practice is changing, with a number of trends evolving:

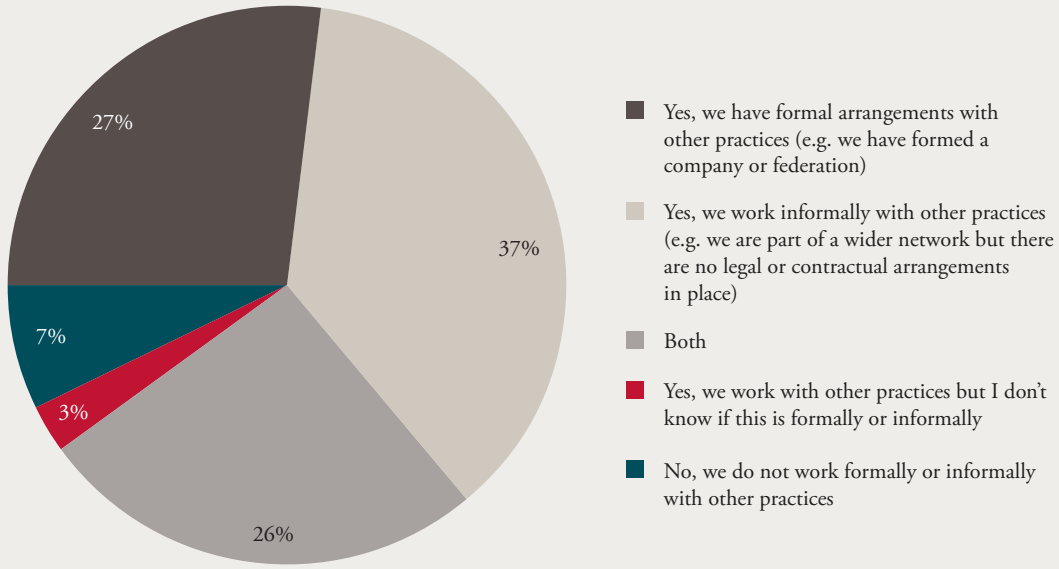
- A new professional skill mix is emerging to supplement and support traditional GP and nursing roles, such as physician associates and health care assistants.
- There is an increasing use of technologies such as:
  - online medication requests and appointment booking
  - email, telephone and Skype consultations
  - remote monitoring of patients' vital signs or wellbeing
  - 'webinars' linking practices for case review and training.
- Some local health systems are achieving data integration between general practice and other services (for example, social care and voluntary sector support) to enable more integrated working and care planning.
- There is a growing emphasis on strengthening general practice's accountability for the care of people living with complex, chronic health problems, and those at risk of unplanned admission to hospital (Castle-Clarke and others, 2016).

In addition to these trends, many practices are either merging into so-called 'super-partnerships' or collaborating through network agreements to deliver selected services to their combined registered patient lists. Other practices are being taken over and run by a parent company operating over multiple, geographically dispersed sites, while some GPs and other clinicians are forming standalone companies to bid for contracts for extended services, beyond the scope of core general practice (Smith and others, 2013).

A recent survey has revealed that many of these emerging larger-scale organisations have formed to achieve economies of scale by sharing back-office functions across multiple sites (see Figures 1.1 and 1.2). Furthermore, some are extending their

clinical services and building new relationships with other care providers, pushing the boundaries of traditional general practice in novel ways. To this end, some have received national funding to improve access (NHS England, 2014c), while others have been awarded vanguard status to develop integrated health and care systems for a defined population (NHS England, 2014a). Yet others are linking with local community and social services to coordinate care for older patients and those with complex problems.

Figure 1.1: Percentage of GPs reporting collaboration with other practices, 2015



Source: Kumpunen and others (2015)

Figure 1.2: Factors motivating the formation of large-scale GP groups

1	We wanted to achieve efficiences through merging back-office (e.g. information technology systems or human resources) (163,14%)
2	We wanted to offer extended services to patients that have typically been provided outside of primary care (148,13%)
3	We were encouraged / supported by our CCG (147, 13%)
4	We wanted to improve clinical outcomes (139, 12%)
5	We wanted to improve the opportunities for collaborative learning and peer review (131, 11%)
6	We wanted to improve access for patients (e.g. offer longer opening hours or increase availability of appointments or offer different types of appointment – e.g. online consultation) (107, 9%)
7	We were encouraged by other local GP practices (96, 8%)
8	We wanted to improve our recruitment and retention (90, 8%)
9	National policy (e.g. NHS England's *Five Year Forward View*) (89, 8%)
10	We were previously financially unsustainable as a single practice (27, 2%)
11	We wanted access to improved premises (22, 2%)

Source: Kumpunen and others (2015)

In this paper we explore two primary care organisations at the forefront of these changes: Brighton & Hove Integrated Care Service (BICS) and Fylde Coast Medical Services (FCMS). Both are owned by GPs (and in the case of BICS, also other primary care staff and BICS' own employees). Both are extending the scope of general practice and transforming services for complex patients in collaboration with wider health and care services. They provide valuable insights into the potential contribution of such organisations to the new organisational models of care emerging in response to NHS England's *Five Year Forward View* (see NHS England, 2014a, chapter 3).

Section 2 briefly summarises the history and evolution of the aims and services delivered by the two organisations. It describes how clinical leaders in each organisation have influenced the services delivered and the approaches to care provision in local practices. It also sets out how the case study organisations address the needs of patients with complex health and care needs, as this patient group will present a particular challenge to emerging primary care provider organisations – and may be of particular interest to emerging vanguard organisations. Section 3 explores the 'internal' characteristics of the organisations and 'local external contextual factors' that have had an impact on their sustainability and success. In section 4, lessons are drawn out for the NHS's new models of care (vanguard) programme.

The two case study sites were selected to be complementary to one another, as the local populations they serve and approaches to delivering complex care are different (see Table 2.1 in the next section for brief summaries of each organisation). The authors undertook thematic analyses of the organisations' websites (see www.bics.nhs.uk/ and www.fcms-nw.co.uk/) using structured data extraction guides, followed by face-to-face and telephone interviews with board members and staff at each organisation, as well as with a representative of at least one of the local clinical commissioning groups (CCGs). Interviews were analysed using the same themes as the website analysis and findings were checked for accuracy with one interviewee at each site.

2. History of the case study organisations: growth in scale and scope

Both BICS and FCMS were founded with a single purpose. BICS was created to develop more integrated services across general practice and specialists underpinned by improved use of data. Initially it did this through delivery of a referral management service for local GPs. FCMS formed as a GP cooperative to provide out-of-hours care and for 15 years it did only this. Each has since broadened the scope of services it delivers in response to different stimuli (described in the following subsections). See Table 2.1 for the characteristics of each organisation.

Table 2.1: Case study characteristics

	Brighton & Hove Integrated Care Service (BICS)	Fylde Coast Medical Services (FCMS)
Population in local CCG	• Brighton & Hove (B&H): 275,800 (Brighton & Hove City Council, 2014)	Covers two neighbouring CCGs: • Blackpool CCG: 172,500 • Fylde and Wyre CCG: 152,000
GP practices	• 45 GP practices (B&H) (also working with practices in Mid Sussex CCG, Crawley CCG and Croydon CCG)	• Blackpool CCG: 57 GP practices • Fylde and Wyre CCG: 21 GP practices
Organisational structure and ownership	• Established in 2008 • GP and staff owned (by 224 local general practice staff and its own staff) • Not-for-profit non-dividend sharing company • Board includes 3 founding members (2 of whom are GPs) and 4 non-executive directors (2 of whom are GPs)	• Established in 1994 • GP owned (every local GP is a member) • Not-for-profit cooperative/company limited by guarantee • Leadership includes 8 directors (5 GPs, 1 practice manager, 1 advanced nurse practitioner, and 1 dentist) and a 22 member management team, including a CEO

Evolution of services offered	• 2008: referral management service • 2009: community eye services and anti-coagulation services with 3 local practices and local specialists and opticians • 2010: community gynaecology, dermatology and musculoskeletal services with 15 local practices and other local clinicians and specialists • 2011: referral management service for 62 practices in Croydon • 2012: primary care mental health services with six practices, the local mental health trust, MIND and Turning Point • 2013: memory assessment service with the Alzheimer's Society, the local mental health trust and local Carers Centre • 2014: prime contract holder for musculoskeletal services with 3 CCGs in Sussex • 2014: Prime Minister's Challenge Fund in collaboration with 16 practices and 17 pharmacies	• 1994–2010: out-of-hours GP care only • 2011: 24-hour access 'hub' for care planning for high-risk, complex patients • 2010: unscheduled care services, including an urgent care centre in accident & emergency (A&E), running A&E reception and an 'acute visiting service' providing GP home visits in response to requests from the local ambulance service • 2012: delivering 'The Silver Line' – a national telephone helpline for older people • 2013: merged with 3 other primary care organisations (this extended the scope of services to diagnostic services, further unscheduled care services and private dental care) • 2014: pilot telemedicine link between ambulance crews, the acute visiting service and care homes • 2014: telephone triage and advice for adults and young people with drug and alcohol dependency in partnership with Delphi Medical
Funding sources	• Contracts with (local and non-local) CCGs, including a £210 million prime contract for musculoskeletal services across 5 CCGs • Prime Minister's Challenge Fund (Wave 1) • Turnover: £52 million	• Contracts with local CCGs for out-of-hours and unscheduled care services • Other NHS contracts for diverse services across North West England • Big Lottery Funding for The Silver Line service • Income from private sources

Fylde Coast Medical Services (FCMS)

Founded as a general practice out-of-hours cooperative in 1994, FCMS is a not-for-profit company limited by guarantee. All local GPs became individual members, rather than gaining membership through their practices. Its executive leadership has remained stable over time, with its original medical director still in post, along with four of the five founding GPs who remain on the FCMS board. Additional clinical board members now include a dentist, a nurse and an additional GP.

Early on, FCMS sought to improve out-of-hours care for end-of-life patients by tagging their patient records and developing personalised guidance on emergency responses. In 2012, this approach evolved into a more extensive care planning initiative

for complex patients as part of the 2012 Fylde Coast Unscheduled Care Strategy (Blackpool CCG, 2012). Blackpool CCG led this strategy work in partnership with local health and care providers, establishing nine workstreams to seek to reduce avoidable emergency admissions. FCMS was well placed to deliver two of the resulting services: care planning and 24/7 telephone access to care plans through the GP out-of-hours service. The Unscheduled Care Strategy has continued to evolve over time, and FCMS currently provides:

- education and development support for care planning to GP practices
- an internal quality assurance team scrutinising care plans to ensure that they contain clear guidance for health professionals attending the patient in an emergency
- a free telephone number for patients with care plans if they have acute health concerns out of hours
- telephone-based 'comfort' calls to patients discharged from hospital who are under the care coordination team and meet relevant criteria
- secure video-conferencing between specially trained North West Ambulance Service paramedics and FCMS clinicians for some 999 calls
- an acute visiting service providing out-of-hours home visits and GP appointments in response to requests from the North West Ambulance Service
- a triage service at A&E reception and an urgent care centre at the Blackpool Victoria Hospital.

The scope and scale of FCMS's operations have also grown beyond urgent care. Building on the call-handling functions of its out-of-hours service, FCMS now provides the NHS 111 service for the North West region in association with North West Ambulance Service, and call handling for 'The Silver Line' – a confidential, free telephone helpline for older people across the UK (funded through the Big Lottery Fund). It also provides telephone triage and advice for substance misuse patients in Blackpool, in partnership with a local substance misuse service. In April 2015, FCMS merged with three other primary care provider organisations, and added walk-in and minor injury, diagnostic and private dental services to its portfolio.

Each of the services provided by FCMS is funded through time-limited, fixed-term contracts, with contracts for care coordination and the acute visiting service that ended in March 2016. Despite this uncertainty about its future role in delivering unscheduled care services, FCMS has continued to grow by extending the geographic area it serves and the range of services it delivers. Interviewees attributed this success to its strong reputation for delivering high-quality care and fulfilling its contractual commitments.

Brighton & Hove Integrated Care Service (BICS)

BICS formed in 2008 with a strategic vision to work with GP practices, NHS organisations and independent sector providers to support whole-system, proactive, integrated care. It was initially commissioned by the local primary care trust – the pre-cursor NHS commissioner organisation before the CCG – to deliver a referral management service, promoting adherence to evidence-based referral guidelines and using data analysis and dissemination to tackle variation in outcomes (Riley and Devlin, 2010).

From 2009 onwards, BICS sought to deliver additional services. It bid successfully to deliver community eye and anti-coagulation services in three general practices and community pharmacies. In 2010, BICS bid successfully to provide community gynaecology, dermatology and musculoskeletal care. Furthermore, in 2012 it launched a collaboration with the local mental health trust and mental health charities to deliver mental health outpatient and advice services in six general practices across Brighton and Hove (BICS, 2012). BICS's role in providing community services has waxed and waned over time, as it has lost contracts for some of its services when they came up for re-tender and taken on others – both within the local health economy and further afield. For example, bidding in collaboration with other organisations such as the Sussex Musculoskeletal Partnership, BICS led as the prime contractor of and won a £210 million contract to deliver an integrated musculoskeletal service across five CCGs.

In 2013, BICS executive directors became partners in a local GP practice with a retiring GP in order to test new models of delivery in general practice. While this, in theory, created a peer relationship with local practices as a provider of GP services, it also created a sense of competitive tension with some local GPs who had an interest in taking over the practice. These complex historic relationships continued to affect BICS until recently. One example involved a BICS non-executive director having to leave the organisation because he had joined the local CCG governing body, and other governing body members felt that there was an unacceptable conflict of interest between the two roles.

An opportunity for growth and diversification for BICS, which also helped to build relationships with local GPs, came in 2013, when it bid successfully for funding through the Prime Minister's GP Access Fund to increase access to primary care and 'de-medicalise' some interactions with health services. The rationale for the bid was to free up GP time to focus on patients with complex needs. BICS bid in collaboration with 17 GP practices (covering 45 per cent of Brighton and Hove's population), with support from 16 local pharmacies and two voluntary organisations (Age UK and Neighbourhood Care), winning approximately £2 million to develop the Extended Primary Integrated Care (EPiC) programme. This aims to improve patient access to new types of professionals in general practice, therefore alleviating some of the work of GPs.

The five workstreams of EPiC programme include:

- interprofessional partnerships between GPs and pharmacists
- supporting community pharmacists to undertake consultations and offer limited prescribing
- training volunteers as 'community navigators' to help people with complex needs access local community resources such as befriending and gardening (EPiC, 2014).

An application to the second wave of the Prime Minister's GP Access Fund and an application to NHS England's new care models programme with a wider group of GP practices have since been unsuccessful. However, BICS has recently won a collaborative bid from NHS England to introduce pharmacists into GP practice teams. BICS interviewees suggested that their role in encouraging practices to come together to discuss and submit bids for new services has helped to develop BICS as a local catalyst for change, which can support practices to submit bids and deliver new services.

In 2014, the CCG asked BICS to lead the development of a city-wide, long-term programme of services for people with complex needs, called ProActive Care. ProActive Care targets 1 per cent of Brighton and Hove's population from the top 10 per cent of the city's population at risk of losing their independence. The programme involves a two-stage care planning process with mini-multidisciplinary teams (a nurse and social worker linked to each cluster of practices) assessing individual care and support needs in primary care with health coaches who review individuals' personal goals and preferences.

BICS is now facilitating a systems review of the local health economy's response to 'what matters to you'. The aim is to improve value for money delivered by primary care and community services by ensuring that:

- patients meet with a team that helps them to set their own outcomes
- patients are matched with services that they report wanting to use (rather than attending clinics that they do not find helpful for their condition)
- patients are coached along the way to achieve their goals.

This in turn frees up GP time to deliver care to patients who need it most.

BICS has procured the Sollis Clarity Patients data analysis system, which is based on the Johns Hopkins University 'Adjusted Clinical Groups' System risk-modelling software, and implementation began in 2015.

3. Discussion

The vision of the NHS *Five Year Forward View* (NHS England, 2014a) is for multispeciality community providers to take on capitated budgets for defined populations. As these new models of care emerge, the primary care organisations at their heart will face tough challenges in terms of moderating demand from complex patients and managing their care in lower-cost settings. This will require a new level of collaboration with wider health, care and voluntary services to deliver care efficiently and effectively. In this section we explore the lessons to be drawn from the two case study organisations.

First, we look at the internal characteristics of the case study organisations that underpin their progress to date, including:

- the ways in which clinical leaders work with member practices
- the role of peer review
- the ways in which entrepreneurial leadership and enthusiasm support rapid change
- the role of data and information in supporting change.

Then, we examine how external factors have influenced the development of the case study organisations and have affected their ability to reshape services in their local area.

Internal factors that enable organisational progress

Strong clinical leaders working to engage members

The two case study organisations illustrate how well-developed clinical leadership and operational management in GP-led organisations can support change in clinician behaviour. As practitioners in the local GP community, medical leaders have ready access to the majority of their peers, drawing in other colleagues to access practices that are less willing to engage. They communicate the vision for local service developments, explain new initiatives and provide clinical advice. Meanwhile, operational and change management support and feedback on quality of care are provided by others in the organisation. This interplay between GP leadership and management support to members is recognised as an important characteristic of successful physician groups (Casalino, 2011; Smith and others, 2013; Thorlby and others, 2011).

Peer review to drive change

Both of the case study organisations use multiple methods to manage and sustain change and maintain contact with members and partners. Central to these initiatives has been a focus on peer review of clinical practice, supported by comparative data on the activity under review. In addition, the quality team at FCMS has reviewed quality of care plans and visited GPs whose plans have been of lower quality in order to talk through how they could be improved. Other methods used to support change have included hosting educational events, visiting practices and involving member GPs in service design.

BICS employs a dedicated support team to project manage service implementation, which runs action learning sets for participating clinicians to design and refine initiatives throughout development and implementation phases. The support team uses dedicated account manager roles to engage in weekly conversations with practices about patterns and changes in their data. They also help to develop and sustain working relationships between the professionals involved in service delivery.

The value of using multiple simultaneous methods to support change in clinical behaviour is described by various researchers (Centre for Reviews and Dissemination, 1999; Grimshaw and others, 2001; Robertson and Jochelson, 2006).

The case studies suggest that support mechanisms were better received by local clinicians because of their involvement in the development of the organisation, and this involvement enabled easier access to practices. Engaged members were also more likely to enable rapid implementation of new initiatives. This observation about the supportive impact of clinical ownership is consistent with research findings by Smith and Goodwin (2006) in relation to the development of primary care organisations in the UK and Smith and Mays' (2007) comparative study on the development of primary care organisations in New Zealand and the UK. With that in mind, new organisational models being created in response to the NHS Five Year Forward View (NHS England, 2014a) should consider carefully the ways in which they involve local clinicians, ensuring that they are able to shape and 'own' the methods used to encourage good practice in member organisations.

Entrepreneurial clinical leadership and enthusiasm

Although neither BICS nor FCMS could be thought of as 'new', they both described an enthusiasm and willingness to turn their hand to new services, which suggested an underlying entrepreneurialism and hunger for innovation. In Fylde Coast, the longstanding, high-trust relationship between local practices and FCMS enabled FCMS to achieve a speed of operationalisation that was not bogged down by the usually slow processes of practice engagement and GP recruitment. In addition, two interviewees described how the staff "just get on and do it" and one said they "sometimes shock the CCG" that they are ready to start delivering a service so soon after it has been agreed that they will do so.

The same interviewees stressed that the organisation's medical directors maintain a relentless focus on quality, which is not compromised in favour of speed of implementation. They emphasised that their business development team and operational managers are motivated by the challenge of developing and delivering new services quickly and to a high standard. This mirrors findings from a study of physician-owned organisations that held budgets in the United States. These organisations had created sophisticated processes to monitor and improve quality and to involve member physicians in this work (Thorlby and others, 2011).

Interviewees at BICS talked about a similar hunger to get on with applying their analytical resources to improve care and develop innovative services, and a frustration with the slow decision-making processes of commissioners. They described their early success being down to their 'dogged determination', and more recent progress as having been enabled by a gradual increase in trust between BICS, the local CCG and local GP practices. A proven track record of delivery against agreed contracts, and stronger relationships being developed between BICS and local GP practices following Prime

Minister's GP Access Fund bids, have also helped. With most vanguard sites selected for their track record of innovation, it is likely that they will have similar levels of ambition and drive to implement change at pace. Lessons can be drawn from these case studies about how to harness this energy effectively in order to support rapid progress.

Data and information to monitor outcomes

Obtaining the data and information needed to support care delivery, monitor performance and evaluate outcomes remains a challenge for both case study organisations. For BICS, data integration and analysis represented a founding aim of the organisation, and significant progress has been made towards this goal. Outcome measures for its early services were under-developed, but have become more comprehensive for recently commissioned services, such as wellbeing services, musculoskeletal services and the EPiC programme, which is funded by the Prime Minister's GP Access Fund.

In Fylde Coast, data from hospital and community services, the ambulance service and FCMS are pooled by the commissioning support unit (which provides analytical support to the CCG) to support risk stratification and aspects of contract management. Thus, integrated performance reporting across the network of provider organisations is theoretically possible, but not routinely undertaken. There are a number of technical reasons for this, including the fact that each provider uses a different software system, which codes similar encounters in different ways.

The case study organisations had made progress with evaluating the impact of particular service developments. For example, before the FCMS–North West Ambulance Service paramedic acute visiting service was implemented, the majority of patients with long-standing complex medical needs phoning 999 were transported to the emergency department for assessment. With the implementation of advanced care planning, coupled with the acute visiting service, this has fallen to only 9 per cent. BICS was also encouraged as part of the Prime Minister's GP Access Fund Wave 1 cohort to measure a range of access indicators, but not all objectives of the project were captured. For example, the initiative to offer GPs administrative support for care planning measured GP time saved (which was calculated to be 45 minutes of a GP's time per day), but there was no measure to assess whether extra time was being spent with the most complex patients on GPs' lists, which was a central aim of the programme.

To date, neither organisation has managed to link health and social care data, preventing the development of more holistic outcome measures and risk stratification tools that could help to target interventions at groups of people with the most complex needs. Thus, while there is a good level of data linkage within health services in both case study organisations, issues of technical data management and incomparable datasets across other parts of the health and care system mean that these wider resources remain under-developed for supporting service change, monitoring outcomes and evaluating impact.

As part of the ProActive Care programme, BICS and the CCG have agreed a framework of practice-, cluster- and CCG-level process measures for 2016 onwards. BICS has also agreed to measure patient-level satisfaction using 'I' statements across six domains of quality (for example, equitable: 'I can access support throughout the week when I need it'; safety: 'My medication does me no harm and I take it appropriately').

These will be measured alongside clinical outcomes (for example, reductions in Quality and Outcomes Framework exception reporting). The concept of 'I' statements was developed by National Voices (a coalition of health and care charities) as a tool to measure what matters most to patients and services users in person-centred coordinated care (National Voices, 2013). Evidence from both case studies suggests that, in the absence of rigorous reporting requirements and with limited funding from commissioners to collect data, it remains difficult to evaluate the impact of initiatives to reduce overall service use.

The impact of the external commissioner and policy context

Growth through a mix of collaboration and market competition

Implicit in the NHS *Five Year Forward View* (NHS England, 2014a) is the idea that collaboration between providers in relation to a defined patient population will support service transformation and demand management, and thus improve quality and efficiency. It leaves open options for how the commissioner function might be organised and managed. The two case studies allow us to explore how relationships between the case study organisations and their commissioners have affected their progress, and thus raise questions for the future.

The experience in Fylde Coast demonstrates that a dedicated care coordination role can emerge as part of a local strategic plan (Blackpool CCG, 2012), informed by imperatives such as rising hospital admission rates, worrying levels of ill-health and deprivation, and national policy priorities such as the implementation of the NHS 111 telephone advice line (Crown Publications, 2011) and efforts to reduce rising numbers of A&E attendances. As an established local, GP-led organisation, respected and trusted by the CCG, FCMS was able to help the CCG and its partners to define problems with local unscheduled services and develop a strategy (in the form of new services) to address these. In addition to this growth through whole-system collaboration, FCMS has also taken other opportunities presented by the emerging market in health care. Thus, the breadth and scale of its service offer have increased through bidding successfully for services such as The Silver Line, and merging with providers of diagnostic and dental services.

The interplay of national and local priorities in Fylde Coast in many ways demonstrates the 'receptive context for change' described by Pettigrew and others (1992) in their study of achieving sustainable strategic change in health care. It also points to the skill of the FCMS's leaders at capturing opportunities that will sustain and diversify the organisation. Pettigrew and others (1992) identified eight characteristics of a supportive context for change:

- environmental pressure
- quality and coherence of policy
- key people leading change
- simplicity and clarity of goals
- cooperative organisational networks
- effective manager–clinician relationships

- a supportive organisational culture
- a clear change agenda.

These factors seem largely to be present between Fylde Coast and its two CCGs, and within the FCMS organisation itself, and were argued by local respondents to our case study work to have supported the introduction and development of the care coordination service for patients with complex needs.

In the case of Brighton and Hove, the journey has been different. Formed with a vision to improve primary care, BICS's early work was undertaken through a joint initiative with the-then primary care trust to use data and peer review to challenge and change GP referral patterns. Its subsequent development was shaped in significant part by tactical responses to market opportunities. NHS reforms introduced following a government White Paper in 2010 (Department of Health, 2010) led to a hiatus for BICS, as national policy dictated that primary care trusts reorganise into CCGs,[1] and hence the local commissioner undertook a new phase of needs assessment prior to commissioning further services. Following this, the Prime Minister's GP Access Fund gave BICS an opportunity to demonstrate its ability to lead major service collaboration across primary and other urgent care providers in the local area. BICS has continued to respond to market opportunities and recently won a £210 million competitive tender to provide musculoskeletal services across Sussex. Thus, after eight years in operation, BICS is now starting to co-produce a proactive care programme for people with complex needs, a long-held strategic priority of the organisation.

In contrast to FCMS, the characteristics of Pettigrew and others' (1992) receptive context were not as evident between BICS and its CCG, and some of the supportive characteristics that did exist when BICS first formed, changed over time. For example, the leadership of the commissioning organisation changed when the primary care trust assumed its statutory responsibility as a CCG in 2013; organisational networks changed as GP practices aligned into clusters; and commissioning goals and priorities evolved over time. Thus, BICS's operating context has been less stable than that of FCMS. Furthermore, some of its stakeholders are reported to have been less trusting of the organisation and it has therefore had to be more tactical in its development strategy.

Nevertheless, both organisations have a clear strategy to:

- avoid being dependent on a single NHS commissioner
- diversify the range of services offered across a wider geographic area
- improve their resilience through operating at increased scale.

A nimble, receptive local commissioning context is vital if organisations such as FCMS and BICS are to continue to develop their role in their 'home' health economy. A particular test for the NHS *Five Year Forward View* (NHS England, 2014a) will be whether governance and payment arrangements emerge for multispeciality community providers that will simplify commissioning decisions enough to allow them to grow and innovate at pace.

1 303 primary care trusts were reduced to 152 in 2006, and in 2013, primary care trusts were replaced by 212 CCGs.

The complexity of NHS commissioning

Both case study organisations described the organisational instability associated with the complexity and slow pace of decision-making by commissioners. One provider interviewee described being able to turn an idea for a new service into an implementable operating plan within days or weeks rather than months because they were "not bogged down" by what they saw as bureaucratic processes and excessive governance. In contrast, the timescales for decision-making within CCGs were seen as slow and, at times, cumbersome, and were argued to have delayed implementation of some initiatives. These accounts are consistent with the conclusions of a National Institute for Health Research study of NHS commissioning for long-term conditions (Shaw and others, 2013). This report concluded that the labour-intensive work of commissioning was often disproportionate to the gains achieved and that commissioning processes tended to focus unduly on service design and collaboration with stakeholders, at the expense of making actual decisions to change the funding and delivery of care.

The impression gained from both case study organisations was one of frustrated entrepreneurialism, as primary care provider organisations struggled to make timely changes to local services within a complex commissioning system. They also faced uncertainty of funding and service continuity when commissioners (CCGs) adjusted their commissioning decisions and priorities in line with shifting national policy and transient funding sources. It is, however, possible that what these relatively small primary care provider organisations were facing was the challenge of bringing about significant change to local health services, something that larger health providers have long experienced.

While NHS commissioning is indeed complex, it may be that BICS and FCMS, as growing providers, need a different level of organisational, management and technical support (Smith and others, 2013). Furthermore, it may be that new forms of payment – such as capitated budgets for 'accountable care organisations' (as suggested in the NHS *Five Year Forward View*; NHS England, 2014a) – offer an alternative to the frustrations experienced by the two case study organisations when relying on serial tendered contracts for services. However, there is a possibility that the bureaucracy that accompanies the statutory decision-making roles of CCGs will transfer to providers of new models of care, slowing the progress of new and emerging large-scale provider groups. This is something that policy-makers should be mindful of in shaping guidance around provider governance processes.

The impact of short-term tendering by commissioners

Fylde Coast interviewees described several consequences of receiving non-recurrent funding for both care coordination and unscheduled care services. These included:

- devoting significant management resources to bidding and re-bidding for services tendered by the CCG
- difficulties in recruiting clinical staff to temporary roles
- difficulties in persuading partner organisations to stay involved in the longer-term effort to develop integrated care for people with complex needs.

The impact of piecemeal and short-term funding on the delivery of better-integrated local NHS services is well recognised and The King's Fund has called for sustained longer-term investment in services using a place-based approach to commissioning

(Appleby and others, 2014; Ham and Alderwick, 2015). This is of particular importance where services are for people with complex needs, as these forms of integrated and community-based care can take years rather than months to develop and sustain (Bardsley and others, 2013). BICS and FCMS have both developed business cases for long-term recurrent funding but, to date, funding has remained largely piecemeal.

A further consequence of commissioners allowing short-term contracts, as reported by the case study organisations, was difficulty in developing whole-system outcome measures that are used by all providers involved in an integrated care system. Piecemeal, short-term funding had resulted in a disjointed selection of outcome measures collected by the different organisations involved in urgent care delivery. Although each organisation reported having to submit weekly performance and outcome data to the Commissioning Support Unit, there is no common set of measures used by all unscheduled care providers. For example, in FCMS, the acute visiting service was monitored using the metric 'readmissions to hospital within 30 days of discharge', while telephone calls to the care coordinator hub were evaluated by staff reports of 'whether an admission would have taken place if they had not intervened'. This meant that interviewees could not comment on trends in the overall system impact of their services, underlining the concerns about data and information outlined earlier.

4. Conclusion: implications for the NHS Five Year Forward View

The NHS *Five Year Forward View* (NHS England, 2014a) envisages primary care at the heart of new models of care – particularly in multispeciality community provider models. Indeed, in five of the 14 multispeciality community provider vanguards, large-scale general practice groups are the lead organisations and FCMS is part of a vanguard health economy.

These primary care provider organisations will face interesting decisions about:

- the extent of financial risk they will take on
- the models of change they will adopt to achieve the goals of their vanguard development
- how they will allocate human and financial resources.

On the one hand, they could focus primarily on their vanguard objectives, adapting and developing their services in response to national policy on new models of care. On the other hand, if local commissioning processes are too slow and cumbersome, they could seek out new market opportunities to diversify their income sources and increase the scale of the services they provide. This might increase their organisational and financial stability but dissipate the effort they would otherwise apply in their local health economy.

Findings from the two case studies provide some useful insights that could be applied in multispeciality community provider vanguard sites:

- **The organisation and practice of 'commissioning' decisions in relation to new models of care will be a key determinant of their ability to make rapid progress.** With new contracts for vanguard organisations under development, details of how financial risk will be distributed between participating organisations remain to be agreed, but certainly longer contracts are on the agenda and the case studies suggest they are much needed. The extent to which primary care provider organisations will take on financial risk remains to be seen and work to develop sustainability and transformation plans across 44 'NHS footprints' may or may not include GP-led organisations. If they are not involved in developing sustainability and transformation plans and CCGs continue to hold commissioning budgets and carry financial risk, then the pace of decision-making may not change and GP organisations may focus their attention elsewhere.
- **Rapid progress is needed along with the definition of a common set of measures for use across all collaborating providers through which to monitor and evaluate new services.** Separate measures for each type of new vanguard site (that is, multispeciality community providers and primary and acute care systems) were due to be defined by NHS England by October 2015, but they have not yet

been published. There is also a possibility that the development of 44 sustainability and transformation plans across England will further complicate the growth of the definition and use of 'outcomes' for primary and integrated services. The next challenge to providers will be to produce, synthesise and analyse this data in a timely and accurate way. The case studies highlighted how differences in definition and incompatibilities between data collections systems can hinder well-intentioned efforts to monitor and improve services.

- **The creation of effective, nimble, governance systems that support rapid decision-making, enable timely implementation and assure service quality is vital.** Case studies of integrated care (Rosen and others, 2011) have concluded that successful integrated care organisations have governance arrangements that:
  - develop clear, strategic objectives for integration
  - respond rapidly to changes in the policy, regulatory, financial and organisational context
  - provide the necessary resources to support delivery.
- **The challenge of harnessing and not losing the entrepreneurial energy of primary care provider organisations is necessary for innovation and the sustainability of provider organisations.** The two case studies reported in this paper displayed the energy and implementation skills needed to achieve the scale and pace of service development exhorted by the NHS Five Year Forward View.

References

Appleby J, Galea A and Murray R (2014) *The NHS Productivity Challenge: Experience from the front line.* The King's Fund.

Bardsley M, Steventon A, Smith J and Dixon J (2013) *Evaluating Integrated and Community-Based Care: How do we know what works?* Research summary. Nuffield Trust. www.nuffieldtrust.org.uk/publications/evaluating-integrated-and-community-based-care-how-do-we-know-what-works . Accessed 22 April 2016.

Blackpool CCG (Clinical Commissioning Group) (2012) *Fylde Coast Unscheduled Care Strategy*. NHS Blackpool.

Brighton & Hove City Council (2014) *Brighton & Hove City Snapshot: Summary of statistics 2014*. Brighton & Hove City Council.

Casalino L (2011) *GP Commissioning in the NHS in England: Ten suggestions from the United States.* Nuffield Trust. www.nuffieldtrust.org.uk/publications/gp-commissioning-nhs-england-ten-suggestions-united-states . Accessed 22 April 2016.

Castle-Clarke S, Kumpunen S, Machaqueiro S, Curry N and Imison C (2016) *Digital requirements for new primary care models: a briefing for clinicans and managers.* Nuffield Trust

Centre for Reviews and Dissemination (1999) *Effective Health Care: Getting research into practice*. Centre for Reviews and Dissemination, University of York.

Crown Publications (2011) *Call 111: When it's less urgent than 999.* Crown Publications.

Dayan M, Arora S, Rosen R and Curry N (2014) *Is General Practice in Crisis?* Nuffield Trust. www.nuffieldtrust.org.uk/sites/files/nuffield/publication/is_general_practice_crisis.pdf . Accessed 22 April 2016.

Department of Health (2010) *Equity and Excellence: Liberating the NHS.* The Stationery Office.

EPiC (Extended Primary Integrated Care) (2014) *Extended Primary Integrated Care*. EPiC. http://epic-pmchallengefund.uk . Accessed 22 April 2016.

Grimshaw JM, Shirran L, Thomas R, Mowatt G, Fraser C, Bero L, Grilli R, Harvey E, Oxman A and O'Brien MA (2001) 'Changing provider behaviour: an overview of systematic reviews of interventions', *Medical Care* 39(8 suppl 2), 112–45.

Ham C, Alderwick H (2015) *Place-based systems of care*. King's Fund, London

Kumpunen S, Curry N, Edwards N, Holmes M, Price H and Ballard T (2015) *Collaboration in General Practice: Surveys of GPs and CCGs.* Nuffield Trust and Royal College of General Practitioners. www.nuffieldtrust.org.uk/sites/files/nuffield/publication/national_survey_results_slide_set_final.pdf . Accessed 22 April 2016.

National Voices (2013) *A Narrative for Patient-Centred Coordinated Care.* NHS England. www.nationalvoices.org.uk/publications/our-publications/narrative-person-centred-coordinated-care . Accessed 23 April 2016.

NHS England (2014a) NHS *Five Year Forward View.* NHS England.

NHS England (2014b) *Providing Proactive Care and Avoiding Unplanned Admissions for Vulnerable People: A programme of action for general practice.* NHS England.

NHS England (2014c) 'Prime Minister's GP Access Fund'. www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access/ . Accessed 22 April 2016.

Pettigrew A, Ferlie E and McKee L (1992) 'Shaping strategic change – the case of the NHS in the 1980s', *Public Money & Management* 12(3), 27–31.

Riley M and Devlin P (2010) *Understanding Referral Practice in Brighton and Hove*. Brighton & Hove Integrated Service.

Robertson R and Jochelson K (2006) Interventions that Change Clinician Behaviour: *Mapping the literature*. National Institute for Clinical Excellence.

Rosen R, Mountford J, Lewis G, Lewis R, Shand J and Shaw S (2011) *Integration in action: four international case studies*. Nuffield Trust.

Shaw S, Smith J, Porter A, Rosen R and Mays N (2013) 'The work of commissioning: a multisite case study of healthcare commissioning in England's NHS', *BMJ Open* 3, e003341.

Smith J and Goodwin N (2006) *Towards Managed Primary Care: The role and experience of primary care organizations.* Ashgate Publishing.

Smith J and Mays N (2007) 'Primary care organizations in New Zealand and England: tipping the balance of the health system in favour of primary care?', *The International Journal of Health Planning and Management* 22(1), 3–19.

Smith J, Holder H, Edwards N, Maybin J, Parker H, Rosen R and Walsh N (2013) *Securing the Future of General Practice: New models of primary care*. The King's Fund and Nuffield Trust.

South East Coast Ambulance Service (2013) *999 Call Survey: Findings of a patient/caller experience and satisfaction questionnaire surveying people who called 999 in December 2013*. South East Coast Ambulance Service.

Thorlby R, Rosen R and Smith J (2011) *GP Commissioning: Insights from medical groups in the United States.* Nuffield Trust. www.nuffieldtrust.org.uk/publications/gp-commissioning-insights-medical-groups-united-states . Accessed 22 April 2016.

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