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New models of primary care: practical lessons from early implementers

Event report: *Rebecca Rosen and Helen Parker*

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General practice in England is under pressure. The traditional GP partnership model, which currently serves an average of around 6,650 patients per practice, is widely acknowledged to be too small to respond to the financial and demographic challenges facing the NHS (Smith and others, 2013).

Small practices have limited infrastructure to improve access and address variations in quality. They are vulnerable to marginal reductions in income and have insufficient staff to respond to new clinical, administrative and regulatory demands. Policies to avoid hospital admissions and discharge people earlier from hospital have resulted in more acutely ill people needing care in the community. But small practices may struggle to provide high-quality care for these patients because they lack formal links with other services and organisations. The resulting pressure on GPs, and frustration for patients and carers as they move between poorly coordinated teams of professionals, has been well documented (Rosen and others, 2011; The King's Fund, 2011).

Clinical commissioning has also set new expectations of general practice within the wider health system. Clinical commissioning groups (CCGs) are exploring how to engage GP members in developments that go well beyond their traditional provision of general medical care for registered patients. CCGs are promoting collaboration between practices to address variations in care and achieve commissioning goals. Many have clustered member practices into groups that work together to peer-review clinical care and implement local commissioning plans. Yet a recent study shows slow progress in CCGs, with widely varying levels of involvement (Naylor and others, 2013).

Despite widespread debate about the viability of traditional general practice, there is also a case for preservation. There is clear evidence that patients like small practices (Kontopantelis and others, 2010) and value the relational continuity associated with a small practice team (Hill and Freeman, 2011).

This event report summarises three Nuffield Trust seminars that took place to discuss three of the new organisational models described in *Securing the Future of General Practice* (Smith and others, 2013). These models aim to balance the benefits of small and local organisations with the scale and capacity to improve quality and deliver a wider range of services. The models are:

- **Super-partnerships**: Large-scale single partnerships created through list growth and formal partnership mergers.
- **Multi-practices:** Small-scale GP partnerships managing multiple practices and services.
- **Federations or Networks:** Collaborations between multiple practices through informal linkages (networks) or formal legal contracts (federations).

The seminars included two examples of super-partnerships, one multi-practice, one network and one federation (see the Appendix for case study summaries). This report shares insights about the approaches taken by the case study sites, the experiences of their leaders and their learning to date, with the aim of informing the many similar discussions that are currently underway amongst practices across the country.

Ingredients for change and sustainability

The case studies demonstrate some common characteristics that enabled successful transformation of general practice to address the challenges described above.

A compelling case for change: All case studies identified the *national* drivers for change described above as their motivators for organisational change. There was consensus that increased patient demands, and contractual and regulatory requirements, risk overwhelming small general practices. Increasing the scale and scope of general practice was seen as essential to create sustainable, efficient organisations for the future. There was also agreement that future policy was likely to create opportunities for wider service provision that would be difficult for small, isolated providers to respond to. The new organisational model chosen in each case study site was influenced by the *local* context in which general practice operated. Factors such as the historical ways in which local practice had developed and the degree of trust between practices were critical in determining whether to pursue practice mergers or a looser association between practices.

A clear vision and capable leaders: Success depended on a shared vision amongst all participating GPs and the ability to communicate this vision to staff. Central to the visions presented at the seminars was the drive to improve the quality of local primary care while also ensuring long-term organisational sustainability. This included keeping what is valued by staff and patients of small and local general practice, while achieving economies of scale. The federated or network models which combine multiple small practices found this less of a challenge, but also recognised limitations of retaining the autonomous practice model. The large single organisations found that operating from multiple practice sites, rather than a single large 'polyclinic', enabled this balance to be achieved. However, it was essential to have active management, and good processes for listening to and responding to patient and staff feedback.

Strategic business planning: It was important to translate the vision into a business plan. These plans varied from simple statements of intention that were shaped by ongoing discussions and local commissioning intentions, to sophisticated plans with strategies for organisational development, workforce development, and property and financial viability. Some plans included strategies to diversify income streams in order to reduce future dependency on the core GP contract. Case study organisations that have significantly increased their scope of provision have had to balance upfront investment in staff and facilities with the risk of short- to medium-term contracts.

A focus on quality: A compelling 'narrative' for change is needed which focuses on reducing variation and improving the quality of general practice. In each model, this work was underpinned by regular audits and review of practice data, combined with peer review, and initiatives to standardise care and respond to specific quality problems. The network model used monthly meetings between member practices, local consultants and other professionals to combine peer review, professional education and the development of shared approaches to improving performance. In contrast, the Vitality super-partnership established an internal 'turnaround team' to ensure all its sites delivered a standard level of high-quality clinical care, according to key performance indicators.

Information technology and data analysis: This commitment to quality had driven the case study organisations to develop their own integrated IT solutions, such as linking practices through EMIS web. Vitality and the Hurley Group had developed bespoke performance improvement 'dashboards' to enable sophisticated data analysis and manage performance centrally.

Diverse skills and processes to support organisational change: In addition to GP leaders, the case studies highlighted the need for people with business and organisational development skills who could provide additional capacity to manage the workload associated with organisational change. It was important to recruit the right people, who had these skills, but who also understood the nature and culture of general practice. Success has also depended on GP partners' willingness to personally invest their time and resources, over and above their day-to-day clinical practice. This is very challenging, given current pressure on GP income. GPs from the single organisation models reported that having one shared business plan for all partners had enabled this to happen. Networked and federated practices had to manage the tensions between collective plans and the interests of individual member practices. It was easier to distribute rewards or investment within one organisation than across member practices where contributions to provision may vary.

Positive relationships with other organisations: The vision for broadening the range of services offered in general practice and building larger, more influential organisations had to be handled sensitively in terms of impact on other local providers. GPs had managed local politics through dialogue with other local practices, commissioners, acute trusts and the consultant community. It was also important to frame the benefits accruing to the local health and care system, not just the GP partners.

The experience of change

In each case study site, change has been driven by one or more of the partners, whose job it has been to coax, encourage and enable their colleagues and peers to work in new ways. These leaders accepted that to manage the additional workload this brings, their primary focus in the organisation should be on organisational development whilst other partners continued with other areas of practice improvement.

Each site faced significant challenges in implementing their vision for a new way of delivering general practice. The following pages feature personal descriptions of the leadership roles fulfilled by a GP leader in three of the case study organisations.

The Hurley Group
Dr Arvind Madan, GP Partner and CEO

There was no particular plan to grow. In 2006 we were quite content to run our 12,000-patient practice in Kennington, feeling proud of our 1,000 QOF [Quality and Outcomes Framework] points, substance misuse service and culture of going the extra mile for patients.

Commissioners needed help supporting two local single-handed practices with their issues, which we did. Events unfolded and as Hurley Clinic partners we found ourselves starting a new practice for a new population in Vauxhall. Meanwhile, Southwark PCT [primary care trust] decided to divest itself of three PCT-run practices and the staff in one of them encouraged us to apply. The turnaround of this troubled Peckham practice took us a year. We then bid to help stabilise another one nearby, and when this came to the market a few months later, commissioners decided they wanted it to be the local walk-in centre. The team there felt like family by then so we applied and suddenly found we had to quickly learn how to manage urgent care too. During this period, we developed a passion for the clinical challenge of transforming failing practices and developing new services, and just kept going – always keeping our focus on serving London's most deprived communities.

We now run 18 practices in ten London boroughs with 100,000 registered patients, as well as caring for 250,000 minor illnesses and injuries a year, from eight locations. The team has grown from 25 members in 2006 to over 300 now, but we have remained a traditional NHS GP partnership in our structure. Along the way we branched out into providing asylum seeker and substance misuse services, a sick doctors service, several premises schemes, and a school health education and anti-bullying programme. We also developed partnerships with several social enterprises so we could have impact on the wider determinants of health in our communities.

More recently, we have been developing technology services for primary care – a platform to source frontline peer and specialist advice, with learning shared across all clinicians, and virtual surgeries conducting online consultations with patients. We are hopeful that this will not only improve the patient experience and outcomes, but also enhance practice efficiency.

Our growth has been rapid and we have learned to live without much sleep. However the thrill of feeling like we might be making a difference to the health care of whole populations more than compensates. We have had to mature as a business and a larger GP service provider. With the help of talented senior managers, we now monitor our own access, health outcomes and efficiency using a comprehensive dashboard tracking performance of each site, which we share with all staff every month. We survey over 10,000 patients a year to ensure their voice is at the heart of our patient offer and service blueprint.

Our model is heavily influenced by our quarterly staff barometer, which is used to ensure team morale remains high and we remain focused on our organisational purpose – delivering the best care to the most deprived. We have a robust organisational development programme for nurturing talent, and attractive career pathways for all staff categories. Many of our senior GP tier now come out of other GP partnerships to join us. We invest heavily in education, training and research, and are developing a Hurley Academy to host our in-house mentoring, leadership and skills training programmes. We also plan to create internal fellowships for individuals to operationalise solutions to frontline problems.

Having been closely involved in the initial design of networks in Tower Hamlets in 2007, we now find ourselves able to contribute to the trend towards cross-practice service provision, emerging federations, and discussions about capitated and pooled budgets, wherever we have a presence. The next challenge will be assisting the creation of a new model of care that is right for patients and general practice, within the wider NHS.

Vitality Super-partnership
Dr Naresh Rati, Executive Partner

The Partners of Handsworth Wood Medical Centre and Laurie Pike Health Centre established the Vitality Partnership in Birmingham in June 2009. At the time, both practices were large, well-established and high quality achieving in their own right. The motivations of the partners to create a large 'super-partnership' were varied: to provide better general practice to a larger population; to offer a broader range of patient services; to transform the local NHS landscape; to diversify into other business areas; and to protect incomes.

General practice understands partnerships very well and so the concept of a local super-partnership was relatively easy to put forward as the preferred model to the partners. Since the inaugural partnership was established, we have expanded further and now cover additional practice sites across Birmingham and Sandwell, serving over 50,000 patients and employing over 180 people. We have a five-year strategic business plan to become a GP-led integrated care organisation serving more than 120,000 patients by 2016. The practices currently operate fairly independently, under the umbrella of the Vitality Partnership, but we are going through a major process of 'back-office' centralisation to realise economies of scale and build efficiencies.

It has been a very steep learning curve. Each of the mergers has been unique. All have been time consuming and required a partner to devote the necessary energy and time to make it happen. It also required good management support to ensure all the diligence documentation is robust. Post-merger, it doesn't end there: the first single-handed practice we merged took over 12 months to turn around and required considerable resource (partner time and monetary investment). Nevertheless, seeing such a previously under-performing practice improve on quality metrics (such as QOF or public health targets) has been extremely rewarding and makes it all worthwhile.

As we have grown, one of the key lessons learned has been ensuring effective communication, both amongst the partnership, and the staff and our patients. In the early years, we relied on partners cascading information to staff via practice managers. However, the level of information received by the staff varied from practice to practice. Things improved after setting up a monthly email newsletter to all staff and regular email updates. Each practice has its own patient participation group (PPG) group, which is a sub-group of the larger Vitality-wide Patient Participation Group. This has worked well to ensure patients are involved in and shape the services we currently deliver and wish to deliver in the future.

We have continued to modify the partnership agreement and structure to reflect the expanded partnership and the new services we offer, which any good organisation should do. Moving to a more corporate partnership structure (to deliver on our business plan) is a very new concept for general practice. This has proved to be challenging to articulate to potential incoming practices and some local practices have been put off merging as a result. However, those GPs, especially the single-handed practices, that have joined have found the clinical and administrative support has meant they are able to enjoy general practice once again without having to worry about administrative burdens. It can be intimidating coming into a large partnership, especially in terms of clinical exposure, if you have been practising as a single-handed GP for many years. A significant part of my role has been to ensure these GPs are welcomed, settled in and made to feel an integral part of the partnership.

Another key lesson has been to ensure that staff contracts are harmonised sooner rather than later. It took a great deal of time to go through the organisational change process so all staff were on standardised Vitality contracts. We also understand some of the local commissioning issues/tensions and see ourselves as active contributors to the solutions, being a significant local provider of health services. We have started to build upon historical working with our local acute trust and are forming relationships with the local authorities to integrate across health care and social care for our practice population. Size really does matter in this context.

Tower Hamlets general practice networks
Dr Simon Brownleader, Chairman of Network 2

If anyone asks me what makes a network tick, I tell them it's the glue. It's not just one thing, but many components that make an organisation gel together. Networks have their own personalities and how they function is a composite of the individual units that are brought together. Our particular mix consists of a small practice that looks after homeless patients, with four other practices that serve a local community of about 40,000 people.

It has not always been a smooth journey and there have been challenges along the way. Historically, our local practices had very little to do with each other, despite being geographically close, but through network development and engagement, relationships have been forged and trust gained to enable us to create cohesion and collaboration. Obvious factors such as shared incentives based on collective performance have helped to encourage this, but other important aspects have contributed to our onward progression.

One key element that has helped to reinforce this bond between practices has been the creation of a network learning set involving members from each practice. Having regular safe spaces where the trials of primary care can be shared and problems solved allows for a much better understanding of the challenges each practice has to experience and the development of mutual trust. This can best be highlighted when we frequently look at our collective performance data together and analyse how we are operating. We never view this exploration as a stick-waving exercise, but as a genuine desire to help out our fellow practices and to learn from those that are doing well so that we can improve our own performance.

Educational sessions and monthly multidisciplinary meetings across the network have been another key ingredient to our success. During these sessions health professionals from the network practices have opportunities to engage with each other, share real clinical experiences and learn from each other.

None of this would happen effectively without the organisational layer sitting above the day-to-day running of each practice, which facilitates the activity of the network. Where demands on individual practices are great and time is increasingly stretched, this structure and overview has allowed us to pool resources, improve efficiency and reduce variability, to the benefit of each practice and ultimately the patients. A good example of this is unused nursing time for diabetics sometimes being redistributed from one practice to another with more demand.

We acknowledge our individuality as a group of network practices and the strengths we each bring, such as our local presence, understanding of our local population, and independence in the way we run our practices. These variations allow for different perspectives and often creativity in dealing with the issues that span across our network.

We also value our place in the community and feel the network has allowed us to become more community facing in a way that we have never been before. Community network activities such as after-school clubs, Bengali women's exercise classes and outreach pop-up clinics in the local markets have shown we have the collective desire to help our local community beyond our front doors and to reap the benefits with better patient education and engagement.

Barriers to progress

The case study organisations each had ambitions to extend their services beyond core general practice into the delivery of care in community settings and whole system transformation. The super-partnership[1] is already delivering a range of specialist and diagnostic services and the Suffolk Federation[2] (another case study organisation in the Nuffield Trust seminars) was created to do the same.

This ambition to work with local specialists, community and social services to deliver more care in the community was seen by participants in the Nuffield Trust seminars as consistent with national policy and local commissioning plans. Yet participants highlighted numerous challenges to this, including policy and regulations at both local and national level.

Difficulty creating 'headspace' for strategic planning: Participants described how difficult it is to find time away from busy practice workloads to undertake the work required to develop new models and lead change. This had been largely achieved in their own time, but some had also been allocated specific management sessions to lead the organisational change. Some sites created additional capacity by funding external management support.

Conflicts of interest and competition: Part of the rationale for each new model is the ability to create continuity and efficiency between primary and community-based services. Developing organisational scale by taking on additional business created general practice organisations that were confident at operating within a market-based environment. This raises the problem of perceived conflict of interest between GPs as commissioners and provider. The case study organisations actively managed this with commissioning colleagues when bidding for new services by adhering to explicit local policies to manage conflicts of interest. GPs in the case study organisations had adopted either a provider or commissioner role to create separation within their own organisation. Participants in the seminars were uncertain about how to apply competition rules in relation to extending GP services. They expressed confusion about when the proposed benefits of integration between core and extended GP roles could justify commissioning through single tender actions, and when open competitive tender would be required.

The workload of competitive tendering: The workload involved in responding to competitive tenders for community services was identified as a barrier to general practice increasing its scope of provision. But it also reinforced the view that larger GP organisations, with their additional business resource, were better placed to do this.

[1] www.nuffieldtrust.org.uk/talks/slideshows/helen-parker-naresh-rati-model-super-partnerships
[2] www.nuffieldtrust.org.uk/talks/slideshows/david-pannell-developing-federation

Questions for the future

How big should 'new practices' become? Although the current small-scale model of general practice is considered to be outdated, during the seminar discussions there was no consensus about the optimum size for future models. It was felt that different services required a different critical mass of patients, and careful analysis is needed to understand the risks and opportunities as organisations grow. Learning from the case studies identified that organisational development needed to align with business growth.

Is it better to federate or merge? In weighing up the costs and benefits of federations and mergers, most participants in the seminar felt the federated model could only take transformation so far, without compromising the autonomy of individual practices, creating additional conflicts of interest and slowing down decision making. Participants from super-partnerships acknowledged the significant effort and resource required to create larger, single practices through practice mergers. However, the closer alignment of all decision making and a shared 'risk reward' approach of super-partnerships was felt to offer more potential and long-term sustainability.

Does scaled up general practice have to be geographically linked? The models were compared in terms of those that were developing around local communities and providers and those, such as the multi-practice model, that were spread across a larger area. Achieving a local identity and improving integration through developing strong professional relationships with local specialists was seen as an advantage, but it also potentially created a monopoly provider within primary care. Achieving scale through the acquisition of multiple contracts across a wider geographical area made developing local relationships more of a challenge, but created opportunities with more than one CCG.

How can the right leadership be nurtured for practice development? Participants debated whether the leadership for transforming general practice was predominantly a provider or commissioner role. They agreed that leadership from both, working in partnership, is essential for changing local services, but acknowledged that the drive and motivation for transforming general practice had to come from GP partners, as the business owners. This would create the ownership of organisational transformation required for change to be sustainable. CCGs could support this through education to raise awareness about new forms of general practice and facilitate discussions to explore new models.

What should the role of CCGs and NHS England be? It was agreed that transforming general practice requires a collaborative approach between CCGs and NHS England, but the role of the two organisations was unclear. Too narrow a focus by NHS England on quality improvement *within* practices could distract from wider ambitions to develop the role of general practice for the whole health system. Yet CCGs, which use contracts for new community services to encourage 'collectivisation' of practices, could fall foul of competition rules. Seminar participants described early efforts to build relationships between their local CCG and NHS England, and acknowledged the importance this work.

Conclusions

The pressures that are driving new models of general practice to emerge are unlikely to diminish in the near future. This event report has described how general practice could better equip itself to withstand external pressures if it is organised at a larger scale than current practices. It has also argued that larger practices have huge potential to manage demand, improve care coordination and deliver extended services. These functions are much harder to achieve when providers are fragmented in small businesses.

Nationally, policies which could encourage general practice to operate at larger scale include (Smith and others, 2013):

- Incentives in the general practice contract to deliver improvements in care across a defined population that is larger than a typical GP practice. This would encourage practices to participate in the kind of peer-led change and improvement described in the Tower Hamlets network case study, and could tip the balance in favour of merging for practices that are already considering such a move.
- An alternative contract could also act as a vehicle for new general practice organisations to provide extended clinical services.
- A clear national vision for the contribution of primary care to community-based health services and a national strategy to support general practice and other primary care providers to develop extended roles. This would enable better strategic planning amongst practices considering federating and extending their future roles. An alternative contract could be used as a vehicle for commissioning such extended services.
- Greater clarity about the application of competition rules in relation to general practice provision of extended services and guidance on quality and access standards which should apply.

Locally, CCGs have a clear role in supporting general practices to consider options and manage change in relation to new organisational arrangements. This could include:

- providing analytical and business development support to practices to help them create and implement business plans for working with other practices
- providing professional development support to enable selected clinicians and managers to develop the skills needed for organisational change
- creating opportunities for strategic thinking by funding 'time out' for selected clinicians and managers to develop local plans for collaborative working.

CCGs must collaborate with NHS England's Local Area Teams to create a coherent local approach for primary care and general practice development.

It will not be easy to sustain practice business at a local level and maximise the future opportunities of additional contracts with CCGs. The leaders from the case study organisations did much of the work, in addition to their usual clinical roles, and continued to combine onerous clinical and managerial responsibilities. In the current financial climate, there is unlikely to be adequate support to make these transitions comfortable and a culture change is needed in

practices which are used to NHS funding for organisational development. GPs around the country will have to decide whether the long-term rewards in terms of quality of care, organisational sustainability and more diverse professional lives will justify the short-term discomfort of organisational change.

Appendix: Case studies

Super-partnership: Vitality Partnership, Birmingham, UK	
Date established	September 2009
Legal status	Partnership
Main drivers	• Delivery of services at scale – greater potential for expansion • Integrated generalist and specialist care within primary care • Greater ability to bid for Any Qualified Provider services • Scale facilitates longer term financial investment to increase range of services provided • Greater level of local provider influence • Increased career opportunities for partners and staff, clinical and non-clinical • Increased patient choice and access with multi-site working • Opportunity to adopt best practice and standardise clinical care and management processes across sites • Future business sustainability due to diversification of income streams – less reliance on core contract.
Local levers	Health economy plan to reduce number of hospital beds and services. Agreed level of activity to shift to primary care and community providers.
Number of partners	15 full equity, three fixed share
Registered population	51,000
Care locations	Eight practice sites
Service portfolio	• General medical services • Specialist services with consultants working from practice sites • Enhanced diagnostics including x-ray • Private medical services including immigration and aesthetics. Provides some services to non-registered patients
Number of employees	200+ (25 nurses, 26 GPs (WTE))
Identified benefits	Improving quality demonstrated by: • Increased access • Savings on tariff for specialist services • Increased QOF achievement at all sites • Increased uptake of immunisations and vaccinations • Reduction in outpatient referrals • Integrated care pathways between generalist and specialist care • Single patient record via EMIS Web • Peer review of referrals and prescribing • New models of patient engagement • Internal promotion and development of practice staff • Dedicated leadership roles for partners improving business planning and management • New partnership structure to promote recruitment and retention of salaried GPs and GPs with a special interest.

Super-partnership: Whitstable Medical Practice	
Date established	Ongoing growth in list size since practice mergers in 1970s. Opening of new premises allowing expansion of role in 2009.
Legal status	Partnership
Main drivers	• Provide a better patient experience • Deliver higher quality of care for less money • Improve integration between GPs, community services and specialists • Improve access to wider range of local services • Reduce waiting times • Improve management of long-term conditions.
Local levers	• Practice vision to provide community integrated health care in order to enhance the patient experience, and health care outcomes at less cost • An acceptance by GP partners that there would need to be personal financial investment • Good patient and public engagement.
Number of partners	19
Registered population	34,000
Care locations	Three practice sites including Estuary View Medical Centre – a large 'polyclinic-type' centre housing diagnostics, specialist and community services.
Service portfolio	• General medical services • Outpatient services provided by consultants and GP with a special interest • Diagnostics (digital x-ray, ultrasound, echocardiography, upper endoscopy, and mobile MRI) • Level 3 minor injury unit, open 12 hours a day, 365 days a year with fracture clinic • Day surgery suite • Physiotherapy • Hearing aid clinic • Long-term condition management project for diabetes, cardiac disease, chronic obstructive pulmonary disease (COPD) and mental health • Screening services (retinal screening, abdominal aortic aneurysm ultrasound, genetic counselling) • Community café and pharmacy on site • Ambulance response base on site • Joint consultant and GP visiting project to care homes. Provides some services to non-registered patients.
Number of employees	130 (34 nurses, no salaried GPs)
Identified benefits	• Savings on tariff for specialist services • Improved access; some services available out of hours • Improved coordination of care through joint care planning • Improved and more efficient care pathways • Increased continuity of care • Single patient record • Tangible increased job satisfaction for partners and staff • Improved patient and public engagement • Enhanced patient satisfaction.

Multi-practice model: The Hurley Group, London, UK	
Date established	Practice formed in 1969 but expansion began in 2007.
Legal status	Partnership
Main drivers	• Poor care to marginalised groups • Increased demand for primary care • Financial constraints across health and social care economies • London workforce crisis • Opportunity for innovation • Improve integration • Business sustainability.
Local levers	Procurement of Alternative Provider Medical Services (APMS) contracts across London
Number of partners	Four partners with 22 lead GPs (one at each site) on a profit share
Registered population	100,000 registered + 250,000 minor illness and injuries per annum
Care locations	18 general practices Five urgent care centres
Service portfolio	• General medical services • Minor injuries • Enhanced diagnostics including x-ray • Substance misuse services • Refugee and asylum seeker care • Practitioner health programme caring for sick doctors and dentists in London.
Number of employees	300
Identified benefits	Improving quality demonstrated by: • Improved access • Improved patient experience indicators • Improved clinical outcomes • Turnaround of nine failing practices in deprived communities • Value for money services to commissioners • Increased QOF achievement at all sites • Increased uptake of immunisations and vaccinations • Reduction in outpatient referrals • Integrated care pathways between generalist and specialist care • Peer review of referrals and prescribing • Internal promotion and development of practice staff • Telehealth projects including online consultations and virtual peer and specialist second opinions, sharing of best practice and service awareness.

Network: Tower Hamlets Network 2	
Date established	2008
Legal status	Network 2 formed as a company limited by shares.
Main drivers	• PCT strategy to improve primary care in Tower Hamlets • Improve local management of long-term conditions • Reduce variations in standards of local practice.
Local levers	• Administrative and financial support to help form networks • Financial incentives for improved outcomes • Shared contract for services additional to core GMS/PMS (general medical services/personal medical services) • Payment for 'backfill' to attend network review and educational meetings.
Number of practices	Network 2 includes five practices. There are eight networks across the whole of Tower Hamlets.
Registered population	Approximately 34,000. Registered populations range from 24-40,000 across the eight networks.
Care locations	All care is provided within member general practice.
Service portfolio	Since 2011, an APMS contract has been held between the PCT (now CCG) and each of the eight networks. Due to CCGs now not being able to commission with an APMS contract, these services are now commissioned through the NHS standard contract. The contract is in addition to core GMS/PMS services and sets *network average* standards (higher than those in existing contracts) for: diabetes, COPD, cardiovascular disease, end-of-life care, immunisation and vaccinations, and drug and alcohol use. These 'network improvement services' require practices to work collaboratively to improve services. Thirty per cent of the contact value is paid retrospectively if the average standard for each condition is achieved across the practices.
Number of employees	Each network has a manager, an administrator and a care planning nurse to develop annual care plans for people with long-term conditions.
Identified benefits	• Improved quality and reduced variation between practices • Development of clinical and organisational skills in GPs • Better use of data to monitor care and drive change • Multidisciplinary team with GPs and other clinicians • A culture of collaboration between practices.

Federation: Suffolk GP Federation	
Date established	April 2013
Legal status	Community interest company
Main drivers	• Support and strengthen primary care and CCG objectives • Share practice resources to increase efficiency • Increasing clinical workload • Reduced income to general practice • Workforce challenges in GP recruitment and retention • Maintaining practice sustainability.
Local levers	History of practice collaboration
Number of practices	60
Registered population	539,000 combined
Care locations	General practice
Service portfolio	Includes: • Diabetes • Ultrasound • Lymphoedema • Cardiology • Urology.
Number of employees	30 employees plus a board consisting of nine GPs, three practice managers and the Chief Executive.
Identified benefits	Evaluation underway.

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