

Transforming general practice: what are the levers for change?

Briefing

Rebecca Rosen

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Foreword

This report sets out the thinking and conclusions of a workshop held by the Nuffield Trust to consider how general practice might change as part of a wider transformation of the NHS.

It is generally accepted that general practice has a key role to play in addressing many of the challenges facing the NHS. Indeed, this has been a theme of government policy stretching back many decades. Whether as commissioners of care (starting with general practitioner (GP) fundholding in 1990) or as increasingly significant providers of service, most governments have seen GPs as a key ingredient to reform – even if the precise recipe has been contested.

The *Five Year Forward View*, published by NHS leaders in 2014 (NHS England, 2014a), carries on this tradition. Enhanced general practice is at the heart of many of the ‘new models of care’ it promotes. This makes sense. The *Forward View* calls for more preventive, more local and better-coordinated ways of caring for complex patients. With its holistic responsibilities for lists of registered people, general practice is the most local part of the NHS, and the best understood by the public. It is founded in long-term relationships with patients, and encompasses prevention and treatment.

So if an expanded and vibrant general practice sector is so obviously the ‘answer’ and has been for such a long time, one might question why workshops such as the one held by the Nuffield Trust are still necessary. In part, the answer may lie in the fact that there have been numerous attempts to reform general practice – maybe too much policy attention has been placed on it and the sector has suffered from competing initiatives. It is also true that GPs themselves have felt increasingly under pressure – at the front line of an increasing wave of demand from an ever-more assertive public with ever-greater levels of need. Dealing with this pressure may crowd out the energy to reform from within (even as it makes the case for reform more compelling).

But if general practice is to advance with the pace and ambition implied within the *Five Year Forward View*, it also needs to develop greater scale and to morph from small practices into larger organisations or networks. These will need to have the managerial scale and capability to implement new forms of patient access and to deliver a far wider range of services, many of which are currently accessed through hospitals.

Here we have grounds for optimism as the movement to create ‘GP federations’ and ‘super-practices’ has gained significant ground (and examples of this are described in this briefing). So if the vehicle for a dynamic general practice is coming into being, the key question is how to encourage and support the delivery of desired new care models. The national ‘vanguard’ sites, demonstrating new models of care involving general practice, are part of this answer. But if the ‘gaps’ in funding, quality and health, set out in the *Five Year Forward View*, are to be closed, general practice will have to transform in every locality – not just in a selection of pioneering areas.

This briefing helpfully and judiciously sifts both evidence and experience to identify some key recommendations for policy-makers and for primary care itself if this transformation is to be achieved.

Richard Lewis
Partner and Health Advisory Leader, EY



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Key points

- The organisation and scale of general practice is evolving from small clinics to networks and larger partnerships, creating opportunities to broaden the range of services delivered, improve quality and reduce variations in practice. There is a need to develop existing knowledge about effective ways to support change and improvement in general practice and primary care.
- Targeted financial micro-incentives are one method for achieving change and are in widespread use. However, evidence suggests that while they can stimulate change in specific areas of care, they do not result in deeper service transformation.
- A different balance is needed between creating financial incentives for change and providing developmental support to practices. Such support should address skills deficits, strengthen inter-professional working relationships, build leadership capability and develop new organisational systems and processes.
- Workforce development is an important enabler of change and should combine both short-term skills development and longer-term curriculum development. The latter is important for ensuring that trainees are exposed to new ways of consulting with patients, new technologies to support general practice and collaborative inter-professional working practices.
- Tools are needed to estimate the costs of transformation initiatives and these must cover professional time to participate in change programmes alongside other aspects of change management. Creating ‘headspace’ and dedicated time for transformation work is essential if the general practice workforce is to adapt to new ways of delivering services or take on new forms of service delivery.
- A minimum dataset is needed for general practice to allow analysis and monitoring of inputs, outcomes and progress towards new ways of working. This should be a policy priority in addition to changing data governance rules to support risk stratification and sharing of clinical information between providers.
- Commissioners should take a pragmatic approach to developing risk and gain-sharing arrangements with new GP provider organisations as it will take time for them to learn how to manage financial risk.
- Instead of immediately seeking to impose new policy arrangements upon general practice and primary care, politicians and policy-makers should consider creating a more permissive culture that allows emerging GP provider organisations to experiment with new ways of delivering services, recognising that some will fail in their efforts.



Introduction

General practitioners (GPs) in England are facing unprecedented demands from patients and high expectations from policy-makers, politicians and regulators to respond to those demands. Alongside the quest for reduced variation in patient care, better patient experience and more coordinated care, GPs are being asked to form federations, to undertake more preventive work, to collaborate in order to offer extended access and to develop extended clinical services within integrated care pathways. Unsurprisingly, many are struggling to know how to respond and what to prioritise.

The pressures facing practices are well known. They include:

- recruitment and retention problems, leaving practices understaffed
- compliance with regulatory standards and preparing for inspection by the Care Quality Commission
- increasing demand and patient expectations
- coping with budget cuts and cash-flow pressures
- increasing administrative workload.

In addition, participation in clinical commissioning swallows up time, and in some practices effort is also devoted to delivering additional services commissioned through local contracts.

So what approach should be taken by policy-makers, regulators, professional bodies and local commissioners to promoting change in general practice? All are charged with improving primary care, but each is using different methods to achieve this. If the current array of initiatives to drive change and improvement feels overwhelming, how can the potential contribution of different 'levers for change' be better understood and applied in a way that will deliver sustainable improvements in the future?

Methods

This briefing is based on a workshop held at the Nuffield Trust. The workshop drew on the experience and views of a range of primary care professionals, academics and policy-makers (see the Appendix for a list of participants) to explore the 'levers' available to achieve sustainable change and improvement in general practice. Although a wide range of primary care services were included within the scope of the workshop, much of the discussion focused on levers to change and improve general practice and to support the evolution of practices from freestanding partnerships into larger organisations. The focus of this briefing is therefore on levers to change general practice.

The briefing describes the main presentations given at the workshop, and pulls together the expert opinion and the evidence presented into a series of recommendations aimed at policy-makers, commissioners and providers.

The next section briefly explores what high-quality general practice will look like in the future. The following section gives an overview of levers for change that have been used in the last two decades. Presentations on two contrasting methods to drive change and improvement in primary care – financial incentives and the reorganisation

of professional work – are then described. Following this, summaries of four short NHS case studies are presented in order to explore how various levers for change have been deployed in different contexts. The subsequent section summarises discussion on how different levers for change could be deployed to ensure that in future, general practice is of a high quality and is capable of participating effectively in transformed health and care services. Finally, recommendations and conclusions about supporting transformational change in general practice are presented.

In parallel with the workshop, the Nuffield Trust carried out a rapid review of the evidence on levers for change in general practice and primary care. We have published this separately [here](#) (Barai, 2015) and we encourage readers to refer to it for a fuller discussion of the evidence base underpinning the discussions at the seminar.

An emerging consensus on the future of general practice

There is no single, widely accepted definition or set of measures of quality in general practice. A recent report by the Health Foundation entitled *Improving Quality in General Practice* (De Silva and Bamber, 2014) concluded that definitions and measures of quality are shaped by the target audience and the purposes for which they will be used, but frequently cover patient experience, safety and effectiveness. Other domains or attributes are also commonly included under the rubric of quality in general practice and these have been examined in a previous report by the Nuffield Trust and The King's Fund (Smith and others, 2013). Drawing on a brief review of literature, the report concluded that a model of high-quality care put forward by the Agency for Healthcare Research and Quality (AHRQ, 2013) in the United States (US) combines the basic attributes expected from any health care service, with qualities that reflect the distinctive role that should be played by primary care in the United Kingdom (UK). The model stipulates that primary care services should be:

- comprehensive
- patient-centred
- coordinated
- accessible
- safe and high quality.

This broad conceptualisation of quality is evident in an array of recent policy initiatives. For example:

- the Prime Minister's Challenge Fund seeks to improve access to general practice
- national designated enhanced services include financial incentives to reduce avoidable unplanned admissions through the coordination of care for people with complex health and social care needs
- the new Care Quality Commission general practice inspection regime examines several dimensions of quality, including safety, caring and effectiveness
- the core attributes of accessible, proactive and coordinated care are highlighted in a proposal to transform primary care in London (NHS England, 2014b).

Running alongside debate about the characteristics of high-quality primary care are parallel and inter-related questions about what is the right organisational form for primary care. There is growing agreement about the need for general practice to be delivered through larger organisations and a number of different 'scaled-up' models are emerging. These have been described in *Securing the Future of General Practice* (Smith and others, 2013) and include organisational arrangements ranging from practice networks through to merged 'super-partnerships' and multi-site practices owned by a single parent company.

Although evidence about the impact of scale in general practice remains limited, prototype scaled-up primary care organisations are emerging throughout England. This marks the start of a long journey towards practices operating through networks or mergers, with wider relationships with community services, hospital specialists,

pharmacists and others. These emerging organisations are also likely to play a part in some of the new models of care described in the *Five Year Forward View*, particularly the multi-speciality community provider model (NHS England, 2014a).

The speed at which new primary care organisations are forming has surprised many and the factors that underpin their formation have been described previously (Rosen and Parker, 2012). While little is yet known about how they will affect clinical quality and patient experience, they are increasingly seen as a necessary step in the development of sustainable, high-quality general practice (see, for example, The King's Fund, 2011; Royal College of General Practitioners (RCGP), 2012). The focus of the workshop on which this briefing is based was on ways in which these organisations could be supported to succeed and to improve the quality of care delivered to patients. The following section briefly considers methods for achieving change in general practice that have been used over the last two decades.

A complex mix of methods to drive change and improvement in primary care

The last two decades have seen numerous methods used to drive change and improvement in general practice – some through national policy, others through local initiatives.

Some have sought to improve clinical care delivered within practices. Others have supported comparative work *between* practices, encouraging comparison of performance and peer learning about opportunities for improvement.

Other schemes have sought to influence the relationship between general practice and other parts of the health service – such as attendance at Accident & Emergency departments and the avoidance of hospital admissions, even though these are not fully in the control of GPs. And more recently, a number of clinical commissioning groups (CCGs) have sought ways to encourage the formation of practice networks and federations and to draw general practice into integrated care pathways with community and acute hospital services.

These methods can be grouped into six broad areas, listed below, some of which have stayed in regular use while others have come and gone as the policy context has changed.

Financial incentives

- Financial micro-incentives (i.e. targeted payments for specific activities or outcomes) associated with the Quality and Outcomes Framework (QOF).
- Local enhanced services – often used to fund specific interventions such as insulin initiation in diabetic patients or care plans for patients with several long-term conditions.
- Commissioning incentive schemes to support the achievement of local commissioning priorities.
- Key performance indicators for the personal medical services contract – negotiated locally between NHS England and practices/local medical committees.
- Designated enhanced services – national incentive schemes used to achieve government priorities such as early diagnosis of dementia or care planning for complex patients.

Contractual levers and national targets

- National performance targets such as the 48-hour access target for general practice, with increasing interest in introducing seven-day 8am–8pm access standards.
- Annual changes to the GP contract – general medical services and personal medical services contracts – to change the core services delivered in general practice.
- Practice-based commissioning initiatives – determined locally by each practice-based commissioning group.
- Local commissioning of new community-based services – currently undertaken by CCGs. This creates opportunities for practices to bid for and/or deliver extended community-based services such as anticoagulation monitoring, selected diagnostic services, minor surgery and selected areas of specialist care.

Audit, data transparency and benchmarking

- Medical audit advisory groups and clinical audit programmes.
- Practice-level performance comparison to monitor quality of care, commissioning initiatives and local peer-led improvement schemes.
- Comparative prescribing data created nationally and distributed to individual practices.

Professional accountability and peer-led change

- The Royal College of General Practitioners' Membership by Assessment of Performance – a modular approach to improving the overall organisation and quality of a general practice, which is externally assessed by fellow professionals.
- Peer review of clinical practice – examples include practice meetings to review all referrals to secondary care, or peer review in networks or between practices to compare clinical practice or use of hospital services.

Regulation

- The Care Quality Commission's inspection of general practice, which started in 2012 – focuses on five dimensions of high-quality care: safety, effectiveness, caring, responsiveness and leadership.

Multi-method initiatives and collaboratives for organisational development

- The NHS Institute for Innovation and Improvement's Productive General Practice programme.
- Modernisation Agency initiatives in general practice.
- Primary care collaboratives.
- London Innovation Challenge, a funding programme aimed at stimulating innovation and enterprise in general practice.
- Leadership development initiatives for general practice, including the Health Foundation 'Generation Q' programme and Darzi fellows.

The Nuffield Trust has carried out a rapid review of the evidence on the effectiveness of these approaches, which we have published alongside this briefing (Barai, 2015), and we encourage readers to refer to this for a fuller discussion. The evidence is mixed but, overall, there is evidence to suggest that some of these methods can achieve modest short-term benefits. However, the question remains about which combination of these approaches will result in sustainable, transformational change of the kind envisaged in the *Five Year Forward View* (NHS England, 2014a).

Presentations and case studies

The workshop included two presentations that put forward two contrasting approaches to improving care: Matt Sutton (Professor of Economics at University of Manchester, UK) provided an overview of evidence on the impact of financial incentives in general practice and the wider NHS; and Kecia Wherry (Former Network Director, Richmond Market, at ChenMed, US) described ChenMed's multifaceted approach to delivering high-quality, cost-effective care by redesigning professional practice. These are described in the next two subsections.

Financial incentives for change

A variety of financial incentives have been used to influence general practice and the wider health service over the last decade. The national Quality and Outcomes Framework (QOF) is the largest incentive scheme, available to all GPs, but many other national and local incentives have operated alongside the QOF. For example:

- national designated enhanced services have linked financial rewards to a specific initiative such as diagnosing dementia or setting up patient participation groups in general practice
- local commissioning bodies (first primary care trusts and now CCGs) have used local enhanced services and local commissioning incentive schemes to stimulate GPs to participate in initiatives linked to their specific commissioning objectives.

In his presentation, Sutton summarised his research on financial incentive schemes and reviewed wider evidence on the impact of targeted financial incentives in general practice and in the wider health service. He cautioned that many studies of financial incentives in health care are methodologically weak and context specific.



Improvements from the Quality Outcomes Framework are limited to narrow areas of care and the QOF has not driven wider quality improvements in non-incentivised areas of care

Describing the impact of the QOF micro-incentive scheme, Sutton concluded that there is evidence that it has influenced clinical outcomes – with sustained higher-quality outcomes in the conditions targeted by QOF micro-incentives and relative reductions in hospital admissions compared with non-incentivised conditions. However, the improvements are limited to narrow areas of care and the QOF has not driven wider quality improvements in non-incentivised areas of care.¹

Sutton also reviewed a broader quality improvement initiative in the north-west of England – the Advancing Quality Alliance (AQuA) programme, which was launched in 2008 to improve standards of health care provided in hospitals and CCGs across the region. The programme brings together clinicians, managers and other health and care professionals, and uses a collaborative methodology to deliver a set of quality standards that define and measure good clinical practice. The programme combines:

- financial incentives
- educational initiatives
- leadership development
- whole-system improvement projects.

It is important to note that less than half of the AQuA programme's £13 million budget for the first 18 months of its work was spent on financial incentives, with the rest allocated to running costs and its wide range of improvement projects and development support programmes.

In contrast to the ChenMed example, described in the next subsection, which is a single provider, the AQuA programme is a whole-health-system initiative, which aims to improve care within clinical teams (micro-level improvements), along integrated care pathways (meso-level improvements) and to develop a supportive context for change across whole health and care economies (macro-level improvements). An evaluation of the programme by Sutton and his colleagues (Meacock and others, 2014) concluded that, in its first 18 months, the programme achieved a short-term, six per cent reduction in mortality and significant reductions in bed days, equating to £4.4 million in savings. Although the reduced mortality was not sustained, the researchers concluded that, overall, the programme was cost effective.

“ Financial incentives are most likely to stimulate transformational change if they are large scale and high profile – with finances and reputations at stake if they fail

¹ Studies of the QOF by other research groups have criticised the QOF for focusing effort on a narrow range of interventions at the cost of more innovative approaches to quality improvement; for improving processes of care rather than outcomes; and for creating an administrative burden (Barai, 2015). In their research, Dixon and others (2011) concluded that the scheme had made no impact on primary prevention and reducing inequalities and had entrenched a mechanistic, medical model of care that did not support holistic, person-centred clinical practice.

As a third example of the use of financial incentives, Sutton described an evaluation of the £1 billion Commissioning for Quality and Innovation (CQUIN) programme, which was launched in 2009 to improve quality in NHS providers. The research team concluded that the programme had resulted in no measurable improvements. They proposed that:

- the money was spread across too many locally defined projects
- the definition of indicators was inadequate
- there was poor follow-up on projects
- the programme created too many targets for providers to follow (Kristensen and others, 2013).

In conclusion to his presentation, Sutton proposed that incentives are most likely to be effective if they are large scale and high profile – with finances and reputations at stake if they fail. They also need to be:

- focused on a small number of initiatives
- well planned, with careful attention paid to the technical design of the incentives (such as the indicators to be used and measurement methods)
- part of a multifaceted improvement strategy
- supportive of a popular mission.

Professional behaviour change through organisational redesign

In the second presentation, Kecia Werry described a contrasting approach to changing and improving the quality and efficiency of health care for older people, which is less dependent on direct financial incentives.

ChenMed is an organisation in the US that is committed to offering high-quality primary care to older people (aged over 50 years). It runs a capitated pre-paid health plan for older people living with long-term conditions in urban communities in eight US states. In return for a risk-adjusted annual budget, the plan offers comprehensive health care services, including a prescription service and transport to and from ChenMed's clinics.

Werry explained that the starting point for ChenMed's efforts to deliver high-quality, cost-effective care is the getting the doctor–patient relationship right. It recruits physicians and other staff for their attitude as much as for their aptitude and experience, looking particularly for an interest in holistic, collaborative care. It invests in developing a culture of professional responsibility for patient-centred care. This is achieved through:

- clarity about how physicians should practice – continuity of the doctor–patient relationship, shared decision-making, anticipatory contact with patients and clinical practice in line with evidence-based guidance
- role modelling of these behaviours by clinical leaders
- investment in training and development in order to work in this way
- availability of decision support tools within consulting rooms
- formal review mechanisms to monitor clinical practice.

In addition, standardisation of process and infrastructure (every clinic and consulting room is laid out in an identical way) is used to reduce errors and maintain safety and efficiency. Additional services such as free patient transport, on-site pharmacies and wellness activities, remote health monitoring technologies, and visiting specialist physicians who work closely with the primary care doctors aim to make it as easy as possible for patients to access services and enable coordination between service providers. Weekly multi-professional team meetings and regular physician meetings to peer-review treatment decisions and continuity of care during transitions between hospital and community all serve to coordinate clinical decision-making around the needs of individual patients.

Organisationally, ChenMed uses rapid learning cycles (equivalent to the 'Plan, Do, Study, Act' – or PDSA – cycles used in the UK) to test different ways of working in any new location in which it operates. It has simple organisational governance structures to ensure that decisions can be made and implemented quickly. It works collaboratively with its payers (insurance companies) to maximise use of available data, generating risk stratification data and decision support information, which is available during clinical consultations. It adapts care coordination programmes to suit to each location in which it operates and introduces new specialised programmes in collaboration with payers where they are needed.

Wherry argued in her presentation that, in combination, these organisational systems and initiatives support clinicians to deliver high-quality, patient-centred care. ChenMed reports:

- 38 per cent fewer inpatient days for its enrollees compared with the national average
- 92 per cent continuity with a named physician compared with 40 to 60 per cent nationally
- a high net promotor score (equivalent to the NHS Friends and Family Test score) in surveys of patient satisfaction.

In contrast to a typical English GP with a list size of 1700 to 2000 patients, each ChenMed physician has a list size of 400 to 500 people, although those on its registered lists typically have complex co-morbidities. Staff physicians have 10 to 15 per cent of their total income over time tied to performance, subject to review by a direct supervisor.

NHS case studies of implementing change in general practice

The application of some of the methods used to implement change described above was further examined in the workshop through small-group discussions based on four NHS case studies. Following a short presentation by a lead professional from each case study site, the groups explored the factors that had helped to bring about change in each case study site and considered how policy and practice could support similar transformation in other areas. They also looked at the factors that had hindered change. This was followed by a plenary discussion on the main issues raised. A summary of each case study is presented in the following subsections. Key points from the plenary discussion are presented in the next section.

Case study 1: Formation of the Vitality GP ‘super-partnership’ in Sandwell and Birmingham
Introduced by Sarb Basi, Managing Director, Vitality Partnership

Service transformation described in the case study

In this case study, nine individual GP practices merged into a single partnership organisation with over 70,000 patients and 13 clinical sites. Called the Vitality Partnership, it has developed a standardised, systematic approach to quality improvement and assurance across all sites. As new practices merge with the established Vitality Partnership, they join shared services such as a call centre and web resources and are required to adapt their established working practices in line with the partnership’s operating processes. There is also a single management structure and a corporate way of working as a business.

Main levers used to promote the service change

- A supportive context for change brought about when a reconfiguration of local hospitals triggered large-scale service redesign and interest in an extended role for general practice in integrated pathways. In addition, some local GPs were looking for ‘exit strategies’ from their practices as they approached retirement.
- Creation of an attractive offer for potential staff, including opportunities for career progression and role variety, to ensure that recruitment is not a barrier to delivering good care.
- Close attention being paid to communication with all staff.
- Skilled strategic and operational managers executing organisational development initiatives and improvement projects effectively.

Case study 2: Development of multidisciplinary team working in Inner North West London
Introduced by Mark Spencer, Medical Director, NHS England, North West London

Service transformation described in the case study

The Inner North West London Integrated Care initiative aimed to improve outcomes, reduce emergency admissions and promote collaborative working across institutional boundaries. The initiative introduced care planning and multidisciplinary team (MDT) work across hospital, community and social care services and general practice for older patients (aged over 75 years) and those with diabetes.

An integrated information technology tool was developed to identify high-risk individuals and to support data sharing and the development of shared care plans. The main transformational change was to introduce proactive care planning into general practice and involve GPs and other practice clinicians in MDT working.

Main levers used to promote the service change

- A financial micro-incentive, which is offered to practices to develop care plans and participate in MDT meetings.
- Significant investment in: the information technology system; leadership training; coordination of MDT meetings; and overall project management to support implementation.
- Development of new working relationships between GPs and specialists, which was valued by GPs and helped to sustain the pilots of the initiative.
- Lack of time to participate in MDT working was noted to be a major barrier.

Case study 3: Emergency admission avoidance in Nene CCG through enhanced multidisciplinary care
Introduced by Ben Gowland, Chief Executive and Accountable Officer for Nene CCG

Service transformation described in the case study

In this case study site, six local clusters of GPs are working together to reduce emergency admissions. Each group is being funded to deliver multidisciplinary care and is deciding how to organise services to do this. Three different approaches are emerging:

- within-practice multiprofessional working to improve coordination and respond to clinical deterioration
- working jointly with the community and mental health trust
- working with local voluntary organisations.

Main levers used to promote the service change

- A local commissioning incentive scheme, which is creating a micro-incentive.
- A strong foundation of integrated working that the new schemes can build on.
- Involvement of frontline staff in design and implementation, which helps to build engagement.

Case study 4: Care coordination for complex individuals in Greenwich
Introduced by Rebecca Rosen, GP lead for Greenwich Coordinated Care Pioneer Programme

Service transformation described in the case study

Greenwich Coordinated Care is an intervention targeted at people with complex health, social care and other needs. It is focused on identifying and addressing each service user's 'I statement' of personal goals, alongside their clinical needs. The intervention aims to link existing integrated community health and social care teams to clusters of general practices, local voluntary organisations and other health and social care providers.

Care navigators co-create care plans with services users and these are shared across all agencies. The role of each participating professional, team or organisation is defined in order to address each individual's goals and service needs.

Main levers used to promote the service change

- No local financial incentive used but participation has helped GPs to undertake necessary work for the designated enhanced service for care planning.
- A dual narrative about benefits to patients and how participation in the coordinated care initiatives will make the GP working day easier.
- Leadership across primary care, community health services and adult social care, which is modelling joint working and collaboration.
- Workshops and action learning sets involving community health and social care workers, GPs and other professional groups to develop shared goals and values and aligned working practices.

Main themes emerging from the case study discussions

Plenary discussion focused on how different levers for change could be used to support general practice to provide high-quality care and to transform from a predominantly stand-alone service to one that is integrated with other health and care providers and capable of contributing to a transformed health service landscape. Five main themes emerged, and these are discussed in the following subsections.

The limitations of financial micro-incentives and possibilities for macro-incentives

While acknowledging that micro-incentives can result in sustained change in specific areas of care, there were several criticisms of this approach:

- GPs were thought to be responding to too many different incentives at the same time, including the QOF, key performance indicators for the personal medical services contract, national designated enhanced services and local commissioning incentive schemes.
- Many of these are focused on narrow clinical problems or specific clinical measures rather than broader initiatives to support strategic change across a whole-health economy.
- Achieving incentive payments often requires considerable clinical and administrative effort and practice resources, leaving little time for clinicians to engage with a more fundamental transformation of primary care.
- Where financial incentives are used to achieve whole-health-system goals such as reduced emergency admissions, many of the factors that determine outcomes are beyond the control of GPs themselves, so the incentives may be perceived as unfair.

Participants considered ways in which financial incentives could be used more effectively to support primary care's contribution to whole-health-system strategic change. One option was to suspend existing incentive frameworks and use that money to create local incentives for general practice to contribute to redefined care pathways and reconfigured services. Alternatively, targeted micro-incentives could be abandoned in favour of whole-system payments in which contributing GPs participate in risk-and gain-sharing arrangements. Both of these approaches could be adopted through co-commissioning arrangements.

These approaches could be used to concentrate incentives into a smaller number of substantial change programmes rather than numerous small changes, each of which is linked to a financial micro-incentive. In addition, the possibility of replacing multiple micro-incentives with an investment fund for transformation was discussed. Such a fund could be used to achieve pre-agreed outcomes and various forms of developmental support could be offered to clinicians to enable them to deliver the desired changes.

Skills deficits for transforming general practice

A second theme emerging from the case study discussions related to skills deficits in the primary care workforce, which restrict its ability to deliver transformed services.

Workshop participants thought that many of today's GPs lack exposure to innovative practices and need to develop additional skills to enable new ways of working. Deficits include:

- a limited understanding of population health
- weak relationships with community health and social care professionals
- lack of familiarity with technologies that could support and transform clinical consultations
- limited skills in data analysis and comparison to support peer-review and quality improvement work.

In terms of training, participants commented that current training arrangements for GPs and community nurses do not expose trainees systematically to new ways of working, for example in the following areas:

- population health management
- use of new communication technologies
- integrated working with community health and social care teams.

“ Current training arrangements for GPs and community nurses do not expose trainees systematically to new ways of working

Some will work in practices using universal telephone triage. Others may see the innovative use of web and phone app technologies for selected consultations, but not experience telephone triage systems. Overall, the essence of GP training remains practice-based, one-to-one consultations, with limited focus on understanding and managing population health.

For practice managers who have typically worked in the small business environment of a single GP practice, few were thought to have skills in strategic planning or in developing standardised operating systems and performance management arrangements that underpin high-quality, efficient care in large-scale practices and integrated services. The Vitality Partnership case study emphasised the important role that strategic planning and operational management skills had played in supporting the rapid growth of the partnership while maintaining a focus on quality and outcomes.

The value of bottom-up change: developing new relationships between frontline professionals

The ChenMed presentation and the four NHS case studies demonstrated the value of bottom-up change, rooted in building new working relationships between diverse professional groups. Different approaches were used in each setting, but some common themes were evident.

First, clinician involvement in the design and delivery of change programmes was of value. In Nene CCG and in Greenwich Coordinated Care, the ongoing involvement of clinicians was thought to be strengthened by their early involvement in design and development.

Equally important were the enhanced interprofessional relationships between GPs, community providers and specialists that grew out of regular multidisciplinary reviews of complex patients. The Inner North West London Integrated Care case study showed that financial incentives to participate in care planning increased participation in the process but not necessarily commitment to its value. A 'Care Academy' was launched to improve awareness and understanding and an evaluation of the first year of the Integrated Care initiative reported enhanced interprofessional working and levels of knowledge associated with MDT reviews (Bardsley and others, 2013).

In ChenMed, several methods are used to change clinical practice, which blend whole-organisation systems and processes with changes in frontline professional practice. Thus, a supportive context for delivering high-quality care is achieved through investment in infrastructure such as information technology systems, patient transport, data analytics and decision support tools. This is strengthened by:

- regular clinician-to-clinician peer review
- co-location of different professionals
- role modelling by clinical leaders.

The need for standardised internal systems to support change

ChenMed uses standardised operating systems for physicians and patients to support the organisation and delivery of care. Rather than incentivising physicians to carry out specific interventions, standardised room layouts, pathways and operational processes have been developed as a core element of ChenMed's tightly managed health system. These are seen as an important way to promote safety and efficiency and to support high-quality, patient-focused care.

The Vitality Partnership also reported using standardised operating processes to support its efforts to change and improve clinical practice. It has created a standardised approach to integrate new practices into the larger organisation (when Vitality merges with a practice). Managerial staff follow a codified process for merging clinical and organisational information into the Vitality systems and clinical staff ensure that gaps in the care of incoming patients are addressed. This approach also allows staff to work in different clinical sites. Also, regular monitoring of an organisational dashboard allows the Vitality Partnership to track improvements (where these are needed) in the incoming practice.

Leadership for transforming care

The nature of the leadership that underpinned efforts to change and improve care varied between the case study sites. In Inner North West London, a whole-system leadership group spanning health and social care had secured investment in information technology and established governance arrangements to support the introduction of care planning and multidisciplinary working. At the same time, local GP leaders were important in explaining the ambition of using care planning and MDT working to improve care for older people in order to reduce hospital admissions.

This helped to engage clinicians, but micro-incentives also played an important part in building participation in MDT meetings.

This contrasted with the early phase of integrated working in Greenwich where two senior managers (one in community services, the other in social care) were widely seen as ‘inspirational’ and instrumental in kick-starting integrated working. They had support from their executive officers, who freed up their time and provided limited resources to engage staff in a programme of change. However, the role of the two senior managers in explaining the potential for integration to improve care and modelling collaborative, flexible, interprofessional working was seen as central to success. As the integrated teams have become more established, the current team managers (drawn from both community services and social care) are increasingly taking on a leadership role, maintaining the culture and working patterns of integration.

In Nene CCG, there was a history of integrated working across the health economy. Leaders of those historic initiatives have collaborated with GP leaders in each of the GP clusters, focusing on benefits to patients and to the whole-health economy.

An interesting question was raised in the plenary discussion about how to achieve transformational change and improvement when there are no obvious inspirational leaders working in a health economy. Responses focused on the importance of developing and communicating a coherent narrative for change that explains potential benefits to patients. Drawing on work by Casalino (2011a), a narrative that also includes potential benefits to clinicians, going beyond a focus on financial incentives, will stand more chance of success. Casalino identified four main groups of clinician benefits that increase the likelihood of clinicians’ participation in change:

- a better working day
- better outcomes for patients
- better income (that is, financial incentives)
- recognition or peer approval for working in new ways.

Recommendations

Drawing on the case studies, the views and opinions of the workshop participants and the wider literature, in this section we suggest six ways to support the transformation of frontline professional activities in general practice. These overlap to some extent with the findings of a recent report by the Health Foundation entitled *Constructive Comfort* (Allcock and others, 2015), which concluded that change could be supported through a combination of:

- people-focused initiatives to inspire and engage staff
- methods (such as incentives and targets) to ‘prod’ organisations to change
- proactive support to enable staff to change the way services are delivered.

However, we suggest here that the amount of ‘prod’ should be limited, and focused on a narrow range of carefully designed priority areas for change.

Successful transformation of general practice will certainly require a strong focus on proactive support in various forms, outlined below. Perhaps more than this, it will need:

- time and headspace for people to engage
- a willingness to take risks – for not every initiative will succeed
- considerable patience – for transformation does not happen quickly.

1. Strike a different balance between financial micro-incentives for small-scale change and investment for sustainable improvement in general practice

The current combination of national and local incentive schemes and contract performance measures risks overwhelming GPs and limiting their ability to engage with efforts to achieve sustainable, transformational change. All stakeholders in primary care development, including commissioners, NHS England, regulators and politicians need to identify a small number of priorities for change to be supported by a multi-faceted investment programme linked to a limited number of carefully designed financial incentives.

In their research into the use of incentives in primary care, Macdonald and others (2010) concluded that financial incentive programmes tend to be relatively blunt instruments which are not well suited to contexts of high goal ambiguity and complexity. This can lead to prioritisation of some goals over others, as well as unintended and dysfunctional consequences. The authors argued that the dysfunctional consequences can often be predicted and incentives can be designed to reduce the risk of perverse outcomes if careful attention is paid to defining the varied problems they are intended to solve.

The concept of investment in change advocated by workshop participants *can* co-exist with the use of financial incentives, so long as the latter do not become overwhelming. Furthermore, the AQuA programme and the professional development model used by ChenMed illustrate the diverse approaches that can be combined together to achieve fundamental changes in service delivery. These are described further in the accompanying [literature review](#) (Barai, 2015).

Co-commissioning offers CCGs an opportunity to rethink the use of micro-incentives that have underpinned many commissioning incentives and GP development schemes to date. Prioritising a limited number of transformation initiatives, using multiple levers for change that combine developmental support, workforce development and limited use of carefully designed financial incentives, may be the best route to sustainable change and improvement in the future.

2. Create a greater coherence between existing workforce strategies and training curricula that ensure exposure to new ways of working

In the short term, support is needed for novel approaches to workforce development that:

- involve different staff groups within general practice, not only GPs and nurses
- promote inter-professional working
- increase exposure to new forms of consultation
- support the development of new roles such as care navigators.

In the longer term, the bodies responsible for professional training need to broaden their curricula and the numerous existing workforce development strategies need to be harmonised to ensure that newly qualified practitioners are capable of multi-professional, technology-enabled, patient-centred professional practice.

Design principles for general practice set out in *Securing the Future of General Practice* (Smith and others, 2013) describe how current practice might adapt in order to deliver care in future. The principles suggest that, in future:

- GPs will need skills in consulting using new technologies and adapting their consultation style and content to individual patient needs
- other practice staff will play a greater part in care navigation
- managerial staff will have a key role in the strategic development of general practice and will need skills to work across organisational boundaries.

The principle that general practice is delivered by a multidisciplinary team, making full use of all team members, creates opportunities to extend the scope of practice of current staff and also to develop new professional roles such as doctors' assistants.



General practice delivered by a multidisciplinary team creates opportunities to extend the scope of practice of current staff and also to develop new professional roles

Experience from the Greenwich case study site suggests that this kind of transformation depends on fundamentally changing professional relationships, requiring extensive staff engagement and interprofessional collaboration to redesign services. This takes time and is hard to achieve in addition to routine work (NHS Greenwich Clinical Commissioning Group, 2014).

Novel short-term workforce development programmes are emerging across England, but their success is likely to depend on creating time and headspace for staff from different professional groups to participate. In London, a new educational infrastructure is emerging in the form of Community Education Provider Networks (CEPNs). These bring together health and social care providers, community groups and education providers to create learning communities that can learn from each other in order to improve public health outcomes (NHS Confederation and NAPC, 2014).

ChenMed has illustrated another, multifaceted approach to training and skills development using multiple in-house methods to support clinicians to practise in new ways. And innovative general practice organisations such as AT Medics (London) are using web resources across their network of practices to offer training and development for all practice staff, reducing working hours.

Taking a longer-term view, numerous workforce development strategies exist, with overlapping aims and approaches. For example:

- Health Education England's 15-year strategic framework describes a long-term vision to train people through 'system-based' learning – so that they can adapt core professional competencies to specific contexts (Health Education England, 2014).
- A General Medical Council (2013) report on the future of medical training recognises the need for more generalist skills and for exposure to community services during specialist training.
- The Royal College of General Practitioners plans to transform GP training, emphasising a new mix of skills for future GPs, which will combine clinical skills, generalist care coordination skills and leadership skills (RCGP, 2014).

There is perhaps less clarity about training the future general practice nursing workforce. Furthermore, The Queen's Nursing Institute (2013) notes a confusion of titles and roles in the community nursing workforce.

Despite this profusion of strategies, curricula for professional training still lack key elements to ensure that the future general practice (and primary care) workforce has the necessary skills. For example, the Royal College of General Practitioners' curriculum does not include a requirement for training in consultations using new media nor in the analysis and management of population health (RCGP, 2014). In addition, an NHS Careers overview of training for practice managers (NHS Careers, 2015) lacks reference to skills highlighted in *Securing the Future of General Practice* (Smith and others, 2013) – such as strategic planning, business case development, managing innovation, and governance across organisational boundaries.

A single, unified vision for training and skills development is needed to unite medical, nursing, allied health professional and primary care managerial training. Good strategic documents exist for most professional groups but these need to be ‘glued together’ and their scope broadened to include:

- technology-enabled working practices
- public health knowledge and skills
- flexibility across professional roles and organisational boundaries.

3. Develop realistic estimates of the costs of transformation programmes, including the cost of the professional participation

Tools are needed to estimate the costs of transformation programmes to ensure that they are adequately supported in future. Estimates will need to cover the costs of:

- the professional time needed for participation in change programmes
- the development of leadership and other skills
- project management
- organisational development.

In addition, those responsible for the governance of general practice, including NHS England, need to make sure that governance requirements associated with investment in transformation are proportionate, in order to avoid sapping energy and stifling progress through overly onerous reporting arrangements.

The emerging vision for high-quality, scaled-up general practice working closely with other primary care and community providers is gaining traction. This vision has been described in certain strategic documents (see, for example, *Strategic Commissioning Framework for Primary Care Transformation in London*: NHS England, 2014b). However, a coherent approach to supporting change is needed.

‘Enabling’ workstreams have been identified as having an important role in supporting change, including workforce development and investment in premises and technology to support innovative practice and improve access.

Another key enabler will be effective leadership and the involvement of a cadre of clinicians with the time and headspace to engage in the design and implementation of new models of care. This will not be easy given current levels of work stress (Hann and others, 2013). However, the Greenwich and Nene case studies highlighted the importance of involving frontline clinicians in designing and leading the implementation of change. Having established local transformation priorities, investment in a multifaceted change and improvement programme will be essential – with or without the use of financial incentives – of which back-filled clinical time, and resources for skills development and leadership training, are essential elements.

The London Strategic Commissioning Framework for Primary Care Transformation (NHS England, 2015a) estimates that between 2 and 5.3 per cent of the health care budget must be invested to support primary care transformation and at least part of

this investment should go to provider support – for individuals, for practices, for work between practices and for whole-system development.

A model to estimate the scale of investment needed for development programmes is needed to support realistic resource allocation for transformation and might encourage those in charge of change to modify their transformation proposals in line with available resources. Any such model must take account of the range of inputs described above. Furthermore, any investment must be linked to proportionate assurance and governance arrangements to avoid distorting priorities through overly onerous reporting requirements. That said, the Health Foundation and The King's Fund have identified difficulties with raising transition funding, including a lack of funds for the processes of change and one-off costs such as staff training and development (Health Foundation, 2015).

4. Invest in information and data linkage to support transformation

A minimum dataset for general practice is urgently required and the government needs to take the lead on this. Such a dataset should be held by the NHS Health & Social Care Information Centre to support the monitoring of population-level activity and of performance and outcomes. The ability to define baseline activity and quality of care will be an essential starting point for evaluating the impact of change in general practice.

In addition, simple arrangements are needed that are compliant with data governance rules through which to share information between health care providers, with social care and, increasingly, with patients themselves in order to support functions such as risk stratification, clinical decision support and quality improvement.

Despite widespread use of computers in general practice dating back to the 1990s (Protti, 2007), data on general practice and wider primary care are patchy and not linked at a national level. The Quality and Management Analysis System (QMAS) database contains aggregated data from all NHS GP practices, allowing practice-level comparison of clinical outcomes, but does not provide data on inputs or activity. Large research datasets formed through voluntary contribution of data from self-selected practices are available through the Clinical Practice Research Datalink and Q Research Database, but again they do not contain information on inputs.

Data analysis for large patient populations is available to research groups linked to practices that have agreed to share data. For example, the East London research database can draw on data on over 300,000 patients in East London whose GPs have agreed to share data with each other through the EMIS Web data system. All these data on millions of patients are submitted voluntarily by selected practices but are not available to generate routine reports on the activity, inputs or outputs of general practice.

This patchy availability of data on general practice is unacceptable given the high penetration of electronic records and rich combination of datasets that exist. The supply of general practice data to a national primary care dataset should be agreed between government and providers as a matter of urgency.

In terms of sharing clinical information to support care coordination, risk stratification and other approaches to improving patient care, progress has also been slow. The

emergence of scaled-up general practice organisations and implementation of the Prime Minister's Challenge Fund are increasing the number of practices needing to share data through linked electronic records in order to deliver care efficiently. However, data governance issues are an important rate-limiting step in these initiatives. Recent work by the Southend Integrated Care and Support Pioneer site has clarified the barriers to data integration and work is now in progress to address these (NHS England, 2015b). However, labyrinthine information governance processes needs to be simplified urgently if we are to remove barriers to integration and to support data synthesis and analysis for better patient care.

5. Set realistic timeframes for delivering outcomes and managing risk

As new models of care emerge in response to the *Five Year Forward View* (NHS England, 2014a), and larger general practice organisations consider taking on capitated contracts, a sensible trajectory is needed for scaled-up general practice organisations to take on financial risk.

Commissioners should take a pragmatic and realistic approach to risk- and gain-sharing agreements. Evidence suggests that it will take time for providers to learn new ways of working and to implement changes that may deliver efficiencies in the longer term. Financial risk should therefore be introduced gradually to avoid organisational failure.

The use of risk- and gain-sharing arrangements to incentivise quality and efficiency was considered in the previous section in relation to financial incentives. The success of new models of general practice may depend on a gradual adoption of financial risk. ChenMed never takes on full global risk in the first six to twelve months after taking on a new contract with insurers and always starts a new risk-sharing arrangement in shadow form. This approach is widely used in the NHS and was evident in many practice-based commissioning groups when they first started. As noted, a realistic trajectory is therefore needed.

Evidence suggests that clinically led organisations holding budgets at financial risk take years to gain stability and deliver change (Casalino, 2011b; Thorlby and others, 2011). In the US, the majority of emerging accountable care organisations have opted for gain-sharing contracts in their early years, rather than mixed gain sharing and risk sharing (Jha, 2015). In England, a range of GP provider organisations have been operating at financial risk for years, taking on Alternative Provider Medical Services (APMS) contracts to run practices and practice-based commissioning contracts to run services. However, losses have followed from some of these contracts. Furthermore, lessons from the US (Casalino, 2011b) suggest that many will fail if they:

- take on too much too quickly
- do not conduct risk adjustment accurately
- do not manage financial risk effectively.

6. Avoid excessive policy to guide primary care transformation

Focus instead on a creating a permissive culture for experimenting with new approaches to primary care.

The broad policy direction towards larger-scale GP organisations and new models of care is articulated in the *Five Year Forward View* (NHS England, 2014a). An array of guidance exists about policy implementation and CCGs and emerging GP provider organisations have some clear opportunities to redefine the role of general practice through whole-system reconfiguration and care pathway redesign. However, GPs are already overwhelmed by the demands made of them and are starting to turn down participation in incentive schemes (Lind, 2013).

Rather than more policy to codify and shape change, a period of permissiveness is required – in which emerging GP organisations are allowed to experiment and, at times, to fail. However, a delicate balance will be needed between this permission and freedom to test out new ways of working and proportionate governance and accountability for the investment of public funds to support change. Methodological challenges also exist in terms of how to evaluate things rapidly to identify what works and then disseminate learning about success. Here too a proportionate approach is essential so that innovators are not bogged down in excessive reporting and research requirements.

Conclusion

There is significant change already in progress across general practice. While numerous different mechanisms are being used to drive and support change, there has been a heavy dependence on micro-incentives. These have delivered important improvements, which have sometimes been sustained, but it is time to shift the levers for change into new settings.

Past efforts to achieve change in isolated (albeit important areas) of clinical practice need to give way to a broader set of approaches. A different balance is needed between initiatives focused on clinical quality and outcomes and those which seek to redefine the role of primary care in whole-system changes. It is vital that policy-makers understand the impact of the various levers that they use and how they interact with each other.

Appendix: List of participants in the workshop

Name	Role
Kushal Barai	Academic visitor, Nuffield Trust
Sarb Basi	Managing Director, Vitality Partnership
Keziah Bowers	Project Officer, Primary Care Transformation, NHS England London
Eleanor Brown	Chief Officer, Merton CCG
Nigel Edwards	Chief Executive, Nuffield Trust
Jane Fryer	Responsible Officer for South London, NHS England London
Jemma Gilbert	Head of Primary Care Transformation, NHS England London
Steve Gillam	General Practitioner
Anita Goraya	Director, Ernst & Young LLP
Ben Gowland	Chief Executive, Nene CCG
Richard Lewis	Partner, Ernst & Young LLP
Louisa Pettigrew	Visiting Clinical Fellow, Department of Health Services Research and Policy, London School of Hygiene and Tropical Medicine
Stephen Richards	Regional GP Advisor, Care Quality Commission, London
Rebecca Rosen	Senior Fellow, Nuffield Trust
Ros Roughton	Director of NHS Commissioning, NHS England
Sarah See	Director of Primary Care Improvement, Barking and Dagenham, Havering, and Redbridge CCGs
Mark Spencer	Deputy Regional Medical Director, NHS England London
David Sturgeon	Head of Primary Care, NHS England South London
Matt Sutton	Professor of Economics, Manchester University
Simon Webley	Research Director, Institute of Business Ethics
Kecia Wherry	Former Richmond Market Manager, ChenMed

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About the author

Rebecca Rosen is a Senior Fellow in Health Policy at the Nuffield Trust and a General Practitioner in Greenwich. She is also an accredited public health specialist. Her current policy interests include integrated care, primary care, new organisational models for general practice and NHS commissioning.

Rebecca is a clinical commissioner in Greenwich Clinical Commissioning Group, where her lead areas are long-term conditions and primary care development. Within her GP practice, Rebecca leads work to improve the continuity and quality of care for people with chronic complex ill-health and to apply the principles of the chronic care model in a practice setting.

In the past, Rebecca has worked as Medical Director of Humana Europe; as a Senior Fellow at The King's Fund; and in NHS and academic public health departments. Past research interests include the diffusion of new medical technologies, patient choice and primary care policy.

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Telephone: 020 7631 8450
Facsimile: 020 7631 8451
Email: info@nuffieldtrust.org.uk

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