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# Is bigger better? Lessons for large-scale general practice

*Research summary*

*Rebecca Rosen, Stephanie Kumpunen, Natasha Curry, Alisha Davies, Luisa Pettigrew and Lucia Kossarova*

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## About this report

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

This research summary presents the key findings from a 15-month study of large-scale general practice organisations in England. It was informed by an extensive literature review, and combined national surveys with in-depth case studies of contrasting, large-scale general practice organisations and analysis of 15 quality indicators.

**The full report can be accessed at: www.nuffieldtrust.org.uk/large-scale-general-practice**
**Read the literature review at: www.nuffieldtrust.org.uk/large-scale-general-practice-literaure**


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# Contents

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

This research summary is drawn from a 15-month study of large-scale general practice organisations in England. The study examined the factors affecting their evolution and their impact on quality, staff and patient experience. It was informed by an extensive literature review, which is published separately, and combined national surveys with in-depth case studies of contrasting, large-scale general practice organisations and analysis of 15 quality indicators.

This summary presents the key findings and conclusions from each aspect of the analysis. The summary also provides a set of recommendations that are primarily for policy-makers and commissioners to enable them to create a receptive context in which emerging groups can thrive. The full report, available at www.nuffieldtrust.org.uk/large-scale-general-practice, provides additional detail on all of the research themes, together with practical guidance drawn from the case studies to assist emerging groups with developing their organisations.

## Key points

### Rate of formation

Our survey found that almost **three quarters of GP practices are now in some form of collaboration** with other practices, almost half of which formed during 2014/15. The two most commonly cited reasons for forming were to 'achieve efficiencies' and to 'offer extended services in primary care'.

### Sustainability

The case studies demonstrated how **larger scale can help to improve sustainability in core general practice** through operational efficiency and standardised processes, maximising income, enhancing the workforce, and deploying technology. The ability of organisations to create a more sustainable workforce by broadening skills, creating role flexibility and role enhancement through peer support was particularly valued by staff. However, the leadership and resources needed to develop and maintain the organisation and introduce these approaches are significant.

### Governance arrangements and models of change

Governance arrangements varied considerably and changed over time. The case studies highlight the **importance of board accountability to member practices in order to build trust and engagement** and the role of the board in allocating resources to achieve organisational goals.

Methods for implementing strategic plans and changing services in member practices were influenced by whether the larger organisation or member practices held contracts for core general practice services. A more directive style of change was seen where the central organisation held these contracts while federated practices that retained their own contracts demonstrated a more consultative or 'concertive' approach to managing change.

## Quality of care and patient satisfaction

The **case study sites routinely used quality improvement methods** such as peer review, electronic clinical templates and standardised coding. However, our analysis of 15 quality indicators in eight of the GP Learning Network organisations was **unable to detect marked differences in quality of care compared to the national average**. Nor was there evidence of consistent improvement over time or reductions in organisational variation between member practices across the indicators considered. There were significant improvements in prescribing indicators, but no single large-scale organisation consistently outperformed or underperformed the others on all indicators, and three of the case study organisations performed significantly better than the national average on over half of the measures.

## Patient involvement and experience

**Patients had mixed views about large-scale general practice**. Some patients valued new forms of access but others voiced concerns about losing the ongoing, trusted relationship with their own GP and their own practice. Emerging organisations must find ways to harness the benefits of larger scale while preserving the localism and 'expert generalism' of general practice. The case studies also demonstrated that large-scale general practice organisations can use their resources to engage with their surrounding communities.

## Staff experience

**Staff were broadly positive about working in a large-scale organisation**, with administrators and receptionists reporting the highest overall satisfaction scores and salaried GPs reporting the lowest. They particularly valued education and training opportunities and peer support arrangements across practice boundaries, which provided rapid access to clinical and operational advice and reduced professional isolation.

## Extending the range of services offered

The case study organisations have **established high-quality specialist clinics** in the community that are popular with patients, but are **mainly small scale at present**. None of them had yet tried to redesign care delivery across a whole speciality or operated at the scale envisaged for new models of care.

## Working with the local health economy

**Relationships with commissioners and providers influenced the ability of general practice organisations to extend their remit beyond core services**. The quality of relationships with specialists shaped their potential to deliver extended services, while the quality of relationships with CCGs – in terms of trust, engagement and collaboration – shaped the role each organisation could play in its local health economy. It was harder for organisations that crossed CCGs to build relationships with commissioners.

CCGs had to **manage the paradox of supporting large-scale groups to develop so they could contribute to commissioning plans while also managing conflicts of interest**. These arose because GPs were both CCG members and owners of these private provider organisations. However, while some were for-profit, others were community interest companies and so far, all had reinvested savings back into their organisations.

## Realistic expectations

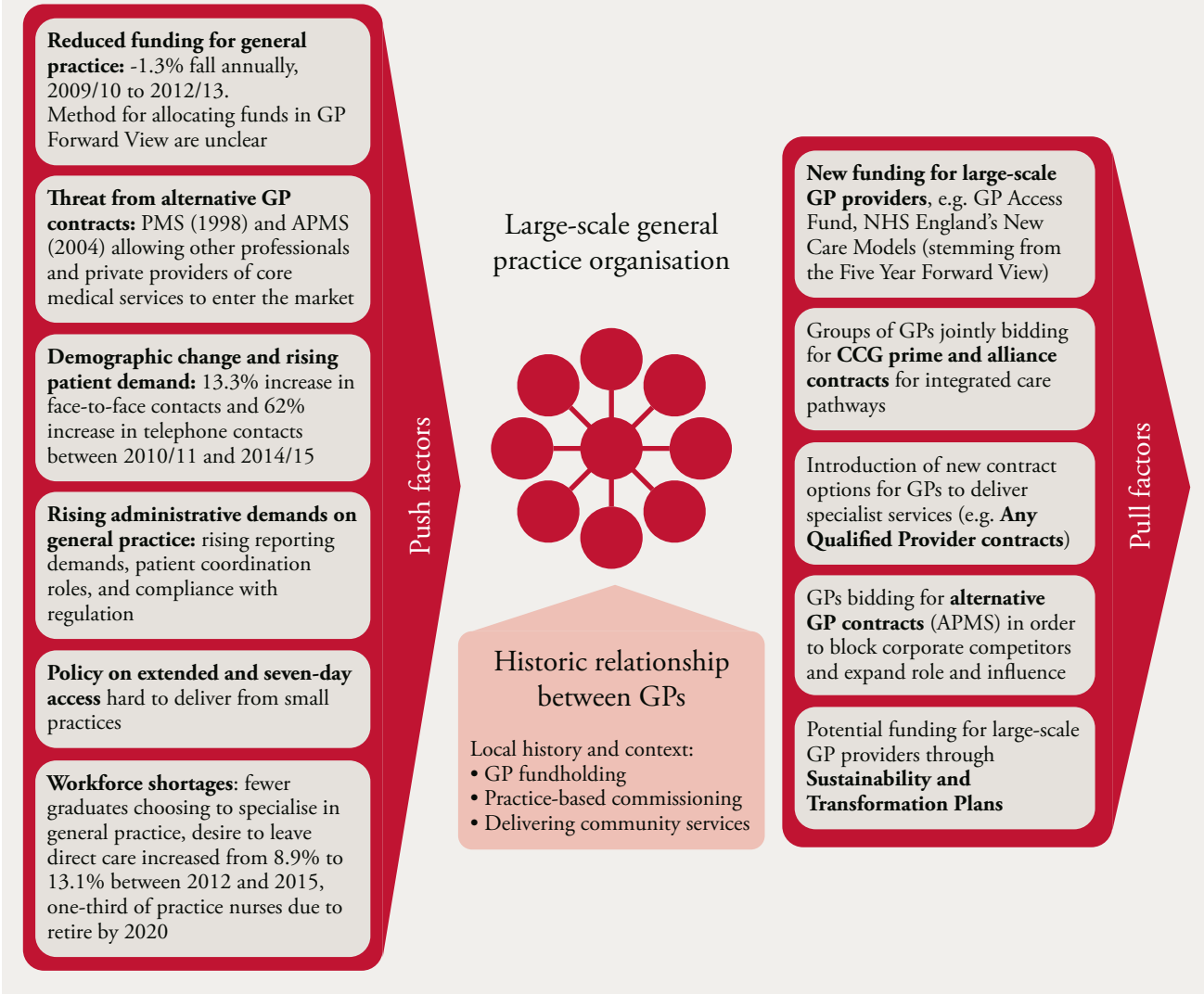
The case study organisations had been operating for many years and **newer groups may struggle to establish the systems needed** to deliver efficient, high-quality services if too much is asked of them too quickly. National and local policy-makers and commissioners need to have **realistic expectations of what large-scale primary care organisations can achieve** in their early years.

# Introduction and context for this research

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

But it is also changing, and after over 20 years of collaboration in relation to activities including fund-holding, practice-based commissioning and out-of-hours cooperatives, over three quarters of practices are now working with other practices to deliver services at larger scale. Some have been pushed into collaborating in order to withstand pressures on individual practices such as falling funding and workforce shortages. Others have been pulled together by a desire to bid for new funding streams and contracts only offered to larger groups. The factors driving change are summarised in Figure 1.

Figure 1: Push and pull factors driving collaboration in general practice



Literature from the last 20 years describes collaborations between groups of GPs and other health professionals including clinical commissioning, out-of-hours services, integrated care initiatives and clinical networks. While little of this focuses on large-scale general practice organisations, some insights can be extrapolated from research on other forms of collaboration. This suggests that enforced collaboration can result in clinician disengagement and dampen innovation compared to collaborations that have emerged from the bottom up (Goodwin and others, 2004; Guthrie and others, 2010). If current collaborations emerge from past organisations, legacy relationships exist which may facilitate or hinder progress (Erens and others, 2015; Miller and others, 2016). Research also suggests there are important trade-offs to be made in terms of size, hierarchical or flat governance structure, forming loose networks or tightly run single organisations and different ownership models.

Four studies of the impact of general practice networks on quality reported improvements in selected quality indicators (Cockman and others, 2011; Hull and others, 2013; 2014; Robson and others, 2014), although this followed significant financial investment and organisational development support which may not be generalisable in other areas. To date, there has been very little economic evaluation of different forms of large-scale general practice organisations in England, so their cost effectiveness remains unknown. Likewise, there have been no studies evaluating their impact on patient experience.

Overall research suggests that the theoretical potential of large-scale collaborations between health professionals is not always realised as expected and the time, resources and personal effort needed to form and run them are often underestimated (see full literature review by Pettigrew and others, 2016).

Whatever has drawn them together, these groups are now seen by policy-makers as an important part of the future NHS landscape – resilient to the pressures affecting smaller general practices and forming the basis of the new models of care described in the *Five Year Forward View*. With over 260 large-scale general practice organisations now formed, how ready are they to take on the new roles envisaged for them, and how can policy-makers support them to take on these roles? This summary presents the key findings and recommendations to practitioners and policy-makers from a 15-month study of large-scale general practice.

## Research aims and methods

The research aimed to assess how general practice is changing, and to assess how quickly, why, and in what form new large-scale provider organisations are forming. Also, for a group of four mature organisations, the research looked in depth at:

- How they have emerged and evolved over time
- How organisational, local, national and other contextual factors have affected their ability to achieve their goals
- What impact the organisations are having on their patients, staff and local health economies
- Whether these large-scale general practice organisations have had an impact on quality of care.

Research methods comprised:

- Two national surveys of GPs and clinical commissioning groups (CCGs) undertaken in collaboration with the Royal College of General Practitioners.
- Case studies of four mature, large-scale general practice organisations which were selected (from members of the Nuffield Trust General Practice Learning Network) as archetypes of the four main organisational forms for large-scale general practice that have emerged in recent years.
- Quantitative analysis of 15 quality indicators over time (2009–2014/15) to assess the impact of large-scale general practice organisations on four domains of care: prescribing, use of hospital services, Quality and Outcomes Framework performance, and patient satisfaction. Data were analysed from eight large-scale general practice organisations, including three of the case study sites and five others which are members of the Nuffield Trust General Practice Learning Network.

The following sections present findings from the national surveys and provide a summary of the key findings from a set of key research themes.

# Survey findings: extent of collaboration and current activities

Responses were received from 94 CCGs (45% of all CCGs) and from 982 GPs and practice representatives (from 184 CCGs, 87% of all CCGs) who identified their affiliations with about 210 large-scale collaborations. Full results are available online.

## What do large-scale general practice collaborations look like?

- 73% of practice-based respondents reported that their practices worked in collaboration with other practices
- 44% of respondents said that their main 'collaboration' formed during 2014/15
- 84% of respondents said their collaboration was with practices in the same CCG area.

Of those who said that they were part of a formal collaboration:

- 66% provided care for 50,000 or more patients
- 64% of practice-based respondents described their organisational forms as a federation of independent practices – only 2% were super-partnerships.

## Why did large-scale collaborations form and what did they aim to achieve?

Among the stated motivations for collaborating, the top two were to 'achieve efficiencies' and to 'offer extended services in primary care'. The third most common reason was because their 'CCG had encouraged them', with a few respondents reporting that their collaborations formed to avoid being left out of tendering for contracts offered by their CCGs to incentivise collaboration.

Their main achievements since founding are summarised in Table 1, illustrating the time it takes to achieve the theoretical potential of collaborations described in the literature.

**Table 1: Achievements of existing large-scale general practice organisations (2015)**

| 0–12 months (n=151 collaborations) | 13–24 months (n=100 collaborations) | 25+ months (n=97 collaborations) |
|---|---|---|
| • Developed an organisational strategy or plan (n=38) | • Extended the range of services available in primary care settings (n=34)<br>• Invested in staff training and development (n=29) | • Extended the range of services available in primary care (n=43)<br>• Aligned clinical pathways (n=37)<br>• Developed new ways for patients to access services (n=37)<br>• Pooled human resources (n=36)<br>• Invested in staff training and development (n=34)<br>• Introduced more flexible opening hours (n=33)<br>• Developed an organisational strategy or plan (n=30)<br>• Introduced new clinics (n=29)<br>• Developed back-office functions/processes (n=29)<br>• Brought in new workforce from community and social care (n=28)<br>• Collectively invested in information technology (n=25)<br>• Carried out peer review (n=24) |

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

Source: Kumpunen and others (2015)

## What support is needed?

Practice-based and CCG respondents agreed that the main challenges faced when forming were building trust between practices; convincing all members of the benefits; and finding time to develop collaborations. To overcome some of these challenges, practice-based respondents suggested that their most urgent need was help with managing demand for general practice services (potentially to free up time to participate in network development). They also wanted support with organisational development and legal advice. However, CCGs acknowledged that demand management was an issue, but prioritised the need to develop new leaders in the NHS.

## Learning from established organisations

Case studies were conducted in four contrasting large-scale organisations. All of them formed between eight and twelve years ago, so each had extensive experience of working at larger scale than traditional general practice. Each also had experience of adapting the services they provide in response to local and national changes in policy and commissioning priorities. The sites were:

- **AT Medics Ltd:** a multi-site provider of general practice services focused on improving quality and developing educational support within practices.
- **GP Care Ltd:** a federation owned by 100 GP practice shareholders providing community diagnostic services and collaborating in a GP Access initiative.

- **Harness Healthcare Ltd:** a federation and community services provider rooted in its local community, formed to improve quality of care, reduce health inequalities and ensure sustainability of general practice.
- **Modality Partnership LLP:** a GP super-partnership rooted in its local community and formed to improve general practice and extend the scope of services provided, now embracing the Five Year Forward View challenge of leading whole-system change.

The organisations were archetypes of the main organisational types that were identified in the national surveys as forming across the country, as illustrated in Figure 2.

The main characteristics of the four study sites are shown in a table in the full report and are presented in brief here in Table 2. Key findings and practical suggestions on each analysis theme are summarised below. The full report provides additional detail about each theme together with practical guidance drawn from the case studies to assist emerging groups with developing their organisations.

Figure 2: Organisational forms of large-scale general practice organisations

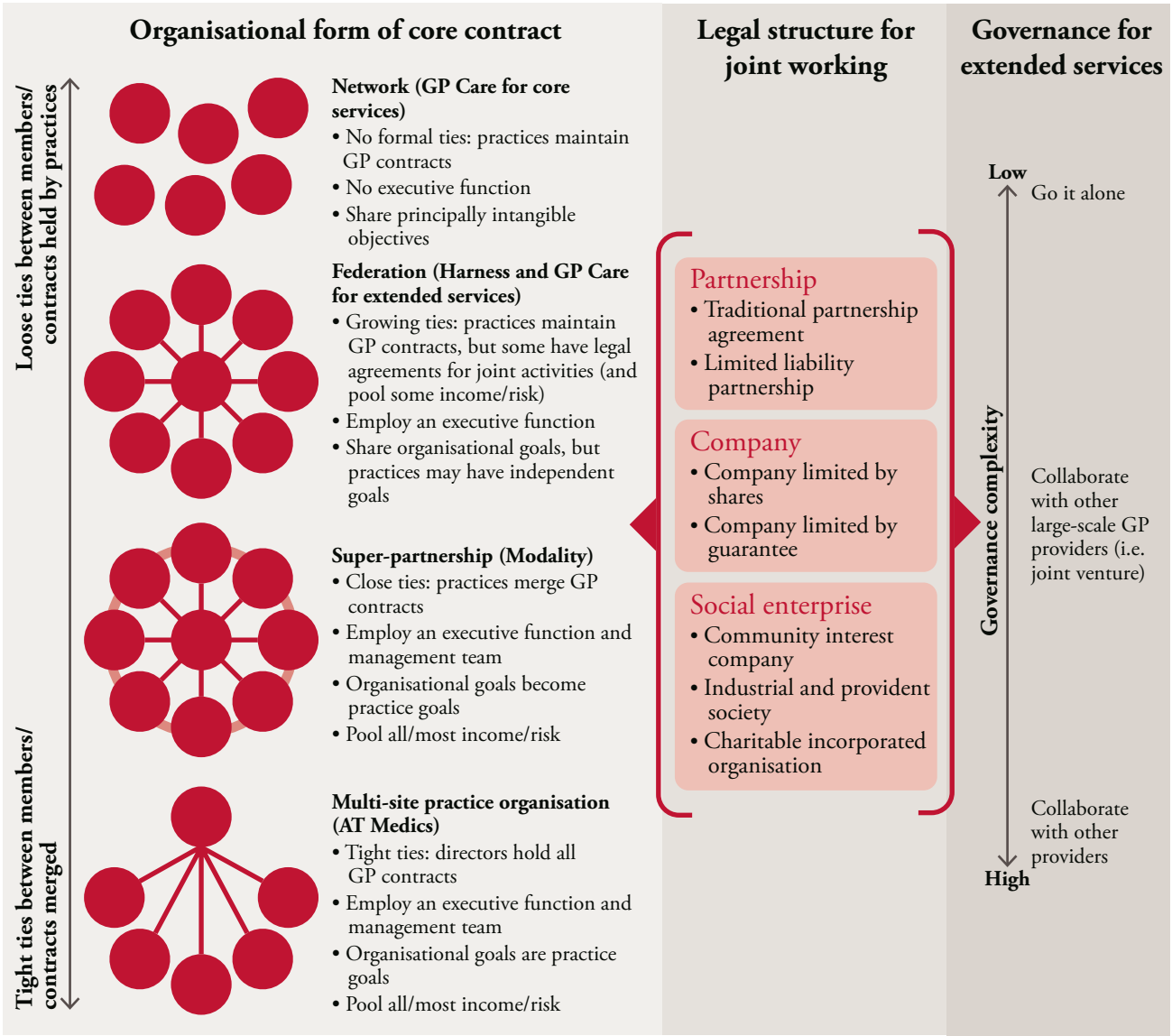


Table 2: Summary overview of the case study organisations

| | AT Medics | GP Care | Harness Healthcare | Modality Partnership (formerly Vitality Partnership) |
|---|---|---|---|---|
| **Founding aims** | • To run general practices in ways that improve quality, efficiency and access for patients, focused mainly on practices in deprived areas<br>• GP training | • To deliver community-based specialist services<br>• To protect local community services offered for tender from being taken over by private providers | • To create a support network among local practices to improve local health outcomes and reduce inequalities<br>• To protect local general practice from take-over | • To create a large partnership to provide sustainable and high-quality integrated services<br>• To improve patient experience and be the preferred provider of primary care services in the region |
| **Year founded** | • 2004 | • 2006 | • Harness GP 2006<br>• Harness Care 2008<br>• Harness Health 2014 | • 2009 |
| **Location** | • London (working in 12 CCGs) | • Bristol, North Somerset and South Gloucestershire | • Started in Harlesden/Neasden, a locality in Brent CCG | • Greater Birmingham (coterminous with 3 CCGs) |
| **Legal status, organisational form and structure** | • A limited for-profit company<br>• A single-parent company, running 26 general practices across London through time-limited contracts | • A company limited by shares (changed from a limited liability partnership in 2008)<br>• Also participating in a joint venture with the BrisDoc out-of-hours service called 'One Care', to deliver Prime Minister's GP Access services | • A group of companies (best described as a federation) to suit the legal needs and values of members, formed of:<br>  • 1 GP cooperative of 19 practices<br>  • 1 limited not-for-profit company<br>  • 1 limited for-profit company | • A super-partnership. All partners joined contracts into a limited liability partnership<br>• Number of sub-organisations including property, community interest and private organisations<br>• Some companies are for profit; community interest company is not for profit<br>• Run by an executive board with support from a senior management team on behalf of GP partners |
| **Number of practices** | • 1 (2004)<br>• 18 (2014)<br>• 20 (April 2016) | • 80 (2008)<br>• 100 (April 2016) | • 12 (2006)<br>• 16 (2008)<br>• 21 (2014 and April 2016) | • 2 (2008)<br>• 9 (2014)<br>• 16 (April 2016) |
| **List size, April 2016** | • 135,000 patients | • Shareholders have a combined list size of 800,000 patients | • 120,000 patients | • 87,556 patients |
| **Contract types** | • APMS<br>• NHS standard contracts for unscheduled care services | • 3-month rolling community-based specialist and diagnostic services, mainly in the Bristol area but some are in more distant CCG areas<br>• 1-year NHS contract for the Prime Minister's GP Access Fund | • Cooperative arm: GMS, PMS<br>• Provider arm: APMS<br>• NHS standard contract for walk-in services<br>• Local authority contract for public health services | GMS, PMS, PMS+ |

# Findings from the case studies

## Organisational structure and governance arrangements

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

## Leadership and culture: managing and supporting change

- A range of leadership styles were observed to change the day-to-day work of member practices. A more 'directive' style was seen where the central organisation held individual practice contracts, although this was not used if the executive team thought that compelling clinicians to change practice would reduce engagement or damage trust. A more collaborative style of 'concertive' change management – informed by data about variation and implemented through peer pressure, peer review and outreach support from the central team – was seen where practices were federated and held their own contracts.
- Leaders in the case study organisations worked long hours and fulfilled many roles in their organisations. This kind of 'heroic leadership' appears to be effective at engaging staff and delivering change, but may not be sustainable over time.
- If rapid change is required in the way services are delivered, then member practices may need to cede decision-making authority and control (temporarily or permanently) of day-to-day work processes to the larger-scale organisation.
- Implementing standardised processes and new ways of working requires considerable time from leaders and senior managers as well as other resources. Boards and executive teams must ensure the necessary resources are available.

## Enhancing financial and organisational sustainability

- Organisational sustainability can be improved through operational and administrative initiatives to improve efficiency, technology and workforce redesign. Measures to improve efficiency included centralised administration teams and central call centres to book appointments as well as standardised operating processes and joint procurement of equipment and services.
- Technology was used to increase administrative efficiency through web-based functions (such as new patient registrations, remote data searches and automated performance reporting). Shared clinical information technology systems were also important to support standardisation and to improve communication among staff.
- Workforce initiatives that improved sustainability aimed to increase role flexibility and develop additional skills in practice staff, enabling them to cover each other across member practices and to deliver additional services that may generate income. Formal and informal support networks were highly valued by most interviewees and helped to reduce the sense of isolation felt by staff in small practices.

## Improving and assuring clinical quality

- Monitoring and improving quality was reported as a priority for each central management team with significant resources allocated to identifying and addressing weak performance in individual practices and services.
- Methods used to improve quality and reduce variation included:
  - Education sessions for all staff groups
  - Informal real-time advice from colleagues about managing complex patients (using instant messaging)
  - Help from peers to deliver interventions to meet targets (e.g. immunisations)
  - Sharing data on practice performance among senior staff.
- Organisational systems and processes for quality assurance and improvement included:
  - Unified computer systems across sites to support data extraction for comparative audit
  - Routine review of quality and key performance indicator dashboards by senior teams
  - Use of standardised protocols and reporting templates across all sites.
- Clinical and managerial leaders played an important role in building a culture where quality was considered important by modelling adherence to clinical guidelines when working in different practices and responding promptly to address identified problems.

## Staff experience, training and education

- Data from the staff survey showed that:
  - Most staff reported that they valued working in large-scale organisations, but they felt more engaged and cared for by the leaders of their own practice than leaders of the larger organisation.

  - Salaried GPs were the least satisfied of all roles with their overall employment situation, while administrators, receptionists and GP partners were among the most satisfied.

- Most staff valued rapid access to peer support with clinical and operational problems through organisation-wide networks, as well as training and career development opportunities offered by the wider organisation.
- The infrastructure, meetings and relationships that enable advice and peer support across practice boundaries take time to build but do not necessarily require significant financial investment.
- Staff valued contact with senior leaders – both through their role in training sessions and through informal day-to-day contact – which helped to build trust in their leadership and engage staff in service changes.

## Patient experience and involvement

- There was little patient involvement in the decision to operate at larger scale in any case study site. Patient participation groups (PPGs) were typically informed after the decision had been made and were subsequently invited to help to design shared services.
- PPG interviewees suggested that some patients were anxious about larger-scale organisations because they feared losing access to their regular GP and not being recognised by staff.
- Whole-organisation patient meetings did not seem to have drawn our patient interviewees into working with other practices and there was continued appetite for PPG meetings based in individual practices, which may be a good place to address patient anxieties about losing contact with the practice and their usual doctor.
- Links between large-scale general practice groups and local civic and community groups can create new opportunities for delivering services and promoting health and wellbeing.

## Working with providers and CCGs across the system

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

### Relationships with CCGs

- General practice provider groups whose member practices were located in a single CCG had an interdependent relationship with their commissioner, while multi-site providers operating over several CCGs found it harder to build collaborative relationships and thought they were less likely than local groups to win bids to deliver services across a CCG.
- Relationships with CCGs developed over time and appeared to be strengthened if the general practice organisation could address population health need or help to achieve commissioning priorities. Conversely, it was harder to build good relationships and trust where CCG staff perceived the large-scale general practice organisation as a private company motivated by profit. At times, this created a

dilemma for CCGs about the acceptability of investing resources in order to help the organisations to develop.

- The inherent conflicts of interest between GPs in their provider and CCG roles were managed by ensuring that GPs who hold executive positions in both provider and commissioner organisations either stood down from one role or declared their conflicts and assessed whether they made a CCG role untenable. However, CCGs needed to use the expertise of GPs who had developed extended services in provider organisations to help redesign clinical pathways.

### Relationships with providers

- The majority of specialist services we learned about were grounded in strong, trusting relationships with a small number of specialists who contributed to service delivery but did not necessarily engage other specialist colleagues in their hospital department.
- Developing specialist clinics can be resource intensive and may not result in the strong relationships with specialists that are needed if whole pathways of care are to be transformed to enable fuller integration between primary and secondary care.

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

We analysed data from eight large-scale general practice organisations, including the three case study sites delivering core general practice services, in a detailed quantitative analysis to determine how quality in large-scale organisations compared to the national average and changed over time.

Our aim was to select a range of indicators of primary care quality, including those covering:

- areas of care nominated by network members as having potential to improve through working at scale
- areas of care identified in published literature as having potential for improvement in large-scale organisations. Over 400 measures were examined and the final indicator list included 15 indicators as proxies for the quality of care across four domains.

### Findings

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

**Quality and Outcomes Framework:** We were not able to monitor trends in Quality and Outcomes Framework (QOF) indicators over time, as indicator definitions changed too frequently during the period of analysis (2009–2014). We therefore analysed performance relative to the national average at single points in time. Half

of the organisations performed significantly better than the national average on total QOF (in 2014), clinical QOF (in 2014) and organisational QOF (in 2013).

**Hospital activity and patient satisfaction** (four indicators each): Performance on the indicators of hospital use by registered patients and patient satisfaction showed trends of deterioration over time which mirrored national patterns. The trends may reflect wider challenges in the health and care sectors, and the limited influence of general practice on unscheduled hospital use.

**Overall:** We were unable to detect marked differences in the quality of the large-scale general practice organisations compared to the national average – most organisations followed national trends. No single organisation consistently outperformed or underperformed the others on all indicators. We also examined the variation in performance of member practices within organisations and similarly found no patterns. There were also no associations between characteristics (such as size, geographic location of member practices, or organisational form) and explained differences in performance.

There are a number of limitations to this analysis of quality indicators. We did not measure how organisations performed against their own, specific quality improvement goals – which would have required data collection and analysis beyond the scope of this study, and would not have allowed comparison across organisations. Regular changes in the membership of large-scale organisations created a methodological challenge, complicating efforts to quantify changes in quality of care over time, especially when the consistency and representativeness of the indicators also changed (e.g. QOF). Finally, we only analysed a sample of eight large-scale organisations – only a fraction of the many heterogeneous, large-scale general practice organisations that now exist. Therefore, our quantitative findings should be interpreted cautiously when drawing conclusions about the ability of large-scale organisations to improve quality of care.

# Conclusion

## Aspirations for scaled-up general practice

Our research highlights the pace at which large-scale general practice organisations are forming, albeit with varied objectives and different levels of support from their local CCG. Despite the variability, we identified three broad inter-related aspirations across both emerging and mature groups: **sustaining core general practice; delivering extended services;** and **leading a population health system** (seen in one case study site). These were not mutually exclusive and it is possible to offer support to member practices while also developing wider services and roles.

### Sustaining core services

The case study organisations contributed to the sustainability of member practices by **improving efficiency and maximising income, making selective use of technology and strengthening the workforce**. Efficiencies were achieved through centralised management and administrative activities, standardised and streamlined operating processes, and centrally employed staff who helped practices to improve performance. The use of technology contributed to sustainability through clinical, training and administrative functions and underpinned the delivery of new forms of access. Workforce initiatives relating to role sustainability, teaching new skills and enhancing job satisfaction all contributed to the sustainability of services. Many of

these approaches were beyond the reach of an average-sized practice and illustrate how larger organisations can invest resources that can be shared across practice boundaries. However, implementing these initiatives also required sustained hard work from trusted and skilled clinical and managerial leaders, raising questions about how emerging organisations can identify and enough resources to develop leadership capacity throughout the organisations and avoid dependence on 'heroic' leaders for progress.

Many of the initiatives were aimed at non-clinical staff, and the staff survey suggested that this may affect overall job satisfaction since receptionists and administrators were the most satisfied staff groups overall. These opportunities were valued by staff and some reported they would make them more likely to continue working in the organisation.

### Delivering extended services

The delivery of extended services was an important goal of all four case study sites and each had established community specialist clinics – albeit at relatively small scale, and none had yet led the delivery of a whole specialist service or pathway of care. These services highlighted inter-dependencies between general practice organisations, the specialists they work with to deliver these services and the CCGs that commission them. Most extended services were rooted in strong collaborative relationships with local specialists, but some had limited support from local specialists and needed consultant input from other health economies.

### Leading population health systems

The potential for general practice to play a central role in new models of care was described in the NHS Five Year Forward View and only one case study site was involved in this scale of development. Modality's acceptance of Vanguard status in NHS England's new models of care programme brought new resources to the organisation and new opportunities to broaden its range of services. However, it also added complexity in terms of governance requirements and created challenges in terms of keeping member clinicians engaged, while driving change in clinical practice. The case studies were completed too early for these organisational changes to be evaluated.

These three interrelated aspirations evolved over time as new opportunities arose and external policy changed, and they offer a framework around which emerging organisations can establish their goals. However, the case studies also revealed a range of challenges to be addressed, including their limited impact on quality and patient satisfaction; developing lean but effective governance arrangements; managing their conflicted relationship with CCGs; and adapting their work in response to national policy. We now deal with each of these points in turn.

## Challenges for scaled-up general practice

### Impact on quality and patient experience

The results of our analysis of 15 indicators were disappointing in that none of the organisations showed consistent improvement over time across all the indicators – although three of the case study sites significantly improved in over half of the measures over time. There was no consistent association between larger size and higher performance on quality measures. All three sites improved on prescribing measures and there was patchy improvement on QOF measures, but worsening performance – in line with national trends – on emergency hospital use.

Perhaps more surprisingly, patient satisfaction measures assessed by the national patient survey appeared to deteriorate over time, despite local efforts to improve access in each site. Patient interviewees highly valued their continuous, ongoing relationship with their own practice, their own doctor and the wider practice team. This presents a difficult challenge for the leaders of large-scale general practice organisations: how best to harness the opportunities for efficiency and better access (outlined in the full report) but still respond to the feelings and preferences of patients who want to retain continuity of relationship and care by their usual GP? Further research is needed on how larger scale will affect the ability of GPs to maintain continuity and fulfil the role of the 'expert generalist' outlined by the Royal College of General Practitioners (2012), which enables them to manage clinical risk and keep patients in the community.

## Governance, leadership and models of change

Governance arrangements, leadership and models of change were all key themes in these organisations – particularly in terms of how best to link member practices with the board and executive team in ways that build commitment and trust. Another key theme was the extent to which contracts for core services were retained by individual practices or merged into a new organisation. The two main models of change we saw seemed to be shaped by whether the new large organisation held the core contracts of member practices – in which case a more 'directive' model of change could be used with executive staff able to instruct staff to change the way they worked and then follow up by helping them to do so.

This contrasted with a slower, more consultative model of change management, underpinned by peer review and peer pressures and described by Sheaff and others (2012) as 'concertive control' – which is more likely to be seen in federations where individual practices kept their own separate contracts. These two models were not mutually exclusive. As a single organisation, with a single executive team managing all the merged practices, Modality had the option of using directive change methods, but did not do so if the executive team thought this would cause clinicians to disengage from organisational goals and lose trust in clinical leaders.

New governance challenges are also arising in response to higher-value contracts for extended services offered by CCGs. Many of these require financial assurances which are beyond the scope of most large-scale general practice organisations, driving them to form joint ventures with other organisations to qualify to bid. This adds complexity to governance arrangements and new challenges in terms of engaging member practice over a wider area – something the case study organisations were only just beginning to address.

## Local context: challenges for CCGs

For CCGs, the delivery of specialist services by large-scale general practice groups has created various challenges and paradoxes. The services could provide more accessible community-based alternatives to hospital care, thereby making an important contribution to CCG commissioning priorities, but two of the case study organisations commented that their local CCGs perceived them as private companies and were reluctant to invest in the general practice group. In contrast, two CCGs had strong collaborative relationships with case study sites, involving them in developing and implementing commissioning plans and other local priorities.

CCGs in the case study sites – as well as those who responded to the survey – were struck by the paradoxical nature of wanting to support these groups to form effectively

and sustain general practice services, while at times being reluctant to invest in them as private organisations. With no easy way to resolve this dilemma, one option for CCGs is to assess whether large-scale general practice groups are contributing to health improvement goals and commissioning plans and to use this as a criterion for deciding whether to invest in these organisations in the future. Equally, adherence to new guidance from NHS England (2016b) and drawing on worked examples of managing conflicts of interest from Monitor (2015) will help to address these issues.

### The impact of national policy

The new models of care described in the *Five Year Forward View* include a potential role for large scale general practice organisations as leaders of multi-speciality community providers. Casalino (2011) helpfully describes the experiences of US budget-holding medical groups that took on a similar role. The work highlights, among other things, the importance of investing in management support, data and IT systems and clinical leadership, as well as the need for strong collaborative relationships with specialists, if these groups are to succeed. Our research shows how long it has taken for the case study organisations to clarify goals, set up governance arrangements and establish the clinical and operational processes that are needed to deliver new services. Modality is well placed to develop the functions of a multi-speciality community provider, but it remains unclear how long it will take for the organisation to establish its new organisational model and deliver innovative services.

Of wider significance to emerging large-scale groups are the proposals and funding streams set out in the *General Practice Forward View* (NHS England, 2016a) to bolster core general practice services and increase the sustainability of primary care. Many of these are aimed at GPs working at scale and have been designed to address recognised pressure points in general practice. This research presents detailed accounts of how emerging groups can take advantage of these opportunities.

With an optional new contract planned for 2017, some emerging organisations are exploring the opportunities offered from development into population health systems. At present, few have experience of the governance, the care redesign or the implementation across practice and other organisational boundaries that will be needed to manage such a health system. However, the mature organisations described here provide important insights regarding the skills, resources and time needed to take on such a role.

## Recommendations

With the above observations in mind, we conclude by making the following recommendations to general practice organisations; CCGs and national policy-makers that have an interest in sustaining and improving core services.

### Recommendations to large-scale general practice groups

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

- Invest time and resources to develop staff roles across practice boundaries and to create peer support and peer learning opportunities.
- Design the simplest governance arrangements possible for delivering agreed goals and be prepared for them to evolve and become more complex as the organisation's objectives develop. Also, agree the level of decision-making authority given to the board that will best balance pace of change with ongoing engagement of member clinicians.
- Ensure resources are available to achieve agreed goals and be clear about the level of risk (in terms of investing money and/or resources) that members are willing to take to obtain these.
- Engage with patients to co-design services that address diverse needs and preferences, including achieving an acceptable balance between rapid access and continuity of relationship with clinicians.
- Where general practice organisations are seeking to establish extended services, ensure these are underpinned by positive, collaborative relationships and shared goals with specialists.
- Work collaboratively with CCGs to address population health needs and commissioning priorities and demonstrate the value of the organisation to the local health economy.

## Recommendations to clinical commissioning groups

- Have realistic expectations about the capacity of large general practice groups to take on extended roles and the pace at which they can develop specialist skills and build their capacity to set up new services. CCGs should involve large-scale organisations at a pace that allows emerging groups to bid for and (if successful) establish new services that are high quality and sustainable.
- Facilitate local debate between patients, the public and other stakeholders about how emerging large-scale general practice organisations can make a positive contribution to the local health economy while minimising conflicts of interest. Follow guidance on conflicts of interest, but avoid excluding GPs with an expert knowledge of specific areas of care from service redesign work.

## Recommendations to national policy-makers

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

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# About the authors

**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 quality. Within her GP practice, Rebecca leads work to improve 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.

**Stephanie Kumpunen** joined the Nuffield Trust in 2014 as a Fellow in Health Policy. She specialises in qualitative research and policy analysis. Prior to joining the Trust, Stephanie was a Research Officer at LSE Health and Social Care where she was part of an FP7-funded team examining choice and public reporting in health and long-term care across Europe. She was seconded to the Department of Health (England) in 2013/14 to advise on choice and personalisation policies in the NHS. Stephanie has an MSc in Health Promotion from Western University in Canada and a MSc in Health Policy, Planning and Financing from the London School of Hygiene and Tropical Medicine and the London School of Economics.

**Natasha Curry** joined the Nuffield Trust in 2011 as a Senior Fellow in Health Policy. Her research interests include clinical commissioning, primary care provider models, integrated care, international health systems and NHS reform. Prior to joining the Nuffield Trust in July 2011, Natasha was a fellow in health policy at The King's Fund. During her six years at the Fund, Natasha published widely on a number of subjects, including practice-based commissioning, the management of long-term conditions and approaches to clinical and service integration. Previously, Natasha worked as a consultant in health at Matrix Research and Consultancy Ltd and as the evaluations officer at the Chinese National Healthy Living Centre.

**Alisha Davies** is a Fellow of the Faculty of Public Health and was a Senior Research Analyst at the Nuffield Trust. She joined the Trust in 2014 and has a particular interest in evaluation of innovative models of health and social care, with a focus on prevention and quality improvement. Prior to joining the Nuffield Trust, Alisha worked in public health roles in a primary care trust, a local authority and an acute trust supporting service redesign and evaluation in practice. She recently took up the post of Head of Research and Development at Public Health Wales.

**Luisa Pettigrew** is a Visiting Clinical Fellow in the Health Policy team. She is based at the London School of Hygiene and Tropical Medicine's Department of Health Services Research and Policy as an NIHR In-Practice Fellow. She also works as General Practitioner. She has policy and research interests in non-financial incentives in general practice and emerging organisational models of care in general practice in the UK. She also has interests in the international development of primary care. Luisa has worked as a GP since 2008, holds a Master's degree in Health Policy, Planning and Financing and has previously worked on various projects relating to medical education and training, health systems financing and global health development with a focus on primary care.

**Lucia Kossarova** is a Senior Research Analyst at the Nuffield Trust. She joined the Trust in April 2014 and is involved in quality of care and international comparisons projects. She has over 10 years of experience in international health policy and health systems research and analysis. She joined from the London School of Economics and Political Science (LSE), where she had been a Teaching Fellow. While at LSE she taught on various MSc courses, worked as a researcher on different EU-funded projects, and worked as Assistant Editor for Eurohealth. Prior to that, Lucia worked in the Quality Team at the Health, Nutrition and Population unit of the World Bank in Washington DC. She has also worked as senior consultant at a private health care consulting company involved in health system reform and HIV/AIDS projects in Central Asia, Eastern Europe and Central America. Lucia obtained her PhD in Health Policy from the LSE. She also has an MA in International Relations (Development Economics and International Development) from School of Advanced International Studies, Johns Hopkins University and a BA in Social Sciences from University College Utrecht.

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59 New Cavendish Street
London W1G 7LP
Telephone: 020 7631 8450
Facsimile: 020 7631 8451
Email: info@nuffieldtrust.org.uk

www.nuffieldtrust.org.uk

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