

Securing the future of general practice

New models of primary care

Summary

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General practice in England is under significant strain, with many GPs and their teams caught on a treadmill of trying to meet pressures, while lacking time to reflect on how to provide and organise care for the future. To inform the challenges facing primary care, the former Midlands and East Strategic Health Authority – now NHS England Midlands and East – commissioned the Nuffield Trust and The King's Fund to undertake a review of UK and international models of primary care, focusing on those that could increase capacity and help primary care meet the pressures it faces.

Although this report has implications for the whole of primary care, the focus of this research has been primarily on general practice. We examine how GPs and their teams are responding to pressures by forming new organisations to allow care provision at greater scale. We consider what is required if primary care is to be fit for the future, proposing design principles to be used when planning future provision and suggesting what needs to be done by both policy-makers and practitioners.

This project was commissioned by Dr Penny Newman and Jill Matthews at NHS Midlands and East Strategic Health Authority, as part of a suite of work the organisation conducted into the pressures facing primary care. We would like to thank them for their continued support and advice throughout the project.

Key Points

- Primary care in England is under significant strain. GPs and their teams are caught on a treadmill of trying to meet demand from patients while lacking time to reflect on how they provide and organise care.
- New models of care organisation are emerging organically in some areas to meet the challenges facing primary care. The 21 UK and international models examined in this report aim to extend the range of services offered, thereby enhancing the sustainability of practices. They emphasise the need to balance the benefits of organisational scale with preservation of the local nature of general practice.
- Our review of their development has confirmed that, while the ability to extend the scope and scale of primary care is important, no one organisational model of primary care provision should be advocated. Local context plays an important role in determining organisational form, and the precise mix of functions will likewise depend on the nature and priorities of the local population.
- This report proposes a set of design principles to be used when determining primary care provision that can address the pressures facing GPs, and ensure that both the needs and priorities of patients and the public are met, and that primary care will be fit for the future.
- When the design principles are combined, fundamental changes to the organisation and delivery of general practice and primary care become necessary. These include the linking together of practices in federations, networks or merged partnerships in order to increase their scale, scope and organisational capacity. This will need to be done while preserving the local small-scale points of access to care that are valued highly by patients.
- This move towards more networked and larger-scale primary care provision is mirrored in countries such as New Zealand, the Netherlands, Canada and the United States.
- Change at this level would require support and incentives, as well as permission for GPs and other primary care practitioners to test out new approaches to the delivery and organisation of care.
- To help make this happen, we recommend NHS England work with clinical commissioning groups, GPs, patient groups and professional bodies to create a national framework for primary care. The framework should set out the outcomes and overall vision for primary care, both in relation to service provision and the wider role of primary care in the health and social care system. The vision should be underpinned by design principles as set out in this report.
- Alongside the framework, a new alternative contract for primary care is required (in parallel to the current general medical services contract). The contract needs to be crafted by NHS England in a way that encourages groups of practices to take on a collective responsibility for population health (and ideally also social) care across a network of practices, without specifying the detail of implementation – this should be a matter for local determination.



Introduction

Primary care is considered to be the bedrock of NHS care provision, offering people comprehensive first-point-of-access advice, diagnosis and treatment, together with ongoing care coordination and support. In international research, strong and effective primary care is judged to play an important role in improving health outcomes and containing costs.

General practice in England is under significant strain, facing pressure from a range of supply, demand and health service factors. At the same time, it is being asked to do more to relieve increasing pressures on emergency and out-of-hours services, support the development of better integrated care for people with long-term conditions, and play a central role in commissioning. The former Midlands and East Strategic Health Authority commissioned the Nuffield Trust and The King's Fund to undertake a review of UK and international models of primary care, focusing on those that could increase capacity and help primary care meet the pressures it faces.

In this report we examine how local general practitioners (GPs) and their teams are responding to pressures by forming new organisations to allow care provision at greater scale. We consider what needs to be done if primary care is to be fit for the future: proposing design principles to be used when planning future provision; and suggesting what is required from policy-makers and practitioners. Although this report has implications for the whole of primary care, the focus of this research has been primarily on general practice.

General practice under pressure

Internationally, primary care finds itself having to support health systems that struggle to meet the twin demands of constrained public spending as a result of the global economic recession, and many more people living with long-term conditions. Other factors driving a need for new forms of primary care provision include:

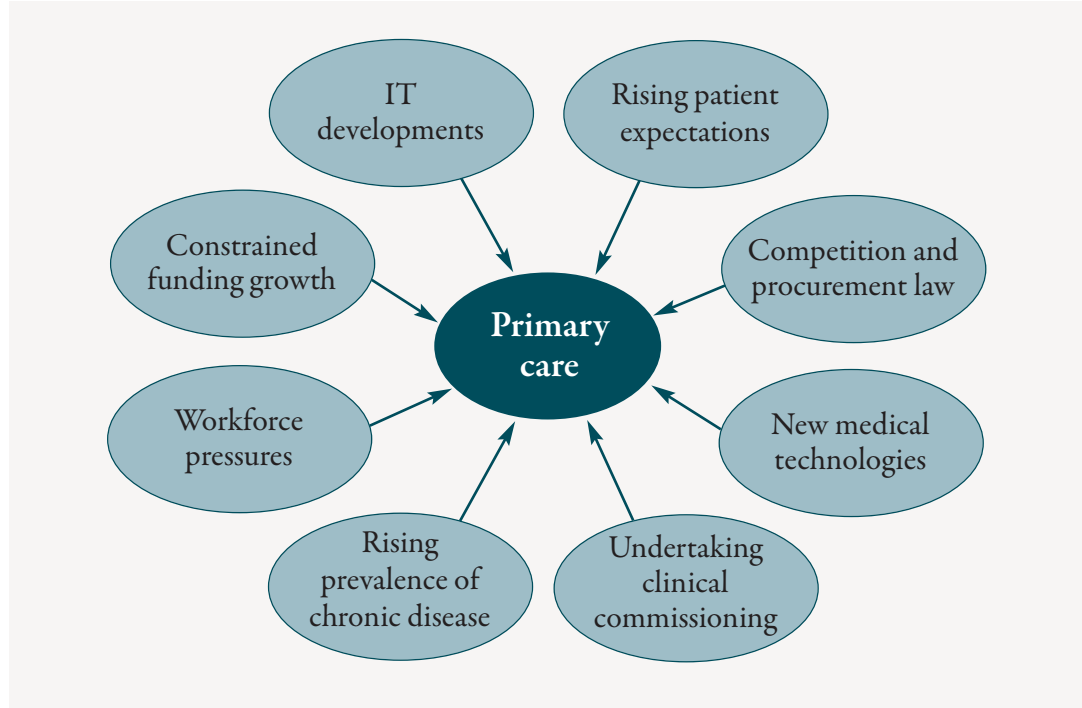
- technologies that enable new forms of information, access and involvement for patients
- innovative drug treatments and therapies that enable more community and home-based care
- changes in patients' expectations about access to care.

In addition, general practice in England faces pressure from:

- rising demand for GP appointments
- calls for general practice to reassume responsibility for out-of-hours care at a time when urgent care is under particular strain
- changes in workforce demography which means there are insufficient trainees to meet future need
- reduced funding for primary care as a proportion of the total NHS budget
- demands on GP time to support clinical commissioning.

Furthermore, any changes to primary care provision have to be made in the context of a new NHS regulatory framework that requires evidence of appropriate contestability. The pressures on primary care are summarised in Figure 1.

Figure 1: Pressures on primary care in England



The response by general practice

GPs and their teams are caught on a treadmill of trying to meet these pressures while lacking time to reflect on how to provide and organise care for the future. They are aware that more of the same is not the answer, but there is a shortage of analysis of how the future could be different, for the delivery and organisation of services, as well as for the working lives of practice teams.

New models of care organisation are, however, emerging organically to meet the challenges facing primary care. Indeed, we have seen different organisational forms taking shape within general practice since the passing of the NHS (Primary Care) Act 1997, and this process seems to be accelerating given current pressures.

In this research, we examine models of provision in the UK and overseas that are seeking to address the pressures facing primary care by 'scaling up' their services and organisation. We identify 21 different models of primary care organisation, covering 12 organisational types. The models are summarised in Table 1:

Table 1: Summary of the models reviewed
Accountable care organisations

- Monarch HealthCare, US

Community-owned

- Hokianga Health Enterprise Trust, New Zealand

Community health organisations

- Bromley by Bow Centre, UK
- Community Health Centre Botermarkt, Belgium

Community health organisations with inpatient facilities

- Kangasala Health Centre, Finland

Marginalised groups

- Health E1, UK
- Leicester Homeless Primary Health Care Service, UK

Networks or federations

- Midlands Health Network, New Zealand
- ZIO network, Maastricht, the Netherlands
- Primary care networks in Alberta, Canada
- Tower Hamlets, UK

Professional chambers

- Pallant Medical Chambers, UK

Regional and national multi-practice organisations

- The Hurley Group, UK
- The Practice PLC, UK

Specialist primary care

- ParkinsonNet, the Netherlands

Super-partnerships

- Whitstable Medical Practice, UK
- Dr HM Freeman & Partners, UK
- The Vitality Partnership, UK

Super-partnerships with inpatient facilities

- Nairn Healthcare Group, UK

Vertically integrated systems

- Geisinger Health System, US
- Kaiser Permanente, US

Analysis of these models was undertaken to identify those which have the greatest potential to enable the provision of high-quality primary care, in the context of the pressures set out above.

We examined the:

- ability to offer an extended range of services in primary care, including rapid and local access to specialist advice
- focus on population health management as a way of addressing inequalities in health
- extent of organisational scale to enable new forms of care for people with multi-morbidity
- capacity to offer career options and development for professional and other staff
- overall scale to permit peer review and the development of strong clinical governance infrastructure.

The four organisational types that showed greatest promise were:

- networks or federations
- super-partnerships
- regional and national multi-practice organisations
- community health organisations.

We set out here a summary of each of these models of primary care provision and the benefits they appear to offer.

Networks or federations

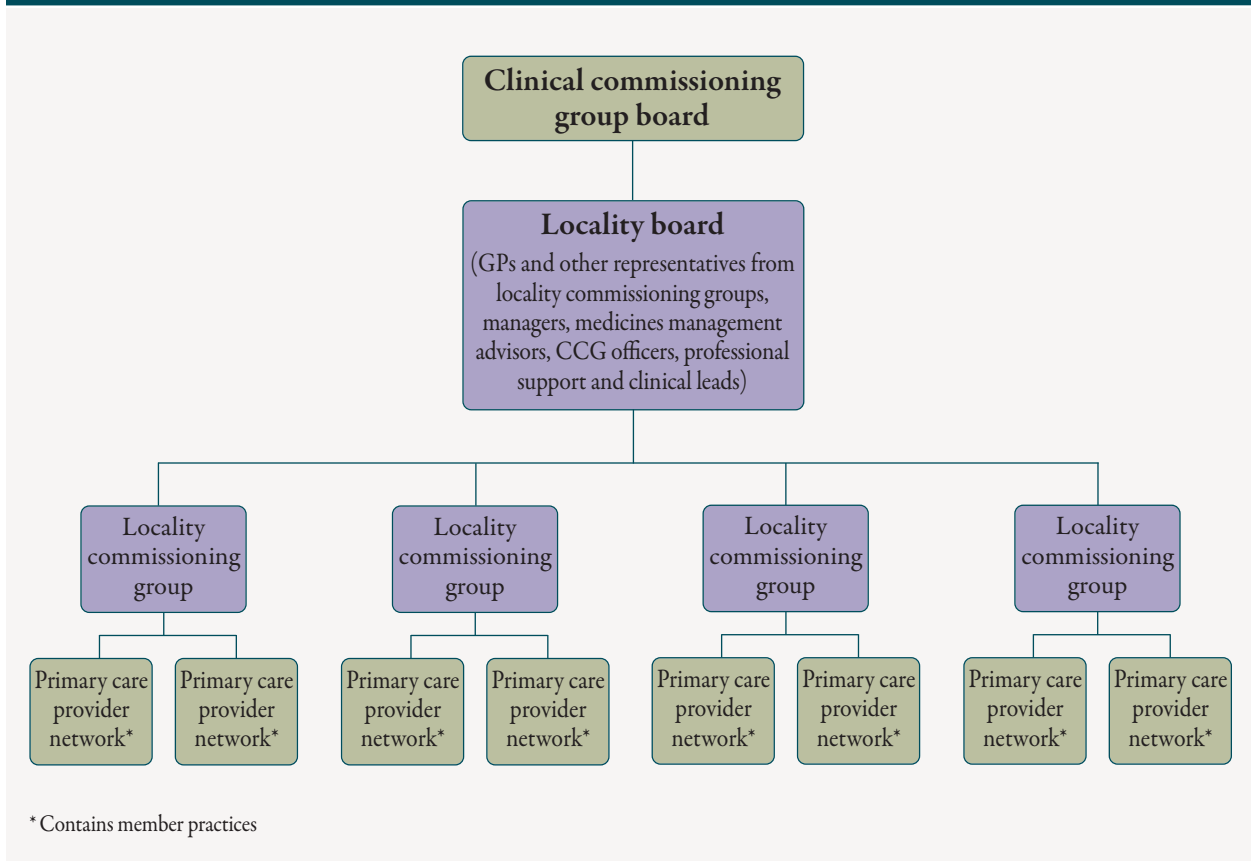
Networks or federations are groups of general practices that come together (sometimes with other primary care and community health services) to share responsibility for functions that can include:

- ensuring continuous improvement of core general practice
- the provision of extended care for people with long-term conditions
- the development of new forms of out-of-hours care
- training and development
- peer review and clinical governance
- sharing back-office support.

Their organisational and legal form varies according to the purpose of the federation, the extent of integration across practice services, and preferences of local clinical leaders. Some take the form of a limited liability partnership, a community interest company, or limited company, while others remain as informal collaborations. Governance arrangements likewise vary, although a more formal approach is taken where the federation is assuming contracts for collective service delivery across practices, and this will typically comprise a joint management team funded by constituent practices with a board of governance elected by GPs and their teams.

An example of the organisational arrangements of a network examined in this research – Tower Hamlets – is set out in Figure 2.

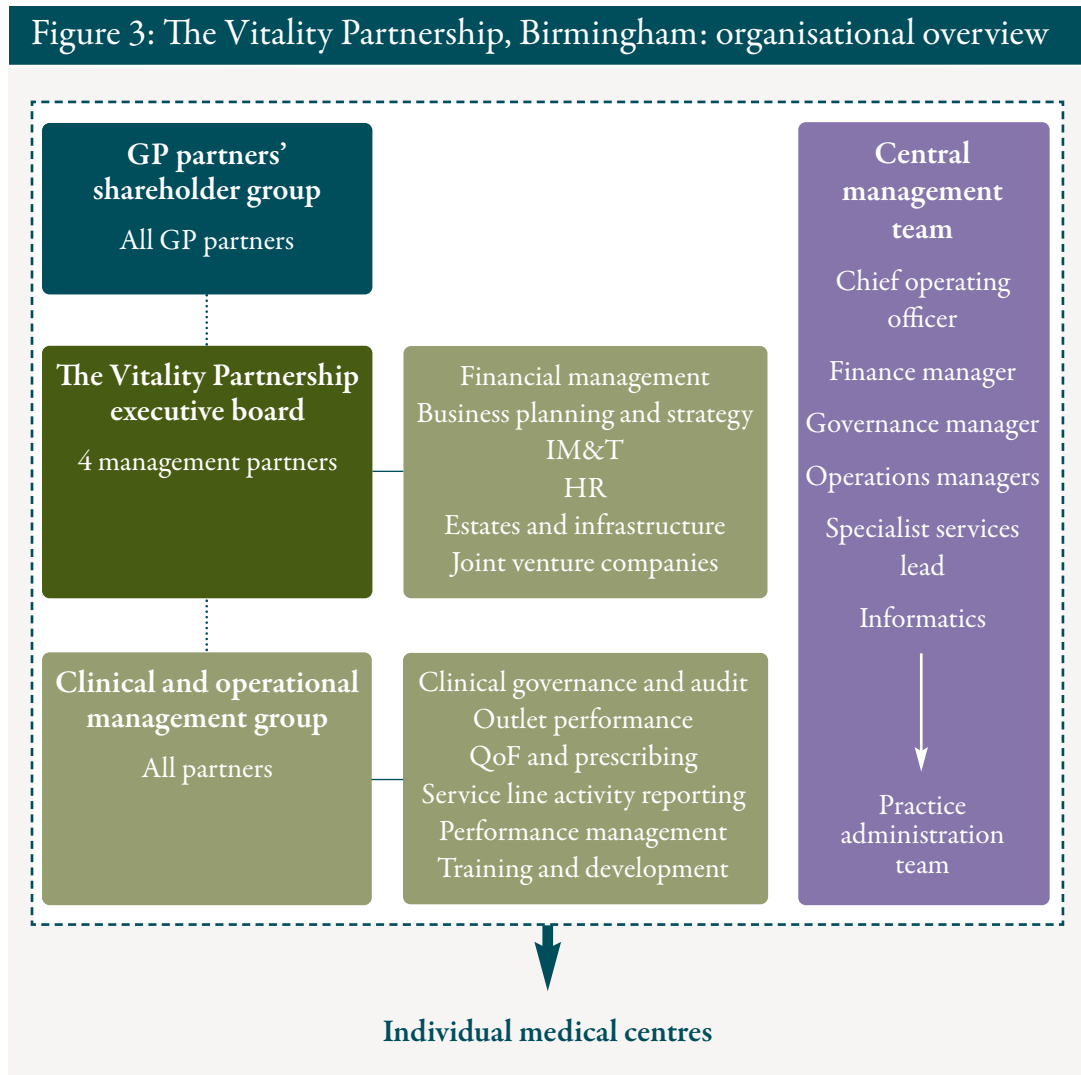
Figure 2: Tower Hamlets primary care network: organisational overview



Super-partnerships

A super-partnership is a large-scale single general practice partnership structure that has been created through formal partnership mergers. It seeks to achieve a greater degree of scale for local general practice, offering a wider range of integrated primary and community health services, and using its scale to offer community-based diagnostic services and consultations with specialists. Its scale also enables a wider range of career development opportunities for GPs and their teams. Super-partnerships seek to benefit from diversification of income streams, for example, they often bid to provide community and outpatient services previously delivered by NHS trusts or foundation trusts. Their organisational and legal form is a single large corporate-style GP partnership, although they often establish one or more parallel companies that can act as the vehicle for bidding for and managing additional services funded by the NHS or private sources, such as dermatology, immigration medicals, or travel vaccinations. Governance is typically provided by an executive group of partners who hold specific management roles within the super-partnership, this group being accountable to a shareholder group of all GPs within the organisation.

An example of the organisational arrangements of a super-partnership examined in this research – the Vitality Partnership in Birmingham – is set out in Figure 3.



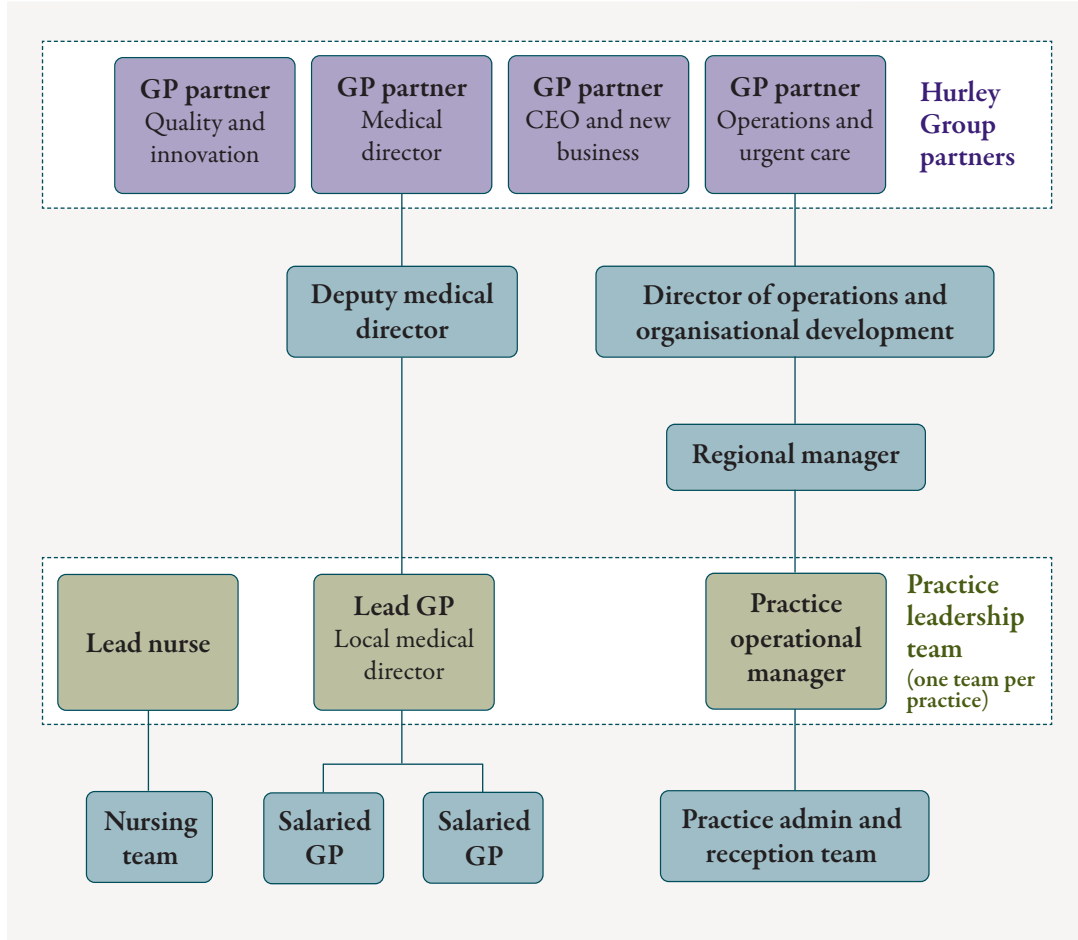
Regional and national multi-practice organisations

In contrast to federations and super-partnerships that are led by GPs operating in a single local community, regional and national multi-practice organisations have developed the scope and scale of primary care in a manner that is more akin to some of the physician group models in the USA. They typically take the form of a single GP partnership or GP-led company that has practices dispersed over a wider regional or even national area, and the partnership centralises management and back-office functions on behalf of its multiple constituent practices. The distinctive aspect of this model is the much smaller ratio of partners to other employed clinicians, the latter being located in the multiple and dispersed practices, supported by a central leadership team of executive partners and management colleagues.

The aim of the model is to improve the quality and range of primary care provision through greater organisational scale, standardising clinical and managerial practices across all care settings. The smaller critical mass of patients in a single locality can, however, limit the extent to which multi-practice organisations can make change within a specific health economy, and can make bidding for extended primary and community health services more challenging.

An example of the organisational arrangements of a multi-practice organisation examined in this research – the Hurley Group – is set out in Figure 4.

Figure 4: The Hurley Group, London: organisational overview



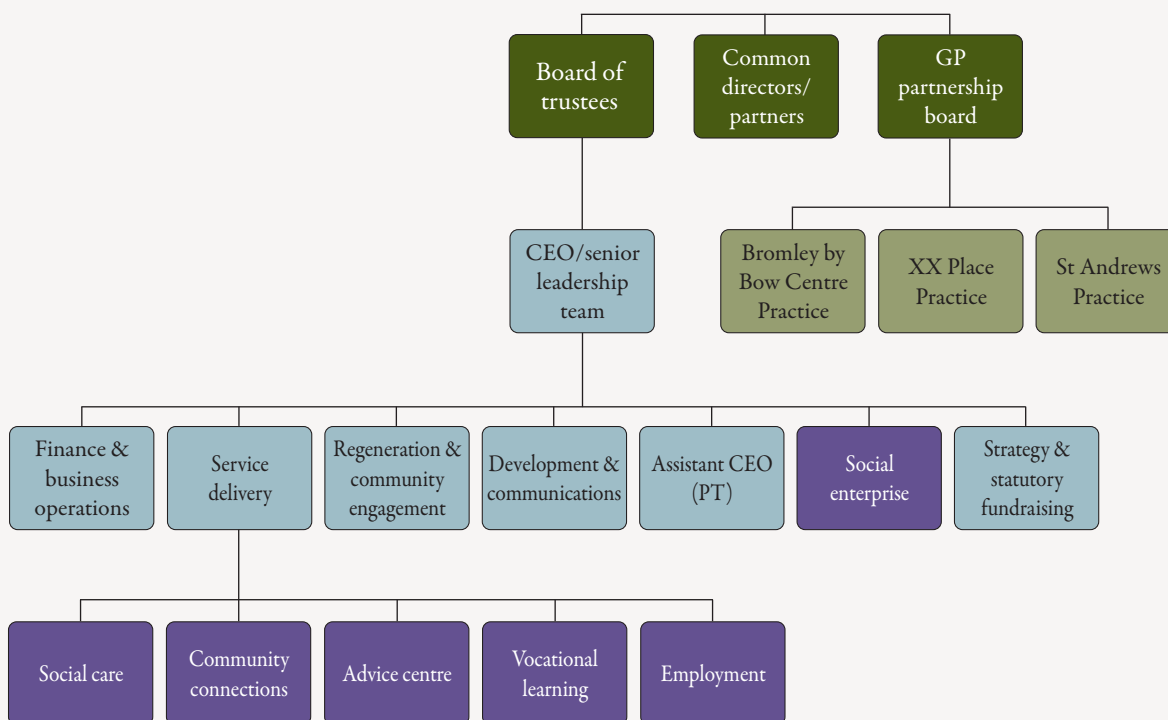
Community health organisations

Community health organisations have a strong population health orientation with a commitment to meet the specific needs of disadvantaged communities and address health inequalities. These organisations – sometimes made up of multiple practices in a network and in other cases in a single building – combine patient-centredness with a strong population orientation and generally have an ownership model with significant community or public involvement. Constituent GP practices often retain their partnership model of governance, within an overarching network which may take the form of a charitable organisation, community-interest company, or other such legal entity. Alternatively, the organisation may be comprised of all salaried doctors and staff, with a governance board including clinical staff and representatives of the local community.

Community health organisations seek to develop an extended range of local health and social care services (including, for example, welfare rights advice, housing support, employment training and parenting support) based on analysis of local needs. The role is considered to be one of community development alongside (or even before) health care provision, with the facilities of the organisation providing an important community resource for often marginalised groups.

An example of the organisational arrangements of a community health organisation examined in this research – the Bromley by Bow Centre – is set out in Figure 5.

Figure 5: The Bromley by Bow Centre and GP partnership: organisational overview



Lessons from these models of primary care

These models are defined by their desire to use greater organisational scale to extend the range of services offered and to diversify income streams, thus enhancing the sustainability of practices. They develop more sophisticated management support to undertake strategic planning and service development, and create new professional, management and leadership roles that offer a new range of career opportunities for professional, managerial and support staff in primary care. It is striking that despite their differing origins and philosophical underpinning, the models of care share a desire to improve and extend primary care services, develop management and leadership capacity, and assume a more significant role in the local health system.

Critically, they all emphasise the need to balance the benefits of organisational scale with preserving the personal and local nature of general practice. Each of the ‘at scale’ primary care models we examined had preserved local practices as the first point of contact for patients, strengthened the network of wider advice and support available, and used organisational scale to enhance (and not undermine) the local accessibility and nature of primary care.

General practice that is fit for the future

Based on a review of the literature on high-performing primary care organisations, primary care provision needs to be capable of fulfilling the five following functions:

- improving population health, particularly among those at greatest risk of illness or injury
- managing short-term, non-urgent episodes of minor illness or injury
- managing and coordinating the health and care of those with long-term conditions
- managing urgent episodes of illness or injury
- managing and coordinating care for those who are nearing the end of their lives.

Our analysis of models of primary care in the UK and overseas was undertaken in relation to how far each model could fulfil the above functions. This led us to conclude that while the ability to extend the scope and scale of primary care was important, we should not advocate any one organisational model of primary care provision. Local context plays an important role in determining organisational form, and the precise mix of functions will likewise depend on the nature and priorities of the local population. What seemed to us to be most important is that primary care provision is designed according to a set of principles that ensure that the needs and priorities of patients and the public are met.

We propose a set of design principles to be used when determining primary care provision that can address the pressures currently faced and that will be fit for the future

We propose a set of design principles to be used when determining primary care provision that can address the pressures currently faced and that will be fit for the future. Some of the principles are focused on the provision of clinical services, and others on organisation.

Design principles – clinical care

- A senior clinician, capable of making decisions about the correct course of action, is available to patients as early in the process as possible.
- Patients can benefit from access to primary care advice and support that is underpinned by systematic use of the latest electronic communications technology.
- Patients have the minimum number of separate visits and consultations that are necessary, with access to specialist advice in appropriate locations.
- Patients are offered continuity of relationship where this is important, and access at the right time when it is required.
- Care is proactive and population-based where possible, especially in relation to long-term conditions.
- Care for frail people with multi-morbidity is tailored to the individual needs of patients in this group, in particular people in residential or nursing homes.
- Where possible, patients are supported to identify their own goals and manage their own condition and care.

Design principles – organisation

- Primary care is delivered by a multidisciplinary team in which full use is made of all the team members, and the form of the clinical encounter is tailored to the need of the patient.
- Primary care practitioners have immediate access to common diagnostics, guided by clinical eligibility criteria.
- There is a single electronic patient record that is accessible by relevant organisations and can be read and, perhaps in future added to, by the patient.
- Primary care organisations make information about the quality and outcomes of care publicly available in real-time.
- Primary care has professional and expert management, leadership and organisational support.

Making this happen

Scaling up and keeping it local

When all or most of the design principles are combined, fundamental changes to the organisation and delivery of general practice and primary care become necessary, including the linking together of practices in federations, networks or merged partnerships in order to increase the scale, scope and organisational capacity of general practice. This will need to be done while preserving the local small-scale points of access to care that are so valued by (at least some sections of) the population. It will similarly be necessary for general practice to develop further its use of different skill-mix and increase multidisciplinary working, along with maximising the use of technologies such as phone, internet, apps and email, as part of improving access and convenience for patients and enhancing organisational efficiency.

Part of the challenge of increasing the scope and scale of general practice implied by our design principles may be achievable within the bounds of the levers described above, for example, maximising the potential of existing primary care contractual frameworks such as alternative providers of medical services, personal medical services and specialist primary medical services. Clinical commissioning groups (CCGs) could be encouraged to tender for some of the new forms of service provision implied by our design principles. Analysis of existing models of ‘at scale’ primary care in the context of the design principles proposed here suggests that reliance on existing mechanisms will not, however, suffice.

Development

The pressures currently facing general practice teams prohibit the necessary reflection, review, planning and development to make the service and organisational changes required. Primary care teams report that what little capacity for strategic work is available is taken up by clinical commissioning responsibilities. Our case study organisations needed skilled facilitation, business planning and professional support (for example, legal, financial, property) when developing plans for their extended services, and while more of this was needed in their early phases, it continued to be a valued and core element of management resource, even 20 years after the establishment of networks, community health organisations or merged partnerships. All reported having underestimated the scale of such support when they started out.

Infrastructure

The case studies in this research revealed the importance of getting the management and organisational basics right, finding ways to deal with the ‘tipping point’ of over-work and stretched capacity and develop larger organisations, and the requirements of sustainable management and leadership for the longer term. The need to professionalise practice management and invest in more senior organisational capacity was emphasised by all case studies, for formal business processes and specialist management support are critical as organisations become too large and complex to rely on management through personal relationships.

New models of governance and decision-making had been put in place by the scaled-up models of care, seeking to maximise the involvement of professional and support staff, yet assuring clarity of executive management and leadership, this being typically vested in a small senior group within the organisation. These new structures were part of the development of more distributed approaches to leadership in many organisations, allocating lead roles to GPs, nurses and others within the organisation, and establishing clear career paths towards new partnership and executive leadership positions.

Community and patient involvement and governance were a significant dimension of many of the primary care models, this having been seen as critical to the wider service and culture change brought about by developing scaled-up primary care networks and organisations. In some cases, the primary care organisation was completely community-governed and owned, as with Hokianga Health in New Zealand.

Primary care has to find the confidence to scale up and ‘transform’, but given current pressures on general practice it does not make sense to put the whole responsibility for this on to existing GP leaders

Leadership

In common with international research evidence, our case studies reported the vital importance of sustained clinical and managerial leadership in the development of larger networked primary care organisations. Reliance on a ‘heroic’ model of leadership where an individual drives the development of an organisation (the most frequently found approach in general practice innovation to date) will no longer suffice in a context of larger and more complex primary care organisations and a majority of part-time and sessional GPs. Sustainable GP leadership for the future requires an approach that regards leadership as being distributed across different levels of the organisation. Time will be needed for professionals to be released from clinical commitments, and for organisations to prioritise the development of new career structures, succession planning, talent management, and ensuring that primary care leadership reflects the diversity of the workforce.

Primary care has to find the confidence to scale up and ‘transform’, but given current pressures on general practice it does not make sense to put the whole responsibility for this on to existing GP leaders. There is a need for a national framework to guide the strategic future of primary care, supported by new contractual and funding options, together with resource for reflection, service design and organisational development.

Next steps

General practice has a strong history of independence and innovation that needs to be harnessed if primary care is to develop the scope and scale of services implied by our suggested design principles. We set out here what needs to happen if primary care is to meet the health, financial and workforce challenges ahead.

A national framework for primary care

NHS England, as the commissioner of general practice services should work with CCGs (who have a responsibility for the development of primary care), patient groups and professional bodies to create a national framework for primary care. This needs to set out the outcomes and overall vision for primary care, both in relation to service provision and the wider role of primary care in the health and social care system, underpinned by design principles as set out in this report. It should not specify the details of how the vision might be achieved, nor the organisational form to be used. This needs to be worked out locally with extensive public and patient engagement. This framework can form a core part of a national narrative to ‘transform’ NHS care to meet the austerity and quality challenge.

A new alternative contract for primary care

A new alternative contract for primary care is required, in parallel to the current general medical services contract, setting objectives and parameters, but not specifying details of local implementation. The contract needs to be crafted by NHS England in a way that encourages groups of practices to take on a collective responsibility for population health (and ideally also social) care across the network of practices. The extent of services for which risk would be assumed would depend on the size of the population covered, scope of services for which the network was responsible, and would likely include: end-of-life, long-term conditions, mental health, older people and children’s care. Another option in the interim is to use existing legislation – the NHS (Primary Care) Act 1997 – to design and promote primary care services tailored to specific local needs, for that legislation has arguably not been used to its full potential to date.

An alternative or intermediate approach to a new contract for primary care is for CCGs to be given a mandate to commission additional services from general practice

A role for CCGs in commissioning primary care

An alternative or intermediate approach to a new contract for primary care is for CCGs to be given a mandate to commission additional services from general practice (over and above core general and primary medical services) and other care providers. This would be another way of encouraging the formation and extension of primary care federations and networks, with groups of practices bidding to provide services in accordance with the design principles proposed here. CCGs are well placed to work closely with patients and the public to design new forms of service provision that can assure accessible and high-quality primary care and advice. There is a need for further clarification by NHS England as to the precise nature of CCGs’ involvement in developing, commissioning and assuring the quality of primary care.

Regulation that supports primary care redesign

It is clear that the provision of primary care services is to fall within the wider regulatory framework in place in the NHS. The sector regulator Monitor has announced a review of primary care services, including examination of issues of choice and access for patients, the ability for new or existing providers of primary care to expand the scope of services offered, the process for commissioning new services, and the enablers or barriers to the integration of primary care and other local services. In developing guidance in this area, Monitor needs to examine carefully the experience and potential of super-partnerships, networks, multi-practice organisations and community health organisations, in order that the benefits of 'at scale' primary care are not compromised by concern about (actual or perceived) limits to choice and competition of practices working in more collaborative ways.

Shared electronic records

An electronic record enables coordination of care across different points of access to care, across in- and out-of-hours services, and ideally also permits the patient to have direct access to the information 24/7. If true integration of care is to be possible, such records should include community pharmacists, community health services and social care. This would need to be achieved through the collaboration of NHS England, CCGs, commissioning support units and others.

An extended primary care team

The extended primary care team has long been discussed in the NHS, yet what people often describe as an extended primary care team is a set of services to which a practice can refer, with little coordination across a patient's care pathway, no joint assessment of needs and a lack of a shared patient record. The case studies in this project include examples of where the extended primary care team has been developed so that general practice can (in line with the design principles) provide a comprehensive range of services, using a shared electronic record to aid coordination and rapidly access specialist care when patients need it. There is a need to think carefully about how services such as pharmacy, dentistry and optometry can play a full part within new primary care organisations or networks. Primary care needs also to be able to control and coordinate out-of-hours service provision, working in an integrated manner with others such as the ambulance service, the extended team reaching beyond what is traditionally considered primary care. NHS England and its local teams, together with Health Education England, can play an important role in brokering, supporting and disseminating examples of good practice, and in helping resolve issues about professional, contractual or other barriers to local progress.

The development of new roles for staff

Redesign of primary care will lead to new roles for clinical professionals, managers and support staff. NHS England and Health Education England will need to support a national framework for primary care by helping local primary care leaders determine roles in primary care organisations that are interesting, sustainable, and fairly rewarded. There is increasing interest in the possibility of having sub-specialisation (especially across a network of general practices) in areas such as frailty, mental health care and children's care. The redesign of local primary care services across a network, federation or merged partnership offers the opportunity to explore such specialisation, and for these to be

supported by pilots of new forms of training and education for doctors, nurses and the wider primary care team.

New opportunities for education and training in primary care

A new alternative contract for primary care will need to address requirements for training and education, so that new expanded services can serve as a base for developing different health professionals and managers. Historically, roles have emerged within general practice to meet service and health needs and demands, and this flexibility has been important and should be retained. Primary care organisations need to become the natural training ground for doctors (and not just GPs – also those specialties that are strongly community-based), nurses, senior managers and allied health professionals. Larger organisations offer significant potential here, and Health Education England, royal colleges, and the NHS Leadership Academy will need to review and revise their approach to the training and development of clinical and other staff in light of the emergence of larger primary care organisations.

NHS England needs to work with CCGs and local clinical leaders to fund and develop approaches to freeing up time in practices to enable reflection and planning

Resource for organisational development

NHS England needs to work with CCGs and local clinical leaders to fund and develop approaches to freeing up time in practices to enable reflection and planning. This should include imaginative ways of enabling GPs to access high-quality organisational development and other planning support. Options could include an investment fund whereby practices could bid for resource that could enable them to have a day a week without 'routine episodic general practice' for a certain number of weeks. The practice could then focus on undertaking detailed personalised care planning for its frail elderly population, along with doing strategic planning for the practice and/or practice network. Alternatively, a CCG or commissioning support unit could be given the resources to fund a programme of primary care development, along with access to advice and support from a range of leadership development organisations.

Indicators of progress

The progress of new primary care models will need careful monitoring in order that commissioners, patient organisations and regulators can be clear that these organisations are providing necessary service and health benefits for local patients and populations. The outcomes required by a new alternative primary care contract will need to be tracked and reported in a regular and public manner, as will levels of satisfaction of patients, staff and organisational leaders. It will be important to assess the extent to which new primary care models are able to improve access to advice and services, and assure improved coordination of care within primary care and across the wider health and social care system.

Conclusion

The development of larger-scale organisations or networks with new services, different skill-mix, and fresh professional and leadership opportunities, is a pressing priority for primary care. It is clear that many commissioners and providers understand the case for change, but find it hard to move from diagnosis to prescription and treatment. Practices and their teams struggle to find the time and space to take stock and plan, and experience from existing models of scaled-up primary care suggests that such planning is vital. Many practices are already in, or are considering, federations, networks or merged partnerships. Such radical change needs support, incentives and permission to test out new approaches to the delivery and organisation of care. This report is intended as a contribution to thinking about the future of NHS primary care at a local and national level.

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About this research


This research summary is based on the report *Securing the Future of General Practice: New models of primary care*, the original research for which was carried out by members of the Nuffield Trust and The King's Fund.

The report is the latest in a series of independent projects into the quality and future of primary care and general practice being carried out by the Nuffield Trust and The King's Fund. For more information see:

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