



# Collaboration in general practice

## Surveys of GP practices and clinical commissioning groups

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# Acknowledgements

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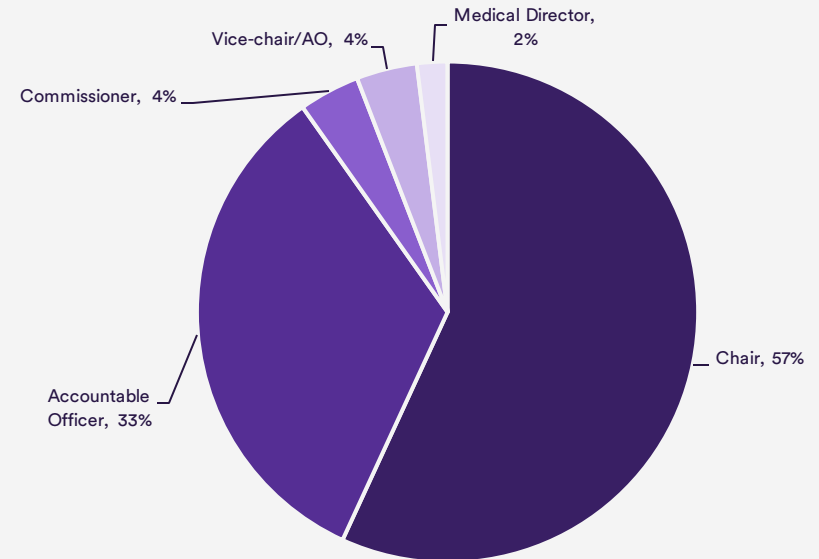
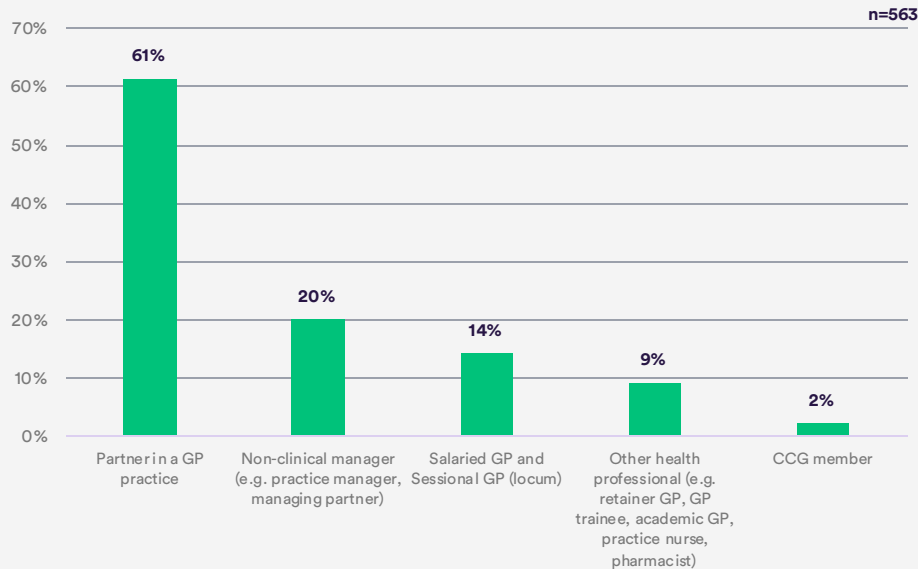
We are appreciative of the time and advice on questionnaire design and analysis provided by our Nuffield Trust colleagues, Luisa Pettigrew and Chris Sherlaw-Johnson.

# Background and purpose of surveys

- Working at scale in collaborative arrangements is widely accepted as the future of general practice.
- Our 2015 surveys<sup>1</sup> found that 73% of practices were already operating in collaborations and were motivated to do so by financial pressures, a desire to expand the range of services offered, and CCG encouragement.
- Our 2017 surveys, one of which went to general practice staff and one to CCG staff, aimed to find out what has changed<sup>2</sup> in the landscape of general practice:
  - How widespread are GP collaborations now, compared to 2015?
  - Did organisations make progress towards their goals in the last year?
  - What do GPs and CCGs feel the future holds for ‘large-scale general practice’?
- The surveys were conducted as part of the RCGP and Nuffield Trust ‘General Practice at Scale’ programme.

# Survey respondents

- **GP practice staff:** We received 565 complete responses. Respondents worked in 162 of the 207 CCGs (78%). We asked them to describe all of their roles - around 60% were full or part-time practice partners.
- **CCG staff:** We received 51 complete responses, representing one-quarter of the 207 CCGs. We asked them to describe their main role - 90% of respondents were CCG Chairs or Accountable Officers.



# Key findings

1. The trend towards collaboration has continued in recent years with 81% of GP practice-based respondents reporting they were part of a formal or informal collaboration in 2017. In 2015, this figure was 73%.
2. Almost half of GP staff said their collaborations were federations (45%) and had formed more than two years ago (46%). Around half (53%) reported having more than 100,000 registered patients.
3. Mapping collaborations is not straightforward. Practices are often part of multiple collaborations of different sizes, operating at both locality and CCG levels, and each with differing aims and expectations.
4. Over half of GP staff and one-third of CCG staff felt practices and collaborations had not been at all influential in shaping the local sustainability and transformation partnership. Only one-fifth of GPs thought STPs would deliver change in primary care, but CCGs were more optimistic with 61% reporting that meaningful change was probable.
5. GPs expressed enthusiasm for holding contracts for community services and selected hospital services. CCGs suggested they were optimistic about collaborations being ready to do so by April 2019.

# Key findings

6. Around half of practice partners (53%) said they would be unwilling or very unwilling to give up their current GMS/PMS/APMS contract<sup>3</sup> to join a new models contract (e.g. MCP or PACS contract<sup>3</sup>). The most common reason was that they did not want to lose control of their practice decision-making and leadership.
7. The main priorities of all collaborations over the last year were: increasing access for patients, improving sustainability and shifting services into the community. These were also the perceived benefits among the minority of respondents not already collaborating.
8. The priorities differed by size of collaboration. Smaller groups (under 100K registered patients) prioritised improving sustainability, staff experience and access. Alternatively, larger groups (100K+ patients) prioritised improving access and transferring services into the community.
9. About one-third of all collaborations said they had fully achieved the aim to increase access, but only one in ten had fully achieved the aim to improve sustainability. Length of time since forming was associated with a wider range of achievements than other characteristics like number of registered patients or level of operation (i.e. locality or CCG level).
10. Both providers and commissioners reported that time and work pressures were the biggest challenges to collaborations achieving their aims.

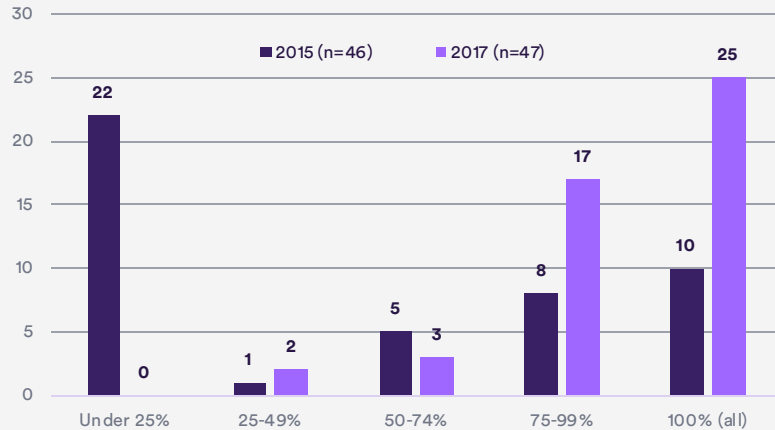
**How widespread is large-scale working?**

**What does the current landscape look like?**

# The trend towards collaborative working has continued: about half work together formally

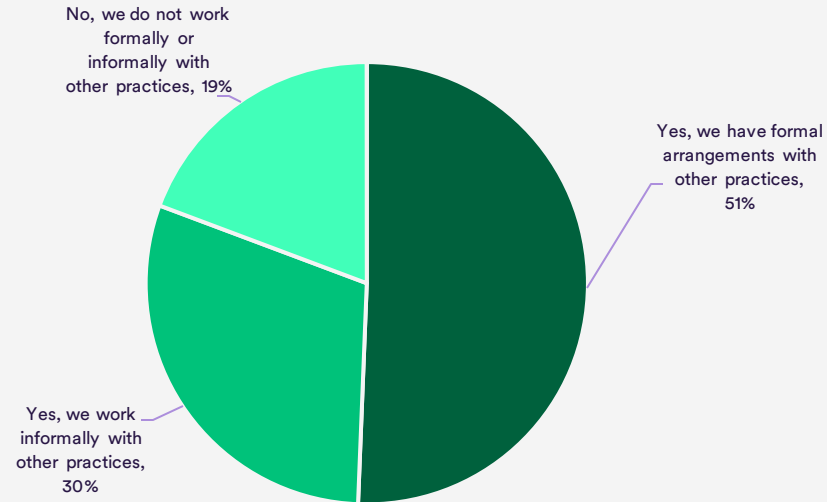
## Collaboration among practices is common

Over half of CCG respondents (n=25) reported in 2017 that all of their practices worked in collaboration compared to only one-fifth in 2015.



## About half collaborate using formal arrangements

81% (n=456) of our GP practice-based respondents said they were part of a formal (51%) or informal collaboration (30%).

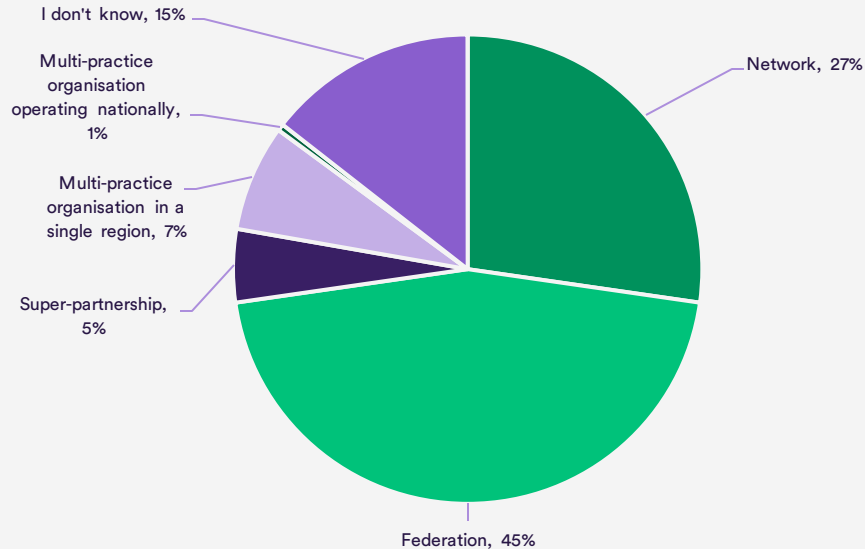




# Almost half of collaborations identify as federations<sup>3</sup> and as having formed 2+ years ago

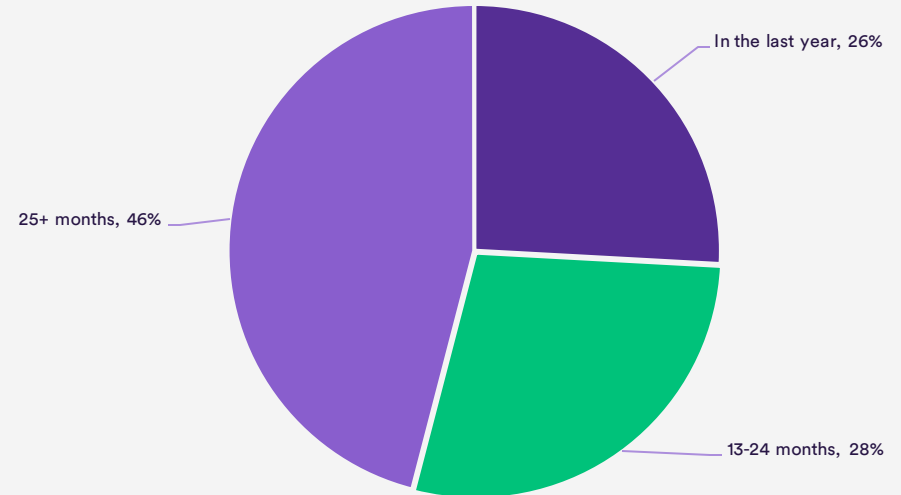
## Almost half of GP respondents report that their collaboration is a 'federation'

Most respondents report their collaboration has taken the form of a formal federation (45%) or informal network (27%) model.



## Almost half of GP respondents report that their collaboration was established more than two years ago

Only about a quarter of GP respondents report that their collaboration formed in the last year.



# But it's a complicated picture - practices can be part of 1-3 collaborations of different sizes

## Many work in multiple collaborations

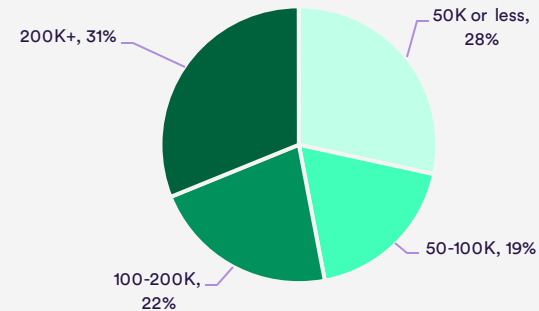
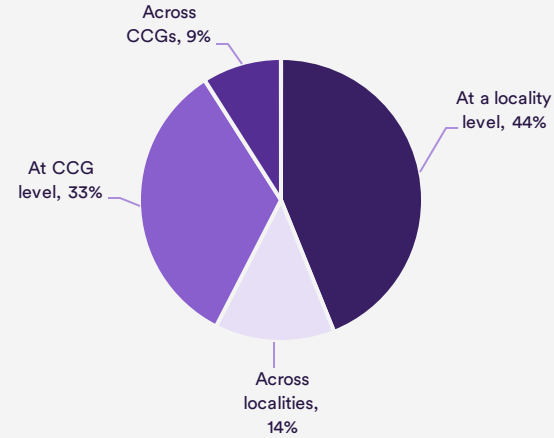
- About 20% (n=112) of GP respondents said their practice participated in two collaborations, and 5% (n=26) said they participated in three or more collaborations – mostly at locality and CCG levels.
- CCG respondents also reported multiple collaborations in their area. 40% (n=19) of them told us that their CCG had between two and five groups. 47% (n=22) described having one main collaboration, but about a quarter of those (n=6) clarified that they also had multiple smaller locality-based groups underneath, which reflects the complexity of arrangements.

## One size does not fit all

- The number of patients registered in collaborations ranged from under 50,000 to over 200,000 in about a third of cases (see chart).
- This spread may reflect the many new models of large-scale general practice being encouraged by national policymakers (e.g. primary care home [30-50K], multispecialty community providers [100K+], sustainability and transformation partnerships [200K+]).

## One-fifth of GP respondents said their collaboration had received national funding

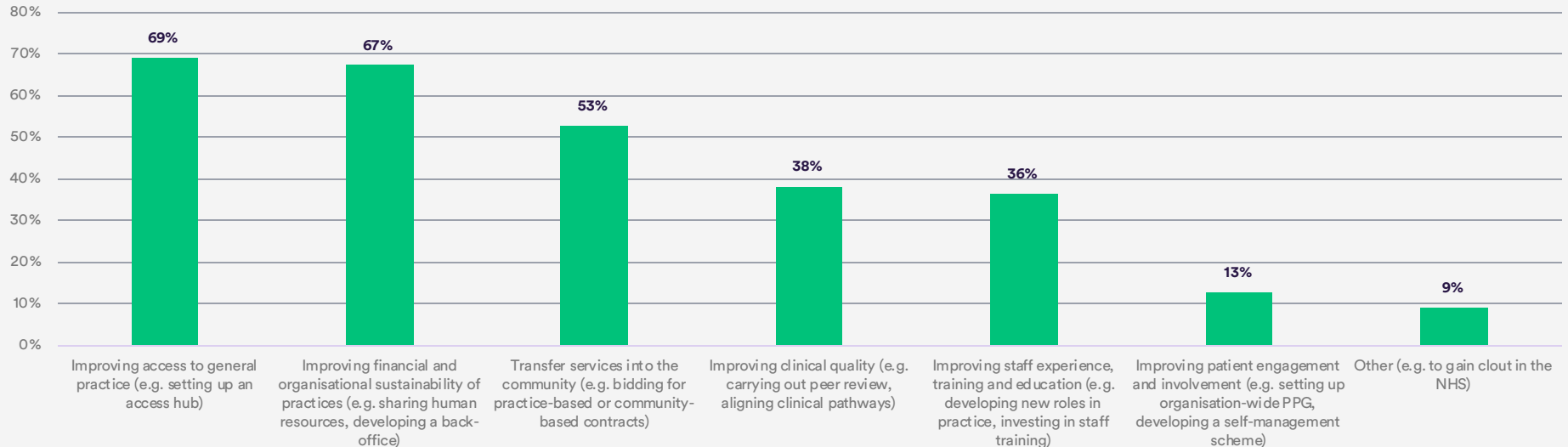
- Of them, almost half were a vanguard PACS or MCP, one-quarter were Prime Minister's Challenge Fund/General Practice Access Fund recipients, and one-fifth were part of a PCH.



# Most not currently working collaboratively are considering it

More collaborations are likely to form, and they are motivated by a range of potential benefits

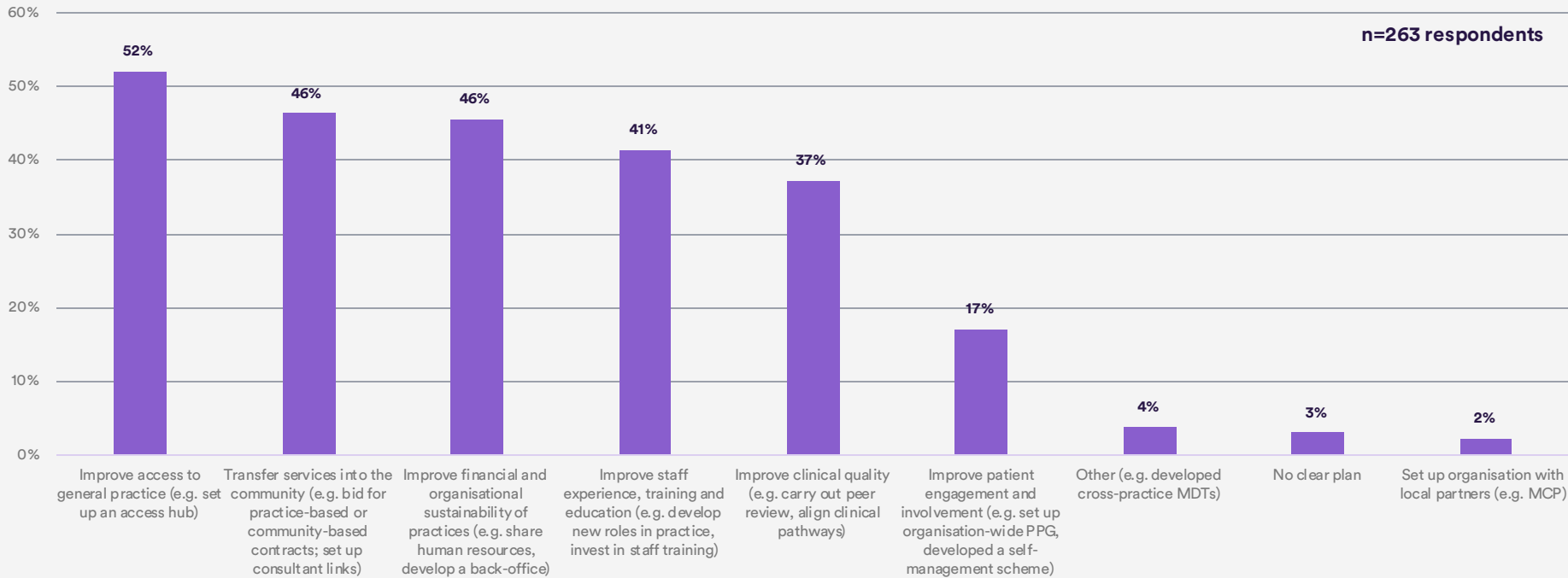
- About one-fifth of GP respondents (n=109) said they were not working in collaborations. Of those, about one-third (n=67) said their practice was considering it. About one-third of those considering collaboration said that they did not know when they would start working with other practices. Half said that it could take them anywhere between 7 months and 2 years to start.
- They see the main potential benefits as the ability to improve access and sustainability and to transfer services into the community.



# What did organisations aim to achieve 2016/17?

What influenced their ability to achieve aims?

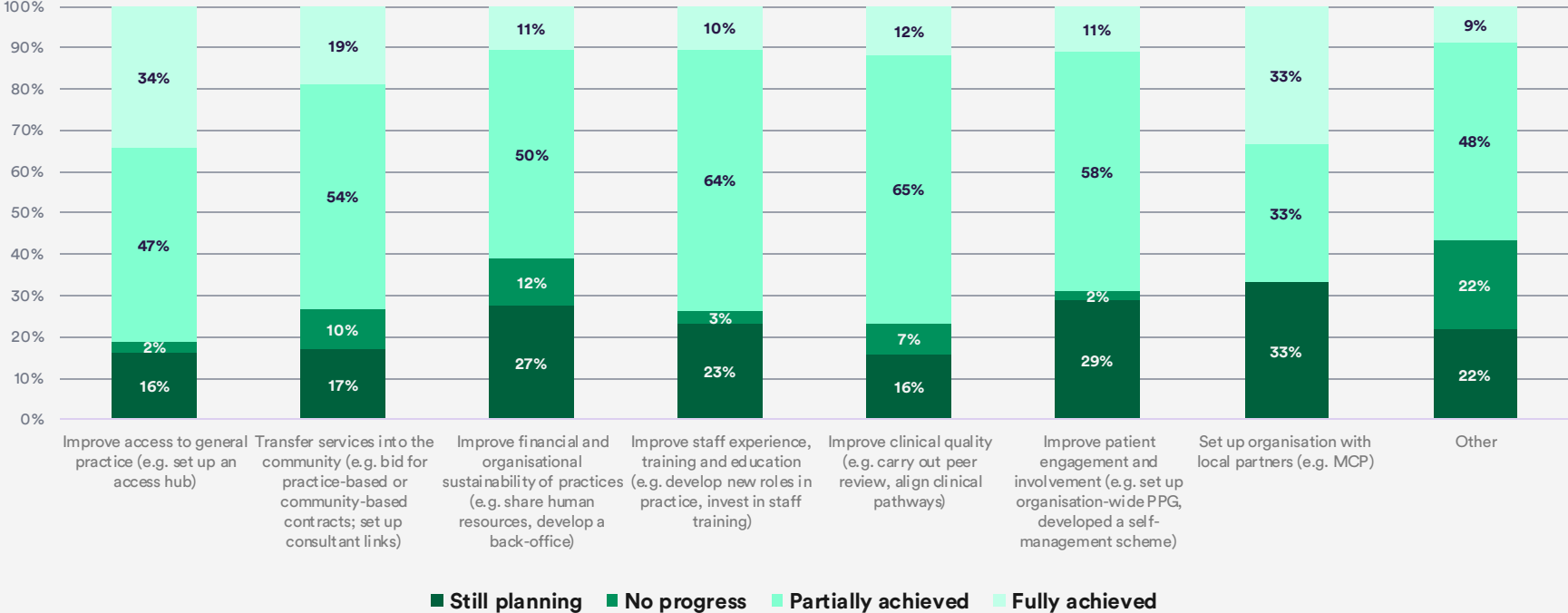
# Access, sustainability and transferring services into the community were priorities in 2016/17



Q: During 2016, in which of the following areas did your named organisation aim to have an impact?

# 34% 'fully achieved' access aim, but only 11% 'fully achieved' sustainability aim

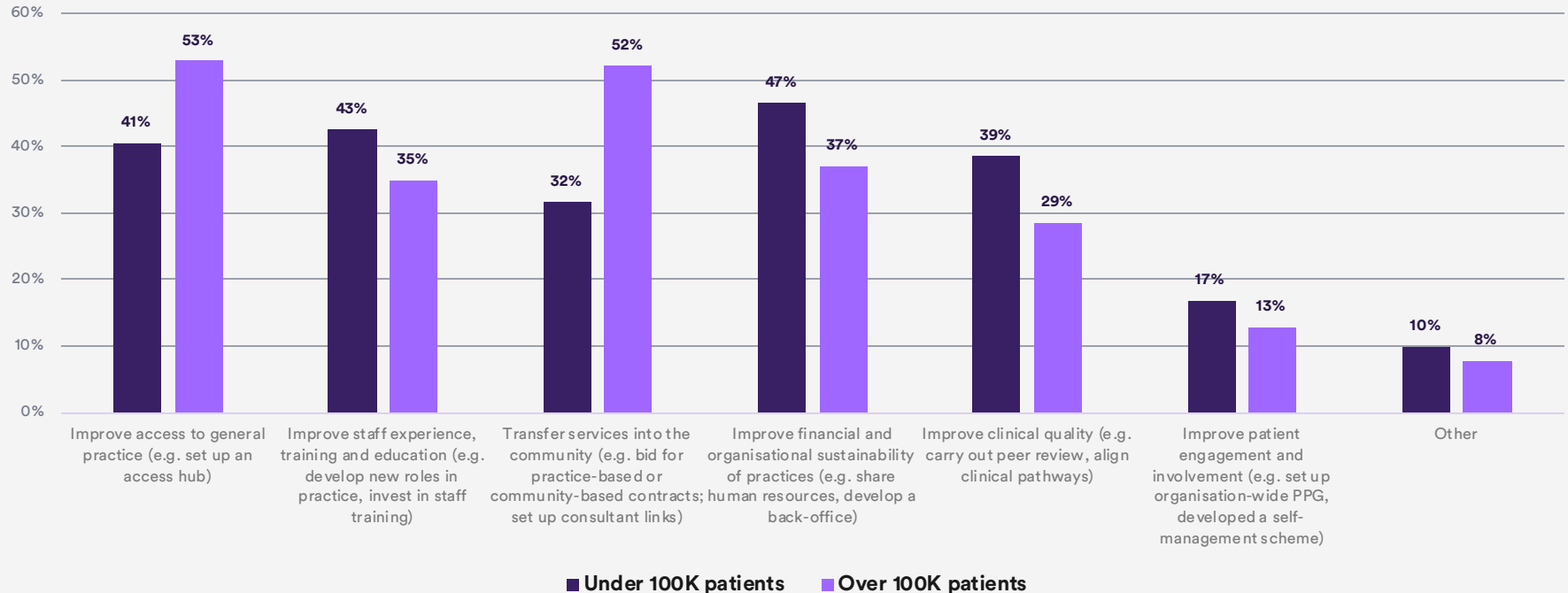
n=254 respondents



Q: To what extent have you made progress towards your aims to date?

# Aims differed by size of collaboration

- Smaller groups (under 100K registered patients) prioritised improving sustainability, staff experience and access.
- Larger groups (100K+ registered patients) prioritised improving access and transferring services into the community.



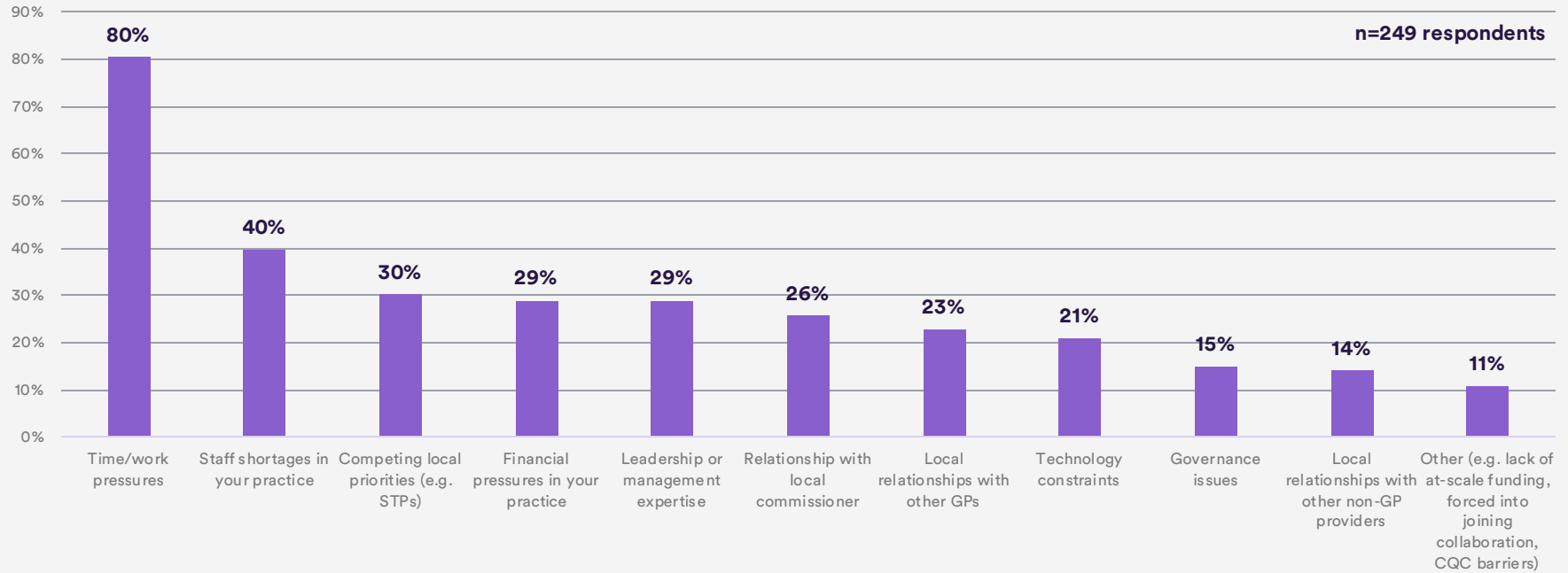
# Length of time since forming was associated with a range of achievements

	Age (length of time since forming)	Level (e.g. locality or CCG)	Size (No. of patients)
Improve practice sustainability	Collaborations formed 2+ years ago were able to fully or partially achieve the aim of improving practice sustainability (p=0.0005)	No association	No association
Improve access to general practice	No association	No association	No association
Transfer services into the community	Collaborations formed 1+ year ago were able to fully or partially achieve the aim of transferring services into the community (p=0.01)	No association	No association
Improve clinical quality	Collaborations formed 1+ year ago were able to fully or partially achieve the aim of improving clinical quality (p=0.01)	No association	No association
Improve staff experience, training and education	Collaborations formed 1+ year ago were able to fully or partially achieve the aim of goal of improving staff experience, training and education (p=0.0003)	Collaborations operating at a CCG or multiple-CCGs level are better able to achieve the goal of improving staff experience, training and education (p=0.01)	Collaborations with 100K+ patients are better able to achieve the goal of improving staff experience, training and education (p=0.01)
Improve patient engagement and involvement	No association	No association	No association

Note: All green boxes indicate statistically significant results (p<0.05)



# Time and work pressure was by far the biggest challenge collaborations faced in 2016/17



Q: What have been the three biggest challenges in achieving the aims of your named GP organisation/network of practices set in 2016? (Please select three options from the list)

# Lack of trust and difficult local relationships were also obstacles to progress



## Local relationships were problematic for some:

- For example, some respondents felt their LMC had not been supportive.
- In some areas, local trusts were described as having too much power in comparison to CCGs that were understaffed or had other priorities.

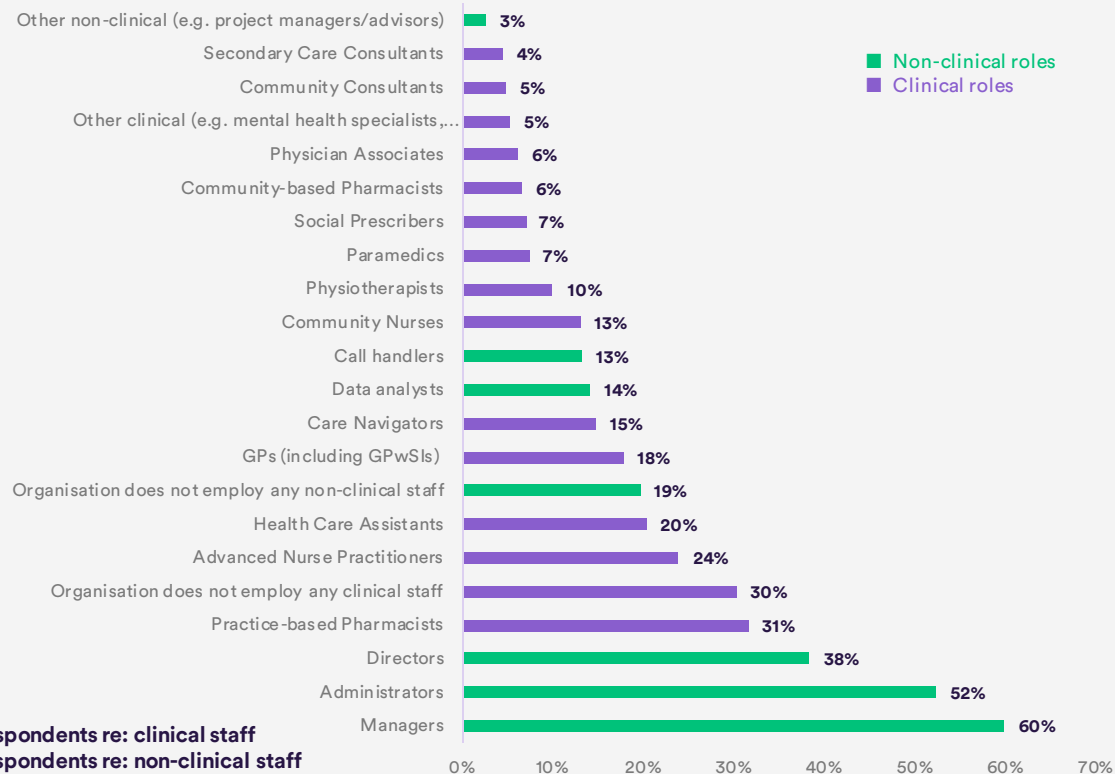
## Collaborations also faced internal challenges:

- In a few instances, organisation directors were described as being involved only for their own benefit and not always being responsive to practices.
- Some respondents highlighted a failure to engage GPs with a clear vision. Some said that practices needed to undergo a transition in mentality when moving from a small GP practice to an ambitious at-scale organisation.

## Complexity of the system made change unnecessarily difficult:

- The complexity of the system posed a problem for some, with a handful of respondents highlighting the need to work with multiple stakeholders on tight timeframes and a comment that there are just too many different levels at which they are being expected to work. Others feel that the goalposts keep changing.
- Confusion over competition and procurement rules; and burdensome bureaucracy (e.g. CQC registration; indemnity; pensions; premises) were also obstacles to progress for some.

# Over half of collaborations have employed non-clinical staff



## Non-clinical roles

- **More than half** of GP respondents' collaborations employ a manager and administrator. **Nearly 40%** employ a director.
- This seems to suggest a 'professionalisation' of the non-clinical workforce in collaborations.
- Statistical analyses revealed no characteristics (e.g. age, size, level) were associated with staff having been hired.
- But still about **one-fifth** of respondents' collaborations did not employ any non-clinical staff.

## Clinical roles

- The most common clinical roles were practice based pharmacist(s) and advanced nurse practitioner(s).
- About **one-third** of respondents' collaborations did not employ clinical staff.

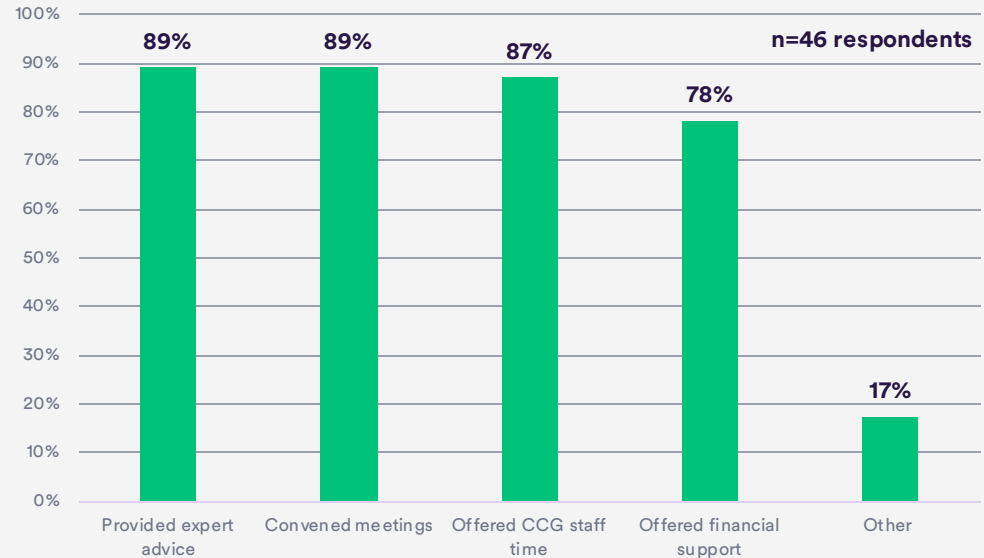
# What role have CCGs played?

What challenged CCGs supporting at-scale working?

# A majority of CCGs supported collaborative working nt

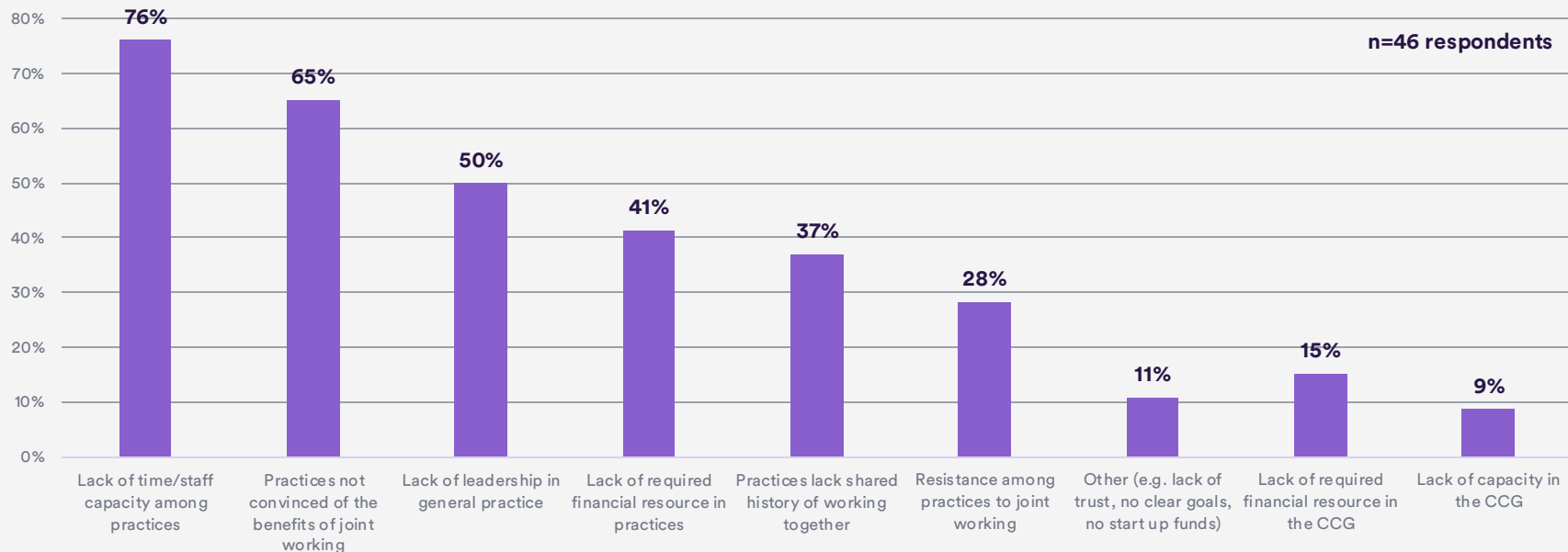
## Almost all CCGs have supported scale

- 98% of CCG respondents reported that they actively encouraged practices to form collaborations by:
  - Providing expert advice
  - Convening and facilitating meetings
  - Offering CCG staff time (e.g. for project management, federation leadership)
  - Offering financial support.
- CCGs also said that they had commissioned new pathways, services and enhanced services that offered financial support for start up.



Q: Have you (the CCG) actively encouraged practices to form GP organisations or networks of practices?

# CCGs supporting scale were most challenged by practices' lack of time/staff

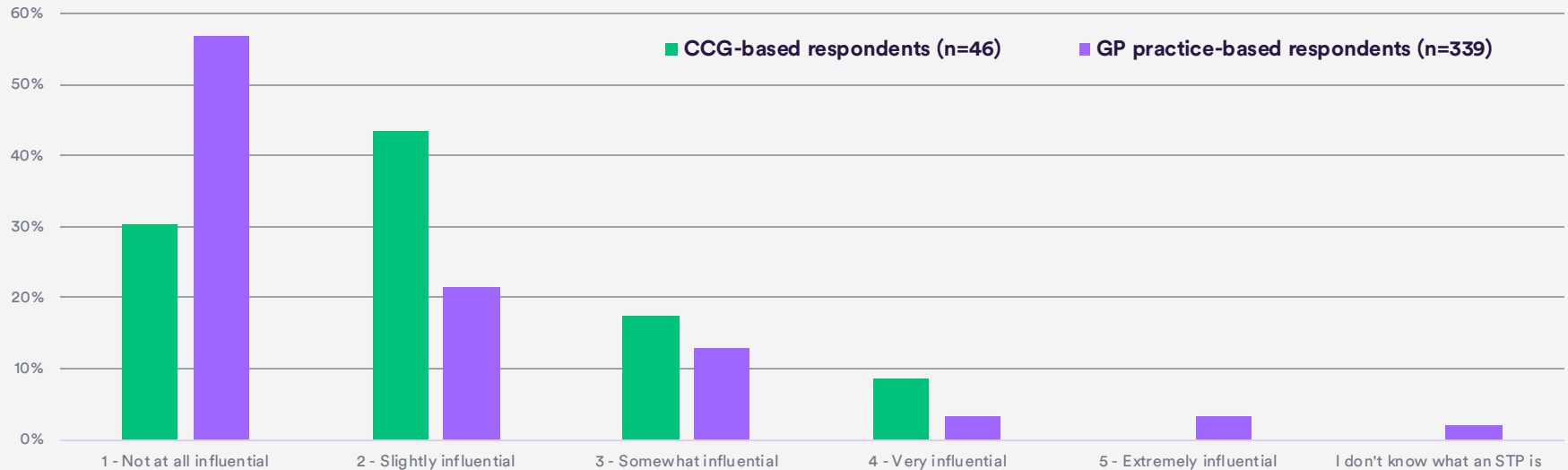


Q: What were the three main challenges you [CCGs] encountered in encouraging practices to form a collaboration?

# What does the future hold?

Regarding STPs, budget-holding, and contract types

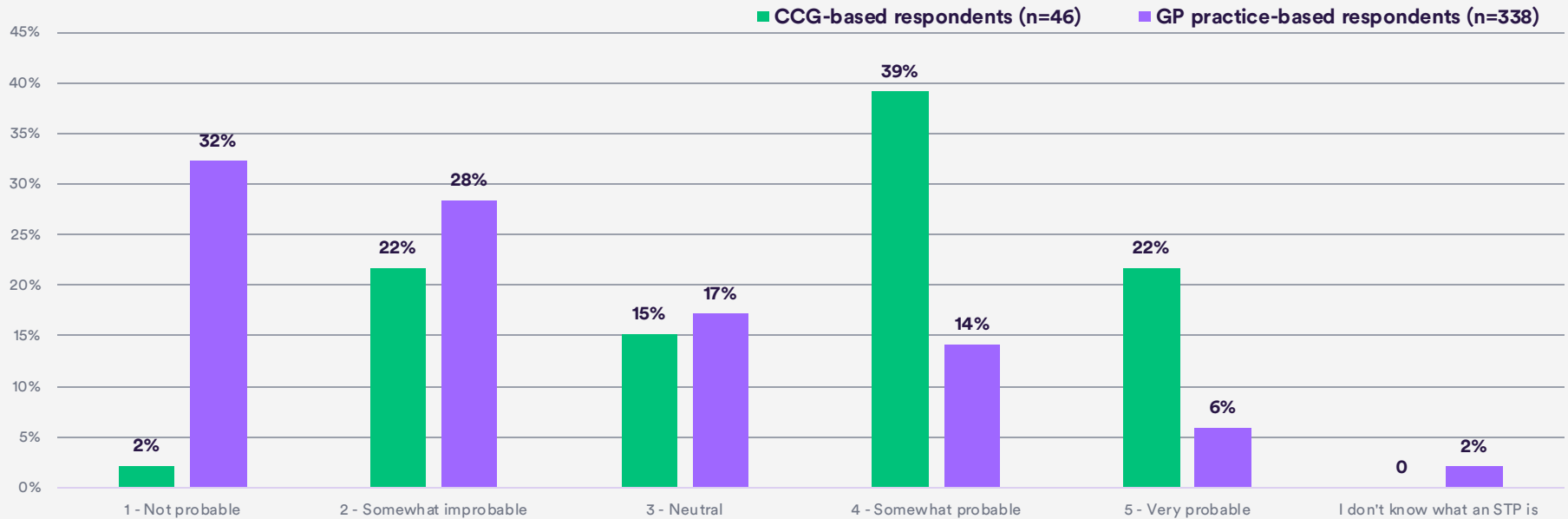
# Over half of GPs and one-third of CCGs felt practices had not been at all influential in shaping their local STP



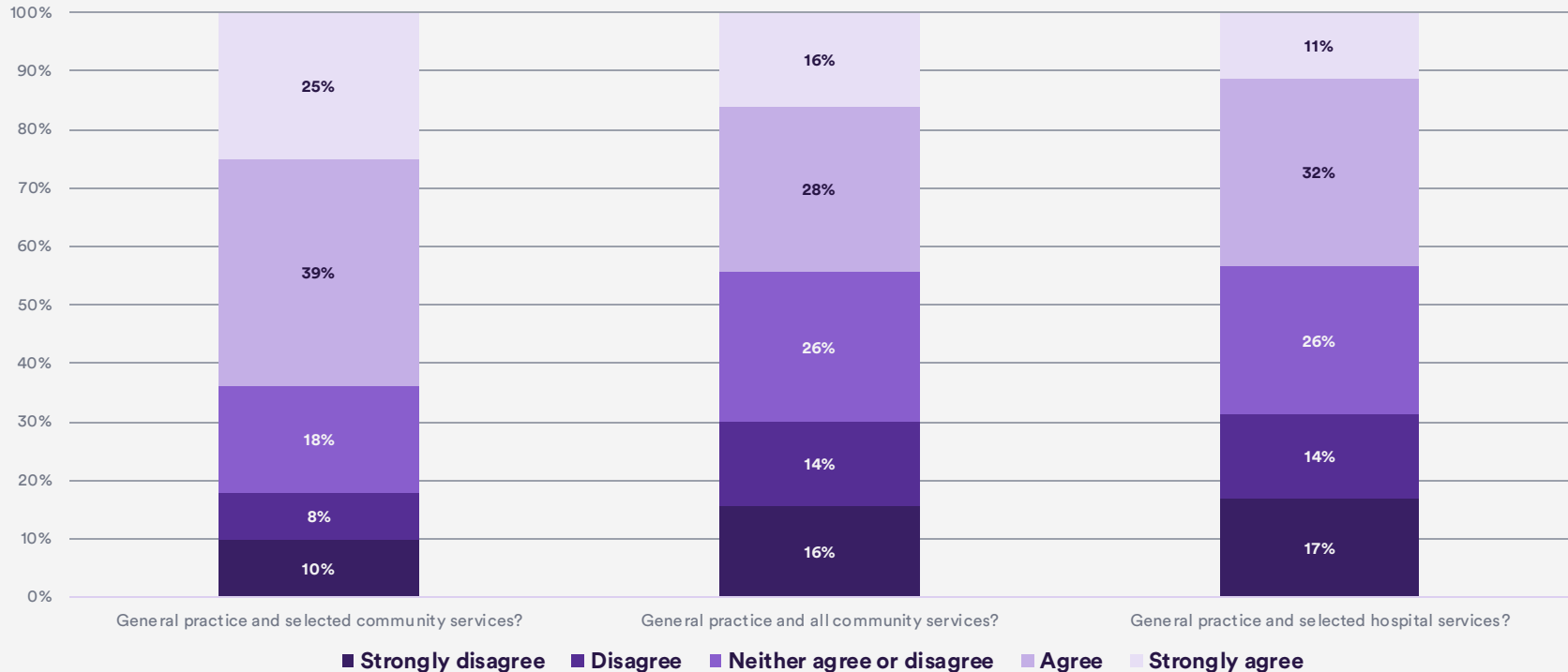
CCG Q: How influential have GP practices or GP organisations/networks of practices been in developing the content of your local STP?  
GP Q: How influential has your organisation or practice been in developing the content of your local sustainability and transformation plan (STP)?



# Only one-fifth of GPs thought STPs would deliver change in primary care – but CCGs were more optimistic

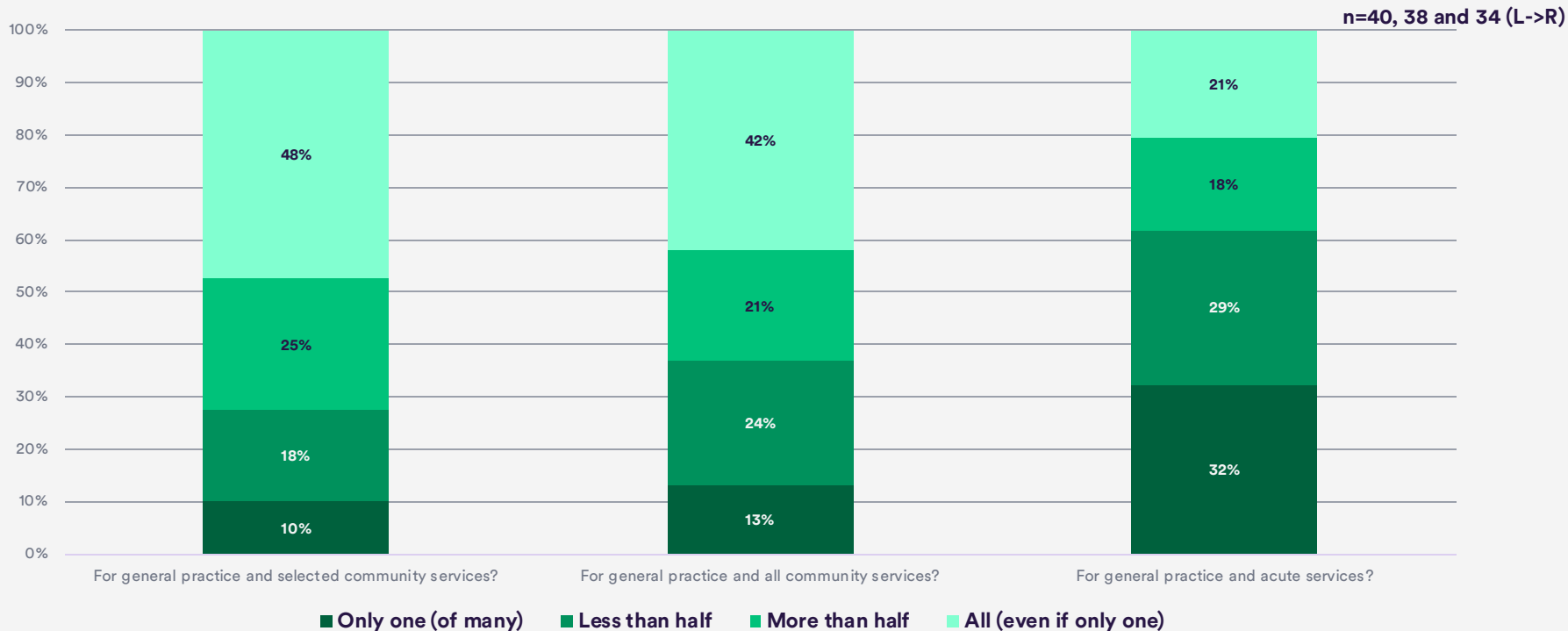


# GPs expressed enthusiasm for holding contracts for selected community services



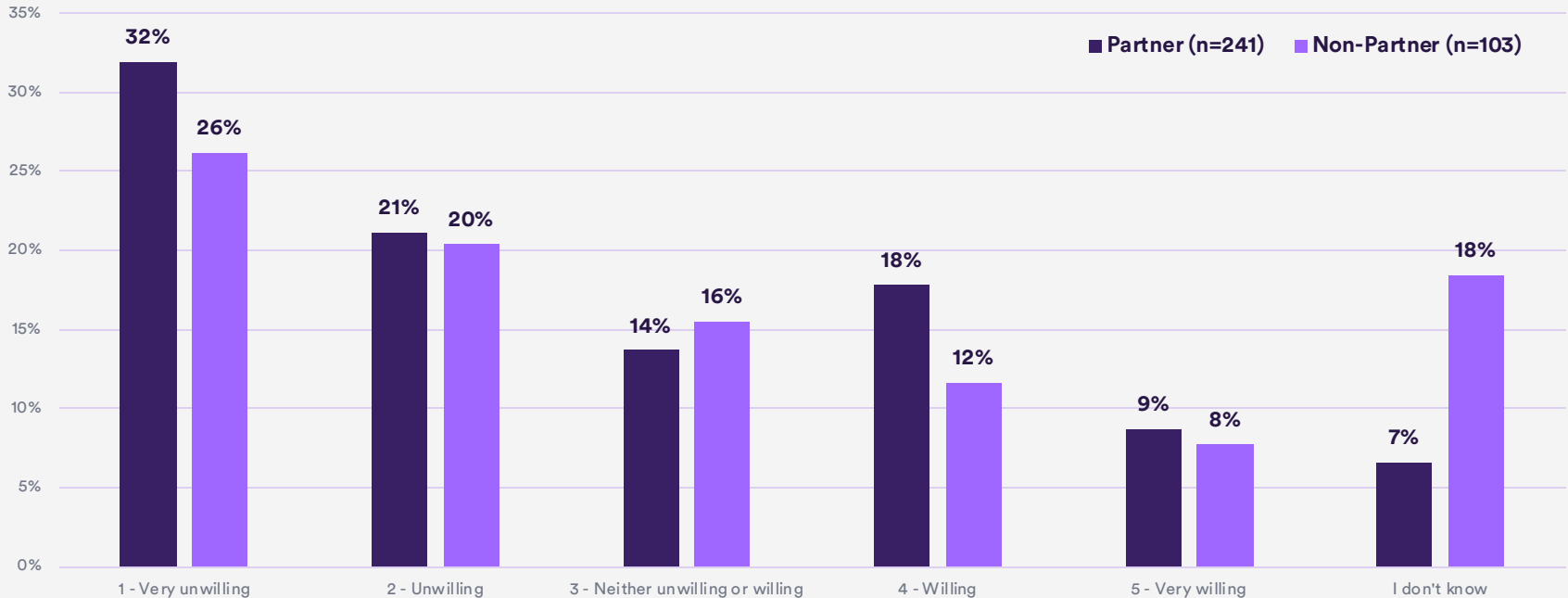
Q: Looking to the future, to what degree would you agree that your GP organisation/network of practices would like to hold a budget (and assume potential risks/gains) for the following: (n=256 respondents)

# CCGs were optimistic that collaborations would be able to hold budgets for community services



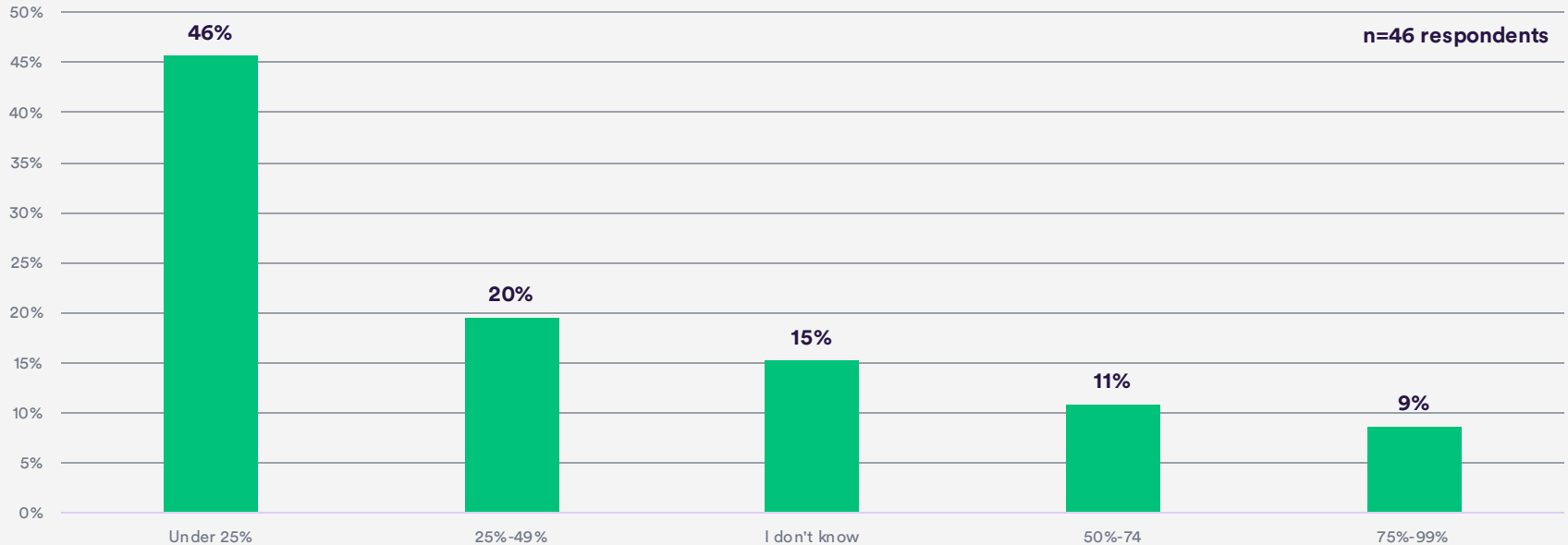
Q: Looking to April 2019, what proportion of the GP organisation(s)/networks of practices do you think would be ready to hold budgets?

# GPs were more unwilling than willing to leave current GMS/PMS/APMS contracts



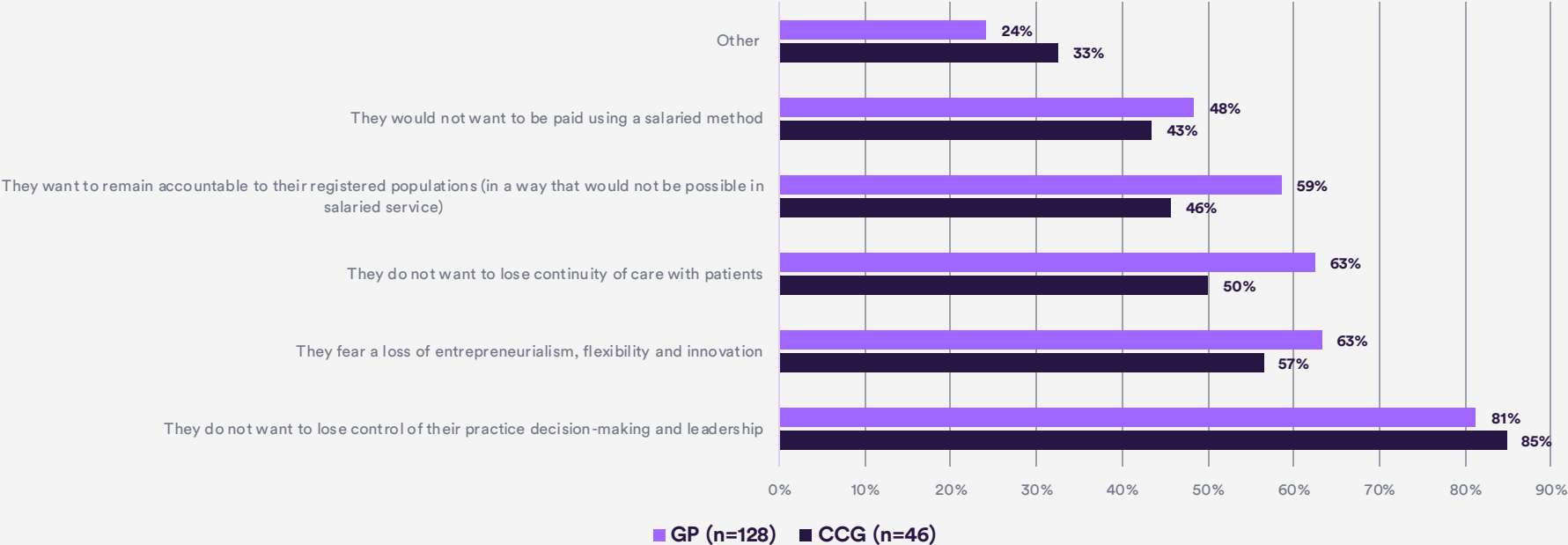
Q: How willing do you think [you / partners at your practice] would be to change [your / their] current practice (GMS/PMS/APMS) contract to become an associate practice in a local collaborative arrangement, such as a Multi-specialty Community Provider (MCP) or a Primary and Acute Care System (PACS)?

# CCGs agreed that GPs would be unwilling to change their contracts



**Q: What percentage of GPs in your area who are currently on a GMS/PMS/APMS contract do you (the CCG) think would be willing to change their contract to become an associate practice in a local collaborative arrangement, such as a Multi-specialty Community Provider (MCP) or a Primary and Acute Care System (PACS)?**

# A loss of control over practice decision-making **nt** was the biggest concern among those unwilling



GP Q: If unwilling, why would you be unwilling to change your practice's contractual status?

CCG Q: What do you think would deter local contract holders from considering becoming associate practices in MCPs and PACSs? (Please select all that apply)?

# Conclusions

## Progress made in large-scale general practice

- The trend towards collaborative working has continued, but time and work pressures have made it difficult to progress, along with other barriers such as staff shortages, practice finances, and competing priorities (e.g. STPs).
- The aim of improving access was most often 'fully achieved' (relative to all other aims). Only around one-fifth of those who had partially or fully achieved that aim had received GP Access Funding, suggesting progress can be made without national funding. Other goals, however, such as improving sustainability, staff experience, clinical quality and patient engagement were more difficult to realise – more work is needed to understand what enablers could help collaborations make better progress.
- Length of operation appears to have been more strongly associated with progress towards aims than other characteristics. A degree of patience will be required from national policymakers and GPs on the ground to see progress happen among recently-formed collaborations.

## Looking to the future

- GPs and CCGs agree that collaborations are likely to be ready to hold budgets for selected community services in the near future. Collaborations will need to think carefully, but positively, about their governance arrangements to enable this.
- GP engagement with their STPs may need to be re-examined quickly to develop better buy in. Further discussions about options for contractual models may also be needed, as a majority of GPs said they would be unwilling to change to a new contract.

# Appendix and references



# Survey respondents

## Our approach to gaining respondents

- Invitations were sent using a number of methods, including direct emails, newsletters (Nuffield Trust, NHS England, RCGP).
- Email invitations were sent to CCGs with the aim of one response per CCG.
- We also used social media to promote the surveys. The combination of methods means that we cannot provide an accurate response rate for either survey.

## Number of respondents

- **GPs and practice-based staff:** We received 578 responses, but 13 were incomplete or provided inconsistent data. 565 responses were analysed. Respondents worked in 162 (78%) of CCGs. We encouraged respondents to describe all of their job titles; around 60% were full or part-time GP partners (see Table 1).
- **CCG Chairs and AOs:** We received 64 responses, but 13 were incomplete or duplicates. 51 responses were analysed, representing 25% of CCGs. We encouraged respondents to describe only one job title; 90% were CCG Chairs or Accountable Officers (see Table 2).

Table 1. Describe all of your job titles (n=563)	Count	Percentage
Full-time partner in a GP practice	188	33%
Part-time partner in a GP practice	158	28%
Non-clinical manager (e.g. practice manager)	98	17%
Part-time salaried GP	49	9%
Sessional GP (locum)	27	5%
Other health professional (e.g. retainer GP, pharmacist)	21	4%
Other non-clinical professional (e.g. managing partner)	16	3%
Practice nurse	14	2%
CCG	13	2%
Academic GP	11	2%
GP trainee	6	1%
Full-time salaried GP	5	1%
Single-handed GP	1	0%

Table 2. Describe your main job title (n=51)	Count	Percentage
Chair	29	57%
Accountable Officer	17	33%
Commissioner	2	4%
Vice-chair/AO	2	4%
Medical Director	1	2%

# References and definitions

1. 2015 survey findings:

<https://www.nuffieldtrust.org.uk/research/collaboration-in-general-practice-surveys-of-gps-and-ccgs>

2. The 2015 and 2017 surveys were both anonymous cross-sections, which means that it is difficult to draw assumptions about trends from only two data points, so we have avoided doing so.

### 3. Definitions used in questionnaire:

- General Medical Services (GMS) contract, Personal Medical Services (PMS) contract and Alternative Provider Medical Services (APMS) contract are the varying contract arrangements between NHS England and the practice(s)
- Multispecialty Community Provider (MCP) and Primary and Acute Care System (PACS) contracts are 'new models of care' contracts aiming, ultimately, at better integration of care
- Network (informal arrangement between practices mainly for care provision purposes)
- Federation (practices linked by a legal contract which enables them to share front and/or back office functions)
- Super-partnership (a large-scale single corporate style partnership with an executive board created through practice mergers)
- Multi-practice organisation operating in a single region (a legal entity with corporate-style governance with lead salaried GPs in practices)
- Multi-practice organisation operating nationally (as above but with practices dispersed across the country)



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