

Securing the future of general practice: new models of primary care

Research report

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This research was carried out by members of the Nuffield Trust and The King's Fund: Judith Smith, Holly Holder, Nigel Edwards, Jo Maybin, Helen Parker, Rebecca Rosen and Nicola Walsh.

A summary of this report is available to download from:

www.nuffieldtrust.org.uk/publications/securing-future-general-practice

Foreword

General practice is the cornerstone of NHS care, yet the demands placed upon GPs and their teams have never been greater. Primary care sees more patients than ever, with more complex needs; it offers a wider range of services; and it is seeking to maintain and improve ever higher standards of care. At the same time, the GP workforce is changing. Significant numbers of experienced GP principals are nearing retirement, the GP workforce is increasingly sessional and/or part-time, and many areas are experiencing difficulty with recruitment. Tough times call for radical change.

This report, commissioned by NHS Midlands and East as part of its primary care ambition, clearly shows why general practice must continue to grow and adapt. It looks at new models of primary care created to address these challenges, and shows in particular the power of GP practices working together and sharing ideas and resources as networks, federations and super-partnerships. As these models may not suit all local circumstances, the report sets out 12 ‘design principles’ that clinical commissioning groups, area teams and practices may want to consider when thinking about the future shape of primary care locally.

This work will form part of the evidence base that NHS England is seeking for its current call to action, to develop a strategic framework for the future of health care in England.

This resource will be complemented by one developed for GP locums. Also described in this report, GP locum chambers may more effectively act as the buffer for practices to fluctuations in demand and supply than individual GPs acting alone, as well as giving the locums the peer, educational and revalidation support they require. ‘A modern solution for tomorrow’s GP workforce: GP locum chambers’ will be published in the next few weeks.

I would like to express my thanks to Dr Penny Newman and Jill Matthews for guiding this work, to local practices and GP leaders for their contributions, and to the Nuffield Trust and the King’s Fund for producing it. I commend its findings to commissioners and providers alike.

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Executive summary

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.

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.

1. Introduction

Background

Primary care is considered to be the bedrock of NHS care provision, offering ‘entry into the system for all new needs and problems, [it] provides person-focused (not disease-orientated) care over time, provides for all but very uncommon or unusual conditions, and coordinates or integrates care provided elsewhere by others’ (Starfield, 1998, p8-9). In the NHS in England, however, comprehensive, continuous care is under significant strain.

The current general practice workforce has insufficient capacity to meet current demand and expected patient needs (Centre for Workforce Intelligence, 2013), whilst primary care is simultaneously being asked to ‘scale up’ to: enable shifts of care from hospital to community settings; improve access to high-quality out-of-hours primary care services; reduce pressure on accident and emergency departments; and bring about better integration of care for frail older people in particular.

In addition, changes to the GP workforce with more part-time and sessional roles, limited access to GP locums, complex organisational requirements, and additional commissioning responsibilities have added to the pressure on GPs as independent contractors responsible for running their own businesses.

This combination of factors has led to debate about the changes needed to ensure that primary care will be sustainable for the future, especially given the financial constraints facing the NHS, and concern for care quality and outcomes (for example, Goodwin and others, 2012; Jones and Charlesworth, 2013).

The project

Over 2011/12, as the new clinical commissioning groups (CCGs) were being established, the former NHS Midlands and East Strategic Health Authority (SHA) undertook a review of the necessary conditions for sustainable GP leadership in commissioning (Newman, 2012). This indicated that GP leaders’ availability for commissioning on top of practice commitments was limited, and that more capacity was needed in the provision of primary care. Although this report has implications for the whole of primary care, the focus of this research has been primarily on general practice.

As part of this work, NHS Midlands and East SHA commissioned the Nuffield Trust and The King’s Fund to undertake a review of models of primary care at practice and multi-practice level. The brief was to explore models that could increase primary care capacity, quality of care provision and general practice leadership capability, and would be sustainable over time. Specifically, the project aimed to:

1. Describe the current pressures on primary care.
2. Identify what high quality in primary care might look like and explore different models that might be able to deliver this.

3. Identify the key characteristics of these primary care models.
4. Based on the analysis above, develop a criteria-based framework for assessing new models of primary care, and general practice in particular.
5. Propose new models for how primary care might be organised in the future.
6. Make recommendations on how these models could be taken forward in NHS Midlands and East SHA, and, as appropriate, more widely in the NHS in England.

The project was carried out between November 2012 and March 2013 and comprised:

- a literature review of high performance in primary care provision
- desk research, and phone interviews with leaders of UK and international models of primary care
- two workshop events with national and local practitioners, and other stakeholders
- telephone interviews with experts in workforce and organisational development in primary care
- testing of project findings with participants at a European Summit on primary care, the Grafton Group of leading CCGs, and a national primary care strategy meeting involving primary care practitioners and managers
- on-going discussion and feedback with NHS Midlands and East SHA.

This report begins with an outline of current pressures facing primary care and makes the case for change. The characteristics of high-quality primary care are then set out, followed by a description of some of the most prominent emerging and established approaches to organising primary care provision. This analysis is used to inform the development of a set of design principles which describe what primary care needs to offer patients and populations in future.

The report concludes with an examination of mechanisms available to bring about change to NHS primary care, and an analysis of the leadership, management and organisational development likely to be required. Suggestions are made about next steps.

This report aims to inform NHS England as it implements a single operating model for primary care commissioning, and develops a strategic framework for primary care. It also seeks to help local leaders in thinking through options for strengthening primary care, and general practice in particular.

2. Case for change

The nature of primary care

Strong and effective primary care is typically considered to be critical to a high-performing health care system because of its role in improving outcomes and containing costs (Starfield and others, 2005). Recent research has concluded that strong primary care is associated with lower rates of avoidable admissions to hospital and fewer potential years of life lost for most of the conditions that were studied; yet requires higher levels of health spending to achieve such benefits, with likely savings accruing in the longer term (Kringos and others, 2013). Primary care comprises those services that lie between self-care and hospital/specialist care, and fulfil a range of functions including:

- prevention and screening
- assessment of undifferentiated symptoms
- diagnosis
- triage and onward referral
- care coordination for people with complex problems
- treatment of episodic illness
- provision of palliative care.

Saltman and others (2006) have argued that this intermediate territory (between self-care and specialist/hospital care) is changing, with primary care playing an increasing part in coordination of care provided by different services.

Furthermore, developments in technology have created opportunities for changes to the location and mode of care: elements of specialist care can now be delivered in primary care settings; electronic prescribing and dispensing are set to change the way in which pharmacists work with patients and general practice; and developments in the internet, telehealth and telecare are leading to a significant reappraisal of where a person's first contact with health advice and support takes place. These new services can be thought of as 'extended primary care'.

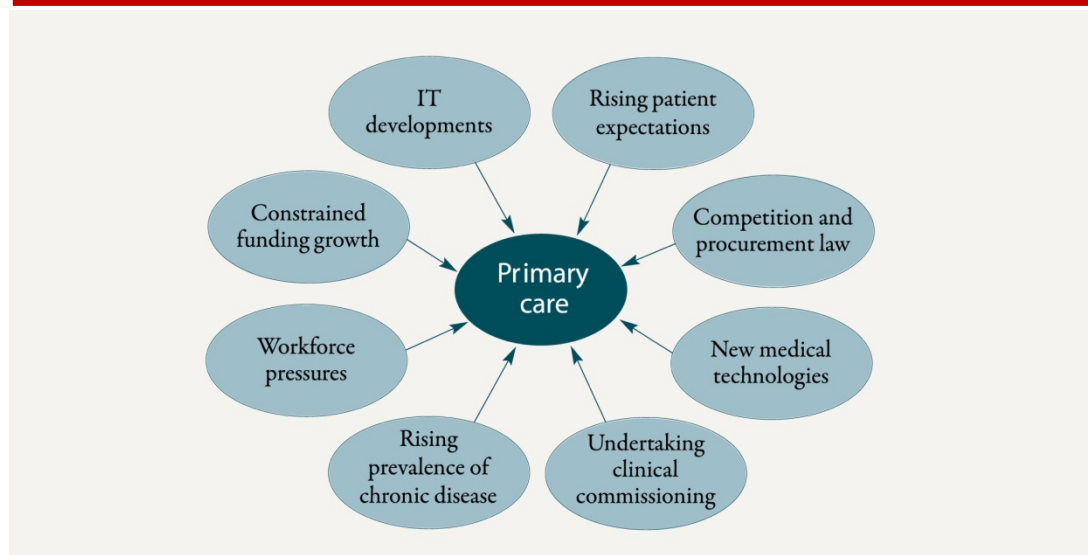
A vital aspect of primary care in the NHS is the registered list of patients held by all practices. This provides practices or primary care organisations (for example, networks or federations, and super-partnerships) with the opportunity to take a more active population-based approach to planning and delivering care for registered patients (Thorlby, 2013).

Drivers of change

Primary care in England is under pressure as a result of multiple drivers of demand (see Figure 1 for a summary). There is evidence that demand for primary care has been rising significantly over time, with the number of general practice consultations having risen by 75 per cent between 1995 and 2009, resulting in an increased clinical workload of over 40 per cent when compared to 1998 (Office for National Statistics, cited by Howard and others, 2013, p6). A substantial proportion of this additional workload may be the result of an ageing population and a significant rise in the number of consultations for patients aged over 60 years old (Centre for Workforce Intelligence, 2013). Other pressures are likely to arise from

IT developments, competition and procurement law, and constrained funding growth.

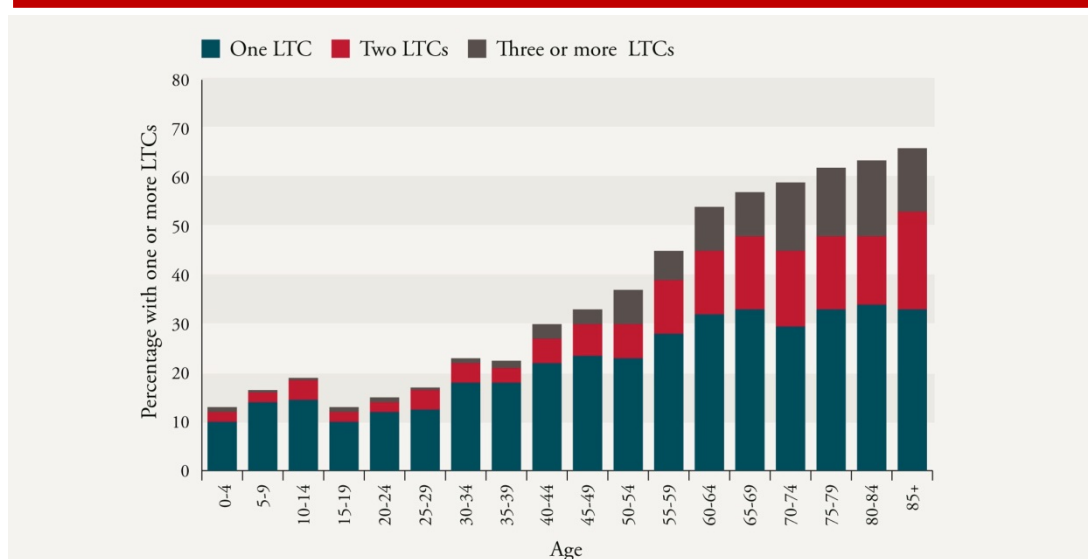
Figure 1: Pressures on primary care in England



Disease trends

The prevalence of long-term conditions continues to rise due to an ageing population, and the need for better coordinated care for people living with complex co-morbidities becomes more pressing (see Figure 2). People with at least one long-term condition account for over 50 per cent of all general practice appointments (Gerada and others, 2012) and by 2025, the number of these patients is due to rise from 15 million to 18 million. The number of patients with multi-morbidity (having more than one long-term condition) is also increasing.

Figure 2: Proportion of people with long-term conditions (LTCs) by age, England 2005



Source: General Household Survey 2005 and population census estimates 2004 for England.

*For those aged 65 or over, an adjustment has been made using 2001 census data to account for those living in communal establishments.

The desire for integrated care

Research suggests that poor communication between primary care, hospitals and medical specialists can result in fragmentation of care, low-quality patient experience and sub-optimal clinical outcomes (Vrijhoef and Wagner, 2009). Indeed, this is an important factor driving international concern as well as national efforts to develop integrated care (Goodwin and others, 2012).

The role of primary care in providing improved coordination of care is a subject of significant debate in the UK and elsewhere, for primary care often struggles to influence care beyond its immediate remit, as was vividly demonstrated by the Francis Inquiry into events at Mid Staffordshire NHS Foundation Trust, where GPs failed to link intelligence about patient outcomes and experience, and hence identify or influence what was a sustained pattern of poor care in the local hospital (Francis, 2013).

Inequalities in access

Inequalities in access to general practice have been a concern for many years, as evidenced in the 1997 Primary Care Act that tried to address the issue through the establishment of new contractual approaches to delivering primary care. These inequalities persist to this day, however, with economically disadvantaged groups of the population often having a smaller number of GPs available to them (Goodwin and others, 2011).

The primary care workforce

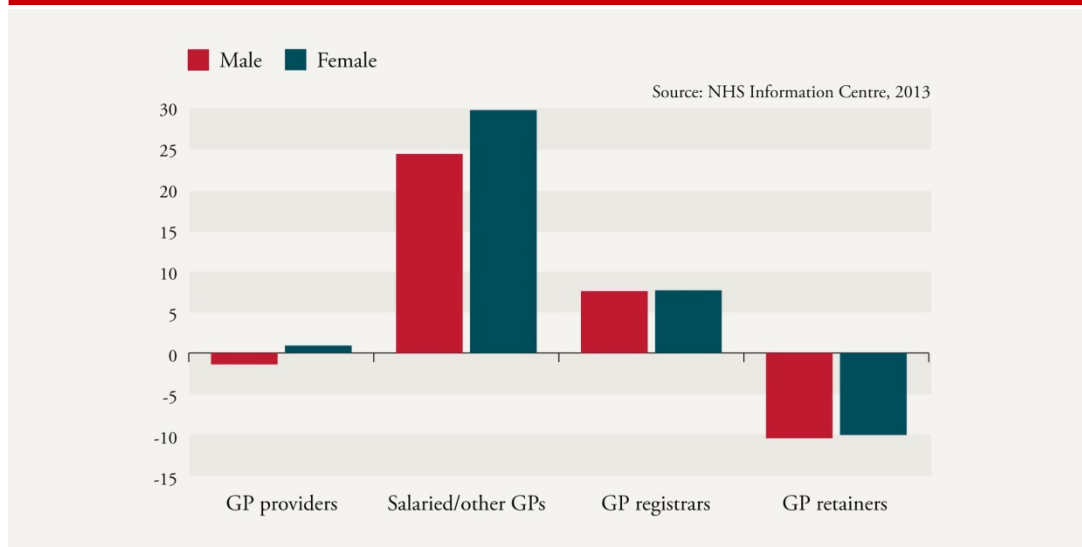
In 2011, The King's Fund Inquiry into the quality of general practice reported trends that included:

- a fall in the number of single-handed GPs, and a trend towards larger practices
- a steady increase in the proportion of female GPs (see Figure 3)
- a significant increase in the proportion of sessional and salaried GPs (see Figure 3)
- increasing demand for part-time and flexible working arrangements
- fewer partnership opportunities
- projected shortfalls in the number of practice nurses and GPs as a 'retirement bulge' occurs in the current decade.

(Goodwin and others, 2011).

Despite evidence suggesting that GPs are struggling to fulfil their role given current demand pressures (Centre for Workforce Intelligence, 2013; Royal College of General Practitioners, 2013), the number of GP trainees is well below the government target, with a gap of 2,850 GP training vacancies in 2013 (Centre for Workforce Intelligence, 2013). Similarly, analysis for NHS Midlands and East SHA argued that the gap between supply and demand for primary care is growing (Howard and others, 2013, p12).

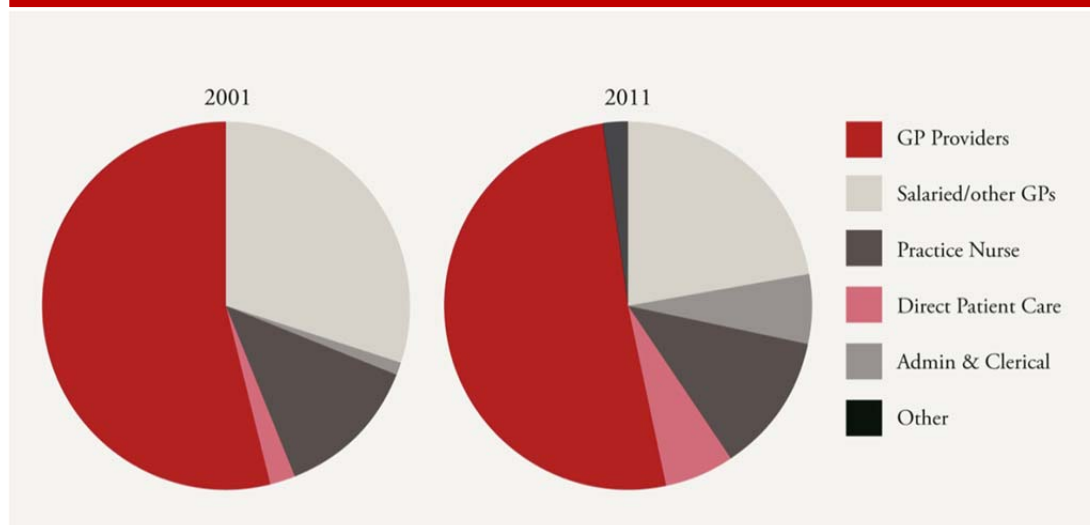
Figure 3: The percentage change in the number of GPs, whole-time equivalents, by type and gender, England 2001-2011



Alongside these developments, an increasing number of primary care services are being provided by non-medical professionals. For example, extended nursing roles in long-term conditions management, minor injury and illness often underpin the delivery of ‘walk-in’ clinics, phone triage services, minor illness services, and primary care for remote, rural communities.

Pharmacists are increasingly providing advice on self-management of self-limiting conditions, public health support such as smoking cessation and weight loss, and some offer tailored support for patients with long-term conditions. Furthermore, health care assistants with basic health training but no professional qualification are, in some instances, taking on roles in primary care that were formally undertaken by nurses. Health care assistants and other similar roles known collectively as ‘direct patient carers’ account for an increasing proportion of general practice staff with the number of full-time equivalents increasing by 13 per cent between 2001 and 2011 (see Figure 4).

Figure 4: Changing proportions of the general practice team, full-time equivalents, England 2001 and 2011

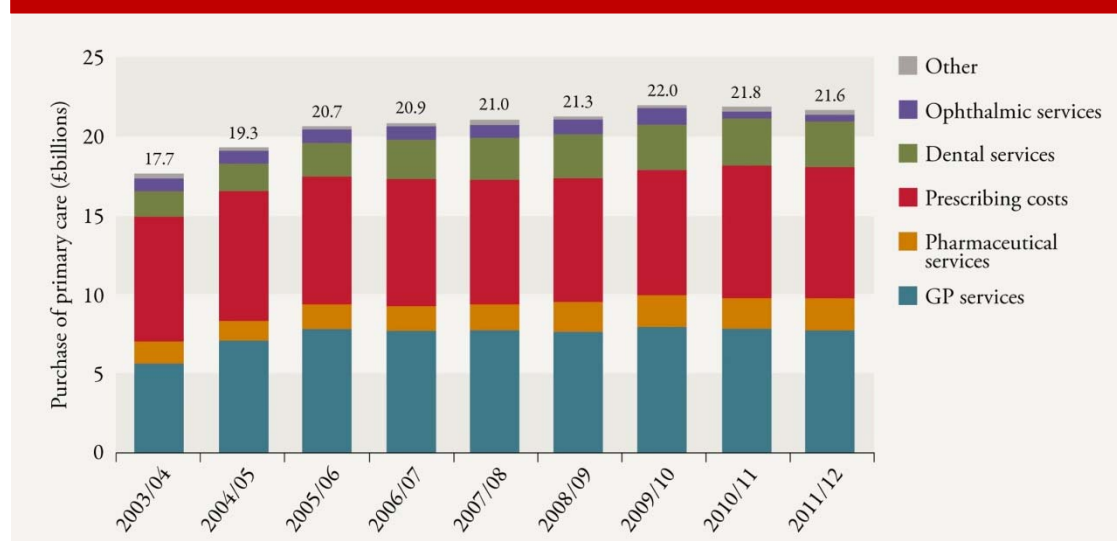


Funding

The impact of constrained funding for health and social care means that the NHS in England faces a decade of effectively flat funding. Sustained and unprecedented increases in productivity will be required to avoid reductions in the level or quality of services (Roberts and others, 2012).

For primary care, this wider financial squeeze comes on top of a period of already reduced funding. Although the amount spent on primary care has increased in the period 2003/04 to 2011/12 (Figure 5), expenditure on primary care as a proportion of overall NHS spending reduced from 26 per cent to 24 per cent, and spending on GP services has been static since 2005 (Jones and Charlesworth, 2013). While 24 per cent of NHS spending went on primary care, secondary care received 53 per cent (Roberts and others, 2012; figures for 2010/11).

Figure 5: Primary care trust spending on primary care in England: 2003/04 to 2011/12



Source: Jones and Charlesworth, 2013

There is no sign that these trends in funding will change in the near future. The General Medical Services (GMS; the main funding for general practice services in the NHS) contract settlement for 2013/14 is at 1.32 per cent, a below-inflation uplift, and the government has signalled its intention to continue to expect further service developments as part of the GMS contract, for example with the shift from paying for organisational work in practices to a requirement for progress in four new service domains: diagnosis of dementia, telehealth, patients' access to records, and providing managed care for people at high risk of hospital admission.

The relatively small size of primary care organisations

General practices are typically small organisations, working in relative isolation from one another, with the exception of some networking for the purposes of out-of-hours cover and involvement in clinical commissioning. Indeed, collective working in recent years has tended to flow more from GPs' role in relation to commissioning, rather than a desire to deliver primary care services in a more collective manner. The resulting small size of most practices presents challenges to enabling full use of the multidisciplinary team, having the necessary resource to fund extended primary care, and lacking management and leadership capacity for service and organisational development.

The impact of commissioning

The requirement for GPs to play a leading role in the new commissioning system in the NHS as reformed by the Health and Social Care Act 2012 places an additional pressure on primary care providers. Research in the Midlands and East region (over the period September 2011 to February 2012) examined primary care leadership and concluded that while increased clinical leadership can deliver benefits in terms of improving quality and reducing costs, there are potential challenges for GPs relating to availability of skilled cover to replace time taken by clinical commissioning work, impact of GP partner absence on the practice, remuneration of commissioning work, and career direction for GP leaders (Newman, 2012). Many GPs also reported having little knowledge of new models of care such as practice federations (networks of GP practices that come together into a network to plan and deliver services in a collaborative manner) that could potentially resolve some of the issues facing general practice.

What does this mean for primary care?

This analysis suggests that GPs and their teams are caught on a treadmill of trying to meet presenting demand whilst lacking time to reflect on how they provide and organise care. These trends are consistent with those identified in national and international research by The King's Fund Inquiry, the Centre for Workforce Intelligence, the European Forum for Primary Care, and as discussed by participants at the Nuffield Trust European Summit 2013. GPs are likewise subject to criticism about what is perceived as their lack of involvement in providing 24/7 primary care services, albeit that many are part of local arrangements for out-of-hours care. What is missing, however, is an analysis of how the future could be different for in- and out-of-hours primary care, about how services might be delivered and organised, and the working lives of practice teams changed.

In the following chapters of this report, we identify the characteristics of high-quality primary care and examine four new types of primary care model which may enable the delivery of high-quality care in the context of the challenges outlined in this chapter. Drawing on this analysis, we develop a series of ‘design principles’ to act as a guide for local practitioners and commissioners working to develop new models of primary care tailored to the needs and resources of their communities.

3. Characteristics of high-quality primary care

Defining high-quality primary care provision

Models for the future organisation of primary care must respond not only to the considerable pressures set out in Chapter 2, but should be guided by principles that articulate what constitutes high-quality primary care.

This chapter proposes a set of characteristics that define a high-quality primary care service. It also includes a description of the different types of care needs which any model must support. The diversity of these needs illustrates how the principles of high-performance will need to be tailored.

The core attributes of high-quality primary care

In order to describe the service quality expected from any future model of primary care, we reviewed a selection of national and international frameworks that set out criteria for identifying high performance (WHO, 2000; Commonwealth Fund, 2008; WHO Europe, 2008; Legido-Quigley and others, 2008; Maxwell, 1984), and in primary care in particular (Kark, 1974; Peterson, 1980; Kark, 1981; Future of Family Medicine Project Leadership Committee, 2004; Showstack, 2004; The King's Fund, 2011).

One framework, recently developed in the United States (US), seemed to us to combine the basic attributes expected from any health care service, with qualities that reflect the distinctive role that should be played by primary care in the UK. This was the framework underpinning the 'Patient Centered Medical Home', which stipulates that primary care services should be (Agency for Healthcare Research and Quality (AHRQ), 2013):

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

In the US, cultivating the Patient Centered Medical Home model has been seen as critical to delivering the so-called 'triple aim' of health system performance: improving patient experience; improving population health; and reducing the per capita cost of health care (Institute for Healthcare Improvement, 2013). The model has gained widespread support in the US from family practitioners, policy-makers and employers (see for example, American Academy of Family Physicians and others, 2007; Kilo and others, 2010; Piekles and Wasson, 2012; AHRQ, 2012).

The Patient Centered Medical Home model builds on decades of research on primary care in the US and internationally, incorporating key features from care models focused on long-term conditions management (for example, Wagner and others, 1996; Bodenheimer and others, 2002), and responding to concerns that care is not sufficiently patient-centred (for example Safran, 2004; Davis and others,

2005). It also recognises the central role that primary care can play as the principal provider and coordinator of patients' health care needs (for example, Starfield and others, 2005; Saltman and others, 2006). As such, the model is particularly suited to equipping providers to respond to some of the pressures on primary care identified in Chapter 2, including tailoring care to meet the needs of patients with long-term conditions and multi-morbidities; improving communication and care coordination between primary care and hospitals; and responding to changes in patients' expectations about the accessibility of services.

Using these five core principles, and their definition by the US State Department's AHRQ (2013) as a starting point, we have adapted the framework for the English context (see Table 1). To do this, we drew on insights from other frameworks as well as the experience and expertise of the research team, and sought feedback on the draft revised framework from clinicians and commissioners participating in our first stakeholder workshop. For example, drawing on Sidney Kark's pioneering work on 'community-oriented primary care' (Kark, 1974; 1981), and the tradition of list-based general practice in the UK, we claim that primary care must be not just patient or person-focused, but also orientated to local *populations*, combining proactive public health work for communities with the treatment of illness and injury in individuals.

Types of care need in primary care

The population for which a primary care organisation is responsible will have a range of health and care needs, which in turn imply the need for a range of different services. Individual organisations may focus on a particular function and/or population group however, although an overarching model of primary care provision will need to be capable of fulfilling the following five 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 at the end of their lives.

In addition to meeting these broad categories of need, any new forms of primary care service should also be able to meet the needs of vulnerable population groups, some of whom currently experience particularly poor health, and are often not well served by existing care models. These groups include:

- children and adults with learning disabilities
- children and adults with physical disabilities
- the frail elderly
- individuals who are socially marginalised, such as the homeless, gypsies and travellers, sex workers, people suffering from drug and alcohol addiction, recently-arrived asylum seekers, and individuals from communities with little or no experience of using primary care services.

This review of frameworks of high performance in health and primary care enabled us to develop core characteristics by which to design primary care that is not only fit to meet future demands, but can also assure high quality and safe care provision. We suggest that these characteristics can form a framework for evaluating the effectiveness of new models of primary care.

Table 1: The characteristics of high-quality primary care

| | |
|------------------------------|---|
| Comprehensive | The organisation is accountable for meeting the majority of patients' physical and mental health care needs, including in relation to wellness, prevention, and acute and long-term conditions care. Where the right skills or services are not available within the primary care organisation, staff play a central role in coordinating virtual care teams involving professionals from other community services and specialists in secondary care, and signposting people to relevant local welfare and other social support services. |
| Person-centred | This is relationship-based, premised on trust, and concerned about the whole person. Patients and their carers are recognised as core participants in decision-making about care and treatment. When registered with a primary care organisation, a patient benefits from continuity of care with a professional, when that is important to the patient and beneficial for their treatment. Person-centred care takes seriously the ways in which broader life experiences (such as wealth, housing and family circumstances) carry consequences for an individual's health and care. |
| Population-oriented | The organisation is responsible for providing services not only to those who attend their premises, but also for a specified population. Depending on the model in question, this might include all individuals registered with the organisation; all those who are resident in a specific geographic area; and/or individuals who belong to a specific population group (e.g. the frail elderly or homeless). |
| Coordinated | Care is coordinated across all elements of health care system, with particular attention paid to overseeing and being accountable for transitions between providers, and building and sustaining open and clear coordination between the patient and their various care teams. |
| Accessible | Patients experience appropriate waiting times for initial consultation and advice, diagnosis and care; they have 24/7 access to medical and nursing advice and care; and organisations are responsive to patient preferences around access. |
| Safe and high quality | Care is evidence-based wherever possible, and clinical decisions are informed by peer support and review. Clinical data are shared within the organisation to inform quality assurance and improvement. The organisation is financially sustainable, such that safety and quality standards will not be compromised by resource pressures. |

Adapted by the authors from the Patient Centered Medical Home model, as described by the US AHRQ (AHRQ, 2013)

4. Models of primary care

This chapter explores the range of existing models of primary care provision, and focuses on those that attempt to ‘scale up’ primary care as a way of increasing care quality whilst tackling the pressures described in Chapter 2.

Primary care organisations

The scale and scope of primary care organisations varies internationally, with standalone clinics run by single-handed doctors being typical in some countries, and large health centres run by multi-professional teams including social care being the norm in others (Meads, 2009). This variation results from factors such as the socio-political context of a country (for example a strong focus on municipality-based health centres in some Scandinavian countries and a history of polyclinics in the Czech Republic), the method of remuneration of family doctors (for example independent contractor status driving traditionally small practices in the UK and the Netherlands), and the degree of self-organisation among groups of doctors (for example independent practitioner associations in California and New Zealand).

This variation is also seen within countries, as in England, where single-handed practices co-exist alongside large extended practices, community health centres, networks of practices sharing common support and clinical services, and GP locum ‘chambers’ models of care. The prevalence of these different organisational forms is shifting. Recent research indicates that only three per cent of the English population now receives primary care from a single-handed GP, and one in seven people are served by a practice of ten or more doctors (Centre for Workforce Intelligence, 2013).

In our research for this project, 21 different models of primary care organisations were identified from both the UK and abroad, covering 12 different organisational types. These are explored further as case studies throughout the report and are detailed in Appendix 1. Table 2 provides a summary of the case studies explored.

Characteristics of models of primary care provision

Analysis of the models of primary care provision was undertaken to identify those which have the greatest potential to enable the provision of high-quality care described in Chapter 3 (Table 1), and to do so in the context of the pressures faced by primary care, as described in Chapter 2. Four organisational types showed greatest promise:

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

Table 2: Summary of the models reviewed

| Model | Website/reference |
|---|--|
| Accountable care organisations • Monarch HealthCare, US | www.monarchhealthcare.com |
| Community-owned • Hokianga Health Enterprise Trust, New Zealand | www.hokiangahealth.org.nz |
| Community health organisations • Bromley by Bow Centre, UK • Community Health Centre Botermarkt, Belgium | www.bromleybybowhealthcentre.nhs.uk www.wgcbotermarkt.be / www.ugent.be/ge/primarycare/en |
| Community health organisations with inpatient facilities • Kangasala Health Centre, Finland | Meads G. The organisation of primary care in Europe: Part 1 Trends – position paper of the European Forum for Primary Care. <i>Quality in Primary Care</i> 2009;17:133–43. |
| Marginalised groups • Health E1, UK • Leicester Homeless Primary Health Care Service, UK | www.healthe1practice.nhs.uk/services www.leicester.gov.uk/your-council-services/housing/homelessness/hostels/the-dawn-centre/ |
| Networks or federations • Midlands Health Network, New Zealand • ZIO network, Maastricht, the Netherlands • Primary care networks in Alberta, Canada • Tower Hamlets, UK | www.midlandshn.health.nz www.zio.nl/home/ www.albertapci.ca www.towerhamletscgc.nhs.uk |
| Professional chambers • Pallant Medical Chambers, UK | www.pallantmedical.co.uk |
| Regional and national multi-practice organisations • The Hurley Group, UK • The Practice Plc, UK | www.hurleygroup.co.uk www.thepracticeplc.com |
| Specialist primary care • ParkinsonNet, the Netherlands | www.parkinsonnet.info |
| Super-partnerships • Whitstable Medical Practice, UK • Dr HM Freeman & Partners, UK • The Vitality Partnership, UK | www.whitstablemedicalpractice.co.uk www.freemanpractice.co.uk/ www.vitalitypartnership.nhs.uk |
| Super-partnerships with inpatient facilities • Nairn Healthcare Group, UK | www.nairnhealthcaregroup.co.uk |
| Vertically integrated systems • Geisinger Health System, US • Kaiser Permanente, US | www.geisinger.org http://thrive.kaiserpermanente.org |

Factors that led to the selection of these models of provision included: their ability to offer an extended range of services in primary care, including local and rapid access to specialist advice; their focus on population health management as a way of addressing inequalities in health; they have sufficient organisational scale to enable the provision of new forms of care for patients with multi-morbidity; they have management structures that provide career options and development for

professional and other staff; and their overall scale permits peer review and the development of a strong clinical governance infrastructure, and secures senior clinical and managerial support for practitioners.

Comparison of four models of provision

The four models of primary care provision that showed greatest promise are described here along with an explanation of how each one seeks to deliver high-quality primary care that meets the design principles proposed in Chapter 5. Summaries of the main dimensions of the primary care models are set out in Tables 3 to 6.

Networks or federations

The concept of a primary care federation was developed by the Royal College of General Practitioners (RCGP) (Field and others, 2008) and is described as ‘an association of GP practices that come together (sometimes with community primary care teams) to share responsibility for a range of functions, which may include developing, providing, or commissioning services, training and education, back office functions, safety and clinical governance’ (Imison and others, 2010, p6).

Federations are most frequently formed for the purposes of developing the provision, rather than commissioning, of services, and they take a range of forms, depending on the purpose of the local federation, the extent of integration of local practices within the federation, and the preferences of local clinical leaders. For example, some join together for the development of shared education activities, clinical governance and peer review, and joint activity such as planning winter flu campaigns. Others form as a way of delivering new forms of extended primary care, as with the Tower Hamlets primary care networks that work collectively to manage long-term conditions and other services on a locality basis with shared incentives and outcome measures. Likewise, some federations exist to deliver out-of-hours care, or to offer specialist clinical services to a range of local practices. The legal structures for federations vary and include: community interest companies, companies limited by guarantee, limited liability partnerships and informal networks. Extensive analysis of the development of federations, along with case studies, is set out in the GP federations toolkit developed by The King’s Fund, the Nuffield Trust and Hempsons Solicitors for the RCGP.¹

In this project, we were struck by how federations or networks such as Tower Hamlets, the ZIO network in Maastricht and the Midlands Health Network in New Zealand have been able to use the benefits of collaborative working across practices as the basis for improving the management of clinical services at practice level. Financial incentives, together with a collective commitment to achieve stretching performance targets for clinical care, have enabled practices to work together on a locality basis to plan and deliver new and extended forms of care for patients with long-term conditions, and in support of public health priorities such as immunisations and vaccinations. A shared IT platform is also a key enabler of progress for many networks. In some cases, as with the Maastricht and Tower

¹ www.rcgp.org.uk/clinical-and-research/clinical-resources/primary-care-federations-toolkit.aspx

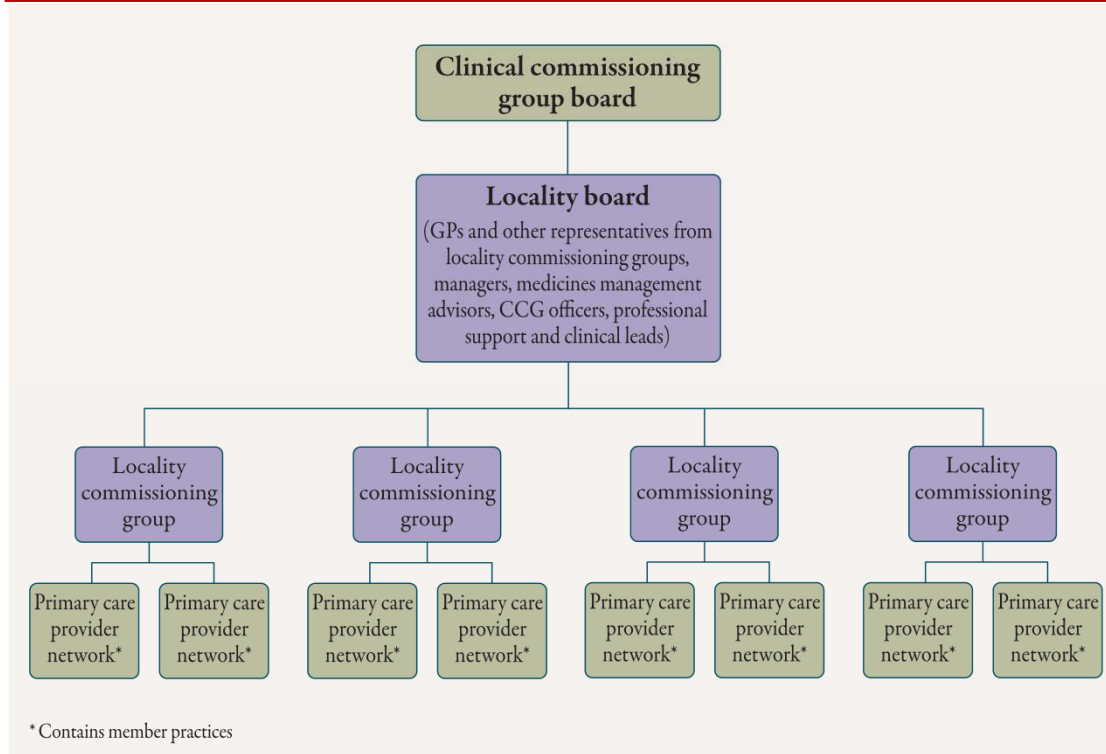
Hamlets examples, federations of practices have taken on (as a collective) contracts to deliver new forms of disease management and care for specific patient populations.

Over time, some federations have evolved into more complex and extensive organisations, using economies of scale to secure senior professional management and clinical leadership support, and develop infrastructure that helps practices manage day-to-day business and extend their reach into new forms of care provision. Other federations remain as relatively loose affiliations of practices, although these might provide the basis for further scaling up of local primary care organisation for the future.

| Table 3: Dimensions of networks or federations | |
|--|--|
| Model | Networks or federations (terms often used interchangeably) |
| Legal status | Collaboration between multiple practices. May be informal in nature or linked as a legal entity, for example, limited liability partnership, community interest company or limited company. |
| Governance | Informally or formally established organisational structures with management teams funded by member practices. |
| Scope | In addition to general medical services provided by member practices, may also provide enhanced services and some examples of specialist services. May also share back-office functions. |
| Main purpose | Using organisational scale to achieve economies. Create local organisational infrastructure to expand scope of primary care provision. Creating a legal entity to hold non-PMS or GMS contracts. |
| Examples from case studies | Midlands Health Network, New Zealand Tower Hamlets, UK ZIO network, Maastricht, Netherlands |
| Potential strengths in relation to delivering high-quality care | Enables the provision of a more comprehensive range of services, which are coordinated and community-based. Retains local practice location and identity, which can help to ensure services are geographically accessible, as well as enabling person-centred care. |

An example of the organisational arrangements of a network, Tower Hamlets, is set out in Figure 6.

Figure 6: Tower Hamlets primary care network: organisational overview



Super-partnerships

The super-partnership is a large-scale single partnership structure, operating from multiple sites, that has been created through formal partnership mergers. The Centre for Workforce Intelligence (2013) has reported that one in seven patients in England is now registered with a practice of ten or more doctors, and the presence of super-partnerships covering as many as 50,000 registered patients is clearly part of (or leading) the trend towards larger practice organisations.

Analysis of the experience of super-partnerships such as the Vitality Partnership in Birmingham and the Nairn Healthcare Group in Scotland reveals that practices have chosen to merge as a way of developing a larger-scale organisation through which a much wider range of services can be delivered with improved coordination of care. This is often linked with a capital development such as the rebuilding of the community hospital in Nairn to be an integrated primary, community and social care services centre within which the merged GP partnership is based.

Merged partnerships offer a wider range of career development opportunities for professional and other staff, including specialist clinical roles, senior management posts, and a clear career structure for doctors and nurses wishing to progress through different clinical, leadership and practice ownership roles. Furthermore, opportunities for peer review and clinical governance are enhanced, and the different super-partnerships examined all had structures in place for developing local quality standards, monitoring adherence to these, sharing data with practitioners, and providing support for practice improvement.

Table 4: Dimensions of super-partnerships

| | |
|--|--|
| Model | Super-partnerships |
| Legal status | Large-scale single corporate style partnership structure created through formal partnership mergers. |
| Governance | Executive board accountable to shareholders' group (membership is all partners of the merged practice). |
| Scope | General medical services, population management and prevention, enhanced diagnostics, specialist services, community services. |
| Main purpose | Create an integrated care organisation built on local general practice as a viable alternative to aspects of hospital care. Improve quality of local primary care Improve career opportunities for GPs and practice staff. Diversification of income stream of practices. Use organisational scale to achieve economies. |
| Examples from case studies | Vitality Partnership, Birmingham, UK Dr HM Freeman & Partners, London, UK Nairn Healthcare Group, Scotland, UK |
| Potential strengths in relation to delivering high-quality care | Enables the provision of a more comprehensive range of services, which are coordinated and community-based, and so potentially more accessible . Facilitates quality improvement through peer review and learning. |

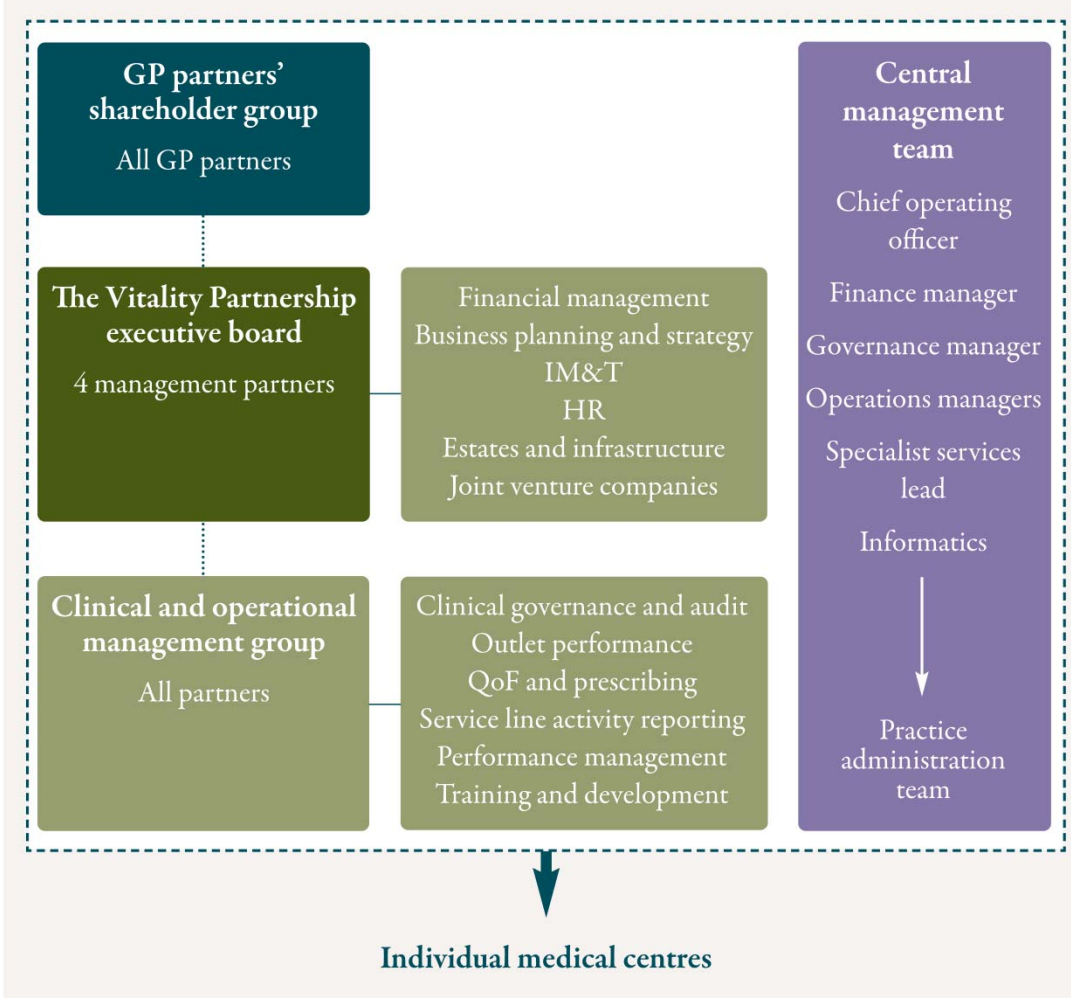
The extended range of services is evident in Nairn's provision of 24/7 nurse-led advice for patients (run and delivered by super-partnership staff), a specialist service for frail older people that seeks to have 98 per cent of this group living at home or in the local community at any one time, and merged health and social care teams based in the community hospital. The Vitality Partnership, although based in a very different context from Nairn, in inner-city Birmingham, has likewise developed tailored services for people with multi-morbidity, enabling new forms of consultation and advice, a range of specialist outpatient services delivered through Vitality practices, and locally-based enhanced diagnostics such as x-ray, with plans for a new ambulatory care centre (a form of urban community hospital) in the future.

Both Vitality and Nairn are taking on additional contracts from health commissioners with which they deliver services previously located in hospital. Thus the super-partnership model enables expansion of the range of services offered to patients, due to economies of scale associated with a larger population base, extended team of staff, and more senior management capacity. The super-partnership also enhances professional opportunities for staff, as well as offering the potential to diversify income streams at a time when resource for general practice has been constrained. More analysis of the super-partnership experience is available from the Nuffield Trust.¹

An example of the organisational arrangements of a super-partnership, the Vitality Partnership in Birmingham, is set out in Figure 7.

¹ www.nuffieldtrust.org.uk/talks/slideshows/naresh-rati-meeting-demand-primary-care

Figure 7: The Vitality Partnership, Birmingham: organisational overview



Regional and national multi-practice organisations

In contrast to federations and super-partnerships that are led by GP partners operating within their local communities, these models of primary care have developed the scale and scope of primary care on a more regional basis and akin to some of the physician group models in America. They have the same ownership structure as usual general practices – a partnership – but 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 in the multiple and dispersed practices, supported by a central leadership team of executive partners and a management team.

An example from our case studies is The Hurley Group, a small GP partnership with over 300 employees providing a range of services across London boroughs. The Hurley Group, with a registered population of 100,000, operates over 17 practice sites and holds contracts for eight urgent care services (seeing 250,000 minor illness and injury cases a year in London) and other community services.

Like some federations and super-partnerships, these examples have transformed the governance model of traditional general practice by combining GP partner

leadership with an executive team bringing senior commercial skills and expertise to the organisation. This level of resource is seen as a strong lever for remaining competitive within a developing market environment; providing the degree of capacity and expertise necessary to respond to tenders efficiently without it impacting on direct patient care or GP workload. However, the legal status and ownership of the organisation will determine the type of general practice contract it can legally hold. As such, they typically hold time-limited alternative provider of medical services (APMS) contracts that do not presume the contractor will personally provide general practice patient services.

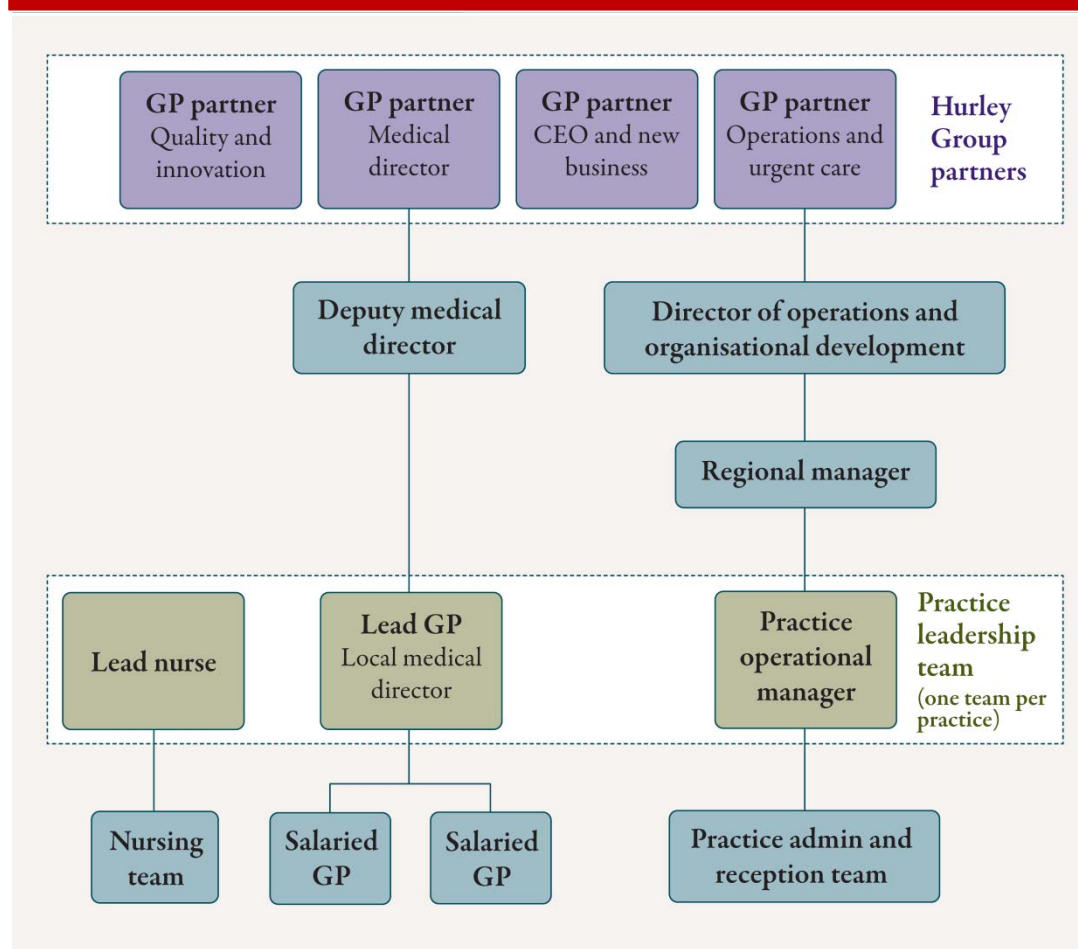
Like the other models examined here, these multi-practice organisations aim to improve primary care through greater organisational scale. They seek to improve the quality of services by standardising clinical and managerial practices across all care settings in the organisation, and use their scale to increase the degree of influence they have within a local health economy. However, the smaller critical mass of patients in a specific locality means that this model is limited in some of the change it can make, compared with primary care provider organisations focused in a geographical area.

The business model of these organisations differs from federations and super-partnerships in that it tends to rely on salaried clinicians, rather than partners, to lead individual practice sites and other services. However, the scale of these organisations enables those staff to be supported by a centralised organisational infrastructure providing HR, information management and organisational development support. This also creates some economies of scale by, for example, centralised finance monitoring and performance management systems. Like other models delivering primary care at scale, these multi-practice organisations provide increased opportunities for career development, education and training.

| Table 5: Dimensions of regional and national multi-practice organisations | |
|---|---|
| Model | Regional and national multi-practice organisation |
| Legal status | Small-scale GP partnership or other organisational/legal entity led by GPs. |
| Governance | Corporate-style management structure with CEO and director team. Lead salaried GPs located in each practice. |
| Scope | Multi-practice model delivering range of general medical services, enhanced diagnostics, and community and specialist services. |
| Main purpose | Improve quality of local primary care. Growth and diversification of income stream through multiple contracts. Use organisational scale to achieve economies. |
| Examples from case studies | Hurley Group NHS GP Partnership, London, UK |
| Potential strengths in relation to delivering high-quality care | Retains local practice location, which can help to ensure services are geographically accessible . Can provide access to an enhanced range of services, offering patients a more comprehensive service. Can enable the development of consistent safety and quality assurance systems. |

An example of the organisational arrangements of a multi-practice organisation, the Hurley Group, is set out in Figure 8.

Figure 8: The Hurley Group, London: organisational overview



Community health organisations

The community health organisation model of primary care provision (sometimes known as community health centres or polyclinics) has a long history within different health systems, and in some cases owes its genesis to community-oriented primary care mentioned in Chapter 3. These organisations – often made up of multiple practices in a network, and in other cases based in a single building – combine patient-centredness with a strong population-orientation and often have an ownership model that includes significant public and community involvement. Examples of such community engagement and ownership include the Hokianga Health Enterprise Trust in New Zealand, which is owned and run by the local community; the Bromley by Bow Centre which links primary care with a wide range of other services including social care and welfare advice; and Community Health Centre Botermarkt in Belgium, which is a not-for-profit organisation focusing on patient empowerment, social cohesion and local participation.

The community health organisation model of primary care provision seeks to develop an extended range of local services – much as with primary care federations or super-partnerships – but is defined by a population health focus

that starts with an analysis of wider social and health needs, and sees its role as one of community development alongside (or even before) that of a health care provider. This model of provision seems most prevalent in deprived or remote areas where the population suffers relatively poor access to health and other care services. The philosophy is typically of bringing services to underserved areas, often with marginalised groups, providing a health centre or network that can cater for the holistic needs of local people, and developing services that are organised to suit specific local challenges, such as poverty, homelessness, or refugee status.

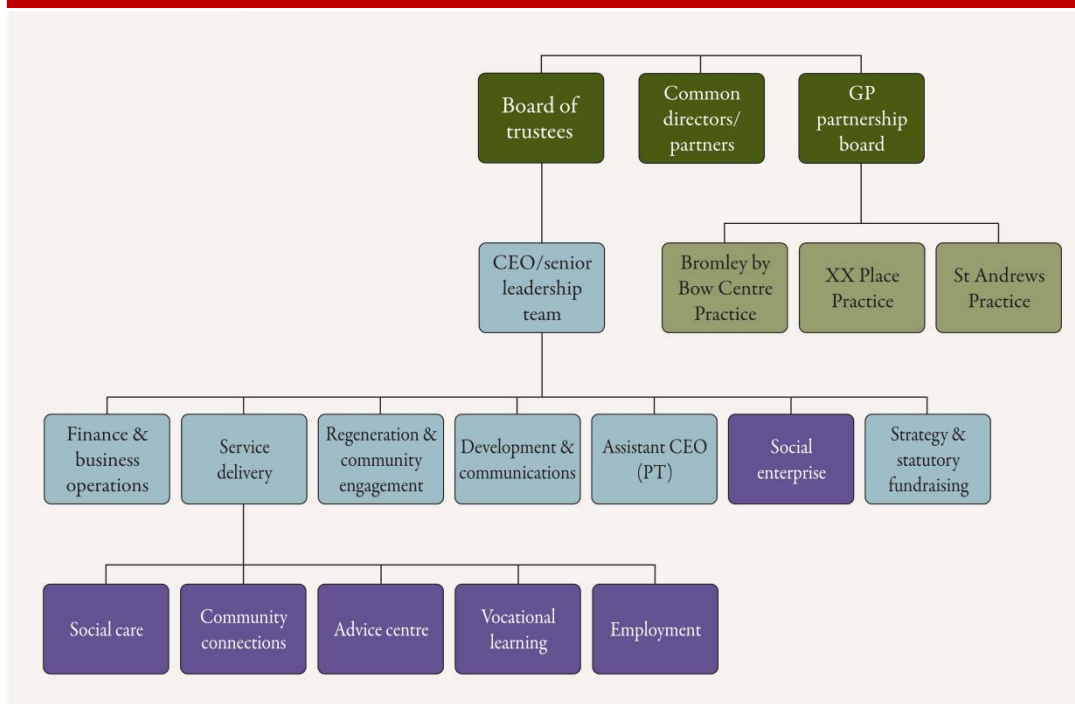
Despite the different philosophical underpinning of the community health organisation compared to the primary care federation or super-partnership that are typically created as a result of professional or business concerns in general practice, it is striking that many aspects of service provision and organisational arrangements are similar. For example, there is a common concern to extend the range of services provided locally, a desire for local access to practice services alongside more specialised services delivered across the network, partnership or community health organisation, and a focus on professional and senior clinical and general management leadership of the organisation. What is distinctive is the concern for population health management as the driving principle of the organisation and, sometimes, a focus on a large single health centre, as reflected in the title of The King's Fund analysis of evidence and experience of community health organisations, *Under One Roof* (Imison and others, 2008).

Table 6: Dimensions of community health organisations

| | |
|--|---|
| Model | Community health organisations |
| Legal status | Range from collaborative groups of organisations to single legal entities such as charities or not for profit organisations. Practices involved retain their independent status. |
| Governance | Various models: <ul style="list-style-type: none"> • Elected members from each organisation • Volunteer boards of directors • Clinical management team |
| Scope | Primary care and community services with or without diagnostics and minor surgery. Some examples include inpatient care and specialist services. |
| Main purpose | A different model of provision rather than organisation. Aims to improve integration of general practice with community and specialist services. |
| Examples from case studies | Bromley by Bow Centre, UK Community Health Centre Botermarkt, Ghent, Belgium Kangasala Health Centre, Finland |
| Potential strengths in relation to delivering high-quality care | Can promote the provision of comprehensive care, attending to welfare and wellness, prevention and treatment services for physical and mental health care needs. Potential to offer better coordinated care which is person-centred , through providing connections to an extended range of specialist and community services. Often engage community members in governance of the service, which can inform the development of a more population-oriented service. |

An example of the organisational arrangements of a community health organisation, the Bromley by Bow Centre, is set out in Figure 9.

Figure 9: The Bromley by Bow Centre and GP partnership: organisational overview



Learning from different models of primary care provision

Our analysis of these four models of primary care provision suggests that they each have strengths which have the potential to address some of the pressures outlined in Chapter 2, and support the delivery of high-quality care as described in Chapter 3. Specifically, the strength of these models lies in their scale which allows:

- an extended range of services with access to specialist advice
- a focus on population health management
- development of tailored care for people with multi-morbidity
- peer review and clinical governance
- professional humans resource, financial and leadership capacity
- career development and support for professional and other staff.

In the next chapter, we draw on research evidence and our discussions with experts and experienced practitioners to translate the high-level vision for primary care in Chapter 3 into a series of ‘design principles’ to guide the organisation and development of local services. Form should follow function: organisational models ought to be developed locally on the basis of a vision for service provision, and in a way that builds on existing local arrangements for provision, as well as local needs and priorities.

5. Design principles

Having established a case for change, and identified the characteristics of high-performing primary care, in this chapter we propose a series of ‘design principles’ for primary care. These comprise a set of principles to apply when reviewing and redesigning primary care provision for a given population or community, together with examples of how they have been put into practice. Some of the principles are focused on the provision of clinical services, and others on organisation.

Clinical care

Design principle 1: Entry to the system

A fundamental principle is to ensure that the patient can speak to a senior health professional as early as possible and both in- and out-of-hours. This is to allow more effective triage and decision-making, reduce the need for repeat assessments, start the process of care more quickly, and enable a better judgement about risk.

By extension, there is a strong case for earlier contact with a senior health professional for patients who want a home visit. Evidence suggests that a significant number of these enquiries can be dealt with by telephone and that a telephone consultation with the clinician leading an individual’s care or a visit as early as possible (rather than at the end of a general practice surgery) can make a difference to hospital admissions (Longman, 2012).

For example, at present the system tends to have a view that patients need to attend ‘appropriately’. There is significant current debate about whether it matters that patients with minor conditions or self-limiting illnesses seek care in other parts of the system, such as A&E departments or minor injuries units, rather than using primary care (for example, *Health Service Journal*, 2013)¹.

The design principle here is that **a senior clinician, capable of making decisions about the correct course of action, is available to patients as early in the process as possible.**

Box 1: Entry into the system in practice²

- Nairn Healthcare Group has developed an integrated health and social care service based in a newly-built community hospital. The group is very clear that it assumes responsibility for its population 24/7 and has taken back responsibility for out-of-hours care, with a team of nurses who answer all emergency calls.
- The Midlands Health Network (New Zealand) is able to provide 24/7 primary care, having developed a network of out-of-hours centres (staffed by network GPs on a rota) to support its member practices. The network is increasing the number and nature of virtual consultations to enable senior medical advice to those in rural communities 24/7.

¹ www.hsj.co.uk/news/acute-care/emergency/nhs-england-probes-new-urgent-care-system/5059908.article

² See Appendix 1 for more details about all the case studies mentioned in this and subsequent boxes. Examples are UK unless otherwise stated.

Design principle 2: Using technology to enhance access

There are examples in the NHS (although by no means widespread), and in other health systems, of primary care organisations offering routine and sometimes 24-hour access to health advice and support through consultations with doctors or nurses that are supported by technology such as phone, Skype or email. There are other ways in which technology is being used by some primary care providers to support care, including: e-access to test results; electronic prescribing; electronic booking of appointments; and email-based queries with practice staff.

These approaches to care have the potential to improve the timeliness of access to primary care, and to reduce the number of face-to-face consultations required. Indeed, there is evidence to suggest that more timely access to primary care helps reduce attendances at emergency departments (Cowling and others, 2013).

The design principle here is that **patients can benefit from access to primary care advice and support that is underpinned by systematic use of the latest electronic communications technology.**

Box 2: Use of technology to enhance access to primary care in practice

- Kaiser Permanente (US) is aiming to get 40 per cent of all consultations to be conducted electronically (personal communication, January 2013).
- Electronic prescribing is increasingly being used by general practices in the NHS.

Design principle 3: Specialism and generalism

While there are many well-documented advantages to having generalists in primary care (for example having the ability to provide comprehensive care with good continuity of provider), there are some patient groups requiring more specialist support.

Referral to a specialist by letter or email will continue to be a route from general practice into secondary care and there is neither capacity nor appetite in the NHS to move away from gate-keeping by general practice in most areas. For example, only six per cent of the 13 million patients who consult their GP with a skin condition are referred on to secondary care (Schofield and others, 2009).

However, alternative approaches to specialist referral are being tested out by primary care organisations and networks, as revealed by our case studies. For example, specialists are being contracted to primary care teams and networks to provide care and advice for people with long-term conditions (for example Tower Hamlets and Nairn Healthcare Group), and sessions of specialist time are being purchased by primary care networks to enable support to GPs and professional development for primary care teams (for example Vitality Partnership). Primary care organisations are working with specialist colleagues to develop shared protocols for diagnosis, referral and treatment, with the aim that referrals are made on the basis of a better established diagnosis, and primary care retains responsibility for care coordination beyond referral and back into primary care. An additional

reported benefit is that the co-location of generalists and specialists in the practice setting upskills the GPs and nurses within primary care.

Where possible, the system should allow for agreed approaches to primary care-based assessment, such as electronic guidelines, that are trusted by other professionals, and avoid unnecessary repeat investigations and screening. The integration of specialists into primary care teams needs to be done in a way that takes account of evidence about quality and cost-effectiveness (for example Roland and others, 2006). It is important to note that different local contexts will mean that the detail of the care pathway may vary – for example, having a fully-equipped local facility with diagnostics and treatment rooms will enable local specialist clinics, as with the example of the Whitstable Medical Practice.

The design principle is that **patients have the minimum number of separate visits and consultations that are necessary, with access to specialist advice in appropriate locations.**

Box 3: Specialism and generalism in practice

- A central principle behind ParkinsonNet (the Netherlands) is to work cohesively across primary and secondary care, bringing in specialist neurologist expertise when necessary, yet having the majority of care delivered at home, through the internet, or by specialised allied health professionals working in primary care.
- Vitality Partnership has incorporated specialist medical consultants into their structure (contracting them for sessions of time) and, as with the primary care networks in Tower Hamlets, has offered GPs the opportunity to become specialists in a particular field, and hence take referrals from GP colleagues within the partnership.
- The Maastricht primary care network ZIO (the Netherlands) strives to deliver 95 per cent of diabetes care in the community and, as part of its capitated risk contract, funds, organises and coordinates specialist care needed by its patients.

Design principle 4: Continuity and access

Patients with complex needs and long-term conditions benefit from continuity of care with their health professional or team because it allows for a better understanding of the patient's preferences, and hence more appropriate and shared care planning (see Coulter and others, in press, for more about care planning and long-term conditions). There are limits to how far continuity of information (for example through a shared electronic record) is a substitute for a continuous relationship between a health professional and the patient. However, even patients with complex needs do not necessarily need this type of continuity for every encounter – sometimes speed of access will trump the desire to see the same person or team, and this can be mitigated by a shared record.

Although the availability of GP appointments has been a government target, there is some evidence that public satisfaction with out-of-hours care is not always being adequately achieved, despite access being measured as easy and rapid (Primary Care Foundation, 2012a). A debate may be needed about what the public have a reasonable right to expect and what can be provided. Nevertheless, general practice

systems such as those where patients have to ring within a short window of time for same- and next-day appointments need to be reviewed, for these systems are rationing access to primary care without any explicit needs criteria.

This design principle assumes that capacity and demand are in balance on most days. However, there are currently no good data available to allow this to be tested and the evidence above seems to suggest that this may be an issue. Implementing the design principles in this report is likely to make achieving this balance more likely.

Arrangements for out-of-hours primary care are often complex and difficult to navigate for patients. Demand has been rising steadily and there are 138 calls per 1,000 population per year in the benchmark group run by the Primary Care Foundation (Primary Care Foundation, 2012b). This is a level of demand beyond the scope of the traditional model of out-of-hours general practice. Simplification of out-of-hours arrangements is required, for they suffer from being artificially separated from other services such as ambulances, out-of-hours community nursing, walk-in services, and accident and emergency. This suggests some subsidiary principles including:

- the system should incentivise primary care providers to ensure that opening hours match the periods of peak demand
- primary care providers should ensure that patients can have problems sorted out in-hours to avoid these patients requiring out-of-hours interventions
- the right kind of appointments should be given to the appropriate people (for example, early morning ones to workers, and middle of the day ones to the unemployed)
- out-of-hours services should be judged on measures that are aligned to the goals of the care system for patients, including access, reduced numbers of hand-offs and care coordination.

The overall design principle here is that **patients are offered continuity of relationship where this is important, and access at the right time when it is required.**

Box 4: Continuity and access in practice

- Kaiser Permanente (US) offers some 40 per cent of its outpatient consultations remotely now, through internet or phone. Face-to-face consultations are reserved for complex cases, or for where it is felt that continuity and personal presence are important.
- Community Health Centre Botermarkt (Belgium) offers a tailored service for people with multimorbidity, with specifically scheduled longer consultations which are sometimes multidisciplinary, and a range of services deemed to meet the needs of the individual. The health centre provides 'standard general primary care' services to other patients who do not have multiple long-term conditions.

Design principle 5: Anticipatory and multidisciplinary care

Many primary care teams and organisations are increasingly providing anticipatory, rather than reactive approaches, using disease registries, risk stratification, and other population health assessments to manage patients at high risk of admission for long-term conditions (Thorlby, 2013). Key components are use of the multidisciplinary team and case-based management of people's care.

The design principle is that **care is proactive and population-based where possible, especially in relation to long-term conditions.**

Box 5: Anticipatory and multidisciplinary care in practice

- Tower Hamlets primary care networks provide evidence-based care that is grounded in the concept of a 'year of care' and active case management, alongside strong patient education and self-management. Practices are incentivised (as a collective of practices) to meet certain targets such as patient experience, care planning and control of diabetes. Evidence-based care pathways include conditions such as diabetes, chronic obstructive pulmonary disorder (COPD) and childhood immunisations.
- The Maastricht primary care network ZIO (the Netherlands) likewise delivers evidence-based care for patients with diabetes or COPD, working within a contract with health insurers that specifies and incentivises adherence to the evidence-based case management approach. They also provide care for asthma, anxiety or depression, and care to the frail elderly and those in need of vascular risk management.

Design principle 6: Multi-morbidity

The adoption of evidence is critical. However, the question of what constitutes value for patients and how best their goals can be met may be a much more important question than the implementation of all elements of the evidence-based guidelines for each of their different clinical conditions. Participants in our international seminar argued for a shift towards a more balanced approach to understanding the needs and aspirations of patients, and starting with this as the basis for organising care for this group, rather than sticking to a narrower biomedical model (see De Maeseneer and Boeckxstaens, 2012, for more detail).

Another important theme is the growing recognition of the importance of residential and nursing homes as a key part of the system. Primary care services have been developed that are tailored to nursing homes, including ward rounds by GPs who are contracted to provide care for all residents in the home, regular medicines reviews by pharmacists nominated to be part of the nursing home team, and careful attention by the nursing home primary care team to continuity of care and support for care-givers.

A consistent theme in discussions forming part of this research was the importance of incorporating mental health services much more centrally into the design and operation of primary care. This is important because of the significant mental health co-morbidities associated with long-term conditions, the rise in levels of dementia, and the already high burden of mental health problems in primary care.

The design principle here is that **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.**

Box 6: Multi-morbidity in practice

- Community Health Centre Botermarkt (Belgium) is developing a tailored service for people with multi-morbidity, with a focus on determining care goals in partnership with patients, offering longer consultations with the practitioner most suited to the care goals, and an interdisciplinary range of health and social services deemed to meet the needs of the individual.
- Nairn Healthcare Group has frail older people with multi-morbidity as its core client group, and has a particular concern to enable high-quality (and where possible, home-based) end-of-life care. The primary care group has responsibility for coordinating a range of services in place to meet these complex needs; covering home care, primary care, nursing homes, the community hospital and secondary care.

Design principle 7: Patient self-management

Supporting patients in becoming more active in their own management, and setting their own goals, is central to the new long-term conditions strategy being developed by NHS England. There are, however, some gaps in the evidence about the extent to which patient self-management is effective in reducing demand and improving outcomes (for example, Challis and others, 2010; Hinder and Greenhalgh, 2012; Nease and others, 2013). However, there is an ethical imperative and it may be that research has not been assessing the appropriate measures of success in this area.

The design principle is that, **where possible, patients are supported to identify their own goals and manage their own condition and care.**

Box 7: Patient self-management in practice

- The Leicester Homeless Primary Care Health Service offers homeless people a wide range of services (from acupuncture to substance misuse services) aimed at helping people to manage their health and care, and sustain independent living. Individuals can refer themselves directly to the service.
- The Bromley by Bow Centre situates itself as a community organisation providing general practice and community health services, and supports people beyond their health needs, teaching them new skills and activities, and aiming to give them confidence in order to achieve their goals. This includes, for example, cross-referral routes between primary care and employment services.

Organisation

Design principle 8: Making the most of the multidisciplinary team

Primary care services in the UK are highly dependent on GPs as the first-line caregivers. Even though this has shifted over time with increasing use of practice nurses to manage services such as the management of long-term conditions, and

immunisations and vaccinations, NHS primary care continues to rely on GPs to a greater extent than some other health systems, where use of nurse practitioners, pharmacists and physicians' assistants is more extensive.

The multidisciplinary team has long been considered a core element of NHS primary care, yet in practice it could be used to fuller effect, for example by having pharmacists work much more closely alongside or within practice teams, or having nurse practitioners providing phone and email consultations to patients. There is likewise potential to develop further the skill-mix in general practice. This point was made strongly to us during interviews for this research.

For smaller practices with few staff, access to a wider multidisciplinary team could be facilitated through a network or federation. For example, Tower Hamlets achieves this by employing specialist nurses and other staff as a resource to practices in a network.

The design principle here is that **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.**

Box 8: Making the most of the multidisciplinary team in practice

- Community Health Centre Botermarkt (Belgium) offer patients with multi-morbidities a comprehensive consultation at which the patient's individual care goals are explored and agreed. This is used as the basis for designing a range of subsequent services and interventions by the wider care team that will meet patients' specific needs.
- ParkinsonNet (the Netherlands) is a radical new approach to providing specialist yet community-based support to people with Parkinson's disease (designed by the whole network including patients), and allows patients to use an interactive tool to locate services in their area. These services are supported by specialists (for example educational updating, supervision and help with the most difficult problems), but delivered by doctors, nurses and allied health professionals in primary care wherever possible.
- The Your Health Partnership in the Black Country (a sister organisation of the Vitality Partnership) has a clinical pharmacist (with prescribing rights) based in its two practices as a core member of the clinical team, supporting medicines management, care of people with complex co-morbidities, and reviewing and improving overall prescribing practice in the team.

Design principle 9: Diagnostics

Primary care in the UK has traditionally had limited access to diagnostic technology, both within the surgery and to referred services such as complex imaging. This seems to be an anachronism and an obstacle to high-quality, comprehensive care, particularly given advances in technology and electronic reporting. The case studies here illustrate that primary care organisations are finding ways of offering locally-based diagnostic services, including:

- Point-of-care testing for common blood tests, that is during the same practice visit as the GP or nurse consultation

- availability of plain x-ray or ultrasound scanning in local community-based facilities
- direct access by primary care to MRI scanning and protocol-controlled access to CT scans
- the availability of a wider range of physiological measurement services.

The design principle is that **primary care practitioners have immediate access to common diagnostics, guided by clinical eligibility criteria.**

Box 9: Diagnostics in practice

- Many of the primary care case studies have begun providing their own diagnostic services. Examples include: The Hurley Group, Vitality Partnership, Nairn Healthcare Group and Whitstable Medical Practice. In most cases, plain x-ray and ultrasound were available in the main hub of the primary care organisation (for example one practice, or a community hospital); in others, the services were purchased from private diagnostic providers (for example Midlands Health Network).
- In Kaiser Permanente (US) sites, they aim to provide primary care, specialist care, pharmacy, some laboratory tests and x-rays under one roof, as the norm.

Design principle 10: Patient records

Patient records need to be accessible by different professionals within the primary care team and by relevant external organisations. Ideally this record will be updated in real time, allow for care planning and case management, and perhaps in future be added to by the patient and their carer. This would also facilitate an electronic conversation between patients and caregivers. A number of existing GP systems and other providers are already starting to show how such arrangements can be worked out.

In addition to the use of records in direct care, there are also ways in which anonymised or pseudonymised records can be used to inform care choices. For example, these data can be used to scan the whole population to target interventions at people at high risk of hospital admission or to identify gaps in care. Such tools ideally exploit the linkage of hospital and GP data. Population-wide data can also inform the way services are organised in terms of resource allocation, performance monitoring and prioritising areas for investment.

The design principle is that **there is a single electronic patient record that is accessible by relevant organisations and can be read and, perhaps in future be added to, by the patient.**

Box 10: Patient records in practice

Electronic patient records accessible by professionals in different sectors are exemplified in Vitality Partnership, Midlands Health Network, Bromley by Bow Centre and Kaiser Permanente (US). Kaiser Permanente has designed an online tool called My Health Manager. This allows patients to email their doctor, make routine appointments, refill most prescriptions and view test results.

Design principle 11: Quality and information

New models of primary care delivery will require more systematic approaches to improving quality, reducing variation and making benchmarking information available to patients and the public in easily accessible form. A wider range of measures beyond narrow biomedical indicators, reflecting population health, will be required. Public reporting of primary care data needs to become the norm, and the form of such reporting should be discussed between patient groups and clinical leaders as part of the development of services that aim to meet the design principles. This also needs to take place within a broad framework set by NHS England for the future delivery of primary care.

The design principle is that **primary care organisations make information about the quality and outcomes of care publicly available in real time.**

Box 11: Quality and information in practice

- The Vitality Partnership and The Hurley Group have established internal performance management frameworks that enable partners and staff to have real-time information on all statutory and contractual clinical and non-clinical indicators, as well as internal quality and organisational markers. Indicators include: GP and practice nurse appointments booked and attended; A&E attendances and out-of-hours calls/visits by practice patients; public health data including breastfeeding rates, vaccinations, BMI and alcohol screening; complaints and compliments; staff absence; website hits; and staff training. These dashboards of indicators create the internal infrastructure and capability for enabling practices to share real-time information with commissioners and patients.
- The Community Health Centre Botermarkt (Belgium) has embraced the use of performance and outcome measures that are focused on the goals of patients for their care and wider life, rather than on more narrow biomedical indicators.

Design principle 12: Organisation and management

To achieve these design principles, new models of primary care will need to be professionally managed (see Chapter 7). Primary care networks and organisations require expertise in population health needs assessment, information systems, human resource management, process improvement, strategic planning and general management.

An important design principle is the requirement for a more systematic approach to accountability, measurement, assurance systems, clarity of strategy and purpose, and close alignment between clinical and financial decision-making. For many practices, clinical care is delivered alongside relatively weak accounting systems that may reflect largely a book-keeping function. High-quality financial and management systems enable practices to monitor clinical activity and expenditure, and promote strategic business planning. The Vitality Partnership has recognised this to be one of their most significant organisational development needs to date.

The design principle is that **primary care has professional and expert management, leadership and organisational support.**

Box 12: Summary of 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.

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.

6. Mechanisms for change in general practice

This chapter examines how the design principles might be put into practice, and the implications for design of contracts, incentives and other mechanisms used to bring about change in primary care.

Redesigned primary care

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:

- linking practices together (in networks, federations or merged partnerships) to increase the scale, scope and organisational efficiency of general practice
- changing the professional skill-mix of general practice and increasing the extent of multidisciplinary working
- adopting new technologies to improve access, convenience for patients and organisational efficiency in general practice (including personal technologies such as smartphone apps)
- working differently with individual patients and populations.

National policy on funding and regulation

A variety of policy, financial, regulatory and professional factors have driven change in general practice over the last decade. For example, the Quality and Outcomes Framework (QOF) has increased standardisation of care for selected long-term conditions and, since 2011, has required local practices to work together to jointly review and plan improvements in selected areas of care. Locally Enhanced Service (LES) payments have been used to incentivise GP participation in the design and use of new care pathways for conditions such as COPD, or to extend their roles in areas such as minor surgery. PMS contracts – locally negotiated contracts for extended primary care services – have been used by many practices and their commissioners since the introduction of these contracts following the 1997 Primary Care Act. In some cases, practices on PMS contracts negotiated to have elements of hospital and community health services funding incorporated into the PMS contract (so-called PMS Plus) and we are aware of a few practices that continue to work within such an arrangement.

Financial pressures on practices as GMS contract income has been capped, together with the workload created by preparing for Care Quality Commission (CQC) registration, have also resulted in practices developing new joint working arrangements with their neighbours. These include shared back-office functions and joint use of consultancy staff and independent advisers to prepare for CQC registration.

The case study example of primary care development in Tower Hamlets illustrates how, in response to a national performance framework (the primary care trust had very poor primary care outcomes in 2006), general practices can fundamentally change their working practices by forming a network, supported by strong clinical

evidence, appropriate incentives, and a sense of mission in respect of improving care for local people. This case study also highlights the organisational and contractual levers that can be used to achieve change and improvement (see Box 13).

Box 13: Tower Hamlets Primary Care Networks

Eight networks of GP practices covering approximately 30–40,000 patients were formed in Tower Hamlets PCT in 2006 to improve the quality of general practice for selected long-term conditions. Start-up funding was available, allowing each network to employ a manager, administrator and additional clinical staff if wanted. ‘Care packages’ were developed (initially for diabetes, then immunisation and other long-term conditions) which established standards of care to be followed by practices (for example 45-minute appointments for care planning to be undertaken by nurses) and clinical outcome measures in excess of QOF. The care packages also required practices to work collaboratively to improve services, and 30 per cent of incentive payments were based on performance across the network in improving care outcomes, and not just on how an individual practice performed.

Service agreements for care packages were pooled into a single APMS contract between the primary care trust and each of the networks to drive improvements in care for patients registered with network practices. Since the advent of CCGs (that are not allowed to hold APMS contracts), the Tower Hamlets networks have migrated to NHS contracts held by the CCG. Member practices have formed limited liability companies to hold the contracts, and are jointly accountable for performance. Network members meet regularly to review their performance and ensure that they collectively achieve required standards of care. In some networks, performance review meetings are combined with continuing professional development – forming an accredited education session on the clinical conditions covered by the network’s contract. General practices in Tower Hamlets now perform among the best in the country for the nine measures of high-quality diabetes care, having been previously among the worst.

Another example of how changes in policy and funding arrangements can drive significant change in general practice is in the Netherlands, where a new payment system for diabetes care, introduced as pilot in 2008, drove collaboration between general practices, and the formation of a primary care network in Maastricht (see Box 14). Here, central government policy to achieve better coordinated long-term conditions care included a ‘year of care’ payment for diabetes. Contracts for a full year of diabetes care (as defined in evidence-based guidelines) could only be negotiated between insurers and *groups of GPs* – not with individual practices; in a similar way to how Tower Hamlets shaped its incentives for networks, as well as individual practices.

Box 14: ZIO: Integrated Diabetes Care in Maastricht, the Netherlands

ZIO is an umbrella organisation for all 89 GPs in the Maastricht area (pop 170,000). It was established in 2006 in response to national policy on integrated diabetes funding. All practices joined the organisation – which holds the budget for diabetes care – reimbursing practices who deliver the required standard of care and paying for hospital care on a fee-for-service basis where patients need access to specialists.

New bundled payments were developed for specific disease-treatment combinations (DTC or ‘DBC’ in Dutch) with insurers buying a pre-agreed annual package of diabetic care for an agreed sum of money per patient (adjusted to reflect case severity). ZIO negotiates with health insurance companies on behalf of its member GPs and to agree contracts for integrated diabetes services in the community. In Maastricht, around 95 per cent of diabetes care is now provided through the primary care network, which includes funding for advisory consultations by specialists.

As well as negotiating chronic care contracts with insurers (ZIO has also launched a bundled payment scheme for COPD, asthma, vascular risk management, frail elderly and anxiety/depression), the network provides administrative support, education and training, data and IT infrastructure, premises development advice and other support to GPs.

Contractual levers

For many years, payments for LES and designated enhanced services (DES) have been used to extend the range of services provided by GPs in the NHS in England. Recent guidance from NHS England describes the eight national designated services it will commission, including childhood immunisation, minor surgery, extended access and patient participation.¹ It explains that less use will be made of LES payments in future, implying that CCGs will need to use the standard NHS contract to commission additional services from general practice. CCGs may have to offer these additional services to any qualified provider, and not just to GPs.

Table 7 sets out the range of contracts available to CCGs and NHS England to commission services from GPs that are beyond the scope of core general practice. While these contracts can be used to commission specific, discrete services from practices, there is an opportunity to use them to transform traditional ways of working; encouraging practices to work together in federations or networks providing selected services for non-registered patients.

¹ www.commissioningboard.nhs.uk/wp-content/uploads/2012/03/fact-enhanced-serv.pdf

Table 7: Contract options for developing and extending the role of primary care

| Contracts that can be held with CCGs | Role in delivering extended primary care services | Potential role in supporting transformation of core services |
|---|---|---|
| <p>NHS standard contract for local priority services CCGs to commission additional community-based services in response to local needs and priorities using the standard NHS contract.</p> | <p>Contracts for new community services may be held with one or more GP practices or other providers. Contracts are time-limited and CCGs will decide whether the service is best ‘attached to a registered list’ or whether it could be delivered by any provider. If the latter, it will need to be put out to tender for either a single or limited group of providers, or using the ‘Any Qualified Provider’ route.</p> <p>Contracts can be used to transfer selected interventions (for example joint injections) or services (for example anticoagulation) from hospital to primary care. They could also be used to commission part of an integrated pathway of care (for example insulin initiation) from GPs or other community providers.</p> | <p>Contracts with groups of practices could encourage development of shared administration and organisational ‘infrastructure’ such as telephony, IT or audit, and outcomes assessment (see Maastricht case study on page 42).</p> <p>Collaboration between practices to deliver additional community services may build a culture of collaboration that can be harnessed for other services (for example extended hours of access) There could be potential for workforce development and shared staff across practices (see Tower Hamlets case study on page 41).</p> |
| <p>APMS Contracts Contracts for ‘alternative providers of medical services’ which can encompass GMS-type services, unscheduled care for non-registered patients (for example walk-in-centres) and other primary care services.</p> | <p>Contracts have been awarded to groups of practices (see Tower Hamlets case study on page 41, where these were used until the advent of CCGs), promoting inter-practice collaboration to achieve higher local performance standards and greater standardisation of care for selected areas of core general practice (for example diabetes).</p> | <p>APMS contracts have been used to improve access to general practice through extended opening hours, and to set additional quality standards (over and above QOF) for selected areas of care.</p> <p>Contracts have been awarded to groups of practices (see Tower Hamlets case study on page 41), promoting inter-practice collaboration, and the development of clinical posts that are shared across a group of practices.</p> <p>It should be noted that CCGs cannot hold APMS contracts, so Tower Hamlets CCG now uses an NHS contract with its primary care networks.</p> |

| Contracts that can be held with CCGs | Role in delivering extended primary care services | Potential role in supporting transformation of core services |
|--|---|---|
| Specialist Provider of Medical Services (SPMS) Contracts SPMS is a PMS agreement but with the key difference that patients do not have to be registered with the provider to receive care. | <p>SPMS arrangements build on the ability in PMS to address local health and service needs, and recognise innovation. SPMS is designed to give commissioners and providers flexibility to deliver services to people whose needs may not be fully met by other primary medical services options, for example, the homeless, teenagers or asylum seekers.</p> <p>Pennine MSK Partnership Ltd, Oldham holds a SPMS contract to provide a rheumatology, orthopaedic and chronic musculoskeletal pain service.</p> | <p>The contract has potential for expanding the scope of primary care, although it has not been widely adopted by commissioners to date.</p> |
| Accountable Lead Provider (ALP) Contracts | <p>An outcome-based contract could be awarded to a practice for an accountable integrated programme of care. The primary care organisation could be a provider responsible for integrating related pathways within that programme for a specified population and within a capitated budget. The provider may sub-contract care within the programme to other local providers but retain overall accountability for outcome delivery.</p> | <p>Mechanism for integrating specialist ambulatory care within a primary care setting, and driving improved integration with core primary and social care and tertiary care.</p> <p>A model under development, but there is experience from Oldham PCT in contracting lead provider Pennine MSK for musculoskeletal services, Bedford CCG currently commissioning an ALP for musculoskeletal services, and Oxfordshire CCG developing an ALP contract for frail elderly services.</p> |
| Alliance Contracting | <p>A collaborative contracting model that brings together local providers within a unified contract to deliver an agreed programme of care to a specified population. These contracts are commonly used in other sectors such as construction and minerals, and are now being adapted for use in health care in Australia and New Zealand. The alliance contract is a mechanism for shared accountability, and a driver for integrating local care provision and pathway redesign. An alliance could typically include general practice, hospital and community providers. It seeks to facilitate the 'accountable care organisation' approach to service delivery.</p> | <p>Scope of contract could range from discrete groups such as frail elderly or specified long-term conditions, or could extend to larger populations. Shared budget could drive new pathways that aim to transform the core provision of primary care.</p> |

| Contracts to be held with NHS England | Role in delivering additional services | Potential role in supporting transformation of core services |
|--|---|--|
| National Directions Will be commissioned from GPs by NHS England to deliver selected national priorities. These will be offered to all practices. ¹ | <p>In March 2013, eight specific nationally-directed services are being promoted by NHS England.</p> <p>Practices can choose whether or not to deliver these services, including extended access, childhood immunisations, and health checks for people with learning disabilities.</p> | <p>National Directions are specifically focused on non-core general practice services.</p> |

¹ www.commissioningboard.nhs.uk/wp-content/uploads/2012/03/fact-enhanced-serv.pdf

Clinical commissioning groups

Some practices are experimenting with the kind of ‘in-house’ changes to primary care services described in Chapter 5, but it is CCGs that will set overall local strategy for extending the boundaries of care that is delivered in general practice beyond the core GMS.

CCGs have two distinct roles. First, they are responsible for commissioning secondary and community care services for their local population. Second, they have a role in supporting quality improvement in general practice. These two roles are closely connected – it is not possible to commission secondary care effectively without also considering the way patients are supported in primary care. Thus we can expect that many CCGs will look to encourage the development of new models of primary care to support their plans to shift care out of hospital and enable better coordinated care.

It is, however, still unclear as to how CCGs will be able to exert influence over the services delivered by the practices that are members of the CCG – CCGs do not contract with practices for their core services (that is the role of NHS England) and they do not have direct legal authority over the clinical behaviour of practices. Legislation on clinical commissioning is, however, clear that CCGs have a role in supporting improvements in primary care, and research from the Nuffield Trust and The King’s Fund reveals that some CCGs do indeed see general practice and primary care development as a core function (Naylor and others, *in press*). In the final chapter of this report, we return to this issue, suggesting that CCGs should assume delegated rights for commissioning primary care.

Competition

Competition is one of the mechanisms available to CCGs wishing to bring about change in the provision of local health services. Their forerunner, PCTs, used competitive tendering when seeking alternative forms of primary care provision, such as walk-in centres, clinics for vulnerable groups, and teams to run vacant practices. Research into this commissioning of alternative forms of primary care has shown that procurement and contracting processes can be costly and time-consuming, and that there is often considerable local opposition to the use of competition in securing new forms of primary care provision (Coleman and others, 2013). However, the same research noted that commissioning managers felt that the perception of likely local competition has led existing practices to improve their services.

There is still some uncertainty about the extent to which commissioners will be expected to competitively tender for contracts. The recently-enacted regulations on procurement and competition (Health and Social Care Act 2012, Section 75) state that commissioners are expected to improve services, and ensure that services are delivered ‘in an integrated way’. Under the terms of the regulations, commissioners are expected to consider whether more competition and choice might improve quality, although the same regulations also allow commissioners to award a contract *without* competition if the commissioner is satisfied that only one provider is

capable of delivering that service. The regulator, Monitor, has issued guidance for commissioners, stating that if commissioners want to avoid competition for a particular service, they will need to provide evidence that no other provider exists and that services will genuinely be better quality from the intended provider (Monitor, 2013). In practice, much will depend on the capacity of Monitor to oversee the multiple commissioning decisions being taken at commissioner level, and follow up on complaints from providers who feel they are being excluded from market opportunities.

The regulations also require commissioners not to discriminate against any type of provider. However, the capacity of small practices to respond to competitive procurement processes will be limited and they are likely to need support. Collaboration between practices will be important to make the most of resources available to respond to competitive tendering.

Where does this leave us?

Achieving changes of the scale and scope implied by application of the 'design principles' for primary care presents a fundamental challenge to NHS general practice. Part of this challenge may be achievable within the bounds of the levers described above, for example through adaptations to national contractual frameworks, requirements for practice registration, or encouragement of CCGs to tender for new forms of service provision.

A further challenge posed by our analysis is the need to achieve organisational and service delivery scale in primary care, addressing the problems posed by the typically small scale of general practice organisations, whilst preserving the local, small-scale points of access to care that are so valued by (at least some sections of) the population.

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 suffice, given that the majority of practices appear to be caught on a treadmill of activity, and lacking time and space to plan and enact new forms of care within more extensive and professionally-managed organisations.

In the next chapter, an examination is made of some of the case studies that have sought to implement at least some of the 'design principles' for primary care, and what this has meant in terms of leadership, management and organisational development.

7. Leadership, management and organisational development

Successful health care organisations are able to ensure maximum staff productivity, professional satisfaction and optimal care for patients (Britnell, 2013). In other words, they are able to organise care in ways that assure at least three of Larry Casalino's four critical factors for clinical engagement (Casalino, 2011): improved quality of care for patients; assured or improved physician income; a better quality working day; and respect from peers. This raises a question about how to make change within and across multiple small general practice businesses. This chapter explores this leadership, management and organisational development challenge, and how it might be met.

Enabling new models of primary care

This research revealed that 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 feeling as though they are 'on a treadmill', and that what little capacity for strategic work is available is taken up by clinical commissioning responsibilities. Time for review of how to improve and sustain the provision of primary care services appears to be lacking in most places.

The organisational development required to bring about the new models of primary care described in this report can be categorised as follows: learning from past experience; developing larger organisations; and sustainable leadership for the future. Each of these dimensions is explored here, using practical examples from experience of developing new models of primary care, drawn from our case studies and interviews with established experts in the development of primary care organisations.

Learning from past experience

Research into the development of primary care organisations has described the core elements of organisational support that need to be addressed in order to assure safe, well-functioning, organisations that have their roots firmly in general practice (for example, Mays and others, 2001; Smith and Goodwin, 2006; Dowling and Glendinning, 2003; Meads, 1996). These elements include:

- support in defining, reviewing and developing the respective roles of those leading and governing new primary care organisations
- expertise to enable meaningful professional and lay involvement in the governance of primary care organisations
- training and development for those doctors, nurses and other professionals leading local primary care organisations, both in relation to core competencies, and overall team and organisational development
- identification and development of the next generation of clinical leaders in a locality, that is not just focusing on those currently in leadership positions
- regular analysis of local primary care workforce capacity and demography, as the basis for organisational planning and development

- on-going work to review and support the development of primary care teams.

The national evaluation of total purchasing pilots in the 1990s (these were a sort of prototype CCG) reported that larger primary care organisations were in particular need of organisational development support if they were to be able to achieve their objectives (Goodwin and others, 1998). Professional project management support was seen as being particularly critical, as was engendering collective responsibility for the organisation among all practitioners, and securing commitment to follow care and organisational protocols developed by the pilot. This offers important pointers to those practitioners and managers seeking to develop primary care networks, GP federations and super-partnerships, which likewise entail the drawing together of small primary care practices into a larger collective.

We asked leaders of our case study primary care networks and organisations to reflect on the development support they had required, and offer lessons for others following a similar path. Two case studies are set out below: the Vitality Partnership in Birmingham, and the Nairn Healthcare Group in Scotland. These examples underline 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.

Box 15: The Vitality Partnership – developing the organisation

The Vitality Partnership has brought together seven GP practices and 40 GPs (15 partners and 25 salaried GPs) into a merged partnership that services 51,000 patients in Central and West Birmingham. The leaders of the Partnership report that the development effort required to put in place and sustain the new organisation was significantly beyond their original estimates. Development support has been needed in relation to: strategy; commercial and business development; governance; systems; workforce; skills and capacity; patient engagement; premises; and leadership.

Strategy

Vitality has had extensive facilitation support – procurement of external business development consultants to work within the organisation on a full-time basis to lead and manage mergers, organisational change, and support strategic business planning. In addition, legal services and property expertise have been commissioned. This investment is on-going with the business and organisational development skills now provided in-house following recruitment. Development of a five-year strategy has focused on: a clinical service growth plan based on practice mergers to create scale; integration of generalists and specialists; integration with community services; a new model of patient engagement; corresponding workforce development; and premises development and investment. Extensive analysis of population health data has informed the five-year plan, and the overall focus has been on supporting GPs to think on a more long-term basis about service design and investment.

Governance

Vitality has had to put in place a completely new model of decision-making and accountability, as it has grown too large for all partners to take part in all decisions. An executive board has been put in place, led by an executive partner (effectively the chief executive) and a chief operating officer, and a shareholder group of partners engages in strategic planning and oversight of the executive board.

Lead GP management roles have been created for all strategic areas (these GPs report to the board and to the shareholder group), and a board-level medical director is responsible for clinical governance across the organisation and its component practices. Extensive work has gone into the development of clinical quality standards, and the measurement of these feeds into a performance management framework for the organisation. In addition, every outlet has a clinical director, akin to a hospital divisional structure, who is held to account for the day-to-day operational and performance issues at each site.

Workforce

A workforce strategy has been developed in support of the overall business plan for the partnership. There is a new model of partnership for GPs, with phased options of ownership and responsibility that offer a clear career structure for salaried and equity colleagues. There is a single nursing team across the practices with recognition for special interests and management responsibilities. New roles are being developed for receptionists and back-office staff, to reflect the centralisation of many of these functions. A new approach to front-of-house reception work is being developed, with tailored training and support to reflect the background and experience of staff. Professional senior management expertise has been drawn into the partnership, including a chief operating officer who has a background as a PCT director of primary care.

Skills and capacity

Vitality has had to invest in external support for business planning, legal, property and organisational development skills, as much as in the traditional general practice support areas. Additional senior management capacity has been employed. Once the organisation reached a population base of 50,000, these skills (with the exception of property and legal) were brought in-house.

Patient engagement

Vitality has established a strong patient engagement function with a GP lead in each practice that is part of the partnership, and has worked to develop patient participation groups that are strategically-focused, work to common standards, and have a clear link into the governance and decision-making of the organisation.

Premises

Vitality has developed a five-year strategy that includes long-term plans for investment in premises, aligned with their service development plans. A property company has been established, owned by the GPs and a private sector third party. Plans include the development of a diagnostic and outpatient facility to support all the practices within Vitality and other local practices, and in particular the local delivery of specialised services in primary care.

Leadership

The partners have had to adapt to new ways of working as part of a larger partnership. This has required strong leadership from the executive partner and support to develop new models of communication and decision-making. The GPs with lead roles have dedicated management sessions each week, and capacity for this is created by the use of salaried or sessional doctors. There is a central management team designed to support the new organisational model which is more corporate and collegial, and less focused on the model of a single senior partner. For GPs, new elements of training have included long-term planning, understanding investment options, and collective team-working. Developing the model has required a high level of motivation and commitment from all partners to ensure its sustainability.

Box 16: Nairn Healthcare Group – developing the organisation

The Nairn Healthcare Group started out as one of the total purchasing pilots in the mid-1990s, where groups of GPs could opt to take on a total budget with which to purchase care for their local population. The group now comprises an integrated primary, community health and social care centre based in a new community hospital developed by the group. All out-of-hours and emergency primary care is delivered by the GP and nursing team of the health care group. Practices merged to form the current group in 2012 (12 doctors in total), and there are plans to assume a capitated budget with which to deliver holistic care for frail older people.

A specialist organisational development consultancy has been used by the GP practices since 1992 when they embarked on GP fundholding. This has been drawn from private consultants and from research-based organisations. In the early days, such support was funded by the Scottish government. When funding ran out, the practice group elected to continue funding this themselves, for they found the development and facilitation support to be vital.

Specific areas of development support have included:

- team building
- negotiation skills (for both the health board and the practice group, so that proper negotiations were possible)
- understanding of finances, including long-term planning
- locality planning, focused on local health needs and identifying services and skill-mix
- dealing with conflicts of interest across commissioners and providers of services.

The group has also invested in regular evaluation and assessment of progress with their developments, these being carried out by independent academic organisations. Such evaluations are considered by the group to be a core part of their reflective practice and development.

Developing larger organisations

The development of primary care organisations is a case study in enabling multiple small businesses to come together to form a larger, more complex and structured entity. For the NHS in England, this is a new way of delivering primary care and challenges the small partnership model that many GPs are attracted to. What is striking from our review of the literature on primary care organisational development, and examination of case studies, is that larger multi-practice organisations remain the exception rather than the rule. However, what cannot be underestimated is the cultural change required by those used to leading a small organisation to become part of a larger decision-making unit (Walsh, 2006). The case studies also demonstrate the requirement for GPs to make significant investment of their time and income to develop new models at a time when income is reducing and demands on GP time increasing (see Chapter 2). Developing a larger organisation inevitably leads to the need for new forms of governance, a different order of professional support for financial, legal, property and HR matters, and support for strategic planning by an executive group on a long-term basis.

We now explore the development and leadership required to make the strategic development of primary care organisations a mainstream, rather than ad-hoc, activity.

Training and development

What is striking from these two case studies is the combination of basic management training and development provided for all staff (GPs, nurses, managers and reception staff), including team-building, negotiation skills, and understanding finance, and more sophisticated and tailored support for the expanded organisation taking on a wider range of responsibilities.

Expert facilitation and advice

In both cases, external facilitation support has been used by the senior leadership team (in the case of Nairn, over a 20-year period) to develop and review strategic plans, linking these to finance, workforce and premises strategies. This support has not been seen as some form of ‘nice to have’ activity, but rather as core expertise to enable professional strategic planning; something that is not typically associated with small-scale general practice that tends to operate with more informal and short-term planning. It is also of note that as the organisations have grown, so they have developed new forms of governance and leadership with additional career opportunities for doctors, nurses and other staff, supported by professional and senior management capacity.

Sustained clinical and managerial leadership

What Vitality and Nairn both demonstrate is the time and sheer hard work entailed in developing small practice units into wider networks or integrated organisations, whilst at the same time maintaining the quality of clinical care. The leaders of these organisations under-estimated the time and capacity needed for management, leadership and organisational development; something that is echoed in international experience of establishing effective primary care-based organisations (for example, Walsh, 2006; Casalino, 2011; Thorlby and others, 2011; Thorlby and others, 2012). In a study of medical groups in California (Thorlby and others, 2011), it was noted that larger networked primary care organisations require formal business processes and specialist management support, for the organisations are too large and complex to rely on management through personal relationships. The same study concluded that the three critical aspects of organisational support required for long-term sustainability were: investment in high calibre managers; timely and accurate data and information; and rigorous financial management and accounting processes.

Time to reflect

What is also clear is that primary care teams need the time and space to reflect on current service provision and working practices, and for this reflection to be used to develop plans for how future services might be designed and organised. An important lesson from existing multi-practice organisations is that planning and making the move from a number of small practices to a larger network or organisation requires significantly more time, facilitation, project management and resource than is anticipated at the outset. We therefore suggest that any offer of new

funding or contract to enable primary care redesign is supported by resource for planning, service design and organisational development.

Toolkits to be used

In approaching the design and development of new multi-practice organisations, practices are not starting from scratch. There have been previous initiatives to draw together resources and advice to support such moves, for example the RCGP's GP Federations Toolkit (Imison and others, 2010). This toolkit covers issues such as: legal structures; federation governance; involving patients and the public; engaging the wider primary care workforce; education and training; improving quality and safety; sharing back-office functions; developing and redesigning services; and working with an external partner.

There are already significant resources available to practices wanting to redesign their workflow and processes. Expertise and tools from the NHS Institute, Primary Care Foundation, Vanguard and others is enabling many practices to improve their productivity, professional satisfaction, and patient experience. This aspect of service design (that is improving current services) is an important pre-requisite to more radical service planning, and can in itself start the process of organisational change and development, and release valuable time for planning work.

Sustainable leadership for the future

A framework for leading change in primary care

Mark Britnell (2013), in a recent paper on the characteristics of organisations that can adapt to create productivity, professional motivation and compassionate care, argued for the following five characteristics to be in place:

1. an authentic and strategic dedication to services that are high value (quality of care divided by costs of securing these outcomes)
2. a commitment to giving professionals greater autonomy
3. applying leading-edge business and care redesign methods
4. improving clinical and managerial information so that it is used routinely in day-to-day activities
5. having unambiguous staff performance management and accountability frameworks.

This type of framework may appear foreign to primary care practices and networks, yet any move to develop scaled-up organisations that meet the 'design principles' suggested in this report will require a clear strategic approach to inform their organisational development. As Britnell (2013) noted in his article:

"the best organisations seem to have an inner self-confidence and discipline to pursue their mission and implement these changes despite wider turbulence in local or national systems."

This suggests that primary care has to find the confidence to own the need to 'transform'. Given current pressures on general practice teams, it does not make sense to put all the responsibility for this onto primary care itself. There is a need for national strategic direction for the future of primary care, supported by new

contractual and funding options, with resource for reflection, service design, and organisational development.

A new form of leadership for primary care

A critical question is how general practices will be encouraged, incentivised and supported to form new networks or organisations that can enable the delivery of redesigned primary care. 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 a majority of part-time and sessional GPs (The King's Fund Commission in Leadership and Management, 2011).

Newman (2012) proposed that sustainable GP leadership for commissioning requires an approach that regards leadership as being distributed across different levels of the organisation. More specifically, she cited the importance of time for professionals to be released from clinical commitments, a focus on success planning and talent management, and ensuring that primary care leadership reflects the diversity of the workforce.

Our examination of the Vitality Partnership demonstrates how this distributed leadership for primary care can be put into action, with an executive core team (comprising clinicians and managers with dedicated and funded management time) and a shareholder group of all partners who support and share in decision-making. Lead roles for key doctor, nurses and other staff in Vitality extend the sharing of leadership work and responsibility. A further point to note is the need or opportunity for some GPs to take on full-time leadership roles in new primary care provider organisations, rather than leadership being an 'add-on' to the clinical day job. This points to the need for practice networks/groups to reflect on leadership, governance and decision-making structures as part of their overall strategic redesign work.

8. Next steps

In this final chapter, we suggest how the design principles and lessons from emerging primary care models set out in this report could be built on by policy-makers and practitioners. In particular, we examine how primary care might be incentivised and enabled to make the changes that are clearly required if high-quality and sustainable primary care is to be assured for the long term.

A national framework for primary care

Primary care has a strong history of independence and innovation which needs to be harnessed, but will require strategic direction, together with clear and powerful incentives for groups of practices to develop different and scaled-up primary care services, whilst retaining the benefits of small, local practices valued by patients. NHS England, as the commissioner of general practice services, should work with CCGs, GPs and professional bodies to create a national framework for primary care. This needs to set out the outcomes and overall vision, underpinned by design principles such as those described in this report. It should, however, steer clear of specifying the details of how this vision might be achieved and the organisational forms that could be used. The organisational form of primary care will need to be developed locally with extensive patient and public engagement. This local development of primary care should become a core part of the creation of a national narrative to ‘transform’ NHS care to meet future financial and quality challenges. This narrative would therefore be created from the bottom up by local health and social care practitioners and leaders, working closely with patients and the public (and not as a result of top-down strategy).

A new alternative contract for primary care

A new alternative contract framework for primary care is required (in parallel to the current GMS contract), setting objectives and parameters, but not specifying detail of local implementation. One option for incentivising local practices to come together to design and deliver new forms of primary care – based on the suggested design principles – is to offer a new alternative contract for primary care, based on outcomes. The contract needs to be crafted by NHS England in a way that encourages groups of practices to take on a collective population-based contract and share risk for 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, the scope of services for which it would be responsible, and would likely include older people’s, end-of-life, long-term conditions, mental health and children’s care.

The experience of the Alternative Quality Contract (AQC) developed by Blue Cross Blue Shield in Massachusetts is instructive, for the AQC was a five-year voluntary contract made available to physicians who wished to take on a capitated budget in return for delivering on mutually-agreed quality and financial outcomes (Song and others, 2011). Some safeguards such as open book accounting would be required. It should be noted that in the interim, existing contractual forms (as set out in Chapter 6) could be used, with a greater emphasis being placed on the assessment of health and service outcomes.

A role for CCGs in commissioning primary care

An alternative approach would be for CCGs to commission additional services from general practice (over and above core GMS/PMS services) and other care providers. This would be another way of encouraging the formation or extension of primary care federations and networks, with practices coming together to bid to provide new services in accordance with the design principles proposed here. CCGs could also use their role as local statutory health organisations to work closely with patients and the public in designing specifications for primary care services in line with the suggested design principles. 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

The case studies explored in this project reveal the critical importance of having shared electronic patient records to underpin scaled-up primary care networks or organisations. 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. Such records should include community pharmacists, community health services and social care if true integration of care is to be possible. This would need to be achieved through the collaboration of NHS England, CCGs, Commissioning Support Units (CSUs) and others.

An extended primary care team

The extended primary care team is a concept that has been long discussed, and yet is still in the process of being implemented in its true and fully operational form. What people often describe as an extended primary care team is a set of services to which a practice can refer, but with little coordination across a patient's care pathway, no joint assessment of needs, and a lack of shared patient record. The case studies in this project include examples of where the extended primary care team has been developed in such a way 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 access specialist care when patients need it. There is a need to think more widely about how services such as pharmacy, dentistry and optometry can effectively be woven into new scaled-up primary care organisations or networks.

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

Any new contract for scaled-up primary care will need to include requirements for training and education, so that new expanded services can serve as a base for developing different health professionals, given the recognition that much more training needs to be based on non-hospital settings. This should not be restricted to clinical training – there is a parallel need for practice and wider NHS management training to be more focused on primary and community health settings, and larger primary care networks and partnerships offer an excellent context for this.

It is important that leadership and management development for new and expanding primary care organisations, including professional advice for areas such as property and business planning, is made a priority within wider NHS leadership investment, and that this can be tailored to the specific needs of enabling multiple small practices to form and sustain larger collective organisations. This investment needs to include practice nursing and management, as well as clinical leadership development for GPs (partners, sessional and salaried).

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 CSU could be given resource 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. This will mean that progress towards the objectives of the new alternative primary care contract will need to be tracked and reported publicly. These measures of progress should ideally address metrics relating to service delivery, and include monitoring of the experiences 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. In addition, success can be measured through analysis of clinical indicators drawn from data already collected within GP systems. The exploitation of existing datasets that have been securely linked at person-level makes it possible to look at care across the whole population. When linked data extend across primary and secondary care (and even other sectors), it becomes possible to see how improvements in primary care impact on the wider system, for example by leading to more or less urgent care in hospitals.

Conclusion

The development of larger-scale organisations or networks, with new forms of service provision, different skill-mix, and fresh professional and leadership opportunities, is a pressing priority. It is clear that commissioners and providers of primary care understand the case for change, but find it hard to move from diagnosis to prescription and treatment. Providers 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 time and resource intensive. Many practices are already in, or are considering joining, federations or networks. They need 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.

Appendix 1: Case studies

| Organisational type | Example | Primary purpose of organisation | Details |
|-------------------------------|---------------------------|---|--|
| Accountable care organisation | Monarch Healthcare, US | To help physicians advance medical excellence in the communities they serve. The model aims to encourage clinicians, hospitals and other health care organisations to work together to improve the quality of care and reduce spending. | Monarch Healthcare is composed of 2,300 physicians, 18 hospitals and over 40 urgent care centres. 175,000 patients use their services. The organisation states that it provides patients with instant referrals to many specialists and same-day/next-day doctor appointments. They also offer health education and prevention programmes. For certain diseases such as diabetes and COPD, the organisation runs specific programmes. It is physician-led, with physicians operating as part of a network. |
| Community health organisation | Bromley by Bow Centre, UK | To offer a model of integrated health care which links to the widest possible network of support and interventions for patients. The approach has been described as experimental, holistic and relational. | Bromley by Bow Centre is a community organisation working in one of the UK's most deprived wards; supporting families, young people and adults of all ages to 'learn new skills, improve their health and wellbeing, find employment, and develop the confidence to achieve their goals and transform their lives'. They provide services, facilities, information and advice. The primary care services are run as a GP partnership, with the other wider services operating as a charity with distinct but connected governance arrangements. The GP partnership includes: GPs, practice nurses, a health care assistant, phlebotomists and an advocate. |

| Organisational type | Example | Primary purpose of organisation | Details |
|---|---|---|--|
| Community health organisation | Community Health Centre Botermarkt, Belgium | To deliver integrated primary health care, with a focus on patient empowerment and contributing to social cohesion. | The centre is a not-for-profit organisation based in a deprived urban location. The multidisciplinary primary care team provides services to 6,000 patients from over 70 different countries. Services include prevention, curative care, palliative care, rehabilitation and health promotion. The service delivery focuses on accessibility (with no financial, geographical or cultural threshold) and quality. The centre contracts with secondary care providers, physiotherapists, psychologists, palliative services and social services, within the framework of an integrated care system. They also have 'community diagnosis' meetings with local stakeholders (local schools, the police etc) as part of their Community Oriented Primary Care Strategy. |
| Community health organisation with inpatient facilities | Kangasala Health Centre, Finland | To maintain trust and respect in the local health system. | The centre has 82 beds and, as well as general practice, offers the following specialisms: minor casualty, orthopaedics, gastroscopy, paediatrics, psychiatry, obstetrics, rehabilitation, palliative care and occupational health. Management of Kangasala is by seven elected members from five municipality authorities, alongside a lead nurse and dentist, with the GP clinical director and general manager sharing the chief executive role. Operational control of service provision is exercised by the general medical practitioners on the basis of level of education and specialism. Doctors are salaried and public service employees. |
| Community-owned | Hokianga Health Enterprise Trust, New Zealand | To be a centre of excellence for rural health care that is responsive to local needs. | Hokianga Health Enterprise Trust is owned and governed by the people of Hokianga, and provides services to 6,500 people. This includes primary care, hospital, disability support, mental health, oral health and community development. The organisation has managed to maintain its 'no charge at the point of need' policy. It also stresses the importance of low cost and accessible doctor consultations. |

| Organisational type | Example | Primary purpose of organisation | Details |
|---------------------|---|---|--|
| Marginalised groups | Health E1 – homeless medical centre, UK | Nurse-led specialist primary care service, providing mental health and substance misuse services to homeless people in E1 (rough sleepers and those staying in hostels or temporary accommodation). | The medical centre provides: addiction services; sexual health services; mental health services; family planning; and dressings and the removal of stitches. The centre operates as a nurse-led specialist primary care service. Other staff include GPs, a psychologist and clinical nurses who specialise in mental health and substance misuse. |
| Marginalised groups | Leicester Homeless Primary Care Health Centre, UK | To give a range of high-quality primary health care services to homeless people (including rough sleepers and those staying in hostels). | Individuals can refer themselves directly to the service. The service includes: GP and consultant nurse consultations for diagnosis, treatment and medical certificates; health checks; contraceptive services; maternity medical services; minor surgery services; sexual health promotion; weekly visiting therapist for common mental health problems; and acupuncture for muscular and joint problems. The centre is a social enterprise, supported by a non-executive board, with all profits reinvested into the organisation's activities. |
| Network | Midlands Health Network, New Zealand | To coordinate primary care activity and developments across the network. Conduit for practice funding allocated on capitation and delivery of national and local quality indicators. | A new model of care is in place in 'proof of concept' practices aimed at transforming general practice. This includes a centralised booking system and 'Lean' processes within the practice setting. Programme established to shift care out of hospital into community settings. As a network, it is able to coordinate practice-based services with community-based services, including population health profiling and management. Provides 24/7 care and virtual consultations for those in rural communities. |

| Organisational type | Example | Primary purpose of organisation | Details |
|---------------------|--|---|--|
| Network | ZIO, Maastricht, the Netherlands | Providing integrated care to patients with diabetes, COPD, asthma, cardiovascular risk management, frail elderly care, anxiety/depression. They also provide training to staff. | ZIO is a not-for-profit organisation that has been in operation since 2006. The organisation covers 100 per cent of the region, totalling 170,000 registered patients. There are 90 GPs working in 60 practices alongside 52 nurses, 150 physiotherapists and 30 dieticians. The organisation provides integrated services for a variety of conditions. They also provide training to staff, are responsible for quality certification, and provide services varying from deployment of personnel, ICT to development of practices and renting them to GPs. |
| Network | Primary care networks in Alberta, Canada | To improve access to family physicians and other frontline health care providers. | These networks aim to: increase access; provide 24/7 primary care; increase emphasis on disease and injury prevention, and care of patients with complex problems or long-term conditions; improve coordination with hospital, long-term and specialty care; and facilitating the greater use of multidisciplinary teams in primary health care. There are 40 primary care networks operating in Alberta, with a diverse workforce including nurse practitioners, dieticians, social workers and pharmacists. |
| Network | Tower Hamlets, UK | To improve the quality of general practice for selected long-term conditions. | Eight networks of GP practices covering approximately 30–40,000 patients, each with a network manager, administrator and additional clinical staff if wanted. ‘Care packages’ were developed which established standards of care to be followed by practices and clinical outcome measures in excess of QOF. The care packages also require practices to work collaboratively to improve services, and 30 per cent of incentive payments are based on performance across the network in improving care outcomes, and not just on how an individual practice performs. More recently, service agreements for care packages have been pooled into a single APMS contract between the PCT (now CCG) and each of the networks. |

| Organisational type | Example | Primary purpose of organisation | Details |
|---|------------------------------|--|--|
| Professional chambers | Pallant Medical Chambers, UK | To improve the life, welfare and quality of services provided by locum medical staff in general practice. | The company provides locum medical services to general practices. As part of this, it deals with all bookings, billing, superannuation and administration, and focuses strongly on creating a community (chambers) of locum doctors. The doctors receive professional development support, clinical guideline and other resources, assistance with revalidation, clinical governance support, membership of local groups for professional support, and a sense of belonging to an organisation. |
| Regional and national multi-practice organisation | The Hurley Group, UK | Provision of patient-centred GP services and walk-in-centres, particularly targeted at deprived communities. | The Hurley Group is a partnership of 17 practices. While many of their practices offer traditional GMS services, they are developing many additional services including: diagnostics (x-ray and ultrasound); specialist clinics (substance misuse and services for sick doctors and dentists) and minor surgery; mental health professionals as part of practice team; health education; care for residents of 140-bed hostel for refugees and asylum seekers stratified as most medically-vulnerable; support with arranging benefits advice and collaboration with social enterprises to provide various joint health/social services. They are also developing innovative new forms of consultation including: a multi-professional team delivering specialised services for doctors or dentists with complex mental health or addiction issues; community-based addiction nurses; online consultations, health advice and prescription requests; open-access self-referral physiotherapy services; and co-locations with dentists and pharmacies. |
| Regional and national multi-practice organisation | The Practice Plc, UK | To provide personalised care in the most appropriate setting, as close to the patient's home as possible. | The Practice is a private company holding contracts for over 50 GP surgeries and GP-led health centres, and over 120 community outpatient clinics per week. The organisation offers: GP surgeries, ophthalmology, dermatology, ear, nose and throat, cardiology, urology, gynaecology and sexual health services in primary or community care settings (depending on area). There is also a GP service based in A&E. |

| Organisational type | Example | Primary purpose of organisation | Details |
|-------------------------|---------------------------------|--|--|
| Specialist primary care | ParkinsonNet, the Netherlands | To provide everyone with Parkinson's disease or atypical Parkinsonism with the best care possible, and in the community whenever possible. Representation of regional communities of cooperating health care professionals that are specialised in treating and coaching patients with Parkinson's disease or related disorders. | <p>ParkinsonNet is a nationwide professional network of specially trained caregivers who can provide care to those with Parkinson's disease and related disorders. Each regional community currently includes 12 professional disciplines, including neurologists, Parkinson's disease nurses, physiotherapists, speech therapists, occupational therapists, dieticians, social workers, sexologists, pharmacists, psychologists and psychiatrists. Each year additional disciplines are being added, and all networks will soon involve all of the 19 disciplines involved in the care for Parkinson's disease patients. The communities of health care professionals are centred around community hospitals. They hope to provide expert treatment and personalised care that is provided close to home.</p> <p>There is an online tool where patients can type in their postcode and find their nearest available ParkinsonNet team members.</p> <p>Independent evaluations indicate increases in the quality of care received by patients.</p> |
| Super-partnership | Whitstable Medical Practice, UK | To deliver high-quality primary care and specialist services within a community setting. | The organisation is owned by 18 GP partners. The team also operates with practice and specialist nurses, physiotherapists, radiographers, chiropractors and a care of the elderly team. The practice offers: primary care, a range of specialist and outpatient services, x-ray and MRI, ultrasound, a minor injury unit, an operating theatre for local anaesthetic procedures, and a community cafe to support dementia care. |

| Organisational type | Example | Primary purpose of organisation | Details |
|---|------------------------------|--|---|
| Super-partnership | Dr HM Freeman & Partners, UK | To achieve scale in general practice to create greater organisational resilience and efficiencies. | A large practice, covering a registered population of 65,000 over five sites, with seven GP partners and a manager at each of the sites overseen by a practice director. There is also a team of practice nurses who are led by a senior practice nurse, along with salaried GPs and other allied health professionals. The group offers core GP services, counselling, minor surgery and family planning. There are also plans for new premises that will include outreach diagnostic services. |
| Super-partnership | The Vitality Partnership, UK | To create a GP-led integrated care organisation led by local GPs coordinating generalist, specialist and community care around the registered list through mergers and acquisitions. | The partnership offers patients: primary care, a range of outpatient services, x-ray, intermediate care, private aesthetics and private immigration services. The partnership operates with an integrated IT system, real-time patient feedback mechanisms, joint delivery clinics between the GP with a special interest and consultants. The organisation is based across multiple sites, covers 50,000 patients and delivers specialist services to the wider non-registered population. Its strategic aim is to continue to grow and develop into a 100,000 plus integrated care organisation and ultimately an accountable care organisation. |
| Super-partnership with inpatient facilities | Nairn Healthcare Group | To provide integrated primary, community and social care to the people of Nairn; this care being based in the home, nursing home or community hospital, wherever possible, and admissions to secondary care for older people being considered a last resort. | Staff in the healthcare group include: 16 doctors in general practice, seven practice nurses, three health screeners, three practice management staff, district nurses, health visitors, community midwives, community mental health team, physiotherapists, podiatry, social workers, dentists, community hospital staff and specialists (for example geriatricians, psychiatrists). The group also offers ultrasound, diagnostics and minor surgery. The development of a merged general practice, focused on the community hospital and, with as many services as possible co-located, is all about trying to develop an integrated and accessible approach to care for local people in a rural location. There is a desire to increase the number of people dying at home rather than in hospital, and to have at least 98 per cent of people cared for at home or in the local community at any one point in time. |

| Organisational type | Example | Primary purpose of organisation | Details |
|------------------------------|-----------------------------|---|---|
| Vertically integrated system | Geisinger Health System, US | Physician-led, multidisciplinary care and coordinated provision, with evidence-based practice. Physicians are brought together to jointly plan and budget for care. | Geisinger Health System includes three hospitals and 40 community practice clinics (because of the rural location), and serves a population of 2.6 million. In addition to directly-employed staff, Geisinger also contracts with 18,000 independent providers and community hospitals. Physicians receive bundled payments for certain procedures to encourage them to follow best practice and promote consistent quality and reduce complications. As well as hospital-based pathways (ProvenCare), Geisinger has also developed ProvenHealth Navigator, a community-based advanced medical home for individuals with multiple long-term conditions. |
| Vertically integrated system | Kaiser Permanente, US | The model emphasises the integration of care, combining the role of insurer and provider. | The largest non-profit-making health maintenance organisation in the US, serving 8.6 million people in eight regions across the country. Permanente Medical Groups receive a capitation payment to provide care to members, including responsibility for clinical care, quality improvement, resource management, and the design and operation of care delivery. Clinicians across primary, secondary and tertiary care share responsibility for the budget and quality of care. |

References

- AHRQ (2012). Federal PCMH Activities [online]. US Department of Health and Human Services, Agency for Healthcare Research and Quality website. Available at: http://pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/pcmh_federal_pcmh_activities_v2
- AHRQ (2013). Defining the PCMH [online]. US Department of Health and Human Services, Agency for Healthcare Research and Quality website. Available at: http://pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/PCMH_Defining%20the%20PCMH_v2
- American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association (2007). Joint Principles of the Patient-Centred Medical Home [online]. Patient-Centred Primary Care Collaborative website. Available at: <http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home>
- Bodenheimer T, Wagner EH, Grumbach K (2002). Improving primary care for patients with chronic illness: the chronic care model, Part 2. *JAMA* 288(15), 1909-14.
- Britnell M (2013) 'Cut the platitudes and get staff motivated' *HSJ* 30 January 2013.
- Casalino L (2011) *GP commissioning in the NHS in England: Ten suggestions from the United States*. Nuffield Trust.
- Centre for Workforce Intelligence (2013) GP in-depth review. London: Centre for Workforce Intelligence. Available online at: <http://www.cfwl.org.uk/publications/gp-in-depth-review-preliminary-findings>
- Challis D, Hughes J, Berzins K, Reilly S, Abell J, Stewart K (2010) *Self-care and case management in long-term conditions: the effective management of critical interfaces*. The Stationery Office.
- Coleman A, Checkland K, McDermott, Harrison S (2013) The limits of market-based reforms in the NHS: the case for alternative providers in primary care. *BMC Health Services Research* 13(Suppl 1), 53.
- Commonwealth Fund Commission on a High Performance Health System (2008) *Why not the Best? Results from the National Scorecard on US Health System Performance*.
- Coulter A, Roberts S, and Dixon A (in press) *Building the house of care: delivering better services for people with long term conditions*. The King's Fund.
- Cowling TE, Cecil EV, Soljak MA, Lee JT, Millett C, et al (2013) Access to primary care and visits to emergency departments in England: a cross-sectional, population-based study. *PLoS ONE* 8(6), e66699.
- Davis K, Schoenbaum SC, Audet A-M (2005). A 2020 Vision of Patient-Centred Primary Care. *Journal of General Internal Medicine* 20(10), 953-7.
- De Maeseneer J and Boeckxstaens P (2012) Multimorbidity, goal-oriented care, and equity *British Journal of General Practice* e523.
- Dowling BD, Glendinning C (2003) *The New Primary Care. Modern, Dependable, Successful?*. Open University Press.
- Field S, Gerada C, Baker M, Pringle M, Aswani K (2008). *Primary Care Federations: putting patients first*. Royal College of General Practitioners.
- Francis R (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. The Stationery Office.
- Future of Family Medicine Project Leadership Committee (2004). The future of family medicine: a collaborative project of the family medicine community. *Annals of Family Medicine* 2(Suppl 1), S3-S32.
- Gerada C, Mathers N, Thomas M (2012) *Patients, Doctors and the NHS in 2022. Compendium of Evidence*. Royal College of General Practitioners
- Goodwin N, Mays N, McLeod H, Malbon G, Raftery J (1998) Evaluation of total purchasing pilots in England and Scotland and implications for primary care groups in England: personal interviews and analysis of routine data. *BMJ* 317, 256.

- Goodwin N, Dixon A, Poole T, Raleigh V (2011). Improving the quality of care in general practice. Report of an independent inquiry commissioned by The King's Fund. The King's Fund.
- Goodwin N, Smith JA, Davies A, Perry C, Rosen R, Dixon A, Dixon H, Ham C (2012) A report to the Department of Health and NHS Future Forum – Integrated care for patients and populations: improving outcomes by working together. The King's Fund and the Nuffield Trust.
- Health and Social Care Act (2012). Available online: www.legislation.gov.uk/ukpga/2012/7/contents/enacted
- Hinder S, Greenhalgh T (2012). "This does my head in" : ethnographic study of self-management by people with diabetes. *BMC Health Services Research* 12, 83.
- Howard J et al (2013) *East of England Multi-Professional Deanery General Practice & Primary Care Task Force*. East of England Multi-professional Deanery.
- Imison C, Naylor C and Maybin J (2008). *Under One Roof. Will Polyclinics Deliver Intergrated Care?* The King's Fund.
- Imison C, Williams S, Smith JA and Dingwall C (2010) Toolkit to support the development of primary care federations. RCGP, The King's Fund, Nuffield Trust and Hempsons.
- Institute for Healthcare Improvement (2013). The IHI Triple Aim [online]. IHI website. Available at: <http://www.ihio.org/offerings/Initiatives/TripleAim/Pages/default.aspx>
- Jones N and Charlesworth A (2013) *The anatomy of health spending, 2011/12*. Nuffield Trust.
- Kark SL (1974) *Epidemiology and Community Medicine*. Appleton-Century-Crofts.
- Kark SL (1981) *The Practice of Community Oriented Primary Health Care*. Appleton-Century-Crofts.
- Kilo CM, Wasson JH (2010). Practice Redesign and the Patient-Centered Medical Home: History, Promises, and Challenges. *Health Affairs* 29(5), 773-8.
- The King's Fund (2011). *Improving the Quality of Care in General Practice. Report of an independent inquiry commissioned by The King's Fund.*
- The King's Fund Commission on Leadership and Management in the NHS (2011) *The future of leadership and management in the NHS: no more heroes*. The King's Fund.
- Kringos DS, Boerma W, van der Zee J and Groenewegen P (2013) Europe's strong primary care systems are linked to better population health but also to higher health spending. *Health Affairs* 32, 686-94.
- Legido-Quigley H, McKee M, Nolte E and Glinos I (2008). *Assuring the quality of health care in the European Union*. European Observatory Studies Series No 12.
- Longman H (2012) *Comparison of mode of access to GP telephone consultation and effect on A&E usage*. Patient Access.
- Mays N, Wyke S, Malbon G and Goodwin N (2001) *The purchasing of health care by primary care organisations: an evaluation and guide to future policy*. Open University Press.
- Maxwell RJ (1984). Quality Assessment in Health. *BMJ* 288, 1470-1.
- Meads G (1996) *Future options for primary care*. Radcliffe Medical.
- Meads G (2009) The organisation of Primary Care in Europe: Part 1 Trends – position paper of the European Forum for Primary Care. *Quality in Primary Care* 17, 133-43.
- Monitor (2013) *Hypothetical case scenarios – Procurement, Patient Choice and Competition Regulations*.
- Naylor et al (in press) *The evolution of clinical commissioning: learning from local experience* Details available at: <http://www.nuffieldtrust.org.uk/our-work/projects/evolution-clinical-commissioning-learning-local-experience>
- Nease RF, Glave SF, Zarin L (2013) Choice architecture is a better strategy than engaging patients to spur behavior change. *Health Aff (Millwood)* 32(2), 242-9.
- Newman P (2012) Sustainable GP leadership for commissioning: building foundations for the future. NHS Midlands and East Strategic Health Authority

- NHS Information Centre (2013) *NHS Staff 2002 – 2012, General Practice*.
- NHS Institute for Innovation and Improvement (2007) *Stour Access System – a new way to manage GP appointments*.
- NHS Midlands and East Strategic Health Authority (unknown) *NHS Midlands and East Facts and Figures*.
- Peikes D, Zutshi A, Genevro J, Smith K, Parchman M, Meyers D (2012). *Early Evidence on the Patient Centred Medical Home*. AHRQ, U.S. Department of Health and Human Services.
- Peterson M (1980). The Institute of Medicine Report. A manpower policy for primary health care: a commentary from the American College of Physicians. Introduction and discussion. *Annals of Internal Medicine* 84, 843-51.
- Primary Care Foundation (2012a) *Benchmark of Out of Hours*.
- Primary Care Foundation (2012b) *Out Of Hours Benchmark – Index and Summary*.
- Roberts A, Marshall L and Charlesworth A (2012) *A Decade of Austerity? The funding pressures facing the NHS from 2010/11 to 2021/22*. Nuffield Trust.
- Roland M, McDonald R, Sibbald B, Boyd A, Fotaki M, Gravelle H and Smith E (2006) *Outpatient Services and Primary Care: a scoping review of research into strategies for improving outpatient effectiveness and efficiency*. NHS Service Delivery and Organisation Research and Development Programme.
- Royal College of General Practitioners (2013) *The 2022 GP: a vision for general practice in the future NHS*.
- Safran DG (2004). Primary care performance: views from the patient, in Showstack J, Rothman AA, Hassmiller SB (eds.) *The Future of Primary Care*. Jossey-Bass. p 17-39.
- Saltman R, Rico A and Boerma W (eds) (2006) *Primary Care in the Driver's Seat?* Open University Press.
- Schofield J, Grindlay D and Willams H (2009) *Skin conditions in the UK: a healthcare needs assessment*. University of Nottingham.
- Showstack J, Rothman AA, Hassmiller SB (2004). *The Future of Primary Care*. Jossey-Bass.
- Smith JA and Goodwin N (2006) *Towards managed primary care: the role and experience of primary care organisations*, Ashgate Publishing.
- Song Z, Safran D et al (2011) Health Care Spending and Quality in Year 1 of the Alternative Quality Contract. *New England Journal of Medicine* 365, 909-18.
- Starfield B, Shi L, Macinko J (2005) 'Contribution of primary care to health systems and health' *The Milbank Quarterly* 83(3) 457-502.
- Starfield B (1998) *Primary Care: Balancing Health Needs, Services and Technology*.
- Thorlby R (2013) *Reclaiming a Population Health Perspective*. Nuffield Trust.
- Thorlby R, Rosen R and Smith JS (2011) *GP Commissioning: Insights from medical groups in the United States*. Nuffield Trust
- Thorlby R, Smith JA, Barnett P and Mays N (2012) *Primary Care for the 21st Century: Learning from New Zealand's Independent Practitioner Associations*. Nuffield Trust.
- Vrijhoef B and Wagner E (2009). Fragmentation of chronic care: a call for clarity. *J Integr Care* e172.
- Wagner EH, Austin BT, Von Korff M (1996). Organizing care for patients with chronic illness. *Milbank Quarterly* 74(4), 511-44.
- Walsh N (2006) *In whose interests? The nature of organizational change in GP practices using personal medical service contracts*. Doctoral thesis, University of Manchester.
- WHO (2000). The World Health Report 2000. Health Systems: improving performance. Available at: <http://www.who.int/whr/2000/en/>
- WHO Europe (2008). The Tallinn Charter: health systems for health and wealth. Available at: <http://www.who.int/whr/2000/en/>

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