

Learning about and learning from GP Federations in the English NHS – an exploratory longitudinal study.

Ruth McDonald¹, Lisa Riste², Simon Bailey⁴, Fay Bradley³, Jonathan Hammond², Sharon Spooner², Rebecca Elvey², Kath Checkland².

1 Alliance Manchester Business School and Centre for Primary Care and Health Services Research, University of Manchester.

2 Centre for Primary Care and Health Services Research, University of Manchester.

3 Alliance Manchester Business School, University of Manchester.

4 Centre for Health Services Studies, University of Kent.

Keywords: Federation, General Practice, Longitudinal Study, Primary Care, Case Studies, Qualitative Study, Organisations.

Contact author: ruth.mcdonald@manchester.ac.uk

Declared competing interests of authors: McDonald, Spooner and Checkland report grants from NIHR, outside the submitted work.

Other authors have not declared competing interests.

Word count 66,299

Disclaimer - This report contains transcripts of interviews conducted in the course of the research, or similar, and contains language which may offend some readers.

© Queen's Printer and Controller of HMSO 2019. This work was produced by McDonald *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health and Social Care. This 'first look' scientific summary may be freely reproduced for the purposes of private research and study and extracts may be included in professional journals provided that suitable acknowledgement is made and the reproduction is not associated with any form of advertising. Applications for commercial reproduction should be addressed to: NIHR Journals Library, National Institute for Health Research, Evaluation, Trials and Studies Coordinating Centre, Alpha House, University of Southampton Science Park, Southampton SO16 7NS, UK.

A 'first look' scientific summary is created from the original author-supplied summary once the normal NIHR Journals Library peer and editorial review processes are complete. The summary has undergone full peer and editorial review as documented at NIHR Journals Library website and may undergo rewrite during the publication process. The order of authors was correct at editorial sign-off stage.

A final version (which has undergone a rigorous copy-edit and proofreading) will publish as part of a fuller account of the research in a forthcoming issue of the Health Services and Delivery Research journal.

Any queries about this 'first look' version of the scientific summary should be addressed to the NIHR Journals Library Editorial Office – journals.library@nihr.ac.uk

The research reported in this 'first look' scientific summary was funded by the HS&DR programme as project number 14/196/04. For more information visit <https://www.journalslibrary.nihr.ac.uk/programmes/hsdr/1419604/#/>

The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The HS&DR editors have tried to ensure the accuracy of the authors' work and would like to thank the reviewers for their constructive comments however; they do not accept liability for damages or losses arising from material published in this scientific summary.

This 'first look' scientific summary presents independent research funded by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health and Social Care. If there are verbatim quotations included in this publication the views and opinions expressed by the interviewees are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health and Social Care.

Scientific Summary

Background

GP practices have begun working collaboratively in GP federations. These federations vary in scope, geographical reach and organisational form. Hypothesised benefits of federations include efficiencies of scale and scope, strengthening capacity to deliver services outside hospital and improving local integration. At the same time, federations may present many challenges including balancing individual practice ways of working, autonomy and identity with the requirements of more centralised and standardised procedures which federations imply. Federations are substantially different to the traditional partnership model, however, little is known about how federations are organised, their aims and the impact on staff and patients. It is important to understand how federations are emerging and operating in order to produce early lessons to inform their future development.

Objectives

We aimed to shed light on the ways in which emerging GP federations were organising themselves. We wanted to explore federation aims and assess progress towards these aims, as well as examining working processes and approaches more generally. In addition to learning about and from federations specifically, we aimed to produce findings which would have implications for the organisation of general medical practice more generally.

Methods

Study design

We used a qualitative, longitudinal case study approach, which involved following federations over time. Since these organisations were relatively young and in a process of evolution, we did not include a formal, quantitative assessment of outcomes. Instead, we examined progress towards each federation's stated aims using qualitative methods. We chose four federations, which was a compromise between breadth required to capture sufficient variation and the depth that we need for detailed exploration.

Recruitment and data collection

We used four contrasting federations to reflect a range of types, characterised respectively by

© Queen's Printer and Controller of HMSO 2019. This work was produced by McDonald *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health and Social Care. This 'first look' scientific summary may be freely reproduced for the purposes of private research and study and extracts may be included in professional journals provided that suitable acknowledgement is made and the reproduction is not associated with any form of advertising. Applications for commercial reproduction should be addressed to: NIHR Journals Library, National Institute for Health Research, Evaluation, Trials and Studies Coordinating Centre, Alpha House, University of Southampton Science Park, Southampton SO16 7NS, UK.

- i) a commitment to standardising systems and risk-sharing across practices
- ii) collaboration becoming more formalised as the federation is increasingly involved in bidding for contracts and providing new services
- iii) a provider entity separate to, but owned by, GP practices
- iv) GP practices with collaborative arrangements but without a significant provider function.

We were keen to avoid sites where federations were participating in other qualitative studies and those involved in national large-scale change initiatives such as NHS Vanguards, as overlapping initiatives involving the same practices would make it difficult to tease out the specific impact of the federation.

We used observation of meetings (n=139), interviews (n=205) with participants and analysis of documents. Field notes taken during observation of meetings were added to at the earliest opportunity following the end of the meeting. These were typed in word documents by the observing researcher to enable easy access for analysis by core research team members. Interviews were conducted with a range of stakeholders including practice partners and other staff, federation employees and staff working in other organisations interacting with federations. We also interviewed patients and policy makers. Interviews were digitally recorded, where consent for this was given, and transcribed verbatim.

Data analysis

In addition to inductive analysis, identifying themes emerging from the data, we used literature on 'meta-organisations' (MOs) and networks to provide a theoretically informed analysis. MOs, are organisations whose members are not individuals, but other organisations. Members are not employees, therefore. There is a potential tension between the meta-organisation's requirement for a degree of authority to organise its members and each member organisation's need to organise itself.

Findings

All of our federations were 'bottom up' organisations relying on voluntary membership, aiming to support member practices. We found that the way in which federations pursued the broad goal of

© Queen's Printer and Controller of HMSO 2019. This work was produced by McDonald *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health and Social Care. This 'first look' scientific summary may be freely reproduced for the purposes of private research and study and extracts may be included in professional journals provided that suitable acknowledgement is made and the reproduction is not associated with any form of advertising. Applications for commercial reproduction should be addressed to: NIHR Journals Library, National Institute for Health Research, Evaluation, Trials and Studies Coordinating Centre, Alpha House, University of Southampton Science Park, Southampton SO16 7NS, UK.

supporting practices varied across sites. The approach of each federation central authority in terms of the extent to which it a) sought to exercise control over member practices and b) was engaged in 'system proactivity' (i.e. the degree of proactivity in working across a broader spatial and temporal context) was important in explaining variations in progress towards aims. We developed a typology to reflect the different approaches and found that a high level of both top down control and system proactivity was effective in securing agreement for a single Care Quality Commission (CQC) registration, standardising systems for accounting and payroll, intranet system and staffing solutions and building capacity at sub-federation level. One site adopted this (high control and system proactivity) 'Authoritative' approach. This site was the only one where member practices were required to make changes to the ways in which they worked and to engage in sharing risk across practices. A focus on longer-term time horizons and capacity building at sub-federation level, as well as influencing system (STP) level processes and actions also made this site unusual. In another site, rather than creating expectations of practices, the focus was on supporting them by attempting to solve the immediate problems they faced. This site was characterised by low control and lower levels of system proactivity, but this 'Indulgent' approach was more effective, compared with our two other sites. These were characterised by low levels of both control and system proactivity, with more distant 'Neglectful' relationship with practices.

In addition to this, other key factors explaining progress (or lack thereof) were competition between federations (if any), relationship with the Clinical Commissioning Group, money, history, leadership and management issues, size and geography, and these interacted in a dynamic way. The fact that the context was one of GP scarcity, relative to workload, acted to make these factors particularly salient. At all sites, federations were often reliant on key individuals to sustain progress and this raises questions about federation sustainability, especially in the context of additional pressures created by the requirement to participate in PCNs.

We found that federations produced positive benefits for member practices. These included bringing staff together for training and assisting with workforce issues, as well as providing new services for patients. However, progress was slower than federation leaders desired and anticipated. Building relationships within the federation took time. Shared goals, which were specified in relatively vague terms, enabled federations to build and maintain a collective identity and to work out goals and values in dialogue as they went along. This facilitated flexibility in adapting to external events, but required discussion and debate as part of the process. At the same time, despite the constraints

created by their status as MOs, in the context of a tight deadline and fixed targets, federations were

© Queen's Printer and Controller of HMSO 2019. This work was produced by McDonald *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health and Social Care. This 'first look' scientific summary may be freely reproduced for the purposes of private research and study and extracts may be included in professional journals provided that suitable acknowledgement is made and the reproduction is not associated with any form of advertising. Applications for commercial reproduction should be addressed to: NIHR Journals Library, National Institute for Health Research, Evaluation, Trials and Studies Coordinating Centre, Alpha House, University of Southampton Science Park, Southampton SO16 7NS, UK.

able to respond to the requirements to provide additional services as part of Improving Access to General Practice in a way, which would not have been possible in the absence of federations. Building relationships with other organisations was sometimes hampered by what federation leaders viewed as slow and bureaucratic decision-making processes, of those organisations, compared with general practice. In addition, budget reductions experienced by potential partner organisations also influenced the ways in which federations interacted with these bodies.

The ability of federation leaders to adopt multiple perspectives and to be able to shift perspectives appeared to be important in influencing their effectiveness. In only one site was there a mechanism built in to facilitate this, leaving this to chance elsewhere. In addition to identifying organisational development needs, we found that federations had to grapple with issues relating to legal and financial rules, in a context where available expertise was scarce. This suggests a need to provide support to assist federations with these issues. The changing context (including federation evolution and CCG reorganisations) meant that the organisations from whom federations sought advice were not always able to provide it.

Public and patient engagement was minimal or completely absent and most patients had little or no knowledge of federations. Patients were generally more concerned about their local practice and the services provided, but given their lack of knowledge, they may fail to see a link between those and the activities of the federation. Involving patients and local communities requires careful thought and takes time and effort. In a context where federations were still developing ways of engaging with member practices, a failure to focus on patient engagement may be understandable, but this will need to be addressed by 'at scale' organisations, which in our study lacked meaningful patient perspectives and input.

Conclusions

GP practices working collaboratively can produce benefits, but this takes time and effort. The voluntary nature of federation membership suggests that these organisations are perceived as adding value for GP practices and consideration. At the same time, creating clear expectations of members, monitoring compliance and a focus on longer-term and 'big picture' processes and goals appeared to be effective in enabling capacity building and coherence. Importantly, practices accepted the constraints imposed by these arrangements in a context of voluntary participation. Yet these constraints were largely concerned with changes to administrative functions rather than

having implications for clinical autonomy. Consideration needs to be given to the potential adverse
© Queen's Printer and Controller of HMSO 2019. This work was produced by McDonald *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health and Social Care. This 'first look' scientific summary may be freely reproduced for the purposes of private research and study and extracts may be included in professional journals provided that suitable acknowledgement is made and the reproduction is not associated with any form of advertising. Applications for commercial reproduction should be addressed to: NIHR Journals Library, National Institute for Health Research, Evaluation, Trials and Studies Coordinating Centre, Alpha House, University of Southampton Science Park, Southampton SO16 7NS, UK.

effects on GP practices of a move towards collaborative forms, which encompass a high degree of compulsion. Linked to this, although it is necessary to provide expertise and support to facilitate at scale working, where possible this should avoid implying 'top down' mandates attempting to constrain local freedoms. A reliance on groups of key individuals to sustain progress raises questions about federation sustainability, especially in the context of existing workforce pressures and additional pressures created by the requirement to participate in PCNs.

Funding

Funding for this study was provided by the Health Services and Delivery Research programme of the National Institute for Health Research.