The impacts of GP federations in England on practices and on health and social care interfaces: four case studies

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Disclaimer: This report contains transcripts of interviews conducted in the course of the research and contains language that may offend some readers.

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Scientific summary

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Background

General practices have begun working collaboratively in general practitioner 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 the ways of working, autonomy and identity of individual practices with the requirements of more centralised and standardised procedures that federations imply. Federations are substantially different from 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 to produce early lessons to inform their future development.

Objectives

We aimed to shed light on the ways in which emerging general practitioner federations were organising themselves. We wanted to explore federation aims and assess progress towards these aims as well as examine working processes and approaches more generally. In addition to learning about and from federations specifically, we aimed to produce findings that 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. As 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 the breadth required to capture sufficient variation and the depth needed for detailed exploration.

Recruitment and data collection

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

1. a commitment to standardising systems and risk-sharing across practices
2. collaboration becoming more formalised as the federation is increasingly involved in bidding for contracts and providing new services
3. a provider entity separate to, but owned by, general practices
4. general 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 the observations of meetings were added to at the earliest opportunity following the end of the meeting. These were typed in Microsoft Word (Microsoft

Corporation, Redmond, WA, USA) 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 practice staff, federation employees and staff working in other organisations interacting with federations. We also interviewed patients and policy-makers. Interviews were digitally recorded, when 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' and networks to provide a theoretically informed analysis. Meta-organisations are organisations whose members are not individuals but other organisations; therefore, members are not employees. There is a potential tension between a meta-organisation's requirement for a degree of authority to organise its members and each member organisation's need to organise itself.

Findings

All 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 supporting practices varied across sites. The approach of each federation central authority in terms of the extent to which it (1) sought to exercise control over member practices and (2) 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 an approach comprising high levels of both top-down control and system proactivity was effective in securing agreement for a single Care Quality Commission registration; in standardising systems for accounting and payroll, an intranet system and staffing solutions; and in building capacity at subfederation level. One site adopted this 'authoritative' approach (high levels of control and system proactivity). This site was the only one in which 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 subfederation level, as well as on influencing system (sustainability and transformation partnership)-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 levels of control and lower levels of system proactivity, but this 'indulgent' approach was more effective than the approach used in the other two other sites. These federations 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, the history of previous local collaborations, leadership and management issues, size and geography; these interacted in a dynamic way. The fact that the context was one of general practitioner 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 primary care networks.

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 meta-organisations, in the context of a tight deadline and fixed targets federations were able to respond to the requirements to provide additional services as part of NHS Improving Access to General Practice policy in a way that would not have been possible in the absence of federations.

Building relationships with other organisations was sometimes hampered by what federation leaders viewed as the 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. There was a mechanism built in to facilitate this in only one site; it was left 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 an environment 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 Clinical Commissioning Group reorganisations) meant that the organisations from which 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 in which 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

General 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 general practices. 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 effects on general 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 primary care networks.

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