# A general practice provider federation in a mixed health economy in England – a case study examination

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## Abstract

For over 70 years GP practices have existed within the NHS as independent contractors playing a significant role in the equitable delivery of primary health care. The traditional model of general practice has developed over time, but features such as independent contractor status, the professional partnership business model, and professional autonomy remain as key characteristics. The profession is faced with significant challenges, including increased demand on services with more complex multiple morbidities prevalent in an ageing population, workforce shortages precipitating the need to introduce new disciplines of staff, and the long-term sustainability of the partnership business model. The cumulative effect of these factors challenge the existing model of general practice, and practices are being encouraged to move from what has been termed a small cottage industry (Digby, 1999; Mathers & Lester, 2011; Mathers, 2012) to larger organisational group arrangements. General practice is the empirical setting for this research which adopts pragmatism as a research philosophy within a mixed methods single organisational case study. The study is an example of a GP Federation established as a corporate venture by a group of entrepreneurial GPs. The study examined what insights business theory could offer in explaining how a group of GP practices developed their venture and what advantages and challenges this offered. A mixed methods approach to data collection included interviews and surveys with the executive team who led the venture, GPs, managers and nurses from the member practices, and other senior personnel in the health economy. The activities pursued over an eight-year period (2011-2019) that contributed to strategy were identified, with some aspects of strategy more successful than others. Benefits were realised through activities that all practices participated in, including education, training, research, and quality improvement. A lack of commercial opportunities within the health economy limited the ability to develop a portfolio of services which ended up taking several years to establish. Purpose and vision were identified as important features to ensure continued engagement from practices as sponsors, and the level of investment in leadership and management to dedicate to the venture should not be underestimated. At the beginning of the study in 2011 health policy was focussing on implementation of the Health and Social Care Act (2012) with significant changes introduced in the commissioning landscape. After a period of eight years in 2019, national health policy introduced initiatives to support the ailing sector of general practice through the establishment of Primary Care Networks, and this study reflects on the learning from federated working between 2011-2019 as practices prepared to establish a Primary Care Network though a formal contractual arrangement (NHS England, 2018).

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## Acknowledgements

I am extremely fortunate to have had the opportunity of conducting a study with unique access to a group of GPs and practices who pursued their vision of establishing a federation. During this study I witnessed the personal drive, enthusiasm, commitment and dedication of a cohort of motivated GPs who genuinely believe in preserving a model of general practice that delivers the highest quality care.

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## Author's declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this thesis has been approved. Approval has been sought and granted by the University Ethics Committee On 29 August 2013.

I declare that the word count of this thesis is 85,594 words.

Name: Jill Mitchell

Signature:

Date: 22 July 2021

## Glossary

| | |
|---|---|
| BMA | British Medical Association |
| CCG | Clinical commissioning group |
| CQC | Care Quality Commission |
| FHSA | Family health service authorities |
| GMS | General medical services |
| GPC | General practitioner committee |
| GP | General practitioner or general practice |
| MAAGs | Medical audit advisory groups |
| NHS | National Health Service |
| QOF | Quality and outcomes framework |
| PMS | Personal medical services |
| RCGP | Royal College of General Practitioners |
| UK | United Kingdom |

# Chapter 1 – Introduction

## 1.1 General practice within the NHS in England

General practice is a key feature of the United Kingdom's (UK) National Health Service (NHS). The NHS was established in 1948 following the publication of the NHS Act (1946). The underlying principle of the NHS Act (1946) stated that everyone should have free access to healthcare from a family doctor regardless of their ability to pay, hence access to a GP in England is state-funded and free at the point of delivery. In 1978 the World Health Organisation Alma Ata Declaration (1978) outlined that every nation should devote a share of its resources to ensure the public has access to a basic provision of health services with the foremost emphasis on primary health care. General practices are often the first contact that patients have with the NHS and have a role in coordinating care by accessing additional care that may be required, for example specialist hospital care or specialist mental health care.

## 1.2 The independent contractor status of GPs

In 1948, when the NHS was established, it was conceded by the Labour government at the time that it was unrealistic to impose a unified administration on the NHS and therefore general medical practitioners, dentists, pharmacists and opticians retained their independent contractor status, regulated by executive councils (Loudon et al, 1998). To the current day, this independent contractor status has remained a key feature of general practice (Pollock, 2005), but some argue this has created a sector of healthcare motivated by financial incentive (Smith and York, 2004). General practices are contracted by NHS England to provide a range of primary healthcare services to a defined registered population, ensuring comprehensive access to general medical services. The basis of this contractual arrangement is a capitation fee based upon a registered list size, with other payments generated through the delivery of a quality and outcome-based incentive scheme (Quality and Outcomes Framework (QoF), 2004) or delivering an extended range of additional services. The bargaining power of GPs as independent contractors is supported through a national contractual negotiation process involving the British Medical Association and NHS England (BMA, 2019).

## 1.3 Partnership as a prominent general practice business model

As independent contractors, GP practices hold contracts for the provision of a range of general medical services and have traditionally existed as individual businesses. These

range from single-handed practices run by one GP partner to larger group arrangements with multiple GPs working in partnership. Although other business forms exist, the professional partnership has been a dominant business characteristic, where two or more self-employed GP partners hold an equity share in the business. Within this partnership arrangement, after expenses are deducted, GPs share the profits that are remaining and are individually liable for tax payments on the basis of self-employed status. The many benefits of the GP partnership have been recognised to include security, personal and professional autonomy, influence and the ability to shape the delivery of local services to a registered population (British Medical Association (BMA, 2015). An independent review undertaken in 2019 made a series of recommendations to the government to support this form of business construct in primary healthcare, identifying key strengths of GP partnerships as including a freedom to innovate, autonomy, accountability to a community, the desire to succeed as businesses and providing value for money (Department of Health and Social Care, 2019).

### 1.4 A pressurised sector of healthcare

The healthcare system in England is made up of a range of provider organisations and it has been recognised that any effective healthcare system requires a functioning quality primary care system. Promoted as the jewel in the crown of the NHS (Lown et al, 2015; Marshall, 2015) for provision of cost-effective and locally-accessible primary healthcare, it is proposed that there is a need to shift from what has been termed the cottage industry of general practice to one that delivers primary care organised at scale (King's Fund, 2011; Nuffield Trust, 2012; RCGP, 2008; Mathers and Lester, 2011). This suggests a change to either the business model of general practice or the organisational structure supporting individual practices is needed, hence the timeliness of this study. There is a multitude of contemporary pressures general practice is faced with, threatening the stability and viability of practices. These include a workforce crisis and increasing demands from an ageing population, with each endangering the viability of a key sector of healthcare in England. These include demographic changes from an ageing population, an imbalance between supply and demand of GPs creating workforce shortages (Baker, 2014; Mathers, 2016), and the profitability of practices as independent businesses. The seriousness of this crisis and the vulnerability of general practice was noted by Roland and Everington (2016) in that if general practice fails, the entire NHS system will fail. In recognition of this looming crisis, NHS England provided a package of support for the profession which was outlined in the "The Five Year Forward View" (NHS England, 2016), signalling one of the most important investments in general practice since the GP Charter of 1966, with recurring funding for

general practice set to increase by approximately £2.4 billion by 2020–2021 (Mathers, 2016).

### 1.5 The emergence of federations

To counteract and mitigate the challenges facing general practice as a profession, the notion of groups of practices working together across larger populations was promoted by the Royal College of General Practitioners (2008). Working collaboratively within alternative business constructs or collaborating through existing practice structures are options to achieve this. Historically, general practices have operated competitively against each other to attract registered patients because the registered patient list provides the core-funding component of the GP contract. The development of federations promoting a shift to collaborative working will rely on individual GP practices coming together to pursue alternative operational strategies through a shared vision and common purpose. Over the last decade examples of GP collaborations have emerged in various organisational and business formats, yet minimal evidence exists within the academic literature indicates that this is an under-researched area.

The broad focus of this study was to examine one model of a GP federation from a business strategy perspective as federated models provide the opportunity to operate on a larger scale than that of the individual small business unit. This strategic shift in focus will require the subscribers (member practices) to engage and support the development of this form of reorganisation, and this case study explores the approach that was adopted by one group of GPs who formed a federation and tracked the journey over an eight-year period (2011-2019). This research study is therefore both contemporary and relevant in presenting the experience from one pioneering GP federation that was established in 2011.
Several forms of collaboration have been identified (e.g. federations, alliances, super-partnerships) which can be underpinned by a variety of business constructs (e.g. partnerships, limited liability companies, social enterprise, etc.), suggesting there is not a one-size-fits-all model to federated general practice. The national initiative to improve access to general practice (NHS England, 2014) was a catalyst, with many pilot sites forming federations to collaborate on delivering extended access on a larger population footprint (NHS England, 2015). Policy developments from the Health and Social Care Act (2012) introduced significant reform around the commissioning infrastructure in England, with greater involvement of GPs in the commissioning process. However, there was less of a focus on the development of general practice with the majority of reform being organically developed by local groupings of practices seeking to collaborate. The Five Year Forward

View for General Practice (2018) set a national strategic direction to support the revitalisation and development of general practice with a five-year investment programme that incentivised GP practices to form primary care network groups. This investment included the phased employment of additional disciplines of staff to support practices.

### 1.6 The intersection between business strategy and general practice

The underpinning principle for any business is that it is financially viable and able to generate a profit on products or services delivered (Atherton, 2012; Omri et al, 2015). Unlike other sectors of healthcare in the NHS where staff are employees, GPs are classed as independent contractors and are effectively business owners and self-employed. The viability of individual practices as autonomous businesses is a key concern and, similarly, GP federations established as new organisational entities also need to exist as viable propositions in order to sustain their existence. However, there is a lack of evidence about how this can be achieved. Whilst the contract between NHS England and the GP practice forms the basis of the revenue stream that substantiates the practice as a business, the requirement to substantiate collaborations or federations of GP practices working at scale may rely upon alternative sources of funding to ensure that the individual practices are not financially disadvantaged. Therefore, principles of business management and strategy implementation to develop and maintain a viable business are pertinent to the sector of general practice, whether this be at an individual practice level or at the level of practices operating in larger groupings. To operate at scale, there is a need for strategic cohesion amongst multiple independent GP practices which, in some formats, may pose a threat to individual practice autonomy and the traditional partnership model, and this could act as barriers to change.

There are a range of management functions required to support effective strategy implementation, including activities such as planning, organising, leading, motivating and communicating. These require dedicated capacity and capability to be resourced and allocated to the venture.

### 1.7 The role of leaders within the federation

Leadership challenges in developing at-scale models of general practice include establishing a compelling vision and maintaining the engagement of individual practices. Contemporary conceptualisations of leadership promote a shift from traditional individual models of leadership to collective, shared or distributed leadership models, whereby collective activity

accomplishes the shared objectives of the organisation (Yukl, 2013). Therefore, in the context of federations, the member practices would play an important role in contributing to the success of the organisation. Strategic leadership theory highlights the vital role of senior executives in being able to transform organisations to respond to increased competition, and technological and social change (Finkelstein and Hambrick, 1996). Therefore, the leaders will have a role in assessing the contextual environment within which the federation is established and emerging business opportunities. Leadership is an important consideration within corporate ventures where multiple business invest in the establishment of a new business. In the context of this study, multiple GP practices made a financial investment to the set-up of the federation as a separate business entity, and an executive team was nominated to develop and lead this new venture on behalf of all of the member practices. In essence, the executive team's role was to set up a viable business venture that all practices would benefit from, highlighting a symbiotic relationship between the executive team and the practices. Authentic leadership theory, based within the theory of positive psychology (Yukl, 2013), suggests that important facets of leadership include the positive values of leaders and the need for a trusting relationship between leaders and followers (Avolio et al, 2004; Gardner et al, 2005; Ilies et al, 2005; Yukl, 2013). Cannella et al (2008) professed there is an important link between senior executives and their ability to influence the performance determinants that are a measure of organisational success. Therefore, the role of the federation's leaders in effectively developing and conveying the federation's vision and strategy to their professional peer group and member practices is an important facet of gaining engagement. This has also been reported by Hambrick and Cannella (2009) and resonates with the characteristics of authentic leadership.

### 1.8 Rationale for thesis

The emergence of GP federations signalled a new era of development for general practice in England. Led by innovative GPs and groups of GP practices, new organisational forms began to emerge organically without top-down policy directive. This research provides a detailed insight into the journey of one federation from when it was established in 2011 through to 2019. Over an eight-year period there was an opportunity to follow the development of the federation and identify changing factors within the operating environment, such as the impact of reform in healthcare commissioning with a focus on increased choice and competition. The longitudinal element of this study captures the experience of the federation when healthcare policy was promoting choice and competition through a plurality of providers, particularly as the operating environment should have supported the emergence of new provider organisations where business opportunities for

GP federations existed. Exploration of such a pioneering example of a federation provided an insight and understanding of the factors that impacted upon the emerging business model and the requirements to sustain the federation as a business entity. Towards the end of the study in 2018, health policy shifted focus from competition towards integration of care and the formation of primary care networks as a top-down central initiative. This study captured the reflections, learnings and experiences from the practices who were members of the federation as they prepared to establish a primary care network.

## 1.9 Study aims

Taking account of the context within which general practice operates, the shift towards federated arrangements, and the requirement to develop and implement strategy on behalf of multiple member practices, the overall research question was posed as:

> *'What insights can business theory offer in explaining how a group of GP practices in the North of England developed a GP federation, and what advantages and challenges did this business model offer?'*

The aims of the study were to:

1. Examine the model of the federation as a business construct and a vehicle to deliver new business opportunities.
2. Identify the advantages, disadvantages and opportunities the federation offered individual general practices that they would not otherwise have had.
3. Identify the key factors that influenced the federation as a viable business model.
4. Examine the role of the executive management team and the leadership approach that was adopted in establishing and directing the federation.
5. Identify the challenges and lessons learned for this model of federation within the health economy.

## 1.10 Structure of the thesis

Chapter Two outlines the historic background and policy context to general practice as the empirical setting of this research. Key features prevalent in general practice, including independent contractor status which underpins professional autonomy, the traditional partnership as a business model of general practice, and the contemporary commissioning and contracting environment are discussed. The concept of federations supporting collaboration across multiple GP practices and the various emerging organisational forms is

presented and explored. The theory of business strategy and strategy implementation is examined to contextualise and explain GP practice collaborative ventures within a business context.

Chapter Three describes the methods applied in the study and discusses pragmatism as the research methodology adopted within this longitudinal case study. A mixed methods approach to data collection was designed and the various strands of quantitative and qualitative data collected are presented. Thematic analysis was applied across the multiple data sets, eliciting the key findings from the study. The challenges of case study and the limitations of the study design are discussed, together with the factors around the position of the insider researcher.

Chapters Four, Five, Six and Seven present the findings from the research within the framework of a single case study. Chapter Four describes various aspects around the background and context of the federation and the key drivers that supported its establishment. Chapter Five describes the governance and structure that was established for the federation as a corporate venture which was a departure from the partnership business model prevalent across all of the member practices. Chapter Six presents how the leaders supported the implementation of a strategy for federated working, the aspects of strategy that were successfully implemented and the challenges that were encountered. Chapter Seven provides an insight into perspectives around galvanising support and sustaining engagement with the venture at three time points during the study: 2013 Denison survey results; 2015 feedback from workshops with practice personnel and the executive team; and 2019 through a series of interviews with GPs, managers and nurses from the member practices.

Chapter Eight critically reflects and discusses the study findings and learning, examining the business model adopted and the benefits this provided and the activities and initiatives that supported the implementation of a federated strategy across multiple independent practices. The chapter also considers the implications of the study and the contribution of this thesis, strengths and limitations of the approach adopted, implications for policy and practice, and areas for future research. It is envisaged that the findings from this study will provide an insight into the world of GP practices working as a collaborative and, as there is little knowledge about federations as business ventures, the lessons learned from this study will inform other groups of GPs who are pursuing similar strategies.

## Chapter 2 – Background, policy and theoretical context

### 2.1 Introduction

The context of health care in England is heavily managed, influenced and shaped by central government policy that is determined by party political philosophy, and this results in layers of complexity within the operating environment. Saunders and Lewis (2012) identified that operating environment and context are important considerations for organisational research. They also highlighted that: at a macro level, general practices exist within a health system; at a meso level they exist within a health economy; and at a micro level they exist as independent business organisations. At a macro level there is the context of national health policy, with a state-funded primary care service predominately free at the point of access and a central tenet of UK government policy subject to policy instruction dependent upon party political intent and national regulatory requirements (Ham, 2004).

The notion of general practice as a business stems from the status that GPs hold as independent contractors, yet the business environment of general practice is less evident within the academic literature (Newton, 1996; Ramsay et al, 2018). The underpinning principle of business strategy is that organisations achieve their goals, allowing the business to survive and prosper as a viable entity (Grant, 2008). Thus, in the context of GP federations, there are two orientations to consider. First is the viability of the individual GP practice as a business and second is the viability of new configurations of GP practices working within federated arrangements. Over the last decade, individual GP practices have sought various alternative group formats to preserve their existence as independent individual businesses, whilst others have opted for alternative business models in the form of larger primary care organisations. These models range from informal networks to formal arrangements in new business constructs.

There are specific characteristics that define general practice, and important contextual factors such as current health policy, the independent contractor status, and the partnership model of general practice are relevant to the subject of this study. The purpose of this chapter is to provide contextual background and explore the federation as a business venture.

## 2.2 Theoretical framework and approach to reviewing the literature

The theoretical framework for this study is based upon three areas of literature. Firstly, the political focus on healthcare recurrently influences national policy that has shaped healthcare provision, and influenced the four major contractual revisions to the GP contract in 1990, 1996, 2004 and 2019. Secondly, the construct of general practice as a business and the literature around business strategy is examined to explore the characteristics of general practice and the contemporary challenges faced by this sector of healthcare. Thirdly, the phenomena of general practice re-organising into alternative group arrangements is examined to identify the various models that are emerging and the benefits that this offers to individual practices. The academic literature around business strategy is voluminous, divergent and spans many decades, yet it has been recognised that the business of general practice is an under-researched area (Newton, 1996; Iliffe 2006). Database searches included, ASSIA, CINAHL, Cochrane Library, Proquest, Science Direct and Web of Science, with targeted specific databases included (e.g. British Journal of General Practice, British Medical Journal). Supporting the conceptual framework of the study, the literature review was focussed around several areas of exploration. A review of policy developments in healthcare in England between 1948 and 2019 provided a summary of Government White Papers and policy revisions. A broad database search of the literature around the business of general practice, GP federations and strategy implementation was undertaken with a specific search of the Healthcare Administration Database:

- Key search words in the English language were ‘general practice’ and ‘strategy implementation’, and identified 20,986 articles. This search was refined to the time period between 2012 (the period after the Health and Social Care Act was introduced) and 2019, and identified 41 articles.
- Key search words ‘general practice’ and ‘business strategy’ between the policy timeframe of 1997-2017 identified 44 articles for review.
- Key search words ‘general practice’ and ‘business organisation’ between 1990-2019 identified 1754 articles, but were refined to the time period 2000-2019 and identified 22 articles for review.
- Key search words ‘GP federations’ or ‘general practice federations’ between 2008 and 2019 identified 581 articles, of which many made only passing reference to GP federations, and this was refined to 34 articles for review.
- Key search words ‘general practice’, ‘GP partnerships’ and ‘business models’ identified 122 articles between 2011-2019, of which 45 were reviewed.

- Searches including ‘corporate venturing’, ‘corporate entrepreneurship’, ‘strategic entrepreneurship’ and ‘cooperative corporate venturing’ in relation to healthcare identified 43 articles for review.

A search of the British Journal of General Practice (a journal specifically related to the study sector) identified 720 articles with the search reference of “federation” and 288 articles relating to the term “alliance”. However, the search identified no results in relation to strategy or strategy implementation in GP federations. A search of the British Journal of Management (a management journal relating to developments in the UK) identified 447 articles relating to strategy implementation. 11 were identified as relevant and reviewed as part of the literature review. A search of the Strategic Management Journal identified 974 articles, of which 24 were identified and reviewed.

### 2.3 The role of general practice

General practice plays a key role within the NHS, and Vuori (1985) and Macdonald (1992) stated that it could be described as: a set of primary healthcare activities that are provided within a community setting; a level of care when considered against the backdrop of other services (e.g. hospital care); a strategy for how care is organised; and also as a philosophy underpinning primary healthcare. General practice is recognised as a route to access the wider healthcare system, with GPs assuming a care co-ordination role, such as referral for specialist hospital-based care (Starfield, 1998). This gatekeeping role became prominent in the reform agenda of GP fundholding in the 1990s (Malcomson, 2004) and the GP commissioning arrangements that followed, with GPs acting as advocates in purchasing transactions on behalf of their patients (Peckham, 2006, Gerada, 2011).

The role of the doctor-patient relationship is a key component of general practice, with a lifelong relationship between GPs and patients (Balint, 1979; Myerson, 1992). However, it has been noted that continuity of care may be reduced by both patients exercising choice around consulting with a wider range of practitioners, and increased use of locum GPs (Aboulghate, 2012; Jeffers and Baker, 2016). Delivering person-centred care to meet undifferentiated need is a key feature of the holistic care provided in general practice (Starfield, 1998; Heath, 1995, Ramsay et al, 2018). The role of the patient is also changing from passive recipient of care to a partnership of shared decision making (Leopold et al, 1996; Eaton et al, 2012; Coulter and Collins, 2011; Elwyn et al, 2012), which is evident within recent initiatives such as ‘house of care’ for people living with long-term conditions and a focus on realistic medicine (Fenning et al, 2019). General practice also plays a key

role in public health, as practices hold access to a registered population list which enables them to adopt a focus on population health (Hart, 1992). Contractual reform over the years has supported a greater focus on public health initiatives, such as lifestyle advice around smoking, diet or exercise, with GP practices central to implementation.

## 2.4 The influence of policy changes in healthcare in England

Reform of the NHS in England has been subject to political influence since its inception in 1948, with each government publishing policy to reform how health services are governed, designed and delivered. Over the decades, general practice has been subject to a series of contractual negotiations. This has resulted in a turbulent relationship between the government (policy makers) and GPs through the influence and support of the BMA as professional body and trade union acting on behalf of GPs, reinforcing the status and power of GPs as independent contractors. This section aims to provide a summary of reform that has taken place and the implications on general practice.

### 2.4.1 Policy developments influencing the 1966 GP contract update

General practice is one of the oldest professions in England and can be traced back to 19th century when people frequented apothecaries for preparations or prescription of drugs, and the term general practitioner emerged when apothecaries passed membership examinations with the Royal College of Surgeons (Thompson, 2001). The Dawson Report (1920) proposed the structuring of health services into a service model to include the formation of doctors' surgeries, community services (e.g. health visiting and pharmacy) and hospital services, but these changes were only implemented when the NHS was formed in 1948 (Loudon et al, 1998). Although now a prominent feature of the healthcare system, Loudon et al (1998) highlighted there was a high level of resistance from GPs to the introduction of the NHS, and a survey undertaken by the British Medical Association in January 1948 revealed that 84% of general practitioners voted against the introduction of the NHS (Petchey, 1998). Nevertheless, the profession united in the interests of patients and joined the state-funded health system (Loudon et al, 1998). Between 1948 and 1966 free access to primary health care was granted to the entire population, which included registration to a general practitioner's patient list that became the foundation of a single lifelong record of health and illness. The establishment of the Royal College of General Practitioners (RCGP) in 1952 influenced the development of post-graduate training for doctors through the Royal Commission on Medical Education (1968) for entry into general practice as a profession.

The RCGP continues as a member organisation supporting the philosophy of developing skills through education and training to deliver the best possible care.

The Gillie Report (1963) described general practice as a “cottage industry”, criticising the model of working and recommending greater scope in the way general practice operated, including greater access to hospital diagnostics and access to funding to support capital development of larger health centre premises. Shortly after the publication of the Gillie Report (1963), the Review Body (who reported on general practitioner remuneration) produced recommendations that enraged the profession and resulted in the British Medical Association inviting a mass resignation of GPs which was submitted to the British Medical Guild in 1965. Subsequent negotiations resulted in the publication of the Family Doctor Charter in 1966, which supported a change in the payment to doctors, a system of loans to develop premises, and a subsidy scheme for the employment of nurses and support staff. Following the 1966 contractual changes there was a decline in the number of single-handed practices and the emergence of practices operating on a larger scale (Bosanquet and Leese, 1989).

### 2.4.2 Policy reform between 1980 and the 1990 GP contract update

During the 1980s, general practice was relatively unaffected by NHS reform. The RCGP (1985) highlighted variation across general practice, with some practices providing a comprehensive range of high-quality care whilst others provided poor care resulting in patients accessing emergency care through A&E departments. By the late 1980s, there was a greater emphasis on improving primary care through public health disease prevention, anticipatory care and multi-disciplinary teamworking, which was outlined within the White Paper ‘Promoting Better Health’ (HMSO, 1987), and practices with access to a registered population list were central to developing initiatives to support preventative care (Szczepura, 1992).

By the end of the 1980s the political landscape was changing and concepts such as markets and consumers were introduced within the NHS as a mechanism to drive efficiency, choice quality and accountability (Lewis, 1998). The 1990s was characterised by the White Paper ‘Working for Patients’ (1989), which shifted the balance of power between the generalists in primary care and the specialists in secondary care, with developments including the engagement of GPs in the purchasing or commissioning of healthcare. Working for Patients (1989) proposed several developments involving primary care including setting indicative practice budgets for prescribing expenditure, the establishment of GP fundholding, the

formation of medical audit advisory groups (MAAGs), and the establishment of family health service authorities (FHSAs) to act as commissioners and establish effective management of primary care. These developments informed the 1990 contract revision for general practice and were formally enacted through the NHS Community and Care Bill 1990. During the GP contract negotiations of 1989, GPs voted three to one in a ballot to reject the proposed contract yet, despite this strength of feeling, the Government imposed the contract on the profession, signalling a shift in the relationship between the profession and the policymakers with GPs required to justify their contractual performance (Klein, 1990; Lewis, 1998).

### 2.4.3 Policy reform between 1990 and the 2004 GP contract update

The NHS and Community Care Act 1990 (Department of Health, 1990) legislated the internal market in healthcare with a split between purchasers and providers. In a purchasing (GP fundholding) experiment between 1991 and 1998, GPs were given annual budgets to purchase routine (non-urgent) secondary care services and pharmaceuticals for their registered population. The 1997 NHS (Primary Care) Act provided local discretion to regional health authorities to commission locally-negotiated GP contracts (Lewis et al, 1999), which resulted in the first wave of personal medical service (PMS) contracts introduced in 1998. This introduced salaried GPs, either within partnerships or other organisations, alongside practice-based contracts, and a single budget for general medical services, prescribing, and other hospital and community services (Lewis, 1998). This new contractual framework provided flexibility for GP practices to apply to change their GMS contracts in favour of PMS contracts, and negotiate an enhanced range of local services to be delivered. Notably these PMS contracts were time limited and could be renegotiated, unlike the perpetuity guaranteed by GMS contracts.

The market reforms introduced in the 1990s supported a shift in focus from acute care to primary care, with GPs assuming prominent roles within fundholding arrangements, influencing care development through commissioning and also through a stronger focus on public health (Peckham, 2006). However, not all GP practices participated in fundholding and local authorities assumed the role as purchasers on their behalf. Mixed reviews of the success of fundholding emerged and, whilst fundholding promoted competition between hospitals and achieved efficiency savings in prescribing, the overall impact of marketisation as a policy was minimal, it created inequality in some areas, and high transactional and management costs were required to support the initiative (Iliffe, 2002). The premise of GPs in the role of both purchaser and provider was that it would incentivise GPs to manage referrals to secondary care and reduce costs (Peckham, 2006).

In the mid-1990s there was a policy shift from marketisation towards social orientation, with the publication of Choice and Competition: Primary Care: The Future (Department of Health, 1996) which outlined the central role of primary care practitioners extending beyond GPs to include dentists, pharmacists, nurses, therapists and managers. The publication of the White Paper Primary Care: Delivering for the Future (Department of Health,1996) and the National Health Service Primary Care Act (1997) endorsed the role of multi-disciplines of staff delivering a range of primary care services. This included a set of principles of good primary care and also set out the requirement for partnerships to be developed between GP practices, other primary care professionals in the community and other organisations including social services. By the end of 1997, the White Paper The New NHS: Modern. Dependable formally ended GP fundholding as an initiative and, whilst retaining the purchaser-provider, split there was a clear focus on more locally-integrated solutions to the provision of care. In line with a policy of social orientation, in Spring 1999 multi-disciplinary primary care groups (PCGs) were established to commission services for local populations (Iliffe, 2002). The White Paper Our healthier nation (1999) strengthened the focus on public health with the aim of increasing life expectance and narrowing variations in health inequalities.

The NHS Plan published in 2000 (Department of Health, 2000) outlined a ten-year modernisation programme and led to the establishment of hospitals as NHS foundation trusts, with financial freedoms and independent regulation. Primary care groups evolved into primary care trusts in 2001, coterminous with local authorities. The plan set out included investment in additional staffing within the NHS to improve access and reduce waiting times. In May 2001, the NHS Plan was formalised through the Health and Social Care Act (2001). By January 2002, primary care trusts were set up across England with a remit that included both the provision of primary and community services and the purchasing of secondary care services (Department of Health, 1999). In some geographic localities, this policy development saw the establishment of care trusts (rather than PCTs) and these organisations had a focus on integrated care (health and social care), based geographically around local authority areas.

In 2003, negotiations commenced around a new contract for general practice which was implemented in 2004. This significant contractual change, was regarded as a major investment in primary care with an increase in earnings of 30% from 2003/04 to 2004/05 (Kmietowicz, 2006), and included the option for GPs to withdraw from provision of out-of-hours care, and the implementation of a quality and outcomes framework (QoF). This

contractual change was supported by the BMA, who recognised that general practice constituted value for money based on GPs providing 90% of NHS care, or 300 million consultations per annum. Roland (2004) also suggested that the 2004 contract was the most ambitious performance-related contract in healthcare in the world. Whilst the new contract introduced a simpler remuneration structure with a fairer capitation scheme, there was a major investment into primary care over a three-year period through the introduction of a national quality initiative that would reward high-quality care. The QoF scheme resulted in approximately 18% of GP income being based on the delivery of 146 indicators and quality measures. Thus, it was regarded as a method of rewarding cost-effective practice through a series of structured processes improving outcomes of health care and by encouraging teamworking and peer review (Smith and York, 2004). Between 2004 and 2012 there was continual revision and refinement of QoF as the mechanism for standardising the delivery of structured care across a range of indicators and improving health outcomes.

The 2004 GP contract enabled primary care organisations to commission a wider range of community-based services aligned to the needs of local populations, and this provided general practices with additional income to supplement the core contract in return for delivery of an extended range of services. The literature also notes mixed perspectives on QoF. Whilst it has been a driver for quality improvement and the implementation of evidence-based medicine, it has not influenced health inequalities and has added considerable bureaucracy at a practice level (Ashworth and Guillford, 2017; Appleby, 2014; Doran et al, 2008). At the same time as the 2004 contractual changes for general practice, other reorganisation was implemented through the Health and Social Care (Community Health and Standards) Act 2003 with the establishment of both foundation trusts as autonomous providers and independent regulatory inspectorates.

### 2.4.4 Policy reform between 2004 and 2012

The involvement of GPs in locality commissioning arrangements was outlined in the NHS Improvement Plan of 2004 (June 2004), signalling a shift to devolved models of commissioning. The publication of Creating a patient-led NHS (March 2005) provided further detail on the devolution of commissioning from PCTs to a practice-based commissioning model with full implementation to be achieved by 2006. Practices were offered indicative budgets and flexibility as to their level of involvement in the commissioning process, with the actual budgets remaining with the PCT. The White Paper, Our health, our care, our say, (2006) was published promoting better health prevention services with earlier intervention, increased patient choice, tackling inequalities and improving access to community services,

and increased support for people with long-term needs to live independently. A ten-year vision for the NHS in 2008 High quality care for all proposed measures to improve quality of care and included a major reconfiguration of hospital care, particularly the centralisation of specialist services. The development of large polyclinics was proposed to support reform in community and primary care. In January 2009, the NHS Constitution set out a set of principles for decision-making and values for NHS staff and patients based upon dignity and respect and informed patient choice.

During mid-2009, the focus on the need to achieve efficiency savings emerged, resulting in a range of strategic initiatives to support quality and productivity (Department of Health, 2009). At a macro level the government's economic recovery programme placed significant pressures on public services in England, with central austerity initiatives posing specific fiscal constraints on publicly-funded services (Baird et al, 2016, Murray, 2018). This presents a significant challenge to maintain levels of service provision whilst managing increased demand and service costs.

In 2010, major organisational and structural change was outlined within the White Paper Equity and excellence: Liberating the NHS (2010), which outlined plans to strengthen commissioning with groups of GPs at the forefront of commissioning reform. In 2012, the Health and Social Care Act formalised the formation of clinical commissioning groups with the abolition of PCTs and regional strategic health authorities. The aim was to have clinical commissioning groups established across England by 2003. At the centre of this reform was a policy focus on competition and choice through plurality of providers. From a provider perspective during this period of reform there were no major changes to the core GP contract, other than the threat that services traditionally commissioned from general practice may be subject to competitive tender.

### 2.4.5 Policy reform resulting from The Health and Social Care Act 2012

The NHS Future Forum report Choice and Competition – Delivering Real Choice (2011) and the Health and Social Care Act (2012) emphasised the role of competition in the NHS as a tool for the commissioning of clinical services. Under the Act, services were to be commissioned from providers who were best placed to deliver according to the needs of the population, utilising open procurement and competitive tendering where appropriate. The system re-organisation of the national commissioning structure established local clinical commissioning groups to assume responsibility for the purchase of local health services and a national commissioning board for England (NHS England, 2012).

Implementation of the Health and Social Care Act (2012) provided clarity between the role of CCGs in commissioning hospital services and the role of NHS England in commissioning primary care services (including GP services). However, such was the concern about conflicts of interest between GPs in their dual roles as commissioners and providers, NHS England issued guidance and a code of conduct (NHS England, 2014) aimed at ensuring CCGs conduct their statutory responsibilities in a fair and transparent manner. The NHS Procurement, Patient Choice and Competition Regulations (2013) were introduced under Section 75 of the Health and Social Care Act (2012) governing the use of choice and open competition in the procurement of healthcare. Competition is not a new concept in healthcare and the political emphasis of market principles introduced into the public sector in the UK in the 1980s was regarded as the mechanism to drive efficiency, choice, quality and accountability (Lewis, 1998). Historically, commissioning organisations, such as primary care trusts, that existed prior to the 2012 re-organisation, purchased a range of enhanced services from primary care, but these services no longer formed part of the core contract and could be subject to competitive tender under choice and competition regulations (BMA, 2013). This posed a financial risk and a threat to the viability of practices, with the potential need for practices to compete in a market environment and meet the challenges of complex procurement processes (BMA, 2013). However, with a strategic focus on extending access to healthcare markets to a greater range of provider organisations, this presented an opportunity for groups of practices to come together to compete for contracts.

General practices exist within a defined health economy where there are multiple provider organisations, such as acute hospital trusts, community providers, primary care contractors (e.g. dentists, optometrists, community pharmacists) and voluntary sector organisations (Ham et al, 2012). Commissioning groups (CCGs) are clinically led and have responsibility for the purchasing of acute, mental health and community care services, whilst NHS England retained responsibility for the purchasing of primary care services, including general practice, dentistry and community pharmacy. Therefore, general practices operate within a defined health economy alongside multiple providers of health and care services and, in the context of a quasi-market environment, may end up competing for services. In 2015, clinical commissioning groups were offered additional delegated commissioning authority from NHS England, with some assuming responsibility for the joint commissioning of general practice in partnership with NHS England.

### 2.4.6 An emphasis on regulation of healthcare

There are many contemporary structural factors that stem from the Health and Social Care Act (Department of Health, 2012). The NHS Commissioning Board (NHS England) was established to deliver the agenda around choice and competition, Monitor (now known as NHS Improvement) was established as the financial regulator of NHS Foundation Trusts and to ensure against anti-competitive behaviour, and the Care Quality Commission was established to support the regulation of quality and standards within health and social care services. From 2014 all GP practices in England were contractually required to register their business with the Care Quality Commission, for which there is an annual registration fee, and practices are subject to regular inspection to ensure services meet defined national quality standards (CQC, 2015). Similarly, all new providers (e.g. AQP contractors) delivering NHS contracts are required to be registered with the healthcare regulator.

### 2.4.7 Supporting resilience in general practice - the 2019 contract revision

In 2014, the Five Year Forward View was published setting out a vision for the NHS around improving quality of care, reducing health inequalities, and achieving significant efficiency savings in the region of £30 billion. The reform proposed various organisational models for the delivery of integrated care to be outside of a hospital setting. This included multispecialty community providers, where local groups of community professionals come together to deliver care, or the establishment of primary and acute care systems where multiple providers integrate to deliver care. By 2016, Sustainability and Transformation Plans were published from 44 geographic areas across England which articulated how the health reforms would be implemented across health economies.

In January 2019, the NHS Long Term Plan articulated the establishment of integrated care systems combining commissioning with NHS trusts. A £2.8bn new contract for general practice was negotiated and agreed between the BMA and NHS England over a five-year period. Core funding for GP practices would be increased by £1bn over a five-year period within £1.8bn allocated to support the practices to organise into primary care networks in groupings covering 30-50,000 populations. The formation of networks was contractually linked to a direct enhanced service with the expectation that each GP practice in England would be a member of a network (NHS England, 2020). Over a five-year period, the phased employment of additional staffing would include social prescribers, clinical pharmacists, musculoskeletal physiotherapists, physician associates, paramedics and advanced practitioners (Iacobucci, 2019). To support networks develop, a payment of £1.50 per patient

would be provided on a recurrent basis, and thus for a network of 50,000 patients, a payment of £75,000 would be received. Other aspects of the contract were aimed at reducing bureaucracy and administration with initiatives such as reducing the number of QoF indicators and renewing the focus on quality improvement without financially disadvantaging practices. The contract also introduced measures to improve access to general practice, such as direct booking of GP appointments from patients or other organisations, such as NHS111.

### 2.5 Workforce challenges in general practice

It has been identified that there are significant workforce challenges facing general practice, with many GPs eligible for retirement. The report from the Centre for Workforce Intelligence (2012) highlighted that 22.5% of GPs in 2012 were aged 55 and over and approaching retirement age. A further report in 2014 identified that the number of GPs in England had fallen from 61.5 GPs per 100,000 population in 2009 to 59.6 GPs per 100,000, and predicted that the demand for GPs would outstrip the supply of newly qualified GPs resulting in a national staffing shortage by 2020 (Centre for Workforce Intelligence, 2014). The report identified geographic variation across England, with areas in the North East and North West encountering recruitment problems. A report by the BMA (2015) also identified the increasing feminisation of the profession as a significant workforce feature. Historically the profession of medicine and general practice was male dominated (Baggott, 1998), but between 2002 and 201, it was reported that there has been a 62.2% increase in the number of female GPs working in general practice (Centre for Workforce Intelligence, 2012). In an attempt to address the gap between demand and supply of GPs, a series of measures were introduced by the government, including a commitment to recruit an additional 5,000 GPs by 2020. Between 2015 and 2016 there was a 9% increase in the number of people starting GP training, alongside a series of further initiatives including encouraging retired GPs to return to practice, an international recruitment drive, and support for GPs approaching retirement (Ewbank, 2017). However, by 2016, rather than an overall increase in the number of GPs, their number decreased by 0.3%, demonstrating that the number of GPs leaving the profession was outstripping the number of GPs entering (Ewbank, 2017). The combination of these factors (a reduction in the number of GPs in the workforce, an emerging workforce with a preference for salaried employment as opposed GP partnership, and a workforce that seeks flexible, family-friendly working arrangements) creates pressure on individual practices. Through collaborative arrangements, federations may be better placed to support workforce planning and develop innovative solutions to alleviate recruitment pressures (Marchand and Peckham 2017).

## 2.6 The impact of demographic and societal changes on general practice

The increased burden of demand for general practice is a significant factor (Dayan et al, 2014) as a result of the demographic and societal challenges of an ageing population that is living longer with more complex co-morbidities and long-term conditions (Health Education England, 2015). Between 1995/96 and 2008/09 consultation rates in general practice rose by 41% as a result of increased consultations in people aged 60 and over (Health & Social Care Information Centre, 2009). This increased growth was greater than the growth in the workforce, with the majority of consultations being delivered by practice nurses and an overall increase in consultation rates, therefore placing increased pressure on existing staff with the need for greater productivity. The Centre for Workforce Intelligence (2012) reported that between 2010 and 2030 the number of people aged 80 and over in the UK is expected to double. It is also recognised that older people consult health services more often, at between 12-14 times per year in 2008/09 compared to 6-7 times per year in 1995, thus creating an increasing demand for health services. Cooke et al (2017) identified that between 4-7% of patients consume around a quarter of all GP appointments through frequent attendance at their practice. The Centre for Workforce Intelligence (2014) estimated that in England in 2013 there were 340 million GP consultations (1.3m consultations per weekday), compared to 15 million hospital admissions in 2012/13, highlighting the volume of consultations that take place in general practice. The deployment of additional resource to meet this demand at a practice level results in increased expenses, whilst the foundation of the core GP contract capitation payment is based on a registered patient list irrespective of how many times a patient consults the practice over the period of a year.

## 2.7 Practice management and multi-disciplinary teams

Practice management has become recognised as a management discipline central to the effective functioning of a practice. Historically, GPs worked singlehanded with support from family members, but contractual changes over the years have required greater accountability and complex remuneration schemes resulting in the need for greater administration and management (Bolden et al, 1992). The need for leadership, long-term planning and delegation skills was identified for GPs as business owners to balance being in control of the direction and ethos of their organisation, whilst being able to practise their profession (Harrison and Burns, 1994). The discipline of practice management developed as GP practices developed through successive contract changes, placing additional demands on practices. The relationship between the practice manager and the GP partners has been

identified as an important facet, and for practice managers to be effective in their role it requires the partners to understand the value that the role brings, trust the management expertise of the practice manager, and delegating operational decision-making to them (Harrison and Burns, 1994). Whilst some practice management posts are employees, with the GPs as business owners/employers, it is not uncommon for practice managers to be partners in the practice and have an equity share in the practice as a business.

In a study of practice management roles in eight GP practices in Scotland, Westland et al (1996) identified variation in the roles of practice managers across practices. Larger practices were found to have enhanced management functions and managers were able to develop more of an executive role by delegate tasks, thus allowing them focus on planning. This was less evident in smaller practices where the manager assumed an administrative role with less autonomy. The study identified that activities undertaken by practice managers included the operational management of the practice, planning, management of finances, personnel management, IT, both external and internal communication, and management of complaints. Grimshaw and Youngs (1994) also noted considerable variation in pay and responsibility amongst practice managers. Education for practice management and administrative staff is provided by the Association of Medical Secretaries, Practice Managers, Administrators and Receptionists (AMSPAR, 2020), supporting development of practice staff and creating an environment for career progression.

In addition to the development of practice management as a discipline, contractual changes has introduced other disciplines of staff to general practice. The employment of additional roles has supported the development of general practice and introduced an enhanced focus on teamwork (Finlayson et al, 2012). The role of practice nurse within the primary healthcare team is well established and it is commonplace for nurses to lead population-based initiatives, such as chronic disease management (e.g. QoF), screening (e.g. cervical screening) and health education (e.g. weight management; smoking cessation). The development of nursing career pathways in general practice encompasses healthcare assistant roles undertaking routine tasks (e.g. phlebotomy), practice nurses leading on chronic disease management programmes, and advanced nurse practitioners working alongside GPs delivering both urgent care and complex routine care. The contract revision of 2019 introduced funding to support increasing additional clinical roles to general practice in order to contribute to managing demand and to supporting the workforce shortages of GPs. Advanced practitioner roles are regarded as central to the new reforms and the role of clinical pharmacists in supporting effective prescribing has already been evidenced (Anderson et al, 2019) in conducting medication reviews and chronic disease management

clinics (Petty et al, 2003; Tan et al, 2013; Zermansky et al, 2006). This highlights the benefit these roles bring to general practice. The original configuration of single-handed GP practices in 1948 has significantly developed to configurations of multi-disciplinary teams providing primary healthcare.

### 2.8 Business strategy in the context of general practice

Mintzberg (1994) defines business strategy at both a corporate level (the scope or form of the organisation within the industry or competitive environment), and a business level defining how the organisation competes within an industry or market. Contemporary strategic analysis professes that the underlying principle of business strategy is to achieve organisational goals that allow the business to survive and prosper (Grant, 2008), whilst also ensuring that there is a strategic fit between the organisation and the industry it operates within (Ansoff, 1965; Porter, 1980; Porter, 1985; Jones and Hill, 2010). Successful business strategy is where a business locates itself within an industry where there is an attractive return on investment and competitive advantage can be obtained (Grant, 2008). Porter (2008) highlighted that the underlying drivers of profitability are the same across all organisations irrespective of the industry, including threat of new entrants (alternative providers), bargaining power of buyers, threat of substitute products or services, bargaining power of suppliers, and rivalry amongst existing competitors. At a macro level, general practice operates in an environment where they are implementers of national policy and strategy on primary healthcare.

As independent contractors, general practices have existed either as single-handed businesses or in partnership arrangements since the inception of the NHS in 1948 (Baggott, 1998; Pollock, 2005). Each general practice exists as a separate business entity, holding a contract for the provision of medical services to a registered population, which has resulted in primary medical services being provided by multiple small independent businesses (Pollock, 2005). GP practices run in the same way as other businesses, in that they employ staff, have operating processes that support service delivery, and even competed with other practices for registered patients (Irvine, 1992). The basis of core contract funding for general practice is based upon registered list size. Therefore, if there are several practices within close proximity of each other, they could be competing for patient registrations to boost practice income. However, notable differences between practices and other business have been identified, including the concept of the practice as a professional service with a culture based upon individualism and autonomy (Boaden and Zolkiewski, 1998). Szczepura (1992) recognised that general practices were not just businesses motivated by turnover, income

generation and profit, but they act as agents on behalf of patients and therefore have a professional obligation to organise the most appropriate care. The funding which makes up the core of the GP contract is based upon a capitation fee per registered patient. In addition to this core funding, practices can enhance their income by delivering an extended range of services and also by delivering services which attract a fee (e.g. private medical examinations). Another unique feature of the operating environment within which general practice operates is the sale of goodwill. When the profession became part of the NHS in 1948, there was a restriction placed on the sale of goodwill which is an accounting term that is used to value the non-assets of a business and prevents the open market sale of general practice contracts. Therefore, unlike other businesses that can be sold as a going concern for profit, the sale of GP contracts is not allowed under general medical service regulations (Department of Health, 2003).

### 2.9 GP partnerships

Partnership is a business model that is common amongst professional groups and has been a dominant business construct in general practice, where two or more self-employed GP partners have an equity share in the business (Centre for Workforce Intelligence, 2012). The cost effectiveness and value for money of the partnership model of general practice was highlighted by Schneider et al (2017), therefore there are economic benefits to the health service for this business model to prevail. The benefits of this partnership model include security, personal and professional autonomy, influence, and the ability to shape the delivery of local services for a registered population (BMA, 2015). Underpinning partnerships in general practice is the requirement for partners to have a partnership agreement with the BMA in place, offering a standard template with guidance around aspects to be included including sessional commitment, profit share, capital investment and dispute resolution (BMA, 2020).

As independent contractors, GPs are essentially owner-managers and are effectively self-employed, although specific issues within the GP partnership model have been highlighted by Harrison and Burns (1994). Decision-making within partnerships requires consensus amongst partners, and personality issues and differences in perceptions around ethical considerations can impact upon effective and timely decision-making. It was also noted that delayed decision-making occurred when changes that needed to be resourced from the partnership required agreement from all partners. Another issue prevalent within GP partnerships was conflict when there is a need to work or think differently, and often out-dated partnership agreements proved inflexible and unhelpful in situations of conflict

(Harrison and Burns, 1994, Newton et al, 1996). Another feature of GP partnerships is that senior partners are rewarded for status through a remuneration system which forms part of the GP contract. Whilst senior partners may display qualities that support mentoring and development of junior staff, Harrison and Burns (1994) noted that the senior partners are not always best placed to adopt leadership roles for developing modern general practice.

After the 2004 GP contract was introduced there was an increase in the number of salaried GPs being employed in practices. Salaried GPs were regarded as a cheaper, more cost-effective option for practices, rather than offering equity-based partnership shares. However, tax changes introduced under the Finance Act (2009) reduced the tax differential between salaried and GP partners, making it less financially attractive (BMA, 2013). The BMA National Survey of GPs (2015) revealed that 55% of salaried GPs and 77% of freelance GPs reported that they would not be pursuing a partnership in the near future, signalling a shift away from the traditional partnership and potentially the demise of the partnership business model of general practice. The foremost reasons reported for GPs opting for salaried contracts of employment were flexibility and the desire for an appropriate work-life balance.

Within the literature, there are contrasting views around the sustainability of the professional partnership within such a dynamic changing environment and, in one study within England, specific concerns around the viability of partnerships were expressed by GP partners themselves (Mills et al, 2019). Such were the growing concerns around the impact of a fall in the number of GPs joining partnerships, an independent review of GP partnerships was commissioned by the Government (Department of Health and Social Care, January 2019). This review explored the challenges and benefits of the partnership model of general practice and published a series of recommendations to revitalise and transform this professional business construct. In order to enhance the attractiveness of the partnership model, the recommendations included measures that would reduce personal risk and liability for GPs. This included support around ownership of premises, which is often regarded as a barrier for GPs entering partnerships where a financial investment is made into buildings owned or mortgages held by the GPs. It was also noted that alternative legal structures, such as limited liability partnerships, company limited by guarantee or share, or mutuals, may be more attractive to GPs, but such change may be subject to competitive tender under current procurement regulations. At present, as independent contractors, GP practices are legally required to have appropriate professional indemnity which can be individually arranged or organised on a group basis to cover all staff within the practice. Thus, a shift away from this personal liability model to a state-backed indemnity scheme, currently available to salaried employees within NHS organisations, may also increase the

attractiveness of the partnership. Workforce was also a key feature within the recommendations and included the need to develop alternative GP roles, such as primary care fellowships, and also to support GPs to develop portfolio careers by combining direct patient care in practice whilst developing specialist clinical interests (e.g. shared posts working between primary and secondary care). The need to include partnerships and business management within the GP training curriculum was noted, alongside enhancing the range of disciplines of staff working within practices, such as physiotherapists, clinical pharmacists and advanced practitioners. Concerns around the viability of the partnership model are noted (Dellow, 2015), and the impact of these supportive measures to improve the attractiveness of partnerships within general practice is yet to be evidenced and only become apparent over coming years. In addition to partnership as a model of business, business strategy offers alternative constructs to consider in relation to the phenomena of GP practices organising into federated organisational arrangements.

### 2.10 NHS funding allocated to general practice

The NHS makes national funding allocations across the various sectors of healthcare, and general practice receives a percentage share. In 2016 the general practice allocation dropped to a level of 8.5% compared to 11% in 2006 (Roland, 2016). To rectify this under-investment over a decade, the allocation was forecast to increase to 10% by 2020, with additional investment through the Five Year Forward View (Roland and Everington, 2016). RCGP (2014) noted that around 90% of the total NHS episodes of out of hospital activity is delivered in primary care.

In 2014, NHS England conducted an equitable funding review of general practice contracts (NHS England, 2014), which concluded that there was an inequitable funding allocation between general medical service (GMS) and personal medical service (PMS) contracts in England. A national rebasing exercise was introduced to reduce PMS practice income on a phased basis to equalise funding across contracts over a five-year period. Although funding gained from this exercise was available for re-investment by local commissioners, it posed a specific threat to the viability of some practices with a reduction in income. The funding of individual practices is set out through a contract between the practice and NHS England, with the core payment (global sum payment) made based upon a weighted capitation allocation model (Beech and Baird, 2020). In essence, this form of contract could be considered as a block contract with a payment made for a block of activity (BMA, 2020). This contrasts with hospital care, where services are commissioned on a national tariff basis for episodes of care delivered, and increased demand and usage of hospital services results in

increased income to foundation trusts based on tariff payments. However, increased demand and attendances in general practice is not always visible, as practices are paid on a capitation basis to provide a minimum range of services to a defined population irrespective of activity volumes. Therefore, increased work for general practice from delivering more care per patient can become a cost to the practice if additional staffing resource is required to meet this demand, which ultimately impacts upon the profitability of the practice and reducing the profit share available for distribution amongst the GP partners.

Increased demand delivered within existing resources places pressures on existing practice staff, creates longer waiting times to access GP appointments and impacts on patient satisfaction. This misalignment between payment systems in the NHS where tariff-based payment structures provide financial benefits to providers through increased demand and service utilisation, is contrasted against block contract mechanisms where payments are set regardless of increases in activity. In one study, Irish and Purvis (2012) suggested that a 10% shift of this work from primary to secondary care, based on a tariff-based payment system for secondary care activity, would overwhelm the entire healthcare system. It is therefore in the interests of the health economy to have a functioning primary care system that manages demand and acts as a gatekeeper to accessing hospital-based services (Baggott,1998).

The core contract for general practice, based upon capitation of a registered patient list, is negotiated nationally on an annual basis by the General Practice Committee (GPC) on behalf of the profession and NHS England (BMA, 2015). As part of the 1996 GMS contract, a formal statement of fees and allowances was introduced, which defined the range of core services to be delivered and the associated remuneration and payment arrangements. Central to the 2004 GP contract revision was the introduction of the Quality and Outcomes Framework (QoF) as a quality incentive scheme where practices could enhance their income based on attainment of a range of clinical and quality indicators (National Institute of Care Excellence, 2018). This additional income stream allowed practices to employ additional staff to deliver the level of structured care required through QoF. An advantage of a national quality scheme is that it standardises the approach to care based on a robust evidence base. However, a potential disadvantage from a business perspective is that the additional revenue has been absorbed as the norm and any withdrawal of this funding may have a destabilising effect and be perceived as a financial threat to the individual practices that come to rely upon this source of income.

There are various contracts for the provision of primary care: general medical services (GMS) contracts, personal medical services (PMS) contracts, and alternative personal medical services contracts (APMS) (Health and Social Care Information Centre, 2013). Whilst the core GMS contract is nationally negotiated and agreed between NHS England and the British Medical Association's General Practice Committee (GPC), locally negotiated PMS contracts were introduced following legislative changes in the Primary Care Act 1997. The PMS contract was regarded as an alternative to GMS and, when introduced in 1998, was negotiated between local primary care organisations and individual practices. It was also regarded as a flexible option to develop services to meet local need that was not subject to the national negotiations and collective bargaining. APMS contracts are similar to PMS contracts in the ability for the contract holder to be a non-registered medical practitioner (The National Health Service (Personal Medical Services Agreements) Regulations, 2004), whereas GMS contracts must be held by a GP registered to practise with the General Medical Council. According to Beech and Baird (2020), 70% of GP contracts held are GMS, 26% are PMS and 2% are APMS. Therefore, the nationally-negotiated GMS GP contract remains a key characteristic of general practice.

In addition, within the core contract held by GPs, additional funding can be achieved through the delivery of a range of enhanced services. These services can be nationally defined and offered to all GP practices nationally or locally to meet the needs of local populations (NHS England, 2020). Although participation in delivering enhanced services is voluntary, by agreeing to deliver additional services to the criteria within the defined service specification, practices are able to increase the income generated from the NHS and contribute to the viability of the practice as a business entity.

### 2.11 Organisational life cycle and business renewal

Organisational life cycle is a concept that outlines a process of establishment or start-up (Tichy, 1983; Hanks 1990), growth or expansion (Mintzberg, 1984; Hanks, 1990), maturity, renewal, consolidation, diversification (Kimberly and Miles, 1980; Hanks, 1990), and decline (Hanks, 1990). Considering how organisational life cycle relates to general practice, the sector is characterised by multiple businesses holding contracts for the delivery of medical services, with contractual requirements outlined within the National Health Service (general medical services contracts) Regulations 2015. The regulations are detailed and complex, and place practices in a unique position as contracts can be held in perpetuity, which is different to that of other businesses. GP partners working within a partnership are able to add new named GPs to a GMS contract as partners change (e.g. through retirement), which

in essence provides continuity and security to the partnership with the knowledge that as long as the contractual requirements are fulfilled, there is no threat to its continuation. General practices in decline and unable to fulfil their contractual obligations can pursue alternative strategies of merger to combine contracts and form larger practices. Or, if practices are found to be in breach of contract, NHS England as the commissioner of general practice can serve notice on contracts, re-procure them through a competitive tender process and appoint a new contractor (NHS legislation, 2017).

### 2.12 The relevance of business strategy and planning to GP federations

Whilst the traditional view of business strategy promotes a linear and structured strategic planning process (Ansoff, 1965; Mintzberg, 1994), more contemporary perspectives argue that effective strategy comes from viewing the world from a different perspective, with strategists being able to think in new and unconventional ways (Ohmae, 1982). Campbell et al (2011) highlight that perspectives vary and, whilst some propose there is a deliberate or planned approach to strategy, others argue that an emergent or incremental approach is more favourable. Therefore, there are parallel arguments for both achieving competitive advantage through competitive positioning and also for a competency or resource-based approach. In the 1980s and early 1990s there was a dominant view that deliberate strategy should be aligned with competitive positioning (Porter, 1980; Peters and Waterman, 2015). Porter's (1980) contribution included the use of analytical frameworks and tools to assess business environments with a focus on competitive positioning and outperforming rivals from a competitive perspective. However, this has been criticised for an over-emphasis on the industry determining organisational profitability. Deliberate strategy is characterised by logical, rational and systematic processes that form corporate and business objectives which facilitates the organisation of complex activities and align business objectives, set targets and monitor performance against targets (Campbell et al, 2011). Whether strategic positioning is applicable within public sector organisations is debatable. However, certain conditions can support this approach, such as a high degree of organisational autonomy, performance-based budgets where there is an opportunity to out-perform competitors, and market conditions (Hansen and Ferlie, 2016). Whether these conditions exist within the environment that federations are establishing requires further exploration.

The resource-based view of strategy emerged in the1990s (Prahalal and Hamel, 1990), with greater emphasis on the individual business, as they are regarded as complex social organisations that exist within rapidly changing environments. Thus, strategy emerges through social interactions between the organisation and the environment. It is noted that a

combination of resources, skills, knowledge and technology differentiates organisations from their competitors and form the basis of organisational learning, and this organisational distinctiveness in turn creates competitive advantage (Prahalal and Hamel, 1990). However, one disadvantage of the resource-based approach is that it can result in a lack of purpose and a difficulty in evaluating performance because, without specific strategic objectives, performance is difficult to measure and evaluate (Campbell et al, 2011). A resource-based view of strategy can be applicable to non-private companies where there is a focus on adding value, and also on efficiency and efficient use of resources (Peteraf and Barney, 2005).

In the context of healthcare, providers are subject to the implementation of planned national strategies for delivering services to defined quality standards and contribute to improving health outcomes. This takes place within a structured performance framework of measures set by NHS England, which could be argued to be a highly-structured and planned macro approach to strategy implementation. Similarly, GP practices are also subject to national contractual updates within this same structured framework, and undertake local planning at a practice level to define how contracts will be delivered and what resources are allocated to achieve this. Whilst market conditions have become evident within healthcare, whether there is a genuine market environment to align with competitive positioning is questionable. Within the context of any qualified provider, providers can compete for market share but cost and performance outcomes are pre-determined, therefore limiting competitive market conditions.

The concept of business planning in general practice has evolved since the health reforms of the 1990s, thus influencing the development of GP practices with the need for greater management and leadership. In addition to consulting with patients, GPs had greater involvement in management by reviewing various aspects of their practice, including prescribing and referrals to secondary care services. The notion of business planning through the development practice plans became commonplace, and through processes of team involvement and engagement, the direction of the practice and resources required to deliver the plan were documented and implemented (Harrison and Burns, 1994). In the context of new ventures some profess the benefits of business planning (McGrath and MacMillan, 2000), whilst others contend this view (Bhide, 2000; Carter et al, 1996), suggesting that efforts are better directed at action-orientated activities such as seeking external capital and activities to support marketing and promotion (Bhide, 2000; Carter et al, 1996). Organisational theory promotes that planning provides a structured framework that improves quality of measurable actions that occur (Ansoff, 1991; Locke, 1980). Business planning can facilitate new venture development and provide benefits such as supporting

faster decision making and effective allocation of resources to the delivery of goals (Ansoff, 1991). The process of planning prior to taking action supports people to test their assumptions before expending resources (Armstrong, 1982). In relation to federated models of general practice that are established and led by local groups of GPs/practices, strategy may be emergent or planned depending on the reasons why the federation is being established.

### 2.12.1 Organisational vision and mission

Organisational vision and mission have been described as a statement of purpose or desired future state (Hill Jones, 2009; Collins and Porras, 2005), orientated towards the customer (Sainidis et al, 2012). Mission and vision are translated into a set of goals and objectives which are specific, measurable, challenging, realistic and timely, and can be expressed in financial terms (Hill Jones, 2009). Leadership plays an important role in articulating an organisation's vision in a way that energises people (Hill Jones, 2009). Within the context of healthcare providers, mission and vision are not new concepts and are requirements that the regulator expects organisations to possess through an articulated statement of purpose (Care Quality Commission, 2018), whether the organisation is a single GP practice, an NHS foundation trust, or a GP federation. For emerging federations of GP practices, articulation of vision underpins the overall purpose of federating.

The concept of strategic thinking is also relevant to GP federations as it supports innovation by imagining new and different future states that may result in organisations redefining their core strategies (Graetz, 2002 p456). A combination of strategic knowledge, context and organisational awareness shapes, reshapes and redefines business boundaries and directs resources to gain competitive advantage (Campbell et al, 2011 p22). Key attributes of strategic thinking have been noted to include: adopting a systems perspective; being focussed on intent; thinking in the present time; being hypothesis-driven; and pursuing intelligent opportunism (Liedkta, 1998). All of which align with the entrepreneurial process of creating new ventures. When groups of practices form alternative group arrangements, strategic thinking will be evident amongst the GPs taking the leadership role in promoting these alternative business constructs. The link between strategic thinking and leadership is therefore important, as it is recognised that senior executives play a significant role in monitoring the external environment to identify threats and opportunities and the formation of strategy for the future survival and growth of the business (Yukl, 2013). Senior executives also have the ability to influence the performance determinants that are a measure of organisational effectiveness (Yukl, 2013).

Approaches to strategy can be planned or emergent, and the applicability of traditional functions such as setting a vision or mission, identifying core values, and the translation of vision and mission into a set of goals and objectives are key features. Some critics argue that a rigid approach to strategy inhibits the flexibility required in volatile business environments (Stacey, 2007; Stacey and Griffen, 2011). GP practices forming federations should have a strategic vision for what the collaboration aims to achieve, and also be able to articulate how the vision will be realised. However, within such a dynamic, changing environment it is debatable whether a planned approach is wholly applicable, or whether an emergent approach is more appropriate to federations within an environment where there is uncertainty and complexity in relation to context and direction of health policy.

### 2.13 Quasi-markets in healthcare

Economic theory states that competition and markets drive efficiency, quality and control costs, yet the NHS is state funded and therefore full market conditions cannot exist and would result in inequalities for those unable to pay for treatment or health insurance. The NHS Constitution (2008) outlined the rights that each citizen can expect from the NHS, consistent with the principles of a state-funded service. Competition in health resulted from the publication of the Griffiths Report (1983), which labelled the NHS as a hierarchical monopoly with a lack of accountability and poor quality (Gorsky, 2013). Griffiths introduced the concept of general management, with a focus on performance management, and stated that the NHS should learn from the private sector and market principles would drive efficiencies, promote innovation and improve quality (Frith, 2016). The establishment of quasi-markets, consumerism and patient choice in healthcare were evident in the 1980s, supported through initiatives such as GP fundholding. Following this, policy reform from the Health and Social Care Act (2012) enhanced competition and markets in healthcare, with Section 75 of the Act providing the legal framework for the opening up of NHS contracts to the market. Through initiatives such as Any Qualified Provider (AQP), the Act developed the supply side of markets by introducing multiple providers to deliver services, thus offering patient choice. As a consequence, competitive rivalry is generated with providers competing for contracts and market share, with patients able to select where to access services (Frith, 2016). However, some argue that the financial constraints and rationing within a state-funded health service cannot fully deliver a quality service and what is provided is a value-for-money service (Klein, 1995).

Considering market principles within the NHS in England, Garattini and Padula (2019) argue that in the context of economic theory healthcare should be considered as an example of market failure. They state that patients as consumers are not able to shop around for the best deal because they are vulnerable and do not have all of the required information to make informed choices. Where patients do not have all of the information required to make informed choices, this is often provided by doctors acting as agents on behalf of patients. From a supply perspective, market competition requires multiple providers delivering the same service with the ability to compete on cost and quality, with easy entry and exit from the market. As GP federations began to develop after the Health and Social Care Act (2012), the introduction of new entrants (service providers) to the market may have been perceived by GP practices as a threat. If commissioners applied flexibilities (under Section 75 of the Health and Social Care Act, 2012) to develop local healthcare markets, substitute providers would be identified to deliver services traditionally delivered by practices (e.g. enhanced services). Or, if new entrants emerged as new providers of general practice (e.g. hospital trusts diversifying into primary care delivery, or private sector organisations), this can in turn generate a defensive reaction from existing providers (Porter, 1985). However, imperfect conditions within a quasi-market may generate either limited or no competition and the reality for emerging federations seeking to develop businesses portfolios may be inhibited by contextual factors within the commissioning environment (Leys, 2017).

### 2.13.1 Customers and consumers

The Citizen's Charter (Cabinet Office, 1991) termed service users as customers, with the aim of improving standards across public services. Meanwhile, the Patient's Charter (Department of Health, 1991) documented standards of care that consumers could expect from the health service, including waiting times for treatment and the introduction of a standard complaints process. The NHS Constitution (Department of Health and Social Care, 2015) outlined the underpinning principles and values of the NHS, detailing what every patient can expect from the care they receive. Consumerism within the NHS is a broader perspective of healthcare underpinned by five principles: access, choice, information, redress and political influence (Sage, 1991). In defining the customer in the context of healthcare, Sage (1991) suggests that the customer is the patient or service user who accesses various departments as part of an episode of care. Therefore, a relationship is developed between the patient and the organisation and individual departments as they access care. Thus, ultimately, a quality service requires an understanding of need and how this need can be met. Service marketing theory states that there is a link between an organisation's internal customer orientation and value creation, and, in turn, there is a link

between customer satisfaction and employee satisfaction (Bateson, 2002; Parasuraman et al, 1985). Internal marketing theory suggests that employees need to be motivated to generate customer satisfaction (Schneider, 1994). Service quality theory suggests that customer satisfaction occurs after various points of contact, and the point of interface is the exchange where value is created (Parasuraman et al, 1985; Zeithaml et al, 1988). Kotter (1998) suggests that value is the benefit that the customer perceives as a result of using a service. Within the strategic marketing literature, customer-orientation is described as a key capability within an organisation, and organisations that have an effective customer-orientation have a greater rate of success (Kotter, 1998). For GP federations the ability to define the customer may be multi-dimensional: as a contractual requirement practices already have established mechanisms for assessing customer satisfaction and many have patient groups used to inform strategy and receive feedback; there may be a requirement for new services to demonstrate customer satisfaction; and, in contrast, federations may also support practices by ensuring principles of consumerism are enhanced across member practices, and using population-based approaches to their advantage.

### 2.14 Business scenarios and the renewal of general practice

Several business scenarios are relevant within the context of emerging forms of federations, and business strategy provides a perspective to understand these various forms. Practices can federate on a virtual basis and participate in discreet activities and sharing of services, or can federate by forming separate companies for the purposes of pursuing shared business interests (Nuffield Trust, 2012). With regard to the new models that have been identified (Dayan et al, 2014; Rosen, 2015; Baird et al, 2016), there is an issue about the extent to which they divert from the traditional independent contractor model of general practice which may decrease individual practice autonomy and control. For example, multiple independent practices who operate in an informal network retain the independence of the individual practice and a high degree of local autonomy. In contrast a model of salaried GPs shifts away from the independent contractor status to a more centralised organisational function and is established where all GPs are salaried by one single organisation. It is therefore relevant to consider whether federating preserves the existing model of general practice or offers an alternative format and business theory around merger and diversification. General practices, where practices consider themselves to be financially viable with a stable workforce and have no desire to change, are likely to maintain the status quo and favour strategies that preserve the individual practice as a business entity. Such practices may opt to collaborate in ventures that support this ethos of preservation which can be on a formal or informal basis.

Within the literature around the professional organisation, Brock et al (1999) identified that the potential for change can only be realised if groups in favour of change have the power (sufficiently concentrated) and capability (leadership and technical skills) to support the level of change that is required. These are relevant considerations for practices seeking to work in collaborative arrangements. Brock (2006) noted that difficulties can emerge within professional organisations when alternative organisational forms are presented because it challenges existing systems, processes, values and beliefs. Therefore, such change needs to be presented in a way that is consistent with the existing interpretive scheme of the professional body, otherwise it is unlikely to succeed in the short and medium term. It could be argued that the profession of general practice holds a deeply institutionalised interpretive scheme that spans back to the formation of the NHS in 1948, and is characterised by collegiality, independent contractor status, the professional partnership and multiple individual practices. Therefore, the concept of collaborating or federating on a larger scale could prove problematic if it deviates from the values and beliefs of the individual practices and GP partners.

At the time of designing this study in 2011, there was no evidence around the number of actual GP federations that had been formed in England, but a survey conducted by RGCP and the Nuffield Trust (2017) with 565 GP respondents (60% of whom were GP partners in practices), stated that 81% of practices were involved in some form of collaboration. This was an increase from the 73% reported in 2015, signalling a rise in the number of collaborative arrangements in place but the exact nature and extent of the collaboration was not detailed. From the 81% involved within a GP collaboration, around half (45%) were part of a federation that had been in existence for two years or longer. The survey also reported that 53% of GP partners were unwilling to relinquish their existing GMS, PMS or APMS contracts in favour of the new models of care contracts. The reason cited for this was that they did not want to lose control of the decision-making and leadership of their practice. Over half (57%) of respondents reported the fear of losing their entrepreneurialism, flexibility or innovation in moving to new contractual arrangements, and the two highest reported factors that inhibited the development of collaborative arrangements included time and work pressures (85%).

### 2.14.1 Growth through merger and acquisition

Practices that are unable to fulfil their contractual requirements, or no longer exist as a viable business, can pursue a strategy of merger into a larger single practice under a single

contract which will yield operational efficiencies providing enhanced workforce resilience. Business theory notes that external mechanisms of growth can be achieved through process of merger or acquisition. Whilst mergers occur through the coming together of two organisations where both are equal partners in forming of a larger organisation, acquisitions are often referred to as takeovers and apply to situations where there is a dominant party that purchases or subsumes the other party (Campbell et al, 2011). There is evidence in England that the provider landscape of general practice is changing, and data from NHS Digital (2017) suggests that there has been a decline in the number of GP practices (7,435 in 2017 compared to 8,106 in 2013) and an increase in the average practice list size (7,860 in 2017 compared to 6,967 in 2013). This suggests that there is a shift towards the creation of larger practice units, which is likely to have been achieved through a process of merger and/or acquisition. NHS regulations (2018) state that GP practices seeking to merge contracts with other practice(s) can apply to NHS England for approval after full public consultation takes place. The guidance also notes that there is an approval process in place for the incorporation of practice contracts to move from a partnership construct to a corporate business construct. This may be subject to procurement and competition law, indicating a complex set of regulations to comprehend around forming group arrangements that impact on individual GP contracts. Regulations also permit GP contracts to be offered through procurement, which provides the opportunity for service providers to bid to hold contracts and hold individual or multiple contracts, thus acquiring a portfolio of practices in multi-site GP practice organisations. An example of this model was identified by Pettigrew et al (2019) where one organisation founded and owned be a small number of GPs held 50 GP practice contracts across England.

### 2.14.2 Diversification as a strategy of business renewal

Diversification is an alternative strand of business theory that offers a perspective to review federating within a business construct. Ansoff (1988) proposes four directions to enhance corporate strategy based upon both products/services and markets, and noted that most organisations exist with either a product or service within a defined market (and have the option to either penetrate the existing market further), or develop new products/services and pursue alternative markets. Diversification can be classed as either a strategy of related diversification based upon related connections with the existing business, or unrelated diversification based upon diversification with new products or services with no connection to the existing business. A range of drivers can influence business diversification, but value-creation is particularly important within economies of scope that can be achieved by using existing resources to achieve efficiency gains, and can include sharing of corporate

managerial competencies across a portfolio of businesses (Sainidis et al, 2012). Strategies for growth through related diversification occur where there is a commonality or link between the existing business and a new market or industry, and benefits are obtained through the transfer of competencies, sharing of resources or bundling of products (Jones, Hill, 2010). Therefore, GP practices pursuing a strategy of related diversification would be seeking to develop an extended range of services complementary to the existing services provided. Similarly, practices or groups of practices opting to develop a portfolio of multiple GP contracts could also be considered as a form of growth through related diversification, where skills and expertise exist within the organisation. Organisations pursuing strategies to develop products or services in new markets where they have less or no experience can be classified as pursuing a strategy of unrelated diversification, and no examples of this are cited within the literature around GP federations.

### 2.14.3 Networking, strategic alliances and joint ventures

A further strand of business theory relates to other forms of collaboration through networking, strategic alliances and joint ventures. The phenomena of GP practices collaborating has gained popularity, and collaborative advantage can be achieved through the creation of networks, strategic alliances and joint ventures where two or more organisations agree to collaborate for a common purpose (Campbell et al, 2011). Strategic alliances can be short-term informal arrangements or longer-term formal arrangements, and can take various forms. Successful alliances occur where there are complementary skills and capabilities, the alliance has a high degree of autonomy from the parent organisation and there is trust between partners within the collaboration (Campbell et al, 2011). Other success factors include complimentary skills, compatible goals, and co-operative cultures towards the new venture (Brouthers et al, 1995). Joint ventures take the form of legally-binding agreements between two or more organisations, and can be used to support growth in competitive markets or for pooling of resource to achieve efficiencies and economies of scale (Campbell et al, 2011). Block and Macmillan (2005) identified corporate venturing as a form of diversification that supports strategic renewal and growth, and internal corporate ventures are created where there is an internal transfer of resource to create a new business unit (Jones Hill, 2010). However, based on learning from the 1990s, Block and Macmillan (1995) caution that such internal corporate ventures can have a high rate of failure (33% - 70%), mainly due to small scale market entry, lack of product or service commercialisation, or poor corporate management of the venture. Within the body of literature around corporate entrepreneurship and venturing (MacMillan et al, 1986; Turro et al, 2013; Kuratko et al, 2014; Parker, 2011), one description offered by Sharma and

Chrisman (1999) explains the process of renewal through the collaboration of existing individuals/organisations:

> *"the process whereby an individual or group of individuals, in association with an existing organisation, create a new organisation, or instigate renewal or innovation within that organisation" (Sharma and Chrisman, 1999, p18).*

This description suggests that corporate venturing occurs when a new organisation is formed to support founding organisations and joint initiatives are pursued. Evidence of successful joint ventures have also been noted in the public sector. King (2017) presented a successful venture of integrated diabetes care, yielding financial efficiencies through integrated commissioning. Meanwhile, Floris et al (2019) provided an example relating to higher education as a result of national educational reform, and Ferry et al (2018) presented an example of local authorities creating joint ventures to facilitate alternative methods of service delivery. The various descriptions and models of federations that are emerging are now examined.

### 2.15 Federating general practice

It has been suggested that GPs should work in collaborations or federations to reduce fragmentation of care, reduce health inequalities, and address the needs of people with multiple co-morbidities (RCGP, 2008; Kumpunen et al, 2017). The term federating, applied to general practice, can relate to practices collaborating for a defined purpose, can take various organisational forms, and can be underpinned by different legal business constructs (Addicott and Ham, 2014; Kumpunen and Curry, 2015). Although the notion of GP practices operating on a larger scale has been promoted for over a decade, the literature around the phenomena of GP practices organised into larger collaborative structures is not widespread. The concept of meta-organisations, promoted by Gulati et al (2012), emerged in the 1980s where there was increased collaboration across organisations and industries for the pursuit of a common system goal. Whilst examples cited relate to private sector organisations, the principles are relevant to public sector collaborations. A key factor within the model is that organisations collaborate for a common purpose without the commitment of formal employment relations. The designers of such network arrangements establish control over membership, and principles of self-motivation, self-selection and self-regulation are evident within the model. In a systematic review of the literature, Pettrigrew et al (2018) identified only a small sample of studies of at-scale GP organisations, with limited evidence around the impact in relation to quality, costs, and workforce satisfaction. The integration across organisations can involve formal arrangement such as mergers, co-ordinated provider

networks (virtual or actual), or service delivery contracts between different organisations (Fulop et al (2015). Until the publication of the Five Year Forward View (2018), there was no national policy directive promoting the implementation of new business models in the sector of general practice, nor any blueprint as to the form or function. Consequently, between 2008 and 2018, a variety of examples emerged (Rosen et al, 2016).

### 2.15.1 The espoused benefits of federating

The espoused benefits of GP practices collaborating on a larger scale have been noted to be both systemic and practical for the constituent practices. Despite a policy focus on competition and plurality of providers within the NHS (Health & Social Care Act, 2012), the King's Fund (2012) proposed that efficiencies within the NHS could only be achieved through more integrated care which avoids duplication of services within geographic localities, delivers care out of hospital, makes best use of the resources available across a health economy, and ensures a model in which service providers come together to deliver population-based services. This concept suggests that a wider range of provider organisations come together to develop integrated models of care. To deliver more care out of hospital, it was mooted that the current model of general practice may no longer be fit for purpose. As such, Deloitte Centre for Health Solutions (2012) challenged general practice to work differently and develop a mind-set that supported a shift in focus from individual health to population health. This, in turn, would require a shift from the small business model to one of a collaborative networks of integrated service providers. The benefits to individual practices include the opportunity to realise economies of scale through creating more efficient operating processes, shared recruitment and staffing (British Medical Association, 2013). A report by Nuffield Trust (2015) stated that the benefits of federating include greater bargaining power during procurement and tendering, risk sharing across multiple practices, shared cost of resources such as premises and staff, workforce development through specialisms and extended roles, improving access to services through extended hours, initiatives and alternative modes of access, development of clinical leadership, governance, research and teaching skills, and supporting innovation through new technology, multi-disciplinary teams, research and peer review. The Kings Fund (2012) identified significant variation in quality across general practice, and Mathers (2012) highlighted the need to develop a quality improvement culture and suggested that federations would be well placed to support how this is organised across practices. This notion was supported by Sanfey and Ahluwalia (2016), who recognised that federations can facilitate and support system learning across multiple practices.

### 2.15.2 Collaborative organisational forms

When reviewing the literature around GP federations, the language and terminology suggests a wide description of models of organisation or collaboration which can be confusing to the reader. In an environment where there has been no uniform national policy supporting the organisational restructuring of general practice between 2008-2018, and based on a review of emerging GP organisational forms, the Nuffield Trust (2012) proposed four conceptual models: informal networks or group arrangements, formal federations or alliances, super-partnerships or salaried models of service. After a literature review and interviews with senior primary care personnel in the UK and internationally, the King's Fund (2016) subsequently suggested three conceptualisations - loose federations or networks, multiple practices operating through a single organisation, and super-partnerships. The Partnership Review (2019), informed by an engagement exercise with GP professional organisations (e.g. RCGP, BMA) and practitioners, described nine different models: a corporate model with different components; primary care home; GP lead partnership; employee ownership trust; super partnership; federation; NHS limited company; NHS trust vertically integrated model; and primary care network. Within these models there are differing levels of financial and administrative bond between the practices, differing legal rights and responsibilities, differing arrangements for financial liability, and variation in the scope to generate profit (Pettigrew et al, 2016; Mills et al, 2019; McDonald et al 2020). This highlights the variation between the different approaches that have developed, and highlights that there is no single consistent solution to support practices to work together. Some of these models support the preservation of the autonomous independent GP practice (e.g. primary care home, federation), whilst others involve pooled or merged contractual arrangements which signal a shift away from the traditional independent autonomous practice (e.g. NHS trust vertically integrated model).

### 2.15.3 Informal federated models

Informal models of collaboration are referred to as informal networks, loose federations, or alliances (Nuffield Trust, 2012; Kings Fund, 2016). Practices operating within such arrangements come together around a common set of goals or for a common purpose but individual practices remain independent (Mills et al, 2019). The informality of these models means that there is no financial risk to the practices and no overhead costs from establishing new corporate structures. An example of this arrangement was cited by Pettigrew et al (2018) where commissioners supported the establishment of local networks of practices across Tower Hamlets to improve patient outcomes in an area comprising multiple

singlehanded or small practices. The model did not require the practices to alter their existing business format, but funding to support local enhanced services was pooled and distributed on a cluster basis, which required practices to co-operate in initiatives that were incentivised to improve patient care and work within defined geographic networks.

### 2.15.4 Formal federated models

Formal group arrangements, including federations, consist of two or more practices opting to cooperate through a separate legal body to limit liability in the form of limited liability partnerships, community interest companies, or private limited companies (Kings Fund, 2016). These practices remain independent and share financial profit to develop and share activities to the benefit of all practices (Mills et al, 2019). In such examples, practices agree to relinquish control of some aspects of their business to achieve operating efficiencies at a scale that is economically beneficial to the individual practice as a business. This includes, for example, pooled administrative functions or streamlined operational processes organised on a larger scale. The NHS Confederation (2012) offered the following description of individual GP practices working within a collaborative arrangement:

> *"Partner organisations delegate responsibility for aspects of their management and/or leadership to a group organisation, which they co-own. The sovereignty (and responsibility for service delivery) is retained by each member, but some key decisions and functions are made the responsibility of an overarching group board, which each member is represented on to a greater or lesser extent" (NHS Confederation, 2012).*

This description promotes a business model of co-ownership where operational responsibility sits with the individual practices and some aspects of the business are shared with the co-owned company.

Against this backdrop of different forms of group arrangements developing across England, McDonald et al (2020) made a significant contribution to the literature through a longitudinal (2016-2018) cross-sectional case study of four English GP federations. The study highlighted various benefits that had been gained through federating: one site had expanded membership and geographic spread with membership subscription covering central overhead costs; another secured contracts to support improved quality and access, and had a focus around workforce; one site had a focus around quality improvement with a high number of singlehanded practices; and one focussed on quality and sustainability of member practices. It was noted that all four sites were formed organically by groups of GPs, and, whilst all had freedom to act autonomously and pursue activities to meet their aims,

some were more successful in doing so than others. In all sites the federation was a separate entity and co-owned by the member practices, with shared characteristics such as member commitment to standardising systems, risk sharing, and bidding for new contracts. In all sites progress to develop the federation took longer than originally envisaged with concerns around a lack of income-generating opportunities. It was reported that there was a dynamic interplay between factors such as competition between federations, relationships with CCGs, financial resource, history of previous collaboration, leadership and management, size and geography. Through qualitative analysis a typology was developed to describe the federations: expanding, embedded, struggling and small. McDonald et al (2020) reported that a combination of top-down control from the central federation function, whereby practices were mandated to implement change (e.g. adopt standard policies), and proactive system engagement across the health economy were two key components of success. Different styles of management were identified including directive (*authoritative*), supportive (indulgent), and hands-off (*distant/neglectful*), each of which influenced the relationship between the federation and the member practices. The study highlighted that federations were able to respond with agility and flexibility when the national initiative (Improving Access to General Practice) was launched and a range of innovative solutions were swiftly developed and mobilised. Across all sites, patient and public engagement was an area that was under-developed and required further focus as federations matured.

### 2.15.5 Super partnerships

Organisational theorists describe the professional partnership as a model where partners govern and own the firm, and provide a professional service with high degrees of managerial control and autonomy (Greenwood and Empson, 2003; Brock, 2006). Brock (2006) noted that many professional organisations have experienced either a horizontal or vertical redefinition of traditional organisational boundaries because of challenges or threats to the original organisational model, and this resonates with general practice. The notion of a general practice super partnership consists of principles that preserve the benefits of partnership. An example consists of two or more practices merging to form a new partnership, and whilst the individual practices may retain responsibility for delivery of their own GP contract, the overall responsibility and decision-making sits with the overarching partnership. In this example partners may be jointly liable for the actions of other members that make up the super partnership. Another example within the literature is the model of a multi-site practice organisation, where practices are taken over by an organisation that may hold many GP contracts (Baker et al, 2013; Mills et al, 2019). This model can support the company to be limited by shares, hold contracts and limit the liability of individual partners

(Mills et al, 2019). Identifying the shift of professional firms towards a star model where growth is achieved through merger or significant horizontal diversification, Brock (2006) states that this organisational form relies upon the highest professional quality and standards to succeed. This conceptualisation aligns with the multi-practice model, which focusses on efficiencies through standardisation and improving quality standards across multiple GP practice contracts.

### 2.15.6 Salaried models of general practice

The concept of managed professional businesses is evident within the other professional organisations (e.g. legal profession) and is another example of a shift away from the traditional professional partnership (Leopold et al, 1996). Throughout the history of the NHS there has been the notion that GPs should move towards a salaried service model like that of hospital consultants (Loudon et al, 1998), and one model of federated general practice is that of a salaried scheme (Nuffield Trust, 2012). One emerging organisational form is achieved through vertical integration, with some examples of foundation trusts establishing wholly-owned subsidiaries and creating a general practice operational division as part of a larger organisation. This would include practices offering their contracts to be managed by the new organisation in return for salaried positions. Although the evidence is scant around the benefits of such vertically integrated models in England, one retrospective database study of 10 practices operating within this type of model revealed that, although there was no reduction in attendances at the emergency department, there were statistically significant reductions in non-elective admissions and unplanned readmissions to hospital, thus generating significant savings to the health economy (Yu et al, 2020).

Service integration literature suggests that organisations that amalgamate functions can optimise resources (King and Meyer, 2006), reduce fragmentation of service provision, and improve service efficiency. The overall ethos and change management methodologies associated with service integration originate from concepts such as joint ventures, mergers and acquisitions (Appelbaum et al, 2007; Callaly et al, 2010). Service integration is achieved when key operations and strategies are aligned, such as vision, communication processes, and management systems (Callaly et al, 2011). Full service integration is achieved through seamless service provision where individuals identify with the new entity rather than the original organisational structure (Glendinning, 2003). One Australian study of service integration by Aitken and von Treuer (2014) identified key factors for achieving successful service integration, including joint goals and shared vision, clarity regarding the roles and capabilities of all individuals and teams, formal change management processes to facilitate

service integration, and informal processes that foster co-operation such as nominating a lead organisation and involvement of all organisations within the planning process.

### 2.16 Leadership supporting and developing federations

Change management theory states that change that is imposed can be difficult to deal with if there is a perception that the change will have a detrimental effect on individuals involved, or if there is a lack of trust or misunderstanding around the need for change (Harrison & Burns, 1994). In all forms of federating, the process brings together multiple independent businesses in some form of collaboration, whether this be informal or formal group arrangements. Therefore, there is a requirement to gain agreement from multiple business units to collaborate, and for which there needs to be a common vision that practices are compelled to engage with. Within the business literature relating to corporate venturing, a crucial element is the need for both leadership that defines and communicates a unifying vision and to develop a strategy that delivers the vision (Block and Macmillan, 1995). Specific leadership competencies are required to support effective strategic planning and also day-to-day planning around the activities needed to turn the vision of the organisation into a reality (Alimo-Metcalfe et al, 2010). In professional organisations, Brock (2006) argues that change needs to be aligned with the interpretive scheme of the organisations that are changing. Therefore, it would be appropriate in the context of federating general practice for leaders hold a value base that is consistent with their peers to influence change and understand fear and resistance. Organisational archetype is referred to as an expression of ideal organisational form, and successful change requires the traditional archetype to be challenged and an alternative to be presented (Brock 2006). If the vision for federated general practice departs too far from the traditional model, it may be unattractive to practices.

The literature around leadership is extensive and multi-dimensional. According to Yukl (2013), contemporary leadership theory highlighted the role of strategic leadership and senior executives in being able to transform organisations to respond to increased competition, and technological and social change. It is noted that new conceptions of organisational leadership are emerging, in particular the shift in focus from traditional individual models to collective leadership models through relational leadership and shared/distributed leadership, whereby collective activity accomplishes the shared objectives of the organisation. Literature on authentic leadership identifies the importance of positive core values, consistency in action and the ability to develop trusting relationships with followers (Avolio et al, 2004; Avolio et al, 2005; Avolio et al, 2006; Gardiner et al, 2005;

George, 2003; Ilies et al 2005). With its foundations rooted in positive psychology, authentic leadership promotes ethical behaviours, skills and traits (Yukl, 2013). Also, it is suggested that positive psychological traits portray confidence, hope, optimism and resilience, and moral reasoning influences behaviours and actions that result in high levels of morality and integrity (Northouse, 2013). George (2007, 2010) was one of the earliest business leaders to promote the concept of authenticity in leadership through five dimensions: passion, values, relations, self-discipline and heart. He professed that leaders develop and learn these traits through a lifetime of experience, which results in leaders that know their purpose, practise solid values, establish connected relationships, demonstrate self-discipline, and lead with heart. Walumbwa et al (2008) defined authentic leadership as:

> *"A pattern of leader behaviour that draws upon and promotes both positive and psychological capabilities and a positive ethical climate, to foster greater self-awareness, an internalised moral perspective, balanced processing of information, and relational transparency on the part of leaders working with followers, fostering positive self-development" (Walumbwa et al, 2008, p94).*

Whilst the positive aspects of authentic leadership are aimed at improving organisational ethics, culture and environment (Jensen and Luthans, 2006), critics argue it may not always be possible for leaders to be authentic (Alvesson and Sveningsson, 2013; Ford and Harding, 2017; Alvesson and Einola, 2019). Authentic leaders may present as examples of high moral standards (Gardner et al, 2005), yet this may not necessarily result in authentic or ethical leadership (Ladkin and Taylor, 2010; Resick, et al, 2011). Ford and Harding (2017) profess that it is impossible for people to act as their true self, and suggest that there are two contrasting aspects between authentic transformational leaders demonstrating behaviours that are consistent with altruistic values, and the notion of fake authenticity with some people motivated by self-interest (Martinko et al, 2018). Other negative aspects include that authentic leadership can result in a method of excerpting control (Costas and Fleming, 2009) and domination (Ford and Harding, 2011, Ford and Harding, 2017) and can also lead to destructive dynamics within organisations (Ford and Harding, 2017). Sparrow (2005) suggests that the concept of understanding the self before understanding others can generate narcissistic tendencies. It was also noted that some leaders may act immorally, but their behaviour aligns to their personal values, and this challenges the theoretical foundation of authentic leadership (Price, 2003). Some academics suggest that authentic leadership is not always transformational (Gardner et al, 2005) and relies instead upon self-awareness and transparency to gain the support of followers (Ilies et al, 2005). Einola and Alvesson (2019) question the intellectual foundations of authentic leadership and, whilst they suggest it may be a fashionable fad surrounded by a positive ideology, they also suggest that there is

value in the contribution authentic leadership makes in terms of followership and improvements in workplace relations. In a recent contribution to the literature, Sidani and Rowe (2018) focussed on followership and argued that rather than being a leadership style, authentic leadership is an outcome of a process that is co-created through interaction between leaders and followers. Thus, they offered the following definition:

> *"Authentic leadership represents legitimated follower perceptions of a leader's authenticity which are activated by moral judgments." (Sidani and Rowe, 2018, p623)*

In a contribution from Sidani and Rowe (2018), they state that leaders are individuals who adopt a value system which they believe in and their behaviours are consistent with this value system, and this is recognised by others. Followers legitimise the leader as being authentic through their modelled behaviours (Antonakis et al, 2016), and through a process of evaluative judgement followers assess whether the individual is a role model acting in a manner that is true to his/her values and beliefs.

Aligned with authentic leadership is an emerging body of literature around entrepreneurial leadership, which is specific to small businesses or new corporate ventures where there is often a dynamic and volatile business environment (Leitch and Volery, 2017). Vecchio (2003) argues there is nothing distinctive about entrepreneurial leadership, and it merely occurs in a specific setting. Meanwhile, Leitch et al (2013) identified entrepreneurial leadership as a role that takes place in an entrepreneurial setting. However, Renko et al (2015) suggest that entrepreneurial leadership centres around influencing and directing by recognising and pursuing entrepreneurial opportunities. Swiercz and Lydon (2002) identified personal characteristics: intellectual integrity, putting the company before the individual, utilising external advisors, and creating a sustainable organisation as key features of entrepreneurial leadership. Leitch et al (2013) suggest that there are commonalities between entrepreneurial leadership and authentic leadership, because entrepreneurs who are at the centre of a new business venture are influenced by their individual experiences, values and beliefs and consequently are naturally authentic in progressing the business idea. However, Block and Macmillan (1995) identified specific leadership challenges around corporate venturing, which include the need to gain legitimacy (internally and externally), competing for internal resources, and organisational indifference or resistance amongst the contributing business units. Effective leadership is a key determinant in promoting and championing change. Thus, the establishment of federations of general practice requires leaders to visualise and gain support for formal federations as new business ventures.

## 2.17 Factors that influence strategy implementation

Whilst the literature around strategy is extensive and multi-dimensional, there is less evidence around how strategy is implemented and no studies specifically related to business strategy implementation in federating general practice. In a study conducted by Le Grand and Bartlett (1993), organisations reported to have an understanding of environmental factors and strategic intent, but had less of an understanding how to effectively implement the changes required to delivery strategy effectively. In its broadest sense, strategy implementation relates to how resources are allocated, and the management practices that are applied to achieve the desired results. These functions include organisational structure, resource allocation, information and decision-making processes, approaches to leadership and managing human resources. Some frameworks that support strategy implementation have emerged within the literature, including the 7 'S' framework (Waterman et al, 1980) and a model promoted by Beer and Eisenstat (2000) which includes six factors that influence effective strategy implementation. The elements of the 7 'S' framework include structure, strategy, systems, skills, style/culture, staff, and shared values. The Beer and Eisenstat (2000) model identify six factors: top down or laissez-fair management; unclear strategies and conflicting priorities; ineffective senior management team; poor vertical communication; poor co-ordination across functions, businesses or borders; and inadequate leadership skills and development. These six factors can impact upon three components of strategy implementation: quality of direction; quality of learning; and quality of implementation. Okumus (2003) identified that factors such as the external context, including environmental uncertainty or changes, and internal contextual factors such as organisational structure (power structures, decision-making) and organisational culture (traditions, values and standards) impact upon strategy implementation. The influence of operational processes, such as operational planning, resource allocation, communication, human resources, and control (performance and feedback), are all influenced by the nature of the strategy that is being pursued. The combination of operational processes influence the delivery of strategy, and outcomes achieved can either be intended or unintended.

Sull et al (2015) recognised the wealth of literature around strategy, yet highlighted the lack of literature around strategy implementation. Also, from their large multinational study they provided a valuable insight into common beliefs around strategy implementation that they proved were untrue, whilst also identifying five common myths around strategy implementation. The first myth identified was that in strategy execution equals alignment. Whilst managers could articulate processes that supported strategy (objective setting, monitoring performance, reward), coordination and commitment across business units was

lacking and impeded successful implementation of strategy. This would suggest that a common issue within organisations is an incorrect assumption by the senior team that all staff within the organisation are aligned with the vision. The second myth identified was that execution means sticking to the plan. Strategic planning and budgeting were regarded as key components of strategy implementation, but can cause rigidity or inflexibility. Sull et al (2015) argued that the nature of business environments requires a degree of flexibility. Thus, rigid processes can hinder the flexibility required to seize opportunities and an approach to dynamic reallocation of resources (capital and human) should be adopted to counteract this. They also cautioned on the need for disinvestment when plans are not realised as intended. This suggests that there is an assumption at the top that strategic plans will be implemented effectively, but within the research this was not the case, meaning therefore that systematic implementation of plans cannot be assumed.

The third myth identified was that communication equals understanding, where strategic objectives were often poorly understood by people throughout the organisation. However, it was not the amount of communication that was the problem, but the lack of clarity and understanding around the communication by people throughout the organisation. This suggests that although communication methods and mechanisms are in place, it should not be assumed that all people comprehend the messages that are being conveyed. The fourth myth centred around the notion that a performance culture drives execution. Although the study identified that a culture that supports effective strategy implementation includes reward and recognition as well as flexibility, teamwork and ambition, an over-emphasis on performance can inhibit strategy implementation. Thus suggesting that a rigid approach to managing and monitoring performance is not always a positive factor. The fifth myth identified was that execution should be driven from the top, and findings concluded that successful strategy implementation required distributed leaders throughout the organisation who could effectively communicate strategic intentions in a manner that engaged staff, rather than leadership being concentrated at the top. The contribution from Sull et al (2015) concluded that there are common assumptions made by organisations that need to be challenged. These include, for example, that having an organisational vision does not guarantee everyone aligns with this vision, and having a communication plan does not guarantee that corporate messages are understood by the intended audience. Therefore, the process of strategy implementation can be influenced by many factors and there are some common misconceptions made in relation to implementing strategy (Sull et al, 2015).

### 2.17.1 Implementing a strategy of federated general practice

With the alternative organisational forms emerging to support the restructuring of general practice, components of strategy such as purpose, vision, values and business planning have grown in importance, and should both define the purpose of federating and inform the type of organisational form that is established. Ultimately, the vision and purpose for the GP collaboration requires clarity around the strategy that is being pursued (Beer and Eisenstat, 2000). This clarity of vision will determine whether the intended purpose of federating is to preserve the independence and autonomy of existing individual businesses, or support the restructure of the current form of general practice. These are potentially two opposing philosophical stances: one supporting the existing model of autonomous practices (retaining individual contracts) and one supporting redesign with alternative contractual implications.

An externally-focussed strategy may be characterised by practices collaborating to seek new business opportunities, or to extend the range of services delivered, and in doing so generates income to support the practices. An internally-focussed federated strategy may be characterised by practices working collaboratively to redesign and improve the efficiency of practices as individual businesses, and can include alternative business constructs (e.g. super-partnership). Both strategic orientations can be influenced by the contextual environment (Okumus, 2003) and any form of collaboration in general practice will require strategic cohesion between multiple practices. Organising federated services at a practice level and on a larger scale requires well developed inter-practice relationships. and collaboration occurs when practices recognise the value of joint working (Watt, 2011). Leadership and management are factors for consideration within the context of implementing a strategy of federated general practice. Beer and Eisenstat (2000) highlighted the need for distributed leadership throughout the organisation and avoidance of top-down management. Thus, within the context of GP federations, distributed leadership across multiple practices can be achieved by engaging representatives from member practices. Other important facets for consideration included working across businesses and communication, and the complexity of achieving this across multiple practices should be considered within effective strategies for communication and engagement.

Smith et al (2013) identified characteristics and features from a group of ten early implementers of collaborative models of general practice in England, and identified that local context was an important consideration in deciding the type of collaboration that was pursued. In each example, a shared vision was evident, communicated and owned by the group. Strategic business planning was identified as an important process which translated

the vision into a defined business plan, but recognised that some approaches to business planning were more formalised in some sites but was not widespread. Quality improvement was recognised as an important feature and encompassed processes such as audit and peer review, supported by informatic solutions. The study identified that business skills and organisational development resource were important features for collaborations with a need to understand the cultural context of general practice. The considerable personal investment from local GP leaders to champion change and lead on areas of reform were identified as common factors, and considerable investment was made in developing positive relations and open dialogue with other stakeholders.

### 2.18 Summary

This chapter has provided the historic and contextual background to the environment of general practice and the complexities that exist. It is evident the role of general practice is varied and important, with 90% of all patient contacts taking place within this setting. The independent contractor status of general practice provides a high degree of professional autonomy, but there are a range of pressures that practices are facing. Some argue that GP partners are a dying breed (Croxson et al, 2017), with newly-qualified GPs seeking flexible and portfolio careers where they can work part-time in a practice and combine roles elsewhere to fit with personal commitments. This flexible workforce, coupled with an imbalance between the number of GPs nearing retirement age and the supply of newly qualified GPs, presents a significant workforce challenge. Additionally, the increased demand on health services from an ageing population with multiple co-morbidities requires new and alternative ways of designing and delivering primary medical services.

The independent contractor status places the profession in a unique business context with professional partnership remaining the traditional business model. This results in partners earnings being based upon the profitability of the practice, and this requires a business orientation to ensure cost-effective operational delivery and the survival of practices as profitable businesses. These challenges require general practice to seek strategies for renewal of the independent practice model, and one method of achieving this can be through local groups of GPs collaborating for a common purpose. However, the complexities around scope, scale and format of federating presents a challenge to local GPs to decide what is the optimum business strategy to pursue. It is also noted that individual practices may not have the skills to propose an alternative operational delivery model, as concepts such as strategic thinking and strategic analysis may be alien concepts within the small business environment. To pursue alternative business strategies, it is recognised that there

is a need for a compelling strategic vision and a clearly articulated future state. However, as Brock (2006) identified, any alternative vision that challenges the existing interpretive scheme of professionals may act as a barrier to change. The profession of general practice is characterised by multiple independent contractors with business autonomy and decision-making through professional partnerships, and the strategic coherence required to collaborate within a group arrangement will require effective leadership to galvanise and maintain the support of followers (individual practices). Turning a vision into reality requires strategy to be defined into a tangible plan that can be articulated, and the literature around strategy implementation suggests that there are both internal and external factors that support or inhibit change.

Whilst examples of federations have been recognised in the literature (Pettigrew et al, 2018; Mills et al, 2019; McDonald, 2020), there are no examples of detailed single case studies over a longitudinal timeframe. The purpose of this study is therefore to examine in detail one example of an emerging federation that was established in 2011, at a time when environmental contextual changes were taking place. Exploring the federation through the lens of business strategy examines the nature of the collaboration and the extent to which member practices were willing to commit. The study provided the opportunity to identify the factors that influenced the establishment and development of the federation as a collaborative venture, and how the strategy of federating was realised. It captures the successes and challenges that were encountered over an eight-year period between 2011 and 2019. The methodological underpinnings and research methods applied to the study are presented in detail in the following chapter.

# Chapter 3 – Research methodology, methods and design

## 3.1 Introduction

This chapter describes the research methodology, methods and design that were applied within this study. The considerations around the ontology (nature of reality), epistemology (relationship between researcher and participants) and methodology (how knowledge is gained) are discussed. This chapter outlines the argument for pragmatism as the underpinning philosophy of this single organisational case study that adopts a mixed methods approach to data collection. It also discusses is a longitudinal timeframe which captures the progress of the federation over a period of eight years (2011-2019). Research design within social science is important to ensure that the data collection strategy answers to the overall research question(s) (de Vaus, 2001), and should provide logic to the structure of the data collection methods (Saunders and Lewis, 2012). Saunders et al (2009) identified that an appropriately designed research study takes account of a variety of factors, including the overall research philosophy, the research strategy adopted, selection of a single or mixed methods study, relevant time horizon, and the techniques and processes adopted within the methods and design. This chapter presents how these factors relate to the study that was undertaken.

## 3.2 Research purpose and aims

General practices exist within the NHS in England as independent contractors predominately within the business construct of partnership. However, over the last decade there has been a growing debate about the need for multiple independent businesses to collaborate within larger groupings. These independent businesses operate within an environment that is dynamic and frequently changes in line with national policy on health and social care, and they are required to respond to national initiatives. These businesses are also subject to pressures such as diminishing workforce, increased demographic demand of an aging population, increased prevalence of chronic disease and disability, and increasing administrative bureaucracy. The combined impact of these factors are placing considerable strain on the small business model of general practice. Consequently, there is a need to seek solutions to become more operationally efficient and financially viable, with collaborative models of general practice being proposed as one way to achieve this (Rosen, 2015; Chambers et al, 2016; Sonsale et al, 2018).

The overall purpose of this study was to provide insight into one model of a GP federation from a business perspective to gain an understanding of what this form of organisation can offer general practice, and what outcomes were achieved through federated working arrangements. The federation was established at a point in time when legislative changes were being implemented because of the NHS Health and Social Care Act (2012), and the operating environment was subject to constant change because of both political and social drivers. Therefore, it was important to adopt a research strategy that captured the contextual influences and how they impacted upon the federation.

The overall research question posed was:

> *'What insights can business theory offer in explaining how a group of GP practices in the North of England developed a GP federation, and what advantages and challenges did this business model offer?'*

The aims of the study are to:

1. Examine the model of the federation from a business construct as a vehicle to deliver new business opportunities.
2. Identify what advantages and disadvantages the federation offered individual general practices, and what opportunities arose as a result of being part of a federation that they would not have otherwise had.
3. Identify the factors that influenced the viability of the federation as an alternative business model.
4. Examine the role of the executive management team and the leadership approach that was adopted in establishing and directing the federation.
5. Identify the challenges and lessons learned for this model of federation within the health economy.

To address the study aim, one model of a GP federation was examined in detail at a time when national healthcare policy was promoting the transformation of general practices from single businesses to larger operating units. It was untested as to whether the federated model, as a form of collaboration, would provide a viable proposition from a financial and service delivery perspective, and the long-term viability of such a collaboration may be dependent upon a range of contextual factors. From a business perspective, federated models provide the opportunity for general practice to organise into larger business units and operate on a larger scale than that of the individual smaller practice unit. This strategic shift in operational mode requires the member practices to engage and support the development of this new organisational form, requiring a degree of strategic cohesion

amongst practices. Therefore, how this model developed (business strategy) and how members came together (strategy implementation and leadership) are central areas of interest within the study.

### 3.3 The unit of study

The unit of study is a single GP federation in the north of England that was established in 2011 as a joint venture by 14 individual GP practices. When established, the governance structure of the federation included a board of directors who were senior personnel from each member practice. The board delegated strategic and operational responsibility to an executive management team, i.e. a smaller group of executive directors and practice management personnel who were a key group within the study due to their influential role in developing and leading the federation. The opportunity to study the federation presented speculatively to the researcher who was employed by the federation in a consultancy capacity between 2011-2016. In 2011, the phenomenon of federations was not widespread in England, and no data existed around the number that had formed, despite the RCGP (2008) promoting this model of working several years earlier. At the time, there was little known about the factors that would contribute towards the implementation and operations of a federated model of general practice. Therefore, this unique level of access provided an opportunity to contribute significantly to the body of knowledge about federated working from a business perspective. It was recognised that undertaking a single case study would be an approach that could provide an in-depth analysis and a detailed account of the federation as it established and developed as a business venture within the context of policy changes within the NHS.

### 3.4 Pragmatism as a research philosophy

Communities of researchers in the behavioural and social sciences can be categorised based on their preferred research methodology. Historically, this has been a dichotomy of quantitatively-oriented social and behavioural scientists (QUANs), who focus on quantitative or numerical data analysis, and qualitatively-oriented social and behavioural scientists (QUALs), who focus on qualitative or narrative data analysis. More recently, mixed methods research has emerged as an alternative which incorporates both quantitative and qualitative data analysis (Teddlie and Tashakkori, 2006). Mixed methods research advocates the use of whichever method best addresses the question at hand. This approach is described as pragmatism (Johnson and Onwuegbuzie, 2004; Onwuegbuzie and Johnson, 2006; Johnson et al, 2007). One of the major benefits of pragmatism is that it enables the researcher to

generate hypotheses from qualitative observations which are then testable empirically using quantitative measurements (Morgan, 2007).

There are both ontological (the nature of reality) and epistemological (what constitutes valid knowledge) considerations to be accounted for when considering research paradigms. Saunders et al (2009) outline four key research philosophies that are applied within research: positivism, realism, interpretivism and pragmatism. Within realist ontology there is an assumption that there are real world objects apart from the human knower, thus there is an objective reality (Denzin and Lincoln, 2011). Critical realists assume that our ability to know about reality is imperfect, and claims about reality must be subject to wider critical examination to achieve the best understanding of reality (Bhaskar, 2016; Danermark, 1997). Meanwhile, subtle realists assume that we can only know reality from our own perspective of it (Hammersley, 1992; Kirk and Miller, 1986). Epistemology underpins the researcher's view of what is considered acceptable knowledge within a discipline (Schwandtz, 2000; Saunders et al, 2009), and central to this notion is whether the social world can be studied in the same way as natural sciences (Bryman, 2012). Therefore, ontological considerations in research design must take account of social entities, and whether these are objective and have a reality that is separate from that of the social actor, or whether reality is constructed from the actions and perceptions of the social actors (Bryman, 2012). Research philosophy frames the assumptions about how the world is viewed and the design of a research study needs to reflect the underpinning philosophical stance (Saunders and Lewis, 2012).

Kuhn (1962) promoted the perspective that single paradigms form science whilst quantitative purists believe that there is separation between the researcher and the subject of observation (Ayer, 1959; Maxwell and Delaney, 2004; Popper, 1959; Schrag, 1992; Saunders and Lewis, 2012), hence the quantitative researcher should be value-free (McNeill and Chapman, 2006). At the other end of the philosophical spectrum, qualitative purists (Guba and Lincoln, 1989; Lincoln and Guba, 2000; Schwandt, 2000; Smith, 1984) profess the superiority of constructivism and interpretivism as research philosophies and reject the notion of positivism (Johnson and Onwuegbuzie, 2004). They argue that the researcher and the researched cannot be treated as separate entities and, as such, a different approach is adopted to produce a written detailed and rich description of the research subject (Johnson and Onwuegbuzie, 2004). Paradigms when considered as a continuum will have positivism at one end and constructivism at the other, with pragmatism placed in the middle (Teddlie and Tashakkori, 2006). Tashakkori and Teddlie (1998), Teddlie and Tashakkori (2009), Morgan (2007), Onwuegbuzie and Johnson (2006), Denscome (2008), and Creswell and Plano Clark (2011) all identify pragmatism as an appropriate paradigm for conducting mixed

methods research, and an approach to scientific inquiry where there is an attempt to seek theories that work and make a practical difference to an intellectual problem. Founded by Peirce (1878; 1905), pragmatism has a focus on purposeful human activity. Peirce's theoretical perspective was further developed in different directions by James (James and Burkhardt, 1975) and Dewey (1917), but retained the central notion of supporting purposeful human activity. Peirce's perspective on pragmatism is that the truth of science is indicated by the fact it serves our purposes, whereas the Jamesian perspective argued that it serves our purpose but no better or worse than any other type of inquiry. Within this philosophical stance, the starting point of inquiry is human purpose, and the endpoint is whatever is appropriate for us to believe is an appropriate solution to the problem. According to Johnson and Onwuegbuzie (2004), pragmatism considers what works in order to answer the research question, rather than adopting a positivist/postpositivist or constructivist paradigm.

Whilst deduction is typically associated with quantitative research and induction with qualitative research, Teddlie and Tashakkori (2009) argue that pragmatism requires abduction to move back and forth between the mixed methods applied, thus providing the flexibility for multiple realities to be drawn from both qualitative and quantitative data (Creswell and Plano Clark, 2011). Morgan (2007) suggests that intersubjectivity exists by working with objective quantitative data methods and subjective qualitative data methods, and through a process of communication shared meaning is created which is consistent with the notion of paradigms as shared beliefs. Morgan (2007) professed that with a pragmatic approach researchers can claim that there is a single reality, but individuals will draw their own interpretation of that reality. When considering transferability of research findings, Guba and Lincoln (2005) discussed whether something learned in one context can be applied within another. Morgan (2007) argued that researchers cannot assume that research methods applied within one study can be either generalisable or context specific, and highlighted the importance of understanding the factors that affect whether knowledge gained from one setting can be transferred to another.

The stimulus for this study was to examine the establishment of a GP federation and what opportunities and challenges presented within this organisational format. Adopting pragmatism as a theoretical perspective meets the practical needs of the researcher, using a mix of research methods to make conclusions about the federation and what it offered the member practices.

### 3.5 Case study as a research strategy

Case study is regarded as an appropriate research strategy that can accommodate a variety of data collection methods (Saunders and Lewis, 2012, Saunders et al, 2009). One of the strengths of case study is that it can provide an in-depth understanding of the study subject, and the potential depth and richness of case study can provide a detailed understanding of the subject within its natural environment (Bryman, 2012, Yin, 1989). Case studies can be applied to individuals, programmes, events, activities or organisations (Stake, 1995; Saunders and Lewis, 2012), but defining the unit of study is an important consideration as it sets the boundaries and scope of the study (Yin, 2012). Various levels or components within the case can be studied, which is referred to as either holistic, where a single unit of study is undertaken, or embedded, where multiple units are studied (Yin, 1989). Idiographic explanations provide a complete explanation of a case which is generated by examining multiple factors (de Vaus, 2001), and this study aims to provide such an explanation by examining and identifying events and developments of the federation within its operational context and environment. This aligns with the methodological approach of case study in providing a holistic perspective and overview of the case in question (Yin, 1989).

Case study is an appropriate approach for conducting research in healthcare and has been applied within the context of the NHS in the UK (Crowe et al, 2011), where innovation can be frequent and rapid. Examples include: a study of a management development programme implemented within a primary care trust in England (Smith et al, 2011); a mixed methods study undertaken by Greenhalgh et al (2010) around the implementation of the shared electronic patient summary record; an in-depth study of four mergers of healthcare provider organisations (Fulop et al, 2005); and a multi-level case study approach to study the implementation of lean methodology within NHS organisations (Radnor et al, 2012). Single case studies are equally applicable in healthcare. In one example, Smith and Treschuk (2018) identified that there were multiple models of transitional care and undertook a single case study of one of the identified models. Concurrent with the work of Crowe et al (2011), the studies listed above were conducted in areas where new innovations were being introduced, and where contemporary developments were occurring in the environment of healthcare.

One of the limitations regarding single case studies relates to generalisability, but single case studies are considered legitimate when they present a convincing approach to either generating or testing a complex theory (Yin, 1989, Flyvbjerg, 2006). Stake (1995) argues that the richness of the data facilitates the reader to generate their own perspectives on the transferability of the findings. To substantiate the approach of a single case study, the

establishment of GP federations is a process that is being replicated across England to seek solutions for general practice to operate at scale. There are contextual factors that could inhibit or facilitate the development of the federation as a viable business model, and these are explored within the study. Therefore, rather than generalising from this single case study, the formative lessons learned could be transferable to other groups pursuing similar business ventures, and the knowledge gained will be relevant in the context of health policy and the strategic development of general practice.

Interpretation is another feature that is important to the validity of single case studies. Qualitative data gathered through interviews consists of the people involved in the unit of study telling their stories, so a specific challenge for the researcher is to preserve and convey an accurate reflection of this to the reader (Van Maanen, 1988; Flyvbjerg, 2006). Flyvbjerg, (2006) argues that adopting an open approach to the case study allows for the complexity and richness of perspectives from within the case study to be accurately reflected. The richness and skilful construction of the narrative enables consumers of the research to assess what is relevant and transferrable to other situations (Stake, 1995). This study required an approach to present a detailed insight into a federation where real-life examples were illustrated through interviews with the individuals involved.

Case study is relevant to asking why questions and, consequently, the purpose of investigative strategy can be exploratory, descriptive or explanatory (Saunders and Lewis, 2012; Neuman, 2007; Yin 2012). An exploratory approach may be applied as a method of exploring the feasibility of further study, and generally focuses on the what questions. However, a descriptive approach presents an accurate description of the phenomenon and generally focuses on the how and who questions (Neuman, 2007; Yin 2012). Despite this, both exploratory and descriptive purposes are often closely aligned in practice (Neuman, 2007). An explanatory approach attempts to answer the why questions through mechanisms to examine the relations between variables and provide an explanation of the phenomenon. Adopting an explanatory approach can enrich the explanation of a theory within the phenomenon and extend a theory within a new context (Neuman, 2007).

Within this case study, an explanatory study was adopted to provide a clear understanding of the way the actors conceived the organisation and its purpose. This was achieved by describing the reality of the situation as it was perceived by the study population, thus providing a detailed insight and explanation of the phenomenon of one model of federated general practice. The interpretive nature of case study examines a phenomenon within its contextual environment and takes account of subjective meaning (Yin, 2012). Thus, it relies

on contextual framing in explaining the subject being studied (de Vaus, 2001). An important facet of this study was to identify the contextual factors within the operating environment and capture how the federation responded to these factors. As such, case study was considered an appropriate method of exploring and presenting these findings.

Saunders and Lewis (2012) explain that both deductive and inductive approaches can be applicable within research, and inductive reasoning attempts to explain the meaning that people attach to specific events, thus offering a broader generalisation. An inductive approach facilitates theory building where the researcher develops an understanding of the meanings that humans attach to events or situations and provides an element of flexibility to the research strategy as it develops (Saunders, Lewis and Thornhill, 2009). Theory building within social science research can be derived from observation, which Merton (1968) refers to as post-factum theory. Within this study an inductive approach provided a method of building up an understanding of the federation gleaned from the data collection methods and study design.

In summary, a single organisational explanatory case study was designed to examine one model of a GP federation within the context of the NHS in England. A single case study was selected due to the unique subject access available, and included features such as: an inductive approach to support theory building; an explanatory approach to examine the reality of the federation in its operating environment; and a longitudinal approach to capture progress and developments over a period of time.

### 3.6 Mixed methods

Mixed methods is considered as the third approach to research, placed centrally between the extremes of quantitative and qualitative research (Johnson and Onwuegbuzie, 2004; Creswell, 2003; Tashakkori and Teddlie, 1998 and 2003). Denzin (1978) notes that the use of mixed methods within social science research assists with the '*convergence of truth'* in understanding social science phenomena, thus facilitating the construction of superior explanations. The following definition of mixed methods research is offered by Johnson et al (2007):

> *"mixed methods research is the type of research in which a researcher or a team of researchers combine elements of qualitative and quantitative research approaches (e.g. use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and collaboration"* (Johnson et al, 2007).

Mixed methods research began to emerge in the work of cultural anthropologists and sociologists (Gans, 1963). Johnson and Onwuegbuzie (2004) state that the purpose of mixed methods is to elicit the strengths of both qualitative and quantitative approaches, and also minimise the weaknesses within single research studies. Recognising the increasing nature of interdisciplinary research, Johnson and Onwuegbuzie (2004) state that mixed methods provide the opportunity to adopt a non-purist approach and achieve superior research outcomes. However, there are controversial perspectives on mixed methods, with purists of either qualitative or quantitative methodologies defending the position of the superiority of singular approaches. Adopting a mixed methods approach is not without controversy as a research method. Creswell (2009) identified that there is a need for extensive data collection, which can pose a challenge to the researcher due to the intense nature of analysing both text and numerical data, and identified the need for the researcher to possess an understanding of both qualitative and quantitative research methods.

Triangulation within mixed methods research is regarded as analysing the same event by combining different perspectives (King et al, 1995). This can be achieved through data triangulation (in this study survey and interview data are combined) and from an analytical perspective (the longitudinal element of time in the study combined with data from various groups of personnel provided differing perspectives (Denzin, 1978)). Morgan (2019) noted that triangulation within mixed methods research is an unhelpful term, and stated that there are three possible outcomes from triangulation: convergence, complementarity and divergence. Bryman (2006: p105) justified the combination of mixed methods to provide:

1. Triangulation: convergence, corroboration, correspondence or results from different methods.
2. Complementarity: “seeks elaboration, enhancement, illustration, clarification of the results from one method with the results of another” (Greene et al, 1989: 259).
3. Development: ‘seeks to use the results from one method to help develop or inform the other method, where development is broadly construed to include sampling and implementation, as well as measurement decisions’ (Greene et al, 1989: 259).
4. Initiation: ‘seeks the discovery of paradox and contradiction, new perspectives of [sic] frameworks, the recasting of questions or results from one method with questions or results from the other method’ (Greene et al, 1989: 259).
5. Expansion: ‘seeks to extend the breadth and range of enquiry by using different methods for different inquiry components’ (Greene et al, 1989: 259).

Influenced by the justifications listed above, it was considered that a mixed methods approach would be an appropriate strategy to address the research question. In the design of the study, complementarity would be applied through focus group exploration of results from the questionnaire survey to gain greater understanding and contextualisation of the results. Meanwhile, expansion would be achieved by exploring emerging themes from face-to-face interviews with the executive team within a focus group setting with other professional groups (e.g. nurses, managers, GPs). Johnson et al (2007) state that mixed methods research can have either a qualitative or quantitative dominant aspect, and recognised that there are situations where the addition of quantitative data can provide an additional dimension to a qualitative research study and vice versa. In this study, qualitative interviewing explored the experience of the social actors engaged within the federation and offered the opportunity to explore the business challenges encountered and opportunities that presented. Meanwhile, questionnaires provided a perspective on specific aspects of the study around business and leadership.

Creswell (2013), Creswell et al (2003) and Greene et al (1989) examined the purpose of integrating mixed methods, which include triangulation, explanation or exploration. Johnson and Onwuegbuzie (2004) state that quantitative data collection can provide independence in that results are numerically and statistically based, and are independent of the researcher. Meanwhile, they also suggest quantitative survey tools add an alternative dimension and can be used to explore the subject from various aspects, e.g. organisational culture and the link to organisational performance (Denison survey) and leadership (ALQ with the Executive team). The use of validated survey tools that are supported by an evidence base can enhance the study by comparing survey cohorts against other organisations or peer groups, and such tools can be used to provide an independent perspective to explore the nature and context of the Federation at an early stage of its development. Also, they can also be used to inform further exploration through follow-up qualitative interview.

### 3.7 A longitudinal time dimension

A time dimension can be accommodated within case study research (Creswell, 2003; Neuman 2007; de Vaus, 2001), either in cross-section where a case is undertaken at a single point in time, or longitudinal where the study is undertaken over a defined time period (Neuman, 2007). Thus, a longitudinal study of the federation maximised insights by enabling the organisation's operational context, development and social change to be captured (McNeill and Chapman, 2006). The case study was conducted over an eight-year period to examine the factors that would support or inhibit the federation to become a self-sustaining

business venture. Over this time period, it would become evident what opportunities would present through formally-commissioned services as CCGs matured and procurement strategies were developed, and whether the federation would be successful in bidding for services. As commissioning strategy developed alternative sources of funding to substantiate the venture would be then also examined. Data collection and analysis included collation of internal documents, and the tracking of events sequentially over time, to provide an explanation of how the federation developed and pursued its business strategy. This provided a chronological richness to the study in capturing events over time and presenting the historical background that influenced current working practices within the context of the study. Data collection through interviews and questionnaire surveys were undertaken at various time points during the study capturing the processes, business decisions and developments. This provided a reconstruction of the history of the organisation and captured the lessons learned during the time from the formation of the organisation in 2011 until 2019.

### 3.8 Data collection methods

In line with the mixed methods study design, various methods of data collection were applied and included qualitative interviews, both face-to-face and focus groups, and quantitative questionnaire surveys. These methods are presented and the purposive sampling strategy applied is described.

#### 3.8.1 Sampling strategy

Participants in all phases of the study were recruited through a technique of purposive sampling, which is a form of non-probability sampling involving the judgement of the researcher to identify the subjects for inclusion within the study (Creswell, 2009, Saunders and Lewis, 2012, Neuman, 2004). There were various considerations applied when defining the sampling strategy applied within the study. The internal sample group for the study included people who fulfilled roles within the federation, either actively in a senior capacity or as personnel from member practices, as categorised below:

i. The federation's directors - the federation was made up of 14 individual member practices. Each of the member practices nominated a director to represent their practice on the board of the federation. Therefore, it was considered that the board of directors would provide an important strategic perspective on what the federation was set-up to achieve and how they envisaged it would develop over time.

ii. The executive management team - four directors from the board were elected as to form an executive management team to lead and develop the federation on behalf of all the member practices. Access to the executive management team would provide a valuable insight into the individuals within this leadership role, and into the delivery of the business strategy and organisational development of the federation.
iii. Practice managers - each member practice employed a practice manager, who was considered personnel of relevance as they held prominent roles within their respective practices and also came together within a professional grouping on a monthly basis. Their management perspective would provide a valuable insight into supporting the development of the federation and implementation of initiatives developed by the federation.
iv. General practitioners – each member practice consists of a number of GP partners and salaried GPs. Obtaining a perspective from the GPs would provide an insight into what they perceived to be the benefits of federating and what had been learned during the period of the study.
v. Practice nurses – across member practices there are a number of practice nurses employed. The views of the nurses would provide an insight into their involvement with the federation and the perceived benefits and challenges from their professional perspective.
vi. Executive manager – this role was key to supporting the executive team in developing the federation. Between 2011-2016 this role was fulfilled by the researcher. In 2017 a new appointment was made and an interview conducted with this interviewee provided an insight into the challenges and opportunities that had been encountered.
vii. Lead nurse (education & training) – activities such as research, education and training were developed by the federation. A key member of the strategic education group was a lead nurse who had been involved with the group since it was established, and continued to support the group during the time period. The perspective and insight from this individual would provide understanding into developments over the period of time.

The external cohort of interviewees were also identified as a purposive sample group by the researcher. This involved a review of the organisations within the health economy and identification of executive personnel to be invited to participate in interview:

viii. Senior health economy personnel - it was recognised that the federation existed within a defined health economy, and obtaining a perspective from external

stakeholders may provide an alternative perspective to those personnel directly engaged with the federation. The stakeholder group consisted of influential leaders within other organisations in the health economy who would have differing experiences of working with GP practices, and would hold views on the organising of practices into larger groups. The table below summarises the sample groups that were identified and the various data collection methods that were applied to each group:

| Sample Group | Data Collected | Rationale |
|---|---|---|
| **External health economy personnel** | Face-to-face interview | To provide an external perspective on the reasoning and rationale for general practices to federate. |
| **Federation executive management team** | Face-to-face interviews | To provide an internal perspective on the rational for forming a federation, an insight into the contextual factors, and intended purpose of the federation. |
| **Federation executive manager** | Face-to-face interview | To provide insight into the work programme of the federation, and the success, challenges and contemporary issues facing the federation. |
| **Federation lead nurse (research, education & training)** | Face-to-face interview | To provide professional nursing insight into developments that supported research, education and training. |
| **Federation research facilitator** | Face-to-face interview | To provide insight into the development of research across the member practices and the benefits gained. |
| **Federation board of directors and practice managers** | Denison organisational culture survey | To provide an insight on a range of factors from a senior perspective of the board members who established the federation and support its development. |
| **Federation executive management team** | Authentic leadership questionnaire | To provide an insight into the authentic leadership traits of the team leading the development of the federation. |
| **Federation executive management team** | Focus group interview | To explore in depth specific topics of exploration that emerge from interviews and questionnaire surveys. |

| | | |
|---|---|---|
| **Practice managers** | Focus group interview & workshop | To provide a management perspective on the opportunities and challenges faced by the federation. |
| **Practice nurses** | Focus group interview | To provide a nursing perspective on the opportunities for the profession of nursing within a federated model, and to gain insight into the impact of the federation on practices and outcomes achieved. |
| **GPs** | Focus group interview & workshop | To provide a clinical perspective on the federation and what has been learned through the process. |

Table 1 – Personnel included in study design

### 3.8.2 Face-to-face interviews

Conducting face-to-face interviews is a well-recognised method of collecting data in research (Creswell, 2009; Yin, 2012; Saunders and Lewis, 2012). Kvale (1983, p174) describes a qualitative interview as:

> *"an interview, whose purpose is to gather descriptions of the life-world of the interviewee with respect to interpretation of the meaning of the described phenomena".*

Yin (2012) identifies the interview an important source of case study information, and individual semi-structured interviews are deemed appropriate to gain an insight into people's opinions and experiences (Denscombe, 2010; Warren, 2002). In line with the research philosophy, semi-structured interviews are a vehicle for the gathering of rich, in-depth information about a phenomenon (McNeill and Chapman, 2006). With case studies, the benefit of capturing the unique experiences of interviewees through open-ended questions around themes of investigation is supported by Stake (1995) to gather the descriptions and interpretations of others. Stake (1995) highlights the benefit of capturing the unique experiences of interviewees through open-ended questions around themes of investigation, and the study undertook a range of interviews with both personnel involved within the venture and also external perspectives.

The initial interviews with the executive management team were broadly themed to gain an insight into the background as to why the federation was established and an understanding of its intended role and purpose. An iterative approach was adopted, whereby findings from data gathered were used to inform the topics that were explored in subsequent data collection over the longitudinal period of the study. This iterative process of establishing

topics of investigation gathered authentic descriptions and interpretations from the perceptions of the personnel within the federation. Yin (2012) also highlighted fluidity within the interview process as a guided conversation that follows a consistent line of enquiry, which is applied to face-to-face interviews through a semi-structured approach. Individual semi-structured interviews with the executive management team provided an insight into the reasons for establishing the federation, and provided a method of exploring the development of the organisation through the stories of the players involved in leading the process. A review of company records identified key issues and developments, and subsequent interviews were used to identify and explore these issues that influenced the strategy of the organisation. Following the initial face-to- face interviews with the executive management team, a series of focus group interviews were conducted to examine specific areas of interest. This provided a longitudinal aspect to the study that enabled exploration of the development of the federation and its establishment within the local health economy. Alongside this, it also provided the opportunity to explore the strategic challenges that the executive leadership team encountered at different points in time. Interviews were scheduled for approximately one hour in duration, and each interview was audio recorded and transcribed verbatim. The interviews were held at a time and place that was convenient and agreed with the participant.

### 3.8.3 Development of the interview guide

The research questions discussed during the interview were broadly framed around areas of the social problem or interest relevant to the research topic. Within this study the questions posed were framed within the context of: the healthcare environment that the federation existed in; the emergence of federations; the challenges facing general practice; and the intended purpose and vision for the federation. The questioning strategy involved exploring the perceptions and experiences of the executive management team in their role as leaders of the federation to gain an insight into the perceptions of senior personnel interviewed. It also aimed to access the espoused strategic vision for the federation and how the strategy for federated working was implemented. Within the focus groups, the interview guide was developed in line with the theme of discussion. For example, one focus group discussion centred around the findings from the survey questionnaire with specific exploration around customer focus, which rated lowest within the questionnaire survey.

To understand the phenomenon of a GP federation, it was important for the research participants to account for what Silverman (2001: p90) terms as their *“lived experience”* relating to the business and strategy of the federation. Gubrium and Holstein (1997) highlight

an emotional aspect to interviews where interviewees are encouraged to describe their experiences and their feelings. Whilst an emotionalist approach to interviews elicits a deep understanding of the lived experience of the subjects, there are limitations to this approach including the empathetic role that the interviewer may play, which can result in an imbalance of power between the interviewer and the interviewee. Silverman (2001: p112) highlights that *"interview responses are displays of perspectives and moral forms"* and such an approach is concerned with "*eliciting accounts of subjective experience"* through a process of open-ended questioning and building a rapport with each interviewee. It was important that the interviewees provided a true depiction of their experiences of their involvement with the federation, or their perspectives on the model of federated general practice.

### 3.8.4 Interviews with external stakeholders

In designing the study consideration was given to perspective, as a study solely designed around the people involved within the federation, as leaders or as member practices, would provide an internal perspective. Therefore, it was felt that conducting interviews with a range of external stakeholders within the health economy of the North East of England would give an alternative perspective to the study. To provide this, interviewees from an external cohort were asked to offer their perspectives on the perceived challenges that general practice faced, the need for practices to organise into larger operational forms, and to provide an insight from their respective senior roles within the health economy. These stakeholders were considered by the researcher to have a view and perspective about GP practices coming together in collaborative arrangements. Interview topics included an exploration of the key issues facing the health economy, such as strategic vision, the requirements of an effective primary care system, collaborative working, integrated care, and challenges and opportunities.

It was important for the authenticity of the case study that an external perspective was obtained because federations of general practice would be developing within the context of a defined health economy where multiple provider organisations exist. These external stakeholders would hold a different worldview on this emerging phenomenon, which would provide a balanced representativeness to the study subject (Gillham, 2001). A successful health economy needs high-quality, well-organised primary care systems and, ultimately, the development of new models of primary care could be influenced by interplay between internal and external perspectives.

A purposive sample of ten senior executives was identified from a range of organisations across the North East health economy where the case study of the federation was located.

Selection criteria for the purposive sample included personnel in executive positions (director or chief executive) and those who held influential strategic positions within the health economy. The group of stakeholders were selected to represent an organisational perspective, but their identity, roles and the organisations they worked for have been excluded to preserve anonymity. The range of organisations represented included:

- NHS acute hospitals foundation trusts
- NHS England (area team)
- Clinical commissioning group
- GP federation leaders
- Locality local medical committee
- Regional local medical committee

The process of identifying the interview cohort group included listing the organisations within the health economy and identifying the names of the senior personnel in executive or director roles. A cohort of ten potential participants were identified, with nine agreeing to participate in a face-to-face interview. Each interview took approximately one hour in duration, and following the interview each participant was provided with an interview transcript to add any points of clarification or amendments to ensure it was an accurate account of the interview.

### 3.8.5 Interviews with federation personnel

Individual face-to-face interviews were carried out with the executive management team (n=6) around the topics of corporate strategy, business strategy, vision, values, strategic intentions, and organisational function. This was to provide authentic, vivid descriptions of the development of the federation and the continuously changing environment within which it operated. The interviews focussed on the role of strategic leadership in the implementation of corporate and business strategy, which is relevant within the context of the federation as a business venture with multiple members as stakeholders. To gain an insight into the dynamic environment and development of the federation, a series of interviews were undertaken with the executive management team at various time points during the study. Following individual face-to-face interviews at the beginning of the study, further focus group interviews were undertaken between 2014 and 2019 to explore areas including business development, the growth of the federation and the key leadership challenges encountered. This longitudinal approach provided a comprehensive account of the federation over a period to identify how it established itself as a collaborative venture.

### 3.8.6 Focus group interviews

Focus group interviews were regarded as an appropriate method of collecting data around the development of the federation to explore issues within a group setting and allow participants to interact with each other. Focus group interviews are a well-recognised method of collecting data within social research (Kitzinger, 1994, 1995; Morgan, 1997; Kreuger, 1988). Powell and Single (1996, p499) offer the following definition of a focus group:

> *"a group of individuals selected and assembled by researchers to discuss and comment on, from a personal experience, the topic that is the subject of the research".*

Unlike individual interviews, that can be wide-ranging in discussion, focus groups provide the opportunity to take a subject area and explore this in greater detail (Bryman, 2012). The use of focus groups facilitated an exploration of the range of perspectives amongst the leadership team, and with various disciplines of staff (GPs, managers, nurses) on a variety of topics. Thus, a multiplicity of views and a range of perceptions to be aired and discussed in a group setting were uncovered. The topics for discussion were identified through an iterative process. This included, for example, the findings from the questionnaire survey which informed a series of focus group discussions with the executive team.

Kitzinger (1994, 1995) identified that an important feature within a focus group interview is the interaction between participants, as this allows individuals to express their view of the world and captures the values and beliefs that people hold about a certain situation or topic. This group interaction facilitates cross-questioning between participants and provides the opportunity for individuals to re-evaluate and reconsider their understanding of specific lived experiences (Kitzinger, 1995). Focus group interviews provided an environment to allow participants to openly discuss and offer explanations to the issues presented for discussion.

The focus group interviews conducted consisted of between five and eleven participants and lasted approximately one hour in duration. MacIntosh (1993) recommends between six and 10 participants as an optimum focus group number, whilst others have used as many as 15 (Goss and Leinbach, 1996) and others as few as four (Kitzinger, 1995). The number of focus group participants depends upon the type of focus group being conducted, and the purpose of the focus group in assembling a group of targeted personnel to elicit their perspectives on a single topic (Vaughn, Schumm and Sinagub, 1996). The focus group interviews were conducted with the executive management team as a homogenous group of leaders within the organisation, and as they were identified for their strategic role in leading and developing

the organisation on behalf of the board and member practices. A series of three focus group interviews were conducted over a period of three years and provided a platform for in-depth exploration and discussion with the federation's leaders.

The first focus group was conducted in November 2014 and provided an opportunity to feedback and discuss results of one of the questionnaire surveys that was carried out (Denison Organisational Culture survey) with the board of directors and the practice managers. The purpose of the discussion was to explore the areas of strength and weakness, and to explain nuances and variations that emerged from the survey. The second focus group was conducted in June 2015 following a series of development workshops that the federation held with representatives from member practices to gain feedback on the role, purpose and remit of the federation, and also to illicit the challenges that the federation faced in relation to implementation of strategy. The session was facilitated by an external management consultant and the parable "Who Moved My Cheese" (Johnson, 1999), which is commonly used in business to describe and illustrate the need for organisations to be adaptive to respond to change, was used as a framework to structure the discussion. The parable illustrates that change is an inevitable process and, as the cheese moves, the mice trying to find the cheese become exhausted and demoralised until they realise that they need to adapt their approach to find the cheese and survive. It illustrates that you can learn to anticipate, monitor, and adapt to change. The importance of this focus group interview became evident as it occurred at a point in time that could be considered as a strategic inflection point for the federation as it considered its future role and purpose.

The third focus group conducted was in November 2017 with the executive management team and presented the interim findings from the case study. It was an opportunity to validate the study findings, identify any inaccuracies and inform any necessary revisions. As the study was conducted over a longitudinal timeframe, the executive team felt that it had been beneficial to reflect upon the various stages of development of the federation and what had been achieved. They felt that the presentation of data back to them as a leadership team was beneficial in identifying areas that could be improved, including involvement and engagement with member practices.

Three further focus groups were undertaken in Autumn of 2019. A focus group of 11 GP representatives from member practices was undertaken and, with the exception of one GP, all GPs who had been involved with the federation since its inception in 2011, and two of the participants, were members of the executive team. A focus group with the managers included the executive manager, the research facilitator and ten practice managers, of whom

eight had been in post since the federation was established, and two were new managers that had come into post within the previous four years. Two of the participants in this focus group were the managers that supported the executive team since the federation was established in 2011. A practice nurse focus group was conducted with six nurses, two of whom had come to work in a member practice within the last three years.

### 3.8.7 Workshops with GPs and practice managers

Workshops are an effective way of bringing groups of people together within a collaborative arena to discuss a variety of issues and where sharing of perspectives can occur. The notion of strategy workshops, often referred to as away days, was presented by Johnson et al (2010) where time is set aside by a group of individuals to discuss strategic issues. Such events can often be led by specialist facilitators (Frisch and Chandler, 2006) and can inform strategy and shape the strategic direction of an organisation (Jarzabkowski and Seidl, 2008). The workshop process removes individuals from their routine work environment where there is social informality and often restricted access to a group of individuals (Johnson et al, 2010). Workshops can produce 'openness' in participant engagement and also be a 'cathartic experience' (Bell, 1992, p172). It is also noted that workshops can generate emotional energy from participants. In the study, two workshops were organised in 2015 and included 30 GPs (partners and salaried) and practice managers from the member practices. The espoused purpose of the workshops was to gain feedback on the federation's current strategy and gain ideas to inform the future strategic direction, and the Executive team were keen to establish if there was a desire amongst practices for a greater level of collaboration. All GPs and managers from the member practices were invited to attend and confirmed their attendance in writing. The participants freely offered their views during the workshops, which were held in an informal evening venue and facilitated by the researcher's PhD supervisor and management consultant. Participants were also asked to provide written feedback of their reflections and views arising post-event.

Observation as a research method can be structured (researcher is non-participant) or unstructured (researcher is participant and observer) and different types of ethnographies exist (Van Maanen, 1988; Atkinson, 2014). Analysing field notes and the production of ethnographic monographs is not without controversy when considering the role of the researcher, particularly due to issues such as informed consent/deception, subject access and field notes. Within the workshop setting, the role of the researcher was observer and note taker, distanced from participation in discussion and debate, which was highlighted to the workshop participants in advance. Informed consent was applied through participant

invitation with an outline of the subject for discussion and debate. Attendance was confirmed in writing, which assisted with ensuring the workshop venues were suitable. Different styles and approaches to recording field notes is noted, and can include descriptive (e.g. physical setting, etc) and the capture of dialogue of what is spoken (Emerson et al, 2001). The field notes taken during the workshops were reviewed immediately after each workshop and analysed, with additional notes and questions based upon reflection. Field notes can portray a personal account of a particular situation and, within the study, these notes allowed the researcher to make a contribution to a post-event evaluation report. This report was written at the end of the workshops and captured both written feedback offered by participants and also commentary from the external facilitator/management consultant. The external facilitator provided objectivity to both how the workshops were conducted and had literary ownership of the content within the final evaluation report (accessed as secondary data).

### 3.8.8 Questionnaire survey tools

The use of quantitative methods within a case study allows for the validity of the case to be strengthened, and can also serve to enhance the study validity/reliability through the triangulation across multiple data sets (Stake, 1995). Rather than relying on qualitative interview data alone, the benefits of using survey tools include the ability to measure outcomes across larger populations, and to test if they agree/disagree on constructs. For example, in this study, rather than relying on interviews with the executive management team (six people), a questionnaire survey of the board of directors and senior personnel (30 people) provided a broader focus from a wider group of stakeholders. Analysing the Denison survey responses by various cohort groups provided the opportunity to review areas of agreement/disagreement between the GPs and the managers. Teddlie and Tashakkori (2009) note that whilst deduction is typically adopted within quantitative research and induction within qualitative research, pragmatism requires abduction to move back and forth between datasets. In line with an iterative approach to the study, the results of the questionnaire surveys highlighted specific issues that were further explored in follow-up interviews.

Two questionnaire survey tools were used within the study: the Denison organisational culture survey and the Authentic leadership questionnaire. Both questionnaires required each respondent to complete a standard set of questions (de Vaus, 2001) based on the two survey tools selected. Each of the tools was self-administered and were completed online by each of the respondents. As Saunders, Lewis and Thornhill (2009), and Bryman (2012) have identified, there are limitations to the use of questionnaires. The process of self-completing

questionnaires presents no opportunity for prompting or probing by the researcher and, if the respondent encounters a problem with any of the questions there, is no opportunity to verify this with the researcher. Also, as respondents had to answer questions sequentially they are not able to view questions in advance (Saunders, Lewis and Thornhill, 2009). The adoption of a mixed methods approach addressed this limitation as there were opportunities to explore issues further through the focus group interview.

With regards to respondent bias, there is a risk that self-rated questionnaires (such as the Authentic leadership questionnaire) would be responded to more favourably by the respondents as the questions were directed at their personal leadership style. With regards to the Denison survey, respondents were asked to answer the questions from a federation perspective and not that of the respondent's practice, therefore there may be a risk of contamination if respondents did not adopt this approach. The invitation email to the respondents did state that the response was required from the perspective of the federation, and the use of the word federation was also inserted into the survey questions on the online tool.

### 3.8.9 Denison organisational culture survey

A literature review conducted by Jung et al (2009) identified 70 different culture instruments, of which 48 were psychometrically reviewed. Only two survey instruments that measured culture against areas of organisational performance were identified. One of the instruments, the Denison organisational culture survey (www.denisonconsulting.com/model-surveys/denison-surveys/organisational-culture) was a tool that the academic supervision team had experience of using within healthcare and the public sector in England, and was considered to be appropriate to be applied within the context of this study. The Denison organisational culture survey is an internationally validated tool used to map cultural aspects of an organisation to defined areas of organisational performance (Denison,1990; Denison and Mishra, 1995; Denison and Neale, 1996; Gillespie et al, 2008). It is an on-line tool developed by the Denison Group and has been in used internationally for over 20 years. Organisations can benchmark their ratings against a global database of over 1,000 companies worldwide, and develop action plans to improve their current practices and organisational effectiveness. The survey is designed to assess an organisation's strengths and weaknesses as they apply to organisational performance. Jung et al (2009) stated that successful organisations have an organisational culture that is based upon shared beliefs and supported by effective strategy and structure. The Denison survey tool used formatively would explore areas of the federation's culture and identify strengths and weaknesses, and highlight areas that would be beneficial to focus on from a business perspective. The survey

has 60 items that measure specific aspects of an organisation's culture across four traits and twelve management practices, as illustrated below:

| | |
|---|---|
| **Mission**<br>Strategic direction and intent<br>Goals and objectives<br>Vision | Do we know where we are going? |
| **Adaptability**<br>Creating change<br>Customer focus<br>Organisational learning | Are we able to change and adapt in response to the needs of our customers and the marketplace? |
| **Involvement**<br>Capability development<br>Team orientation<br>Empowerment | Are our people aligned, engaged and capable? |
| **Consistency**<br>Co-ordination and integration<br>Agreement<br>Core values | Do we have the values, systems and processes in place to execute and deliver on our mission? |

Table 2 –Denison organisational culture survey domains

The survey tool is made up of 60 questions across four broad traits (mission, adaptability, involvement, consistency) and 12 indexes (sub categories of the traits), and is used to map scores to features of organisational culture. The response to each index is ranked as a percentile score and these percentile scores are moderated against the Denison global normative database of over 1,000 organisations**.** In the example illustrated below, the organisation scored at the 53$^{rd}$ percentile in team orientation. This means they scored higher than 53% of the organisations in the Denison global database.

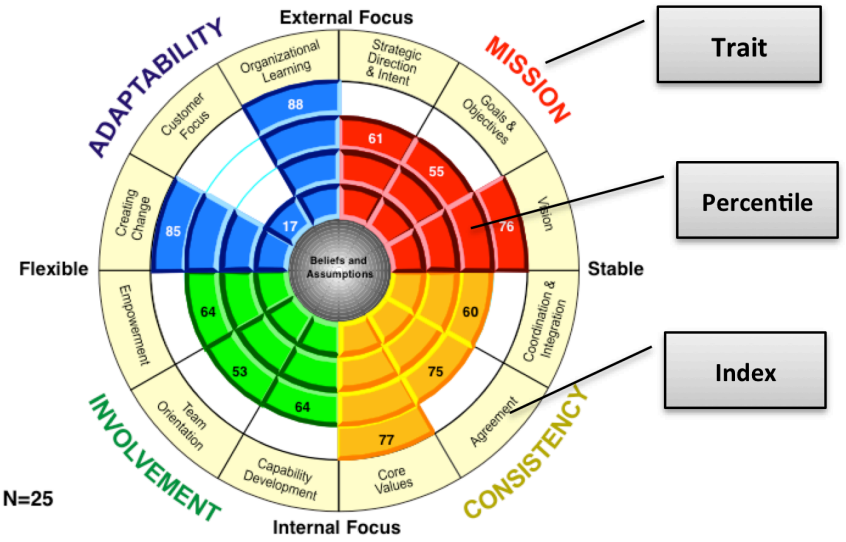



Figure 1 – Example of a circumplex report

This survey tool provided a framework to investigate the views and perceptions of the board of directors and senior managers of the federation, who were asked to identify strengths and weaknesses of the federation against a range of business domains. The survey also identified differing perspectives across functional groups (i.e. GPs and managers), and therefore respondents were asked to complete the questionnaire from the perspective of their role within the federation. The questionnaire survey is an on-line questionnaire, which was accessed by participants through a web link established specifically for the cohort. The survey sample was a purposive sample of the federation's board of directors and practice managers (n=30). This cohort was identified on the basis that they were the senior personnel within the federation. The directors of the organisation were selected to complete this aspect of data collection because they have legal and fiscal responsibility for the organisation as a limited company. Respondents were invited to complete the survey on a voluntary basis through a web link which was emailed individually to the sample group. Although participation was voluntary, it was endorsed by the executive management team, as a high response rate would provide a valid and baseline assessment of the federation's strategic alignment against the traits included in this survey. The sample included the board of directors and practice managers (representative of each the 14 member practices), two lead GPs (education and R&D), and one research facilitator. In summary, the cohort included the following staff breakdown:

- 16 general practitioners
- 14 managers

Of the 30 questionnaires issued, there were 25 completed responses resulting in an overall response rate of 83% (75% of GP questionnaires were completed and 93% of manager surveys were completed). Two responses were only partially completed and therefore excluded from the analysis and results.

| | GP directors | Managers |
|---|---|---|
| Number of questionnaires issued | 16 | 14 |
| Number of incomplete questionnaires | 1 | 1 |
| Number of completed questionnaires | 12 | 13 |
| Completed response rate | 75% | 93% |

Table 3 – Denison survey response rates by cohort

Participants were asked to complete the on-line organisational survey within a period of two weeks. Two reminders were sent to the entire sample group to encourage completion of the questionnaire after the two-week response deadline and a week later. The reason why less

GPs completed the questionnaire was not known, as this could be due to time pressures or a lack of interest. Limitations of the survey were also considered, and it was recognised that as the survey was completed individually there was a lack of opportunity to state the interpretation or motivation in providing responses, with answers open to interpretation by respondents. In some instances focus group interviews were used to explore answers further (e.g. customer focus, section 7.2.2) but not in all areas. The non-responders were not identifiable, as completion was anonymous and not attributed individually. This also means that it was not known which practices did not respond, and therefore it was not known if it was the smaller or larger practices that refrained from participation. The findings from the survey report were used to assess the strategic alignment and development of the federation at a specific point in time, that being two years after it was established. This provided an overview of organisational factors within the context of the federation and provided an insight into leadership challenges and development opportunities for the federation. Specific issues reported in the survey were also used to inform subsequent interview discussion, e.g. customer focus was explored during the interviews with the executive team.

### 3.8.10 Authentic leadership questionnaire (ALQ)

Kouzes and Posner (2011) recognised that stakeholders have certain expectations from leaders which include integrity as a core leadership quality, Similarly, Walumbwa et al (2008) believe that leaders can be authentic and demonstrate integrity when they have an awareness of their true values and beliefs. In understanding their true values and beliefs, leaders display behaviours and actions that are consistent with them (Walumbwa et al 2008). The Authentic leadership questionnaire (ALQ), designed by Avolio et al (2007), is a multidimensional theory-based questionnaire designed around theoretical dimensions that define authentic leadership. This tool was selected as a facet of the study to understand the motivations and drivers behind the establishment of the federation and the leadership challenges that were encountered. On the basis that the executive management team were appointed to lead and develop the organisation on behalf of the member practices, authenticity, integrity and acting in a manner that was consistent with values and beliefs were regarded as an appropriate lens of exploration. The four theoretical dimensions of the survey explored:

- Self-awareness – to what degree is the leader aware of his/her strengths, limitations, how others see him/her and how the leader impacts on others?

- Transparency – to what degree does the leader reinforce a level of openness with others that provides them with an opportunity to be forthcoming with their ideas, challenges and opinions?
- Ethical/Moral – to what degree does the leader set a high standard for moral and ethical conduct?
- Balanced processing – to what degree does the leader solicit sufficient opinions and viewpoints prior to making important decisions?

The purposive sample for this aspect of data collection was the executive management team comprised of three GPs and three managers (n=6). A total of six responses were received, representing a 100% response rate. The purpose of the group report was to assess authentic leadership characteristics within the team. One of the limitations of the questionnaire survey is that participants may respond based upon how they perceive themselves or how they wished to be perceived. The individual survey reports generated were shared with the participants to support continuous personal development, but for the purpose of this study only the consolidated group report was used.

### 3.8.11 Summary of data collected

In line with the design of a mixed methods case study, the following summarises the data collected:

| Data Collected | Participant Grouping | Date | Number of participants | Sample Group |
|---|---|---|---|---|
| Face-to-face interviews | A cohort of senior personnel within the health economy (external to the federation) | November 2013 – May 2014 | 9 | 10 |
| Denison organisational culture survey | Federation's board of directors and practice managers | December 2013 | 25 | 30 |
| Authentic leadership questionnaire | Federation's executive management team | May 2014 | 6 | 6 |
| Face-to-face interview | Federation's executive management team | November 2014 | 6 | 6 |
| Focus Group Interview | Federation's executive management team | November 2014 | 6 | 6 |

| | | | | |
|---|---|---|---|---|
| Workshops | GPs & practice managers | May/June 2015 | 30 | 68 |
| Focus group interview | Federation's executive management team | June 2015 | 6 | 6 |
| Focus group interview | Federation's executive management team | November 2017 | 5 | 6 |
| Focus group interview | Practice managers | September 2019 | 10 | 14 |
| Focus group interview | GPs | September 2019 | 11 | 14 |
| Face-to-face interview | Lead nurse (education & audit) | October 2019 | 1 | 1 |
| Face-to-face interview | Executive manager | November 2019 | 1 | 1 |
| Focus group interview | Practice nurses | December 2019 | 6 | 33 |

Table 4 – Data collected

A total of 17 face-to-face interviews were conducted, six focus groups were conducted with a range of disciplines of staff with a total of 44 participants, two workshops with 30 participants were conducted; the Authentic leadership questionnaire was completed by six executive team members, and 25 GPs and managers completed the Denison survey questionnaire.

### 3.9 Organisational data

Secondary data can relate to the re-examination of data collected for another purpose or data gathered from secondary sources which may be published or unpublished (Smith & Smith, 2008). Such data can be numerical (e.g. surveys, census data, etc) or non-numerical (e.g. documents, photographs, etc). Hox and Boeije (2005) note that there are three aspects to consider in relation to secondary data: data sources, retrieval of data and quality of data. To address the research question, a range of secondary data sources were accessed between March 2011 – October 2019 (Table 5). Documents were selected to provide insight into the activities and business operations of the venture and to provide a timeline of key events and developments aligning with the longitudinal aspect of the study design. These documents were accessed through a data sharing agreement between the organisation and the researcher. It was recognised that whilst some documents are publicly available, some company documents (e.g. accounts, internal business proposals) were confidential and were treated as commercial in confidence.

| Documents accessed | Number of documents | Contribution |
|---|---|---|

| | | |
|---|---|---|
| Articles of association | 2 | Understanding around corporate structure and governance review undertaken |
| Members' agreement | 2 | Background to governance arrangements/expectations of member practices and the federation |
| Business plan 2011-2013 | 1 | Identification of areas of strategic focus |
| Executive team meeting minutes (2011-2019) | 68 | Chronological record of decision making and monitoring corporate events/opportunities over a period |
| Annual members' meeting summary reports | 3 | Summary of progress, financial position and future areas of focus |
| Research and audit group meeting minutes | 12 | Evidence of active audit and research activities |
| Time out event programmes | 5 | Evidence of member practice education activities |
| Funding/project applications | 15 | Evidence of federation's activity to secure external funding sources |
| Member development meetings – feedback & evaluation paper | 1 | Evidence of perspectives of federating across wider group of GPs and practice managers from member practices |

Table 5 – Summary of corporate documents reviewed

Although these data sources had a purpose in developing a chronological summary of activities and events, the limitations of such data have been considered. When considering the use of secondary data it is helpful to ascertain what biases may be present. Meetings can vary in formality and minutes are abbreviated or summarised accounts of discussions. They are also compiled by individuals who may possess varying levels of skill in note taking and portray a sanitised account of discussions which can be open to interpretation. Annual reports may also present a bias toward portraying a positive account of events in order to appease stakeholders and investors. Clarification of issues from these documents were validated through member checking with members of the relevant teams.

### 3.10 Analysis of data

Data analysis is the process applied to manage raw data and identify and extract themes that emerge from the data (Bryman, 2012). Creswell and Plano Clark (2011) defined mixed methods research as *"collecting, analysing, and integrating quantitative data and qualitative data within a single study or multiple phases of a program of research"*. One of the main challenges of a mixed methods study is the integration of data and findings from the separate data sets into a cohesive framework of analysis (Plano Clark et al, 2015), as noted below:

> *"The integration of quantitative and qualitative data may take many forms including connecting results from one data set to the collection of data from another;*

*juxtaposing quantitative and qualitative results for comparison; transforming one form of data to facilitate the other form of analysis; or forming interpretations from two sets of results." (Cresswell & Plano Clark, 2011, 299)*

The complexity and challenges of integrating datasets within longitudinal mixed methods studies has been the subject of debate (Plano Clark, 2010; Van Ness et al, 2011; Plano Clark et al, 2015). Van Ness et al (2011) identified three models of longitudinal mixed methods studies in clinical biomedical research: prospective, retrospective, and fully longitudinal where qualitative and quantitative methods were used in specific sequence. In a systematic methodological review conducted by Plano Clark et al (2015), further variations to these models were identified and aligned with the specific design or characteristics of each study reviewed. Within case study, Yin (2012) promoted the organisation of primary data within a descriptive analytical framework to allow for analysis across datasets, whilst Creswell (2009) identified a sequential transformative strategy, which is often characterised by sequential phases of data collection. Yin (2012) also suggested that developing a case description is an analytic strategy appropriate for case study to assist where large volumes of data have been collected, and to provide a framework so causal links or overlapping themes can be identified.

Within longitudinal mixed methods study, timing and integration are two dimensions of relevance. Whilst timing considers when both quantitative and qualitative methods are used relative to each other, integration considers the point where the two methods interact (Morse, 2009; Plano Clark et al, 2015). In this study, each of the data sets were initially analysed separately and integration occurred at the point of analysis and interpretation. Aligned with pragmatism, the process of abduction allowed the researcher to move flexibly between quantitative and qualitative datasets to draw multiple realities from the data gathered. All qualitative data sets were analysed by the researcher, whilst the questionnaire surveys used were analysed by the companies supplying the survey tools as part of the agreement for use, with results interpreted by the researcher to seek meaning within the context of the study. Thematic analysis was applied by collating the findings from each data set and the following processes applied:

- Connecting results from one data set to another: the AQL profile of the executive team was reviewed alongside data from interviews.
- Juxtaposing quantitative and qualitative results for comparison: the results of the Denison survey and focus group interview with the executive team were compared.

- Transforming one form of data to facilitate the other form of analysis: results from the Denison survey informed the topic of discussion for subsequent focus group interview.
- Forming interpretations from two sets of results: data from interviews with the external cohort of interviewees, when compared to interviews with the executive team highlighted, differing perceptions around scale and ambition for federated models of general practice.

A "bookend" approach to data collection (Plano Clark et al, 2015), whereby qualitative data is collected at the beginning and end of a study, was applied through interviews with the executive team at the beginning of the study providing a prospective perspective of the intentions for the business venture, and through focus group interview at the end of the study providing a retrospective reflection on the experiences and lessons learned. The Denison survey results were embedded within the case description to illustrate the contextual environment that the venture was established within, and the areas of business strategy that required development.

To assist with the organisation of large volumes of qualitative data and text, the use of computer-aided tools is common practice (Bryman, 2012). For this study, NVivo10 was used to assist with the organisation of data from interview cohorts and the coding of data. It supported the identification of themes from individual data sets and provided a framework to identify similar or contrasting perspectives across multiple data sets.

### 3.10.1 Analysis of qualitative data

This section presents the approach that was taken to the analysis of the qualitative data sets, as various approaches and techniques can be applied, with Neuman (2007, p335) identifying that qualitative data analysis as:

> *"[the] search for patterns in data… once a pattern is identified, it is interpreted in terms of a social theory or the setting in which it occurred. The qualitative researcher then moves from the description of a historical event or social setting to a more general interpretation of its meaning".*

Brymen (2001) identified thematic analysis as a method of analysing qualitative data, and an iterative approach towards final data analysis is facilitated where the researcher moves "*from vague ideas and concrete details in the data towards a comprehensive analysis" (*Neuman, 2007, p335). Thematic analysis was applied to each of the interview data sets

and, through an inductive approach, themes and assumptions were derived from the data without fitting data into a pre-existing frame of analysis.

The study collated multiple sets of qualitative data, and Creswell (2009) stressed the importance of adopting a systematic approach to the analysis of qualitative data to provide validity and accuracy. In line with Creswell's (2009) approach, the following steps were applied across all interviews undertaken:

1. Collating raw data: each interview followed pre-determined lines of enquiry. Each interview was audio recorded to allow for an accurate account of the interview to be gathered and retained in line with study protocol and principles of good research governance.
2. Organising and preparing the data for analysis: each interview was listened to prior to transcription. A full transcription of the interview was undertaken by the researcher, and each interview stored as a separate Word document. Each Word document was subsequently uploaded to computer-aided software (NVivo10) for ease of organising copious amounts of data.
3. Reading through the data: each interview transcript was read several times to ensure the researcher had a thorough understanding of the responses and to familiarise with the content. Reference was also made to research notes that were taken immediately after the interview, which Neuman (2007) identified as analytic memo writing.
4. Coding the data: each interview transcript was reviewed, and each sentence or paragraph coded into a set of emerging themes, with the assistance of computer-aided software and new themes added as they were identified.
5. Summarising themes or descriptions: the software provided a summary of the list of themes (NVivo nodes) that were identified, and a summary list of the most common themes allowing for the most common or recurring themes to be identified.
6. Identification of interrelating themes or descriptions: for each theme that was identified, an individual report was generated from the computer-aided software. This report was used to compile a summary of the key findings from each data set.

Neuman (2007) identified three stages to the coding of qualitative data: open coding, axial coding, and selective coding. Open coding focuses on the raw data, and a first review of the data was undertaken with the purpose of bringing *"themes to the surface from deep inside the data"* (Neuman, 2007, p330). This basic level of coding related to the interview question that was posed, and focused the researcher on the actual data. Axial coding shifts from the

open coding of the raw data to focus on the emerging themes. A second review of the data was undertaken to organise it into a set of codes or themes. This second data review was a filtering process and allowed for new ideas or additional themes to be identified. The process facilitated the researcher to explore and question causes and interactions within the data to assist with processing it into categories or concepts, and allowed for connections between emerging concepts to be captured. This process also strengthened the validity of the analysis by identifying multiple instances of themes that were linked to the data (Neuman, 2007). Selective coding was then applied after a third review of the transcript data, scanning for previously identified codes and themes. The process was undertaken after the key themes or concepts were identified and the analysis commenced around the core ideas and generalisations that emerged from the data (Neuman, 2007). An example of a theme from the interviews undertaken with the federation's executive team illustrates the 'Challenges for general practices' and the sub-themes (factors) that contributed to these challenges:

| Theme | Sub-theme | Researcher Notes |
|---|---|---|
| **1. Challenges for general practices** | 1.1 External political influences | *The NHS is subject to constant change depending upon political influence and changing health policy. General practice has to constantly adapt to change.* |
| | 1.2 External threats | *Health and Social Care Act (2012) set to introduce competition through market principles and threaten viability of existing GP practices.* |
| | 1.3 GP contracts (block) | *The GP contract is essentially a block contract, payment (per capita) based on number of patients registered with a practice irrespective of the number of times a patient consults with their practice. This is different to other organisations operating on a tariff-based payment regimes.* |
| | 1.4 Diminishing GP income | *In a partnership model, GP partners share profits once expenses and liabilities are paid. The core contract remains the same but as expenses rise, the partner share (income) is reduced.* |
| | 1.5 Small business model | *GP practices operate as independent businesses and practices with smaller registered list sizes are finding it difficult to maintain the practice as a viable business.* |
| | 1.6 Workforce | *Several compounding factors: reduction in number of GPs who wish to become partners and commit to the practice as a business; increase in salaried GPs who wish for more appropriate work/life balance; increasing number of female GPs seeking part-time hours.* |

Table 6 – Example a theme and sub-themes from executive team interviews

The outputs from the focus group discussions were analysed in the same thematic way, with each focus group interview recorded and transcribed verbatim. The approach to transcription included listening to the recorded interview to gain an overview of the interview content. A process of listening and typing the transcript into a Word document provided a rich understanding of the interview content, and highlighted the interaction that took place between the group participants. The transcript was then reviewed against the recording to correct any errors in the transcription process. The transcript outputs were not attributed to any individual, practice or professional group to maintain confidentiality of the participants. Participants were sent a copy of the focus group transcript and offered the opportunity to comment on the contents to ensure it was an accurate reflection of the discussion.

### 3.10.2 Analysis of quantitative data

As part of the agreement to utilise the questionnaire surveys within this study, the respective companies own the databases that the questionnaire results are reviewed and benchmarked against. The raw data was therefore analysed externally, and summary results presented back to the researcher. The Denison organisational culture survey is a commercial survey tool which is made available to academic researchers at no charge, and part of the agreement for use of the tool is that data collected are sent to Denison for analysis against their global database of organisations that have used the tool. The raw data was sent to Denison in an agreed spreadsheet format, analysed using a normative scoring system and compared to a global database of over a thousand organisations (from multiple industries, regions and sectors) that had completed the survey. The data were presented back to the researcher in a graphical profile that conveyed the results in the form of percentile scores which act as a benchmark of the organisation's results when compared to the complete database of international data. This method enables the organisation to benchmark its scores against other higher and lower-performing organisations worldwide, providing a measure of the organisation's progress toward achieving a high-performance culture and optimum performance.

The results of the survey were analysed and are presented in detail in section 7.2. The key themes that emerged from the survey were included within the analytical framework that was used to facilitate cross data set analysis and review. The following illustration presents the overall circumplex report from the survey, and highlights 'Customer focus' as an area of weakness:

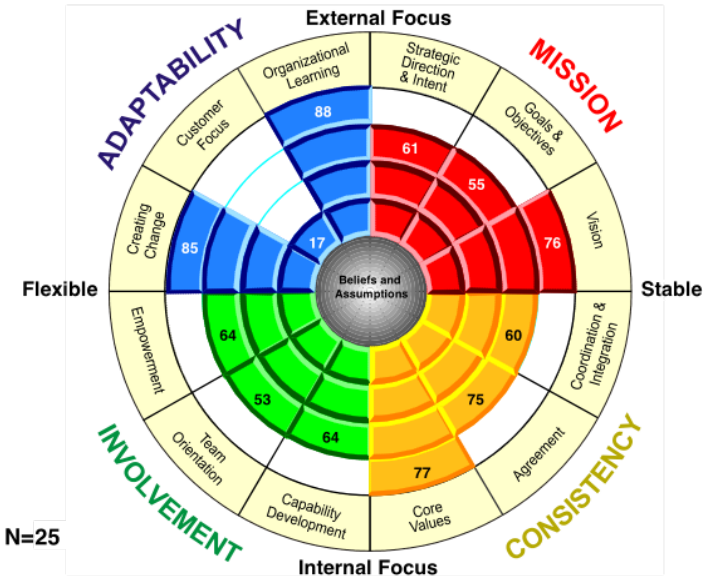



Figure 2 – Federation's circumplex results

As an example of connecting one data source to another, the results from the Denison survey were used to inform the topic of exploration through focus group interview, as illustrated below where four differing conceptualisations of the customer were identified through group discussion:

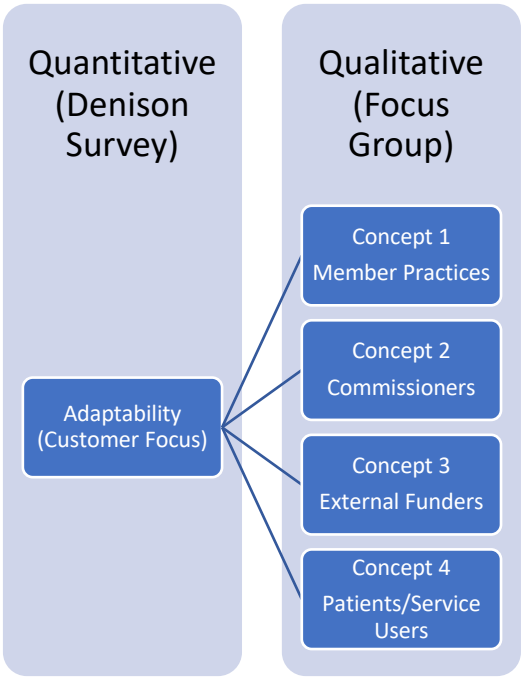



Figure 3 – Example of quantitative survey data informing qualitative data collection

The Authentic leadership questionnaire was completed online by members of the federation's executive management team, and individual reports were generated and shared

with respondents for the purposes of personal development. To provide a group profile, the individual responses were created into a group report which was used to provide a profile of the executive team. The analysis of the individual questionnaires and compilation of the group report were generated through the online survey system. The process for reviewing the group report involved the following stages:

| | |
|---|---|
| **Stage 1** | Reviewing the group report findings: the report was reviewed to see how the group reported themselves against the four AQL categories. This involved identifying any trends, gaps or areas for further exploration. |
| **Stage 2** | Analysing the group report findings: this involved an interpretive review of the group report based upon:<br>• The group's authentic leadership profile.<br>• Group agreement (standard deviation).<br>• Authentic leadership scales and normative comparison against sample groups.<br>• The group's authentic leadership strengths and developmental opportunities. |
| **Stage 3** | Summarising the report findings and sharing results within the focus group interview. |

Table 7 – Stages of review of ALQ data

### 3.10.3 Analysis of organisational data

Analysis of primary data in the form of corporate documents and internal documents (listed in section 3.10) was undertaken using content analysis, which is a method of reducing large volumes of data to gain an understanding of situations (Weber, 1990). This is a form of emergent coding where themes (or events) are identified following an initial review of the data (Weber, 1991). Rather than the traditional word count analysis that is often applied in content analysis, a more detailed review of individual documentation was undertaken to identify key milestones, strategic decisions, and organisational developments between 2011-2019. These were summarised into a chronological timeline of noteworthy events and decisions to provide an overview of key developments and milestones within the study. Chronology is an analytic strategy which is a form of time-series analysis that can support specific events to be identified and tracked over time (Yin, 2012). This approach to organisational data charts key events in relation to business development, and identified examples of how business strategy was being implemented, as illustrated below:

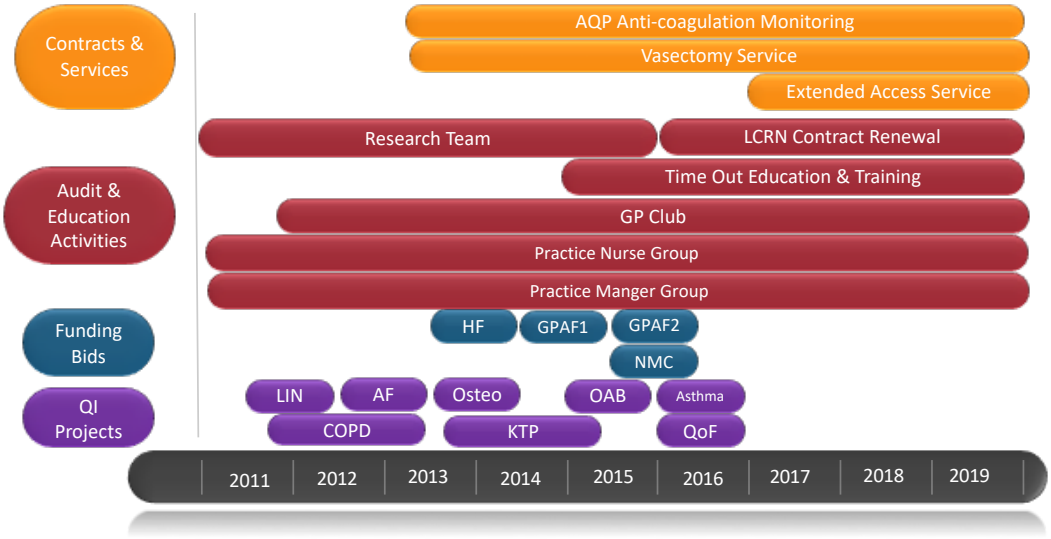



Figure 4 – Activity timeline compiled from organisational data

This timeline indicates when the vasectomy, anti-coagulation and extended access service developments were implemented, captures the range of audit and education activities and when they were established, highlights the external funding bids that were made during the period of the study and details the quality improvement projects undertaken.

### 3.10.4 Thematic analysis across multiple data sets

A large volume of data was collated across multiple data sets and, in addition to the analysis of each data set individually, there was a requirement to bring all the findings together to present a comprehensive and cohesive case description of the study. Thematic analysis was considered an appropriate approach to support this process (Bridgelal et al, 2008), and involves a sequence of staging the analysis of data in an organised and pragmatic manner (Ritchie and Spencer, 1994, Ritchie et al, 2003). A process of separate but inter-related steps was followed:

1. The first stage involved familiarisation with the data in the form of the key findings from each of the datasets.
2. The second stage involved identifying key or recurrent themes across the individual datasets which assisted in developing the theoretical framework.
3. The third stage involved indexing the data to define the key findings.
4. The final stage involved summarising the findings and synthesising and interpreting them in relation to the study. These findings were used to define the section headings within the narrative of the case study.

Mind mapping (Buzan and Buzan, 1996) is a process that can support multiple themes and ideas to be captured, expanded and linked. Thus, to support the approach of thematic analysis across the multiple datasets, mind mapping was used to capture the themes that emerged. Figure 5 illustrates how a key theme (health policy) from the external interview sample group was expanded to capture the content and themes from interview transcripts, illustrating the breadth of discussion.

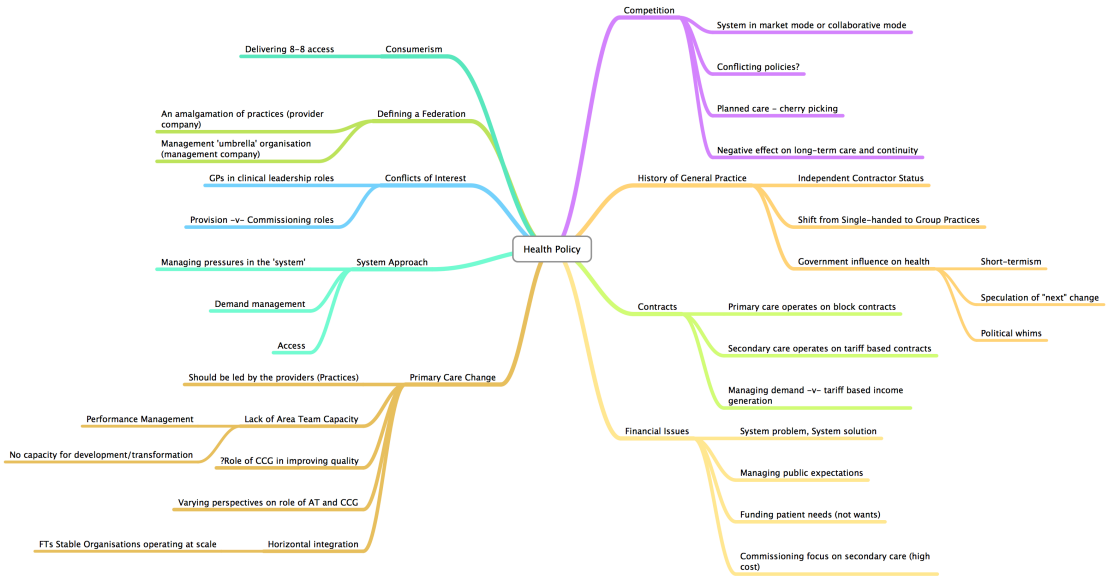



Figure 5 – Mind mapping applied to interview theme

This process allowed the researcher to illicit each of the themes from the data set, and to organise them in a thematic framework which supported cross data set analysis. The process allowed for comments to be made to capture thoughts and provide meaning to the findings of the study.

## 3.11 Ethical considerations

Research ethics are central to the design of any research study, and this study was conducted within the ethical regulations and standards set by the University of Northumbria. The study did not deviate from the original ethics application that was presented to the University Research Ethics Committee, and approved on 29 August 2013 (Appendix 1). This section explores the ethical considerations that were taken into account within the study and how particular issues were addressed.

### 3.11.1 Preserving anonymity and confidentiality

The advantages of undertaking a case study of an organisation is that it provides richness, depth and a detailed insight to the subject area. Due to the nature of this study as an

exploration of *"a contemporary phenomenon in a real-life context"* (Yin, 2012, p73), there was a requirement for care and sensitivity to be applied by the researcher, and central to any study is the requirement to protect human subjects (Yin, 2012). Within the methodological literature it is noted that there is a balance between the rich description and detail of the case that enhances the utility of the findings and the requirement to maintain anonymity (Yin, 2012; Stake, 2005). This, as both Yin (2012) and Stake (2005) note, means that maintaining confidentiality within case study can be challenging. Within the individual face-to-face interviews, candidates were open and candid in their conversations and, in some instances, it would have been inappropriate to include direct quotes which could be attributed back to an identifiable individual. The subject access that was granted to the researcher contained access to both confidential and commercially-sensitive data. In the presentation of the findings, care was taken not to breach confidentiality. For example, no detail was provided in relation to the remuneration of individuals or practices.

Yin (2012) identified specific ethical considerations for conducting case study research which were accounted for and applied within this study. Participants were issued in advance with an overview of the study to provide background information, and to inform their choice around participation. To maintain the privacy and confidentiality of the organisation and the participants, the name of the federation was not used, direct quotations or vignettes were not attributed to named individuals and, where it was deemed appropriate, participants were referenced to via the role of the individual (e.g. GP, Manager). In presenting quotations, these were not attributed to individuals (e.g. GP1, GP2, etc) to preserve the anonymity of the individual participants. Within the study, it was also identified that there were contrasting perspectives between the external interview cohort and personnel internal to the federation, and these contrasting perspectives were included in the writing of the thesis but not shared with the individual interview candidates/interview groups. The study also captured data that was considered sensitive and not included in the study findings, as it could have breached the confidentiality of the unit of study and participants.

There is a specific challenge in maintaining confidentiality and anonymity of the study subject, in this case the federation. Whilst the case can provide a rich detailed insight, this level of detail may allow the subject to be identified and, by association, it may be evident who the participants were. Similarly, by association as an insider researcher, the study subject may be identifiable. To address these issues, specific attention was applied to ensure that quotations were attributed to the roles of participants and within the sampling strategy categories of external participants were linked to roles and not specific organisations.

### 3.11.2 Informed consent

Informed consent was obtained from participants in advance of interviews (both face-to-face and focus group), and participation in the study was on a voluntary basis, which was made clear to participants in advance and prior to consent being obtained. Two consent forms were signed, one retained by the researcher and one by the participant. Candidates who agreed to be interviewed were consented in advance with a full overview of the study presented and discussed with them. A similar approach was adopted for the focus group interviews, where a consent form was presented to the group in advance, with an overview of the proposed process and topic of discussion. All consent forms were retained within the study protocol file.

To preserve the anonymity of participants, a master list of interviews undertaken was retained by the researcher and each interviewee was provided with a unique identifier number, which was subsequently used to name each transcript. The only way of identifying the interviewees was cross-referencing back to the original list, which was maintained confidentially, thus preserving the anonymity of the individual participants. Each focus group interview was named using the same principles of allocating a unique identifier, and focus group participants were identified by their role (e.g. GP or Manager) within the transcript to preserve their anonymity. To support accuracy checking, all interview transcripts were sent to the interviewees to ensure that they were are an accurate account of the discussion, and any amendments or points of clarification offered were noted and an updated file saved. Thus, this ensured that there was an appropriate audit trail of the interview documentation retained.

### 3.11.3 Management and storage of data

Digital recording was used for capturing interview data, and all digital audio files were saved onto a secure server provided for students by the university. The original digital audio files were deleted from the audio machine after the file was uploaded, and copies of the interview transcripts (retained in Word format) were filed. These included both the individual interviews and the focus group interviews. Documentary data (in the form of word and excel files) were stored on a folder on the shared drive, and all computer folders and files were password protected.

The cohorts of personnel identified to complete the online questionnaire surveys were invited to complete the survey tools electronically. Emails were issued on an individual basis

with an electronic link to the survey tools, and the covering emails issued with the questionnaire tools advised that participation and completion of the tool was completely voluntary. When following up questionnaire completion, the researcher was unaware of who had completed the surveys because this was non-identifiable to any individual. Therefore follow-up reminders were sent to all members of the group.

### 3.11.4 The position of an insider researcher

There are ethical considerations that need to be taken into account for researchers who are members of the group being studied and considered as 'insider researchers' (Adler and Adler, 1994; Costley et al, 2010). Bonner and Tolhurst (2002) note that the position of insider researcher can provide advantages, such as having a greater understanding of the subject being studied, supporting the natural flow of social interaction, and having an intimacy that promotes judging and telling of the truth. However, disadvantages can include loss of objectivity through familiarity with the study subject (Bonner and Tolhurst, 2002), and bias through unconsciously making wrong assumptions (Smyth and Holian, 2008). Specific considerations for this study include access to the study subject, pre-understanding of the phenomena, role duality, and boundaries of confidentiality. The use of a research diary can apply as a research technique in collecting data (Symon and Cassell, 2012; Alaszewski, 2006) and as a reflexive tool for researchers (Barrett et al, 2020; Nadin and Cassell, 2006). Within this longitudinal study, a research diary allowed for notes to be taken at specific points in time to capture detail around significant events in the development of the venture. It also helped to reflect upon interviews and capture observations and discuss this with the supervision team.

Access to study the federation was supported by the executive team and board of directors. This included designing the study to include key personnel within the federation and access to internal documentation. As the researcher was known to the federation's member practices, participants may have felt compelled to participate and, to mitigate against any coercion, voluntary participation was made clear to participants in all sample groups in advance and informed consent was applied. Within the study, a 100% response rate was not achieved in face-to-face or focus group interviews or completion of questionnaires, thus demonstrating that people were not coerced into participating. Case study as a research strategy supported multiple perspectives to be captured and presented during the course of the study.

The researcher, when employed with the federation between 2011-2016, had a pre-understanding of primary health care and specifically general practice, having worked in the NHS over several decades. The researcher had been employed in a senior role within the health economy and had a knowledge of the contextual environment and commissioning reform as a result of the Health and Social Care Act (2012). It was important for the design of the interview schedules to pose questions to allow participants to portray their views without any researcher bias. Discussion with the supervision team provided a sense-check of the objectivity applied within this process. This pre-understanding of the health economy assisted in identifying the purposive sample of senior executives to be included within the external interview cohort, and through voluntary participation not all of the sample group participated in interview.

Role duality (Gerrish, 1997) was also a factor for consideration as researcher who had worked as a contractor providing management support to the federation on a part-time basis between 2011-2016. Providing management support to the executive team inevitably assisted with the development of the federation by pursuing activities on an employed basis and provided a unique level of access to the study subject. Awareness of balancing duality of roles was an issue to consider within the design of the study. It was important to distinguishing between the role of manager/researcher, for example when focus groups were organised their purpose was clearly stated that they were for research purposes. However, the management position held by the researcher also provided ad-hoc opportunities for sense-checking with members of the federation at various points during the study, for example validation questions could be asked of individuals after meetings without having to set up formal meetings. Access to the federation's executive team and monthly meetings with the supervision team provided fora for discussing findings and the analysis of data to ensure that objectivity was considered and any potential bias was recognised. To minimise potential bias in discussing the results of the Denison survey with the executive team, this focus group was conducted by an external facilitator.

In relation to boundaries of confidentiality, consideration was given to the sensitivity and confidential nature of the data collected through the interviews and information accessed within internal documents. In some instances, it was not deemed appropriate to present data that could breach the anonymity of the organisation or individuals. In relation to the dissemination of findings, care was applied to preserve anonymity. The federation or individual participants were not named, and quotations used were attributed to the function of respondents (e.g. GP or manager) and not to individuals. Whilst this may be perceived as

a weakness within the study, ethically it was deemed the most appropriate way preserve anonymity.

### 3.12 Validity

Validity in the context of qualitative research is the process of checking the accuracy of the findings. Within qualitative case study research, it is important to gain multiple perspectives that need to be represented within the study (Yin, 2012). Stake (2005) highlights the importance of validation, which is achieved through the accuracy of measuring data and the logic applied in interpretation. Therefore, the process of data analysis is a key factor to provide an accurate depiction of the case. Guba (1981), Lincoln and Guba (1985), Guba and Lincoln (1994), and Creswell (2009) stress the importance of quality criteria within qualitative research to demonstrate trustworthiness and authenticity, and measures were taken to comply with good research practice and framework analysis provided a structure for data analysis. Educative and ontological authenticity within qualitative research requires the researcher to represent various viewpoints in a written format that gives the reader a greater understanding of the study. This was achieved within the study by including various interview cohort groups and using direct quotations to illustrate the different world views that were portrayed.

The process of methodological triangulation increases the confidence in interpretation within case study (Stake, 2005). In this case study, methodological triangulation was achieved through a mixed methods approach and multiple methods of data collection, including interview (individual and group), questionnaire survey and internal document review. In line with mixed methods, findings from each of the data sources was reviewed as a single dataset and was subjected to a process of holistic examination across datasets through framework analysis, thus allowing for data checking and validation of findings across multiple datasets. As often seen within studies with pragmatism as the underpinning philosophy, the ability to move freely between datasets supported the process of abduction.

To enhance validity, several strategies for member checking were applied within the case study. Interviewees were provided with transcripts of their interviews and asked to check for accuracy and correct representation. A formal log was maintained to ensure that all comments received were amended and catalogued as appropriate. The findings from interviews, the Denison report, and the organisational data timeline were summarised and verified through discussions with the executive management team. The focus group findings were member checked and a transcript from each of the focus groups was shared with

participants, inviting accuracy checking to ensure that the report reflected an accurate summary of the debate.

As an insider researcher there was an awareness of the potential bias in the interpretation of findings, which may have been influenced by the researcher's position within the organisation. Therefore member checking was an important inclusion to negate any potential bias. Pragmatists argue that, at times, research will be objective by not interacting with subjects, whilst at other times it is subjective by interacting with subjects to construct realities (Teddlie and Tashakkori, 2009). This flexibility results in multiple realities being derived from both qualitative and quantitative data (Creswell and Plano Clark, 2011). Morgan (2007) professes that intersubjectivity exists by working with objective quantitative data methods and subjective qualitative data methods, and through a process of communication shared meaning is created, which is consistent with the notion of paradigms as shared beliefs. Morgan (2007) suggests that with a pragmatic approach researchers can proclaim that there is a single reality, but individuals will have their own interpretation of that reality.

To enhance the authenticity of the study, respondent validation was incorporated, and this took place in the form of a focus group in November 2017 with the federation's executive management team to present, discuss and validate the interim findings from the study. The focus group presented the key findings from the study and member discussion provided feedback that the findings were accurately portrayed, and a credible account of the federation had been achieved. At the point of writing up the findings from the various phases of data collection, the accuracy of findings was tested with key members of the executive management team, which validated that the findings were presented as a true and accurate depiction of the case.

### 3.13 Summary

Pragmatism is the ontological assumption that underpins this research study and has been identified as an appropriate paradigm for conducting mixed methods research (Tashakkori and Teddlie, 1998; Teddlie and Tashakkori, 2009; Morgan, 2007; Onwuegbuzie and Johnson, 2006; Denscome 2008; Creswell and Plano Clark, 2011). Pragmatist inquiry poses a practical question and ends with a resolution that best serves the purpose of the inquiry. The nature of the federation is complex and it operates in a dynamic environment because of developments relating to healthcare policy. The study examined the situation where multiple independent businesses (GP practices) voluntarily came together to form a corporate venture to explore new business opportunities, and focused on the phenomenon

of the federation from the perspectives and actions of the social actors engaged within it. Over the timeframe of the study, the members of the federation were in a constant state of adaptation as they made sense of the venture that had been created, and the role and function of the federation within the contextual environment it existed in. At the time of commencing the study, it was unknown how the federation would develop. Therefore, an approach underpinned by pragmatism, combined with the research methods outlined, provided a detailed and intensive analysis of the organisation from when it was formed in 2011 until 2019, as it established itself in the local health economy. The findings from the research methods applied are now presented in the following chapters.

## Chapter 4 – Case study findings: Drivers and context influencing the establishment of a federation

### 4.1 Introduction

This chapter presents the findings regarding the background and contextual factors that influenced the formation of the federation, and examines the business successes and challenges that were encountered over an eight-year timeframe. Factors such as the pressures on the model of general practice and potential opportunities for delivering an extended range of services in response to the Health and Social Care Act (2012) were key drivers for exploring ways for practices to work closer together. Interviews with the founding GPs highlighted the recognition that the operating environment within which general practice existed was changing, and that strength and unity could be achieved by practices coming together to work more collaboratively. A critique of the approach to the set-up of the federation and its business construct are explored in Chapter 5. Strategy implementation and activities that successfully galvanised practices to collaborate, such as education, research, audit and quality improvement, and services developed to deliver local services for patients, are presented in Chapter 6. Furthermore, the challenges around sustaining engagement and maintaining commitment and engagement with member practices are discussed within Chapter 7 at three distinct time points (2013, 2015 and 2019).

### 4.2 Local context

Members of the executive team reported that towards the end of 2010 discussions were taking place between GPs from four GP practices to explore options for closer working amongst practices within a defined geographic locality. Within the locality there were 15 independent GP practices operating as separate businesses, of which 14 opted to form a federation. As a corporate venture, the practices formed a new company and provided initial capital investment to support this, which is discussed in further detail in section 5.7. At the time of these discussions, the North East region of England was forming into seven clinical commissioning groups, with 270 GP Practices covering a population of 1.76 million. Only one GP collaborative had been formed to deliver an out-of-hours GP service in one of the CCG areas, therefore the process of establishing a federation was pioneering and uncommon within the region. The founding GP indicated that they drew on the guidance that had been published by the Royal College of General Practitioners (2007) that outlined the practicalities and considerations around establishing a GP Federation, including the various business models (e.g. limited company structures), advice on clinical indemnity,

considerations around governance, how to approach patient and public involvement, and implications for skill-mix of the workforce.

### 4.3 The changing commissioning environment

When the federation was established in 2011 there was significant structural change in the healthcare environment. The Health and Social Care Act (Department of Health 2012) abolished primary care trusts in England and established new statutory organisations for the provision of healthcare commissioning through clinical commissioning groups led by GPs. Under the Act, the transfer of responsibility for the commissioning of core primary care services transferred from primary care trusts to newly established area teams, which were regional outposts of NHS England. Whilst primary care trusts previously held responsibility for commissioning of both primary care and general health services, the new arrangements saw a separation in commissioning responsibilities. This resulted in a clear demarcation of the role of commissioning and provision in the health economy. The GPs who led the establishment of the federation identified the opportunity these changes presented:

> *"Then the big change happened, which I think was manna from Heaven really as it clarified the need to form a cooperative or a federation - and that was the separation of provider and commissioning and I thought that was our big moment, our opportunity to form an organisation."*

This participant highlighted the view that the new commissioning arrangements created the opportunity to establish a separate provider entity which allowed practices to come together to work collaboratively. This GP highlighted the importance of being aware of, and responding to, the environment that general practice businesses exist within. One GP candidly reported:

> *"Before the clinical commissioning group formed and it was practice-based commissioning, I think practice-based commissioning group in our area was going to get into trouble because it had already dabbled in provision … and I thought straight away that the new locality commissioning group was going to get into trouble if it was perceived that they were providing [services]. I felt it was an ideal opportunity to avoid the conflict of interest that was occurring in practice-based commissioning."*

This participant regarded the formation of the federation as a mechanism for avoiding conflicts of interest between GPs appointed to commissioning roles with the clinical commissioning group, with a separation between GPs leading and developing general practice provider organisations. One GP interviewee explained how it was envisaged that the federation would develop a portfolio of services:

> *"At the beginning, I think what we envisaged was we were moving into a new phase of commissioning contracts would come and go, AQPs [any qualified provider] would be flying around, enhanced services flying around and lots of investment in additional pieces of work that could be done and delivered across practices rather than being done as individual practice. Economies of scale could be achieved through either delivering services as a group or from the procurement end of things."*

This illustrates that this GP had a clear sense of purpose around the federation positioning to respond to opportunities that would competitively present through new commissioning arrangements, and that the federation would hold contracts on behalf of the member practices, thus building a portfolio of commissioned services. Throughout the interviews with the executive team, the GPs discussed how the federation provided a mechanism for building a portfolio of services that could be delivered to the wider population within their geographic locality, and would provide opportunities for the practices to gain income for services delivered. This aspiration would enable practices to participate to a greater or lesser extent, depending upon specialist interests or local capacity to deliver an extended range of services, for which they would be remunerated.

### 4.4 Previous experience of locality collaborative working

At the beginning of the study, GPs discussed how collaborative working was not a new concept, with local practices participating in GP fundholding (1991-1997), operating as a primary care group (1991-2001) which became incorporated as part of a care trust (primary care trust 2001-2013), and as a practice-based commissioning group (2005-2010). These arrangements emerged as a result of various health policies, involving groupings of GP practices for the purposes of commissioning services and, in some instances, for the purposes of provision of services. One GP partner reflected on his experience of working through these various phases of reform:

> *"There have been different phases of investment over the last 25 years. During the '90s the investment was through fundholding where there was a real incentive not to refer [patients to hospital services], to manage differently and to use resources differently - and it was real money, not take-home money but [money] for developing local services. And of course, the total purchasing pilots which was the bigger way of getting more services because single practice working alone could only do so much, bigger practices working as a cluster could – that's why there were so many direct access services in [the local hospital] and we've still got some – we still have direct access MRI which started in the total fund days that no-one else had."*

GP fundholding and total purchasing were initiatives where GPs were given an indicative budget for their population and had control over how this was used (Williams et al, 1997). This quotation suggests it was a positive experience whereby GPs were able to influence the development of local services. It also highlights the experience where being a total

purchasing pilot provided the incentive for smaller practices to work together and collaboratively benefit from the results of schemes that were developed on a larger scale. Another factor relating to these previous group arrangements was the level of influence that GPs possessed. As fundholders, the GPs were able to influence the development of local services for their registered population, which was captured in the following GP quotation:

> *"[Fundholding] ended in '97/'98 when the Labour government came in and it went to primary care groups (PCGs). Now, PCGs still had influence and as a locality-base had a lot more influence and power than actually the CCG has at the minute – from a practice level, at ground level."*

This GP highlighted the perceived influence of group arrangements, such as fundholding, which transferred into Primary Care Groups (PCG) and suggested that this influence was greater than the level of influence they experienced in the clinical commissioning arrangements resulting from the Health and Social Care Act (2012). When established in 2011/12, clinical commissioning groups became statutory organisations within the NHS, and all GP practices were required to become members of the CCG. Therefore, practices theoretically should have had a high degree of influence within commissioning decision-making processes. GPs were recruited to lead clinical commissioning groups, requiring delineation between the roles of GPs as clinical commissioners and GPs as providers to avoid conflict of interest in decision-making around the purchasing of healthcare.

### 4.5 Renegotiation of personal medical services contracts

Interviews with the executive team at the beginning of the study cited the influence of PMS (personal medical services) contracts as a major factor in the decision to form a federation. Since 1966, the contract for commissioning GP services had been through a general medical services (GMS) contract, which is a nationally-negotiated contract between the Department of Health and the British Medical Association's (BMA) General Practice Committee (GPC). Both GP and practice manager interviewees identified that in the late 1990s a more flexible, locally-negotiated personal medical services (PMS) contract was introduced. One GP interviewee highlighted:

> *"There was investment through PMS and apart from two or three practices all the rest had enhanced PMS payments and that paid for extra nurses and GPs."*

When introduced, practices had the option to apply to the commissioner to convert their GMS contract to a PMS contract and, as illustrated above, interviewees revealed that this was regarded by local GPs as an opportunity to provide a greater range of services and enhanced contract values were negotiated. Interviewees reported that 10 of the 14 member

practices of the federation opted to hold PMS contracts, which allowed them to develop a range of local services within their rural geography. Meanwhile, the other four member practices of the federation retained GMS contracts. Interviewees also reported PMS contracts were a way of extending the primary care quality agenda by working together. One example, cited by an executive team GP, was the delivery of enhanced diabetes care, where practice staff received a programme of training from the hospital consultants and patients were managed by their local GP team rather than having to be reviewed in a hospital setting. Although PMS contracts were negotiated and held by the individual practices, interviewees recounted that funding from PMS arrangements supported the development of a clinical governance system that supported the delivery of high-quality primary care across all practices. With the assistance of central funding from the primary care trust, a GP from one practice led a programme of clinical governance work that included clinical audit, peer review and joint education, and initiatives such as collating individual practice clinical outcome data were shared and discussed across practices. This dedicated role developed both a structured approach across practices, and also systems and processes where the outcomes of clinical audit were used to identify education and training needs.

Interviewees also reported that six of the smaller practices were not technically eligible to participate in the PMS scheme under the guidance because their registered list sizes were too small. In 2002, these practices opted to form a multi-practice PMS group that allowed them to combine their list sizes to participate within a group arrangement, which enabled them to come together and develop services across multiple small practices. Thus, through pooling resources, part of their PMS funding allocation was used to fund a management team to work across the six practices. One practice manager, who was actively involved within the multi-practice PMS group, recalled their perception that smaller practices had significant challenges within the system:

> *"you were in it together because the big boys were out there …… because they had some of the resources that we never had."*

This quotation suggests a perception of inequity where the larger practices had access to resources that the smaller ones did not, yet interviews revealed the PMS collaboration allowed the smaller practices to collaborate and benefit from developing services and jointly employ staff to work across multiple sites. Cited examples included the employment of a nurse practitioner who worked different days in different sites, and a nursery nurse who worked with children and families across a larger geographic area. However, despite PMS

being regarded by the GPs as a contractual method of enhanced contractual funding to deliver an enhanced range of services, in 2006 the primary care trust undertook a review of PMS funding and decided that the inequity in funding between GMS and PMS needed to be rebalanced. Interviews revealed that the financial effect of the PMS review resulted in a tapered withdrawal of practice funding over a three-year period between 2007-2010. One Practice Manager described how the combined contract renegotiation resulted in an average 12% reduction in the PMS budgets of the 10 PMS practices in the locality. The budget reductions to the individual practices ranged between £41,000 (a 5% contract value reduction) and £128,000 (a 24% contract value reduction), which posed significant financial pressures to individual practices. One GP interviewee reported:

> *"We had a considerable amount of our funding removed through the PMS review. It became very clear that in the future we were going to have to work closer together to support each other in any future challenge of that type, that we were far stronger as a group of practices than we would ever had been if we had tried to tackle that issue many times over. That was one clear drive for the need for something …. a sort of umbrella body, and as a group you can have more influence than you can if you are an individual working alone in that way."*

This statement highlights the perception that practice staff felt vulnerable as individuals within the negotiation process, and there was a belief that collaborating with other practices in some form would provide a stronger negotiating stance in the future. In recounting the experiences of the PMS review, interviewees reported that although this process was a negotiation between the providers (the individual practices) and the commissioners (the primary care trust), there was a perception that the outcome had been imposed upon them, as summed up by one GP:

> *"There was the financial impact but also the sense of vulnerability - that was made clear to us through that process and again a very clear message that came from the LMC (local medical committee) was that you guys are going to have to start (particularly for the smaller rural practices) collaborating more if you are going to equip yourselves for what is to come in the future because this is just the beginning. It was kind of put in those terms, and for me that was probably the point that this came real rather than 'wouldn't it be nice if we did this', but right we are going to have to get on and do it."*

This quotation captures the sense of vulnerability that was experienced by practice staff and the perceived lack of negotiating power. This sense of vulnerability became one of the key drivers that influenced discussions about forming a federation, and the need for individual practices to collaborate for strength and unity. Interviews with the GPs and practice managers revealed that the withdrawal of PMS funding resulted in the collapse of group arrangements, such as the multi-practice PMS group. GP interviewees went on to describe the retrenchment of practices from all locality-based work to solely focus on the individual

practice business, as the practices planned and prepared for reductions in income and the monetary impact of this on individual partnership arrangements. One GP highlighted the impact:

> *"I think that the main reason for the lack of capacity is more around demand and the financial pressures, so most practices are now not covering absences with locums, they are not replacing partners who leave, not taking on additional staff to cope with the additional pressure so that means that there is less and less time to do anything external.*
>
> *Whereas there was a degree of leeway, financial leeway in the past, I think we have got to the point now over the last five or six years where any fat in the system has been cut, there is very limited scope to make further savings and so the difference between costs and income is now directly impacting upon GPs personal pay which means that there isn't any scope to be paying other people to come in."*

Whilst practices benefitted from PMS contractual investment, these quotations highlight that the financial impact on individual practices was significant, and influenced recruitment and staffing decisions that were being taken by practices to manage the financial loss. The reported retrenchment into practice-facing activities lasted several years, and GP interviews revealed that, in 2010, a couple of years after the PMS renegotiation, informal discussions had ensued amongst some of the GPs around more collaborative working arrangements across practices. These GPs recognised the benefits and strengths of previous collaborative arrangements, and of working together, and they championed the concept of the federation as a vehicle to bring practices together. In order to influence the discussion with other practices, these GPs had the support of their own practices to form a joint venture, and the process of engaging other practices began from this initial coalition.

### 4.6 Pressures affecting general practice

The interviews with GP and managers in 2014 highlighted significant contextual factors, such as workload and financial stability, that influenced the formation of the federation. One GP offered the following insight:

> *"The biggest challenge is survival, in its current form particularly partnerships, particularly independent contracting and I just think it's getting more and more dodgy for us to carry on for very much longer."*

This statement highlights the pressure on practices and the notion of 'survival' suggests that it is becoming increasingly difficult to maintain practices as viable businesses. The challenges of balancing supply of clinical resources against rising consumer demand, managing an increasing workload, and the financial pressures impacting on the viability of practices as independent businesses were also highlighted. Managing patient demand

emerged as a recurring theme during interviews with both GPs and managers. The following statement from one of the managers illustrates this point:

> *"The biggest challenge on a day-to-day basis, is matching demand with capacity and managing demand in such a way that it doesn't run away with us. Managing capacity as a small business - GP practices have to keep cost under control whilst at the same time providing enough resource to meet the demands of patients to a sufficiently high quality."*

This insight highlights the challenge of matching clinical capacity to meet demand and increasing expectations of patients, and suggests cost containment of staffing resource is a key consideration for practices as a business. The importance placed on delivering a quality service, and a desire to ensure that patients are satisfied with the service that the practice provides, is also noted. Therefore, there is a tension between the ability to match capacity to meet demand and the financial resources available, and without tight control the budgetary impact of employing additional resource (staff) could affect the profitability of the practice as a business. In turn, this would diminish profitability and result in less money being available for GP partners to draw as earnings from the business.

Another significant issue that emerged through interview with the GPs and managers was the workload pressures that general practices were experiencing, which is illustrated in following statement from one GP:

> *"I think that there are practical challenges in terms of capacity and workload has increased exponentially over the last 10 years or certainly since the last new GP contract came into place. I think that this is impacting upon GPs' ability to do anything but the core clinical work, so education, some of the leadership stuff otherwise would be getting done, people don't have the capacity to do it."*

It is noted that increased workload had resulted in GPs focussing on delivery of their core contract, and an ensuing lack of capacity to focus on engaging in additional or extracurricular activities. Another GP also reflected on the level of clinical activity that had transferred from the hospital setting to primary care, which had also created additional workload:

> *"The main challenge for primary care is, as a GP, the workload is increasing day on day. It feels like now there is a lot more work that is coming out of secondary care into the primary care sector - which is completely appropriate. I think that the workload can be done in primary care, but we've not been given any extra cash to do the work or any extra time to do it in and therefore the workload is just becoming unmanageable really."*

This insight suggests that as different parts of the health system attempt to manage demand and achieve operational efficiencies, some activities are being transferred to other care

settings with unintended consequences. One example cited was that some aspects of post-operative care (such as blood monitoring or wound management), which historically had been done in the hospital setting, was being transferred to general practice and, as identified by the GP interviewee, whilst this may be the correct thing to do for the patient, there had been no planning around increasing capacity in general practice to account for this. Therefore, as GP systems flex to accommodate additional activity without remuneration, over time this transfer of activity places additional pressure on access to already pressurised appointment systems. The interviewees were aware that in other areas, CCGs had commissioned enhanced services to remunerate GP practices for providing additional services, and this allowed practices to plan for increased staffing capacity to account for the additional activity. However, this was not something that was available to the practices within the federation. Building upon this point, another issue that emerged was the diminishing profitability of general practice, as several GPs noted:

> *"On top of [increasing workload] the fact that our wages have gone down year on year and the amount of money we've been getting [the budget], has gone down each year. I think that makes it unsustainable from the [financial] point of view. We can't employ extra staff because our money is going down and therefore workload is just going up and it is also very demoralising to earn less and do more work. I think that the job is therefore becoming less appealing and therefore there is going to be a recruitment crisis in the future."*

> *"[The practice] income is going down and expenses going up. Our expenses generally haven't but that's because we are doing more and more of the work ourselves and we are not replacing staff as they are leaving, so that's making the job more difficult for our staff as well because they are having to work harder and longer hours as well."*

These quotations draw attention to the financial pressure placed on practices as businesses, where GP income is based upon money that is drawn from the practice once expenses have been paid. In an environment of reduced funding with rising expenses, the profitability of the practice diminishes, which has a direct impact on GP earnings. Practices had previously employed locum staff to cover staff shortages during periods of absence, but rather than employ additional staff and incur costs GPs reported that they were absorbing the additional work. This paradoxically created additional pressures on the workforce at a time when consumer demand was increasing. General practice has traditionally been regarded as the gateway for patients to access healthcare and onward referral from GPs to hospital services. One GP suggested there was a need to look at a different model of access into primary care:

> *"The main challenges are financial constrictions, lack of investment in primary care and defining where primary care sits in health care generally. I think the terms*

*primary, secondary and tertiary are becoming more defunct and there needs to be a new way of thinking about the gateway to healthcare for populations."*

This concept would challenge the historic role of the GP as gatekeeper, and require a fundamental redesign of how patients access health services. One GP summarised his perceptions of the key challenges for general practice, recognising the workforce challenges facing the profession:

> *"[The challenge is to] deliver the quality [of care] within the resources available. Money is short, expectations are high, workload is going up left, right and centre. The demands of other quality areas such as QoF, and there's the CQC - the regulation of CQC. So, pressure is growing in terms of demand, quality and expectations, and resources have been dropping continually - that then leads to being a less attractive profession which leads to workforce issues. So, we have got workforce and workforce planning issues."*

These quotations provide an insight into the pressures that practices were facing, and factors such as increased workload and patient expectations, coupled with the financial challenges of managing practices as independent businesses, have the potential to create uncertainty for the longevity of practices. These factors influenced a group of GPs to explore options for practices to work together through a joint venture to support each other.

### 4.7 The challenge of bringing practices to work together

Setting up the federation required individual GP practices to agree to work together for a common purpose, and this was a complex process, as one GP highlighted:

> *"Since 1948, and before 1948, there has been a fierce independence and pride in the culture of individual practices – they have their own atmosphere and character and if you listen to patients they will say that. It is about people in the end and I fully support that, but rather than acting as islands I think there has to be a bit of connectivity across those islands – whatever you want to call it communication, cross-pollination, working together and particularly working through the practice managers who are also employed to maximise the profits of these individual business. So, to get into bed with competitors, and in some cases, there are practices who historically didn't actually get on and who were more than rivals, they actually didn't like each other - I think is one very big challenge."*

This statement points to the independent autonomous nature of practices and how the proposal to federate presented an opportunity for practices to work together, whilst recognising the challenges this presented. Paradoxically, the notion of federated or collaborative working is set within an operating environment where GP practices have traditionally operated as individual business units. Also, practices are commissioned individually and hold a registered list of patients which their contract and core practice income is based upon. In business terms, practices compete for a market share of the

population to be registered with their practice. As core GP contracts are based upon the number of patients registered with a practice, the list size determines the core funding of the business. Therefore, the challenge of bringing practices to work together, and shifting the focus from the individual practice, cannot be underestimated, and the notion of federating was regarded by the participants as both an opportunity and a threat to the individual practices.

The changes in the commissioning environment in 2011/12 and national policy initiatives created some uncertainty around procurement of service, patient choice and competition. This resulted in an uncertainty around how these policies would be implemented locally and this was noted during interview. The sense of fear and the unknown within the operating environment was discussed by one GP:

> *"I think practices are motivated by either development or threat and they are in it because of the threat… at the moment that's what I think the motivation is, their concern and they have been willing to put some money in to do that. To get us to this stage is about understanding that threat. We have had at least a familiarity with working together and good leadership - it absolutely needs the leadership of somebody to actually grasp it and say 'if we don't do anything else, let start to pull this together'."*

This GP suggested that whilst there was uncertainty in the operating environment, practices were drawn to work collaboratively by a perceived threat centred around the historical process of commissioning services from GP practices (e.g. enhanced services) that could be competitively tendered under the terms of the Health and Social Care Act (2012). This new approach to commissioning could ultimately introduce new providers into the health economy that would erode the range of services delivered by general practice. In turn, that could result in reductions in revenue streams which could threaten the viability of practices if they were not successful in the tendering process. In response to this perceived threat, the establishment of the federation was a strategy to preserve the existing business of the member practices. One GP recognised that there was a need to work on a larger scale and recognised that the strengths within the current model of general practice should be preserved within the context of a larger organisational unit, as is illustrated in the following quotation:

> *"They [the practices] have got to actually realise that being in it is better than not being in it and that they have got to see that. GPs themselves, I do believe, see the value, they see their strengths, they have got to be allowed to continue to deliver those strengths, and they have got to feel that there is an organisation that represents them or organises things around general practice being the core of it."*

Here this GP suggested that there is a dynamic tension between preserving the strengths of the existing model, whilst still recognising the need to operate on a larger scale. Thus, it was argued that the Federation was intended to be a representative body on behalf of the practices and to function in a way that organises services across practices.

### 4.8 A perspective from external stakeholders

The factors that influenced the formation of the federation were reported from the perspective of internal stakeholders, thus a range of interviews with external personnel in the healthy economy helped to provide an alternative perspective. In late 2013, interviews were undertaken with nine senior personnel in the health economy to explore their perceptions of general practice and the emergence of federated models. Several themes emerged from the external interviews, including the complexities of the new operating environment, the historic model of general practice and the opportunities to organise on a larger scale, the various models that could support this, and some of the leadership challenges in developing federated models of general practice. The challenge of sense-making in the ever-changing NHS environment was captured during an interview with a senior hospital executive:

> *"Understanding the chaos in the system about who does what and what role other bodies play, is a bit of a challenge."*

This suggested that the reorganisation of the NHS in 2011/12 created a general sense that the operating environment and commissioning reconfiguration was at a very early stage of development, and much confusion and lack of clarity existed. Interviewees reported that, in previous commissioning arrangements, primary care trusts had developed a degree of flexibility to design models of care suitable for local populations. However, there remained a general lack of clarity as to what replacement mechanisms would be available in the new system architecture. One interviewee stated:

> *"I think nationally people are very schizophrenic about whether we are in a market mode or collaborative integrated care mode. There is loads of overlap, loads of duplication, transfer, handover and inefficiency which if we were working closely together we could eliminate."*

This interviewee recognised contrasting policy developments around choice and competition and integrated care, and highlighted the benefits of integration to achieve efficiencies. Whilst GP organisations may be formed for commercial purposes, the belief was that integration across organisations may yield greater benefit.

The strengths and weakness of the current model of general practice were discussed and there was a perception that the historical model was becoming unsustainable and needed to change, but the solution was undefined. Interviews with senior personnel in commissioning and provider roles revealed that there was not a single or consistent long-term strategic vision for a redesigned model of general practice, and indeed there was a lack of clarity as to who should take the lead in supporting or delivering the type of strategic transformational change that was perceived to be required.

In exploring the drivers for change, two differing perceptions were presented as to whether change would be driven top-down or organically driven from the bottom-up. There was a general lack of clarity as to what the catalyst or system drivers would be for general practices to change. One hospital executive said that the national contract for general practice could be a tool to drive change if it placed so much pressure on the existing small business model that it would force a drive towards larger organisational forms. For example, the national policy around extended access to general practice over seven days per week could not be delivered or sustained by multiple individual practices, but could be delivered by collaborative arrangements across multiple practices. Another hospital executive argued for change to be driven by local groupings of GPs coming together to preserve the best of the existing models and strengths of general practice, and to seek more efficient ways of working.

In determining the role of federations, the external interviewees recognised that there were potential opportunities for groups of practices in the new NHS landscape resultant from the Health and Social Care Act (2012). Two perspectives emerged as to whether federations would operate as management agencies working on behalf of member practices or whether federations would establish as independent providers of services. However, there was a lack of clarity in relation to the strategic positioning and alignment of these groups in the wider healthcare system. It was unclear whether these groups would strategically align themselves with other provider organisations and seek integrated healthcare solutions, or whether their business models would be built on delivering a range of commissioned services as separate providers. Whilst the Health and Social Care Act (2012) promoted choice and competition, a range of external provider perspectives highlighted the need for a more integrated model of working, which seemed to contradict national healthcare policy at the time. It was suggested that providers needed to come together to deliver integrated solutions and recognise that the current payment system within healthcare, with some parts tariff-based versus parts that were paid on a block contract basis, did not fully support integration. Some participants highlighted alternative visions in the healthcare system for

different models of integration. This included vertical integration, where providers across sectors of health collaborate, and horizontal integration as a single health economy solution.

The external interview cohort identified inefficiencies within the model of general practice, with multiple small organisations repeating processes that could be streamlined and carried out more efficiently. These were identified as corporate back-office functions, such as procurement, recruitment, human resource management, payroll, finance, IT, estates management, and quality management. Several interviewees suggested that the federation could be the body to create this back-office function, which would redesign the processes to support general practice and was regarded as a solution to preserve its strengths (such as continuity of clinical care). Some of the perceived challenges were in terms of human resources: either deploying existing personnel to lead on this function across practices or looking for vacancy opportunities to be filled in a more creative way that supports a federated way of working. Considering the notion of general practice operating on a larger scale, a more radical perspective was presented by one GP:

> *"…a health economy type model [is established] and throw out the rule book. If you could buy off the liabilities, you would need a large organisation to underwrite the liabilities of the practices, and if you did that you could see that you could start to plan effectively."*

This individual promoted an example of a single organisation assuming the delivery of general practice on a large scale, with the parent organisation having the financial capability to take on the liabilities of multiple independent practices. This is a crucial factor when considering some GP practices own their own premises, therefore any new organisational model would require the financial liquidity to be able to underwrite existing mortgage and premises ownership arrangements. Hypothetically, if the host organisation was a foundation trust, this proposal would be an example of vertical integration where hospitals and community providers, including general practice, would work together under a new financial or contracting regime. This type of organisational model would facilitate a shift in the traditional organisational form of general practice as independent self-employed contractors to a model where GPs would potentially be salaried and employed by a single NHS organisation.

Participants also discussed the practical challenges of bringing individual businesses together to work collaboratively, and one GP from the external cohort noted:

> *"For the last 15 years or so everyone has been focussing on the business of practices to actually make their businesses survive, so they have to move from making their business survive to having some sort of collective mentality……...we*

*have bred a culture of individuals who are fighting to be autonomous and then you are asking them overnight to suddenly work into a different way of life and that's the biggest hurdle."*

This statement suggests that general practice had historically operated as small businesses (independent contractors) within the NHS since 1948, and there had thus been a focus on maintaining the viability of the individual practice. They also highlighted the challenge of developing a collective mindset within an environment that has defended the autonomous nature of general practice. Therefore, whilst federating was a proposed solution for general practice, to shift from a singular to a collective approach may prove challenging. The reality of getting multiple diverse practices to collaborate would require a compelling vision to support and engage GPs and practice personnel to engage in any change process. In addition to the embedded autonomous culture of individual practices, the challenge of bringing practices with differing cultural values together was presented by one GP in the external cohort:

*"When you have people on the ethical range between very socialist up to very capitalist, it is that bit that is going to be difficult. So, I think the model, federation, is fine if you have got enough critical mass of people who are going to buy into a vision."*

This individual suggested that there are differing philosophies within individual practices, and recognised that some practices may be characterised as altruistic and having a patient-focussed approach to the service, whilst others may be more business and profit-orientated. This suggests that there is a fundamental challenge in bringing people together from these diverse orientations.

Leadership and the challenge for leaders was also a topic discussed by the external cohort of interviewees, and the following statement captures one perspective:

*"In terms of federations and organisations working together again, I don't think that there is the time or capacity for the majority of GPs to put in that level of organisational development to make it work."*

This participant identified that dedicated GP time is required to focus on federation development, and portrayed both a level of scepticism and realism around the level of investment and resource that would be required. As noted in section 4.6, the ability to draw GPs into federation development activities may be affected by a lack of capacity and a reluctance of GPs to engage with external developmental activities. Therefore, the leadership challenge is significant in attracting GPs to take on roles to support provider development. To compound this, the clinical commissioning arrangements around 2012 had

attracted GPs interested in this type of work into fully remunerated leadership posts, whilst provider development and reform had not been incentivised in the same way.

With regards to the pace and scale of change, it was argued that collectives or groups of general practices that had come together across the North-East region had pursued change incrementally. and one senior GP who had established a provider company to deliver out-of-hours GP services stated:

> *"Nothing happens quickly with general practice and the idea that you can push them to work together very quickly is not right – you have to do it incrementally and gradual. You always have a core of practices that will start it moving and the others will come eventually."*

This viewpoint was based upon the experience of the interviewee where a group of GPs came together to deliver a contract for GP out-of-hours services in 2006, and initially eight out of 31 practices agreed to participate by setting up a separate business to host the contract and deliver the service. Following this, as the company became established, more practices engaged and eventually all practices became members of the company. This example suggests that achieving change through federated models of general practice takes time and should be incremental. It suggests that as the benefits of collaboration are evidenced, other practices will follow the leaders. It was also reported that a strategy of transformational change for general practice needed to be a longer-term vision, and the process of encouraging independent contractors to change would be a gradual process.

In 2011, when the federation was established, it was noted that there were a few recognized GP federations across England, with only one in the North-East region, and the financial viability of this model had been achieved through holding substantial contracts for service provision (e.g. out-of-hours GP services). There was a sense of realism reported by the interviewees, highlighting the challenge of setting up federations as new business entities with no external financial incentive or pump-priming, which would be challenging against the backdrop of financial and workforce pressures in general practice.

### 4.9 Summary

This chapter identified the influences and contextual factors that affected the decision to form a joint venture, with practices facing specific workload pressures and financial challenges. Changes to health policy in 2011 were perceived as an opportunity to deliver an extended range of commissioned services, but were also perceived as a threat to practices if alternative providers entered the market to deliver services traditionally delivered in primary

care, which would have a destabilising effect on the financial viability of individual practices. In addition to the perspectives of the personnel engaged in establishing the new venture, the perspectives of external stakeholders, personnel in senior roles in other organisations within the health economy, were presented. Whilst sympathetic to the pressures faced by practices, they suggested that more radical approaches may be required to support care delivery in primary care, and questioned the availability of capacity from GPs to achieve the scale and level of change required.

## Chapter 5 – Case study findings: Establishing the federation

### 5.1 Introduction

This chapter explores the establishment of the federation as a joint venture in the form of a company limited by guarantee, and examines the implications and benefits for member practices. The intended purpose and vision for the venture is considered, as is the role of the executive team, particularly in relation to leading the venture.

### 5.2 Geographic locality profile and member organisations

The 14 member practices that formed the federation in 2011 covered a rural geography of 2,219 $km^2$ in the North of England. PMS contracts were held by 70% of practices and 30% held GMS contracts. The practices covered a combined registered population of 78,000 patients, with individual practice list sizes ranging between 2,090 and 10,127 (NHS Digital 2020). The demographics of the combined registered patient population suggested an ageing population, with 34% of patients aged between 60-89 years (compared to 22% nationally) and 1.4% of the population aged over 90 years (compared to 0.84% nationally) (NHS Digital, 2020). Indices of Multiple Deprivation across the locality ranged between 8.7 – 20.4, characterising a diverse area with pockets of deprivation contrasted with areas of affluence (Public Health England, 2020). In 2013, the average list size of a practice in England was 6,914 (NHS Digital, 2013), therefore 10 of the 14 member practices (71%) had smaller list sizes than the average practice in England. In 2019, the average practice list size had increased to 8,757 (NHS Digital, 2019), and between 2013 and 2019 there was a 15% decrease in the number of GP practices (8,106 to 6,866), suggesting the formation of larger GP practices, possibly achieved through merger or acquisition. In 2013, two of the smaller practices with registered list sizes of 2,000 and 3,300 patients merged, reducing the number of member practices to 13.

These characteristics define the federation's locality as rural and geographically dispersed, with a population profile featuring an ageing cohort of patients and the majority of practices having smaller than average registered list sizes. This geographic profile brought substantive challenges in providing services in this locality as practices were geographically distanced from acute and regional services, there was an aging registered population in most practices with patients living in isolated communities, there was a number of nursing homes in the locality, and there was a lack of hospice services.

In addition to the GP practices as members of the venture, in 2011 it was agreed by the board that membership would be extended to two NHS foundation trusts within the local health economy to develop relationships and pursue areas of mutual interest. These organisations were given non-voting representation on the board and were invited to meet regularly with the executive team. However, during 2016/17, one of the trusts established a primary care provider organisation and recruited two of the federation's GP practices to work within this new arrangement. This led to concerns about conflicts of interest, and the executive manager noted during interview in 2019:

> *"There was a clause in the existing members agreement, that stated if the legal structure of a member practice changed from when they signed, they automatically cease to be a member of the federation."*

In 2018 a review of the federation's corporate governance arrangements was undertaken, and changes included removal of membership for the hospital providers and eligibility for membership restricted to GP practices only.

### 5.3 Forming the federation

When the federation was established, one GP from the executive team provided the following insight into the intended purpose and function that was envisaged:

> *"I think ideally the federated model would have basically enabled practices to survive as individual partnerships and I think that's how I envisaged it working - that we would all own a business which would be overarching all the practices. The practices would remain as individual partnerships but there would be an overarching business model which therefore would enable the partnerships to work together, and to work much more efficiently because we could have economies of scale and some of the back-office functions, administration, the management side organised as a bigger business but enable each practice to maintain its own individuality."*

This insight illustrates a clear intention to support the viability and independence of practices and maintain the partnership model. The vision that closer collaborative working would improve the efficiency of practices and, as a separate business venture jointly owned by the member practices, the federation would act as a vehicle to pursue activities of common interest. The statement does not suggest that there was any intention to pursue a strategy of merger, where individual GP practices would come together in a formal business arrangement (e.g. within a single, larger partnership arrangement). Several business options were appraised and considered by the three founding GPs, which included setting up an overarching partnership of the existing practice partnerships, but it was concluded that setting up a company limited by guarantee would provide less risk and attract membership from a greater number of practices. Under a partnership arrangement, the perception of the

practices being liable for any financial loss incurred was perceived to be unpopular. Therefore, a limited company structure provided the appropriate governance arrangements for the venture as a separate business entity with minimal risk to the practices. The 14 GP practices (individual businesses) formed a new business venture as a single new company. This was then formally registered with Companies House, the government organisation where all new companies operating within the UK must register to trade, with the requirement to comply with corporate legal and governance arrangements defined by law. This includes registration with HMRC for the purposes of declaration and payment of corporation tax and for submission of audited annual accounts.

Review of corporate documentation from 2011, when the company was registered, including registration files and articles of association, indicated that the federation was set up as a member organisation, where individual practices that were members were able to benefit from services or initiatives that would be developed. A members' agreement was drafted as a legal document which outlined details of the governance structure and membership requirements from each of the constituent practices. The 2011 company registration documentation listed one GP per practice as the named guarantor on behalf of their respective practice, and these guarantors were the partners within each of the member practices. The members therefore comprised of existing GP practices operating as autonomous businesses whilst agreeing to collaborate across organisational and professional boundaries to support practices and deliver services across a larger population.

### 5.4 Vision, purpose and strategic intent

The articulated vision, purpose and intent for the venture were important factors to explore to contextualise the relationship with the member practices about what this new corporate entity would deliver in terms of member benefits. To provide this overview, an analysis of corporate documentation was undertaken, including a review of the company registration files, articles of association, members' agreement and business plan (2012), and minutes from the executive team meetings between 2011 and 2016. Interviews with three of the GPs who were instrumental in drafting the articles of association, provided an insight into the intended vision and purpose of the federation. The articles were drafted by a firm of solicitors in conjunction with the executive team and formally agreed with the member practices through a process of discussion during a series of initial group meetings. The following excerpt from the articles provides a statement of the purpose:

a) *through the collaboration of Members, to provide primary care services which are accessible to the local population and patients across [the locality], to develop,*

*provide and commission new services tailored to the requirements of the local population, and to promote the medical profession; and*

b) *to achieve excellence in primary health care delivered by traditional GP practices, with Members working together to achieve quality, efficiency, strength and flexibility.*

Extract - Company articles of association, July 2011

This insight into the vision that was agreed illustrates collaboration across member practices as a key feature, suggesting a willingness of members to work together in activities of mutual interest. The articles outlined the aspiration to develop a range of new services to be delivered and a desire to support practices to develop and improve existing services. The articles state that delivering excellence in primary care would be supported, inherent in the statement *"healthcare delivered by traditional GP practices".* There was no articulation of the intent to pursue a strategy of merger of individual practices, which in essence set the scope for federated working, where practices were willing to pursue activities where there was a perceived benefit to the individual practice as a business. The business plan developed by the executive team in 2012 outlined key areas of focus:

| |
|---|
| *The federation works **collaboratively** to:*<br><br>*1) Safeguard the viability of primary care*<br>*2) Retain the individual character and foothold of GP practices*<br>*3) Deliver high quality, cost effective primary and community services*<br>*4) Ensure value for money through the efficient use of our resources*<br>*5) Promote evidence-based healthcare and excellence through education, audit, research and development activities*<br>*6) Develop new business opportunities*<br>*7) Promote innovation and new ways of working* |

Table 8 - Extract from business plan 2011/12

The excerpt above highlights that there was a defined vision to preserve the individuality and characteristics of member practices and support the viability of the existing model of independent general practice, which would require member practices to engage and co-operate for this to be successful. The articulation of quality, effectiveness and promotion of excellence in general practice illustrated that quality was an important characteristic for practices to evidence. However, the vision also incorporated the need to create efficiencies, develop new services and promote new ways of working, which potentially creates a paradox in the expression of intent to preserve the individuality of the member practices and recognising the need for new and more efficient ways of working. The vision recognises the need for general practices to seek efficiencies that may be achieved through innovation and new ways of working, which would require member practices to agree to implement change and work differently, demonstrating commitment to federated working.

### 5.5 The board of directors and executive team

Corporate documentation from 2011 revealed that the board of directors had ultimate corporate governance of the venture. Each member practice had a named director on the board to ensure that there was representation at a senior and strategic level from all practices. From this group of 14 directors, four executive directors were appointed by the board with delegated authority to develop and lead the venture on behalf of all members. These individuals were made up of three clinicians (GPs) and one manager (business partner) within their respective practices. These individuals were influential in developing the vision for collaborative working as they took the lead in drafting the articles of association and members' agreement, and engaged in consultation with the member practices to agree these documents. As senior personnel within their practices nominated to lead the venture, they were trusted within their peer group and had been successful in engaging practices to invest in this new venture.

The federation was constituted that the board of directors would meet annually as a minimum, and the sub-grouping of the board that formed the executive team would meet monthly. All education, training and audit activities were directed through a dedicated group that met bi-monthly made up of GPs, practice managers and nurses with an interest in education and research. The structure is diagrammatically illustrated below:

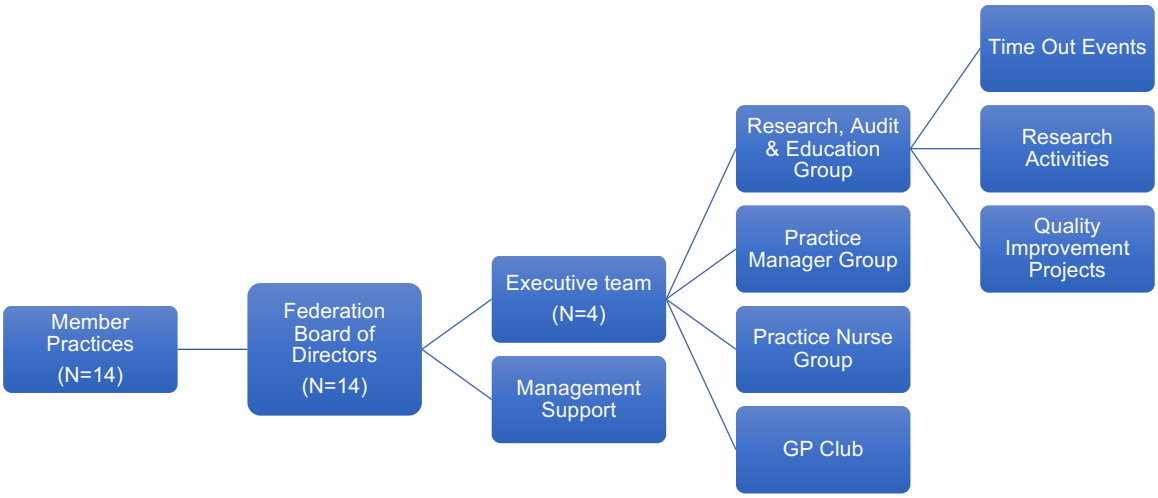



Figure 6 – Federation structure & relationship with professional groups

The composition of the board and executive team was senior personnel in their respective practices with considerable experience of working within the geographic locality. When

formed in 2011, the board comprised of 79% males and 21% females, with 57% of directors over 50 years of age and 43% of directors between 40-50 years. 52% of the board of directors reported that they had worked in their current practice for ten years or longer (33% had worked within their current practice 20+ years), while 48% had worked in their current practice for less than ten years.

During the study there were several changes in the executive team. From the four executive directors that formed the executive team, the following changes were noted:

- Executive GP 1 - continued this leadership role from 2011 for the duration of the study.
- Executive GP 2 - served between 2011-2016. This vacancy was filled by a GP in 2016 who continues to fulfil this leadership role.
- Executive GP 3 – served from 2011-2013 and was replaced by a GP partner between 2013-2017 when they left to take up a post outside the locality. A replacement GP was appointed in 2019.
- Executive business partner – the first appointment served between 2011-2013 when the individual took employment outside the locality and was replaced by another practice business partner in 2013. They continued in this role for the duration of the study.

Directorship excluded practice nurses as they were regarded as employees rather than partners in the practices, although they were recognised as a key professional group and had a key role in the strategic education and research group. The founding GPs believed that the federation needed engagement and commitment from the business owners of the member practices (e.g. the senior partners) for the venture to be recognised as strategically important to them, and for them to make a financial investment. Although the practice nurses were not represented on the board, they felt they did have influence and, in 2020, two nurses reflected positively upon their experience during the focus group discussion:

> *"I think our voice does get heard because the practice managers meet together and if we have issues, if something is raised in here [the nurse forum] and we go to our practice managers and they take it to the managers group, I think we are aware it gets spoken about. They might not agree with us but they do feedback."*

> *"We are all involved in some of the things that happened in a round and about sort of way, because [Manager] was obviously heading up [the federation] at the time and she was quite good at organising meetings and getting things going across the patch and would involve us then, in the decision making in the things that affected us in the way we worked.*

These quotations suggest that the nurses felt that they had a representative voice and there were opportunities to raise important issues or queries. It suggests that there was two-way communication and that when feedback was provided when issues were escalated to the managers it was acted upon.

### 5.6 Personal motivations of the executive team

The executive team took a prominent role in forming the venture and compiling the corporate documentation, including the articles of association and a members' agreement that included the vision and purpose for the venture (section 5.4). When considering the motivations behind why a group of GPs put themselves forward to establish the venture, one GP reflected:

> *"It is a responsibility. I feel a responsibility for my community out there. I don't feel like I am representing [my practice], I feel like I am doing this for the practices."*

This illustrates the personal sense of responsibility that this GP felt as a member of the executive team in the role of developing the venture to benefit all practices. Another GP recounted their desire to be involved in something that practices would benefit from, and highlighted the credibility that they had with their peers:

> *"I just felt people looked to me at the time. I thought that there are some people destined to commissioning which I wasn't going to touch, and I just thought that we needed a bit of different thinking and I thought that I could provide that."*

The desire to influence, lead and shape change was also noted throughout the interview, and is captured in the following quotations from two of the executive team GPs:

> *"I think I have been looking for new challenges over the last couple of years, really. I think I realised over the last couple of years that the NHS is going to change very radically. I wanted to be part of that change rather than that change happening to me and I wanted to be able to mould that to be able to decide about our future and our patients' future and our practices' future rather than sit back and watching other people do it. So, I think it was partly personal that I needed something else and partly because I would prefer to be part of something than rather not."*

> *I wouldn't have said yes to being on the board if I didn't feel like I had a role. So, it's the adage if you want to influence something you've got to be in it."*

These quotations illustrate that there was a sense of purpose and self-determination from the individuals who wanted to be actively engaged in leading the venture, as opposed to change being imposed and being passive within this process.

### 5.6.1 The executive team's authentic leadership profile

The executive team were instrumental in setting up the venture on the principle that it would support practices and be something everyone would benefit from. Factors such as authenticity, integrity and acting in a manner that is consistent with beliefs underpin the concept of authentic leadership. As the executive team assumed a leadership role on behalf of the member practices, their actions would need to be consistent with the interests of the practices. The Authentic leadership questionnaire was completed by team in 2014 and provided an insight into the group's authentic leadership characteristics as summarised below:

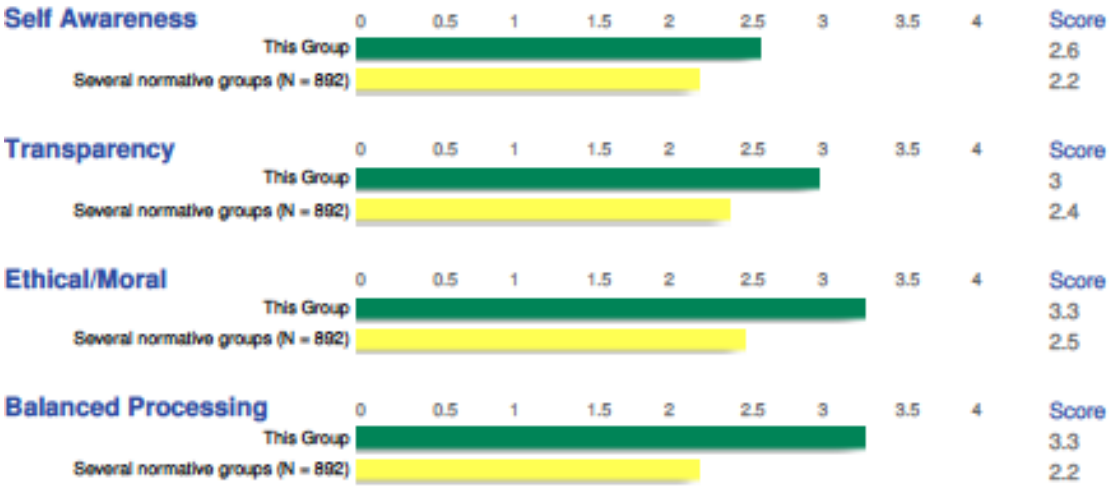



Figure 7 – Executive team ALQ group report

The executive team scored higher in all traits in comparison to other normative groups (comparable groups with a similar professional profile who had previously completed the survey). The standard deviation was 0.4 across all traits, which indicates that there is a high degree of agreement amongst team members. The highest scores were in the ethical/moral and balanced processing traits, suggesting the team operates to high standards of moral and ethical conduct, and seeks opinions and perspectives of others working in the member practices before making decisions.

The ethical/moral trait relates to decision-making and alignment to internal values, and a score of 3.3 suggests that the group's decision-making and behaviour is consistent and aligned with their internal values. The value of acting in the best interests of member practices, and for the benefit of all members, was articulated in the corporate documentation during the setup of the federation and espoused during interview.

The balanced processing characteristic relates to how information influences decision-making, and a score of 3.3 suggests the group objectively analyses data before coming to a decision. This indicates they seek views and perspectives that challenge their own positions to influence their interpretation of a situation and to inform their response to a challenge or opportunity.

The transparency characteristic relates to whether people behave in a manner that is open and transparent. The team scored 3, suggesting the group convey their true intentions in an open and transparent manner, and express their personal thoughts and feelings, thus presenting a true reflection of themselves to others. This indicates that the group's approach is genuine, and they portray themselves to member practices in a way that supports the federation's vision.

The self-awareness characteristic relates to the level of self-awareness and insight that the group possesses. Self-awareness requires leaders to be aware of the impact of their actions on others, and to understand motives and intentions. The team scored 2.6, which suggests the team is aware of their strengths and weaknesses, and gain insight into themselves as a group through their exposure to others. Leaders with high scores in self-awareness have personal insight and can re-evaluate their position on important issues.

The top two leadership strengths reported that the executive team encourage open and honest dialogue from each other and from member practices, and value the input of different perspectives before making decisions. This suggests that as an executive team they like to analyse data before coming to a decision, and their decisions are made based on high standards of ethical conduct and aligned with their core values. Development opportunities included self-awareness in assessing how others view the capabilities of the team and being able to tell the hard truth.

### 5.7 Not-for-profit business orientation

Social enterprise is a status that is awarded to organisations that demonstrate criteria for reinvestment of any profit back into the business or into local communities (Social Enterprise, 2018). One of the founding principles for the venture was that it would operate on a not-for-profit basis and social enterprise status would support this ethos, as highlighted by an executive team GP:

> *"It [social enterprise status] was important at that point because it stopped people looking at it as just a money-making enterprise. I think it was very good in terms of*

*what the potential outside perception of the organisation was because there was a lot [in the media] about greedy GPs, contracts earning huge amounts of money and the fact that we were a social enterprise who have a different approach – non-profit making, I think it just gave out a different message which is very much in keeping with the philosophy that evolved."*

This illustrates the value that was placed upon a not-for-profit business orientation and provides an insight into the concern of how the venture would be perceived by the public. There was a desire that the venture did not attract negative publicity as a private profit-generating venture, and was seen as aligned with the values of the NHS (state-funded and free at the point of access for those who need it). Thus, an application for social enterprise status was granted in 2011. This social enterprise ideology was underpinned by the principle that member practices would be remunerated for services delivered and any surplus generated would be re-invested within primary care across the member practices.

### 5.8 The federation's business model

The business model that was adopted for the venture required initial investment to support set-up costs and develop a business plan to support implementation of the strategy. Corporate documentation revealed that members made a financial contribution in the form of a membership subscription, and this funded the set-up activities during 2011/12 and 2012/13. Executive team interviewees commented that the member subscription was regarded as a method of gaining commitment to the venture and ensured that people were remunerated for work undertaken. The subscription levied was 50p per registered population in the first year and 25p in the second year, thus ensuring that the level of member subscription was proportional to the size of the member practices, ensuring the smaller practices were not financially disadvantaged. In addition to this initial subscription from the practices, two hospital trusts made a contribution towards the set-up of the federation during 2012/13 and 2013/14. Interviewees highlighted that practices agreed membership subscription would be time-limited and the ideology was that the venture would become self-funding based upon a strategy of generating new business and a 10% financial top-slice of any contract value contributing to central overheads. As an illustration, to cover central management and operational costs (e.g. insurance, accountancy and legal fees) in the region of £50,000, a portfolio of services/contracts to the value of £500,000 would be required. The ability for a new company to establish itself within a market and achieve a turnover of £500,000 within a couple of years is a challenging aspiration which needs detailed consideration around how these revenue streams would be generated. When the business plan was drafted in 2012, the detail on how this aspiration would be realised was unclear, and the new commissioning arrangements led by clinical commissioning groups

were at an early stage of development. There was a lack of detail around the commissioning intentions and whether competitive tendering would be applied within the local health economy. Therefore, the idea of the venture becoming self-financing within the timescale that was envisaged was ambitious because of the uncertainty and state of flux within the operating environment. Thus, it demonstrated a leap of faith by the member practices.

### 5.9 Proportionate representation and voting rights

As part of the governance arrangements, voting rights were allocated on a one practice, one vote basis, rather than proportionally based on population list size. Minutes from the executive team meetings in 2011 noted that this arrangement provided equity across practices, and would not disadvantage the smaller practices in any decision-making processes. As noted in section 4.4, in previous group arrangements the GPs and managers reported that there was a perception of inferiority amongst the smaller practices, and it was important that all member practices felt they were equally represented within the venture and had equal standing alongside the other practices.

### 5.10 Management support

Management support to the executive team was provided by two practice managers co-opted to the executive team and a dedicated part-time manager. The importance of practice manager representation at an executive level was captured in this quotation from one GP:

> *"[The managers are] absolutely key people in selling your strategy to their partners. However, in some practices if we wanted to sell something we couldn't do it through their practice manager, it has to be somebody from the board who is a doctor. Going along and talking to the doctors about it and then they can tell the practice manager what they think."*

This suggests that practice managers have a vital role in implementing strategy, and can be influential people within their respective practices around decision making and communicating with the wider practice teams. They were recognised as key people in implementing the federation's strategy at a practice level, and as a professional group they met regularly and had an opportunity to link with the executive management team to influence and shape thinking. However, it is also noted that, in some practices, the managers are less influential than the GPs, highlighting a variation in their status that exists across practices. One manager reflected upon their experience of being able to influence and engage with other managers:

> *"I think in terms of leadership, whilst I wouldn't give myself that label, I do think that there are conversations that we [practice managers group] have outside of the*

*federation's remit. Thinking about practice managers and emails that go around – I can influence a conversation because I've been part and parcel of what's gone on in the federation meetings."*

This comment suggests that whilst this manager did not perceive herself to be in a prominent leadership role, they did recognise their ability to influence others through communication and discussion amongst the manager group. It is noted that being part of executive team discussions is helpful in sharing information with the manager group.

To support the establishment of the federation in 2011 additional part-time management support was recruited to support the executive team implement strategy and pursue opportunities that would contribute to the business model. Part of the role included meeting with practices and networking with external organisations to seek business opportunities, responding to tender opportunities and seeking external sources of funding to support activities such as audit and education. In 2014, one executive team GP reflected upon the benefit of having external resource to work alongside the team:

*"It would be dead if it wasn't for you….because you have kept it going and you keep the thoughts coming and lots of developmental ideas. You've networked for us essentially all by yourself and I think you know that side of things has been essential – we've given you time and money to do that, but you've gone beyond time and money to do that and I think that has been vital to the development of the organisation and to the survival of it potentially."*

This statement confirms the benefits of dedicating resource to a business development role. This manager (the researcher) worked with the federation until 2016, and between 2016 - 2017 the management support for the executive team was provided by the practice managers. In 2017, when the extended access contract was being mobilised, another part-time manager was recruited to support business development and, in 2018, this individual led a review of corporate and financial governance.

### 5.11 Summary

This chapter examined the rationale for establishing a federation. A range of pressures were identified that challenged the viability of the GP practices, and a group of motivated and forward-thinking GPs promoted the concept of federated working with the aspiration of bringing practices to work closer together. Changes in the operating environment around policy and commissioning presented the opportunity for a group of entrepreneurial GPs to galvanise support amongst practices to engage in a collaborative venture. The practices had a history of collaborative working, but budget cuts had a destabilising effect and practices were left feeling vulnerable and isolated. The vision that was espoused centred on

the preservation of the existing model of general practice and continuation of local services within the rural geography. The vision that was set for the federation, and aligned with what the member practices were willing to engage with, essentially activities that supported the existing practices as individual businesses. During the study, the number of member practices reduced from 14 to 11 due to a merger of two practices and two practices opting to join a new primary care organisation which was established by the foundation trust. These eleven practices maintained their practice partnerships during the period of the study and continued to operate as separate businesses.

The corporate model of the federation, through a company limited by guarantee, presented the best option to minimise risk for the member practices, but required an alternative governance structure to that of the traditional practice partnerships. Corporate governance was established through a board of directors and an executive team. The board of directors comprised of partners from the member organisations, providing strategic sign-up to the venture. The members of the executive team were assembled from a sub-group of the board of directors, and did not include wider representation from disciplines of staff such as nurses or pharmacists, although the nurses were key members of the education and research group and were supported through their professional forum. There were several changes to the executive team during the study, but consistency was provided by one GP who remained as an executive team member for its duration. The practice managers were also identified as a key stakeholder group, due to their influence both within their practices and amongst their peer group. The not-for-profit business orientation was supported through social enterprise status in order to support the values of the practices in not wanting to be perceived as profit-making from their venture. The venture was initially established through member subscription, which was ultimately time-limited with the expectation that it would become financially viable and practices would receive a return on their investment. Therefore, one of the challenges was to develop the federation as a viable business.

The following chapter examines the activities that were pursued by the federation between 2011 and 2019.

## Chapter 6 – Case study findings: Implementing strategy

### 6.1 Introduction

This chapter explores the business strategy that was developed, how it was implemented between 2011 and 2019 and what was achieved through federated working across member practices. One aspect of the business plan focussed on supporting the viability of the member practices through a range of collaborative activities that were developed and organised. The other aspect of the business plan centred around developing a commissioned portfolio of services that would emerge as a consequence of changes in the commissioning environment. The following aspects of the business plan are examined within this chapter:

- Supporting practices.
- Creating efficiencies.
- Research & development.
- New business development.

Each aspect is examined to ascertain how it was operationalised, what outcomes were achieved, and what contribution they made towards realising the intended vision.

### 6.2 Supporting member practices

As stated in the articles of association and members' agreement, the vision for supporting member practices centred upon the notion of maintaining high-quality service provision across individual practices. Historically, there had been an arrangement funded by the primary care trust for a structured approach to quality improvement led by a local GP with a focus on clinical governance. However, these arrangements were withdrawn when the PMS funding was removed, and interviews with the executive team and minutes from meetings in 2011/12 revealed that practices valued this approach and it was felt that it was something that should be developed further through the federation. The executive team proposed that a structured programme of clinical governance, supported by audit, was at the heart of the approach to quality improvement, and this was supported by the member practices and re-instated. Delivering quality improvement was also regarded by the executive team as a way of promoting standardisation and reducing variation between the individual practices, thus providing evidence of quality care and enhanced patient outcomes.

Education and training was another area that the executive team identified could be more cost-effectively organised and arranged on behalf of all practices and a dedicated education group was established in 2012 to oversee a range of education, audit and research activities. In 2019, one practice nurse recalled:

> *"I can remember it starting and suspect it started at about the same time as the [federation] was developed and from that they developed what was called the AIRE group (audit innovation research and education). There were different representatives from different practices who would feedback into different groups. I was representative of this group [nurse forum] and it was basically trying to decide in that group, and it is still running by the way, different research projects that we may get involved in, education events, so there were lots of things that discussed there and they were fed back to practice nurses, practice manager teams and all that sort of thing and then information passed back again so it was just a way in and out to forward things, to improve research and education and from there, a separate research team was developed."*

This quotation highlights that nursing representation was embedded within the education group from the outset, and the dynamic nature of the meetings promoted two-way communication between the various professional groups. This insight suggests that all representatives at the meetings were actively involved in influencing and deciding on which projects or activities were pursued, and highlights delegated authority and decision-making to the group.

### 6.2.1 Engaging practice nurses through their professional forum

The practice nurses held a monthly forum where professional issues were discussed and educational activities were planned and aligned to training needs of the nurses working across the member practices. Although this group had been established prior to 2011, the executive team decided that it was important to endorse the function of the group and support the professional activities of the nurses, which was aligned with the vision of supporting practices. As noted in section 6.2, representation from the practice nurse forum was embedded within the strategic education and research group to ensure alignment between both groups.

During focus group discussion in 2019, two nurses who came to work within the locality during the period of the study highlighted the benefit of working together as a professional group:

> *"Before I came here I worked at a practice that wasn't part of a [federation], so it was a very big improvement as far as I could see and that practice nurses getting together through [the federation], it's not just [the federation] you know, but having that added support is really good."*

*"Talking to other practices, practice nurses, is something I never used to do in my last practice. Yes, we used to sometimes have to borrow things but I didn't really know the practice nurses in any of other practices that I worked in, but since I came to [Practice] I have noticed that there is a closer alliance between the different practices."*

In these statements the individuals were able to compare their current working environment with previous experiences, suggesting the current environment was an improvement and contact with other practice nurses to discuss professional issues was beneficial. This suggests that such a collaborative and supportive environment was not commonplace in other areas. Another nurse noted that some staff could feel isolated within their practice if they were the only nurse within that practice, suggesting peer support from a larger professional group was supportive:

*"I think to be working as a team……practice nurse meetings and at time outs you are mixing with other members - so it is not isolating, if you are working on your own you can get support from other practices nurses which is good."*

However, it was noted that not all practice nurses participated with the group, as one nurse commented:

*"There are some practices who do not allow practice nurses to come to this group because they don't feel that it is of benefit to the practice or the practice nurse, so they prefer them not to come here because they don't know what we do. There is a lot of suspicion, still to a degree, from some of the GPs or actually I think the practice managers that we sit and discuss our salaries and whether we are all getting the same or we are just having a whinge, but it is much more than that. We have a professional group and it's vital that we continue this…it's part of our clinical supervision although it's not official, it's not official supervision but it's probably the only supervision we get other than between individuals who work together."*

When questioned further on this point, it was noted that the practices referred to were a minority. It was suggested that not all managers or GPs see the benefit of such groups, and did not allow staff to attend. As highlighted, the forum provided an informal method of supervision and peer support, which was considered professionally beneficial and highlights that clinical supervision does not always take place at an individual practice level. The benefits of shared learning were also reported:

*"I think historically everyone has worked very separately. As GP practices, I think they wanted to protect how they worked and didn't want to share, and I think that has changed over the last few years."*

*"When we started doing the INR, the fact that we could go to another practice within the same group/alliance to work out how to do that, then that's pulling on other people's expertise to enhance our own practice which is good."*

These nurses argued that practice staff became much more open to sharing over time, with nurses approaching other practice nurses in order to enhance their competency and expertise. The nurses discussed their involvement in service developments:

> *"I can see in the future possibly sharing skills across practices at some point. I do wonder about thinks like travel health and having specialist services in one practice - like one practice being a diabetic expert diabetic centre and another one practice having respiratory, I wonder whether at some point that will happen, I don't know but at the moment I don't think there is any burning need."*

This practice nurse was appraising the current situation and presented future options to organise services differently or develop specialisms through closer collaborative working. The ability to raise suggestions with the managers suggests that opportunities to work differently can be promoted by the nursing profession. The nurses had a shared view that they were consulted and engaged in decision-making about changes to services, as captured below:

> *"I think, probably working as a group, we have a bit more of an impact on what happens at the time out events and things that we want to see happen."*

When considering the involvement of nurses at a strategic level, they were not represented on the board and, in focus group discussion in 2019, two nurses reflected on this:

> *"I think as nurses we probably are fairly apathetic about getting involved at a strategic level unless we have got a real burning desire."*

> *"I think your role is just so busy keeping up to date with your clinical skills and the job that you have to do really."*

These participants suggest that there is not a desire for the majority of nurses to be involved at a strategic level, and that they are focussed instead on delivering high-quality care. Therefore, the ability for the nurses to strategically influence through their professional forum and to influence professional development and training was important to them.

### 6.2.2 Educational & peer support through the GP club

A GP from one of the practices developed a GP club to support education, offer an opportunity for shared learning and create a peer support network for the GPs. The club met monthly and delivered clinically-themed education sessions available to any GP (salaried, partner, locum or GP trainee) working in the locality. A programme of educational topics was established in conjunction with the local foundation trusts, who provided consultant input into the programme which was seen as a method of improving clinical care and improving patient pathways. Any GP could suggest a topic for the programme and all

GPs were encouraged to bring case studies for peer discussion and review. Meetings were designed to be an hour in duration, and held in the early evening (6.30-7.30pm) on a midweek day, encouraging GPs to attend after their practice closed and prior to going home. Sessions were informal, no formal minutes were taken and the environment was relaxed and friendly, with light refreshments available. The club continued to meet during the period of the case study, demonstrating the benefit that this forum provided for educational purposes.

### 6.2.3 Developing practice protected learning time (time out)

In 2014, one of the executive directors led the development of a programme of protected time out education events which occurred quarterly. These events provided the opportunity for practice teams and professional groups to learn together and network. Practices were offered centralised on-call GP cover to allow them to release all members of the primary healthcare team to attend. The content for each session was produced with input from the GPs, practice nurses and managers through the strategic education group. These events were an opportunity to discuss both clinical and non-clinical issues, and sessions were organised to focus on the need of both groups. For clinical sessions, new clinical guidelines and clinical audits results were discussed. For non-clinical sessions, the managers invited external speakers and organised professional updates (e.g. pension updates, HR training). For the programme to be cost neutral, sponsorship from the pharmaceutical industry was sought, where representatives were able to meet local GPs and to discuss therapeutic developments with clinicians. These events became an important vehicle for the communication team to an update on federation business and a strategic perspective on federated activities, allowing practices to pose questions to the executive team. The benefits of these events were recognised by the practice nurse group:

> *"I think that the time out meetings which are for GP, staff, practice nurses is a good thing as you mix with GPs, nurses, receptionists - so it is all team members and that is held every quarter."*
>
> *"We were just talking about improvements through [the federation] and time out education and how that's been useful…"*
>
> *"I guess the time out events are an opportunity where we are often discussing topics that are of interest to all of us. So if we felt that there was a need for a big change in something, I'm certain as a group we would be able to push that forward."*

These comments highlight the benefit that participants gained. In 2019, one GP reflected on the culture that had been developed to support education, professional learning and development:

*"Education, there were the events at [location, organised by GP tutor] then me, the time outs which have worked over the years and have been particularly successful."*

This GP highlighted that education was an embedded feature across practices which had been developed over many years. Another GP commented on the benefit for their individual practice, which was based in a rural location some distance away from other practices:

*"The time outs work very well and brings our practice in as we are on the edge, and it's often too late to get to anything, but it has released us to do that and means we meet other GPs in the area which is good."*

The benefits of protected learning time were multi-faceted and a positive development to support federated working. The model of self-funding events was innovative in sustaining the programme on a recurrent basis, and funded the on-call medical cover to release staff to participate.

### 6.2.4 Practice manager group

The practice managers had an established monthly forum which provided a supportive environment for the managers to discuss operational issues and share experiences and learn from each other. There was an educational component and collaborative training was arranged (e.g. annual pension updates), and this was funded by the federation. One manager in 2019 reflected on the benefits of organising training as a group:

*"The benefit of having training organised as well, because that was something that practices have struggled with in this area – it has always been hard to access training."*

One of the executive team was a practice business manager (partner), and two other managers attended executive team meetings which provided formal links between both groups. A review of the minutes from the practice managers' group between 2011-2018 revealed that there was an established culture of sharing information across the practices to support operational efficiency. Although this was not formally linked to the federation's planning processes, it did demonstrate that every year practices did benefit financially from such group arrangements. Where individual practices had adopted a specific innovation, or had streamlined internal processes, there was a culture of information sharing through the managers' group for wider dissemination/adoption (e.g. clinical coding protocols). The managers regularly discussed federated working, as confirmed during the focus group in 2019:

*"We discuss [the federation] at every one of these meetings."*

This suggests that there was on-going discussion amongst the managers, and this included the managers who were co-opted to attend and input to the executive team meetings.

### 6.3 Creating efficiencies for member practices

The federation's 2012 business plan noted that economies of scale could be achieved across the individual practices. For example, staff could be jointly employed by more than one practice, or be employed by the federation to work across multiple practices, to share resource costs on a larger scale and provide practices with access to a larger pool of staff. Through the practice manager group, a staff sharing agreement was put in place in 2013 recognising that there were many part-time staff employed across member practices, which provided the opportunity to develop a flexible workforce that could be mobilised on scale, and this was publicised across practices. The agreement centred around the host practice retaining the employment of the member of staff and a financial recharge mechanism put in place for hours worked in other practices. An interview with one practice manager in 2013 revealed that medical staff sharing had also been put in place through a similar arrangement.

> "*We had a scenario where one of our GPs who does minor surgery was off for a period of time and we hooked up with [another practice] and asked one of their GPs to come and do services here, which meant that we could maintain the service we were wanting to offer and the benefitted from actually receiving the income which was great."*

This example was easily arranged and stemmed from a discussion in the practice managers' forum around sharing of staff and supporting practices. Another example of economies in advertising and recruitment was noted by one manager:

> *"We are advertising today in the [local newspaper], three of us so we've put the [federation's] logo on the advert, three of us doing the recruitment and then we've each saved money on the advert and obviously it makes a bigger impact so you'll probably get more interest."*

Minutes of the practice manager group between 2011-2018 revealed that they identified efficiencies that could be achieved through centralising stock ordering and negotiating discounts through bulk purchasing. Examples of this included bulk purchasing of flu vaccinations from 2012 onwards, which was led by one manager each year on behalf of all practices and achieved discounts. This was recognised as being a valuable arrangement that practices benefitted from, as highlighted by one GP during the focus group discussion in 2019:

*"Obviously there are other things – the practice managers and terms of buying vaccines and obtaining efficiencies that way."*

The federation manager also undertook a negotiation with one of the leading pharmaceutical companies in 2015 to provide a discount scheme on vaccines ordered. All practices were given the opportunity to register with the company for the discount to be applied to the individual practice sales account, but executive team minutes highlighted that less than half of the practices formally registered for the discount. The reasons for non-participation were not reported, and this was an example of autonomous decision-making of the individual practices. This autonomy was noted by one practice manager during discussion in 2019:

*"Well you don't feel that you are compelled – not everything is going to suit all practices, so the choice is there whether you take part or not."*

This highlights the democratic approach that was adopted by the executive team in not forcing practices to participate in activities that they did not want to, or were unable to participate in, for a variety of reasons.

### 6.4 Developing research in primary care

Participating in primary care research was an activity that some practices carried out prior to the federation being established. Through discussion at the research group and with individual practices, the practices agreed that activities around research and development should continue under the remit of the federation and be extended across all member practices. A dedicated part-time research facilitator was recruited, and this post was cost neutral to the practices as the income generated from research activity covered the costs of the facilitator and provided an income stream. A systematic approach to building capacity and capability was developed, and practice staff were given the opportunity to participate in training to be directly involved in research. Involvement in research was offered at different levels, and ranged from practices implementing recruitment strategies (by identifying patients eligible for inclusion to a research study based on eligibility criteria), or by actively delivering clinical components of a research study. The research facilitator explained that participation in research had been incremental, with practices starting by recruiting patients to clinical studies and, once they had gained confidence, they progressed to participating in delivering clinical components of studies. All practices participated in research activities as it was regarded as a method of generating income, as reported by the research facilitator:

*"I'm selling a product that people want and it is easy to get in the door and I think in other areas that's not the case, so that's a positive.....the job is about relationships and if you haven't got that it's much harder. I think what helps in practices where*

*people are cynical is when you can say the amount of money that has been brought in from research."*

This individual had worked to develop positive relations with the practices, thus progressing further income generation schemes. However, it also highlighted the need to demonstrate the benefit to practices of the activities pursued under federated working. Over time, the approach to conducting research developed and evolved as more activities were undertaken and confidence increased. Initially, practice nurses carried out research activities, such as identifying patients suitable for specific studies, but as activity increased this became more difficult as they attempted to balance the demands of research activities with care and treatment of patients:

*"All practices nurses were asked to be involved in research and a lot of us did some training to become research nurses for our practices and to deliver research on the ground but it was almost impossible time-wise to try and do that alongside your ordinary job."*

*"It used to be just nurses allocated time in the practice who would do the research but then it was too much, you know it took the nurse away from duties as a practice nurse, so then it was developed into a separate thing with employed separate nurses to do it, which works better."*

Research activity continued grow, with patients recruited to research studies, and the model evolved whereby research nurses were directly employed to work across all practices, fulfilling research contracts. This way of organising the resource resulted in liberating practice nurse capacity to divert to core clinical activities. By organising this work on a federated basis, practices benefitted from the staff employed centrally to co-ordinate the research programme. One nurse reflected upon the pressures on the nurses as research developed:

*"They were pushing so many [research studies] and it just became untenable really and I think from that they realised that the money that was spent separately into individual practices, if they amalgamated that and created some formal posts for research nurses it would be affordable to do that and I think it was a sort of a win-win situation as practices would get money because they were involved in research, they possible got a little bit less, but it meant that they would have our commitment that their nurse would do the work in their practice which would be paid by the research group which was much better, well I think so anyway."*

A further development took place when the approach to organising research at scale was recognised as a success. In 2018, the local clinical research network funded a dedicated research team, consisting of a part-time GP, part-time research facilitator and part-time research nurse who were employed to implement research activities across all practices. The team attended showcase events organised by the local clinical research network at a

local and regional level, and promoting the model of primary care engagement in research on a federated basis. In 2019, the federation participated within its first industry study, which was considered to be a big development in research activity and the executive manager reflected upon this progress:

> *"Last year we did our first industry study – we learned a lot. When we looked the time it took up we were losing out. It wasn't industry and others [studies], there was only capacity to do industry plus limited others. There was a lot of learning done, which is good because now we are more able to say, how much is this going to cost us and be much more accurate about that."*

This suggests that the research team had reflected on the experience, and learned to calculate the financial benefit of participating in specific research activities and assess the real cost of participation. As highlighted, there was only a dedicated amount of human resource available to allocate to research activities and, in future, more selectivity would be applied in deciding how this finite resource would be applied.

Between 2012-2016, income generated through research activity averaged £73,250 per annum, with all practices participating and benefitting financially. Between 2013-2016, an average of 2,165 eligible patients per annum were recruited to research studies. This illustrates that with the support and endorsement of the federation, an annual income stream had been developed for the member practices and, in 2019, a GP from one of the member practices highlighted the importance of research and the recognition that had been gained:

> *"We have [the research facilitator], plus the accrual rate in the [locality]t was the highest in the whole of [the region] and I think that was down to [the federation] and [the research facilitator]."*

Organising research at scale and the level of collaboration gained through federated working developed the federation's reputation as a credible partner in delivering primary care research. Without the impetus and support of the federation, practices would not have achieved the level of activity apparent, and the process would not have been as structured or organised.

### 6.5 Developing quality improvement on a population basis

The vision for evidencing quality of care was articulated in the 2012 business plan as a founding principle of the federation. To achieve this, there was recognition that the federation would need to attract funding from various sources, and this work was regarded as a way of supporting practices to undertake audit to evidence improving quality in care and reducing variation between individual practices. Reducing variation in outcomes across

practices standardises and improves quality of care provided in line with national guidelines around best practice. The federation embarked upon a programme by creatively seeking external funding from a variety of sources. Initially, the executive team reported that there was a reluctance to seek funding from the pharmaceutical industry on the basis that there was a perception that such relationships may influence prescribing behaviour. However, this perception changed as the team learned that the pharmaceutical industry could work in partnership with health providers (on a non-promotional basis which had no connection to prescribing activity) on projects that benefitted patient pathways and outcomes based upon regulations set by the Association of British Pharmaceutical Industry. The executive team recognised that by co-ordinating audit and quality improvement activities across multiple practices, they could evidence and demonstrate quality improvement not only at an individual practice level, but also on a wider population basis. Therefore, a programme of initiatives was pursued.

The approach of presenting the federation as a collaborative of practices with a registered patient population of 80,000 proved successful in attracting external funding from a range of sponsors. Between 2011 and 2016, analysis of documentation including minutes from the audit group and annual reports revealed that a series of projects had been pursued. The projects focussed on practices agreeing to participate in delivering audit or engaging with projects that focussed on improving patient pathways, and the undernoted table summarises the initiatives that were implemented:

| **Project Title** | **Scope** | **Funding Source** | **Timescale** |
|---|---|---|---|
| Palliative care partnership | Locality network group of multiple providers to improve quality of end-of-life care. | Self-funding | On-going |
| Local integrated network pilot | Pilot project aimed at integrated working between community and primary care. Focussed on reducing unnecessary hospital admissions. | Non-recurrent project funding - NHS foundation trust | 2011/12 |
| Quality improvement COPD | Audit of COPD patients and review of | Educational grant - pharmaceutical company | 2011/2013 |

| | | | |
|---|---|---|---|
| | treatment in line with national guidelines. | | |
| Quality improvement Stroke prevention in AF | Audit of atrial fibrillation patients and review of treatment in line with national guidelines. | Educational grant - pharmaceutical company | 2013/2014 |
| Quality improvement Osteoporosis & bone health | Audit of osteoporosis patients and review of treatment in line with national guidelines. | Academic Health Science Network (AHSN) & Educational grant - pharmaceutical company | 2014/2015 |
| Knowledge transfer partnership | Data mining project to explore demand on general practice and inform future design of work processes. | National KTP funding, technology strategy board & Educational grant - pharmaceutical company | 2013/2015 |
| Quality improvement Overactive bladder | Audit of patients with overactive bladder syndrome and review of treatment in line with national guidelines. | Educational grant - pharmaceutical company | January 2016 |
| Quality improvement Asthma | Audit of asthma patients and review of treatment in line with national guidelines. | Educational grant - pharmaceutical company | October 2016 |
| QoF health check project | Audit of practice clinical information systems to case find and increase prevalence across QoF indicators. | Educational grant - pharmaceutical company | August 2016 |

Table 9 – Summary of innovation projects

These projects illustrate the scope of the quality improvement work encompassed long-term conditions (e.g. COPD, asthma, end of life care), improved preventative care (e.g. stroke prevention, osteoporosis and bone health), and managing workload and demand (e.g. knowledge transfer partnership, local integrated networks).

These projects attracted external recognition from a variety of sources, and it was noted that the palliative care partnership successfully attracted funding to support a PhD student to conduct further research in this area. The findings from the work of the palliative care partnership and the COPD project were presented nationally at the BMJ Quality Conference in 2013. The osteoporosis project was showcased regionally by the AHSN at various stakeholder events and nationally at the National Commissioning Show in 2016. The KTP project resulted in discussions around the commercialisation of the project tools to assist practices nationally. Between 2012 – 2015 an average of £45,000 project funding was raised per annum, and this provided a revenue stream for the federation to be able to develop this programme of work.

The following outlines an exemplar of quality improvement through the work undertaken on an osteoporosis and bone health project which demonstrated that there were discernible clinical and cost-effective outcomes achieved through adopting a systematic approach:

| Case Study - Improving Bone Health Quality Improvement Initiative |
|---|
| **Background/Scope** |
| Bone fractures affect millions of people across the UK with 1 in 2 women and 1 in 5 men over the age of 50 suffering from them. The cost of fragility fractures places a substantial economic burden on the health and social care system with the cost of fragility fractures in the region of £2.3bn.<br><br>The federation made a bid for project funding to the regional Academic Health Science Network. The project was a partnership between the federation, a pharmaceutical company (Kyowa Kirin) and an independent audit organisation (Interface Clinical Services). |
| **Methods** |
| A standard clinical audit template was developed. The audit criteria were aligned to measure patient treatment against national guidelines (NICE CG146). The audit template was compatible with the two different clinical information systems in use across the practices. A clinical pharmacist from Interface Clinical Systems was aligned to each practice. The pharmacist spent a day in each of the practices and ran the audit on the local information system. A series of reports were generated which identified patients who had gaps in care. The pharmacist undertook a clinical review of the patients in conjunction with a named GP in the practice. Patients' treatment pathways were optimised where possible. Interventions included medicine optimisation, self-management advice, and medication compliance support.<br><br>The clinical audit programme was systematically applied across individual practices. Anonymised data from the individual practices was aggregated across all practice and provided a dashboard of audit outcomes.<br><br>The project demonstrated quality improvement applied on a population basis. |
| **Results** |
| • 1609 patients were identified with a diagnosis of osteoporosis and a further 110 patients were identified who would benefit from therapy optimisation.<br>• 209 patients were identified as being eligible for inclusion in the Quality & Outcomes Framework (QoF) generating £50,000 income to the practices.<br>• 36% of patients on QoF registers were not receiving a bone sparing agent in line with national guidelines.<br>• Projected financial savings of hip fractures saved because of therapy optimisation was £174,000. |
| **Promotion** |
| The project was presented at regional events hosted by the AHSN. The project was showcased at the National Commissioning Show (June 2016). |

Table 10 – Bone health project summary

The following case study summarises the work undertaken through the KTP project:

| Case Study – Knowledge Transfer Project (KTP) |
|---|
| **Background/Scope** |
| Knowledge Transfer Partnership (KTP) is a governmental funding stream available through Innovate UK. KTPs help businesses to innovate and grow. The organisation is linked with a university and a graduate to work on a specific project. A successful application was made to the KTP programme by the Federation and a local University. A funding grant of £93,000 was awarded to employ a KTP associate for a 2-year project. |
| **Methods** |
| To understand patient demand and utilisation of GP resources, a data mining project was established. A KTP Associate was employed and based within a nominated practice within the Federation. This practice would become the test site for the KTP development work. Patient data from attendances at general practice and hospital were merged into a single data warehouse and used for data mining purposes.<br><br>Cluster modelling (WEKA) was undertaken on the data to identify cohort groups with similar characteristics/health profiles. Cluster decision trees were applied to the modelling to highlight specific consultation thresholds for patients who were frequent attenders at the practice. |
| **Results** |
| Results from the individual practice scoping revealed:<br>• Over a 5-year period (2009-2013) there was a 4.4% annual increase in consultations.<br>• 84% of the test practice's population had a consultation with the practice during 2013.<br>• 41% of registered patients were on a QoF register.<br>• Patients with high consultation rates are not only accounted for by those on QoF registers and the 80+ population.<br>• 2.5% of the overall population consumed 25% of the total number of GP consultations.<br><br>Results from the WEKA cluster decision trees revealed:<br>• Three significant consultation thresholds - 10+, 15+ and 21+<br><br>A set of search templates were established and tested across multiple practices. These revealed comparable results.<br><br>A range of management strategies were tested to support patients within the consultation threshold groups of 10+, 15+ and 21+. |
| **Promotion** |
| The project outputs are in the process of commercialisation through a partnership between the federation and the university. This will generate income for the partners involved in this venture.<br><br>The federation are named partners in a bid for Health Foundation funding to test the project outputs at scale. If successful, this will provide the evidence of large-scale implementation which will benefit commercialisation. |

Table 11 – KTP project summary

A range of funding streams allowed the federation to pursue activities around quality improvement, evidence improved patient outcomes on a population basis and provide evidence of cost savings that could be achieved to the health system. However, between 2017 – 2019, less of a focus was placed on quality improvement initiatives, partly because the federation had succeeded in gaining a contract that diverted management resource

away from seeking external funding sources to mobilising the extended access service. This highlights that management resource was finite, and by dedicating time to contract mobilisation there was less of a focus on quality improvement through external funded projects.

### 6.6 Developing new business opportunities

The federation was regarded as a vehicle for the development of new business opportunities to deliver an extended range of services. The initial vision was that practices could deliver services and be remunerated accordingly, or staff could be employed centrally or through the member practices to deliver contracts on behalf of all practices. A summary of the tender opportunities, funding applications and services developed by the federation between 2012 and 2019 is provided below:

| Service/Application | Scope | Outcome | Date |
|---|---|---|---|
| **Any Qualified Provider (AQP) Opportunities** | | | |
| Hearing aid provision (Any Qualified Provider) | CCG commissioned service | Not applicable to the federation | 2013 |
| Community dermatology (Any Qualified Provider) | CCG commissioned service | Not eligible - federation did not meet the criteria within the service specification | 2013 |
| Anti-coagulation service (Any Qualified Provider) | CCG commissioned service | AQP contract awarded | 2013-2016<br>2016-2019<br>2019-2022 |
| 24-hour BP monitoring | CCG commissioned service (different locality) | Unsuccessful | 2014 |
| **Local service developments** | | | |
| Vasectomy service | Service level agreement foundation trust | Successful | 2012-Present |
| Integrated GP provision in urgent care centre | Service level agreement foundation trust | Unsuccessful | 2015 |
| Extended access to primary care | CCG commissioned service | Successful | 2017 |
| **External funding opportunities** | | | |

| | | | |
|---|---|---|---|
| Behavioural insights programme | Health foundation | Unsuccessful | 2014 |
| Prime Minister's GP Access Fund (Wave 1) | NHS England national funding programme for extended access to general practice – single federation bid | Unsuccessful | 2014 |
| Prime Minister's GP Access Fund (Wave 2) | NHS England national funding programme for extended access to general practice – joint bid with CCG | Unsuccessful | 2015 |
| New models of care (primary care home) | NHS England pilot site | Ineligible to apply | 2015 |

Table 12 – Summary of tenders and funding applications

This demonstrates that a range of opportunistic funding bids were pursued, and these are discussed in detail in the following sections.

### 6.6.1 Any qualified provider (AQP)

Any qualified provider (AQP) was an initiative introduced as part of the Health and Social Care Act (2012) as a mechanism to increase the range of providers. This allowed new providers to enter the market and compete for market share based on quality through a pre-determined service tariff that was set by the commissioners, hence providers would not be competing on cost. Each clinical commissioning group (CCG) was required to identify a minimum of three services where patients would benefit from having the choice of a range of providers. The local CCG relevant to the case study selected hearing aid provision, community-based dermatology, and anti-coagulation monitoring. Minutes from the executive team meetings recorded that the federation did not qualify to compete for the hearing aid or community-based dermatology contracts because the practices did not have the required skills or competencies outlined within the service specifications. The service specification for community-based dermatology required input from consultant dermatologists, which would require the federation to make a joint bid with one of the foundation trusts. However, executive minutes noted that the local trust intended to bid individually and did not need to collaborate with practices to deliver the service. This was a particular challenge for a newly-

formed Federation to be able to penetrate a market that comprised of larger, more established provider organisations.

In 2014, three years after the federation was set up, it was awarded a contract through AQP for the delivery of anti-coagulation monitoring. The federation acted as an agent on behalf of the member practices in the tendering process and a single bid was made on behalf of practices. The model of delivery was sub-contracted to member practices, bringing revenue to the practices delivering the service. The process resulted in a range of provider organisations being accredited to deliver anti-coagulation monitoring, which would give patients choice around the providers delivering the service. Providers were permitted to advertise their services to attract patients and compete for market share of patients eligible for treatment. However, a review of the service specification noted that a restriction had been placed on the contract that allowed only newly-diagnosed patients to be referred to the new providers, and this restricted the income that could be achieved from delivering the service. A review of executive team meeting minutes revealed that two service delivery options were considered. The first option proposed that a central service could be established through the employment of dedicated staff that either worked from a central location or from a range of practice locations across the locality. The second option was to offer the service from the individual practices that wished to set up dedicated clinics and deliver the service with existing employed staff, and this was regarded by the GPs as the best option for service delivery across a rural geography. One of the practice nurses involved in the mobilisation of the contract recalled the benefits of participating in the scheme and how training was organised to support the nurses:

> *"When INR/warfarin monitoring was being developed and rather than patients going into bigger hospitals for INR monitoring, I think what we tried to do was to bring it in-house and it was easier for patients to access. What we did was deliver some training across the patch with all of the nurses in the other practices that were going to take on INR monitoring. We got other people there, [the equipment supplier] who provided the consumables to help deliver some training so you could then do it in practice."*

Mobilising the service required upskilling of the practice nurse workforce through accredited training required in the service specification to enable them to expand their role. Minutes from the executive team revealed there was a capital investment made by the federation in nurse education, and for equipment to secure the contract and subsequently deliver the service. The contract mobilisation process identified 10 out of the 14 practices had expressed an interest in delivering the service, but only eight practices ended up establishing clinics on the basis that other practices could refer into the service. A review of corporate planning documents recorded that in 2013 there were over 1,000 patients on anti-

coagulation therapy across the federation's practices. However, with the restrictions placed upon AQP providers that only newly-diagnosed patients could be referred into the service, this limited the ability of providers to build up numbers of patients. It was noted that the existing service provider was one of the local NHS foundation trusts that delivered outreach anti-coagulation clinics in community settings. As the service was developed it generated an average of £53,555 per annum. In 2015, a total of 376 patients were being monitored in the service, and this equated to about a third of the eligible patients identified in the 2013 audit. The interview with the executive manager in 2019 revealed that the federation practices were reaccredited in 2015 and extended in 2019, and practices continue to deliver the service but the number of clinic locations reduced to seven. One GP reflected on the process of setting up the anti-coagulation service:

> *"I think the INR [anti-coagulation] programme shows how difficult it really is to set up a new service in primary care in terms of getting practices to engage and do something different and new. Some practices had a very different approach – some are very pro-active at getting patients to come to their INR clinic and others of us just didn't feel that it was appropriate and don't do it. I think it is very interesting how business minded some practice philosophies are and some practices could learn from that. But it did show how difficult it is to run a contract and make money from it in that AQP sense. I think that we have also been very fortunate that the people who have driven this have done so because they think it is a really good idea rather than for financial reward."*

This GP highlighted the differing perspectives that exist across practices, with some being pro-active in setting up, marketing and recruiting patients to their local clinic. He suggested that some practices are business-orientated in recognising this opportunity to generate income, but also that other practices are not so and could learn from being more business orientated. However, the quote also identifies that some practices signalled their intent to set up a local anti-coagulation (INR) service, but then did not do so. Some practices reported that their premises were being used by the existing provider (the NHS foundation trust) and they felt that it would not be in the interests of the patients to set up a competing service in the same location. In this situation, the different providers (the practice and the foundation trust) would be competing to deliver the service to the same cohort of patients registered with the practice. This highlights the tension between local competition and responsiveness to patient need and decisions taken in the best interest of the patient, which can be at the expense of developing the business model. As one practice manager in 2019 reflected:

> *"[The federation] gives a structure so that we have been able to set up services that we wouldn't have had as individual practices, so like the vasectomy service, the INR and more recently the extended hours, and not every practice engages with everything, so you are not forced to do that."*

When the service was extended in 2019 for a further two years, it was noted that activity had been falling following the introduction of a new medicine (novel oral anticoagulants) which did not require testing in the same way as warfarin. In 2019, one of the practice nurses noted:

> *"I think most of them now are taking an alternative medication to warfarin so the need for warfarin monitoring has reduced. I know we have gone down from about just under 100 patients to about 45/50 patients, so half what we were doing 5 years ago. So the need is not there now."*

With the introduction of the new medicines and the reduced demand for anti-coagulation monitoring of warfarin, the income that practices would get from the service would diminish over time as the new medicine becomes more popular. This reduction in demand was not something that the federation could influence, as it was based upon patient choice around medication and treatment. Considering the income that the service generated, the 10% contribution that the service makes to the federation's central management budget was marginal, with the majority of benefits realised by the individual practices.

### 6.6.2 External funding applications

Applications made to the health foundation and SHINE in 2012 and 2014 were unsuccessful. These schemes proved to be highly competitive with many applicants bidding for funding. A lack of detailed feedback was provided as to why the bids were unsuccessful, making it difficult for the executive team to assess the quality and applicability of their submissions.

In 2014, NHS England launched the first wave of a national pilot scheme to provide extended access to general practice during evenings and weekends, with a second wave of pilot sites sought in 2015. In the 2014 call for the first wave pilot sites, the federation made an unsuccessful bid for funding (£360,000) to develop a hub and spoke model to deliver services from two or three locality hubs. A subsequent application was made for the second wave of funding in 2015 as part of a wider CCG bid, which was also unsuccessful.

In 2017, following the success of the national pilots, CCGs across the North East of England were asked to roll-out the extended access service model on an accelerated basis. The federation was approached by the CCG to enquire how they would mobilise such a service across the federation's geographic locality. There was a proposal presented on the proposed service delivery model which was accepted by the CCG. After a period of three months planning, a hub-based service commenced in one of the premises of one of the practices. Patients from all other practices could be referred into the evening and weekend

GP and nurse appointments. This was seen as a significant development and brought recurrent funding in the region of £400,00 to the federation. At interview in 2019, one manager noted:

> *"I think that the hub was a big game changer for [the Federation] and in terms of how we all had to work."*

This highlights that the award of this contract was a major breakthrough for the federation, in terms of both bringing funding but also supporting practices to change the way they work. During discussion in 2019, another practice manager reflected:

> *"I think it has brought practices closer together, especially with the hubs [extended access] they do seem to be working better. We did anyway but we seem to be a lot better than we used to be."*

After the initial hub was established in early 2018, additional hubs were developed which enhanced the engagement of the member practices.

> *"We are working differently - we are operating as a sub-hub which wouldn't suit every practice but because our patients don't want to travel to [main hub site], it is working well for us. So that's recognising the challenges we have because of the geography of the [locality] that gives us that flexibility.*

This initiative was a significant development, and established a substantial revenue stream and brought practices to work closer together to develop the local model of care. Practice managers in 2019 identified the benefits that had been realised through this initiative:

> *"Sharing data and each other's medical records is something we would never have done maybe 5 or 10 years ago, whereas now it is happening every night in the hub and we've moved a long way from where we were on that."*

> *"It's changed practices attitudes really "my practice and my patients" and sort of opening one's eyes to the potential and that it is still your practice but it's a service for patients that we can collectively offer and yet retain your individuality."*

> *"The change in attitudes is really interesting because at the beginning our GPs were thinking ah this won't affect us and all of a sudden they saw what was happening, we've got GPs who regularly work at the hub, and doing sub-hub work at [Practice] and you think well isn't this fantastic, and the patients love it."*

These quotations present the positivity that was felt in terms of practices working together and illustrate that the initiative was implemented in a way which practices engaged with. They also provided a secure income stream as noted by one practice manager:

> *"It's the financial payment also, some of the partners seeing that money is coming back into the practice via [the federation] and I think that's what can be taken forward and that working together is actually a strength rather than a threat."*

It was also reported that this initiative helped improve relations with the CCG, with one manager in 2019 commenting:

> *"The CCG got a lot more engaged when the extended access came because they were being pushed by government policy and suddenly they were interested in using the federation as a vehicle to achieve that."*

This statement suggests that there was greater engagement with the CCG at this point to deliver on national policy which the CCG was required to implement. Co-ordinating this through the federation provided a tangible service development that practices had ownership of brought revenue to the practices.

### 6.6.3 Inter-organisational collaboration

Two examples of intra-organisational collaboration were identified: the successful development of a vasectomy service with one foundation trust and an unsuccessful collaboration to provide unscheduled care with another trust. Staffing constraints in the trust made the vasectomy service an attractive proposition for a joint venture. One practice with a GP qualified in advanced minor surgery took the lead on developing the service. After nine months of discussion and negotiation, a process of due diligence was undertaken which included ensuring that staff were appropriately trained and accredited, and all clinical standards were met. A three-year service was embarked upon through a tariff-share arrangement where the operational costs for both organisations were calculated and a financial model was established based upon an agreed level of anticipated activity over the contract period. At the end of each year, a financial reconciliation was undertaken and, after costs were deducted, the financial balance was shared across both organisations through a process of tariff-share. Feedback received from the trust in 2019 had been positive, and discussions were ongoing with other providers to extend the service across a wider geographic area. The federation's executive manager noted:

> *"We had a review with them [the trust] a few months back in September and they were really pleased, and said that the patient feedback we got was excellent compared to other providers. We are fortunate because the number of other community providers has been reduced."*

These insights into the negotiations between the federation and the foundation trust proved that by collaborating as practices, they were able to present a credible business opportunity which was of mutual benefit. In 2012/13 the vasectomy contract brought revenue of £9,738 and £18,026 in 2014/15. Also, whilst the service provided one of the member practices an income stream and the opportunity to develop a local service with a specially trained GP, it also generated a 10% contribution to the federation's central costs. The executive manager

confirmed in 2019 that this service continued to be offered to patients and generated revenue in excess of £200,000.

With regards to the unsuccessful proposal for unscheduled care, executive team minutes reported after a process of negotiation the business case was rejected as the trust perceived the proposal to be unaffordable.

### 6.6.4 New models of care

In 2015, NHS England invited organisations to apply to become Vanguard sites to test out new models of care delivery. These included three models: integrated primary and acute care systems; enhanced health in care homes; and multispecialty community provider sites. Minutes from the executive team meetings revealed that there was local interest from GPs in the model of multispecialty community provider, as it was felt that this would provide more local accountability and engagement of practices in the design and delivery of integrated healthcare. It was noted that applications to become a multispecialty provider required endorsement by the CCG. When the federation approached the CCG to discuss this, they were advised that it had been decided that a bid would be made on behalf of the health economy to become an integrated primary and acute care system, and this decision had already been endorsed by the CCG and the local medical committee. This illustrated that the federation was not regarded by the CCG as a key stakeholder and that the locus of power within the decision-making process did not include the GP federation.

Executive team minutes from October 2015 also revealed a further model of care (primary care home) was introduced by NHS England and would provide a capitated budget to populations of between 30,000 and 50,000. The federation expressed an interest in being a pilot site and attended a national information sharing event, but minutes revealed that when the application process had been finalised, applications would not be considered from health economies that were already involved in other Vanguard arrangements. Therefore, the federation was ineligible to apply.

### 6.6.5 Varying approaches to commissioning

In the healthcare environment of 2011/12, it was highlighted that making sense of the commissioning process was uncertain, and there was a lack of clarity around services that could be potentially commissioned through GP federations. Interviews with the executive team GPs and practice managers revealed one example whereby the CCG had indirectly commissioned from general practice through a sub-contractual arrangement with the

foundation trust. Rather than commission direct from general practice, which was deemed to be outside of the remit of the CCG at the time, a local arrangement was put in place to monitor the effectiveness and safety of disease-modifying anti-rheumatic drugs (DMARDs) in general practice, rather than in a hospital setting. The CCG commissioned the service from the foundation trust and, in turn, the foundation trust commissioned the service on a sub-contractual basis from individual GP practices. Interviewed in 2013, one GP in a lead commissioning role explained the process:

> *"We are currently paying the acute providers a tariff to initiate and monitor DMARDs, so very simply we sub-contract the work to be delivered in primary care, sub-contract that from secondary care trusts and we pay a proportion of the tariff indirectly to primary care through the foundation trusts."*

This example highlights a complex commissioning arrangement between the CCG and the foundation trust, with the expectation that the trust would sub-contract the service to be delivered in general practice. The federation was excluded from this process, highlighting a lack of recognition where they could be directly engaged to deliver this service on behalf of the practices.

Another example noted in the study identified that in 2014 a neighbouring CCG tendered for a 24-hour blood pressure monitoring service for its population. Whilst the practices in the study already provided this service as part of their core contract, the neighbouring CCG was willing to fund the service on a tariff basis. This highlighted a variation in the services deemed to be part of the core contract in general practice and demonstrated variation in approaches to clinical commissioning. Documentation reported that the tendering process was through an invitation to tender (ITT) process where interested providers make a bid to deliver the service and defined the cost-of-service delivery. Executive team minutes revealed that the federation made a bid which was unsuccessful and, at the end of the tender process, feedback was provided based upon the assessment criteria and the preferred provider awarded the contract was one of the foundation trusts. Minutes revealed that the executive team debated whether it was realistic to compete against large established organisations such as foundation trusts. It was also noted that at the time the foundation trust awarded the contract was a member of the federation, demonstrating the competitive behaviour of providers in the health economy.

### 6.7 Income generated through the federation

A review of accounts submitted to Companies House between 2012-2019 identified the income that had been generated through the Federation, which is noted below:

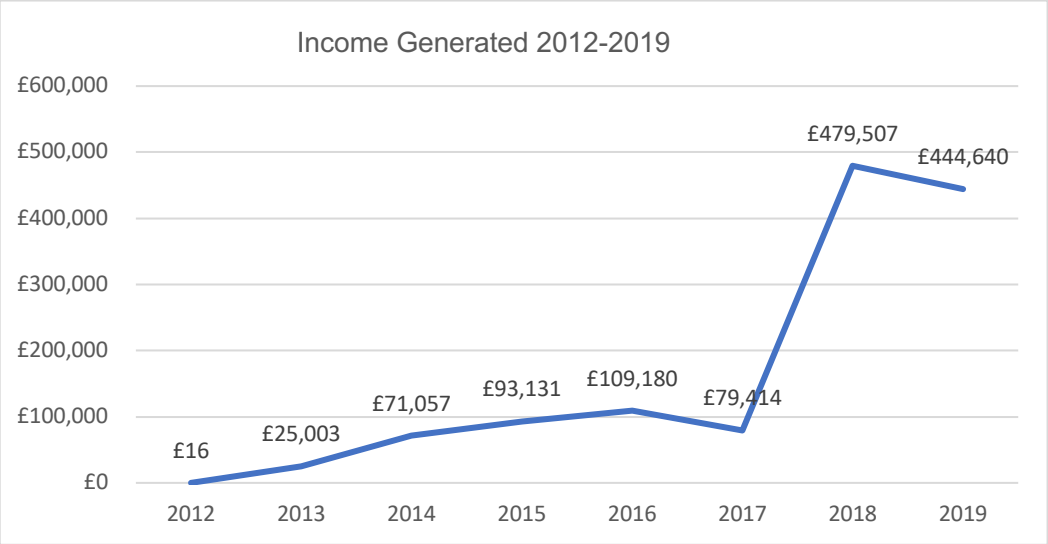


Figure 8 – Income generated by the federation (2012-2019)

This graph illustrates that there was an incremental growth in income generated between 2012-2016, with a fall in income reported in 2017. However, the introduction of the extended access contract was a significant boost in income, which fell off slightly in 2019. The information demonstrates that it took the federation six years to develop into a position whereby there was a significant revenue stream to support service delivery and federated activities.

### 6.8 Reliance upon commissioning and market development

When the federation was established in 2011, and the new commissioning arrangements were at an early stage of development, it was unclear how commissioning intentions would be defined and what level of market development would take place. The federation covered one locality within the CCG area, and when the CCG was established in 2012 there were three other geographic localities within the CCG boundary, but only one federated model of general practice. The role of the CCG, when established, clearly delineated the role of GPs within commissioning of acute services, but separated this from the commissioning of primary care services, primarily due to concerns around conflict of interest.

The federation set an objective to develop new services within the competitive environment that was envisaged would be developed by the CCGs. In 2013/14, interviews with the executive team highlighted the frustration in the ability to develop a service portfolio, and one GP reflected on this within the context of the new commissioning regime:

> *"I think we have been really unlucky with where we have been and where we are. Geographically, in the sense of the CCG not having money to help us develop because I think we could have been years ahead by now and doing some very interesting things on a primary care basis rather than having to go on the coat tails of [the foundation trust]."*

This statement illustrates a sense of frustration with the lack of opportunities and suggests that the negative financial position of the CCG had suppressed the development of market opportunities. Throughout the duration of the study, the CCG did not pursue a strategy of competitive tendering and market development opportunities were limited. It also highlighted the frustration over the inability of the CCG to commission services or work directly with general practice and developing federations, which they felt restricted their ability to flourish and had not been envisaged when the federation was set up.

One of the GPs from the external cohort interviewed in 2013 held a leadership role with the CCG, and provided a commissioning perspective on the ability of the CCG to directly commission services from general practice:

> *"I suspect that we [the CCG] are being more cautious than is absolutely necessary, inevitably there will be challenges to some of the processes that other CCGs have gone through to commission work from primary care."*

This statement points to the cautious approach that was adopted by the CCG and references examples where other CCGs had attempted to commission services from primary care that had been legally challenged by other service providers, thus delaying or halting the implementation of procurement decisions. Consequently, the lack of opportunity in tendering had a significant impact on the federation realising its vision for developing a portfolio of services, and one of the executive team GPs in 2014 reflected on the need for an adaptive approach to strategy:

> *"It was clear from an early stage that we weren't going to get anything from commissioners, so we had to learn how to get money or resources elsewhere."*

This GP highlighted there was a need to seek alternative funding streams rather than rely on the commissioners to develop the market and tender for services. Another GP reflected upon the commissioning process:

> *"I think when we started off we genuinely thought we were going to be able to bid and tender for a whole myriad of things we wouldn't have otherwise attempted to do because as an individual practice you would be too small - how wrong we were!"*

This statement illustrates the level of positivity that was evident when the federation was established around responding to tender opportunities, and illustrates the vision that was

held around the federation being the vehicle to respond at scale to opportunities. However, it also highlights the sense of dejection that this did not materialise. Rather than dwell on the lack of commercial opportunities, there was a continued focus on activities to support member practices. This GP went on to describe the reality of the commissioning landscape and the frustration that members felt:

> *"Yes, we have had the odd contract here and there, but that landscape just never arrived, that background of services being offered, and tenders being considered just never happened. Largely because of the situation our CCG is in and we understand that and appreciate that there just isn't the money out there to develop new things. However, at the same time, I think there has been a lot of procrastination in terms of things that could have been done in a different way, but it was decided wouldn't be because they were worried about conflicts of interest or worried about how it would be perceived from outside and a lot of lost opportunities I suspect along the way."*

This statement captures the disappointment that was experienced and suggests the challenging financial position of the CCG was a rate-limiting factor in being able to develop new services. However, it also captures a sense of frustration around being restricted by perceived conflicts of interest in the system, which, as evidenced in the proposal the federation made to the CCG to develop a vasectomy service, the CCG could not support. The relationship between the CCG and the federation was under-developed when the federation was set up, which contrasted with the report by Naylor et all (2013) that stated CCGs were well positioned to support primary care development, but recognised the extent to which this occurred was variable across England. Several perceptions around relationships in the health economy were presented by the executive team GPs in 2013/14:

> *"because really the person [secondary care, the foundation trust] who has the power doesn't really want us to get too independent. You know we are really useful to them in lots of ways and certainly they have used us in very different ways."*

The quotation highlights the perception that the foundation trusts have significant power and influence within the local health system, and suggests the GPs felt it would not be advantageous for GP federations to become too independent and have a greater influence. Another GP's view is captured below:

> *"We are up against the tide of the commissioning gap, and against the wind of the overwhelming organisational superiority of a foundation trust. We recognise that there is lots to be gained from provider to provider talking as opposed to provider to commissioner talking, we recognise the strengths of that and as soon as they think that we might take business away from them you can just feel the storm building again. You know you are walking this tight rope all the time and balancing that."*

This quotation suggests that when the CCGs were established, there was a time delay ('*commissioning gap'*) as they were formed and developed their role was within the newly

organised health system. It identifies the benefits of provider collaboration, but presents a sense of inferiority from the GPs. It also notes the behaviour dynamics (‘*the storm building’*) around any shift of market share, with the inference that the trusts become defensive and can threaten legal challenge when their market share is threatened. These perspectives capture the complexities within the environment that GPs and emerging federations had to contextualise.

### 6.9 Summary

This chapter examined the strategy that was pursued by the federation, which included both an external orientation and an internal orientation. Both aspects of strategy were explored, including the inter-practice activities organised for the benefit of all practices. Activities such as education and training supported continued professional development, thus enhancing the skills and competences of staff. Research provided an income stream to practices and also provided patients access to clinical trials and research studies. The quality improvement projects were organised through systematic clinical audit and peer review, and supported standardised of care, reducing variation across practices.

The externally-orientated aspect of strategy was based upon the premise that new business would be generated through market development within health. Market development was not a wholescale approach adopted by the commissioners, therefore the process of developing services took longer than anticipated, and results were on a relatively small scale in terms of generating revenue. As a result of a national initiative around accrediting new providers in healthcare (Any qualified provider), the federation was approved to deliver anti-coagulation monitoring. The vasectomy service was set up through a sub-contractual arrangement between the foundation trust and the federation. In the Autumn of 2017, there was a significant development with the CCG contracting with the federation to develop a model to deliver extended access.

The initial ambition for the federation to be an income generating model within two years was difficult to achieve as there was a dependency on external factors, such as the difficulties to maintain competitive tendering within the health economy, which jeopardised delivery of the original business plan. The strategic focus shifted after it became evident that tendering and procurement were not strategies that the CCG were going to pursue, and instead it moved towards generating revenue to support quality improvement initiatives that proved beneficial in supporting collaborative working across practices. A significant learning

point is the timeframe during which the venture was able to generate revenue, as what was expected within a two-year timeframe took six years to achieve.

## Chapter 7 – Case study findings: Galvanising support, sustaining engagement and looking to the future

### 7.1 Introduction

The federation was established as a joint venture by a group of GP practices to be complementary to existing GP practices, therefore support and engagement with the member practices was an important consideration. Practice investment to set up the federation demonstrated commitment and engagement at the outset, and the case study has been able to track and identify some of the challenges that the federation encountered as it established and positioned itself to align with both the practices and also within the wider healthcare environment. This chapter presents insights into maintaining and sustaining engagement through data collected at three different points in time: in 2013, through a questionnaire survey; in 2015, through a focus group with the executive team; and in 2019, through a series of focus group interviews with personnel from member practices.

### 7.2 Learnings from the early stages of developing the federation (2013)

In 2013 (two years after the federation was established), the Denison organisational culture survey provided an insight from 25 key personnel involved in the venture, including the board of directors, the executive team and the practice managers. The survey features organisational characteristics that can influence organisational performance, thus identifying areas of strength and also opportunities for development. From the 25 participants who completed the survey, a summary report was generated and, in addition, responses were analysed and presented from the perspectives of the executive team (n=6), managers (n=13), and GPs (n=12).

The circumplex report illustrated below provides a graphic summary of the questionnaire responses. In this example, respondents collectively rated organisational learning (adaptability) in the 88$^{th}$ percentile, which means the score was higher than 88% of other organisations who had completed the survey from results stored within the Denison global database. Visually, scores coloured within the fourth percentile indicate organisational strengths, whilst scores coloured within the first percentile indicate areas for improvement.

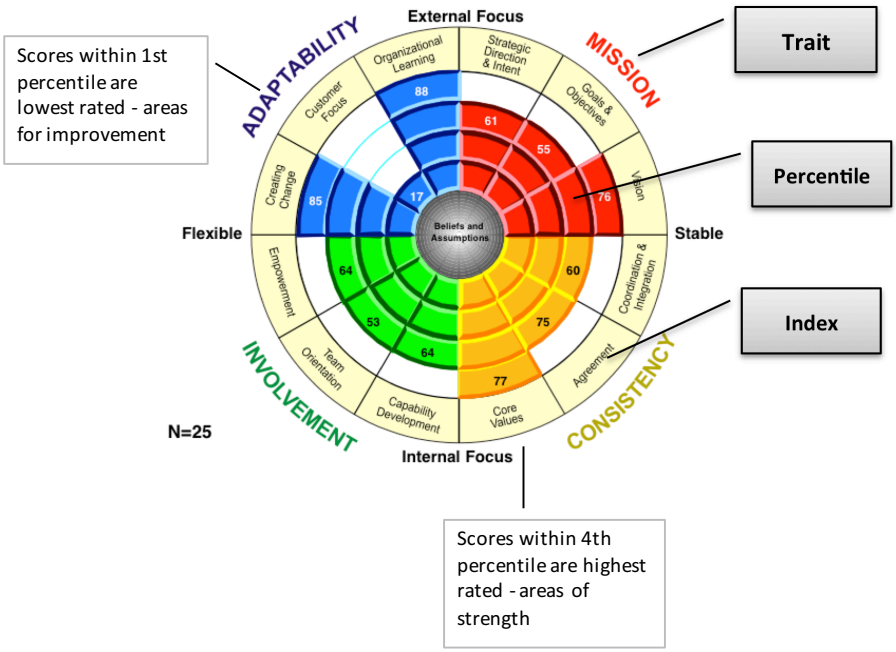



Figure 9 – Example of circumplex

The separate circumplex diagrams presented the responses from the different cohort groups and identified similarities and differences in perceptions. The diagrams presented overleaf highlight that the responses from the GPs and the executive team are similar in profile, but differences are noted in comparing the responses from the GPs with the manager,.

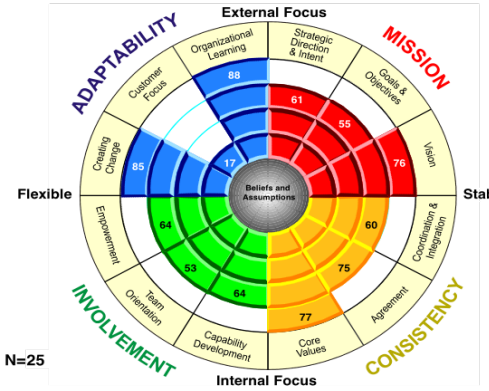



Figure 10 - Summary report


Figure 11 – Executive team report

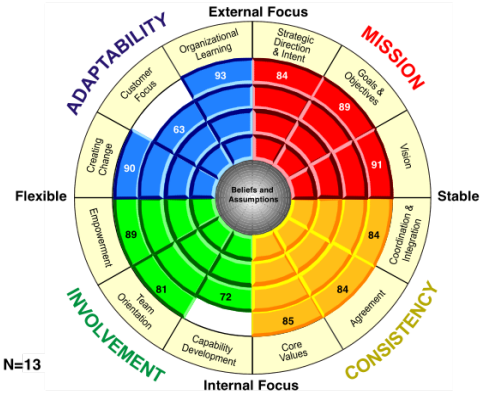



Figure 12 – Manager group report

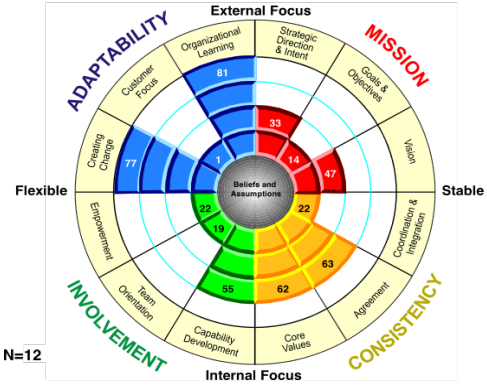



Figure 13 – GP group report

### 7.2.1 Insights around mission

Survey responses were scrutinised around: strategic direction & intent; goals & objectives; and vision. Differences between the managers, GP and executive team were noted:

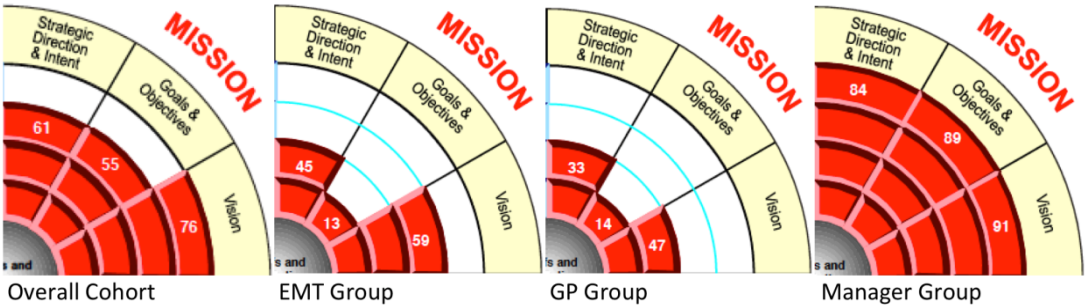



Figure 14 – Cohort results – mission

Responses relating to strategic direction and intent revealed the managers reported there was a clear strategic direction, whilst the GPs reported that there was not a clear mission and no clear direction that provided meaning and direction for the future.

Responses relating to goals and objectives revealed the managers reported there were activities around setting of realistic goals and tracking progress against goals. Meanwhile, the executive team recognised that this was an area for development, which contrasted with the views of the GPs. The GPs did not rate highly that the leaders had articulated the objectives of the venture, whilst the managers felt they had. Both the executive team and GPs indicated that there was not an understanding of what needs to be done for the venture to succeed.

Responses relating to vision revealed the managers reported that there was a long-term vision, but this was not shared by the executive team or the GPs. There was agreement across all cohorts that short-term thinking compromises the long-term vision, and there was also commonality in responses that leaders have a long-term perspective.

These results suggest that there was work to do to develop a long-term vision for the federation that could be communicated, and be engaging for the staff working within the member practices.

### 7.2.2 Insights into the federation's adaptability

Survey responses were scrutinised around creating change, customer focus and organisational learning, with creating change and organisational learning reported as strengths across all groups:

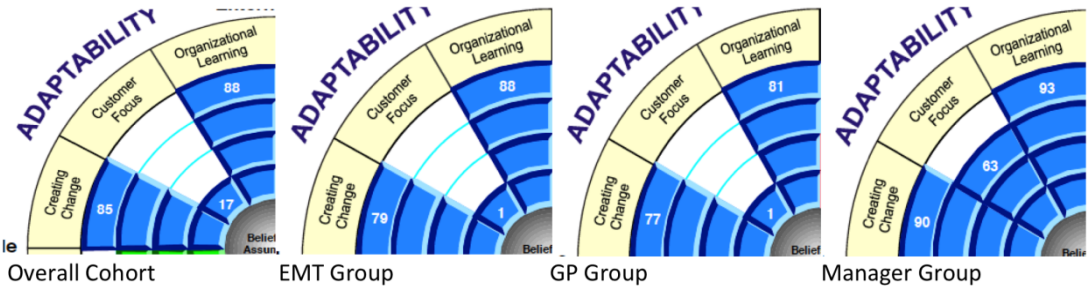



Figure 15 – Cohort results – adaptability

The executive team and managers reported that new and improved ways of working were continually adopted and resistance to change was low, which suggests an environment receptive to change. The ability to respond to competitors and changes in the business environment was noted as an area for development, which may be due to the timing of the survey and a lack of clarity about how commissioning would develop. Only the managers believed that various parts of the organisation (member practices) co-operated to create change, which may be attributed to the frequency of their meetings and the use of this as a forum for discussing and sharing information.

Organisational learning was one of the highest rated areas across all groups, which suggests an environment existed to support learning and improvement and where innovation and risk-taking was encouraged. All groups regarded failure as a learning opportunity, suggesting a willingness to experiment with new ideas and ways of working. Whilst GPs and managers agreed that parts of the system were joined up and aligned, the executive team viewed this differently.

Customer focus was the lowest rated index across all respondents and, whilst the managers indicated that they had a good understanding of customer needs (rated 63), the GPs and EMT responses were much lower (rated 1). Areas of development included customer input influencing change and decision-making. The survey questions did not provide a specific definition of the customer, therefore respondents may have interpreted this question in different ways. Customer focus was explored further during the focus group interview with six members of the executive team (including representation from GPs and Managers). It

was evident that there was ambiguity amongst participants around the conceptualisation of the customer within the context and environment of the federation. The group recognised the difficulty they experienced in defining the customer, and several options were offered and discussed. Three different conceptualisations were presented: the commissioner/payer of services; the member practices; and the patients.

The commissioner of services was identified as one customer who would purchase services from the federation, and the quotations offered below illustrate this:

> *"I would say the customers are the people who have engaged you to provide a service. It's going to be the people who have set up the INR AQP [anti-coagulation any qualified provider contract]."*
>
> *"Well the other way of looking at it is if somebody contracts [the federation] to do a piece of work - they are our customer, so you could say it is the foundation trust or the CCG or the drug company or whoever it may be that has given you money to do a piece of work."*
>
> *"If you were thinking about marketing this as an organisation, [the customers are] the people that you would be marketing this to. Yes, you would want the profile to be high in the eye of the patient, but the people that you are actually marketing to are the people who have contracts who will pay us to do stuff."*

Within the environment there were two main commissioning organisations: the clinical commissioning group and NHS England area team. They also identified other stakeholders that had commissioned services, such as the foundation trusts, pharmaceutical companies and the Academic Health Science Network (section 6.6). This illustrated that there were a range of stakeholders who had funded services or projects.

The member practices were identified as another customer group:

> *"I thought it was going to be the members."*
>
> *"I think it is the members that are our customers. Our customers are the people we are trying to help - the membership."*

Discussion also presented patients as the end users or consumers of services:

> *"I would have read it as patients."*
>
> *"I don't think we provide enough services that are directly impacting on the patients yet."*
>
> *"I read those questions as definitely the patients and I don't feel that we do have patient involvement at this level which is why I would have scored that low."*

These quotations suggest that, at the time of the survey in 2013, the federation was not at a stage of development to engage with patients directly, and there was a perception that when more services were being directly provided to patients that this would become an important consideration. However, one manager expressed the view that patient engagement took place at a practice level, rather than by the federation:

> *"at the patient level you would normally say they [patients] are the customer of the practice – they are the customer once removed from the federation itself. So, we are focussed on them, but we are focussed on them through the member practices."*

This suggests that patients are the consumer of services delivered by the practices and patient engagement activities are undertaken by the practices, rather than through the federation. Recognising the need to raise the profile of the federation with the public, minutes from the executive team revealed that from 2014 onwards advertising the annual flu campaign in the local media had taken place. It was recognised that there should be more of a focus on patients, and considering the venture's not-for-profit orientation one executive team GP stated:

> *"We are a social enterprise, we mustn't forget that. As a social enterprise we must show that there is a benefit to the community, so perhaps we should be redefining who this is for and it is to improve the quality of primary care for all our patients……if we don't get together we are going to cease to survive."*

This GP suggested patients were an important group within the context of the social enterprise status, and argued that there was an opportunity to describe the role of the federation to address this. However, the statement suggests that the message to be portrayed to the public was that the role of the federation was to support the quality and survival of local services. One manager highlighted the notion of capitalising on the loyalty of the patients to their registered practices:

> *"We should be brandishing that we are really at the heart of the NHS family. Your local practices have grouped together. Your local practice still exists and has an identity because that is the thing that people identify with, even more than the NHS. "Their practice" is how people think of it "in my practice" they are never going to say, "my federation" and I think you have to focus on that."*

This manager discussed patients' loyalty to their registered practice, but also highlighted the opportunity for the federation to promote itself as an entity supporting practices in the delivery of high-quality care and supporting the survival of local practices. However, because the NHS is state funded and patients have free unlimited access to their practices, whilst patient satisfaction is important to the providers and the commissioners, the system allows patients to choose which practice they register with and they are vocal when they are

dissatisfied or when there is a threat of taking away something they value (e.g. practice closure).

### 7.2.3 Insights into involvement

Survey responses were scrutinised around empowerment, team orientation and capability development:

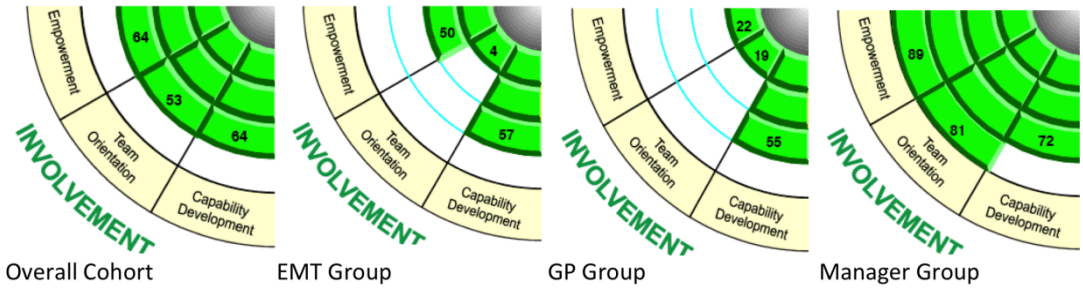



Figure 16 – Cohort results – involvement

Results pertaining to empowerment revealed that the GPs reported that not all employees were involved with the work of the federation. The executive team and managers agreed that decisions were made where information was available, but there were different responses between the managers and GPs around information sharing. Whilst the managers reported that there was effective information sharing, the GPs did not. The managers (and GPs to some extent) agreed that planning was engaging, which contrasted with the perception of executive team, suggesting that the GPs (and practices) believed they were involved in planning and decision-making.

When examining team orientation, there was consistency around the view that people are encouraged to co-operate across practices. However, the perception of team working was rated lower by the executive team and GPs compared to the managers, highlighting an area for development around engaging more people from the member practices in the work of the federation. There was a contrasting view around the organisation of work linked to goals of the organisation, with the executive team and GPs not recognising practice teams as the building blocks of the federation, and reporting that work was not arranged where people saw the relationship between their input and the goals of the organisation. This concurred with the findings around mission and vision, which were identified as an area for development.

Responses from all cohorts reported that capability was constantly improving, and people were regarded as important to competitive advantage. However, they also suggested that authority was not delegated for people to act on their own. The executive team reported that more could be done around skills development and GPs felt that more could be done to develop skills appropriate to the job.

### 7.2.4 Insights into consistency

Survey responses were scrutinised around core values, agreement and co-ordination and integration:

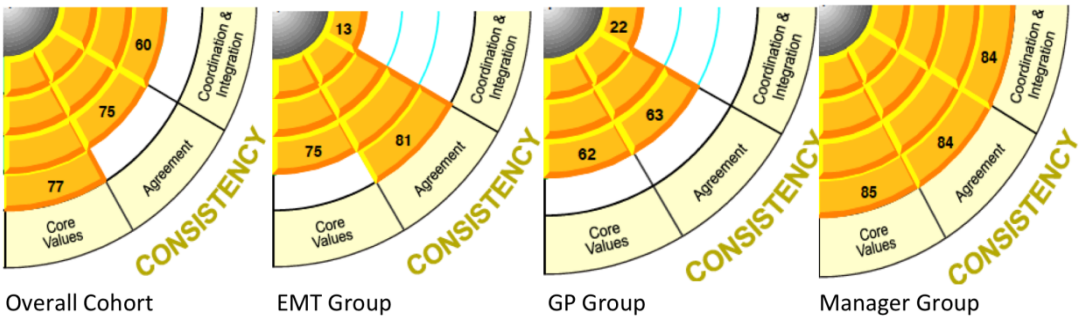



Figure 17 – Cohort results – consistency

Examining core values, managers suggested there was a consistent set of values evident, but this was not shared by the executive team and the GPs. The executive team and managers agreed that there is an ethical code that guides behaviour, and all groups agreed that leaders and managers follow through on doing what they say (practice what they preach), which concurred with the findings from the executive team's authentic leadership questionnaire (Section 5.11).

Exploring the views on agreement, managers reported that when disagreement occurs people work hard to resolve it, and all groups agreed that it was easy to reach a consensus on difficult issues. The managers reported that there was a clear agreement about the right and wrong way to do things.

The coordination and integration responses revealed that the managers reported that it was easy to co-ordinate projects across practices, and that there was a consistent approach to doing business, but the executive team and GPs did not share this view. They felt that people from various parts of the organisation (member practices) did not share a common perspective, and that there was not alignment of goals across the member practices.

### 7.3 A mid-point perspective from member practices (2015)

The Denison survey results suggested that there was a lack of consistent agreement about what the Federation was set up to achieve and the executive team reported they believed there was a lack of co-ordination across practices (Figure 16). In May 2015, four years after the venture was formed, two evening workshops were organised to establish the key challenges for practices and whether these challenges should be responded to by practices individually or collectively. Invitations were extended to all GPs and Managers from the member practices and between both workshops all practices were represented, with a total of 30 GPs and Managers in attendance (25 GPs and 5 Managers). Workshops were facilitated by an external facilitator allowing the Executive team to participate in the discussion.

#### 7.3.1 Creating a Supportive Environment

Participants were positive about the opportunity to come together to share ideas, gain peer support and hear the views from other practices of the common challenges they were facing. There was a perspective that it was beneficial to have the views of the rural locality presented as a collective voice. The vulnerability of the smaller practices was captured in feedback from one senior partner in one of the practices, where two partners left within a short period of time:

> *Workshop feedback GP1*
> *"My main impression is that we are all in very different places. I think that not everyone yet subscribes to the view that maintaining the status quo is not an option. I suppose that as a small practice, which has had its last two GPs leave either to emigrate or retire early, I have had to think very carefully about the future already and essentially feel very vulnerable. I do wonder if some of the larger practices are sitting there and thinking they might benefit from the occasional smaller practice collapsing, thus taking on more patients."*

This GP highlighted the sense of vulnerability and the instability created when partnerships change and partners leave. In the context of shortages in the GP workforce, the impact of not being able to replace retiring or leaving GPs became problematic. Another GP did suggest that there may be a role for the federation in supporting recruitment across practices. There is a Machiavellian aspect around the view that the failure of the smaller practices may be advantageous to the larger practices, who may benefit by obtaining larger list sizes through merger or dispersal of patients if practices close.

### 7.3.2 Varying perceptions on the need for change

Participants highlighted that there were differing views amongst practice representatives on the need for change:

> *Workshop feedback GP2*
> *"Good debate, but it was clear that the case for change still has to be made for some."*

> *Workshop feedback GP10*
> *"Education meetings and sharing views between local practices is a very positive function of the federation. We do not really see any way that more intense collaboration between partnerships would be workable."*

> *Workshop feedback GP6*
> *"We definitely need the federation but there is a reluctance to commit fully."*

> *Workshop feedback GP3*
> *"Overall I think we [the federation] have a future and will start co-operating when we have to. As yet, it is not a financial necessity. The time when it will become so is fast approaching."*

These comments highlight the different views amongst practices and the reluctance amongst some practices to engage fully with the federation. The final statement suggests that practices that remain financially viable in their existing format support the position of maintaining the status quo. Activities such as education and training were valued, but the contribution from GP10 illustrates the strength and individualism of practices as independent contractors, and the influence this has in deciding to what extent practices participate in collaborative activities. There is alignment between this feedback and the Denison results around co-ordination and engagement.

### 7.3.3 Discussing alternative models of general practice

When considering whether the federation had a role in supporting practices to work on a larger scale, participants suggested that practices were at differing stages of thinking in terms of defining what general practice may look like in the future. One GP suggested that there may be a role in developing a super practice, where multiple practices come together in a more formalised contractual arrangement. However, they also felt that practices would need to commit to this in principle before such a notion is pursued:

> *Workshop feedback GP7*
> *"I think there could certainly be a major role for the federation to develop a model to deliver primary care at scale, by some means of a super practice. That said, that will take time and funding and we really need something soon, or at least a firm commitment to be moving to that goal."*

This insight revealed that there may be a willingness to engage at a greater level, but another GP reported that there had not been enough debate about the possibility of other options available to practices:

> *Workshop feedback GP4*
> *"Options for mergers into larger units was shied away from – practices mostly like the current self-determination (even if it is partly illusory)."*

These statements provided varying insights into the need to operate on a larger scale, and whilst there was recognition that working within a different model would be supported by some (GP7), this view was not universally shared (GP4, GP5, GP6). GP3 suggested that there is not a necessity to work on a larger scale to that of the individual practice, implying that when practices experience a crisis they will be forced to react and seek more sustainable solutions. Moreover, GP4 suggested that the option of multiple small practices operating on a larger scale is one solution for practices to become more resilient and sustainable, but there was reticence amongst some practices to consider alternative options, thus recognising that many prefer to retain the traditional partnership model and the autonomy this provided.

### 7.3.4 Alignment to a shared vision and common purpose

Resonating with the findings from the Denison survey around the need to strengthen the federation's strategic vision and focus, some participants argued that this lack of vision may be impeding the development of the debate about alternative models:

> *Workshop feedback GP5*
> *"The session was very useful……. but without a focus to move forward. That could be one of the main reasons that people were a bit reluctant about the value of the federation."*

> *Workshop feedback GP8*
> *"The need for change has become or is becoming apparent to the majority of practices locally. If they were presented with a robust and achievable proposal that met their expectations, then the federation would be well supported."*

There is a suggestion within these statements that there is scope to explore alternatives for practices to work as collective organisations. Another GP suggested that the capacity needed to dedicate to this may be problematic, and identified that the prospect of loss of autonomy was a barrier:

> *Workshop feedback GP9*
> *"I suspect partly because no one has spare capacity and does not want to get roped into more work, but also possibly because I doubt that many of us really like the look of the future. Most of us are GPs because we like the generalist role and want to*

*look after our patients in our own way. The prospect of losing so much autonomy in larger groups is not appealing. At heart we are all thinking of our own circumstances rather than an altruistic aim of 'saving' general practice in the locality. Mass co-operation will probably only happen when we have no other options and I suspect the first thing that will force that will be having to cope with seven-day working."*

These comments illustrated that there was reluctance and reticence that the current model of general practice needed to change, despite the paradox of the pressures that practices individually face meaning they will only move towards a larger scale unit of operation when they are forced to or reach crisis point. One GP highlighted the example of seven-day working as a national initiative that practices would be required to deliver, and suggested that this would force or require greater collaboration between practices because they would have difficulty in delivering the requirements on their own. As reported in section 6.5, activities such as research and the extended access project proved to be enablers that supported a greater degree of collaboration amongst practices.

GP11 highlighted the challenge of getting practices to engage, own and set the direction of the federation. This reflects the findings from the Denison survey where the GP cohort rated the level of involvement (empowerment and team orientation) across the federation as an area for development. This suggests that, when considering the federation's role as a representative body on behalf of the individual practices, it is not perceived by all practices as being integrated with the individual member practices:

*Workshop feedback GP11*
*"One thing that came across to me was that the federation - for some in the room - is very much "them" rather than "us" – in much the same way as the CCG is seen. I don't know how you go about addressing that, but it is difficult to see how things can move forward without getting that sense of ownership, along with the mandate to make delegated executive decisions."*

This suggests that ownership and decision making are key issues for consideration within the context of the federation, combined with setting a compelling vision that practices can engage with. Concurring with the findings from the Denison survey, a greater emphasis was required on empowering and engaging with member practices. One GP reflected the need to dedicate additional time in developing a credible vision and strategy for the future:

*Report extract GP12*
*"Perhaps we are an organisation in waiting. Most of the collective work done in the past has been responsive. If we are to become a voice and a body to negotiate with, it is clear that there needs to be more time invested. Practices are reluctant to invest further without a clear strategy at to what we are investing in."*

Whilst this GP recognised a reactiveness, their statement suggests that there is a lack of strategic vision for federated working. This concurs with the Denison survey, where the GPs

reported a lack of a clear vision which made it difficult for the practices to engage. Financing the venture was another issue that was discussed, with some practices not recognising a return on the investment in the set-up of the federation, and feedback (GP12) highlighted the lack of appetite for further investment.

The workshops presented the opportunity for frank discussion amongst participants. Field notes revealed that the GPs were more vocal than the managers, and perspectives were presented from senior partners as well as salaried GPs who were in attendance. It was evident that the debate was challenging, particularly discussions around new models of care that may have felt threatening to some. The federation was set up as a joint venture to support individual practices, and the discussion around any greater form of collaboration was an insightful barometer of member perceptions.

### 7.4 Mid-point reflections from the executive team (2015)

After the evening workshops had taken place, a focus group interview was held with the executive team to reflect upon the feedback that had been received. Making reference to the "Who Moved My Cheese" parable, the team described the process they had experienced over the past four years in developing and leading the federation:

> *"For the Federation we need to think - where is the cheese, because we are not actually finding any cheese whatsoever."*
>
> *"It feels like there is no cheese."*
>
> *"I think we can smell the cheese, we just don't know where it is."*
>
> *"I think someone has put the aroma of cheese in various places to cause a trail."*
>
> *"I think there is cheese coming and someone is going to grab it before we even find that it is there, that's my major, major concern."*
>
> *"Someone's name is already on the cheese before it arrives, that's how these things work – and it ain't us…"*

These insights portray a sense of frustration in making sense of the operating environment and identifying where opportunities existed. One manager reflected on the reason why the venture was formed and the difficulty of establishing as a new provider in the health economy:

> *"We have developed out of what we perceived was a need, a reaction to what's going on around us – desperately trying to forge some sort of place in the healthcare landscape. That's not typical of other businesses that have set themselves up*

*because they have something to sell or have a gap in the market to plug. How many organisations exist just for the feeling that they ought to be there?"*

This statement suggests that the venture was formed to respond to perceived opportunities that may present, which was different to organisations that were pursuing strategies of diversification with new products or new markets to enter. The statement summarises the challenge of establishing a presence in the healthy economy as a representative body of multiple practices. At the time, there was no need for the commissioning organisations to formally recognise the federation as a collaborative grouping of practices, and market development was limited. Therefore, gaining recognition was challenging.

### 7.4.1 Altruism and group cohesion

The principle of altruism and pursuing activities that would benefit all practices was a core value espoused within corporate documentation, and one executive team GP illustrated that some practices have engaged and financially benefitted, whilst others have not:

*"I've been thinking in federated terms for a number of years …… and trying to create environments that all the practices can make money, and have opportunities, and that's what we've been about. It is interesting that the feedback you get that you haven't done anything, and they think those opportunities haven't arisen. Some practices have made an awful lot of money out of the opportunities that have been put in front of them and some of them haven't. A lot haven't, because they haven't bothered, and we haven't done it for them, but we've put the opportunity there for them and they could have made with a lot of money as well. You kind of lose a little bit of your, you know, group focus."*

This highlights the personal investment made by the individual and the sense of disappointment around negative comments and feedback that were made during the workshops. It highlights a lack of awareness around the initiatives and services that had been developed, and the challenges of engaging multiple independent businesses. Throughout the study there was evidence of differing levels of engagement. One practice benefitted significantly from the vasectomy service that was set up through the federation and received a regular payment for the service provided on behalf of all practices (section 6.7.5). In the example of the anti-coagulation service (section 6.7.4), 10 of the member practices initially committed to delivering the service when it was commissioned. However, only half (seven of 14) of the member practices at the time progressed to set up a service, and those that did only delivered the service to their registered population and not to a wider population of patients registered with other practices, thus demonstrating partial engagement. When considering the challenge of engagement of individual practices, one GP noted:

*"The GP's in particular are like herding cats and to get agreement is a real challenge."*

*"Keeping all practices full of frogs in a wheelbarrow is the real challenge, it is very easy for people to jump out, and to jump out when the CCG intentionally or unintentionally are providing very uneven ground or put blocks in the way. You know you could hit a brick wall with the CCG and all the frogs would fall out - identifying those things and as soon as you see the block coming or you hit it - and half your frogs jump out! It's getting around them again, it's just what happens, it doesn't mean we are wrong – we just have to get back in the wheelbarrow, we have to keep going…."*

These quotations highlight the difficulties in getting individual practices to collaborate as a cohesive group, with both quotations presenting idioms of creatures (cats and frogs) that are perceived to be independent-minded and difficult to control. Herding cats is an idiom that suggests the frantic and skittish nature of an animal that needs personal space for its stubborn and independent nature, making it impossible for them to be shepherded. The idiom of the frogs in a wheelbarrow provides the reader with a visualisation of multiple small creatures who are characteristically nimble and quick to jump within the vessel of an unsteady wheelbarrow. The expression suggests that at every bump or difficulty experienced by the wheelbarrow some of the inhabitants will jump, and the task of grouping them back together again is important and time consuming. Therefore maintaining commitment and engagement from multiple practices with autonomy and individual identities is challenging and requires continual effort to support the collaborative nature of the venture.

### 7.4.2 Direction setting and maintaining engagement

Although all practices actively engaged in the venture when it was established in 2011, it became evident that there was no shared agreement amongst members as to the mandate that they wanted the executive team to pursue on their behalf. This concurred with the Denison survey findings that indicated a lack of strategic direction, goals and objectives (sections 7.2.3 and 7.2.4). Workshop participants highlighted there were varying degrees of engagement (section 7.3.3) and one executive team GP reflected:

*"It is interesting because we think that there has been over the years quite a few small successes to which we advertise, spread the word. The information is presented at the annual general meetings about what we do, so it is all very upsetting to hear that people who perhaps don't read anything, or listen are making judgements that are not based on facts."*

This statement illustrates that the despite efforts to communicate achievements and developments with the member practices, they were not recognised by some. The disappointment felt by this GP was evident around communication not filtering through to the

GPs working in the practices. The federation developed a range of communication methods, including face-to-face communication (e.g. annual general meetings and updated at time out events) where all practice staff were present and also electronic communication (e.g. key messages emailed from the executive team on a monthly basis). Annual reports were compiled and circulated in advance of the annual general meetings which detailed the work and the successes that had been achieved. Documentation in the form of registers of attendance at meetings revealed that not all practice staff attended the meetings, with most practices being represented by the practice managers. One GP reflected:

> *"The managers have a fairly clear picture of what the federation is about, why we formed, where we think we are headed in the future, why we think we need to act the way we do, and I think most managers have grasped it. That's what they would say. I think the GPs are all over the place in terms of where they are on that scale."*

This suggests that the managers had a clear understanding of what the federation was set up to achieve, which concurs with the results of the Denison survey (section 7.2.1) where they reported greater engagement and co-ordination with collaborative activities. A question therefore emerges as to why their role in communicating federation business had not filtered down to the GPs working within their respective practices. Analysis of corporate documents revealed several mechanisms were put in place to strengthen communication with the practices. For example, at the end of each monthly meeting of the executive team, three key communication messages were agreed and emailed to the board directors (lead GPs) and managers in each practice asking them to circulate this communication amongst their practice teams.

### 7.4.3 Personal commitment and investment in leadership

Developing and leading the federation required a significant amount of investment from the members of the executive team, which conflicted with the pressures that they faced within their individual practices. This was summed up by one executive team GP:

> *"Personally, I am so inundated with clinical work, to think about the federation and without protected time it is a real issue. We need more protected time or dedicated time for the federation."*

This statement from one of the GPs on the executive team since 2011 highlighted that it was becoming increasingly difficult to dedicate adequate time to the venture without remunerated protected time to do so. The statement illuminates the dilemma of GPs balancing their roles as active GPs/senior partners within their practices with developing new organisational forms to support practices. Minutes from the executive team meetings in 2011/12 revealed

that during the first six months of set up, the executive team met fortnightly to provide momentum and drive the venture forward. Their input during this set-up phase was partially remunerated, demonstrating a high level of personal commitment both from the individuals and significant additional investment from the host practices that these individuals belonged to. After this period, a payment schedule was agreed for the executive team, but without dedicated time from key personnel it is difficult to envisage how the venture would have progressed.

### 7.4.4 The future role of the federation

When discussing the future of general practice, one GP reflected upon the primary care strategy that was in development in 2015 by the CCG, and the implications that this may have for the future configuration of general practice:

> *"So, the role that we have to think about is 'which model of GP are we wanting to preserve?' and then focus on that - is it the traditional model of GP or is it something different? [The CCG Director of Primary Care] is thinking about all sorts of different things in that primary care strategy and none of them are around the small practice model. So, you know we really have to think about what direction we want to go in – genuinely, as individual practices. So, I think it's all very tricky and we've all got a bit of very serious soul searching about where we are going as business people."*

This statement illustrates the dilemma that practices face when considering the future direction, and highlights the level of reflective introspection that is needed. The CCG had started to form a strategy for primary care, stating the need for practices to consider working at a scale larger than that of the individual practice, but they did not define what this model should be, suggesting that different emerging models would be supported. However, it was noted that there was no financial investment from the commissioners to support the development of such models. This insight suggests that individual practices needed to consider what strengths existed in the current model of general practice, with a view to developing a new model around those strengths. When considering the notion of a shared vision, one GP reflected:

> *"You have to have an idea of what you want to achieve, and I think that's the thing we haven't actually nailed. We have a vague sort of mission – we have the words but actually it's partly dependent on the landscape and partly dependent on which commissioners have money – and we are blowing in the wind a bit really."*

This quotation highlights the vagueness of the vision that was articulated when the venture was set up, at a time where the commissioning landscape was continually evolving. The financial position of the CCG was noted as a factor which inhibited the practices realising the

vision for federated working, and highlights the contextual factors within the health economy that were significant and beyond the control of the GPs' influence.

### 7.4.5 Practice individualism and business orientation

The independent contractor status and autonomy of the individual practices were key factors within the venture, and one executive team GP reported:

> *"I think the influence of the partner model on the lack of success of the federation has been profound, not just protectionism although that is a very strong driver, but if you look at the business model at a practice level you will find the same level of non-engagement in the practice as a business. The partnership model is still based upon valuing clinical work over everything else and being business orientated is considered as 'greedy' or 'just interested in the money' and not altruistic enough…..looking after patients is seen as the overriding priority and the basis for having influence within the practice – everything else is a distraction!"*

This statement suggests that some of the negative comments articulated during the workshops revealed a perception amongst some GPs that the venture had not been a success, despite evidence of the activities that had been pursued or developed. It illustrates the difficulties of engaging practices in the venture, and also provides an insight into dynamics within partnerships of engaging GP partners in the business aspects of the practice. The inference of engaging GPs in business aspects the federation is similar to the challenge that exists within partnerships. It illustrates the preference for GPs to have clinical orientation which is greater than the interest in the business aspects of the practice.

The mixed feedback received suggested there was a disconnect between the executive team and the GPs in the member practices, and questions whether communication methods were effective and whether this impacted on individuals forming perceptions about measures of success. This feedback had a demoralising effect on the executive team, who had invested significant personal energy in establishing and pursuing activities on behalf of the member practices.

## 7.5 Member reflections eight years later (2019)

Despite the mixed perspective aired in 2015, educational and research activities remained, as did the vasectomy and anti-coagulation monitoring services which continued to generate income. In 2017, the CCG were seeking GP practices to deliver extended access to appointments during evenings and weekends, and practices agreed as a federation to establish a large-scale hub-and-spoke model, allowing one practice to develop a central hub where all practices referred patients into. This allowed operational systems and processes

to be developed, and for the administration of the service to be developed centrally before spoke centres were developed in some of the rural practices with the support and co-ordination from the central hub. This allowed for the practices to be engaged in developing the model, supporting ownership and commitment to the service that had been implemented. The funding that this contract brought to the federation allowed external management support to be brought in to support the mobilisation of the service.

In autumn 2019, a series of three focus group interviews with staff from member practices were undertaken: one with eleven GPs, one with ten managers and one with six practice nurses. These discussions explored perspectives from different professional groups eight years after the federation had been established and provided a consistent understanding of why practices formed the venture and opted to work as a collaborative.

### 7.5.1 Supporting the venture

When asked to reflect upon the reasons that influenced practices to form the federation, the changes in the commissioning environment were identified as a key factor, as reported by several GPs:

> *"It was worries about the Health and Social Care Act coming into place and there was a lot of uncertainty about what the act would mean for practices as individual businesses, and concerns about financial viability but also particularly concerns about what the Act meant for the private sector coming into healthcare provision and the risks that that posed particularly, initially for more urban practices but over time what it may mean for us."*

> *"I think it was a risk management thing, to protect us against private providers definitely, it was sold as us grouping together and not letting [services] suddenly been taken over by Virgin healthcare – that was a key driver."*

This highlights the uncertainty around the commissioning changes and the impact on individual practices if private providers delivered primary care services that may have a detrimental effect on practice viability. It recognises the federation was set up to minimise this risk to practices as a means of securing services that may be put out to tender. Another GP suggested that practices operating as a collaborative may be attractive to commissioners, which was the case in the example of the extended access scheme:

> *"I think that there was also a feeling around being in a position to commission as a larger organisation, or for services to be commissioned as a larger collective body which would be more successful that trying to do it as just [my practice]."*

> *"It was also about opportunities as well in terms of what we could do at scale to generate business opportunities and creating income through that."*

This suggests that practices within a collaborative venture may have greater success than the practices individually. However, one GP noted that the intention of the Health and Social Care Act (2012) to support market development did not materialise in the way that was originally envisaged:

> *"There was an anticipation that the changing commissioning environment would put practices or groups of practices in a better position to be able to provide commissioned services and for the CCGs to commission services from practices or federated groups of practices, which actually when the detail of the Act came out that was blatantly not the case."*

One GP also confirmed that the renegotiation of the PMS contract and the subsequent reduction in income had a significant impact on practices deciding to participate in the joint venture:

> *"It came after the PMS review, when we were all pretty bruised with those negotiations and there was a major threat to practices with some significant drops in income and I think perhaps capitalising on that brought people together."*

The motivations outlined above concurred with the original reasons stated by the Executive team when interviewed in 2012, demonstrating that there was alignment and consistency in thinking around the changes within the operating environment, and the threats and opportunities that were perceived. The perceptions of the managers suggested that practices joined as a leap of faith, as it was not known at the time what could or would be achieved, which is captured in the quotation below:

> *"I think practices were already close(ish) because obviously this group has existed for a long time, the commissioning groups in various forms has been going for a long time, so there has always been dialogue between practices and I suppose it formalised that through [the federation]. I think the difficulty is, to start with it was a leap of faith because we didn't really know whether it was going to go anywhere or not, so I think it is difficult to say we signed up because we thought x, y or z was going to happen. I think we just thought it was a vehicle for x, y and z to happen and whether x, y and z would happen or not we didn't know."*

This statement captures the willingness from practices to work together, but recognises that there was no clear vision of what would be achieved or what would be the measures of success. The sense of security being part of a larger grouping was reported by one manager:

> *"I also think it was seen as protection, to have that umbrella as a sort of shield for what may have otherwise be coming our way as individual practices, which is why I think in the early days people were quite happy to pay subscriptions to be a member because it was seen as being an insurance policy in some way."*

This statement suggests that the venture provided a sense of security for member practices. A collective voice was developed and management resource directed to develop relations with other organisations, which resulted in the vasectomy service developed in partnership with the trust and other funding to support education initiatives and research. This feedback suggests that, with minimal risk to the practices, there were multiple reasons why practices subscribed as members of the venture.

### 7.5.2 Benefits of federated working

When asked about the perceived benefits of federated working, a range of perspectives from the GPs were presented. As practices worked closer together, sharing of information became more common (e.g. audit data, income generated through research). One GP reported:

> *"I think, it [federated working] increases the transparency between practices, facilitates ways of working and within [the locality] if you think about practices that are engaged collectively and those that aren't it reduces levels of tension or suspicion between practices."*

This insight suggests there was less suspicion amongst practices when information was shared, possibly signalling a shift away from the mindset of the individual practice to recognise the benefits of working as a group. Other financial benefits were recognised:

> *"There have been some financial benefits too – research has been successful, I know not purely on a financial basis but it's been a good thing to have been involved in and patients have been grateful for the opportunity, and there have been some studies that it has felt good to be part of and that wouldn't have happened unless we'd done it collaboratively and of course the hub has been a great example of doing something together, more latterly."*

Highlighting the benefits of research organised at scale, this GP recognised that there was a financial benefit to practices, but also identified the benefits to patients being part of research studies. Activities such as education and training were also key benefits that were highlighted by the practice nurses (section 6.3.1), and they felt engaged in the process of identifying training needs:

> *"Everyone is getting opportunities for training because not all practices, some practices are not able to go out for training because some don't have the time or allow us to do that, and generally we get an email to see if there is anything we want to be updated on and it's usually, they will try their best to get the speaker."*

> *"We are involved – involved in the updates we want."*

Training organised on behalf of the practices was recognised as providing the opportunity for all practices to engage, and suggests that, without this organised on a federated basis, some practices may not invest in education and training of staff. The nurse participants reported federated working as innovative and progressive, and continued working in this way during the period of the study. Several nurses recognised that this way of working was not commonplace in other areas:

> *"I think it was seen as a fairly quite forward-thinking way of working and I think working as federated practices, at the time, I think I'm right in thinking that the [locality] was one of the first areas to do that and to do it fairly well – I think it has taken off elsewhere but we've carried on doing it haven't we?"*

> *"I think it is unique here when you see other practices in town and they don't work together like we do."*

This suggests that the approach adopted by the practices to work together was innovative and had been embedded. The vulnerability of some of the smaller practices was recognised, with one GP noting:

> *"I think we were conscious at the beginning of the fragility of some practices as well in terms of their size and their viability."*

One of the managers highlighted that over the previous eight years there was some stability amongst member practices:

> *"II think the other thing to say is, whether this has anything to do with [the federation] or not I don't know, but apart from [Practice A] we haven't seen the number of mergers between practices that have probably happened in other areas, so whether [the federation] has helped practices retain their independence is a thing you can kind of debate. I think that the fact that practices do work together perhaps makes it a bit easier perhaps to retain their independence…..but certainly we've got small practices that are surviving, whether they are thriving – I don't know, individual practices would have to comment on that but they have survived in the current climate."*

These statements indicate that the majority of practices were stable within the period of the study, although two of the smaller ones had merged. This suggests that the federation may have had a role in supporting the independence of practices, which was one of the stated aims of the venture. During focus group discussion with the GPs, they recapped on the activities and services that had been developed:

> *"I think one of the positives is being able to look back and list those things. The pace has been, I imagine it has been tricky and it has felt slow and I think that's because of the size and the number of practices that are part of it and that's some*

*learning that we need to take forward to the network. I think it is hard to make change with 13 individual practices."*

This insight recognises that some practice staff may have perceived progress to be slow, but also highlights the difficulties in influencing change and engagement across multiple independent practices. On the topic of decision making, the quotation below illustrates the speed at which the extended access service was mobilised:

*"We can turn things around quite quickly – look how quickly the hub got up and running in a matter of weeks and that couldn't have happened with the kind of governance arrangements that would be required at a CCG level."*

Here, the ability for the Federation to be responsive and adaptive was recognised, and the speed at which the extended access hub was mobilised was illustrated. This suggests that whilst local decisions can be made promptly and actions implemented swiftly, this contrasts with decision-making in larger organisations with more complex organisational structures. One GP participant who was new to the area presented the following perspective:

*"Having come from an area where the federation had been mothballed, I understand the federation here was a protectionist measure after PMS. It is impressive the educational sessions that brought people together where practices could have been very isolated. When we had the GPFV funding to educate staff members [the federation] responded and that was impressive."*

This statement recognises the ability to respond to opportunities. The example cited related to funding that became available for training, which the executive team responded to promptly and efficiently, and secured funding for training. These statements identify a range of benefits were reported by all disciplines of staff, illustrating the value of practices working together.

### 7.5.3 Communication and engagement

When asked to consider communication and engagement, GPs, managers and practice nurses described effective methods of communication, including the newsletter, website and discussion with practice staff. This suggests that following the Denison survey conducted in the early stages of the venture, where engagement and co-ordination were considered areas for development, refinement of communication with the practices and engagement had improved over time. One executive team GP reported:

*"I tend to give feedback but I am in the position of being on the executive."*

This GP provided feedback to his practice team and regarded this as part of his role as a member of the Executive team. Another GP, who was not a member of the executive team, also reported:

> *"We certainly discuss it at our management meeting and give it priority and always have."*

This suggests that the GPs disseminated information at practice meetings, increasing awareness of activities that are developed to support practices, whilst another GP recognised how communications had developed:

> *"I think it has matured over time to and [the federation] has organised in terms of sending updates now and so even if you are not at the executive there is a mechanism that information and messages get fed out, so it has matured in itself in how well it communicates with member practices."*

This statement suggests that the process of communication became more developed over time. When the managers were questioned about their role in disseminating information, they reported:

> *"It's a tricky one that because in some ways the GPs are just so busy, I probably haven't shared everything with them about [the federation], I've shared the stuff they need to know about, but a lot of the discussions I wouldn't necessarily feed back to them unless I felt they needed to know about them, so I suspect if you asked the same question of the GPs they would say that they have had very little engagement with [the federation] but as has been said, it has increased. I certainly haven't really engaged with my admin and reception staff at all…"*

This suggests that in some instances there was selectivity and filtering applied in the information that was shared at a practice level, which may have impacted on some individuals' awareness of the range of work undertaken on behalf of practices. It may also account for some of the perceptions around the success of the venture, as reported in section 7.3. Another manager reported:

> *"A few years ago they weren't so aware of it [the federation] which you could argue that was my fault or the GPs fault …..but it just wasn't seen as something they needed to engage with."*

This suggests that during the early development of the federation, the managers may not have shared information widely as they felt that this was not appropriate. This selectivity may have impacted on staff knowledge about what the federation was set up to do and inhibited engagement in initiatives due to lack of awareness. The nurses presented perspectives on engagement:

*"Every time out event there is an update on what is happening within the federation."*

This nurse noted that at each of the educational events (time out sessions) there was an address from a member of the executive team which was used to update practice members of federated activities. Another nurse identified the use of group email as an effective method of communication:

*"There is email or practice nurse meetings, we have a group email."*

Whilst email was noted as a means of communicating with the professional groups, the effectiveness of the newsletter was noted:

*"We get a newsletter from [the federation]. There is a letter every, I don't know …. every quarter that tells you what is going on."*

The various methods of communication were recognised, demonstrating the effectiveness of a variety of communication methods. When considering differing levels of engagement across the practices, the nurses' reported that whilst some practices were happy to be actively involved, others were happy to follow when others took the lead:

*"I think sometimes there are practices that they want to be involved but they don't want to be involved in the decision making, for someone else to make the decisions for them and they will follow – the sheep!"*

*"I still think that there are some practices that want to keep themselves to themselves and not really engage – they come to education events where there is a topic so they are learning from a consultant or something along those lines, but I do think that some of them really do still want to keep everything pretty much in house and not share very much at all, and I suppose that's different teams ways of working but I think in those practices I suspect the nurses have no or very little impact on making any decisions at all."*

This recognises that not all practices were fully engaged in the range of federated activities but were happy to participate in activities for which they benefit from. The example cited above suggests that such practices participate in educational activities where there is a direct benefit to the individual or the team.

Engagement with practices was an area of development identified through the Denison survey. At the beginning it was noted that communication was variable, and some selective filtering of information may have occurred in some practices. This would have impacted on staff awareness of the development of the federation, however over time it was reported that methods of communication, such as the opening address at the education events, combined with the newsletter and email updates, were effective methods of updating staff. The role of

the professional groups, such as the nurse forum and the manager forum, were also identified as playing an important role in discussing the business of the federation.

### 7.5.4 Generating income

When considering what could have been organised or delivered differently, several views were expressed by the GPs, highlighting that the lack of opportunities to generate income through service contracts, which was regarded as restrictive to the development of the venture:

> *"Money – I wonder if [the federation] when it started had a big income generation contract like [another area] did, I believe that [the federation] would be in a different place in terms of services, employment and we would have been much further ahead of the pack – that was always a bit of an issue wasn't it?"*

Here, this GP suggests that the venture would have developed at a faster pace had contracts been secured at an earlier stage. It suggests that with the drive and ambition that was evident, funding development would have occurred at a much faster pace. Reference is also made to another GP Federation that made rapid progression when awarded a large service contract:

> *"We never had a GMS contract to hang anything on which [other areas] had, we never had that."*

This statement draws attention to the fact that, in some areas, GP contracts became available and federations became the contract holders, highlighting that direct provision of GP services was something that some GP organisations were embarking upon. The variability and differing rates of development were recognised:

> *"It's interesting when you meet people from other areas how differently federations have developed and often it is the money that has let people develop things whereas I think we've always struggled with the money thing. In the early days it was almost run on fresh air really wasn't it…and the enthusiasm of the GPs."*

This suggests contract funding is a key factor in supporting GPs to organise at scale. The challenge of maintaining the venture without funding to support related activities was noted. Contract funding and galvanising practice support to focus on service developments creates a sense of cohesion amongst practices but also generates a revenue stream to support the financial viability of the federation. In the early stages of the venture, the lack of market development led to a shift in focus to attract income from other sources. This income supported individual practices to develop skills which developed into a local service that all practices could refer to (e.g. the vasectomy service). It also provided activities that all

practices benefitted from financially (e.g. research and education) and supported quality improvement work across all practices through systematic clinical audit supported by education.

### 7.5.5 Relationship with clinical commissioning group

When the venture was established and commissioning was in an early stage of development, there was clear delineation between GPs in their commissioning roles and the GPs leading the federation. Due to concerns about conflicts of interest, the group of GPs leading clinical commissioning within the locality was different to the group of GPs who were interested in developing practices to work at scale. When the CCG was established it did not have a remit for commissioning primary care, and there was distancing between the CCG and any GP provider development activities. One manager reflected upon this relationship:

> *"Well, being generous to them, let's say they weren't given any scope to do anything, although on the other hand it did seem that whenever the secondary care trust wanted to do something, there was funding available, but we were always told no!"*

This quotation highlights the limited scope the CCG had to support developments in primary care, which was consistent with the role initially set for CCGs in 2012 that focussed on the commissioning of acute care and NHS England being the commissioner of primary care services. There was a perception that secondary care services were being developed, with the support of the CCG, without the same focus or ability for primary care to develop services. Whilst the CCG had a local presence within the health economy, the NHS England area team with responsibility for commissioning of primary care did not have the same local presence, and were both physically and operationally distant from the federation. Another GP recognised that the remit of the CCG extended beyond their locality:

> *"I think the CCG has a very county-wide view of life as well. So when they have to deliver something across [the county], like extended access they are very happy to work with us. If we want to do something and it is localised, it doesn't work because it is inequitable – because we haven't got federations across [the county], they can't see a way though dealing with one area and not dealing exactly the same as the rest. That happens a lot."*

This highlights the role of the CCG in maintaining equity of service provision and the perception that local service developments may create an inequity which the CCG would not be able to support. Another quotation suggests that inequity already existed in the health economy:

> *"It does, it's a shame but if you look at [the foundation trust] that covers the whole county, they've had lots of services into [one locality] that we don't have in [our locality] and other organisations do the same sort of thing, and you think well surely you should do it based upon population need, geography, deprivation and all those other things but they don't…… the CCG take a county view and say we can't do it for you if we can't do it for them, and they are the only organisation that actually does that, everyone else works on the basis of what's needed."*

The financial position of the CCG was identified as a limiting factor in supporting local service development, and one manager noted:

> *"Unfortunately, there hasn't been too much probably because they [the CCG] were near special measures and were heading that way for a long time and all the talk has always been about overspend which has put the nail in the coffin for any development work."*

This highlights the financial position of the CCG, whose role was to commission health services within a defined budget and to ensure that no overspend was incurred. The managers perceived this budget constraint to be detrimental to developing community and primary care services, and perceived the relationship with the CCG to be a barrier to the development of scaled-up models of general practice:

> *"The CCG, they are one of the major barriers because you cannot work successfully as a federation if you have got no source of income or services to offer, you are just then a ghost organisation that just exists for the sake of it and we know looking across borders that other areas have relationships with CCGs. It has improved I'd say a little bit but historically when we set up and for some years we were more or less just ignored. Certainly there was no concept that we could actually achieve anything or take on a service, everything had to be offered through the secondary care trust, or someone else, by default it was never 'let's go and talk to them'."*

This suggests that the relationship with the CCG did develop over time, but initially was non-existent. Other managers recognised that, after time, federations were beginning to be recognised as mechanisms for supporting practices, and that relations with the CCG improved when they realised the benefits and value of activities such as education and research that had been developed:

> *"I think that's been mainly driven by a formal government policy being 'at-scale' and then suddenly someone switched on and said 'oh yeh, federations are at-scale and that's what they have been talking about'."*

Here, the suggestion was that, as federations of GP practices became more commonplace across the country, the profile increased and examples emerged about their remit and function in supporting primary care. One manager reflected upon the developing relationship with the CCG:

*"The CCG got a lot more engaged when the extended access came because they were being pushed by government policy and suddenly they were interested in using the federation as a vehicle to achieve that."*

Two important factors supported this shift in thinking. First was the ability for the CCGs to commission from general practice through co-commissioning arrangements, and second was the requirement for the CCGs to implement the national initiative of extended access, which required them to work with local practices to implement local solutions. Federations of practices organised in larger groupings were ideally placed to develop these solutions. This also provided evidence to external bodies that federations were able to deliver a range of initiatives, as captured in the quotation from one manager below:

*"You know that they have seen it working as well. The extended access hub is working well and research is really good and the time outs are really good."*

Two other managers commented on improved relations between the CCG and the federation:

*"Only recently I think, when you've got a slot at the end of a CCG meeting to discuss things, that's worked a bit better, and with [the federation chair] leading on that it's made a big difference."*

*"I think we get a bit better recognition from the CCG, slightly better, if we are working towards how [a federation in another area] works – it is improving I think, the relationship, thanks to [the executive managers and the executive group. It certainly feels a bit better, I don't know what the rest of the executive group members think of it. Just a bit more recognition from the CCG would be nice."*

These statements suggest that the evolution of the federation, and also the development of clinical commissioning, has witnessed a different approach adopted to collaborative working which was regarded as a positive development. This maturity of relations took time to develop over a period of years, as at the beginning of the study there was a clear lack of engagement between the federation and the CCG, possibly influenced by interpretation of NHS England guidance on conflict of interest aimed at the GPs in commissioning roles. The role of the CCG also developed over time to include more devolved responsibility for the commissioning of primary care in partnership with NHS England area teams, thus opening up opportunities for more localised commissioning solutions. When the CCG sought to implement the extended access initiative, their initial approach was made to the federation, thus recognising that there was a collaborative of practices who would be able to implement the scheme across a larger population. When the federation responded and implemented

the scheme within a three-month timeframe, it evidenced that the federation was effective and responsive in setting up local services and supporting the credibility of the venture.

### 7.5.6 Reflections and transferring learning to the primary care network

Primary care networks (PCNs) are a contractually-funded initiative introduced by NHS England in 2018 to support GP practices organise into local networks of practices with around 50,000 population. The practices that formed the federation agreed to establish a network with three other practices in the locality as the initiative was a mechanism for bringing funding to support the resilience of general practice through the General Practice Forward View (NHS England, 2016). Focus groups with the GPs, managers and nurses captured the reflections of what had been learned over the previous eight years through federated working, and whether this had equipped them to move forward within the newly-emerging network arrangements. GPs argued:

> *"I think more latterly it's proven a great foundation for the next reincarnation of primary care networks because that puts us in a really good position now."*

> *"We've had an understanding of the governance pitfalls and difficulties from the outset which has been useful, which is something we can take to the PCN structure because we've had to go through quite a bit of restructuring and to be aware of that and informing the PCN from the outset is quite useful. It's the contracts that are already in place that might well get moved into PCNs."*

These perspectives suggest that there had been transferrable learning gained through establishing the governance framework for the federation, and recognition that this needed refinement as the venture developed. It also suggests that the contracts (services) established through the federation could transfer to the PCN, when established. The managers also reflected their views:

> *"I think one of the benefits for the PCNs coming along is having [the federation] already established that we have those links already and we have those discussions and although it is something we have to do, it does feel like we have a bit more of a voice, because we've got that relationships established already."*

> *"One of the things going forward as a PCN is, maybe I'm just being cynical in terms of the number of years I've worked in the NHS, but I think having worked as a federation actually puts us in a better position rather than it being imposed from NHS England and actually we are in a position to push back and say this is how we want to do it, not just being told, so very organic and upwards."*

The established relationships and trust between practices that developed through federated working was recognised as beneficial and transferrable to the network. There was a suggestion that the experience of organically developing the federation gave practices the

opportunity to define how the network will work, based upon previous experience. The nurses presented their view and did not see that much would change, stating:

> *"It's probably going to be a re-invention on what we are already doing."*
>
> *"Just a different name, other than possible like you were saying, we may possibly end up covering another practice's work and sharing of resource."*

The network was regarded by the nurses as the next phase of development and an extension of what the federation had already developed, and there was a sense that federated working would continue to be enhanced. It was noted that federated working took time to develop and mature, and one GP reflected:

> *"I think it has built over time. My own view on that is that it was a very slow burner to start with and through things such as education, trust has been won and the benefit has been seen and it has gathered momentum."*

This statement echoed the sentiment from an interview from the external cohort (a GP leader from another area) who, in 2012, expressed the view that throughout his professional career in supporting collaborative working one of the things he witnessed in primary care was that change takes time to embed, and cannot be rushed and should take into account the individuality and independence of the practices. This recognises it takes time to get initiatives and schemes off the ground and, over time, the concept of federated working gained momentum and credibility. Recounting the experience, one manager reflected:

> "*I think the length of time from when this begun and where we are today there has been a massive shift, because of opportunities that have come along for us to actually deliver services which we didn't have at the beginning which makes practices feel a little bit more engaged in the federation and perhaps have more of a sense of what they are getting back from it, because we are actually beginning to earn money. So that has changed over time, which is good.*"

This confirms that practice engagement and involvement increased when there was something tangible that was financially beneficial to the practices, highlighting the importance of being able to demonstrate the added value that federated working brought to the individual practices in financial terms. The practice nurses discussed how relationships had developed over time:

> *"I'm sure there were scepticism from the partners and the GPs initially in coming together, there was a bit of restlessness, yes, different views and sharing of information, but I think they have grown more confident as time has gone on."*

This statement supports the view that over time the nature of the collaboration amongst practices increased, yet the independent nature of practices was noted:

*"I think historically everyone has worked very separately. As GP practices, I think they wanted to protect how they worked and didn't want to share and I think that has changed over the last few years."*

This suggests the independent nature of practices and protectionism that existed, and how this changed through federated working, with practices more willing to work together in an open and transparent way. Practice participation was not forced, and engagement in activities and initiatives were aligned with their individual practice philosophies. Whilst some practices were willing to develop services and offer these to all practices, others participated on educational activities which benefitted the practice in developing workforce competencies, and both approaches existed in harmony with each other.

The importance of defining a clear purpose was discussed as a key consideration for a new organisation, and one GP reflected the following view:

*"It's about purpose isn't it, it's money as well, but you've got to have a purpose - if the PCN is developing a purpose and there is some money attached then that's the thing that's galvanising – but actually you can have any purpose in the world but if there is no money to do anything. So I guess you capitalise on [the federation] as building relationships, keep relationships going, doing some education, research, grabbing those things you can do well, which [the federation] has done very well but it hasn't really been given enough headroom, headspace or purpose to say 'where next', whereas actually PCNs are the way forward, I hope, PCNs is the way forward – in terms of population health and employing people."*

This statement highlights the need of having a defined purpose and financial assistance as key enablers to develop. One of the benefits of the working together was the trusting relationships that had developed, and these would equip practices to work within a network and develop at pace. As relationships mature and trust develops, practices become less suspicious of each other, and this GP highlights the activities that underpinned these relationships, such as joint education and research, which enhanced rather than threatened existing practice businesses. This quotation also recognised the lack of 'headroom' to be able to develop the venture, which concurs with the feedback from the 2015 workshops where mixed perceptions were presented.

One GP commented upon the structure of the PCN compared to the federation:

*"The [federation's] executive team is quite small, whereas the network board is bigger....and I could see [the network board] having some statutory role in the future and when it does we will be in a difficult role."*

This quotation recognises that the federation's executive team was made up of a small group of personnel, suggesting that it could have had broader representation. It also notes that the funding allocated to the PCN allowed remuneration for a broader representation on the network board. It suggests that the PCN may evolve into a role that includes statutory functions, such as having accountability for the member practices performance, which is different to the supportive role that the federation had assumed. However, one manager presented the view that the primary care network initiative had been imposed, whilst the development of the federation had been an organic process:

> *"I think the whole landscape that we are working in now has changed and with the PCNs coming along – being imposed – it furthers a lot of what we have already done as a federation but it is being done under a slightly different arrangement where you've had to join rather than you've volunteered to be part of an organisation."*

However, this manager elaborated:

> *"[Practices shouldn't] be threatened by working together. I think we are probably quite confident. When I think back to before the federation and I'm not saying it is anything to do with the federation, but sharing data and each other's medical records is something we would never have done maybe 5 or 10 years ago, whereas now it is happening every night in the hub and we've moved a long way from where we were on that. That's partly to do with the environment we are now in, pressure from outside."*

This highlights the evolutionary process of practices working collaboratively. The illustration of sharing information across practices highlights the independence that was evident prior to the federation, and over a period of time practices have become more comfortable in working together. The ability to reflect upon the learning from the experience of being part of a larger collaborative seems to place practices in a positive position to develop their network at pace. Considering whether there was a need for the federation in the future, the guidance issued around the PCN Direct Enhanced Service (NHS England 2019) states that federations that do not hold essential in-hours contracts and are unable to hold PCN contracts on behalf of member practices. This questions whether there is a need for the federation in the future and people were already beginning to consider this. One manager stated:

> *"I think one of the challenges we are beginning to discuss is the place for the federation - will the federation even exist in two years' time, will the PCN overtake that and provide the structure when we didn't have any other alternative. There is every likelihood that the federation as it is at the minute won't exist once we get down the line but there may be other things or reasons that come along."*

This suggests that the role of the federation in the future is uncertain, and may be redundant as the network develops. Another manager highlighted the similarity between the vision for the federation and the intended role of the networks:

> *"I think it is a positive thing [PCN] in a sense, what practices wanted at the beginning - to protect primary care isn't much different to the purpose of the PCN, so it seems a natural way to be going."*

This similarity suggests that there is alignment between what the federation had developed and a transition into the new network arrangements. However, a reservation was expressed around the role of the network in being accountable for practices:

> *"I think the worry I have with the PCN as opposed to the federation is that you don't know what is coming in the future and we will be much more accountable to each other for the services we provide, potentially with targets involved, whereas at the minute with the federation we are all still responsible for our own bit that we do and that's not challenged or micro-managed because we are not accountable to each other in that way, whereas as a PCN if you've got a contract that has to be delivered to a particular standard you've almost got to have some mechanism for challenging each other."*

These statements suggest that people were beginning to think about the evolution of the networks and the role that they may have in the future, which may include holding practices to account for delivery of services/contracts, thus assuming a performance management role, which felt different to the experience of working within the federation.

### 7.6 Summary

This chapter presented the perspectives on being part of a corporate venture from various professionals from the member practices at different time points during the eight years of the study. The findings from the Denison survey highlighted areas of strength to build upon within an environment and culture that supported education and learning. Areas for development were also identified, including vision, engagement and co-ordination across practices and the concept of customer focus. Engagement of practices was important, as the venture had been established by multiple practices who made a financial investment in start-up, therefore maintaining support was important to its continuation.

Feedback from the member practices and the executive team after four years highlighted a sense of frustration about the perceived lack of new service developments, although some services had been established (e.g. vasectomy and anti-coagulation monitoring). It was also reported there was a lack of strategic vision for the future, with mixed views around the need to develop alternative models of general practice. Feedback presented during the

workshops proved challenging for the executive team, who had made considerable personal investment in the venture. Yet, despite this, they continued to support the activities that were considered beneficial to the practices.

After eight years, focus group interviews identified that the perspectives from the practice representatives had changed, and were now more positive about what had been achieved by working collaboratively. Communication with the member practices and practice teams had been strengthened, and included a variety of methods, both face-to-face and electronic. A significant service development (extended access scheme) had presented between the time points, and this galvanised practices to work together and supported intra-practice collaboration. The development of the extended access hub tested the model of delivery, which was rapidly followed by multiple satellite (spoke) sites being set up within the member practices. This brought a revenue stream which practices and individual GPs benefitted from by delivering services directly, and by the staff working within the service remunerated for their work. Thus, it supported supporting viability of practices and rewarded the personnel working within them. Activities such as education, training, audit and research had been established to support all practices, and was reported to be valuable to the member practices to support workforce development and evidence quality of care. The national initiative to support practices to come together into a primary care network also provided GPs with remunerated time to debate and discuss how their network configuration and governance structure would be developed. The GPs reported significant learning had been gained from the venture, and that had informed the governance arrangements within the emerging PCN. Thus, relationships and trust were strengthened across practices working together on areas of mutual interest.

# CHAPTER 8 – Critical reflection and discussion

## 8.1 Introduction

This chapter discusses the findings of the study and critiques the lessons learned and challenges encountered by a group of GPs who formed a federation over an eight-year period (2011-2019). The efforts to establish a new business within a quasi-market in UK healthcare in itself presented challenges, and the ability to gain the support of member practices was also a key factor which took time to embed. This discussion culminates in a series of key issues for consideration that are pertinent to emerging or developing GP collaborations.

### 8.1.1 The purpose of federating general practice – form and function

When the federation in this study was established, the notion of federating was promoted by organisations such as the RCGP (2008). The Health and Social Care Act (2012) was also seen as being a catalyst that generated a response amongst the GPs to drive forward the establishment of a formal collaboration amongst a geographically-aligned group of practices. Hence, there was a policy driver to promote federating, but there was no blueprint for this form of delivery of primary care. Some years after the establishment of the Federation, the General Practice Forward View (2015) promoted the improving access to general practice national initiative, which became a trigger for practices to federate to deliver scaled-up solutions through group arrangements (Hemmings et al, 2018, McDonald et al, 2020). Federating can be a mechanism to support the viability of general practice and can be a mechanism to support autonomy and sustain practices as independent providers. It can also be a mechanism to influence greater change, with a spectrum of examples emerging ranging from informal network arrangements to highly managed forms of practice consolidation (Pettigrew et al, 2016; Mills et al, 2019; McDonald et al, 2020).

The conceptualisation of strategy proposed by Ovans (2015), when applied to GP federations, raises the question about what federating general practice aims to achieve: whether it is about doing something new; building upon what you already do; or reacting opportunistically to emerging opportunities. However, this can prove challenging as findings from this study suggested that when the federation was established there was a general articulation of what federated working could achieve, and this developed and flexed over time. Federations set up to deliver improved access pilots had a specific focus and purpose to set up locally-defined funded services. Federations such as super partnerships can

facilitate consolidation or amalgamation of multiple GP practices by adopting standard systems and processes across multiple sites, and operational efficiencies can be gained as a result. This can be achieved through merging multiple contracts or through retaining individual contracts with an agreement by practices to work to standard systems and processes.

McDonald et al (2020) noted that the level of top-down control exerted to influence the level of change required was regarded as a key feature of success within such situations. The Pettigrew et al (2018) study illustrated the purpose of federating multiple single-handed practices provided a focus on improving standards of care to improve the health outcomes of the population. The function of the federation in this study were multiple: it was a vehicle to host new business opportunities and to organise activities that would benefit the member practices through training and developing the workforce; it aimed to establish a programme of clinical audit to improve consistency of quality of care; and it sought to generate income through primary care research organised at scale. By establishing a corporate vehicle to support this, the aim of the was to establish a venture with a complementary role to that of the individual practices. The concept of doing something new (developing new services) through federating could be termed as form of related diversification, with a vision for creating new business opportunities. This was achieved in the study in several ways, including a programme of primary care research which generated a consistent revenue stream and through delivering new services in a community setting (e.g. vasectomy).

The range of forms (types) of federations is also wide-ranging, from informal network arrangements to large-scale partnerships, to formal corporate entities, with no single off-the-shelf model evident within the literature (Nuffield Trust, 2012; King's Fund, 2016; Partnership Review, 2019; Pettigrew et al, 2016; Mills et al, 2019; McDonald et al, 2020). Within this study the form of the federation (as a formal corporate entity) was informed by its intended function, whilst minimising risk to the members. There was a process of co-production between the GP leaders and the member practices, with an initial proposal presented to members to inform debate. The venture was formed as a company limited by guarantee co-owned by the members, which was a departure from the construct of partnership. Therefore corporate governance had to comply with regulations such as annual filing of accounts, declaration of profit, and payment of corporation tax, and professional legal and accountancy advice sought. Corporate documentation including articles of association and members' agreement were drafted by solicitors, paying attention to issues such as voting structure to give practices equitable representation, dispute resolution, and criteria for membership.

A philanthropic orientation was espoused when the venture was formed, with the intended purpose of establishing a business entity to deliver services that all members would benefit from. There was an altruistic belief amongst the executive team that the new venture would support new business development, which in turn would generate revenue to contribute to the viability of the practices, ensuring continuation of local provision. It was envisaged that efficiencies would be gained from single tender applications, rather than practices responding individually, with operating efficiencies gained through alternative delivery models or single practices offering some services to a wider population (Section 5.4). The construct of a not-for-profit company limited by guarantee posed minimal business risk to the existing practice partnerships, particularly when compared to the traditional partnership arrangement where risk is shared jointly amongst individual partners, as the company limited by guarantee model assumes risk at a corporate level. However, named GP directors acted as the Federation's company guarantors and their limit of guarantee was set at £1. Thus, if the federation succeeded in bringing in new business to the venture all member practices would benefit financially, and if unsuccessful the fiscal impact on the member practices would be minimal as the corporate structure and governance arrangements would mitigate against this. This arrangement would safeguard the practice NHS contracts and allow them to continue to deliver contracted services without financial disruption or risk. Over the period of the study it was noted that all practices benefitted financially from the venture, with payments made for activities that practices engaged with. Therefore, it was a situation of nothing ventured, nothing gained.

This form of collaboration, whereby member practices invested in the company set-up, had similarities with internal corporate venturing, where there is joint investment and ownership of the business with risk minimisation for the investor organisations (Block and Macmillan, 1995; Sharma and Chrisman, 1999; Jones Hill, 2010). Evidence of corporate venturing is emerging within the public sector (Liddle & McElwee, 2019; Hayter et al, 2018; Kuratko, 2017; Dhilwayo, 2017), with context being the only differentiating characteristic between private and public sector organisations (Hayter et al, 2018). Key characteristics include an innovative mindset, taking action that is innovative to pursue opportunities and the ability to push forward issues with tenacity, an environment conducive to innovative activity, risk-taking, activity that can transform the status quo, and an environment that is characterised by uncertainty (Hayter et al, 2018; Kuratko, 2017). Similarities emerge from the study findings that concur with these characteristics, with an uncertain environment stemming from legislative commissioning reform, an internal environment receptive to change (Denison survey), an executive team with an innovative mindset willing to adopt activities such as the knowledge transfer partnership and quality improvement projects, and a willingness to adopt

with a new organisational form which minimised risk to the core business of the individual practices.

### 8.1.2 The nature of collaboration – formal or informal

In a contribution to the general debate about collaborative business models and alliances, de Man and Luvison (2019) stated that the underlying business idea needs to meet with the expectations and interests of all parties. There is a requirement to define what value any alliance creates, whether this relates to scale, skill, risk or a mix of both, and to identify what levers are available to create this value. Defining the nature of the collaboration will impact on level of integration required between parties and the interdependence required to deliver the actions necessary to create the added value. This may be helpful to define the intended purpose of federating: to increase the scale of what practices can achieve as a collective through delivering an enhanced range of services; enhancing the skill mix of the workforce or sharing of workforce resource; and/or minimising risk to individual practices to support viability or sharing of risk through new business creation.

In this study, the formalisation of the federation as a legal entity created a separation between the venture and the practices. In doing so, the executive team believed that collective ownership would be achieved and practices had the opportunity to be represented at a scale greater than that of the individual practice, providing strength and unity. The added value of operating as a new provider in a quasi-market would be achieved through single responses to procurement opportunities, and through activities organised centrally for mutual benefit. The formalisation of the venture placed the GPs in a position to be able to respond when opportunity presented. However, as a corporate entity, consideration needed to be given to regulatory registration, as in 2012 legislation was introduced (Health and Social Care Act, 2012) whereby all providers of health and care services were required to register with the regulator and comply with nationally-defined standards of care which would be subject to inspection. The executive team were keen to explore the benefits of single registration through the federation, but the regulator was unable to provide clear guidance at the time because the phenomenon of federations was not widespread.

Three years later, guidance was published in response to the number of federations that were beginning to emerge (Care Quality Commission, 2015). When the anti-coagulation service was commissioned through AQP, the commissioners concluded that separate registration was not required as the location of service delivery was through the individual practices, who were already registered as providers. This added a complexity to the quasi-

market environment that the executive team had to navigate. Therefore, this questions the need for federations to be constituted as formal legal entities if their role is to act as an agent on behalf of the practices. In this instance it was deemed as a mechanism to minimise risk and foster joint ownership of the venture. In this study, added value was also realised from activities that were centrally organised, such as education, training and research, where practices actively participated. However, this could have been achieved with the agreement of practices without a formal business construct.

### 8.1.3 Funding central management and establishing a credible business plan

For federations to be a viable proposition, attention should be given to how revenue will be generated to fund overheads, including the personnel supporting the organisation and undertaking leadership roles. Consistent with this study, the examples cited by McDonald et al (2020) all required central functions to be established and funded, with all four case study examples having received seed funding from the CCG. This was in stark contrast to this study, where no CCG support was provided, at a time when the development of GP federations was at an early stage and organisational learning within the NHS was starkly underdeveloped. Similarly, the example cited by Pettigrew et al (2018) also identified significant CCG support to establish practices to form local federated networks. This illustrates variation and inconsistency in the role and the approach that CCGs adopted to support local practices to work collaboratively, despite six examples of CCG delegated commissioning cited by NHS England as models of best practice (NHS England, 2017). Examples of CCGs redistributing enhanced services funding to support Federations was also evident (McDonald et al, 2020, Pettigrew et al, 2018).

Therefore, it is important to be able to determine the level of central support that is required and develop a detailed plan around how this resource will be funded on a recurring basis. In this study, the venture was supported through capital investment from practices in the form of member subscription and, whilst there was agreement that all practices would make a capitation-based payment, the expectation was that this would be time-limited and after a period of two years the venture would be financially solvent. In addition to practice subscriptions, funding from the local hospital Trusts supplemented the investment practices were willing to make and sustained the venture beyond the two-year period. The original business plan was based upon a 10% top-slice allocation from contracts to cover central management fees and overheads. In essence, central overheads costing £50,000 would require a service portfolio of £500,000.

The reality of being able to generate revenue was unknown when the venture was established, making detailed business plans difficult. The vision for revenue generation and solvency within two years would have been unrealistic and unachievable if the strategy was solely focussed upon commercial opportunities emerging in the health economy, making it an unattractive investment proposition. Therefore, the ability to generate income from alternative sources was critical to the venture being maintained beyond the initial two-year investment period. Data from business statistics (House of Commons Library, 2021) suggest that 20% of new businesses fail in the first year, with 60% becoming insolvent within the first three years. A survey of 101 start-up failures (CBInsights, 2019) cited the main reason for failure as lack of market for services or products (42%), with 29% failing due to lack of funding/revenue. Issues such as lack of business model, leadership, poor marketing, lack of customer orientation, burnout and failure to adapt were also reported, which are important insights for GP ventures to consider (Ropega, 2011; Schaap, 2017). The rate of failure in new business ventures, combined with the ability to thrive and survive on opportunities within a quasi-market (Garattini & Padula, 2019), should be carefully considered and assessed by GPs establishing and leading federations.

### 8.1.4 Establishing business opportunities

Policy providers from Health and Social Care Act (2012) to develop quasi-markets in healthcare suggested that procurement opportunities would present, and could be exploited to contribute towards a financially-viable business model to allow the venture to survive and prosper. The potential threat of competition from new providers (e.g. Virgin Healthcare) enacted a defensive response from a core group of GPs who believed practice viability would be threatened. Subsequently, this helped to create the impetus to initiate discussions about collaborating to respond, defending the retention of local services and protecting practice income. The GPs believed that galvanising support and this defensive positioning would provide security for the individual practices, whilst taking advantage of business opportunities (section 4.3) and acting as a mechanism to stimulate competitive market activity, as intended through commissioning reform (Porter, 2005). This defensive response was consistent with findings reported in the McDonald et al's (2020) study, where it was also reported that GPs felt threatened, which was a factor in them establishing federations.

Over the period of this study, the threat of new market entrants in the local health economy was minimal as competitive tendering and market development was not a strategy pursued by commissioners. Whilst national policy at the beginning of the study was signalling competition and plurality of providers, a growing evidence base promoting a shift towards

integrated health and social care was being promoted (Ham and Smith, 2010; Lewis et al, 2010; Ling et al, 2010). This was enhanced through Vanguard pilots in 2015 (NHS England), where sites were selected to pioneer new models of integrated care (Ling et al, 2010; Hanratty et al, 2019; Maniatopoulos et al, 2019). This may have accounted for the lack of market development in the CCG where the study federation was located, as the CCG favoured the concept of integrated care which had been a characteristic in the health economy for over a decade. Therefore, positioning the joint venture to respond to market changes that failed to materialise on the scale that was originally envisaged, could be perceived as an unnecessary defensive action, albeit one that posed minimal risk to the practices. Therefore, there is an important link between the business plan of a federation and whether genuine opportunities exist to support its financial viability.

Whilst inter-provider collaboration with one Trust established the vasectomy service, there was also evidence of defensive positioning and competitive rivalry (Porter, 2005), and in the example of the blood-pressure monitoring tender (section 6.7.8) the Federation and the other Trust (a non-voting member of the Federation) competed for the same contract. this illustrated the desire for both organisations to increase market share, demonstrating a lack of collaboration between organisations, despite being part of the same venture. The review of corporate governance in 2018 resulted in the GPs restricting membership to GP practices only. This reframed the relationship with the foundation trusts, ensuring that full decision making was retained by the member practices. The clause to allow practices to apply for membership was retained, allowing for the option for other practices to apply to join the federation, demonstrating their ability to control membership. This was identified as a key feature of federations as meta (member) organisations (McDonald et al, 2020).

### 8.1.5 Implementing a plan for federated working

Strategy implementation requires a clearly defined action plan with measurable activities and regular review of progress. As noted when the venture was established, conducting detailed business planning was problematic due to many uncertainties within the operating environment. From a business perspective, an income target was established by the executive team to cover essential core management costs, but adopting a detailed approach was less certain. Therefore, flexibility and adaptability was key to the venture succeeding beyond the initial set-up phase. The strategy pursued by the GPs in this case study developed two orientations: an external focus (seeking external funding sources) and an internal focus (seeking efficiencies), as outlined below:

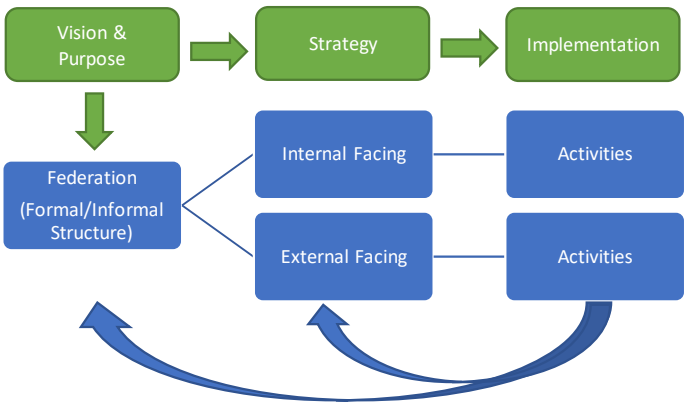



Figure 18 – Strategic orientation of the federation

The aspiration of developing a service portfolio proved more challenging and was dependent on the healthcare commissioners evolving the market where services could be procured in alternative settings (community rather than hospital), or could be procured for less cost (local tariffs rather than national payment-by-results tariffs). Significant effort was taken to bid for funding opportunities (section 6.6) but, despite this, marginal gains were achieved from the single AQP contract and the vasectomy service as a tariff share with the hospital trust. To support delivery of the anti-coagulation service, a single set of policies and centralised training was organised by the federation. However, the frustration around the lack of opportunity became evident through the interviews with the executive team as they grappled to make sense of the operating environment which was in a state of flux for at least three years after legislative change (Health and Social Care Act, 2012) and CCGs were formed. Therefore, the assumption that such legislative measures to support competitive tendering would be enacted by commissioners was a flawed assumption (section 4.3) and, in reality, the ability to compete for contracts was minimal because opportunities did not materialise, and consequently the approach to strategy had to be emergent and adaptive. Small-scale market entry, where there is an inability to generate sufficient revenue, is a common factor that inhibits the success of corporate ventures (Block and Macmillan, 2005). It was not until 2018, seven years after the venture was formed, that revenue from the extended access contract generated income in the region of £500,000 (section 5.8). This incremental development of services over a period of time restricted the growth of the venture in line with the timescales envisaged by the sponsors, suggesting the quasi-healthcare market in this geographic location of NHS England was not a suitable environment to develop a viable venture through procurement opportunities alone.

To support service development, detailed business planning did take place involving the practices. The vasectomy tariff-share was an example where the detailed costs of delivering

the service were calculated to ensure that the proposed tariff which was negotiated covered the practice's costs and generated a surplus to contribute to the federation's overheads. This way of organising funding was novel, and highlighted transparency and trust between the trust and the federation. It also demonstrated a clinical area of mutual benefit to both parties that developed over time. Relationships between business development managers on both sides was mature with them having previously worked together. When the anti-coagulation service was mobilised, costs were calculated with a payment to the practice to cover staff costs and incentivise participation, with a percentage contribution going to the federation to support central overheads, as per the business plan. The planning process that supported the extended access initiative was engaging, and involved all practices in deciding the locations for the hub-and-spoke model and the local rates of remuneration for practices and GPs delivering the service. Therefore, activities such as business planning and negotiating involving personnel from the member practices developed over time.

### 8.1.6 Identifying stakeholders and customers

Customer orientation is fundamental to business strategy, yet the Denison survey revealed this was a significant area for development for the venture. Various conceptualisations of the customer was presented, highlighting a lack of clarity whether the customers were end users of a service, a funder/commissioner, or the member practices. Sainidis et al (2012) highlighted the importance of orientating the organisation's vision towards the customer, and that engagement and communication should be tailored accordingly. However, the concept of stakeholder groups did not appear to be familiar concepts within the primary care ecosystem. Rather than establish separate engagement arrangements with patients, the executive team recognised that all member practices had established processes for patient engagement, with embedded patient reference groups in place, and that the venture was not at a stage in its development whereby this needed to be replicated. This concurred with the findings of the McDonald et al's (2020) study which highlighted patient engagement as an underdeveloped area. However, if the venture had established a public-facing engagement process which was pro-actively managed, it may have benefitted by gaining public support for the aims of developing an extended range of local services and furthering the strategic direction. It should be recognised that this takes dedicated effort and skilled resource to achieve. In the study, the example of pooling resource to advertise the locations of the annual flu vaccination clinics was regarded as a successful method of sharing advertising costs, whilst also raising public awareness that practices were operating as a group. Practices also advertised their involvement with the federation on their websites, increasing the profile with the public.

Focus group discussion based on findings from the Denison survey supported the executive team to identify stakeholder groups and informed their thinking around stakeholder management. The clinical commissioning group was identified as a stakeholder where relations were under-developed. Initially, when the commissioning group was established, it did not regard GP provider development as an area that could be financially supported because responsibility for this remained with NHS England. This changed in 2014 and co-commissioning arrangements were introduced, whereby CCGs were able to commission services directly from primary care (McDermott et al, 2018), and the federation did benefit from establishing the extended access service without a formal procurement process. As the federation represented a quarter of the commissioning group's population, it was the CCG that deemed it inequitable to provide financial support, demonstrating the inability of this particular federation to influence the CCG's decision-making processes. On this basis, the practices that established the federation were disadvantaged because their thinking and formation was much more advanced than other practices across the CCG footprint. This relationship with the CCG was at odds to that reported by McDonald et al (2020), where other federations received much greater support. Yet, during the study, the stance adopted by the CCG did not change and no financial support for federations was forthcoming. The executive team was successful in developing relations with external stakeholders, such as funders, which raised the profile of the venture beyond the boundaries of the geographic locality. Thus, several quality improvement projects were presented at conferences regionally and nationally, and the reputation of delivering primary care research at scale was cited as an exemplar of best practice.

### 8.1.7 Adopting a flexible approach to strategy

The ability to flex direction to meet the aims of the venture was evident within the study as defining a detailed business plan when the venture was established was almost impossible. Therefore, the strategic direction was loosely defined as building a portfolio of commissioned services, which was the planned element of strategy when the venture was established. This lack of detail required the practices to take a leap of faith without the detail of what they were actually engaging in. The methods adopted to establish a business portfolio relied upon being able to respond to appropriate procurement opportunities or pursing joint ventures with other organisations, such as the hospital trusts. Both approaches yielded results (sections 6.6 and 6.7) but over a longer period of time than was originally envisaged, highlighting the time required to incrementally develop the venture. This was concurrent with the findings of the McDonald et al's (2020) study, where it was noted there was

frustration around scale and pace of progress in some sites. When it became evident that developing a portfolio of services would not be a short-term realisation, the strategic focus of the GPs in this study shifted to seeking alternative funding streams to maintain the viability of the venture, thus refocussing efforts to seek alternative funding sources to support a programme of quality improvement activities that practices would benefit from.

Organisational learning and creating change were reported through the Denison survey as key organisational strengths, suggesting a culture receptive to change. The cohesive intra-practice approach to delivering research, education and audit across individual autonomous practices were exemplars of federated working, with active participation across all member practices (section 6.7.1). These activities were a mechanism to engage practices and provided education and training which contributed to the continued professional development of staff, improving patient outcomes through a series of clinical audits, and supporting the organisational culture of learning and development. This was thus highlighted as a key strength in the Denison survey. This allowed practices to test innovative solutions, such as the knowledge transfer partnership (section 6.7.3) to understand healthcare resource utilisation of frequent attenders of general practice (Cook et al, 2017).

A range of other quality improvement initiatives were delivered on a population basis, such as the falls prevention project and the COPD project (Table 11). Evidence of participation in population-based activities provided practices with evidence of wider engagement, which was shared with the regulator (CQC) during inspection and was cited as an exemplar of best practice in inspection reports. Individual practice audit results were compared across practices and aggregated to demonstrate the benefits and outcomes on a population basis, and this appealed to external funders. This aspect of strategy received recognition evidenced through published reports and articles, including the project with the Academic Health Science Network and the knowledge transfer partnership (section 6.7.3) which gained regional and national recognition. The approach to research and development was also an exemplar of working at scale, and generated a consistent income stream and remunerated practices depending upon the level of participation. The approach proved beneficial in identifying and recruiting eligible patients to research studies, and also by conducting searches to inform feasibility studies through academic links within the local foundation trusts, further demonstrating the wider benefits of research. The ability to flex supported the federation to fulfil a purpose in developing activities that all practices benefitted from, and the financial support from external organisations contributed to the financial viability of the venture. Without this strategic flexibility, the venture may not have survived beyond the initial investment period of two years. Therefore, developing activities

to support cohesion and engagement across practices was a key feature, and extended the lifespan of the venture. This provided a collaborative focus until the major revenue stream was secured in 2017, and this put the venture on a firmer business footing.

### 8.1.8 Factors that impacted on strategy implementation

When examining the factors that can influence strategy (Beer and Eisenstat, 2000), issues such as limited market opportunity (Section 6.6.1), differing ideologies amongst practices and across providers in the health economy (Section 6.6.4; 6.6.5; 6.8), and an underdeveloped relationship with the CCG (Section 7.5.5) all had an impact. The factors that influenced strategy within the study are illustrated below:

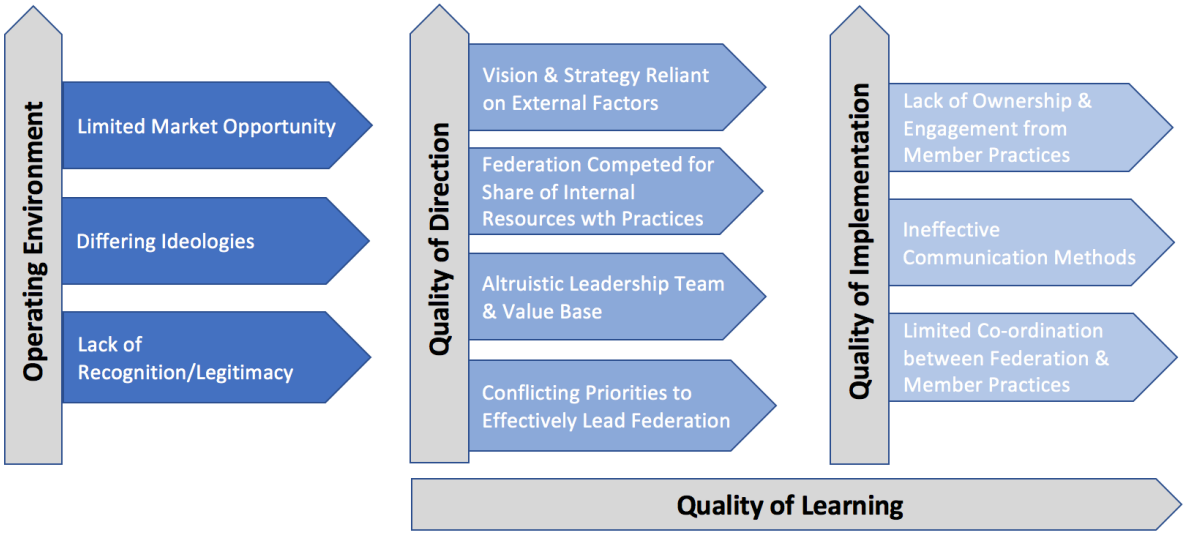



Figure 19 – Summary findings impacting on strategy implementation

Within the study, when the venture was established, there was an over-reliance upon external factors that the GPs had no control over (commissioning of new services). Also, the venture required core funding from the members in the form of time-limited membership subscription, an altruistic leadership team with the desire to pursue activities to benefit all practices, and a with a finite leadership resource available from GPs to dedicate to the development of the venture. Other factors included: the variable levels of ownership and engagement from the member practices, all with differing views around the success of the venture mid-point during the study; the effectiveness of communication methods which were reviewed and improved upon; and a lack of co-ordination amongst member practices which was acted upon to engage a greater range of practice personnel in activities and decision-making. This study presented a unique set of factors that impacted upon how the federation was established and developed over time, and despite health policy such as Health and

Social Care Act (2012) being nationally prescribed, the response to implementation at a local health economy level varied considerably, with some areas embracing market development and others not. Therefore, awareness of the factors evident within each health economy is something that GP leaders need to have in order to be able to ascertain what opportunities may transpire, particularly if the federation is to rely upon external sources of funding.

### 8.1.9 Developing a shared vision

The importance of a shared vision for federated working was highlighted by the GP leaders within the study. According to Altona and Ikavalko (2002), a compelling vision underpins any change process and an absence of one can be a barrier to effective strategy implementation. Within this study, there was a general articulation of strategy and strategic intent within the articles of association, but as Sull (2015) highlighted from a study of 250 organisations, it cannot be assumed that strategy is fully aligned throughout an organisation. Within the context of the federation, developing and embedding a shared vision has the complexity of working with multiple multi-disciplinary primary healthcare teams across member practices, which proved challenging (Section 7.3) and took time to achieve.

Denison survey results revealed the managers felt there was a mission and clear direction, whilst the GPs and the executive team did not and instead reported they felt that there was a lack of strategic direction and intent. This reflects the uncertainty in the operating environment which may have influenced perspectives of the senior personnel. Similarly, the GPs and executive team felt there was no shared agreement on goals and what was needed for the venture to succeed in the long term. Without this clarity of direction, a lack of excitement and motivation was noted in the Denison survey. This was reflected by some people during the workshops, with practice personnel in 2015 suggesting varying levels of engagement amongst GPs and cohesion around a future vision for the federation. The survey also reported that respondents indicated that short-term thinking compromises long-term vision, and adopting a short-term focus within corporate ventures can have detrimental effects because, without senior support and sponsorship, they may be terminated prior to benefits being realised (Garvin, 2002). This further suggests the need to evaluate the venture at specific timepoints (Garvin and Levesque, 2006). Within the study, there were annual general meetings which were used to reflect upon activity and achievements over the previous 12 months, and to seek feedback on proposed projects. However, it was noted that there was an under-representation of executive directors at these meetings (Section 7.4.3). The ability to adopt a longer-term vision and future state was noted as a success factor

within one example in the McDonald et al (2020) study, where one federation was expanding its membership to achieve specific aims. Therefore, building upon the concepts of vision, purpose and function, for any GP collaboration the challenge remains the development and embedding of this shared vision.

### 8.1.10 Aligning and embedding a shared vision

In the study, it was important to the leadership team that practices were actively engaged in federation-led activities and contributed to the strategic direction of the organisation. The McDonald et al (2020) study highlighted varying approaches around practice engagement, and this depended upon the purpose of what the federation was set up to achieve. In one example where there was a requirement for standardisation of policies across practices, the relationship was described as 'authoritative'. In another example, whereby the relationship with practices was a supportive one, this was described as 'indulgent' and 'neglectful'. Within this study an authoritative approach was required to implement services (e.g. anti-coagulation and extended access), with practices required to implement standard operating procedures. Meanwhile, the development of activities to support research, education and quality improvement could be described as indulgent (as per the McDonald analogy) or 'participatory', as it required the practices to want to partake in these activities.

An important leadership function is the ability to articulate a compelling vision with clarity and purpose, as this engages practices (section 2.12.2). but as quoted in the study GP practices have differing business philosophies on an "*ethical range between very socialist up to very capitalist".* This may present a challenge in aligning multiple business philosophies with a common purpose of federating. In the McDonald et al (2020) study, evidence from one site highlighted division and intra-practice competition in response to GP practice contracts that were being procured, with some member practices competing as a separate group, further demonstrating the challenge of aligning a shared vision.

Beer and Nohria (2000; Steinke, 2001; Steinke et al, 2013) suggest that there are two perspectives on whether businesses are economically orientated (focussed on generating income) or organisationally orientated (focussed on people and patients). This centres on the argument that organisations that are predominately organisationally focussed possess a vision or aspiration whereby wealth accumulation is important but secondary to creating an organisation that centres around deeply-held values and a strong culture. These organisations are egalitarian and seek involvement and participation from the wider membership, but it is suggested that a balance between the two is required. In the case

study, the purpose of the venture was shaped by the values of the founding GPs, who espoused the desire to organisationally support the viability and longevity of individual practices, which member practices subscribed to. Therefore, there was an organisational focus that was not purely economically driven, as the values of collaboration and cohesion were deemed important by the senior leaders (section 4.7). If a more economic focus had been adopted, the strategic direction of the venture may have focussed on seeking inter-practice efficiencies, such as pooled or centralised administrative and support functions. However, this would also mean challenging the status quo, which may have resulted in conflict or disengagement. In situations that are perceived as threatening, negotiated order theory (Strauss et al, 1964) and Crozier and Friedberg's (1978) theory of activity suggest that individuals and groups can adopt various strategies to position themselves in situations by maximising their control over uncertainty, and federated activity that challenges the status quo may manifest in defensive behaviour. In this study, to gain cohesion amongst practices, an inclusive approach was adopted to gaining members, with 14 out of 15 practices agreeing to participate (Section 5.3). In the example of the practice delivering the vasectomy service, income was generated through referrals from other practices, highlighting a business orientation from this practice and the symbiotic nature of the relationship between them and the other practices they relied upon to generate income. Therefore, a balanced approach was evident in this study with two orientations of strategy pursued, both business orientated activities and supportive/developmental practice activities.

Sull (2015) noted that it cannot be assumed that strategy is fully aligned across an organisation, and the Denison survey initially reported a lack of engagement and team orientation in the early stages of the venture, thus suggesting a disconnect. The survey also revealed that, in the beginning, the GPs did not have a clear vision for what the federation was set up to achieve, despite this staff group including the company directors and executive sponsors of the venture. Despite efforts by the executive team to improve engagement and communication with member practices, discussion arising during workshops in 2015 provided further evidence of partial alignment. Yet, interviews in 2019 reported a higher degree of cohesion amongst practice personnel, with positive perceptions portrayed around the involvement and benefits of being a member of the federation. Engagement and communication are therefore key organisational considerations (Lewis, 1999; Hunkins, 2020). In this study, the length of time and the communication methods adopted needed to be substantial in order to embed a shared vision, and this should not be underestimated. The importance of checkpoints, similar to the workshops in 2015, was an important learning process which resulted in discussion and critical reflection amongst the executive team, and this generated a renewed focus on effective communication and

engagement. GPs interviewed in 2019 identified with the need for clarity of vision and direction as a key learning point, as practices prepared to work within a primary care network.

### 8.1.11 Leadership and management

To assess the contextual environment and assess what business opportunities exist requires capacity to horizon scan to identify potential business opportunities. The leadership team assumed the role of horizon scanners, together with their management support, but in the initial phases of development there was much uncertainty and complexity within the healthcare environment which the team had to grapple with. The leadership capacity from the GP leaders was finite, and often the ability to balance the role as senior GPs in their respective practices with the time required to develop the federation proved challenging. However, the dedicated management resource created links with external organisations and developed relationships which enhanced the profile of the federation. This management resource was supplemented with practice management support, with managers consistently attending executive team meetings. They were thus regarded as internal influencers and communication conduits within their peer group and respective practices. The blend of clinical leadership and dedicated management support proved effective within this study.

### 8.1.12 Executive leadership

The executive team were devolved the mandate from the board of directors to develop the venture on behalf of the practices, which is commonplace in organisations (Mintzberg, 1993) where a hierarchy is present and supports effective decision making (Rovelli & Butticè, 2020). In the study, the leadership team was appointed to assume greater responsibility for the strategic operations of the business and resulted in the board of directors not being involved in the routine operational management, thus being one step removed. The executive team (section 4.9) comprised a group of motivated, entrepreneurial individuals who recognised the benefits of collaborative working and successfully promoted the vision, thus encouraging practices to form the venture. Although authenticity as a leadership trait is open to debate (section 2.16), the team's authentic leadership profile identified that they acted with integrity and consistency, and sought wider input into decision-making, further suggesting that practice involvement and engagement were important. When considering the role of the executive team in implementing the vision, key functions were required, including communication with member practices and interpreting strategy into activities to support and deliver their vision. The team altruistically espoused the desire that all practices

should benefit from the venture, and they pursued external opportunities to further this vision, which is recognised as a characteristic of entrepreneurial leadership (Renko 2015). The motivations and values that the team aligned with were the personal characteristics of putting the collective before the individual (Swiercz and Lydon, 2002) in the desire to create a sustainable organisation, as was stated within the articles of association and members' agreement.

The change in personnel within the leadership team in 2013, two years after the venture was formed, highlighted differing perspectives on the strategy that was being pursued. Such discord around profit-orientation (generated through private work) and developmental activities such as audit, quality improvement, research and development, was noted. This change in personnel did not destabilise the team, but questions whether having an alternative perspective at a senior level may be helpful in bringing an element of constructive challenge, and counteracting any potential group think (Janis, 1971, 1982, 1989) which occurs when people align their thinking and conform to avoid conflict. Other changes in executive personnel at various points during the study also demonstrated a willingness amongst the GPs to share leadership responsibility and support the venture, thus allowing multiple practices to be represented in strategic decision-making. During the eight-year period of the study, one GP and the business partner remained as founding members of the executive team, providing consistency throughout.

### 8.1.13 Executive leadership capacity

Although the executive team were altruistic and philanthropic, there was evidence of conflicting priorities around the ability to dedicate adequate time to the venture. This was highlighted by the external cohort interviewees, who recognised that the level of the leadership capacity required to support change was considerable in an environment where GPs were already reporting to be under significant workload pressure. As full-time GPs in their respective practices, the time commitment required to dedicate to develop the venture was limited, and the demands of the individual practices took precedence. However, the considerable investment made by the founding individuals in the early days of establishing the venture demonstrated a personal commitment and a desire for the venture to succeed. The time invested in the venture by these individuals was supported by their host practices, which would have created pressures if clinical time was lost in favour of activities (e.g. meetings) which, in effect, would have been a cost to the practices. Without the continuation of this executive leadership, it is apparent that the venture would have struggled to progress

and could have ceased trading as a viable entity. Therefore the time commitment and investment from key individuals on a regular basis should not be underestimated.

### 8.1.14 Developing leadership across practices

Assessing whether implementing strategy is a process that should be driven from the top, from a study of 250 companies, Sull (2015) noted that this should be distributed across the organisation with a collective of organised activities making a contribution. In this study, the executive team had devolved responsibility to lead the venture, but it was important for them that the member practices were fully engaged because they needed assurance that the venture aligned with the values of practices, and met with their needs, to secure their continued support. Examples of distribution of leadership was evident with the educational strategy group devolving responsibility for setting the direction around research and educational activities. The group was led by a GP and an advanced nurse practitioner from two of the member practices, and included representatives across multiple practices (and a retired local GP) who had an interest in developing this aspect of the business. This provided a clear strategic direction for the venture in terms of education and training, which contributed to the strategy of supporting high quality care across local practices. The quality improvement projects were clinically led by GPs, nurses and managers from the member practices, thus sharing the opportunity to be involved across multiple practices and disciplines of personnel. Individual practices led on initiatives such as the knowledge transfer partnership and the GP education club, demonstrating a distributed approach which does rely upon the practices supporting the relevant individuals to be involved in specific tasks. By adopting such an approach, individuals and practices were provided with opportunities to lead on projects which would benefit all practices, and initiatives developed by a wider pool of people demonstrated that not all ideas were established by a small core of people on the executive team. This sharing of leadership and decision making aligns with the notion of distributed leadership, as professed by Bryman et al (1996) and Yukl (1999), and acted as a mechanism to enhance ownership of the federated activities across the member practices. The leadership arrangements for research, education and training were particular examples where this worked well (section 6.4), but individual clinicians taking the lead to champion and co-ordinate the quality improvement projects (section 6.5) were also beneficial.

### 8.1.15 Practice engagement and communication

The level and degree to which practices engage with their federation can be variable, with McDonald et al (2020) noting that the level of control excerpted over practices varied depending upon the nature of the collaboration. Corporate venturing literature suggests that separation between the venture and the sponsors can be common as the responsibility for leading the venture is allocated to a dedicated team of people. However, in this study it was important for the executive team to have practices actively engaging, participating and contributing. After the workshops with practice personnel in 2015 the initial motivation and enthusiasm of the executive team dipped. Some negative perspectives aired during the 2015 workshops questioned the achievements of the venture and the benefits of membership, which dented the enthusiasm and resilience of the executive team and was disappointing after the significant personal investment they made in developing the venture. This suggested a possible lack of internal legitimacy with the member practices, which is a factor that Block and Macmillan (2005) identified can be a weakness within corporate ventures. However, interviews in 2019 with the GPs, managers and nurses revealed that some managers filtered and shared information on a need-to-know basis, and this may have impacted on the perceptions staff had and account for the negative perceptions aired. Selective filtering of information to certain groups of staff (including admin and GPs) within the practices was also noted by some managers who advised that sharing information about the venture had no relevance to some staff (e.g. admin staff). Therefore, it was evident that there was inconsistency amongst practices around the level of information sharing and discussion around the federation. It was also reported that communication improved and developed over time, with key messages being shared both in writing (email updates and the newsletter) and verbally (at education events). This increased awareness and provided consistency.

The effectiveness of communication is important in achieving alignment of vision and, although various methods of communication were adopted, the effectiveness was questionable. The Denison survey revealed that there were differing perspectives on communication and engagement (section 7.2.3) and, whilst the managers perceived that information was widely shared, the GPs did not share this view. This suggested that communication with the GPs was not as effective. During the 2015 workshops, there appeared to be a disconnect between practice personnel and their knowledge around activities pursued on their behalf. As such, managers reported in 2019 that selective filtering of messaging took place in communicating with various staff groups. Interviews with GPs, managers and nurses in 2019 reported improvements around communication and it was

evident that there was much greater alignment with the venture. This was reported across the GPs, practice managers and practice nurses, illustrating that such developments take time to establish and embed.

### 8.1.16 Networking and relationships beyond the federation

The executive team was keen to achieve recognition as a legitimate venture and representative of the body of practices. This was strategically important to further the aims of the venture and be recognised as an organisation that could represent the member practices, develop and deliver local services, and introduce quality improvement initiatives through a cohesive grouping of practices working collaboratively. To achieve this, connections were made through networking with a range of organisations out with the geographic locality, and relationships were developed with a range of stakeholders who may be able to provide project support and funding. The part-time managers recruited to support the executive team became effective networkers and had a remit to support business development, including dedicated time to seek contacts and arrange meetings to further the aims of venture.

Relationships were developed with the two local foundation trusts, who became members and made a financial contribution towards membership, which made a significant contribution to the overheads during the initial stages of development. Trust membership was restricted to a non-voting capacity, illustrating that decision-making and control was retained by the practices. Thus, whilst competitive rivalry is a force that impacts on business strategy, this collaboration between providers potentially counteracts this (Porter 2010). The relationship with one trust was more productive in terms of contributing to a service portfolio (the vasectomy service), whilst the relationship with the other did not realise the same benefit. This is because despite negotiations to develop an urgent care model in partnership, this did not materialise due to conflicting views around the costs of delivering the service.

There was less success in developing a meaningful relationship with the CCG, which may have been influenced by conflict-of-interest guidance around GPs in commissioning roles and GPs in provider roles, the lack of role for CCGs in primary care commissioning until 2014/15, and the lack of concerns around the quality of primary care services or failing practices in the local area. Despite several requests to develop joint meetings between the federation and the CCG, this was not achieved, maintaining the “clear blue water” between the GPs promoting federated working and the GPs leading the commissioning organisation.

Other relations were developed over the period of the study including academic partnerships within the knowledge transfer partnership, the Academic Health Science Network and a range of pharmaceutical companies. These organisations supported the venture through project funding applications, illustrating a flexible approach in developing relations beyond the providers within the health economy. In doing so, this provided the federation recognition beyond the locality, and examples of the quality improvement work were presented regionally and nationally.

### 8.1.17 Differing organisational philosophies

Health care organisations exist within a health economy ecosystem and the study revealed that there were several examples of differing organisational and business philosophies across providers. Whilst the CCG was able to evidence that there was no conflict between roles, this still impacted upon the relationship that the Federation was able to develop, and the inability to influence strategic decisions was noted. This included the Vanguard model of care submission in 2015 (NHS England, 2015). Whilst the GPs within the federation were seeking support for a localised model for their geographic footprint (e.g. primary care home), the CCG made an application for a health economy model (e.g. integrated primary and acute care system) which was perceived as an initiative predominately driven by the acute trust and the CCG.

In another example in 2015, one of the hospital trusts set up a primary care division as a wholly-owned subsidiary company of the trust. This was promoted as an alternative model of general practice where practices could join and be part of a larger operational unit with the support of the foundation trust. The trust was able to invest in supporting practices through joint recruitment of posts (GPs, advanced practitioners, clinical pharmacists) and also through the acquisition of premises owned by the GP partners. Two of the federation's member practices opted to join this alternative model of care and offered their GMS contracts to be part of this organisational form, withdrawing from the Federation. Interviews conducted with health economy personnel in 2013 hinted that this model was being discussed and developed within the trust, and by 2019 seven GP practices had joined this organisation: four practices from the CCG where the federation was located and three from a neighbouring CCG, two of them being members of the venture but withdrew when they joined the trust organisation. These examples illustrate the differing philosophies amongst organisations within the health economy and the independence that individual organisations possess. For federation leaders, awareness of organisational differences and developments

within the health economy are important considerations as they establish their role within a wider health system. The notion of the superiority of hospital trusts was cited in this study (Section 6.8), which is an issue documented in the literature (Pringle, 1998; Addicott & Ferlie, 2007).

### 8.1.18 Key learning and considerations

From the insight and learning generated by this study, several important considerations emerge which are pertinent for other general practice collaborations to consider.

- Define the intended purpose (strategic vision) for the collaboration, such as what does it intend to achieve (developing something new, building upon what practices already do, or reacting opportunistically to emerging opportunities)?
- Define whether the purpose and orientation is to support autonomous practices or influence a greater degree of change (practice consolidation), or is there an incremental process of change that will be pursued?
- Define the nature of the collaboration, whether this is formal or informal. Both will require resourcing of a central function which will be greater if there is a new legal entity formed. A plan for the funding of this will need to be defined and agreed.
- Document the orientation of the collaboration and examine how this aligns with the intended purpose.
- Identify how important it is for all practices to have a shared understanding of the purpose and function of the collaboration. Consider what mechanisms should be adopted to develop and embed a shared vision.
- Articulate what success looks like to the members of the collaboration, as co-production of key success factors will assist in developing ownership.
- Document a business plan to provide structure and assist the collaboration in order to detail how it is intending to deliver its vision. This should identify risks and resources required for each activity, and outline how successes will be defined and measured. Leaders should have the ability to think strategically and adopt a flexible approach beyond the immediate locality to enhance the business plan and seek opportunities to further the aim of the collaboration.
- Identify how business opportunities will be created. An assessment of the operating environment should determine what opportunities exist, e.g. new services through procurement, collaboration between organisations (federation and trusts) or efficiencies across practices.

- Define how the vision for the collaborative will be implemented. What activities will be pursued and to what extent will practices be involved or required to implement change (e.g. authoritative directives from the central team/ autonomous participation/ or non-participatory)?
- Identify leadership and management capacity required to support the collaboration.
- Identify credible leaders with the expertise, time, enthusiasm and motivation required to dedicate to the collaboration. These posts should be remunerated appropriately, and appropriate consideration given to succession planning and development of these leadership roles.
- Consider whether the management capacity and capability is available internally, or needs to be sourced externally.
- Identify what opportunities exist for personnel across practices to lead on initiatives and developments, as this supports sharing responsibility, building capacity, and strengthening engagement.
- Consider the relationship required between the collaboration and the member practices. Establish how integrated/symbiotic this needs to be and whether expectations are clearly articulated.
- Identify the key stakeholder groups (including member practices) and establish engagement and communication mechanisms, and evaluate how successful they are.

### 8.2 Co-existence of federations and primary care networks

The introduction of primary care networks in England in 2018/19 (NHS England 2015/16; Ham & Murray, 2015) signalled significant investment from government to stabilise the GP partnership model, introduce new staffing models to reduce GP workload, and bring practices together in groupings of 30,000-50,000 patients (Fisher et al, 2019). This ambitious programme of change will require greater collaboration amongst practices and community services with a focus on key clinical priority areas (Wilson and Lewis, 2019; Iacobucci, 2020). The ability to deliver on this challenging ambition is yet to be evidenced as it is recognised that additional capacity will be required to deliver this agenda effectively (Murray, 2020).

The practices that had formed the federation in this study also formed a primary care network in 2019, alongside with three other practices (the two practices managed by the

foundation trust primary care organisation and the one practice that did not originally join the federation in 2011). During interviews in 2019, participants highlighted that this national initiative was perceived as top-down, whereas the federation had been organically developed by the practices from the bottom up, via supporting initiatives that the practices were willing to engage with. However, it was recognised that the federation had provided significant learning that could be transferred to the new network arrangements. This included the need for a clear articulation of purpose and vision, and effective methods of communicating and engaging with practices to ensure all practices were equally represented. Although perceived by some as top-down, this new initiative provided investment to support clinical leadership and management, which the Federation had to rely on in the form of member subscription or external funding. As a national initiative, the formation of networks could provide the member practices with recognition as a collective grouping with the CCG, that the Federation was unable to achieve, thus improving the influence that GPs can have as provider organisations within their health economy. Many recognised that the formation of the networks was an evolution of what had been developed by the Federation (section 7.5.6), and regarded it as an extension of the work that had been established with the benefit of funding to recruit additional staff to support the individual practices.

Networks require to nominate a lead practice for the purposes of recruitment and financial management, which does not require new companies to be set up. Therefore, this questions the future role of the federation within the framework of PCNs as to whether it is feasible and viable for both structures co-exist, or whether federations become redundant. At the end of the study, this was being debated by the executive directors and it was recognised that initiatives developed by the federation could transition to the network, but this would take time to organise. A similar situation would also relate to many of the other initiatives, such as primary care research and education, thus complementing the remit of the network. The executive manager running the federation on a part-time basis was also appointed as the primary care network manager, which would be beneficial to harmonise all of the initiatives and services developed by the federation into the network structure, if this was the agreed course of action. As networks emerge a performance management role should be developed, as this would change the collegiate nature of groups and may impact on engagement of practices and the attractiveness of leadership roles.

## 8.3 Contribution of this thesis

In addressing the research question and aims, this study examined in detail the business endeavours of a group of GP practices who embarked upon a business venture with the ideology to maintain individual practices as viable partnerships. A group of motivated, entrepreneurial GPs were instrumental in galvanising support from other practices at a time when federations of practices in the North-East region of England were uncommon. This was revolutionary when the environment of healthcare was in a state of flux, with a national re-organisation of the commissioning infrastructure. The survival of the practices was a key driver in galvanising support for the venture and whilst strategic cohesion amongst multiple independent GP practices in some format may pose a threat to individual practice autonomy and act as a barrier to change, these GPs opted to preserve and maintain the status quo to strengthen the individual partnerships. In the study, of the original 14 member practices, 11 retained status as independent partnerships, whilst two practices merged and subsequently joined the subsidiary organisation of the foundation trust along, with one other practice. There were no further practice mergers, no contracts handed back to NHS England for re-procurement or practice list dispersal, and no further practices joining the alternative foundation trust model. This case study examination of the federation over time not only tracked what happened to the individual practices, it provided insights to the challenges of federated working. It contributes knowledge about strategy implementation and business planning that should be carefully considered throughout the transformation of individual practices to group arrangements for the delivery of primary care.

The venture established by the GPs was pioneering when it was conceived. As a joint venture in a quasi-market environment, the core business contracts of the GP practices would remain intact (GMS contracts held in perpetuity) with minimal risk to the practices, whilst taking advantage of new business opportunities that may present. The venture was an appropriate vehicle to develop business opportunities, but these were limited as commissioning strategy was not aligned to market development within the immediate locality. Although the market was not completely stagnant, with some services competitively tendered, not all were relevant to general practice (section 6.6.1). This resulted in small value services being developed which made a contribution to the overheads of the venture, until the higher value extended access contract generated revenue, thus boosting morale and invigorating practices to work more closely on the model of delivery. To counteract the lack of commissioning opportunities with perseverance and willingness to be entrepreneurial, a creative approach to income generation was taken and external funding sources were sought to continue the pursuits of the venture, thus demonstrating flexibility and adaptability to generate other revenue streams. This approach attracted interest from

external funders in the pursuits of the federation, and raised the profile of the venture through promoting examples of work and projects both regionally and nationally.

The executive team were altruistic in supporting the ethos of maintaining high quality, viable local GP practices and activities that all practices would benefit from, hence the desire for practices to be involved and engaged in the venture. This further ensured that each practice had proportional influence on decision-making irrespective of practice size. An approach to leadership that engaged personnel from the member practices in various aspects of the venture assisted in encouraging practices to shape various activities, including education, training, research and quality improvement. Although engagement was variable across the duration of the study, and gaining legitimacy for the venture amongst personnel from the member practices took time to develop, it was evident that by 2019 reflections were positive about the collective achievements. Gaining legitimacy in the local health economy also took time to develop and, whilst relationships developed with the foundation trusts from an early stage, relations with the CCG were less established. It was evident that differing organisational philosophies emerged, and contrasting views around health economy models of care questioned the influence GPs had at a strategic, decision-making level.

As an executive team, the pressure of dedicating adequate time to the venture was evident, with the individual practice business taking precedence over the venture. Therefore the ability to diversify was challenged by the need to ensure leaders were provided with time to dedicate to the venture. Changes to the executive team did occur over the period of the study, highlighting an appetite from other GPs to assume this role and evidencing that engagement did strengthen over time.

The longevity of the venture over an eight-year period highlights that the venture did become self-sustaining and brought added value to the member practices. The experience gained through federated working positioned the practices to form a primary care network with confidence. The cohesion, trust and collaborative approach to federated working helped the foundations to build upon in an environment where there was financial incentive to establish and maintain the network. The ability for networks to recruit additional staff to work across multiple practices elevates the collaborative arrangement beyond that of the federation. Whether there is a need for the federation to exist alongside the network is yet to be defined, but nevertheless it created a legacy in what is was able to achieve.

## 8.4 Business strategy as a lens of exploration

Examining the federation from a business strategy perspective identified that there are several approaches that can be pursued (consolidation or diversification). Fundamental to the type and form of federation is the intended vision and purpose, to what extent this impacts on the existing practice partnership model, and whether practices would be willing to relinquish the status quo in favour of alternative business forms. The profitability of a business relies upon it being able to generate revenue to cover costs and produce a profit. Federations established as separate businesses ultimately require to exist as financially viable entities.

## 8.5 Strengths and limitations of the adopted research approach

The strengths of this study are that it provided a unique and detailed insight into one example of a GP federation over eight years. This insight was gained during a period where much attention and focus centred on clinical commissioning, with relatively little attention given to GP practices from a provider development perspective. It could also be argued that federations emerged as forerunners to the establishment of primary care networks in 2018. When considering the study limitations, it is recognised that case study can be applied to single or multiple subjects, and this study undertook a single case investigation which has limitations in that it could be perceived as adopting a restricted focus. On the other hand, the study provided unique access and provided an opportunity for a rich and detailed investigation into how it was established and progressed over an eight-year period. This case study investigation presented the experiences of the people involved, provided a lived reality of the study subject and presented the idiosyncrasies of one example of a federation as a corporate venture. Adopting a longitudinal time sequence provided the opportunity to track outcomes of actions over time, when most research is cross sectional or over a very limited time (Pettigrew et al, 2018; McDonald et al, 2020).

There are recognised limitations of undertaking singe case studies that include the generation of large volumes of data. A criticism of case study is subjective bias because of the influence of the researcher's pre-conceived accepted wisdom (Yin, 2012). Within this study there is a potential bias in that the researcher was employed within the organisation for part-duration of the study, therefore the influence of being an insider researcher was considered. Within the study, processes of verification were key to minimising potential subjective bias, and the use of a mixed methods approach to data collection assisted in the process of minimising any researcher subjectivity. Flyvbjerg (2006) argues that research is ultimately a broad phenomenological form of learning, and the goal of the researcher is to

intensively understand the phenomenon of study. The counter argument is that case study research contains no greater bias than any other method of enquiry, and researchers are aware of potential researcher bias. Within this study the findings were validated through a focus group interview with the federation's executive team, and feedback provided the reassurance that an accurate depiction had been portrayed. Further validation was given by reviewing chapters, offering critique and feedback.

From the perspective of the study design as a mixed methods study, there were several reflections on this approach. Johnson and Onwuegbuzie (2004) suggest that within mixed methods studies there can be a dominant or equal weighting between qualitative and quantitative methods, and within this study there was an equal weighting of both approaches. Sequencing of data collection can also be a challenge within mixed methods studies (Bryman, 2012), and in this study this was managed through data collection at the initial stages of enquiry (survey data) informing subsequent lines of enquiry (focus group interview), which was an effective way of achieving greater insight and exploring meaning. The study generated the collection of a significant amount of data which presented a challenge in relation to thematically analysing and interpreting each data set to elicit key themes that depicted an accurate and compelling account of the study subject.

Qualitative interviews with individuals provided rich, detailed data, and presented a vivid and lived experience from personnel within the venture, and also from a cohort of external personnel. Focus group interviews were also an effective form of data collection and allowed for topics to be discussed within a group setting, providing interaction, rich discussion and debate. The questionnaire surveys that were used were effective in presenting a collective perspective from a broader cohort of participants. The utility of the Denison survey was beneficial in capturing responses from the board of directors (GPs) and the managers, and highlighted differing responses between the two groups. The ALQ assisted in summarising the authentic leadership characteristics of the executive team and gave an insight into the level of cohesion between members of the team.

### 8.6 Practitioner research reflections

Practitioner research is contentious in qualitative research as the researcher and the researched are both part of the social world under investigation. Therefore the role of the researcher in society and the impact of this on research are important considerations (Cotterill and Letherby, 1994). After an extensive career in health service management, with more than twenty years working in community and primary care, the researcher's

professional background and knowledge was in-depth and this fuelled a specific interest within this sector of healthcare. This working knowledge may also have resulted in personal preconceptions about general practice federations and the policy context within which they were emerging, having previously experienced many policy developments in the NHS.

The role of insider researcher provided detailed access to the study subject, and without this access this study would not have been possible. I shared the lived experiences of the executive team as they established their venture and had an insight into their behaviours and desire to succeed. As a part-time employee of the federation between 2011-2016, this business development role provided the opportunity to develop networks and business connections out with the traditional boundaries of independent general practices. The role of employee did provide some objectivity compared to that of the GPs who were owners of the venture and personally invested in its formation, and who would financially benefit from any success. Emotions may also influence research and witnessing many failed attempts to secure additional funding could have influenced how this was portrayed within the narrative, but moderation through discussion with supervisors proved beneficial in providing objectivity. The role of the researcher in influencing strategy was also a consideration, particularly the ability to secure funding to support quality improvement shifting focus away from the lack of commercial opportunity within the health economy towards activities that supported the strategy of evidencing high-quality care.

There was also an awareness of the relationship between researcher and the researched, and possible power dynamics that may have influenced the way participants responded during the interview or survey. Voluntary participation was evident throughout the study, with 100% participation not achieved, thus demonstrating non-coercion. In the qualitative data gathered, participants had choice and control over the information that was offered and how to respond during interview, and the opportunity for member-checking was always provided. Research diary notes and reflections from an interview with one senior executive captured the feeling that the interviewee was interviewing the researcher, which was an interesting display of power within the interview process. Access to the executive team also provided the opportunity for points of clarification or sense-checking to be undertaken on both a formal (focus group) and informal basis.

The dual role held by the researcher may have also contributed to the development of the federation. Operating as a freelance consultant provided opportunities for wider networking with other personnel working in developing national collaborations. The organisation of a regional conference with national speakers provided the opportunity for GPs in the North

East region to come together and learn from experts engaged in supporting GP collaborations. Similarly, tools used within the study may have supported development. The individual ALQ reports were shared with the personnel who completed them for the purposes of personal development, and the sharing of the Denison survey results may have influenced actions taken by the executive team.

### 8.7 Implications for future research, policy and practice

Newton (1996) identified that the business environment of general practice was an under-researched area. As this has remained the case, it makes the topic rich ground for further study. Federating general practice is a complex phenomenon and there are multiple factors that can influence type of collaboration that is formed: the business orientation; formality and governance required to support the collaboration; and defining measures of success. Vision, purpose and intent are also important considerations, and the process and effort in aligning multiple independent practices to a shared vision to gain strategic cohesion cannot be underestimated. The literature around what constitutes a successful GP federation is scant, and the influence of factors in the operating environment varies across different geographic localities in England, providing additional contextual complexity.

In terms of further areas for research, there are various theoretical perspectives that could be applied to further research around GP federations. As the phenomenon of federating could be regarded as a process of redefining the boundaries of general practice, there is an opportunity to examine the emergence of alternative organisational forms within the context of how other professional groups (e.g. accountants and solicitors) have developed into larger scale organisational forms. Systems theory (Slocum and Hellreigel, 2009; Geboers et al, 2002) would provide the opportunity to examine the model of federations from the perspective of understanding the inter-relatedness between practices, and how change could be facilitated to achieve operational efficiencies with clear measurement of the benefits. Organisational development (Porras and Robertson, 1992; Goni, 1999) could be a helpful perspective to examine the phenomena of federations where human factors and behavioural science support planned change based upon individual and organisational goals being agreed and implemented. GP practices could be regarded as complex adaptive systems (Crabtree et al, 2001; Plesk and Greenhalgh, 2001) where there is an evolutionary dimension to change and players exist and influence behaviour through the interaction between organisations (practices). Therefore, examining federations from a complexity theory perspective could clarify the motivation and commitment of individual practices to participate in federated activities. The application of quality improvement in this study

evidenced population health improvement. Therefore, studies of the population health improvements achieved through GP collaborations would be of interest to policy makers and planners. The future GP federations within the context of emerging primary care networks are also an area for exploration, to examine whether there is a role for both organisational forms, or whether networks effectively render formal federations as redundant.

From a practice perspective, collaboration offers opportunity for workforce development across practices, particularly for roles that have had limited access to continued professional development (CPD) and clinical supervision. The ability to employ staff, and share the overheads of this, was evident within the study around the organisation of research, but will have greater benefit when extended to other multi-disciplinary roles in general practice (e.g. clinical pharmacists, first contact physiotherapists, community link workers, mental health workers, etc). The ability of federations to develop specialisms and offer services to a wider population (e.g. vasectomy service, spirometry, etc) will provide more patient care in community settings and reduce demand for secondary care services.

The policy for developing primary care networks (NHS England, 2019) states a commitment to supporting a fragile sector of the NHS through national funding for additional clinical roles, and the redesign of care delivery through digital solutions. However, the impact of Covid-19 and pandemic response has further weakened a fragile system (Pettigrew et al, 2020), creating additional pressures to newly formed networks. The increasing trend towards the formal creation of larger practices may continue at pace following the experience of GPs working within pandemic response, and this may result in further re-evaluation of their contractual position and future within general practice as a profession.

### 8.8 Conclusion and personal reflection

This study provides a valuable insight into an example of a GP federation set up as a corporate venture by a group of visionary GPs. The longevity of the venture beyond initial practice investment gave the opportunity to explore the challenges that were encountered over eight years. The mixed methods approach captured various perspectives and provided an in-depth understanding of the factors that were encountered as the venture was established. It has been a personal privilege to have had the opportunity of conducting this study and work alongside a forward-thinking, motivated group of GPs dedicated to preserve local independent practices. Writing this thesis has made me reflect on the experience I have gained throughout the process, and how this has contributed to my own personal development and career progression in the field of primary care.

## Appendix 1 – Ethics Approval

*Professor Kathleen McCourt CBE FRCN*
*Dean*

**This matter is being dealt with by:**
Professor Olivier Sparagano
Associate Dean
Faculty of Health and Life Sciences
Northumberland Building
Newcastle upon Tyne
NE1 8ST
Tel: 0191 2156701
Email: *julie.blackwell@northumbria.ac.uk*

[redacted]

29th August 2013

Dear Jill

**Faculty of Health and Life Sciences Research Ethics Review Panel**
**Title: A General Practice federated provider model in the mixed health economy in England: a case study examination**

Following independent peer review of the above proposal, I am pleased to inform you that Chair's Action was taken on 29th August 2013 and University approval has been granted on the basis of this proposal and subject to compliance with the University policies on ethics and consent and any other policies applicable to your individual research. You should also have recent Disclosure & Barring Service (DBS) and occupational health clearance if your research involves working with children and/or vulnerable adults.

The University's Policies and Procedures are available from the following web link:
http://www.northumbria.ac.uk/researchandconsultancy/sa/ethgov/policies/?view=Standard

You may now also proceed with your application (if applicable) to:

- NHS R&D organisations for approval. Please check with the NHS Trust whether you require a Research Passport, Letter(s) of Access or Honorary contract(s).
- Research Ethics Committee (REC). [They will require a copy of this letter plus the ethics panel comments and your response to those comments]. If your research is subject to external REC approval, a 'favourable opinion' must be obtained prior to commencing your research. You must notify the University of the date of that favourable opinion.

You must not commence your research until you have obtained all necessary external approvals.

Both the University and NRES strongly advise that the supervisor accompany the student when attending an external REC.

All researchers must also notify this office of the following:

- Commencement of the study;
- Actual completion date of the study;
- Any significant changes to the study design;
- Any incidents which have an adverse effect on participants, researchers or study outcomes;
- Any suspension or abandonment of the study;
- All funding, awards and grants pertaining to this study, whether commercial or non-commercial;
- All publications and/or conference presentations of the findings of the study.

We wish you well in your research endeavours.

Yours sincerely

Jim Clark
Chair, Faculty Research Ethics Review Panel

## Appendix 2 – Interview Consent Form

**INTERVIEW CONSENT FORM**

**Full title of Project**:

**Name, position and contact address of Researcher**:

| | | **Please Initial Box** |
|---|---|---|
| 1. | I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. | ☐ |
| 2. | I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason. | ☐ |
| 3. | I agree to take part in the above study. | ☐ |
| | *Note for researchers:*<br>*Include the following statements if appropriate, or delete from your consent form:* | ☐ |
| 4. | I agree to the interview / focus group / consultation being audio recorded | |
| 5. | I agree to the interview / focus group / consultation being video recorded | ☐ |
| 6. | I agree to the use of anonymised quotes in publications | ☐ |

| Name of Participant | Date | Signature |
|---|---|---|
| Name of Researcher | Date | Signature |

**Appendix 3 – Information Sheet for Participants**

## INFORMATION SHEET FOR PARTICIPANTS

**Full title of Project:**
General Practice Federations in a mixed health economy in England: a case study examination

**Name and contact details of Researcher**:
Jill Mitchell
[redacted]

I would like to invite you to participate in this postgraduate doctoral research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully. Please do not hesitate to ask if there is anything that is not clear or if you would like more information.

- The aim of the research project is to undertake a qualitative case study of [The Federation] as a new provider organisation in a market-driven health economy. There are two aspects of the study - one that will examine the organisational development of the [The Federation] from a business perspective. The other aspect is to examine the role of strategic leadership within this corporate venture. The study is longitudinal and the timeframe of the study will be between 2011 – 2019.

- This project is being completely self-funded – which includes all of the time to interview, analyse and report the findings of the research.

- The project is structured into 3 areas of data collection:
    1. Face-to-face interviews
    2. On-line survey questionnaire
    3. Focus groups

- The face-to-face interviews and on-line survey will be aimed at the following personnel:
    - Named GPs who are co-owners (Directors) of [The Federation] (including the Executive Management Team)
    - Practice Managers from the Member Practices
    - Personnel employed by [The Federation] (research team)

- The themes deducted from the interviews and surveys will be used to conduct focus groups which will be open to the following personnel:
    - Named GPs who are co-owners (Directors) of [The Federation] (including the Executive Management Team)

- Member Practice staff

- Participation in the research will be completely voluntary. It is envisaged that the findings from the research will feed into the organisational development plan for [The Federation] over the coming years.

- Information from interviews will be anonymous and will not be attributed to any individual. Interviews will be recorded and transcribed and a copy of the transcript will be provided to the interviewee to ensure accuracy. Recordings of interviews will be deleted upon transcription.

- For the completion of the on-line questionnaire, submission of a completed questionnaire implies consent to participate.

- In compliance with the UK Data Protection Act 1998 transcripts for analysis will be retained in password protected files. There is no external agency involved in any of the data handling related to this study.

- A copy of the final report (unpublished thesis) will be available to all participants.

- Any associated publications arising from the study will be co-authored with [The Federation] (where relevant).

Participation is completely voluntary and it is up to you to decide whether to take part or not. If you decide to take part you are still free to withdraw from the study at any time and without giving a reason. If you do decide to take part you will be given a copy of this information sheet to keep and also be asked to sign a consent form.

If you have any questions or require more information about this study, please contact the researcher using the following contact details:

Jill Mitchell
[redacted]

If this study has harmed you in any way, you can contact the project supervisor, University of Northumbria using the details below for further advice and information:

Professor Dr Glenda Cook, Professor Nursing
Faculty of Health & Social Science, Northumbria University
Newcastle upon Tyne NE7 7XA
glenda.cook@northumbria.ac.uk
T: 0191 2156117

## Appendix 4 – Denison Survey Highest & Lowest Reported Domains

Denison scores are noted below, indicated in red where it was the lowest rated by the respective cohort group, and the highest rated indicated in green.

| **Mission** | **EMT Cohort** | **GP Cohort** | **Manager Cohort** |
|---|---|---|---|
| **Strategic Direction & Intent** | Score | Score | Score |
| There is a long-term purpose and direction | 55 | 38 | 93 |
| Our strategy leads other organisations to change the way they compete in the industry | 46 | 55 | 37 |
| There is a clear mission that gives meaning and direction to our work | 59 | 25 | 80 |
| There is a clear strategy for the future | 28 | 22 | 95 |
| Our strategic direction is unclear to me | 46 | 37 | 81 |
| **Goals and Objectives** | | | |
| There is widespread agreement about goals | 8 | 12 | 76 |
| Leaders set goals that are ambitious but realistic | 88 | 67 | 78 |
| The leadership has 'gone on record' about the objectives we are trying to meet | 32 | 12 | 94 |
| We continuously track our progress against our stated goals | 5 | 26 | 78 |
| People understand what needs to be done for us to succeed in the long run | 2 | 2 | 95 |
| **Vision** | | | |
| We have a shared vision of what the organisation will be like in the future | 12 | 5 | 85 |
| Leaders have a long-term viewpoint | 79 | 56 | 89 |
| Short-term thinking often compromises our long-term vision | 98 | 96 | 98 |
| Our vision creates excitement and motivation for our employees | 12 | 16 | 51 |
| We are able to meet short-term demands without compromising our long-term vision | 55 | 67 | 86 |

| **Involvement** | **EMT Cohort** | **GP Cohort** | **Manager Cohort** |
|---|---|---|---|
| **Empowerment** | Score | Score | Score |
| Most employees are highly involved in their work | 45 | 1 | 55 |
| Decisions are usually made at the level where the best information is available | 89 | 73 | 96 |
| Information is widely shared so that everyone can get the information he or she needs when it's needed | 54 | 21 | 96 |
| Everyone believes that he or she can have a positive impact | 20 | 10 | 51 |
| Business planning is on-going and involves everyone in the process to some degree | 25 | 71 | 89 |
| **Team Orientation** | | | |
| Co-operation across different parts of the organisation is actively encouraged | 72 | 95 | 92 |
| People work like they are part of a team | 4 | 6 | 79 |
| Teamwork is used to get work done, rather than hierarchy | 4 | 5 | 74 |
| Teams are our primary building blocks | 5 | 19 | 75 |
| Work is organised so that each person can see the relationship between his or her job and the goals of the organisation | 1 | 12 | 60 |
| **Capability Development** | | | |
| Authority is delegated so that people can act on their own | 1 | 17 | 30 |
| The 'bench strength' (capability of people) is constantly improving | 93 | 85 | 86 |
| There is continuous investment in the skills of employees | 20 | 39 | 53 |
| The capabilities of people are viewed as an important source of competitive advantage | 99 | 87 | 90 |
| Problems often arise because we do not have the skills necessary to do the job | 34 | 25 | 61 |

| Consistency | EMT Cohort | GP Cohort | Manager Cohort |
|---|---|---|---|
| **Core Values** | Score | Score | Score |
| The leaders and managers 'practice what they preach' | 98 | 88 | 96 |
| There is a characteristic management style and a distinct set of management practices | 13 | 75 | 70 |
| There is a clear and consistent set of values that governs the way we do business | 59 | 75 | 86 |
| Ignoring core values will get you in trouble | 43 | 11 | 25 |
| There is an ethical code that guides our behaviour and tells us right from wrong | 78 | 28 | 83 |
| **Agreement** | | | |
| When disagreements occurs, we work hard to achieve 'win win' solutions | 75 | 75 | 84 |
| There is a 'strong' culture | 52 | 9 | 48 |
| It is easy to reach consensus, even on difficult issues | 89 | 79 | 76 |
| We often have trouble reaching agreement on key issues | 92 | 86 | 87 |
| There is a clear agreement about the right way and the wrong way to do things | 61 | 61 | 95 |
| **Co-ordination and Integration** | | | |
| Our approach to doing business is very consistent and predictable | 33 | 51 | 96 |
| People from different parts of the organisation share a common perspective | 4 | 16 | 65 |
| It is easy to co-ordinate projects across different parts of the organisation | 15 | 10 | 92 |
| Working with someone from another part of this organisation is like working with someone from a different organisation | 38 | 47 | 74 |
| There is good alignment of goals across levels | 9 | 14 | 64 |

| Adaptability | EMT Cohort | GP Cohort | Manager Cohort |
|---|---|---|---|
| **Creating Change** | Score | Score | Score |
| The way things are done is very flexible and easy to change | 91 | 85 | 87 |
| We respond well to competitors and other changes in the business environment | 43 | 53 | 65 |
| New and improved ways of work are continually adopted | 77 | 69 | 80 |
| Attempts to create change are usually met with resistance | 88 | 83 | 95 |
| Different parts of the organisation often co-operate to create change | 31 | 68 | 87 |
| **Customer Focus** | | | |
| Customer comments and recommendations often lead to changes | 1 | 1 | 16 |
| Customer input directly influences our decisions | 1 | 1 | 8 |
| All members have a deep understanding of customer wants and needs | 2 | 25 | 97 |
| The interests of the customer often get ignored in our decisions | 35 | 35 | 86 |
| We encourage direct contact with customers by our people | 12 | 6 | 47 |
| **Organisational Learning** | | | |
| We view failure as an opportunity for learning and improvement | 83 | 83 | 84 |
| Innovation and risk taking are encouraged and rewarded | 97 | 80 | 92 |
| Lots of things 'fall between the cracks' | 50 | 84 | 90 |
| Learning is an important objective in our day-to-day work | 97 | 24 | 86 |
| We make certain that the 'right hand knows what the left hand is doing' | 43 | 86 | 85 |

# Assessing Organisational Culture in a Federated Model of General Practice

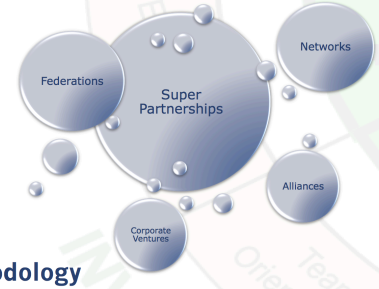
Jill Mitchell, Management Consultant

## Background

The independent contractor model has characterised General Practice within the healthcare sector in the UK since the inception of the NHS in 1948[1]. Currently General Practice delivers approximately 90% of all healthcare activity for 9% of the total healthcare budget[2].

The NHS is facing unprecedented demand from an ageing population - people living longer with multiple long-term conditions presenting with greater complexity of need and utilising more healthcare resources[3]. The profession of General Practice is also facing specific workforce challenges in this context. There is a growing debate that the current small business model of General Practice is out-dated and the "cottage industry" of multiple small independent contractors should be remodelled into an organisational function that is able to provide a broad range of primary care services at scale[4, 5, 6].

The thesis explores the emerging business models from a business and leadership perspective and examines what advantages they offer.




## Methodology

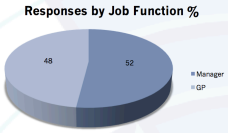
An organisational case study is being undertaken to examine one model of a federation made up of 13 individual GP Practices covering a population of 78,000 registered patients.

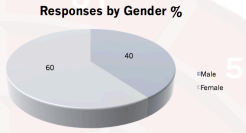
A mixed methods approach is being adopted to provide a rich, in-depth perspective of the business and leadership challenges facing this new model of organisation.

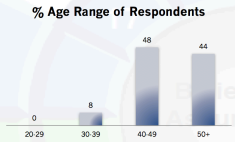
The Denison Organisational Culture Survey[7] was used to assess organisational culture two years after the formation of the Federation.

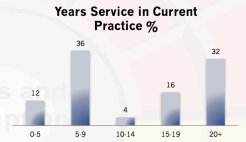
## Results

A survey of 25 executives and managers was undertaken using the Denison Organisational Culture Survey tool. The age profile indicates an experienced sample group (92% aged over 40) with over 48% having worked within their current practice for 15 or more years.

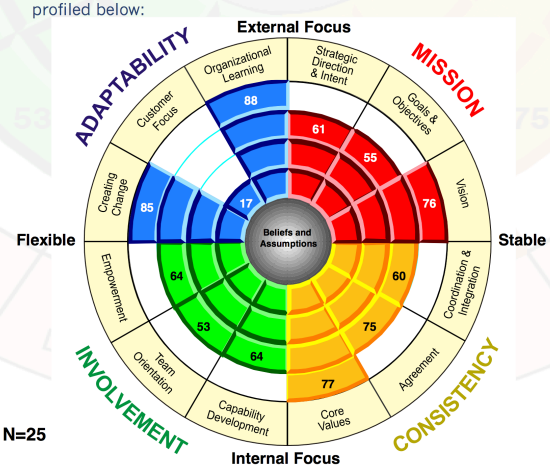



The survey results were compiled into an overall cohort report profiled below:




N=25

## Discussion

The overall cohort profile outlines a balanced profile and organisational strengths are reported in:

- Organisational Learning
- Creating Change
- Core Values
- Vision

A distinct weakness was reported in Customer Focus and further exploration through focus group interview identified that there was a lack of agreement around customer conceptualisation within the context of the organisation's operating environment.

*"so it's probably a bit of ambiguity amongst all of us as to how you define the customer, although we know what we are doing with the organisations we deal with "*

The next phase of research will explore the leadership challenges from the perspective of the Executive Management Team who have devolved responsibility for the development of the federated business venture. Key challenges are recognised in the ability to adapt to the external environment in order to survive but also to integrate internal processes[8]. In this case study these processes may be across existing businesses (GP practices).

## Student profile

Jill Mitchell, Year 3, PhD (part-time)
Faculty of Health & Life Sciences
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## Supervision team

Professor Glenda Cook, Faculty of Health & Life Sciences
Dr Michael Green, Newcastle Business School

## References

1 Pollok A (2005), NHS plc – The Privatisation of Our Health Care, Verso London
2 http://www.hscic.gov.uk/catalogue/PUB11679
3 Transforming the Delivery of Health and Social Care – The case for fundamental change, The King's Fund, 2012
4 Primary Care Federations – Putting patients first; Royal College of General Practitioners, June 2008
5 Transforming the Delivery of Health and Social Care – The case for fundamental change, The King's Fund, 2012
6 Primary Care: Today and tomorrow, Improving general practice by working differently, Deloitte Centre for Health Solutions, 2012
7 http://www.denisonconsulting.com/model-surveys/denison-surveys/organizational-culture
8 Schein E (2010), Organizational Culture and Leadership, Jossey-Bass, San Francisco

May 2015

# Examining Organisational Culture between Functional Groups in a Federated Model of General Practice

Jill Mitchell, Year 3 PhD (Part-time), Faculty of Health & Life Sciences
(jill.mitchell@northumbria.ac.uk)

## Background

The independent contractor model has characterised General Practice within the healthcare sector in the UK since the inception of the NHS in 1948[1]. Currently General Practice delivers approximately 90% of all healthcare activity for 9% of the total healthcare budget[2].

The NHS is facing unprecedented demand from an ageing population - people living longer with multiple long-term conditions presenting with greater complexity of need and utilising more healthcare resources[3]. The profession of General Practice is also facing specific workforce challenges in this context. There is a growing debate that the current small business model of General Practice is out-dated and the 'cottage industry' of multiple small independent contractors should be remodelled into an organisational function that is able to provide a broad range of primary care services at scale[4, 5, 6].

The thesis explores the emerging business models from a business and leadership perspective and examines what advantages they offer.

## Methodology

An organisational case study is being undertaken to examine one model of a federation made up of 13 individual GP Practices covering a population of 78,000 registered patients.

A mixed methods approach is being adopted to provide a rich, in-depth perspective of the business and leadership challenges facing this new model of organisation.

The Denison Organisational Culture Survey[7] was used to assess organisational culture two years after the formation of the Federation.

## Results

A survey of 25 executives and managers was undertaken using the Denison Organisational Culture Survey tool. The age profile demonstrated an experienced sample group (92% of respondents were aged over 40) and over 48% having worked within their current practice for 15 or more years.

An overall cohort report was generated (Figure 1) profiling the group responses. Further analysis between the functional cohorts of GPs and Managers was also examined and illustrates variation in perception (Figure 2 & 3).

## References

1) Pollok A (2005), NHS plc – The Privatisation of Our Health Care, Verso London, 2) http://www.hscic.gov.uk/catalogue/PUB11679
3) Transforming the Delivery of Health and Social Care – The case for fundamental change, The King's Fund, 2012
4) Primary Care Federations – Putting patients first; Royal College of General Practitioners, June 2008
5) Transforming the Delivery of Health and Social Care – The case for fundamental change, The King's Fund, 2012
6) Primary Care: Today and tomorrow, Improving general practice by working differently, Deloitte Centre for Health Solutions, 2012
7) http://www.denisonconsulting.com/model-surveys/denison-surveys/organizational-culture

## Findings


Figure 1 - Overall Cohort Profile

The overall cohort illustrates a balanced profile with the exception of Customer Focus – indicating a lack of customer conceptualisation among respondents.

Further analysis of two functional groups illustrates considerable variation in perception between the GPs and Managers who were surveyed (Figure 2 & 3).

Further exploration identified the importance of the management function in operationalizing the strategy of the Federation through individual Practices. Other features such as regular communication and Practice Manager representation on the Executive Management Team were considered important in aligning the managers with the Federation's vision.

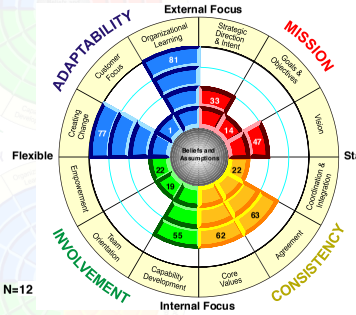


Figure 2 - GP Cohort Profile

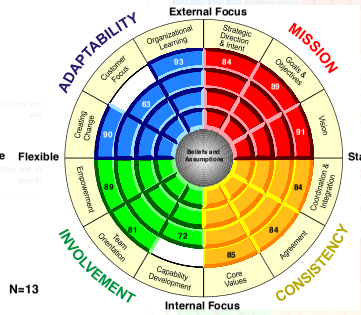


Figure 3 - Manager Cohort Profile

## Supervision team

Professor Glenda Cook, Faculty of Health & Life Sciences
Dr Michael Green, Newcastle Business School

May 2015

# Appendix 7 – MMIRA Conference Abstract 2016

MMIRA Conference 2016

**Moving Beyond the Linear Model:**

**The Role of Mixed Methods Research in an Age of Complexity**

**ABSTRACT**

**Federations of General Practice – the changing professional organisational archetype**

*Jill Mitchell, PhD Student, Northumbria University*

**Abstract**
A mixed methods organisational case study presents a survey of an emerging federated model of General Practice. A longitudinal approach captures the development of the organisation over a four-year time frame.

Interpretivism supports the examination of social phemonenon in a natural environment and research topics involve the social actors on the basis that they play a vital part within the social construct (Saunders & Lewis, 2012). The relevance of interpretivism to this study is that it realises the uniqueness and complexity of the General Practitioners who have come together to form federations as new organisational archetypes. Adopting a constructionist approach there is less of a focus on objective reality and a more of a focus on the values, beliefs and perceptions that people hold about reality of the situation being studied (Neuman, 2007). The study examines the motivations and drivers that have supported individual business leaders (General Practitioners) to collaborate and form a new corporate venture to support the development of General Practice.

The unit of study is one example of a General Practice federation in the North East of England. A mixed methods study incorporates a qualitative enquiry in the form of interview (face to face and focus group). Quantitative surveys have also been incorporated in the study. An organisational culture survey provides a baseline assessment at an early stage of the federation's development. A leadership questionnaire has also been applied to profile the executive management team of GPs and managers who have come together to lead this new organisational archetype.

One of the main challenges of this mixed methods study is the integration of data and findings from multiple data sets into a cohesive framework of analysis. Social constructivism as a strand of interpretivism adopts the belief that knowledge is constructed as opposed to discovered (Stake, 1995). Stake (1995) argues that a constructivist approach within case study does not require the need for generalisation. Stake (1995) summarises that a constructivist approach provides the reader with enough data to be able to draw their own generalisations and the role of the researcher as an interpreter provides the opportunity to explore the subjective meaning and perspectives of the social actors.

This approach provides the study with a detailed insight and in-depth understanding of the members of the organisation. This provided an understanding of the motivations why the business venture was established and the intended purpose.

Neuman, W. L. (2007) *Basics of social research: quantitative and qualitative approaches.* 2nd edn. London: Allyn and Bacon.

Saunders, M., & Lewis, P. (2012) *Doing research in business and management: An essential guide to planning your project*. Financial Times Prentice Hall.

Stake R (1995), *The Art of Case Study Research*. London, Sage.

Additional information:
Conference Web page: www.dur.ac.uk/sass/events/events/mmira2016
Submission of abstracts: www.dur.ac.uk/sass/events/events/mmira2016/abstracts
Contact: MMIRA.Conference2016@durham.ac.uk

# Appendix 8 – BJGP Research Conference Abstract 2018



British Journal of General Practice
bringing research to clinical practice



Oral Presentations

## A general practice provider federation in a mixed health economy in England: a case study investigation

Jill Mitchell

Br J Gen Pract 2018; 68 (suppl 1): bjgp18X696929. **DOI:** https://doi.org/10.3399/bjgp18X696929



**Abstract**

**Background** There is an emerging debate that general practice in its current format is out-dated and there is a requirement to move to a federated model of provision where groups of Practices come together. The emergence of federations has developed over the past 5 years but the factors that influence how federations develop and the impact of this new model is an under researched area.

**Aim** The study explored the rationale around why a group of independent GP practices opted to pursue an alternative business venture and the benefits that this strategy offered.

**Method** A single organisational case study of a federation in the North of England was conducted between 2011–2016. Mixed methods data collection included individual and group semi-structured interviews and quantitative surveys.

**Results** Federations promote collaborative working, relying on strategic coherence of multiple individual GP practices through a shared vision and common purpose. Findings revealed many complexities in implementing a common strategy across multiple independent businesses. The ability of the federation to gain legitimacy was two dimensional – externally and internally. The venture had mixed successes, but their approach to quality improvement proved innovative and demonstrated outcomes on a population basis. The study identified significant pressures that practices were experiencing and the need to seek alternative ways of working but there was no shared vision or inclination to relinquish individual practice autonomy.

**Conclusion** Organisational development support is critical to reform General Practice. Whether central funding through the GP Five Year Forward View will achieve the scale of change required is yet to be evidenced.



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## References


Aboulghate, A., Abel, G., Elliott, M. N., Parker, R. A., Campbell, J., Lyratzopoulos, G. and Roland, M. (2012). Do English patients want continuity of care, and do they receive it? *British Journal of General Practice*; 62 (601): e567-e575.

Addicott, R., and Ferlie, E., Understanding power relationships in health care networks. Journal of Health Organisation Management 2007;21:393–405. https://doi.org/10.1108/14777260710778925

Adler, P. A., and Adler, P. (1987). *Membership roles in field research*. Newbury Park, CA: Sage

Adler, R. W. (1994). Strategic focus: The CEO's key priorities. *Long Range Planning,* 27(4), 78-88

Aitken, K., & Von Treuer, K. (2014). Organisational and leadership competencies for successful service integration. *Leadership in Health Services* (2007), 27(2), 150-180.

Alaszewski, A. (2006). *Using diaries for social research.* London: SAGE.

Alban-Metcalfe, J., Alimo-Metcalfe, B., & Hughes, M. (2010). Selection of chairs of primary care trusts. *Journal of Health Organization and Management,* 24(1), 57-99.

Altona, P. and Ikävalko, H. (2002). Implementing strategies successfully. *Integrated Manufacturing Systems*, 13(6): 415-418.

Alvesson, M., and Sandberg, J. (2013), *Constructing Research Questions: Doing Interesting Research*, Los Angeles, CA: Sage. Management (Paris, France : 1998),17(5), 404-409.

AMSPAR, 2020 https://www.amspar.com (accessed 1 October 2020)

An International Glossary for Primary Care. Report of the Classification Committee of WONCA (1981). *Journal of Family Practice,* 15(5).

Anderson, C., Zhan, K., Boyd, M., & Mann, C. (2019). The role of pharmacists in general practice: a realist review. *Research in Social and Administrative Pharmacy*, 15(4), 338-345.

Ansoff, H. I. (1965). *Corporate Strategy.* New York: McGraw Hill.

Ansoff, H. I. (1991). Critique of Henry Mintzberg's 'The design school: Reconsidering the basic premises of strategic management'. *Strategic Management Journal,* 12(6), 449-461.

Antonakis, J. (2017). Charisma and the "new leadership". *The nature of leadership*. London: SAGE, 56-81.

Antonakis, J., Bastardoz, N., Jacquart, P., & Shamir, B. (2016). Charisma: An ill-defined and ill-measured gift. *Annual Review of Organizational Psychology and Organizational Behavior, 3*(1), 293-319.

Appelbaum, S. H., Iaconi, G. D., and Matousek, A. (2007). Positive and negative deviant workplace behaviors: Causes, impacts, and solutions. *Corporate Governance* (Bradford),7(5), 586-598.

Appleby, J. (2014). Is general practice in trouble? *British Medical Journal.* 349:g6814

Appleby, J., Galea, A., & Murray, R. (2014). The NHS productivity challenge. Experience from the front line. London: The King's Fund.

Armstrong, J. S. (1982). The Value of Formal Planning for Strategic Decisions: Review of Empirical Research. *Strategic Management Journal,* 3(3), 197-211.

Arnaout, B., & Esposito, M. (2018). The value of communication in turbulent environments: how SMEs manage change successfully in unstable surroundings. International Journal of Entrepreneurship and Small Business, 34(4), 500-515.

Ashworth, M., and Gulliford, M., (2017). Funding for general practice in the next decade: life after QoF. *British Journal of General Practice*. 67 (654): 4-5.

Atherton, A. (2012). Cases of start-up financing: An analysis of new venture capitalisation structures and patterns", *International Journal of Entrepreunerial Behaviour and Research,* Vol.18 No. 1, pp. 28-47.

Atkinson, P. (2014). *The ethnographic imagination: Textual constructions of reality*. Routledge.

Avolio, B. J. and Gardner, W. L. (2005) 'Authentic leadership development: Getting to the root of positive forms of leadership'. *The Leadership Quarterly*, 16(3): 315-338.

Avolio, B.J. (2005). *Leadership development in balance:* Made/Born. New Jersey: Erlbaum and Associates.

Avolio, B.J. (2007). 'Promoting more integrative strategies for leadership theory building'. *American Psychologist,* 62: 25-33.

Avolio, B.J. and Luthans, F. (2006). *High impact leader: Moments matter in authentic leadership development.* NY: McGraw-Hill.

Avolio, B.J., Gardner, W.L., Walumbwa, F.O., Luthans, F. and May, D. (2004) 'Unlocking the mask: A look at the process by which authentic leaders' impact follower attitudes and behaviors'. *Leadership Quarterly,* 15: 801-823.

Baggott, R. (1998), *Health and Healthcare in Britain.* 2nd edn. Hampshire: Macmillan Press.

Baird, B., Charles, A., Honeyman, M., Maguire, D., Das, P. (2016). Understanding pressures in general practice. The Kings Fund. Available at: www.kingsfund.org.uk/publications/pressures-in-general-practice (Accessed 29 July 2018).

Baker, M. (2014). Time to put patients first by investing in general practice. *The British Journal of General Practice,* June: 268-269.

Baker, R (2013). Access to general practice in a time of austerity. *British Journal of General Practice*, March 2013: 116-117.

Balint E (1979). The Balint group approach. *Journal of Royal Society of Medicine,* Volume 72, June 1979, pp 469-471.

Barrett, A., Kajamaa, A., & Johnston, J. (2020). How to be reflexive when conducting qualitative research. *The Clinical Teacher,* 17(1), 9-12.

Bartlett, W. and Le Grand, W. (1993). *The theory of quasi-markets.* Basingstoke: Macmillan Press.

Bateson, J. (2002). Consumer performance and quality in services. *Managing Service Quality*, *12*(4), 206-209.

Beech, B. and Baird, J. (2020), Primary Care Networks Explained, The King's Fund (https://www.kingsfund.org.uk/publications/primary-care-networks-explained)

Beer, M. and Eisenstat, R. A. (2000). The Silent Killers of Strategy Implementation and Learning. *Sloan Management Review,* 41(4): 29.

Beer, M. and Nohria, N. (2000). Cracking the code of change. *Harvard Business Review*, May–June: 133–141.

Bell, C. (1992), *Ritual Theory, Ritual Practice*, Oxford: Oxford University Press.

Bhaskar, R. (2016). *Enlightened common sense: The philosophy of critical realism.* London: Routledge.

Bhidé, A. (2000). *The origin and evolution of new businesses.* New York: Oxford University Press.

Blackhall-Morrison, A. (1920). Future Provision of Medical Services: Lord Dawson on the Consultative Council's Report. *British Medical Journal,* 1(3102): 800-802.

Block, Z. and Macmillan, I. C. (1995), *Corporate Venturing: Creating New Business within the Firm.* USA: Harvard Business School Press.

Boaden, R. J., and Zolkiewski, J. M. (1998). Process analysis in general practice - a new perspective? *International Journal of Health Care Quality Assurance,* 11(4), 117-122.

Bolden, R. (2011). Distributed Leadership in Organizations: A Review of Theory and Research. *International Journal of Management Reviews* : IJMR, 13(3), 251-269.

Bonner, A., and Tolhurst, G. (2002). Insider-outsider perspectives of participant observation. *Nurse Researcher,* 9(4), 7-19.

Bosanquet, N., and Leese, B. (1989), *Family Doctors and Economic Incentives,* Aldershot: Dartmouth.

British Medical Association (2018). Enhanced Services. Available at: https://www.bma.org.uk/advice/employment/gp-practices/quality-first/assess-and-negotiate-your-workload/enhanced-services (Accessed 28 May 2017).

British Medical Association 2015 The BMA Survey of General Practice. Available at: http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/surveys/future-of-general-practice (Accessed 12 August 2015).

Brock, D. M. (2006). The changing professional organization: A review of competing archetypes. *International Journal of Management Reviews* : IJMR, 8(3), 157-174.

Brock, D., Leblebici, H. and Murzio, D. (2014). Understanding professionals and their workplaces: The mission of the Journal of Professions and Organisations. *Journal of Professions and Organisations,* 1: 1-15.

Brock, D., Powell, M. J. and Hinings, C. R. (1999). *Restructuring the Professional Organisation.* London: Routledge.

Brouthers, K., Brouthers, l. E. and Wilkinson, T. J. (1995). Strategic alliances: Choose your partners. *Long Range Planning,* 28(3): 18-25.

Brown, N. M. (1969). A cottage hospital study. *The Journal of the Royal College of General Practitioners,* 17(78): 55–57.

Bryman, A. (2006). Integrating quantitative and qualitative research: how is it done? *Qualitative Research,* 6(1): 97-113.

Bryman, A. (2012). *Social research methods*. 4th edition. London: Oxford University Press.

Bryman, A., and Cassell, C. (2006). The researcher interview: A reflexive perspective. *Qualitative Research in Organizations and Management,* 1(1), 41-55.

Bryman, A., Gillingwater, D., & McGuinness, I. (1996). Leadership and organizational transformation. *International Journal of Public Administration*, *19*(6), 849-872.

Buzan, T., and Buzan, B. (1996). *The mind map book: How to use radiant thinking to maximise your brains untapped potential.* New York: Plume.

Callaly, T., Von Treuer, K,, Dodd, S., & Berk, M. (2010). Mental health services for young people – the challenge of integrating services. *Acta Neuropsychiatrica,* 22(3), 158-160.

Calovski, V., & Calnan, M. (2020). Chapter Seven: Creeping Privatisation? Examining Procurement Choices in the 'New'NHS in England. In Navigating Private and Public Healthcare (pp. 131-154). Palgrave Macmillan, Singapore.

Campbell, D., Edgar, D. and Stonehouse, G. (2011). *Business strategy: an introduction. Hampshire:* Palgrave Macmillan.

Cannella, B., Finkelstein, S., & Hambrick, D. C. (2008). *Strategic leadership: Theory and research on executives, top management teams, and boards.* Oxford University Press.

Care Quality Commission (2018). Regulated services available at: http://www.cqc.org.uk/what-we-do/services-we-regulate/find-family-doctor-gp (Accessed 29 July 2018).

Care Quality Commission, Providers of NHS general practice and other primary medical services, an overview of registration with CQC (2012) https://www.cqc.org.uk/sites/default/files/documents/gp_overview_guide.pdf

Care Quality Commission, Requirements for GP practices collaborating to provide a greater range of services (federations) 2015, https://www.cqc.org.uk/sites/default/files/20151104_GP_federations_registration_advice_revised_20160425.pdf

Care Quality Commission, Statement of Purpose. Available at: http://www.cqc.org.uk/guidance-providers/registration-notifications/statement-purpose. Accessed 21 January 2018.

Carter, N. M., Gartner, W. B., & Reynolds, P. D. (1996). Exploring start-up event sequences. *Journal of business venturing,* 11(3), 151-166.

Insights, C. B. (2019). Global Fintech Report Q2 2019. *CB INSIGHTS*.

Centre for Workforce Intelligence. In-depth review of the general practitioner workforce (July 2014).

Chambers, J. B., Dayer, M., & Shanson, D. (2016). Resilience of primary healthcare professionals working in challenging environments. *British Journal of General Practice*, 461.

Chapman, S., McNeill, P., & Mcneill, P. (2005). *Research methods.* Routledge.

Checkland, K. (2004). Management in general practice: the challenge of the new General Medical Services contract. *British Journal of General Practice*, pp 734-739.

Checkland, K. (2004). National Service Frameworks and UK general practitioners: street-level bureaucrats at work?. *Sociology of health & illness,* 26(7), 951-975.

Citizens' Charter (1991). Labour's better deal for consumers and citizens. London: Labour Party.

Collins, J. and Porras, J. (1997). *Built to Last: Successful Habits of Visionary Companies*. New York: Harper Collins Publisher.

Collins, K. M., Onwuegbuzie, A. J., and Sutton, I. L. (2006). A model incorporating the rationale and purpose for conducting mixed methods research in special education and beyond. *Learning Disabilities: A Contemporary Journal,* 4(1): 67-100.

Cook, G. A., Ali, A., Dykins, R., Hudson, R., Johnston, J. and Mitchell, J (2017). Identifying high-frequency attendees in general practice. *British Journal of General* Practice 2017; 67 (660): 322-323.

Costas, J., and Fleming, P. (2009). Beyond dis-identification: A discursive approach to self-alienation in contemporary organizations. *Human Relations* (New York), 62(3), 353-378.

Costley, C., Elliot, G., and Gibbs, P., (2010). *Doing Work Based Research: Approaches to Enquiry for Insider-Researchers.* London: Sage.

Cotterill, P., & Letherby, G. (1994). The person in the researcher. *Studies in qualitative methodology*, *4*, 107-136.

Coulter, A. (2017). Measuring what matters to patients. BMJ : British Medical Journal (Online), 356, BMJ : *British Medical Journal* (Online), 2017-02-20, Vol.356.

Coulter, A., & Collins, A. (2011). Making shared decision-making a reality : No decision about me, without me. London: King's Fund.

Covin, J.G., Miles, M.P., (2007), Strategic Use of Corporate Venturing. Entrepreneurship Theory and Practice. 2007;31(2):183-207. doi:10.1111/j.1540-6520.2007.00169.x

Crabtree, B. F., Miller, W. L., & Stange, K. C. (2001). Understanding practice from the ground up. *Journal of Family Practice,* 50(10), 881-881.

Creswell, J. (2009). *Research design: qualitative, quantitative, and mixed methods approaches*. London: Sage.

Creswell, J. W., and Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into practice*, 39(3): 24-130.

Creswell, J. W., Klassen, A. C., Plano Clark, V. L., & Smith, K. C. (2011). Best practices for mixed methods research in the health sciences. *Bethesda (Maryland): National Institutes of Health*, 2013, 541-545.

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. (2011). The case study approach. *BMC medical research methodology*, 11(1), 100.

Croxson, C., Ashdown, H, F., and Richard Hobbs, F, D. (2017). GPs' perceptions of workload in England: a qualitative interview study. *British Journal of General Practice*, 16 January 2017.

Crozier, M. & Friedberg, E. (1995), 'Organizations and collective action: our contribution to organizational analysis', in: Bacharach, S.B., Gagliardi, P. & Mundell, B. (eds.): Research in the Sociology of Organizations, Vol. XIII, Special Issue on European Perspectives of Organizational Theory, Greenwich: JAI Press, pp.71-92.

Crozier, M., & Friedberg, E. (1979), Macht und Organisation. Die Zwänge kollektiven Handelns, Königstein: Atheanäum (French first edition: L'acteure et le système (1977)).

Danermark, B., Ekstrom, M., Jakobsen, L., & Karlsson, J. C. (1997). *Explaining society: Critical realism in the social sciences.* London: Routledge.

Dawson, B. (1920). Interim report on the future provision of medical and allied services. Ministry of Health. Available at: https://www.sochealth.co.uk/national-health-service/healthcare-generally/history-of-healthcare/interim-report-on-the-future-provision-of-medical-and-allied-services-1920-lord-dawson-of-penn/ (Accessed: 21 January 2018).

Dayan, M., Arora, S., Rosen, R., & Curry, N. (2014). Is general practice in crisis. London: The Nuffield Council.

De Ridder, J. (2003). Organisational communication and supportive employees. Human Resource Management Journal, 4(4), 1-10.

De Vaus, D. A., and de Vaus, D. (2001). *Research design in social research.* London: Sage.

Dellow, A. C. (2015). The inevitable demise of the independent contractor status. *The British Journal of General Practice*, 65(636), 340.

Deloitte Centre for Health Solutions, 2012 Primary Care: Today and tomorrow. Improving general practice by working differently.

De Man, A., & Luvison, D., (2019). Collaborative business models: Aligning and operationalizing alliances. *Business Horizons, 62*(4), 473-482.

Denison Organisational Culture Survey. Available at: http://www.denisonconsulting.com/model-surveys/denison-surveys/organisational-culture (Accessed: January 2013).

Denison, D. R. (1984). Bringing corporate culture to the bottom line. *Organisational Dynamics,* 13(2): 5-22.

Denison, D. R. (1990). *Corporate culture and organisational effectiveness.* John Wiley and Sons.

Denison, D. R. and Neale, W. S. (1996). Denison organisational culture survey. Ann Arbor, MI: Aviat.

Denison, D. R., and Mishra, A. K. (1995). Toward a theory of organisational culture and effectiveness. *Organisation Science*, 6(2): 204-223.

Denscombe, M. (2008). Communities of practice: A research paradigm for the mixed methods approach. *Journal of mixed methods research,* 2(3), 270-283.

Denzin, N. K. (1978). *Sociological methods.* 2nd edition. McGraw-Hill.

Denzin, N. K., & Lincoln, Y. S. (2011). *The Sage handbook of qualitative research.* Thousand Oaks, CA: Sage.

Department of Health 1997 The National Health Service (Primary Care) Act 1997 (Commencement No 2), Order 1997.

Department of Health 2004 The National Health Service (Personal Medical Services Agreement) Regulations 2004. Statutory Instrument No 627. Available at: http://www.legislation.gov.uk/uksi/2004/627/pdfs/uksi_20040627_en.pdf (Accessed 21 January 2018).

Department of Health 2004 The Primary Medical Services (Sale of Goodwill and Restrictions on Sub-contracting) Regulations 2004. GP and GP Practice Data. Available at: https://digital.nhs.uk/organisation-data-service/data-downloads/gp-data (Accessed 24 November 2017).

Department of Health 2012 NHS Health and Social Care Act 2012. Available at: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted (Accessed 1 March 2013).

Department of Health 2013 The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013. Available at: http://www.legislation.gov.uk/uksi/2013/500/contents/made (Accessed 28 July 2018).

Department of Health 2017 The National Health Service (General Medical Services Contracts and Personal Medical Services Agreements) Amendment) Regulations 2017. Statutory Instrument No 908. Available at: http://www.legislation.gov.uk/uksi/2017/908/made (Accessed 21 January 2018).

Department of Health National Health Service Act, 1946.

Department of Health, QIPP Programme http://www.dh.gov.uk/health/category/policy-areas/nhs/quality/qipp/

Descombe, M (2010). *The Good Research Guide.* 4th edition. Mcgraw Hill, Open University Press.

Dewey, J. (1917). The need for a recovery of philosophy. Creative intelligence: *Essays in the pragmatic attitude,* 3-69.

Dhliwayo, S. (2017). Defining public-sector entrepreneurship: A conceptual operational construct. The International Journal of Entrepreneurship and Innovation, 18(3), 153-163.

Digby, A. (1999). *The Evolution of British General Practice*. Oxford.

Doran. T., Fullwood, C., Kontopantelis, E., Reeves, D., (2008). Effect of financial incentives on inequalities in the delivery of primary clinical care in England: analysis of clinical activity indicators for the quality and outcomes framework. *The Lancet.* 372 (9640): 728–736.

Eaton, S., Collins, A., Coulter, A., Elwyn, G., Grazin, N., and Roberts, S. (2012). Putting patients first. *British Medical Journal* (Online), 2012-03-16, Vol.344.

Einola, K., & Alvesson, M. (2019). The making and unmaking of teams. *Human Relations* (New York), 72(12), 1891-1919.

Ellins, J, L, Ham, C. J, & Parker, H. (2008). Choice and competition in Primary Care: Much Ado About Nothing? University of Birmingham.

Elwyn, G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A., Kinnersley, P., and Edwards, A. (2012). Shared decision making: a model for clinical practice. *Journal of general internal medicine,* 27(10), 1361-1367.

Emerson, R. M., Fretz, R. I., & Shaw, L. L. (2001). Participant observation and fieldnotes. *Handbook of ethnography*, 352-368.

Equity and excellence: Liberating the NHS (Department of Health, 2010) https://www.gov.uk/government/publications/liberating-the-nhs-white-paper

Ewbank, L., Hitchcock, A., and Sasse, T. (2016). Who Cares? The future of general practice. Reform Research Trust. Accessed at: https://www.abhi.org.uk/media/1222/reform_who_cares_the_future_of_general_practice.pdf

Fenning, S. J., Smith, G., and Calderwood, C. (2019). Realistic Medicine: Changing culture and practice in the delivery of health and social care. *Patient Education and Counseling,* 102(10), 1751-1755.

Finkelstein, S., & Hambrick, D. C. (1996). *Strategic leadership: Top executives and their effects on organizations.* Minneapolis, MN: West Publishing Company.

Finkelstein, S., Hambrick, D. and Canella, A. (2009). *Strategic Leadership, Theory and Research on Executives, Top Management, Teams and Boards.* Oxford University Press.

Finlayson, M., & Raymont, A. (2012). Teamwork–general practitioners and practice nurses working together in New Zealand. *Journal of primary health care,* 4(2), 150-155.

Fisher, R. F. R., Croxson, C. H. D., Ashdown, H. F., and Hobbs, F. D. R (2017). GP views on strategies to cope with increasing workload: a qualitative interview study. *British Journal of General Practice, February 2017, e148-e156.*

Fisher, R., Thorlby, R., and Alderwick, H. (2019). Understanding primary care networks. The Health Foundation.

Five Year Forward View, NHS England (2014). https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Floris, M., and Pillitu, D. (2019). Improving entrepreneurship education in primary schools: a pioneer project, *International Journal of Educational Management,* 33, 6: 1148-1169.

Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry,* 12(2): 219-245.

Ford, J., & Harding, N. (2017). The impossibility of the 'true self' of authentic leadership. *Leadership* (London, England), 7(4), 463-479.

Fox, M., and Green, P., (2007). Doing Practitioner Research. London: Sage.
Frisch, B., and Chandler, L. (2006). Off-sites that work. *Harvard Business Review,* 84(6), 117-146.

Frisch, B., and Chandler, L. (2006). Off-sites that work. Harvard Business Review, 84(6), 117-146.

Frith, L. (2016). The changing face of the English National Health Service: new providers, markets and morality. *British medical bulletin,* 119(1), 5-16.

Fulop, N., Protopsaltis, G., King, A., Allan, P., Hutchings, A. and Normand, C. (2005). Changing organisations: a study of the context and processes of mergers of healthcare providers in England. *Social Science and Medicine,* 60(1): 119-130.

Gans, R. (1963). Common sense in teaching reading. Bobbs-Merill.

Garattini, L., & Padula, A. (2019). Competition in health markets: is something rotten?. Journal of the Royal Society of Medicine, 112(1), 6-10.

Garattini, L., and Padula, A. (2019). Conflict of interest disclosure: Striking a balance? *The European Journal of Health Economics,* 20(5), 633-636.

Gardner, W. L., Avolio, B. J., and Walumbwa, F. O. (Eds.). (2005). *Authentic leadership theory and practice: Origins, effects and development* (Vol. 3). Elsevier.

Gardner, W.L., Avolio, B.J., and Walumbwa, F. (2006). *Authentic leadership theory and practice: Origins, effects and development.* Amsterdam: Elsevier JAI Press.

Garvin, D. A., & Levesque, L. C. (2006). Meeting the challenge of corporate entrepreneurship. *Harvard Business Review,* 84(10), 102-150.

Garvin, David A. (2002). A Note on Corporate Venturing and New Business Creation. *Harvard Business Review*. 302-091.

Geboers, H., Mokkink, H., van Montfort, P., van den Hoogen, H., van den Bosch, W., & Grol, R. (2002). Comprehensive assessment of the quality of care in small-scale primary care practices. *The Journal of Clinical Governance,* 10(2), 51-61.

George, B. (2010). *True north: Discover your authentic* leadership (Vol. 143). John Wiley & Sons.

George, B., Sims, P., McLean, A. N., & Mayer, D. (2007). Discovering your authentic leadership. *Harvard Business Review,* 85(2), 129.

Gerada, C. (2011). From patient advocate to gatekeeper: understanding the effects of the NHS reform. *British Journal of General Practice;* 61 (592): 655-656.

Gerrish, E. (2016). The Impact of Performance Management on Performance in Public Organizations: A Meta-Analysis. *Public Administration Review,* 76(1), 48-66.

Ghoshal S, & Bartlett CA. (2002). Building competitive advantage through people. *MIT Sloan Management Review,* 43(2), 34.

Gillam, S. (2014). The future funding of health and social care in England. *British Journal of General Practice,* 64(627): 499–500.

Gillespie, M. A., Denison, D. R., Haaland, S., Smerek, R., and Neale, W. S. (2008). Linking organizational culture and customer satisfaction: Results from two companies in different industries. *European Journal of Work and Organizational Psychology, 17*(1), 112-132.

Gillham, B. (2001). *Case Study Research Methods.* London: Continuum.

Glendinning, C. (2003). Breaking down barriers: Integrating health and care services for older people in England. *Health Policy* (Amsterdam), 65(2), 139-151.

Goñi, S. (1999). An analysis of the effectiveness of Spanish primary health care teams. *Health Policy,* 48(2), 107-117.

Gorsky, M. (2013). 'Searching for the People in Charge': Appraising the 1983 Griffiths NHS Management Inquiry*. Medical History,* 57(1), 87-107.

Goss, J. D. and Leinbach, T. R. (1996). Focus groups as alternative research practice. *Area* 28 (2): 115-23.

GP Partnerships (Government) 2019 https://www.gov.uk/government/news/final-report-on-gp-partnerships-published

Graetz, F. (2002). Strategic thinking versus strategic planning: towards understanding the complementarities. *Management Decision,* 40(5): 456-462.

Grant R (2008), *Contemporary strategic analysis,* Oxford: Blackwell Publishing.

Greene, J. C., Caracelli, V. J., and Graham, W. F. (1989) 'Toward a conceptual framework for mixed-method evaluation designs'. *Educational Evaluation and Policy Analysis*, 11(3): 255-274.

Greenhalgh, T. and Stones, R. (2010). Theorising big IT programmes in healthcare: Strong structuration theory meets actor-network theory. *Social Science and Medicine,* 70(9): 1285-1294.

Greenwood, R., & Empson, L. (2003). The professional partnership: Relic or exemplary form of governance?. *Organization studies,* 24(6), 909-933.

Guba, E. G., & Lincoln, Y. S. (1981). *Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches.* Jossey-Bass.

Guba, E. G., and Lincoln, Y. S. (2000). *Epistemological and methodological bases of naturalistic inquiry.* Netherlands: Springer.

Guba, E., & Lincoln, Y. (1989). *Fourth generation evaluation.* London: Sage Publications.

Gubrium, J. F., and Holstein, J. A. (1997). *The new language of qualitative method*. Oxford University Press on Demand.

Gulati, R., Puranam, P., & Tushman, M. (2012). Meta-organization design: Rethinking design in interorganizational and community contexts. *Strategic Management Journal,* 33(6), 571-586.

Ham, C. Dixon, A. and Brooke, B. (2012) Transforming the Delivery of Health - The case for fundamental change. The King's Fund.

Ham, C. (1997). *Management and competition in the NHS.* Florida: Taylor Francis Group.

Ham, C. (2004). *Health Policy in Britain: the politics and organisation of the National Health Service.* 5th edition. Basingstoke: Palgrave Macmillan.

Ham, C., & Murray, R. (2015). *Implementing the NHS five year forward view: aligning policies with the plan*. London: King's Fund.

Hambrick, D.C. and Cannella, A.A. Jr (1989), "Strategy implementation as substance and selling", *The Academy of Management Executive,* Vol. 3 No. 4, pp. 278-285.

Hammersley M (1992) *What's wrong with ethnography?* New York: Routledge.

Hanks, S. H. (1990). The Organisation Life Cycle: Integrating Content and Process. *Journal of Small Business Strategy,* 1(1): 1-12.

Hanratty, B., Craig, D., Brittain, K., Spilsbury, K., Vines, J., & Wilson, P. (2019). Innovation to enhance health in care homes and evaluation of tools for measuring outcomes of care: Rapid evidence synthesis.

Hansen, R. J., and Ferlie, E. (2014). Applying Strategic Management Theories in Public Sector Organizations: Developing a typology. *Public Management Review,* 18(1), 1-19.

Harrison, J, & Burns, P. (1994). Expectations of general practice: Gateways and bridges. *Health Manpower Management,* 20(1), 21-26.

Harrison, J., & Burns, P. (1994). GPs: Principles and Practice. *Health Manpower Management,* 20(2), 16-21.

Hart, S. L. (1992). An Integrative Framework for Strategy-Making Processes. *The Academy of Management Review,* 17(2), 327-351.

Hayter, C. S., Link, A. N., Scott, J. T., Public-sector entrepreneurship, Oxford Review of Economic Policy, Volume 34, Issue 4, Winter 2018, Pages 676–694.

Health and Social Care Act 2012. Available at: https://www.legislation.gov.uk/ukpga/2012/7/contents/enacted (Accessed: 17 September 2018).

Health Education England, 2015 Raising the Bar. Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants. Available at: https://www.hee.nhs.uk/sites/default/files/documents/2348-Shape-of-caring-review-FINAL_0.pdf (Accessed 21 January 2018).

Heath, I. (1995). General practice at night. *BMJ,* 311(7003), 466.

Hemmings, N, Rosen, R., Palmer, W., Keeble, E., Williams, S., Paddison, C., & Imison, C., (2019). Improving access and continuity in general practice: Practical and policy lessons. *British Journal of General Practice, 69*(Suppl 1), Bjgp19X702833.

Hill, C. W. L. and Jones, G. R. (2010). *Theory of strategic management: with cases*. Ohio: Andover.

Hill, C., & Jones, G. (2009). *Theory of strategic management with cases* (8th ed.). Mason, Ohio : London: South-Western ; Cengage Learning

Hinings, C. R., Greenwood, R., & Cooper, D. (1999). The dynamics of change in large accounting firms. *Restructuring the professional organization,* 131-153.

House of Commons Health and Social Care Committee (June 2018). Integrated care: organisations, partnerships and systems. Seventh Report of Session 2017–19 (HC 650).

Howard, S., (1963). The Gillie Report. *British Medical Journal,* 2(5371): 1531.

Hox, J. J., & Boeije, H. R. (2005). Data collection, primary versus secondary.

Hrebiniak, L.G. (2006), "Obstacles to effective strategy implementation", *Organizational Dynamics,* Vol. 35 No. 1, pp. 12-31.

Hunkins, A. (2020). *Cracking the Leadership Code: Three Secrets to Building Strong Leaders*. John Wiley & Sons.

Iacobucci, G. (2019). NHS long term plan: Three new models of care that could be replicated across England. *British Medical Journal* (Online), 2019-01-21, Vol.364.

Iacobucci, G. (2019). Tories promise 6000 extra GPs by 2024. BMJ : *British Medical Journal* (Online), 2019-11-12, Vol.367.

Iacobucci, G. (2020). New primary care network contract won't work, GPs warn. BMJ : *British Medical Journal* (Online), 2020-01-07, Vol.368.

Iles, V. (2013). What is happening to leadership in health care? *International Journal of Leadership in Public Services*, 9(3): 82–89.

Ilies, R., Morgeson, F. P., and Nahrgang, J. D. (2005). Authentic leadership and eudaemonic well-being: Understanding leader–follower outcomes. *The Leadership Quarterly,*16(3), 373-394.

Iliffe, S. (2002). From General Practice to Primary Care: The Industrialisation of Family Medicine in Britain. *Journal of Public Health Policy,* 23(1), 33-43.

Iliffe, S. (2006). Case management of chronic diseases and long-term conditions: Make haste slowly. *Primary Health Care Research & Development,* 7(3), 185-187.

Irish, B. and Purvis, M. (2012). General Practice – Manpower. *The British Journal of General Practice, 62(597): 178-179.*

Ivers, N., Jamtvedt, G., Flottorp, S., Young, J. M., Odgaard-Jensen, J., French, S. D., and Oxman, A. D. (2012). Audit and feedback: Effects on professional practice and healthcare outcomes. Cochrane Database of Systematic Reviews, (6), CD000259.

James, W., & Burkhardt, F. (1975). *Pragmatism* (Vol. 1). Harvard University Press.

Janis, I. L. (1971). *Groupthink.* Psychology Today, November: 43–46, 74–76.

Janis, I. L. (1982). *Groupthink* (2nd ed.). Boston: Houghton-Mifflin.

Janis, I. L. (1989). *Crucial decisions: Leadership in policymaking and crisis management.* New York: Free Press.

Jarzabkowski, P., & Seidl, D. (2008). The Role of Meetings in the Social Practice of Strategy. *Organization Studies*, 29(11), 1391-1426.

Jeffers, H. and Baker, M. (2016). Continuity of care: still important in modern-day general practice. *British Journal of General Practice;* 66 (649): 396-397.

Jensen, S. M., and Luthans, F. (2006). Entrepreneurs as authentic leaders: Impact on employees' attitudes. *Leadership & Organization Development Journal,* 27(8), 646-666.

Jensen, S. M., and Luthans, F. (2006). Relationship between Entrepreneurs' Psychological Capital and Their Authentic Leadership. *Journal of Managerial Issues,* 18(2), 254-273.

Johnson, D. W., & Johnson, R. T. (1999). Making cooperative learning work. *Theory into practice*, 38(2), 67-73.

Johnson, R. B., and Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher,* 33(7): 14-26.

Johnson, R. B., Onwuegbuzie, A. J., and Turner, L. A. (2007). Toward a definition of mixed methods research. *Journal of Mixed Methods Research,* 1(2): 12-133.

Jones, G, Hill C, (2010), *Theory of Strategic Management with cases* (9th edition), South-Western Cengage Learning.

Jung, T., Scott, T., Davies, H. T. O., Bower, P., Whalley, D., McNally, R., and Mannion, R. (2009). Instruments for Exploring Organizational Culture: A Review of the Literature. *Public Administration Review*; November 2009; 69, 6.

Kimberly, J. R. (1980). Initiation, innovation, and institutionalization in the creation process, in Kimberly, J. R. and Miles, R. H. (Eds), The organisational life cycle: Issues in the creation, transformation, and decline of organisations. San Francisco: Jossey-Bass Publishers.

King, G, & Meyer, K. (2006). Service integration and co-ordination: A framework of approaches for the delivery of co-ordinated care to children with disabilities and their families. *Child : Care, Health & Development,* 32(4), 477-492.

King, L., Harrington, A., Linedale, E., and Tanner, E. (2018). A mixed methods thematic review: Health-related decision-making by the older person. *Journal of Clinical Nursing,*27(7-8), E1327-E1343.

King, P. (2017). UK Approaches to Integrated Diabetes Care: Derby—A Joint Venture Model Under the NHS. In: Simmons D., Wenzel H., Zgibor J. (eds) Integrated Diabetes Care. Springer, Cham. https://doi.org/10.1007/978-3-319-13389-8_8

Kirk, J. and Miller, M. (1986). *Reliability and validity in qualitative research.* Newbury Park, CA: Sage.

Kitzinger, J. (1994). The methodology of focus groups: the importance of interaction between research participants. *Sociology of Healthy,* 16 (1): 103-21.

Kitzinger, J. (1995). Introducing focus groups. *British Medical Journal,* 311: 299-302.

Klein, R. (1983). *The Politics of the National Health Service.* London: Longman.

Klein, R. (1990). From status to contract: the transformation of the British Medical Profession. Royal Society of Medicine, International Congress and Symposium, Series No 171: 127-134.

Klein, R. (1990). The state of the profession: the politics of the double bed. *British Medical Journal:* 3 October: 700-702.

Klein, R. (1995). Labour's health policy. *British Medical Journal,* 311: 75-76.

Kmietowicz, Z. (2006). New GP contract: modernization or miscalculation? *British Medical Journal*, 333(7580): 1192.

Kotter, J. (1998). Why change? *Leadership Excellence,* 15(1), 5.

Kouzes, J. M. and Posner, B. Z. (2011). *The five practices of exemplary leadership: government.* San Francisco: Pfeiffer.

Kreuger R. A. (1988) *Focus groups: a practical guide for applied research.* London: Sage.

Kuhn, T. S. (2012) *The structure of scientific revolutions.* University of Chicago Press.

Kumpunen, S. Curry, N. Farnworth, and M. Rosen, R. (2017). Collaboration in general practice: Surveys of GP practice and clinical commissioning groups. The Nuffield Trust and Royal College of General Practitioners Survey. Retrieved 1 October 2017, from www.nuffieldtrust.org.uk/research/collaboration-in-general-practice-surveys-of-gp-practice-and-clinical-commissioning-groups

Kumpunen, S., Curry, N., Ballard, T., Price, H., Holmes, M. and Edwards, N. (2015). Collaboration in general practice: surveys of GPs and CCGs. The Nuffield Trust and Royal College of General Practitioners.

Kumpunen, S., Rosen, R., Kossarova, L. and Sherlaw-Johnson, C. (2017). Primary Care Home: Evaluating a new model of primary care. The Nuffield Trust. Retrieved 1 November 2017, from www.nuffieldtrust.org.uk/research/primary-care-home-evaluating-a-new-model-of-primary-care

Kuratko, D., Hornsby, J., and Covin, J., (2014). Diagnosing a firm's internal environment for corporate entrepreunership. *Business Horizons:* 37-47.

Kvale, S. (1983). The qualitative research interview: A phenomenological and a hermeneutical mode of understanding. *Journal of Phenomenological Psychology,* 14: 171-196.

Kvale, S. (1996). *Interviews: an introduction to qualitative research interviewing.* London: Sage.

Kvale, S. (2007). *Doing interviews.* London: Sage.

Ladkin, D., & Taylor, S. S. (2010). Enacting the 'true self': Towards a theory of embodied authentic leadership. *The Leadership Quarterly,* 21(1), 64-74.

Laurence, L., Andrews, R., Skelcher, C., and Wegorowski, P. (2018). New development: Corporatization of local authorities in England in the wake of austerity 2010–2016, *Public Money & Management,* 38:6, 477-480, DOI: 10.1080/09540962.2018.1486629

Le Grand, J. and Bartlett, W. (1993). *Quasi-markets and social policy--the way forward?* In Quasi-Markets and Social Policy, eds J. Le Grand and W. Bartlett. Basingstoke: Macmillan.

Leitch, C. M., & Volery, T. (2017). Entrepreneurial leadership: Insights and directions. *International Small Business Journal,* 35(2), 147-156.

Leitch, C. M., McMullan, C., & Harrison, R. T. (2013). The development of entrepreneurial leadership: The role of human, social and institutional capital. *British Journal of Management,* 24(3), 347-366.

Leopold, N., Cooper, J., and Clancy, C. (1996). Sustained partnership in primary care. *The Journal of family practice,* 42(2), 129.

Lewin, K. (1951). Field theory in social science: selected theoretical papers (Edited by Dorwin Cartwright.).

Lewis, J. (1998). Contract in the 1960s and the 1990s. *Social Policy and Administration,* 32 (2): 132–150.

Lewis, L. K. (1999). Disseminating information and soliciting input during planned organisational change: Implementers' targets, sources, and channels for communicating. Management Communication Quarterly, 13(1), 43-75.

Lewis, R., Gillam, S., Gosden, T. and Sheaff, R. (1999). Who contracts for primary care? *Journal of Public Health Medicine*, 21(4): 367-371.

Lewis, R. Q., Rosen, R., Goodwin, N., & Dixon, J. (2010). Where next for integrated care organisations in the English NHS. *London: The Nuffield Trust*.

Leys, C. (2017). The English NHS: from market failure to trust, professionalism and democracy. *Soundings,* 64(64), 11-40.

Liddle, J., & McElwee, G. (2019). Theoretical perspectives on public entrepreneurship. International Journal of Entrepreneurial Behaviour & Research.

Liedtka, M. (1998). Strategic thinking: Can it be taught? *Long Range Planning,* 33(1): 120-129.

Lincoln, Y. S., and Guba, E. G. (2000). The only generalization is: There is no generalization. *Case Study Method,* 27-44.

Ling, T., Bardsley, M., Adams, J., Lewis, R., & Roland, M. (2010). Evaluation of UK Integrated Care Pilots: research protocol. *International Journal of Integrated Care,* 10, e056. https://doi.org/10.5334/ijic.513integrated

Locke, E. A. (1980). Latham Versus Komaki: A Tale of Two Paradigms. *Journal of Applied Psychology,* 65(1), 16-23.

Loudon, I., Horder, J., and Webster, C. (1998). *General Practice under the National Health Service 1948-1997.* London: Clarendon Press.

Lown, M., Lewith, G., Simon, C. and Peters, D (2015). Resilience: what is it, why we need it, and can it help us? *British Journal of General Practice,* October 2015: e708-e710.

Luthans, F., Avolio, B. J., Avey, J. B., and Norman, S. M. (2007). Positive Psychological Capital: Measurement and Relationship with Performance and Satisfaction. *Personnel Psychology,* 60(3), 541-572.

MacMillan, I. C., Block, Z., and Narasimha, P. N. S (1986). Corporate venturing: alternatives, obstacles encountered and experience effects. *Journal of Business Venturing, 1: 177-191.*

Majeed, A., Rawaf, S., and De Maeseneer, J. (2012). Primary care in England: coping with financial austerity. *British Journal of General Practice*, December 2012: 625-626.

Malcomson, J. (2004). Health Service Gatekeepers. *The RAND Journal of Economics,* 35(2), 401-421.

Maniatopoulos, G., Hunter, D. J., Erskine, J., & Hudson, B. (2019). Lessons learnt from the implementation of new care models in the NHS: a qualitative study of the North East Vanguards programme. BMJ open, 9(11), e032107.

Marchand, C., Peckham, S. (2017). Addressing the crisis of GP recruitment and retention: a systematic review. *British Journal of General Practice.* Available at: https://bjgp.org/content/early/2017/03/13/bjgp17X689929/tab-pdf (Accessed 28 July 2018).

Marshall, M. (2015). A precious jewel – the role of general practice in the English NHS. *The New England Journal of Medicine,* 372(10): 893-897.

Marshall, M., and Roland, M. (2002), The new contract: renaissance or requiem for general practice? *British Journal of General Practice*, July 2002: 531-532.

Martinko, M. J., Mackey, J. D., Moss, S. E., Harvey, P., McAllister, C. P., and Brees, J. R. (2018). An Exploration of the Role of Subordinate Affect in Leader Evaluations. *Journal of Applied Psychology,* 103(7), 738-752.

Martinko, M. J., Randolph-Seng, B., Shen, W., Brees, J. R., Mahoney, K. T., and Kessler, S. R. (2018). An Examination of the Influence of Implicit Theories, Attribution Styles, and Performance Cues on Questionnaire Measures of Leadership. *Journal of Leadership & Organizational Studies,* 25(1), 116-133.

Mathers, N. (2012). General practice partnerships: An exploratory review. *Journal of Management in Medicine,* 10(2): 62-71.

Mathers, N. (2016). General Practice Forward View: a new charter for general practice. *British Journal of General Practice*, October 2016: 500-501.

Mathers, N. and Lester, H. (2011). From cottage industry to post-industrial care? The King's Fund report on quality in general practice, *British Journal of General Practice,* October 2011, 602-603.

McCartney, M. (2018). Margaret McCartney: Hiding and seeking doctors' conflicts of interest. *British Medical Journal*, 360, k135.

McCartney, M. (2018). Margaret McCartney: When a crisis is the predictable outcome of poor policy making. *British Medical Journal,* 360, k90.

McDermott, I., Warwick-Giles, L., Gore, O., Moran, V., Bramwell, D., Coleman, A., & Checkland, K. (2018). Understanding primary care co-commissioning: uptake, development, and impacts. final report. *Policy Research Unit in Commissioning and the Health Care System (PRUComm)*.

McDonald, R., Riste, L., Bailey, S., Bradley, F., Hammond, J., Spooner, S., and Checkland, K. (2020). The impacts of GP federations in England on practices and on health and social care interfaces: four case studies. Southampton (UK): NIHR Journals Library; 2020 Feb. (Health Services and Delivery Research, No. 8.11.) Available from: https://www.ncbi.nlm.nih.gov/books/NBK554252/doi: 10.3310/hsdr08110

McGrath, R. G., & MacMillan, I. C. (2000). The entrepreneurial mindset: Strategies for continuously creating opportunity in an age of uncertainty (Vol. 284). *Harvard Business Press.*

McNeill, P. and Chapman, S. (2005). *Research methods.* 3rd edition. London: Routledge.

Mills, J., Oyedotun, L., Ridout, J., & Holmes, M. (2019). The opportunities for economies of scale in primary care. I*nnovAiT*, 12(8), 476-478.

Mintzberg, H (1994). *The rise and fall of strategic planning,* New York: The Free Press.

Morgan, D. L. (1997), *Focus groups as qualitative research*. London: Sage.

Morgan, D.L. (2007) 'Paradigms lost and pragmatism regained: methodological implications of combining qualitative and quantitative methods', *Journal of Mixed Methods Research,* Vol. 1, No. 1, pp.48-76

Morse, J. M. (2016). *Mixed method design: Principles and procedures* (Vol. 4). Routledge.

Mott MacDonald (2015). Prime Minister's Challenge Fund: Improving Access to General Practice. First Evaluation Report. NHS England Publication Gateway Reference Number 04123. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/10/pmcf-wv-one-eval-report.pdf (Accessed 18 July 2018).

Murray, R., (2018). Hypothecated funding for health and social care. How it might work? The King's Fund. May 2018.

Murray, R., (2020). GPs condemn new specifications for primary care networks. *BMJ* 2020; 368: m258

Myerson, S. (1992). The new contract and relationships in general practice. *Journal of Management in Medicine*; Bradford Vol. 6, Iss. 1, (1992): 19.

Nadin. S, and Cassell, C. (2006). The use of a research diary as a tool for reflexive practice. *Qualitative Research in Accounting and Management,* 3(3), 208-217.

National Health Service (Primary Care) Act (1997). Available: https://www.legislation.gov.uk/ukpga/1997/46/contents

Naylor, C., Curry, N., Holder, H., Ross, S. and Marshall, L. (2013). Clinical commissioning groups: supporting improvement in general practice. The Nuffield Trust and King's Fund.

Neuman, W. L. (2007) *Basics of social research: quantitative and qualitative approaches.* 2nd edition. London: Allyn and Bacon.

Newton, J., Eccles, M. and Soutter, J. (1996). General practice partnerships: an exploratory review. *Journal of Management in Medicine,* 10 (2): 62-71.

NHS and Community Care Act, Department of Health, 1990 https://www.legislation.gov.uk/ukpga/1990/19/contents

NHS Confederation Healthcare groups: an alternative to merger-mania? NHS Confederation (2012). Available: https://www.nhsconfed.org/resources/2013/05/healthcare-groups-an-alternative-to-merger-mania

NHS Digital (2018). Patients Registered at a GP Practice. Available: https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/august-2018. Accessed 11 August 2018.

NHS England (2012). CCG running costs allowances 2013/14. Available at: https://www.england.nhs.uk/2012/11/ccg-rca (Accessed 28 July 2018).

NHS England (2013). General and Personal Medical Services, England, 2002-2012. The Health and Social Care Information Centre, 2013.

NHS England (2014). CCG Running Cost Allowances 2014/15 and 2015/16. Available at: https://www.england.nhs.uk/2014/02/costs-allowances/ (Accessed 30 June 2018).

NHS England (2014). NHS Five Year Forward View. Available at: https://www.england.nhs.uk/publication/nhs-five-year-forward-view/ (Accessed 28 July 2018).

NHS England (2016). General Practice Forward View https://www.england.nhs.uk/gp/gpfv/ (Accessed 28 July 2018).

NHS England (2017). Managing conflicts of interest: revised statutory guidance for CCGs. Available at: https://www.england.nhs.uk/wp-content/uploads/2017/06/revised-ccg-coi-guidance-jul-17.pdf (Accessed 28 July 2018).

NHS England Vanguard Programme. Available at: http://workingtogethernhs.co.uk/about/the-vanguard-programme/ (Accessed 29 July 2018).

NHS Future Forum report 'Choice and Competition – Delivering Real Choice' (Department of Health, 2011). Available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213749/dh_127541.pdf

NHS Plan published in 2000 (Department of Health, 2000). Available at: https://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960

NHS Procurement, Patient Choice and Competition Regulations (NHS England, 2013). Available at: https://www.england.nhs.uk/procurement-patient-choice-and-competition-regulations/

NICE Quality and Outcome Framework indicators, 2018. Available at: https://www.nice.org.uk/standards-and-indicators/qofindicators (Accessed 21 January 2018).

Northouse, P. (2013). *Leadership : Theory and practice* (6th ed.). Thousand Oaks: SAGE.

Ohmae, K. (1982). The Secret of Strategic Vision. *Management Review,* 71:8-13.

Okumus, F. (2003). A framework to implement strategies in organisations. *Management Decision,* 41(9): 871-882.

Omri, A. Frikha, M. A. and Bouraoui, M. A. (2015), An empirical investigation of factors affecting small business success, *Journal of Management Development,* Vol. 34 No. 9, pp. 1073-1093.

Onwuegbuzie, A.J. and Johnson, R.B. (2006) 'The validity issue in mixed research', *Research in the Schools,* Vol. 13, No. 1, pp.48-63.

Our health, our care, our say, (Department of Health, 2006). Available at: https://www.gov.uk/government/publications/our-health-our-care-our-say-a-new-direction-for-community-services

Ovans, A. (2015). How emotional intelligence became a key leadership skill. *Harvard Business Review,* 28.

Parasuraman, A., Zeithaml, V. A., & Berry, L. L. (1985). A conceptual model of service quality and its implications for future research. *Journal of marketing,* 49(4), 41-50.

Parker, S., (2011). Intrapreneurship or entrepreunership? *Journal of Business Venturing,* 26: 19-34.

Partnership review (Department of Health and Social Care, 2019) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770916/gp-partnership-review-final-report.pdf

Peckham, S. (2006). The changing context of primary care. *Public Finance and Management,* 6(4), 504.

Petchey, R. (1998). General Practice under the National Health Service, 1948-1997. *The British Medical Journal,* 1998: 317-357.

Peteraf, M. A., & Barney, J. B. (2003). Unraveling the resource-based tangle. *Managerial and Decision Economics,* 24(4), 309-323.

Peters, T. and Waterman, R. H. (2015). *In Search of Excellence.* 3rd edition. London: Prentice Books Ltd.

Pettigrew, L. M., Kumpunen, S., & Mays, N. (2020). Primary care networks: the impact of covid-19 and the challenges ahead. BMJ 2020; 370: m3353

Pettigrew, L. M., Kumpunen, S., Mays, N., Rosen, R., & Posaner, R. (2018). The impact of new forms of large-scale general practice provider collaborations on England's NHS: a systematic review. *British Journal of General Practice,* 68(668), e168-e177.

Pettigrew, L. M., Kumpunen, S., Rosen, R., Posaner, R, and Mays, N. (2019). Lessons for 'large-scale' general practice provider organisations in England from other inter-organisational healthcare collaborations. *Health Policy* (Amsterdam), 123(1), 51-61.

Petty, D. R., Knapp, P., Raynor, D. K., & House, A. O. (2003). Patients' views of a pharmacist-run medication review clinic in general practice. *British Journal of General Practice,* 53(493), 607-613.

Plano Clark, V. L. (2010). The adoption and practice of mixed methods: US trends in federally funded health-related research. *Qualitative Inquiry*, *16*(6), 428-440.

Plano Clark, V. L., Anderson, N., Wertz, J. A., Zhou, Y., Schumacher, K., & Miaskowski, C. (2015). Conceptualizing longitudinal mixed methods designs: A methodological review of health sciences research. *Journal of Mixed Methods Research*, *9*(4), 297-319.

Plesk, P. E. and Greenhalgh, T. (2001) The challenge of complexity in health care. *British Medical Journal,* 323, 625-628.

Pollok, A. (2005). *NHS plc – The Privatisation of Our Health Care*. London: Verso.

Popper, K. R. (1959) *The logic of scientific discovery.* London: Hutchinson.

Porras, J. I., & Robertson, P. J. (1992). *Organizational development: Theory, practice, and research.* In M. D. Dunnette & L. M. Hough (Eds.), Handbook of industrial and organizational psychology (pp. 719-822). Palo Alto, CA, US: Consulting Psychologists Press.

Porter, M. E. (1980). Industry Structure and Competitive Strategy: Keys to Profitability. *Finance Analysts Journal*, 36(4): 30-41.

Porter, M. E. (1985). Technology and Competitive Advantage. *Journal of Business Strategy*, 5(3): 60-78.

Powell, R. A., & Single, H. M. (1996). Focus groups. I*nternational journal for quality in health care,* 8(5), 499-504.

Powell, R. A., Single, H. M., and Lloyd, K. R. (1996). Focus groups in mental health research: enhancing the validity of user and provider questionnaires. *International Journal of Social Psychology,* 42 (3): 193-206.

Prahalad, C. K. and Hamel, G. (1990). The core competence of the corporation. *Harvard Business Review*, 68(3): 79–91.

Price, T. L. (2003). The ethics of authentic transformational leadership. *The leadership quarterly,* 14(1), 67-81.

Primary Care Network DES (NHS England, 2020)
https://www.england.nhs.uk/publication/des-contract-specification-2020-21-pcn-entitlements-and-requirements/

Primary Care: Delivering for the Future (Department of Health,1996)

Pringle, R., (1998), Sex and Medicine, Gender, Power and Authority in the Medical Profession. Cambridge: Cambridge University Press; 1998.

Promoting Better Health (HMSO, 1987) Secretaries of State for Social Services, Wales, Northern Ireland, and Scotland. London.

Radnor, Z., Holweg, M. and Waring, J. (2012). Lean in healthcare: the unfilled promise? *Social Science and Medicine,* 74(3): 364-371.

Ramsay, P., Huby, G., Thompson, A. and Walsh, T. (2008). Quality of life among survivors of prolonged critical illness; a mixed methods study. *Critical Care* (London, England), 12(Suppl 2), 508.

RCGP (2008) Primary Care Federations Putting Patients First – A Plan for Primary Care in the 21st Century from the Royal College of General Practitioners.

Renko, M. (2013). Early challenges of nascent social entrepreneurs. *Entrepreneurship theory and practice,* 37(5), 1045-1069.

Resick, C. J., Martin, G. S., Keating, M. A., Dickson, M. W., Kwan, H. K., & Peng, C. (2011). What ethical leadership means to me: Asian, American, and European perspectives. *Journal of business ethics*, *101*(3), 435-457.

Roland, M. (2004). Linking physicians' pay to the quality of care – a major experiment in the United Kingdom. *The New England Journal of Medicine*, 351(14): 1448-1454.

Roland, M. and Everington, S. (2016). Tackling the crisis in general practice. If general practice fails, the whole NHS fails. *British Medical Journal,* 352(i942).

Ropega, J. (2011). The reasons and symptoms of failure in SME. International Advances in Economic Research, 17(4), 476-483.

Rosen, R. (2015). Transforming general practice: what are the levers for change? The Nuffield Trust.

Rosen, R. and Parker, H. (2013). New models of primary care: practical lessons. The Nuffield Trust.

Rosen, R., Kumpunen, S. and Smith, J. (2016). Developing care for a changing population: Learning from GP-led organisations. The Nuffield Trust.

Rosen, R., Kumpunen, S., Curry, N., Davies, A., Pettigrew, L. and Kossarova, L. (2016). Is bigger better? Lessons for large-scale general practice. The Nuffield Trust.

Rovelli, P., & Butticè, V. (2020). On the organizational design of entrepreneurial ventures: the configurations of the entrepreneurial team. Journal of Industrial and Business Economics, 1-27.

Sage, G. C. (1991). Customers and the NHS. *International Journal of Health Care Quality Assurance*.

Sainidis, E., Green, M. J. and Brown, G. (2012). *Understanding Strategy.* Northumbria University.

Sanfey, J. and Ahluwalia, S. (2016). Re-awakening professional identity – the path to a self-correcting NHS. *British Journal of General Practice,* September 2016: 458-459.

Saunders, M., and Lewis, P. (2012) *Doing research in business and management: An essential guide to planning your project.* Financial Times Prentice Hall.

Saunders, M., Lewis, P., and Thornhill, A. (2009). *Understanding research philosophies and approaches.* Research Methods for Business Students. 4th edition. Harlow, Essex

Saunders, M., Lewis, P., Thornhill, A., and Wang, C. (2009). *Analysing qualitative data. Research methods for business students.* 5th edition. Harlow, Essex.

Saving Lives: Our healthier nation (Department of Health, 1999) https://www.gov.uk/government/publications/saving-lives-our-healthier-nation

Schaap, J. I. (2017). The real reasons why organizations fail. *JMSM Journal of Marketing and Strategic Management*, 60.

Schneider, B., González-Romá, V., Ostroff, C., & West, M. A. (2017). Organizational climate and culture: Reflections on the history of the constructs in the Journal of Applied Psychology. *Journal of Applied Psychology,* 102(3), 468.

Schneider, B., Gunnarson, S. K., & Niles-Jolly, K. (1994). Creating the climate and culture of success. *Organizational dynamics,* 23(1), 17-29.

Schrag, F. (1992). In defence of positivist research paradigms. *Educational Researcher,* 21(5): 5-8.

Schwandt, T. A. (2000). Three epistemological stances for qualitative inquiry. *Handbook of Qualitative Research,* 2: 189-213.

Sharma, P. and Chrisman, J. J. (1999). Toward a reconciliation of the definitional issues in the field of corporate entrepreneurship. *Entrepreneurship Theory and Practice*, 23(3), 11–27.

Sidani, Yusuf M, & Rowe, W. Glenn. (2018). A reconceptualization of authentic leadership: Leader legitimation via follower-centered assessment of the moral dimension. *The Leadership Quarterly,* 29(6), 623-636.

Silverman, D. (2001) *Interpreting qualitative data: methods for analysing talk, text and interaction.* 2nd edition. London: Sage

Slocum, J. W., & Hellriegel, D. (2009). *Principles of organizational behavior.* Mason, OH: South-Western Cengage Learning.

Smith, A. D., and Treschuk, J. (2018). Disconnects and Silos in Transitional Care: Single-Case Study of Model Implementation in Home Health Care. *Home Health Care Management & Practice,* 30(3), 130-139.

Smith, J., Holder, H., Edwards, N., Maybin. J, Parker, H., Rosen, R. and Walsh, N. (2013). Securing the future of general practice: new models of primary care. The Nuffield Trust and King's Fund.

Smith, P. C., and York, N. (2004). Quality incentives: the case of UK general practitioners. *Health Affairs,* 23(3), 112-118.

Smyth, A., & Holian, R. (2008). *Credibility issues in research from within organisations.* In Researching education from the inside (pp. 41-56). Routledge.

Social Enterprise UK (2018). Available: https://www.socialenterprise.org.uk/about-us. Accessed 11 August 2018

Sonsale, A., Thorne, T., Kalia, R., Ghattaora, S., and Hawkes, D. (2018). The future of general practice: brave new dawn or dark skies ahead? *British Journal of General Practice 2018*; 68 (666): 4-5.

Sparrow, J. (2012). *The Senior Leader as Pilot. In The Culture Builders* (pp. 199-208). Routledge.

Sparrowe, R. T. (2005). Authentic leadership and the narrative self. *The Leadership Quarterly,*16(3), 419-439.

Stacey, R. (2007). *Strategic management and organisational dynamics : The challenge of complexity to ways of thinking about organisations* (5th ed.). Harlow: Financial Times Prentice Hall.

Stacey, R. (2011). *Strategic Management and Organisational Dynamics: The Challenge of Complexity.* 6th edition. London: Financial Times/Prentice-Hall.

Stake R (1995), *The Art of Case Study Research.* London, Sage.

Starfield, B. (1998). Primary care visits and health policy. *Canadian Medical Association Journal* (CMAJ), 159(7), 795-796.

Steinke, C. (2001). Fitness for change and Alberta health care organizations: a management perspective. Lethbridge, Alta.: University of Lethbridge, Faculty of Management, 2001.

Steinke, C., Dastmalchian, A., Blyton, P., & Hasselback, P. (2013, October). Organizational change strategies within healthcare. In Healthcare management forum (Vol. 26, No. 3, pp. 127-135). Sage CA: Los Angeles, CA: SAGE Publications.

Strauss, A. L. (1978). *Negotiations.* Josey Bass.

Sull, D., Homkes, R. and Sull, C. (2015). Why Strategy Execution Unravels – and what to do about it. *Harvard Business Review,* 93(3): 58-66.

Swiercz, P. M., & Lydon, S. R. (2002). Entrepreneurial leadership in high-tech firms: a field study. *Leadership and Organization Development Journal*, *23*(7), 380-389.

Symon, G. and Cassell, C. (2012). *Reflexivity in Qualitative Research. In Qualitative Organizational Research: Core Methods and Current Challenges* (p. 72). 55 City Road: SAGE Publications.

Szczepura, A. (1992). All Change: What is Happening in NHS General Practice? *International Journal of Health Care Quality Assurance,* 5(1), 5.

Tashakkori, A. and Teddlie, C. (1998) *Mixed Methodology: Combining qualitative and quantitative approaches.* Thousand Oaks, CA: Sage.

Tashakkori, A. and Teddlie, C. (2003) *Handbook of Mixed Methods in Social and Behavioural Research.* Thousand Oaks: Sage.

Teddlie, C. and Tashakkori, A. (2006) 'A general typology of research designs featuring mixed methods', *Research in the Schools,* Vol. 13, No. 1, pp.12-28.

The Five Year Forward View (NHS England, 2014) https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

The Importance of Research Design in Political Science. (1995). *The American Political Science Review, 89(2), 475-481. doi:10.2307/2082445*

The King's Fund (2011) The Future of Leadership and Management in the NHS - No more heroes.

The King's Fund (2012) Leadership and Engagement - Together we can.

The King's Fund, 2012. Transforming the Delivery of Health and Social Care – The case for fundamental change

The Nuffield Trust (September 2012). Primary care for the 21st century – Learning from New Zealand's independent practitioner associations

The Nuffield Trust 2015 Parliamentary Briefing: building sustainable GP services

Thompson, M. (2001). *What's happening in primary care?* London: Emap Public Sector Management.

Tichy, N. (1983). *Managing Strategic Change.* New York: Wiley-Interscie.

Turro, A., Urbano, D., Peris-Ortiz, M. (2013). Culture and innovation: The moderating effect of cultural values on corporate entrepreunership. *Technological Forecasting and Social Change.* 88: 360-369.

Van den Bosch, J. and Duysters, G. (2014). *Corporate Venturing: Organizing for Innovation.* Edward Elgar Publishing Limited. Cheltenham, UK

Van Maanen, J. (1998). *Qualitative studies of organizations* (Vol. 1). Sage.

Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy.* The Althouse Press.

Van Manen, M. (2002) *Writing in the dark: Phenomenological studies in interpretive inquiry.* The Althouse Press.

Van Ness, P. H., Fried, T. R., & Gill, T. M. (2011). Mixed methods for the interpretation of longitudinal gerontologic data: Insights from philosophical hermeneutics. *Journal of Mixed Methods Research*, *5*(4), 293-308.

Vaughn, S., Schumm, J. and Sinagub, J. (1996). *Focus group interviews in education and psychology.* London: Sage.

Vecchio, R.P. (2003). Entrepreneurship and leadership: common trends and common threads. *Human Resource Management Review,* 13, pp. 303–327.

Vuori, J. (2019). Distributed leadership in the construction of a new higher education campus and community. *Educational Management, Administration & Leadership,* 47(2), 224-240.

Walumbwa, F. O., Avolio, B. J., Gardner, W. L., Wernsing, T. S. and Peterson, S. J. (2008). Authentic Leadership: Development and Validation of a Theory-Based Measure? *Journal of Management, 34: 89-122.*

Warren, C. A. B. (2002). Qualitative interviewing, in J F Gubrium and J A Holstein (eds), *Handbook of Interview Research: Context and Methods*, Thousand Oaks, CA: Sage.

Waterman, R. H., Peters, T. J. and Phillips. J. R. (1980). Structure is not organisation. *Business Horizons,* 23(3): 14-26.

Watkins, M. D. (2007). Demystifying Strategy: The What, Who, How and Why. *Harvard Business Review*, 10.

Watt, G. (2011). GPs at the Deep End: connecting with general practice to improve public health. Glasgow: Institute of Health and Wellbeing, University of Glasgow. Retrieved 1 April 2014, from: www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend

Weber, R. P. (1990) *Basic Content Analysis.* 2nd edition, Newbury Park, CA.

Westland, M., Grimshaw, J., Maitland, J., Campbell, M., Ledingham, E., & Mcleod, E. (1996). Understanding practice management: A qualitative study in general practice. *Journal of Health Organization and Management,* 10(5), 29.

Williams, G., Flynn, R., and Pickard, S., (1997). Paradoxes of GP Fundholding: Contracting for Community Health Services in the British National Health Service. *Social Science and Medicine,* 45 (11): 1669-1678.

Wilson, T., and Lewis, R., (2019). Primary care networks: well-intentioned but overambitious. *BMJ, 366*, L5311

Working for Patients (Department of Health, 1989)

World Health Organisation (1978). Primary health care: report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September, 1978, jointly sponsored by the World Health Organisation and the United Nations Children's Fund. Geneva, World Health Organisation, 1978 (Health for All Series No. 1).

World Health Organisation (2004). What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services? Available at: https://www.euro.who.int/__data/assets/pdf_file/0004/74704/E82997.pdf?ua=1

World Health Organisation. Targets for health for all. Copenhagen: Regional Office for Europe, 1985. Available at: https://www.euro.who.int/__data/assets/pdf_file/0010/98398/wa540ga199heeng.pdf

World Health Organisation. The World Health Report 2000. Health Systems: Improving Performance. Geneva. Available at: https://apps.who.int/iris/handle/10665/42281

Yin, R. (2009). *Case Study Research, Design and Methods.* Sage Publications.

Yin, R. (2012). *Applications of Case Study Research.* Sage Publications.

Yu. V., Wyatt. S., Woodall. V., Mahmud. S., Klaire. V., Baile., K., and Mohammed Amin Mohammed. M. (2020). Hospital admissions after vertical integration of general practices with an acute hospital: a retrospective synthetic matched controlled database study. *British Journal of General Practice;* 70 (699): e705-e713.

Yukl, G., (1999), An evaluation of conceptual weaknesses in transformational and charismatic leadership theories. Leadership Quarterly, 10 (2); pp. 285-305.

Yukl, G. A. (2013) *Leadership in organisations.* London: Pearson.

Zeithaml, V. A., Varadarajan, P., and Zeithaml, C. P. (1988). The Contingency Approach: Its Foundations and Relevance to Theory Building and Research in Marketing. *European Journal of Marketing,* 22(7), 37-64.

Zermansky, A., Alldred, D. P., Petty, D. R., Raynor, D. K., Freemantle, N., Eastaugh, J., and Bowie, P. (2006). Clinical medication review by a pharmacist of elderly people living in care homes—randomised controlled trial. *Age and Ageing,* 35(6), 586-591.