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Primary care quality and safety systems in the English NHS: a case study of a new type of primary care provider

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Abstract

Objectives: Although the predominant model of general practice in the UK National Health Service (NHS) remains the small partnership owned and run by general practitioners (GPs), new types of provider are emerging. We sought to characterise the quality and safety systems and processes used in one large, privately owned company providing primary care through a chain of over 50 general practices in England.

Methods: Senior staff with responsibility for policy on quality and safety were interviewed. We also undertook ethnographic observation in non-clinical areas and interviews with staff in three practices.

Results: A small senior executive team set policy and strategy on quality and safety, including a systematic incident reporting and investigation system and processes for disseminating learning with a strong emphasis on customer focus. Standardisation of systems was possible because of the large number of practices. Policies appeared generally well implemented at practice level. However, there was some evidence of high staff turnover, particularly of GPs. This caused problems for continuity of care and challenges in inducting new GPs in the company's systems and procedures.

Conclusions: A model of primary care delivery based on a commercial chain may be useful in standardising policies and procedures, facilitating implementation of systems, and relieving clinical staff of administrative duties. However, the model also poses some risks, including those relating to stability. Provider forms that retain the long term, personal commitment of staff to their practices,

such as federations or networks, should also be investigated; they may offer the benefits of a

corporate chain combined with the greater continuity and stability of the more traditional general

practice.

Introduction

The Health and Social Care Act 2012 will result in radical changes to the English National Health Service (NHS.)[1] Among other changes, financial control for purchasing services will be redirected to general practice (GP) commissioners, who will be organised into commissioning consortia (GP-led Clinical Commissioning Groups or CCGs) overseen by an NHS Commissioning Board (NHS England). The Act places positive duties on the government minister responsible for the Department of Health (the Secretary of State for Health), NHS England and the CCGs to secure continuous improvement in quality and safety. Primary care in England has undergone multiple reforms since the 1970s involving a range of managerial, financial and governance strategies to tackle problems ranging from poor recruitment, retention and working conditions of GPs to 'substandard care'.[2] These initiatives included, as part of the 2004 General Medical Services contract, the Quality and Outcomes Framework (QOF) pay for performance scheme. The QOF sought to improve performance,[2] but it has shown mixed impact and some evidence of unintended consequences.[3,4,5] Changes to primary care governance continue to be introduced: the regulatory body, the Care Quality Commission, is now charged with registering and regulating quality and safety for all general practices; and a practice accreditation scheme has been established in partnership with the Royal College of General Practitioners (RCGP).[6]

A recent King's Fund report into the quality of care found that the majority of primary care was good, but wide variations in performance remained.[7] The report concluded that general practice needs to deliver a form of care described as 'post-industrial', involving performance measurement, quality improvement and transparent reporting. The optimal form of organisational arrangement for delivering improvement is, however, not yet clear. Single practices owned and run by a small group of GPs as professional partnerships[8] have thus far remained by far the dominant model in the UK. Yet increasingly influential arguments are made in favour of alternative models of ownership and

delivery. Some countries have seen the emergence of primary care providers who work collectively, for example, independent practitioner associations in New Zealand[9] and primary care networks in Canada.[10] The UK has seen some pressures towards more collective models. The RCGP has called for the creation of federations of practices to pool expertise and improve quality.[11] The King's Fund report[7] called for more, larger provider organisations or federations, while the NHS Future Forum recommended to the Secretary of State that contracts be changed to incentivise collaboration and integration between practices.[12] This may involve arrangements such as horizontally integrated groups of multiple practices owned by a traditional GP partnership, federated groups of several practices that are each individually owned by partnerships, social enterprises, or a variety of other forms.[13] One distinctive form is that of the large corporate chain, where practices are owned and operated by a company rather than by professional partnerships.

Such corporate chains are a relatively new development in the NHS, and were first made possible by the alternative provider medical services contract (APMS). Since 2004, this has allowed the English NHS to contract with independent providers of primary care under a policy designed to facilitate equal access for all patients.[14] Notwithstanding predictions about the likely fast pace of privatisation of GP provision in the NHS as far back as 2001[15, 16] and official encouragement for alternative providers, their numbers (including voluntary or social enterprises) remain limited.[17] The persistence of the small professional partnership in general practice, rather than larger firms or chains of practices, is in striking contrast to trends in areas such as pharmacy, opticians, and nursing home provision, where larger commercial chains and corporations have become widely established across the UK.[18]

Despite concerns about the potential impact of new types of provider, particularly in the form of corporate chains of practices, on personal care and other issues, [18,19] studies of such providers remain limited. Research has mainly focused on mapping the spread,[19] and on impacts on professional identity and inter-professional relationships.[13] Little evidence has appeared on the

quality and safety strategies used by these new entities. Yet there is clear need to investigate how far any move from professional partnership to corporate chain generates new approaches to managing quality and safety. We characterise the quality and safety systems and processes of a large, privately owned company providing primary care through a chain of general practices in England.

Methods

Our study design was a qualitative case study[20] of a company operating a chain of general practices, which for purposes of anonymisation we dub Primer Health. Data collection involved multiple methods.[21] We used interviews with senior executive level staff and owners, [22, 16] - to explore the policies and systems they established to support quality and safety. These staff included those at the highest level of the organization with responsibility for clinical governance and for performance monitoring, quality and safety. We also conducted interviews and ethnographic observations in three of the company's practices. These practices were selected by the company in response to the researchers' request to represent diversity in setting and context (size and location) across the chain of practices (Box 1). We also analysed a small amount of the company's documentation relevant to quality and safety.

In each practice we interviewed a mix of staff, including general practitioners, other clinical staff, managers, administrators and receptionists. Interviews used a prompt guide based on a review of relevant literature and discussions within the project team, and were recorded and transcribed verbatim. Interviews lasted between 45 and 60 minutes, with the prompt guide used to provide structure to the conversation while allowing flexibility and further probing as appropriate. We undertook two days of observation in each practice, observing interactions between staff and between staff and patients in non-clinical areas. We did not observe consultations themselves. Field notes were recorded and transcribed.

The unit of analysis was the company, not the individual settings we studied. Analysis was based on the constant comparative method,[23] assisted by NVivo software. Though ethnography is committed to discovery rather than the imposition of *a priori* categories on data, we identified some preliminary analytic themes or sensitising concepts[24] to which we oriented our data collection, while remaining open to the possibility that these might be added to, modified, or made redundant, as analysis proceeded. Data were coded by SMcN, and coding was verified by MDW. Research ethics committee approval was obtained for the study.

Results

We interviewed a wide variety of staff across Primer, including nine senior people (senior managers and leaders) and 15 at practice level (four general practitioners, two practice managers, three administrators, four receptionists, and two nursing staff). We conducted approximately 45 hours of observation, including multiple informal chats with staff, across the three practices studied in detail.

Primer was founded by a small number of GPs, who were its sole owners at the time (2011-2012). It operated a chain of over 50 practices dispersed across England. GPs and all other staff working in the company's practices were salaried (directly employed) rather than partners. A proportion of the company's practices were reported to be under-performing by the local primary care trust when taken on by Primer, with problems including inadequate facilities, poor leadership and administration, and weaknesses in care. These practices were often based in severely deprived urban areas that had struggled to attract or retain GP partnerships. Primer was run as a hierarchy, with a relatively small executive team led by the owners of the company. This team set strategic direction, developed policies and procedures, developed new business, communicated with the practices, and sought accountability from the practices.

Our interviews suggested that the executive team saw both a strong commercial need to establish the company as a reputable provider of quality services and a strong moral need to ensure that services provided to patients were of high quality, safe and customer-focused. Strong customer focus and quality of care was seen as key to acquiring patients and growing reputation, but also as desirable in themselves. Primer thus saw a fit between the needs of the organisation for commercial success and the values of the company in delivering a service that patients would appreciate.

> *The more people we have using the services that we offer the better for business. So the two work hand-in-hand. They don't work opposite each other and a lot of, you know, the old born and bred NHS providers will argue that you know, you can't put profit before quality and we never, ever do. Because in our experience if you don't provide quality you are never going to achieve profit. So, you know I see some of the traditional NHS providers providing what I would call really not a very customer focused service at all. (003)*

Protecting patient safety was seen as especially critical to the survival and growth of the organisation. In an environment where commercial provision of health care was viewed with suspicion by some, a major failure in safety was seen as a significant risk to business reputation and survival. The organisation felt especially exposed to these kinds of risks because of its expansion strategy of taking on under-performing practices that were, by definition, already struggling to deliver on aspirations for quality and safety.

> *For us as an organisation because we are different to the standard GP partnership model, we feel we are more exposed and therefore we place an even higher reliance on safety, quality and quality assurance in the organisation because you know we live or die by our rand, so it's of critical importance to us that we do do a good job and that we are able to demonstrate, that we are doing a good job. (001)*

In consequence, the executive team took a very active interest in quality and safety, and described explicit and extensive policies and systems for monitoring and management (Box 2). It stressed in particular the opportunities for improving quality and safety inherent in having a large number of practices. These included the potential for explicitly designed systems, standardisation of processes and practices, simplifying tasks and enhancing training, avoiding bureaucratic burden on clinical staff, and optimising learning across many practices. Interviewees reported that having a chain of

practices meant that information could be disseminated, and procedures and systems updated, very quickly.

> *for instance if something happens in one surgery, and we wanted to prevent it happening in any of our other surgeries then that is how it would all be communicated. (002)*

The structural components of Primer's quality and safety system included a designated governance leader and a committee that reported monthly to the Board on safety incidents. The incident reporting system had been specifically developed by Primer, and included active monitoring of the number of reports from each practice. Incidents were graded by severity, with more serious incidents given more attention. Training in incident reporting was mandatory for staff. Practices reporting lower than the expected number of incidents were deemed cause for further investigation, as low reporting was considered possible evidence of poor sensitivity to quality and safety issues.

> *..there's nothing that worries us more than a site where there are no incidents (007).*

Separately from the incident reporting system, the performance of practices and individuals was monitored and managed through reporting of various indicators, including quality and outcomes framework (QOF) indicators, recruitment and exit of registered patients, numbers of appointments offered and unused, together with feedback and benchmarking. A buddying system was in place with the aim of ensuring that each practice had a clinical and managerial lead to implement policies and improve performance. Staff, including GPs, who did not meet the requirements of Primer were "*performance managed out of the organization" (001).* The organisation reported heavy investment in ensuring the customer focus of their services, and monitoring and improving patient experience through patient surveys and 'mystery shoppers' and staff training in customer service. With the intention of freeing receptionists to attend to patients in their practices and maximise efficiency of appointment allocations, a call centre was established to handle all telephone requests for appointments.

Interviews and observation at practice level generally suggested that the policies developed by the company executive were being applied in the practices. For example, all levels of staff were familiar with the incident reporting system.

> if there is any errors made, anything that sort of needs to be recorded, we have an incident performer sheet, where we have to fill that in. And there is a learning point as well, that goes back to our head office. (015).

> Now we also have, in this organisation, quite developed reporting … from the lowest to the highest category…(020).

> We have a system for escalating any errors of this type and safety problems up through the system and I think mostly attention is paid to that and we're relatively empowered at the local level to make adjustments in the way the organisation works (019).

Staff were aware of the company's whistle-blowing policy, and were usually – though not always - comfortable about reporting concerns. However, they were less aware of reports from head office on lessons learned from incidents that had occurred in other practices.

> ..if anything happen in the practice then straight away we will inform the manager. Then she will inform her manager. Then they probably will ..

> Interviewer: Do you feel safe to talk to the manager about it?

> Yes definitely. (013).

> I mean I would just phone head office and ask who I could speak to. [X] has all our policies and procedures in place. [X] actually, you know, she does all these guidelines and health and safety and things like that and if there was a real issue, you could go to her (018).

The scale of the organization did appear to deliver many of the advantages of standardisation and transfer of learning. For example, an incident with over-flowing bins at one practice one weekend was dealt with quickly by new procedures for ensuring bin hygiene throughout the organisation. Feedback of performance information generated some competition between sites to do well. Practice staff also described the patient feedback system used by the company, although it was not always clear how practices responded to the feedback. The practices had all attempted to establish patient participation groups (PPGs), with variable success. Some reported very positive experiences, with one practice sharing prescribing data with its PPG in order to explain changes that would be made. Others reported less success and found that securing patient participation was frustrating.

Things that I have shared with the PPG for example are prescribing quality information – so I have shared with them, you know we are going to have some changes to prescribing, you might notice a bit of activity going on, this is the reason why (008).

Where we've got a full blown patient participation group yes it does work, but they're very hard to set up and, you know, it's a struggle to keep them going... (021).

Our observations in practices tended to show that the customer focus prescribed by the executive team was well implemented. We observed considerable attention, sensitivity, and responsiveness to patients' needs. For example, reception staff were observed accommodating patients who had arrived late, were courteous and helpful at the reception area, rushed prescriptions to be signed when patients had forgotten them earlier and enabled an acutely ill patient to have her appointment brought forward with the agreement of other patients waiting. Overall, there appeared to be positive, caring attitudes towards patients in the three practices where we conducted observations.

Ensuring consistent levels of quality and safety across a large number of dispersed practices was, however, seen as challenging by practice staff. Innovations – including a much improved system for storing and interpreting scans at one practice – did not always spread quickly beyond the practices where they were developed, resulting in some duplication of effort or inefficiencies. There were mixed views among staff about the call centre for appointments. On one hand, it reduced the number of calls that receptionists had to deal with, and freed them to attend to people on the premises. However, receptionists often had to handle queries from the call centre, and they suggested that patients did not always like the call centre.

The call centre is not popular, [patients] find it hard, there is a time lag before they can get an appointment, there is time lag with how long they have to wait on the phone before it's picked up, all those type of things, so the call centre needs working out …. (005).

Some practices were concerned that they struggled with recruiting patients because of antipathy towards Primer as a commercial organisation, and there were some suggestions from our observations and interviews that being part of a large organisation, where no-one locally owned the practice, meant that staff felt less valued. Some interviewees also reported that the ability to disseminate learning quickly was not fully exploited.

...they phone me quite often and ask you know, how I am doing this and that because I have been here quite a long time and the practice manager at [practice X] she is quite new so you know initially we had quite a lot of contact but obviously she has got used to the system now (024).

I am talking about receptionists, secretaries etc, my impression is because I get to hear a lot of what they think, that they don't always think that the company cares enough about them, I think they often feel undervalued. (006)

There's a lot of knowledge in other practices where they may be identifying errors as well and have found a better way of minimising error than we have and we don't know about them (019).

Perhaps the biggest problems related to relational continuity of care, which was an issue at some practices. Recruitment and retention, particularly of GPs, was a recurrent problem in some practices, especially those that were under-performing when taken over. This resulted in some cases in a heavy reliance on locum or temporary GPs. One GP resigned within a day of starting because of a dislike of the organisational arrangements. Patients were reported to complain about poor continuity of care, and new GPs posed challenges in terms of induction and oversight. GPs were sometimes observed being unsure of procedures and systems, including those relating to test ordering and incident reporting. It was also more difficult to socialise these temporary staff into the culture of the company.

At the moment we got some problem, you know, most of the complaints and everything because the doctors keep changing, the patients not happy, because they [have] no continuity. (013)

Possibly sometimes the downside for the patient, because they end up not always getting maybe the continuity of care that they would like because there are quite a few different doctors working in quite a small practice. (006).

Discussion

Our study describes one new type of provider of GP services in England. Its organisational form, involving a hierarchically organised chain of practices, marks a significant departure from the traditional, professional partnership model. A striking feature of this provider was the extent to which it articulated a clear vision and goals for quality and safety, and paid explicit attention to developing systems for achieving this that were to a large extent consistent with current evidence on good practice in improving quality and safety.[25] Among other things, it took seriously the need to

standardise and simplify systems and processes, and to learn from adverse events. The company

also, however, faced a number of challenges related to quality and safety, principally, but not

exclusively, linked to volatility of staff recruitment and retention.

Our analysis suggests that three features of Primer are interesting for quality and safety processes in

primary care: size and scale; hierarchical governance; and commercial imperatives. Our study

suggests that size and scale were implicated in Primer's motivation for developing explicit and

detailed systems for governance of quality and safety, and was also important in its ability to

implement these systems. Previous studies have shown that corporate standardisation of issues

such as clinical guidelines can help to secure improvement, and that common facility standardisation

can also be beneficial, though standardising administration alone is not sufficient to increase care

quality.[26,27]

 Having a large number of practices within the organisation enabled Primer to develop common

policies that could be widely implemented. Like other larger firms,[28] Primer appeared able to cope

better with standardisation and regulation than small enterprises, the company having the

advantages of added managerial capacity with central leadership and management by concentrating

resources in its head office, and relieving front-line GPs of administrative duties. The question of

which size is optimal is not clear, however. Research in other areas, including nursing homes,

suggests that the impact of new acquisitions on a corporate chain may not be wholly positive, but

rather change a 'chain's capabilities and can create challenges in either aligning the portfolio or

bringing new acquired components into line'.[29]

 There was also some evidence that both staff and patients could feel alienated by the move from

the partnership to the chain model of care. A distinctive feature of Primer was its use of a model of

hierarchical governance, which contrasted with the traditional reliance on 'soft governance'.[30]

Primer was in a position to impose policies on practices and staff, without having to negotiate with

each one individually. It operated a highly controlling system of surveillance and performance

management and was able to remove underperforming staff– including GPs - more easily than would be possible in the traditional partnership.[31] However, this approach was not entirely free of unintended consequences. Recruitment and retention of GPs was a challenge, suggesting that GPs who have not invested in a practice (because they are not partners) may be much more willing or inclined to leave. A transient GP workforce risks problems in relational continuity,[32] and poses challenges for induction, training, and acculturation. Our study did not investigate informational or clinical management continuity, but these might also be affected.

Primer's account of its motivations for its explicit focus and systematic approach to quality and safety, while it identified moral motives, also emphasised commercial imperatives linked to reputational enhancement, a perception of increased exposure to risk, and the need to compete to grow and ensure profitability. Senior personnel saw the need to demonstrate quality in order to compete, and secure credibility in the marketplace. Of course, the traditional general practice is itself a commercial organisation, being a privately owned partnership that contracts with the NHS. What makes the Primer model distinctive is its overt corporate structure, with ownership concentrated in a small number of hands, and its much larger size. This size and structure exposed the organisation to much greater risk of failure than the traditional partnership, not least because a failure in one practice could damage the reputation and stability of all the practices in the company. In a similar way, when the profession of accountancy moved to big, geographically dispersed firms large-scale failure became more of a risk.[33] Patients' perceptions about tensions between commercial ownership goals and profitability versus public goals of service quality identified in our case study could also pose risks for sustainability of this model.

Our study has both limitations and strengths. We have only looked at one type of new provider, and at a particular stage in that organisation's history. The provider had been initiated by a small number of GPs who continued to be leaders in the organisation, and the findings may not, therefore, reflect approaches to quality and safety in organisations established from the start by commercial

organisations. We did not seek to evaluate whether care was safe and of high quality, focusing instead on the organisation's strategy, processes and culture. We did not undertake a 'before and after study' of transformation in the three practices we studied in depth, nor did we make a direct comparison with more traditional GP practices. We interviewed staff and conducted observations in three practices only, and although we have no reason to suspect that these practices were atypical, it is possible that our impression of the quality and safety systems and culture is incomplete. However, the staff we interviewed spoke openly, and there was no evidence that the periods of observation in practices were staged;   we therefore believe our results do represent a reasonably accurate reflection of the organization. Our findings make a potentially important contribution to understanding how quality and safety might best be optimised in primary care.

It is clear that the corporate chain approach offers some benefits for quality and safety processes, but also some risks. It is possible that many of the benefits of scale could be achieved through better networking and federation of existing practices, or larger professional partnerships. Such structures would, if managed well, be able to deliver advantages in terms of standardisation of processes, systems, procedures and incident reporting, and enable the development of high quality intelligence and managerial expertise. This would enable practices to remain locally owned, with correspondingly high levels of personal investment and likely stability, and containment of some risks. These alternative larger organizational forms may thus be better able to maintain relational continuity for those patients who prefer it.[34] However, much needs to be learned about how to make such a model work given the traditional autonomy of the GP partnership.

The multi-unit chain model is proliferating in health care.[27, 29] Future research should seek to investigate the characteristics of different, larger organizational forms in primary care, including ways in which commissioners can reap the benefits of larger organizations without requiring the formal merger of practices. More in-depth comparative studies (both qualitative and quantitative) are now needed, both in the UK and internationally.

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Box 1. Participating practices

1. A fairly small sized inner city practice, with moderately high levels of socio-economic deprivation and high proportions of patients in ethnic minority groups. Quality and outcomes framework achievement in the clinical domain (2010-11) 95%

2. An average sized suburban practice, on two sites, average levels of deprivation. Quality and outcomes framework achievement (2010-11) 95%

3. A small practice in a small town, with low levels of deprivation. Quality and outcomes framework achievement (2010-11) 100%.

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Box 2. Elements of the quality and safety system

a)   Safety

1.   Clinical director with governance role: monthly governance report to the Board that includes all incidents reported in the month, graded into green, amber, orange and red. The Board reviews them all, but considers the orange and red in detail. Analysis of incidents numerically as well, with action plans.

2.   An integrated governance committee

3.   Incident reporting rates for all sites are monitored; every surgery has an expected number (benchmarked), and is checked if the number is not reached. If they are below a certain level, they are rated red, and they are visited.

4.   Training in incident reporting for all staff (mandatory).

5.   At least one risk assessment on each site each year, with actions plans as an outcome

6.   Whistle blowing policy in the staff handbook

7.   Feedback to all sites monthly – sharing measurement.

b)   Managing staff

8.   Leadership structures – clinical leader at each site in partnership with the site manager, plus regional clinical leads who look after several sites, plus national clinical lead

9.   Buddy system – buddy a clinician and manager at all levels of the system

10.   Annual appraisals for all staff

11.   Performance manage poor staff out of the organisation

12.   Incentives for good performance include financial incentives, and more autonomy for higher performing practices, allowing the organization to focus on practices that need improvement (a task force may be used to improve challenged practices)

13.   Performance monitoring for all sites (red, amber green), 'dashboard' that includes list size, performance to contract, QOF, financial performance, access, incidents, serious untoward incidents, staff completing mandatory training, plus a clinical risk assessment score for each site. Prescribing and referral patterns. Volume of enhanced services at each site. Complaints and accolades. Staff levels, including locum use. Sick leave as an indicator of staff morale.

14.   Hero of the month award, voted for by staff

15.   Regular site visits

16.   Monitoring of staff training

c)   Patients as customers

17.   Patients are viewed as customers

18.   Monitoring access - how many GP and nurse appointments per 1,000 patients that are offered (benchmarked), how many appointments are unused (aiming to have percentage of appointments as unused capacity).

19.   Patient satisfaction surveys – freepost card, 5 questions on each card, handed out (access, making appointments, getting through on the phone, how you felt when you saw the doctor or nurse), and the QOF patient survey.

20.   Trying to set up Patient Partnership Groups in each practice to share information with patients and get feedback

21.   Mystery shoppers

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