

# **Levers for change in primary care: a review of the literature**

## **Authors**

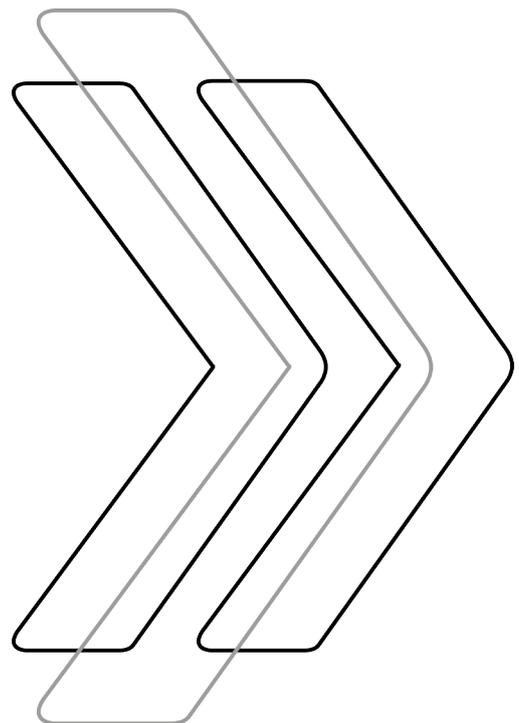
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April 2022



This independent report was commissioned by NHS England. The views in the report are those of the authors and all conclusions are the authors' own.

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# 1 Introduction

This brief literature review was commissioned by NHS England to inform the Fuller Stocktake. This is not a review of the effectiveness of particular innovations or service changes, rather it considers the available literature on the processes and levers used in programmes of change, improvement, innovation and transformation in primary care, with a particular focus on general practice. Drawing from literature from the English health system and international systems, we review key levers of change and suggest the main lessons learned through the evidence.

## 2 Methodology

A database search was conducted by The King's Fund Library Services team. A full list of databases and search strategies can be found in the Appendix. The searches have a date range from 2010–present for work on English system, and 2015–present for international literature. Specialist librarians removed duplicate entries from the overall results and any literature immediately apparent as not being relevant to the research questions of this project. This resulted in 105 potentially relevant items – 51 on the English system and 54 on international systems. Each of the items were reviewed based on title and abstract to determine their relevance to our research. 21 items were rejected on the basis of irrelevance or inaccessibility.

The remaining 84 items were then categorised by theme (based on different kinds of levers for making change). We then narrowed our inclusion criteria to only those papers judged by the research team to be most relevant to our research questions and brief. This left 44 items, which were read in full and findings structured into themes by the research team.

## 3 Findings

### Financial incentives and pay for performance

The financing and commissioning models for primary care in England have meant a focus on using financial incentives and pay for performance systems to leverage improvements. Financial levers for change include:

- payments for specific activities once targets are achieved
- funding for specific new services or interventions at either national or local level (eg, directed or local enhanced services schemes or changes to national contracts)
- commissioning incentive schemes to support the achievement of local commissioning priorities
- recruitment incentives, for example the additional roles reimbursement scheme or new-to-partnership payment scheme
- different funding mechanisms intended to promote change, for example paying at scale (eg, primary care network versus practice) or shared risk approaches to encourage collaboration between organisations

By international standards, the English system has used these kinds of levers far more than most other countries – particularly through the quality and outcomes framework (QOF), which is the largest system of its type in the world (Mandavia *et al* 2017). The pharmacy quality scheme offers a similar performance scheme for community pharmacies in England (PSNC 2022). Despite this, the evidence base for financial incentives creating positive change in primary care services is surprisingly thin (Mandavia *et al* 2017; Scott *et al* 2011; Gillam 2015), with the exception of QOF which has been studied extensively on account of being something of an international outlier in its structure and size (Willcox *et al* 2011).

#### *Key lessons*

- Pay for performance financial incentives can be effective at shifting the areas in which clinicians focus their efforts (NHS England 2018) and increasing activity and quality in specific areas (PSNC 2021), though there is limited evidence on the effect on patient outcomes overall and

potential evidence that they can have an adverse effect on those areas that are not targeted (Doran *et al* 2011).

- Using targeted contracts (eg, locally enhanced services contracts) can create effective new pathways and services, although evidence for cost-effectiveness is not well studied (Baker *et al* 2016). Short-term funding arrangements for these initiatives make it difficult to provide clear evaluation of benefits (Smith *et al* 2013).
- Contracts that require shared financial risk between organisations can improve engagement between organisations but requires significant support and high levels of trust (Addicott and Ham 2014).
  - There is some evidence that the use of pay for performance can increase health disparities, as those in more affluent areas find it easier to achieve targets (Alshamsan *et al* 2010).
- The implementation of financial levers can have adverse effects on staff morale (Mandavia *et al* 2017; Gillam 2015). Best practice suggests working with staff to design any system, so that they do not end up feeling disempowered by the incentive structures, feel like they are compromising ethical standards (Khan *et al* 2020) or feel like the extra administrative tasks they are being asked to carry out to demonstrate that they are achieving targets are more trouble than they are worth (Gosling *et al* 2019).
- Research into the impact of QOF found little evidence to suggest that incentivised areas of focus improve at a faster rate than non-incentivised areas (Gillam 2015).

## Targets and metrics

Target setting and monitoring is a lever that has been used by successive governments in England to drive improvement in primary care. The literature suggests the key benefit of using targets is an increased focus that increases activity in the targeted area, particularly when supported by additional funding (Anselmi *et al* 2015; Boyle *et al* 2010)

### *Key lessons*

- Metrics need to be digestible and relevant to the staff delivering those metrics (Gray *et al* 2018; McCallum *et al* 2018).

- Even where associations are shown between the publication of metrics and quality improvement, concerns are raised about how this kind of approach can lead to feelings of disenfranchisement among staff (Pettigrew *et al* 2018).
- Setting the optimum level for targets is complex, especially ensuring they drive improvement and change for all when the baseline is variable (Khan *et al*, 2020; NHSE, 2011). Single levels for targets can also incentivise conformity or lack of ambition (Khan *et al* 2020), giving practices starting from a higher baseline less reason to try new things or take risks in order to achieve better results.
- Targets and metrics need to support localised decision making, adaptation and adjustment if they are to be effective (Levesque *et al* 2015).
- The range of targets and indicators needs careful consideration: if staff are asked to engage with too broad a range of indicators, focus on specific changes can be lost. Narrow metrics may be easily achieved but miss the broader quality improvements that were originally targeted (Goodwin *et al* 2011). In addition, targets and indicators need to be designed in a way that acknowledges unintended consequences, for example gaming of targets or complacency (Mannion and Braithwaite 2012).
- Increasing activity and creating new initiatives to meet targets can lead to poorly designed and overlapping services that fail to improve outcomes (Tan and Mays 2014). Evaluation of the Advanced Access programme used in general practice in the early 2000s found that not only did most practices not meet the target, the over emphasis on rapid access interfered with providing access to appropriate care (Salisbury *et al* 2007).
- It is critical that different layers of the health system act as one. If different structures are not co-ordinated, and initiatives do not align, then the chances of improvement activities succeeding is limited (Tan and Mays 2014). The risk of misalignment of incentives is high for primary care, as the literature points to a disconnect existing between primary care and the wider health system (McDermott *et al* 2019) with priorities not aligned across structures, nor with clinicians' individual priorities for improvement and change (Gosling *et al* 2019).

## Accountability and regulation

Use of different accountability and regulation mechanisms to encourage change in primary care includes audit, data transparency, benchmarking and inspection (eg, the Care Quality Commission (CQC) inspection regime and the annual GP Patient Survey).

### *Key lessons*

- Evaluation of the impact of CQC inspection found improvement capability and the availability of external improvement support were key determinants of impact and were more often present in the acute and mental health sectors than in general practice and adult social care (Smithson *et al* 2018).
- Evaluation of the impact of patient feedback in general practice has found unclear evidence about its use to stimulate improvement at practice level (Baldie *et al* 2018). Research into the use of patient surveys in England confirmed that while they were seen by national policy makers as a valuable resource for monitoring national trends, they were rarely used for quality improvement within practices, with GPs often sceptical of the reliability and validity of surveys and feeling that they could not provide enough qualitative detail to facilitate change (Burt *et al* 2017; Asprey *et al* 2013).
- The ability of clinical commissioning group (CCG) commissioners to take on responsibility for quality improvement, beyond basic contract monitoring, was constrained due to the reduction in management budgets and existing time pressures (Robertson *et al* 2016). While CCGs were given increasing responsibility and control to manage the quality of care, GPs were less supportive of CCGs use of performance management mechanisms (Holder *et al* 2017).
- A study of the role of CCGs found that the ability to provide comparative data to practices and facilitate peer to peer dialogue could be a strength, although variation between CCGs on how engaged they were with improvement work presented a challenge in terms of creating a standardised culture and setting a clear direction (Naylor *et al* 2013).

## Creating a culture of change

Leadership, both within practices and within the wider system, plays an important role in shaping quality improvement initiatives in primary care. In the context of this review, we take leadership to mean behaviours and approaches taken by senior staff used to encourage and embed change.

### *Key lessons*

- The literature shows a range of cultural factors help enable change and improvement initiatives to succeed. These include: positive team dynamics, skills in evaluation (Gosling *et al* 2019), clarity of staff roles (Allan *et al* 2014), ongoing time and resource commitments, being accepting of imperfection, building momentum and being welcoming of criticism (Kiran *et al* 2019).
- Variations between services and professionals must be considered, and the best strategy of implementing change and improvement initiatives in any given place is always hard to predict (Lau *et al* 2015). It is clear that decentralisation of decisions allowing adaptation to local circumstances is important but should be accompanied by appropriate support and training of local leadership to ensure quality and consistency (Levesque *et al* 2015).
- Cultural factors that can prevent change and improvement from embedding in practices include: a high-pressure environment (Baron *et al* 2020) either in terms of patient or bureaucratic workload; staffing issues (Gosling *et al* 2019); and people's natural resistance to change – particularly if they experience it as a top-down process (Allan *et al* 2014).
- If staff become stressed or frustrated, or feel like they are being bombarded with impossible demands this can lead to increased internal working pressure, which is in itself detrimental to change and improvement (Allan *et al* 2014).
- The role of leadership is not well studied in primary care (Nieuwboer *et al* 2017), with limited evidence on how leadership behaviours and approaches should be encouraged (Swanwick and Varnam 2019). Despite this, there is evidence that leadership is important to the success of quality improvement initiatives (Jackson *et al* 2021).

- Practices need to be 'readied' for change initiatives to give them the best chance of success and clinical and practice leadership is integral to this process of 'readying' (Soylu *et al* 2021).
- Poor leadership can play a large role in impeding the process of change that might otherwise have been successful (Crabtree *et al* 2020). A particular risk to think about here is that if leadership is not co-ordinated between different levels within the practice and the wider system (Naylor *et al* 2013), this can leave staff delivering services unclear of what's expected from them.
- It is key for leaders to find ways to allow staff to own processes of change and take control in order to ensure long term sustainability (Brooke-Sumner *et al* 2019).

## Structural levers for change

While the delivery models in primary care have only changed in a limited way since the creation of the NHS, structural change in the commissioning and oversight of primary care has been a constant theme. There is limited research evaluating the precise effects of the various structural reforms to the NHS over the last decade in terms of their effects on change and improvement in primary care.

### *Key lessons*

- The impact of scale on quality improvement is equivocal. Studies suggest limited robust direct evidence of impacts on patient experience, and no evidence was identified on the cost-effectiveness of scaling up general practice. One systematic review found no consistent association between scale, quality of care or the generation of efficiency saving (Pettigrew *et al* 2018).
- Creating a system in which the structures that govern primary care can help drive improvements requires staff working in primary care to see themselves as active rather than passive participants in organisational change and have trusting relationships between practices (Elvey *et al* 2018).
- Evidence suggests that one of the key ways in which information about improvements is disseminated between practices is through informal networks (Stokes *et al* 2014), and that the strength of these networks is a major predictor of where improvement activities are likely to take place.

- Organisational models to support change in primary care require appropriate management and professional expertise, including change management expertise, data analytics, organisational development and human resources expertise and protected time for change (Smith *et al* 2021; Baird *et al* 2022)

## Learning from Covid-19

It would be difficult to discuss the levers of change in primary care without mentioning the Covid-19 pandemic and its impact on primary care. The uncertainty and urgency of the pandemic focused the minds of the public, government and health care system on a common goal. This resulted in a more permissive approach to delivery that enabled quick decision making while a move to more centralised command and control created clear communications channels.

At the start of the pandemic the primary care sector was able to adapt relatively quickly to digital working due to a number of factors. In many cases this was related to a streamlining of bureaucracy and processes that had existed pre-pandemic, combined with an increased tolerance for risk and a burning platform around safety that overrode some of the cultural barriers to change that had existed before the pandemic (Baird and Maguire 2021). The standard operating procedures for Covid-19 published at the start of the pandemic was felt to offer 'top down clarity with bottom up agency' for local leaders to effectively work across boundaries and create solutions appropriate for their communities (Thorlby and Pereira 2020). Existing contractual and regulatory commitments were suspended, including QOF and CQC inspection, freeing up time and resources for primary care to enact the needed changes (Majeed *et al* 2020). The successful implementation of the vaccination programme likewise saw rapid and creative responses from general practice around a common goal with a focus on local solutions with clear national guidance and clear and frequent communication between national and local leaders and with local communities (Timmins and Baird 2022).

## 4 Conclusions

Whatever levers are chosen, common themes emerge from the literature.

- The NHS in England is an outlier by international standards with regard to the extent it has used financial incentives to try and improve primary care although the evidence base to suggest that financial incentives or target setting improve primary care is surprisingly thin.
- 'Top-down' approaches to driving change and improvement risk alienating workforce and there needs to be space for localised decision making, adaptation and adjustment.
- Changing the focus of activity or increasing activity is easier than improving quality
- 'Soft' levers of culture and leadership are critical for successful initiatives, creating an organisation that offers a safe environment for people to learn and experiment.
- Successful delivery of change requires those implementing it to have the means of acquiring the capacity, time and skills that they need
- Enabling informal collaboration, peer review and support may be more effective than formal structural change.

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## 6 Appendix A: Databases and search strategies

Database	Search terms
<p>Embase: A large biomedical and pharmaceutical database, coverage includes drug research, pharmacology, pharmaceuticals, health policy and management, public health, occupational health and environmental health.</p>	<p>Major subject term: (primary health care OR general practice) AND Major subject term: (diffusion of innovation OR implementation science OR change management)</p>
<p>Emcare: Subjects include nursing, nursing administration and management, medical and nursing education, emergency services, family practice, community and home care, geriatrics and palliative care, healthcare information and management, nutrition and dietetics, public and occupational health, and social medicine.</p>	<p>Title: (transformation or targets or improvement or innovation* or change management or organizational development or leadership) AND Subject term: (primary medical care OR general practice)</p>
<p>Google Scholar: Access to scholarly literature</p>	<p>"change management" "general practice"                      "systematic review"                      "Implementing change" "general practice"                      "systematic review"</p>

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	allintitle: review change OR transformation OR innovation "primary care"
<p>HMIC: Focused on the UK, this resource combines the databases of the DHSC and The King’s Fund. Subject coverage includes health management and policy, social care, service development, NHS organisation and administration. (grey literature)</p>	<p>su:("general practice" OR "general practitioners" OR "primary care") AND kw:("change management" OR "cultural change" OR "organisational change" OR "organisational development" OR "structural change" OR "strategic change" OR innovations OR targets OR improvement OR leadership)</p>
<p>PubMed: A free resource providing access to the Medline database and some additional citations</p>	<p>MeSH major term: (general practice OR family practice OR primary health care) AND MeSH: (health plan implementation OR diffusion of innovation OR implementation science OR organizational innovation OR change management)</p> <p>su:("general practice" OR "general practitioners" OR "primary care") AND kw:("change management" OR "cultural change" OR "organisational change" OR "organisational development" OR "structural change" OR "strategic change" OR innovations OR targets OR improvement OR leadership)</p> <p>Title/Abstract: ("general practice" OR "primary care" OR "family practice") AND Title/Abstract: (transformation* OR targets OR improvement OR innovation* OR "cultural change" OR "culture change" OR "organisational development" OR "organizational development" OR leadership) AND Title: change</p> <p>Title: ("general practice" OR "primary care" OR "family practice") AND Title/Abstract: (transformation* OR targets OR improvement OR innovation* OR "cultural change" OR "culture</p>

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	<p>change" OR "organisational development" OR "organizational development" OR leadership) AND Publication type: (Randomized Controlled Trial OR Review OR Systematic Review)</p> <p>Title: ("general practice" OR "primary care" OR "family practice") AND Title: change</p>
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