Ontario College of Family Physicians
Education | Leadership | Research | Advocacy
A Chapter of the College of Family Physicians of Canada

Evidence Brief: Preparing for a Devolved, Population-Based Approach to Primary Care

Ontario College of Family Physicians

Dale McMurchy Consulting

10/1/2015

Contents

List of Abbreviations

CCG	Clinical Commissioning Group (United Kingdom)
CHC	Community Health Centre (Ontario)
CME	continuing medical education
DGP	Divisions of General Practice (Australia)
DHB	District Health Board (New Zealand)
EMR	electronic medical record
FCC	Family Care Clinic (Alberta)
FHN	Family Health Network (Ontario)
FHO	Family Health Organization (Ontario)
FHT	Family Health Team (Ontario)
FMG	Family Medicine Group (Quebec)
GP	general practitioner
IFHC	Integrated Family Health Centre (New Zealand)
IHP	interprofessional health-care provider
IPA	Independent Practitioner Association (New Zealand)
LHIN	Local Health Integrated Network (Ontario)
LHN	Local Health Network (Quebec)
LHN	Local Health Network (Australia)
NHS	National Health Service (United Kingdom)
PCN	Primary Care Network (Alberta)
PCT	Primary Care Trust (United Kingdom)
PHN	Primary Health Network (Australia)
PHO	Primary Health Organisation (New Zealand)
QIP	Quality Improvement Plan (Ontario)
QOF	Quality and Outcome Framework (United Kingdom)
TPP	Total Purchasing Pilot (United Kingdom)

Executive Summary

Introduction

Building on five position papers developed by the Primary Health Care Planning Group, the Expert Advisory Committee on Strengthening Primary Health Care in Ontario provided the Ministry of Health and Long-Term Care with recommendations for redesigning the primary care sector in early 2015 (the Price Report). It is anticipated that the Ministry will respond to these recommendations and propose greater devolution of the primary and community-based health-care sector to the local level. While the details of such a transformation are as yet unknown, it is assumed that organizations responsible for planning and commissioning primary care services for a defined population of residents ("patient care groups" in the Committee's report) will be formed at the sub–Local Health Integrated Network (LHIN) level.

To prepare itself to support its membership, the Ontario College of Family Physicians commissioned Dale McMurchy Consulting to develop this evidence brief to provide background and information that will help the College become more knowledgeable about this type of primary care model in other jurisdictions. The brief will also help the College to prepare to contribute to and shape the coming change in Ontario.

The document is based on published and grey documents and several key informant interviews. It is mainly based on the experiences of primary care commissioning groups (local organizations that plan, fund, oversee and sometimes deliver care for a defined population) in the United Kingdom (U.K.), Australia and New Zealand. Where applicable, it also includes insights and parallels from the implementation of Family Health Teams (FHTs) and Health Links in Ontario. These jurisdictions have had fund-holding/commissioning roles in primary and community care for some time and have subsequently implemented various changes to these models. This brief reviews the structure and the successes and challenges related to local-level planning and commissioning models, as well as critical factors to consider at the initiation of change, the key levers of change, and the requirements for organizational development and management.

Start-Up Considerations

Experience and evidence indicate that there are a number of key considerations for initiating and implementing primary care transformation, particularly for implementing commissioning groups. Experience shows that when these factors are taken into account, implementation is smoother and the chances of success are greater. At start-up, the guiding principles for reform need to be identified and operationalized. Key considerations include the following:

Making a compelling case for change

Reformers need to make a compelling case for change. The evidence shows that the impetus for change is supported by a strong narrative indicating the potential benefits to clinicians, patients and the health-care system. Central authorities and sector leaders must be clear about the vision and goals of reform – they need to take moral leadership and clearly set out and stand by the aspirational goals for the primary care system.

Getting the right balance between prescription and experimentation

Striking the right balance between prescribed structures/processes and experimentation has been an ongoing challenge in health-care transformation. The balance between practice autonomy and accountability must also be addressed. While most would agree it is important to allow new initiatives to take a form that best reflects the local needs and environment, the Ministry should be definitive in its expectations, including governance structures, performance expectations and penalties for non-conformance, to ensure accountability for the investment of public funds.

Governance

Experience in several jurisdictions indicates that focusing on governance structures and processes throughout the system is critical to the success of transformation. Internationally, the nature and structure of the commissioning groups has evolved over time, often with a greater emphasis each time on corporate governance and skills-based boards and management. This increasing emphasis includes a greater focus on leadership, organizational development and change management.

The application process and requirements

The process by which organizations (or groups of organizations) apply to become commissioning groups is an important consideration for ensuring the creation of strong and effective entities. Both Australia and the U.K. underwent an extensive application process in forming and implementing the most recent commissioning groups. In the U.K., applicants had to complete an authorization process designed to test their core competencies; 80% initially failed to meet at least some of the assessment criteria.

How the funds flow

The way funds flow to primary care practices varies greatly across the jurisdictions studied and it can have varying effects depending on the structure and design of commissioning groups and the health-care system. Ontario's Price Report recommends incremental change, first with a separate stream of funding to family practices and then a merged system of funding flowing through the proposed sub-LHIN commissioning groups.

In each international jurisdiction examined, the fund-holding and flow of funds was varied, multifaceted and complex. Usually, core funding for family physician contracts is set by the central authority, but contracting and accountability may be to the commissioning group. Funding flows and mechanisms are critical to the nexus of control and to incentivizing change (as well as disincentives and unintended consequences) and high performance. There are strong arguments for having a central global budget at the local level for all primary and community-based care to increase integration and efficiency and improve performance monitoring. But important concerns arising from the nature of budget-holding and the flow of funds include the questions of how to

- Ensure the money follows population-based needs and issues
- Promote shared resources and economies of scale and bring groups together in this regard
- Expand services using resources saved by economies of scale and other efficiencies
- Track, monitor and enforce accountability
- Define and clarify who is the funder and who is the service provider

- Address conflicts of interest, especially where family physicians have dual roles with the commissioning groups and their practices

Clarity of roles and responsibilities

The roles and responsibilities of the various stakeholders must be clear in the devolution of primary care to a population-based, locally commissioned model. Central authorities must provide a clear vision for primary care and other community-based health services. They also need to establish a comprehensive strategy that supports family practice and other primary care providers in developing extended roles. Central authorities play a role in strategic planning, establishing system priorities, providing guidance on quality and access standards, defining the core contract and enabling peer-led change. In delegating responsibility to the local level, administrators and clinicians need to be confident that the stated roles and responsibilities and associated authority will in fact be delegated.

During transformation, local commissioning groups play a role in supporting practices in managing change related to the new organizational arrangements. This support can include

- Defining expectations and contracts for service delivery
- Providing analytical and business development support to help practices create and implement business plans
- Providing professional development for the skills needed for organizational change
- Supporting priority-setting and strategic planning by developing local structures and facilitating collaborative efforts to develop local plans

Internationally, the role of commissioning groups was central to the successful implementation of change.

In relation to quality improvement, it is important to define the roles and responsibilities of the various central and regional bodies. It must be clear who is providing leadership, defining goals and targets, taking responsibility for achieving them, engaging and supporting family practices, and monitoring and responding to suboptimal performance.

The role of family physicians must also be well-defined and expectations clearly articulated. If part of the rationale for creating commissioning groups is to engage clinicians, increase their role in local decision-making and benefit from their expertise, commissioning groups need to build and sustain local family physician engagement and clearly define physicians' roles. Family physicians can be involved in a number of ways, including dedicating administrative time to the commissioning bodies as staff or board members, acting as practice representatives, participating in local reform consultation and planning sessions, or acting as practice leaders and champions.

The time required for change to take place

The evidence is clear that reform initiatives need to set realistic timeframes for achieving desired outcomes and managing risk. It takes time for providers to learn new ways of working and to implement changes that improve effectiveness and efficiency in the longer term. Internationally, commissioning models have evolved over time. Few of the models remained static and most changed based on experience during implementation (and changes in government).

As well, various aspects of the models were introduced incrementally. Some models started with reform model pilot projects, while others started by focusing on a particular aspect of the reform, with changes to other components following. An important lesson from these jurisdictions is that early changes influence how the reform evolves. Thus, the first step is critical and lays the groundwork for what follows. The way reform is initiated needs to be designed with consideration of the ultimate goals and the steps that must follow.

As well, clinically led organizations holding budgets and taking financial risk can take time to gain stability and deliver change and, thus, generally do not take on full global risk from the start. For example, in the U.S., most of the emerging Accountable Care Organizations have opted for gain-sharing contracts in their early years, rather than a mix of gain-sharing and risk-sharing.

Realistic estimates of the costs of transformation

International experience indicates that in addition to considering the time involved in transformation, adequate attention must be given to the costs of supporting successful transformation. Many health reform initiatives have faced challenges related to not having enough transition funding to support the process of change or one-off costs. Adequately financing change can increase the likelihood of success, improved efficiency and better outcomes. The following are some considerations for funding change:

- Assessing underlying financial viability
- Assessing local funding allocations and planning for funding continuity
- Knowing the costs of setting up a new organization, infrastructure and team
- Ensuring that project management and organizational development are funded
- Securing resources for dedicated transformation teams staffed by individuals with change management skills and credibility with clinicians to manage and drive the change process
- Providing short-term, external support to inject energy, pace and expertise
- Securing professional time for participation in change initiatives
- Sourcing resources for skills development and leadership training
- Funding visible improvements – “quick wins” – that can build momentum, demonstrate commitment and boost morale
- Funding staff or facilities to ensure service standards
- Investing in financial incentives
- Investing in engagement and collaboration activities

Geography

Internationally, some commissioning groups were aligned with the boundaries of the LHIN-equivalent regional health authorities; some groups spanned several authorities. This latter approach has strengths and weaknesses. It has hindered the ability of regional authorities to streamline activities within their geographic boundaries, and family practices may have commissioning agreements with more than one commissioner. However, some providers have achieved economies of scale by contracting with more than one commissioning groups across a wider geographical area.

A 2014 review of commissioning in Australia found a

> lack of alignment has hindered governance, shared purpose and collaboration, and stymied effective strategies to integrate care, for example hindering multi-disciplinary clinical engagement to create locally relevant clinical health care pathways. Alignment of geographical boundaries is a necessity for clinical alignment and to support patient flows, as most submissions and stakeholders agreed. In some jurisdictions creative approaches may be required to achieve alignment.

Levers for System Change

The literature, and international and national experience, shows that a number of levers support transformation of the primary care system locally, regionally and more broadly. The literature suggests that a combination of approaches – both "prod" and "supportive" – at the organizational, practice and individual levels is often the most effective. The critical levers for primary care system transformation that need to be explored and addressed are as follows:

Acknowledging and addressing barriers to change

When first engaging in reform, it is important to identify, discuss and address stakeholder concerns and perceived barriers to implementing change. This step includes acknowledging the change process and addressing challenges related to resources, time, resistance to change and level of effort.

A change in culture and a culture of change

A change in culture

Across international jurisdictions and across Ontario, many believe it is time for a transformational culture shift within family medicine and that this shift should be reinforced by a systemic structural change. Some argue that without a change in culture, any reform will be flawed and will not achieve its goals. Primary care leaders need to speak out decisively for the aspirational goals of primary care and the health-care system. Some suggest that to ensure real transformation in Ontario, family medicine needs to strongly advocate its vision for primary care and support the voices of leaders, visionaries and younger family physicians over those of dissenters.

A culture of change

In addition to a change in culture (or in the ethos), transformation efforts require a culture of change to be firmly in place. According to one U.K. report on transforming family practice, "the development of this kind of culture is a necessary part of the transformation itself." Change occurs in environments where the culture is open to it and supports it. A culture of change has been described as one that engages people in decision-making based on "co-produced organizational values" and "a motivated workforce that responds to the vision and opts in by committing to improvement activities."

Developing a culture of change can mean convincing people that i) there are critical issues to be addressed and ii) the problems they believe to be intractable can in fact be fixed. In addition to needing motivation to make change, individuals need to see value in the improvement activities over and above their usual roles and they need to be supported in taking action and overcoming the challenges they face when implementing change. A report on accelerating change in the

National Health Service (NHS) speaks of needing "headspace to make change happen" and suggests this entails thinking beyond the day-to-day and creating the culture and attitude that "improving services [is] seen as part of their day job."

Key ingredients for addressing culture

A number of key elements support both a change in culture and the development of a culture of change. Both can be strengthened by

- A more positive tone and rhetoric about the health system and its reform goals
- A critical mass of clinicians actively supporting and advocating for change
- Support for clinicians who take leadership roles that may set them apart from, or against, their peers
- Identifying and nurturing potential clinician leaders
- Role modelling by clinical leaders
- An openness to working together
- Clinician involvement in the design and delivery of the reform initiative
- Developing and advocating for clinical standards, guidelines and performance benchmarks
- Addressing constraints imposed by external stakeholders and professional allegiances
- Central authorities working to create a common understanding and solve common problems
- Increased outreach, meetings and sharing among stakeholders
- Coordinated action across the health-care system
- Creating a sense of ownership
- A strong evidence base for change

Additional methods shown to support a culture of change in clinical practice are outlined in the body of this report. Many of them blend organizational systems and processes with reforming frontline professional practice.

Leadership

Leadership is another critical and defining factor in supporting change in primary care; it is discussed in the literature and by experts with experience in the field. "Leadership – particularly the ability to engage people with a clear vision for change, centred on patients – is arguably the most important factor for achieving successful change. Leadership needs to be collective and distributed throughout different levels of an organisation, with leaders facilitating collaboration and sparking enthusiasm." Some key attributes are associated with *transformational leaders* in health care – these are unique individuals who

- Set an aspirational vision
- Inspire, energize and mobilize people
- Create an evidence-based case and urgency for change
- Are strong and courageous enough to make real changes and to take the initiative rather than waiting for permission
- Visibly commit to transformation and act as role models, exemplifying desired behaviours
- Have a clear understanding of where the sector and/or organization is going, how to get there and how to communicate this direction and inspire others
- Engage stakeholders and frontline staff early and in a genuine manner

- Solicit expertise to solve problems and make better decisions
- Learn from the experiences of others, through trial and error and by taking risks
- Convince others there is a problem and that the solution is the right one and is possible
- Can develop clear, simple goals
- Can develop a credible reform plan and enable "quick wins" to demonstrate change
- Understand how to manage stakeholders, create "headspace" and have the courage to stand their ground on what they believe is right for their sector or organization
- Can successfully navigate "the politics"

High-quality candidates for leadership and senior management are needed to support system reform and ensure success. Experts speak of the importance of having people with the right expertise leading and supporting transformation. These change specialists need i) strong leadership skills to broker consensus and drive implementation and ii) advanced operational and managerial skills. The skills and capacities required (and that often need to be developed or augmented) include the following:

- The ability to identify and understand problems rapidly, to understand their root causes, to plan and prioritize how to solve them, and to manage implementation in a structured way (using data, staff knowledge, and experience and evidence from elsewhere)
- An understanding of how to manage and lead change, including long-term implementation
- The ability to draw on best practices and develop novel approaches to design solutions
- Practical experience in change and improvement methods and tools, and the ability to adapt and apply these to the specific circumstances
- The skills to manage and guide planning and implementation, including developing resource requirements, timelines, milestones, etc.
- The ability to train and empower others
- Skills for and/or a good understanding of data management and analytics and of performance measurement

Family physician engagement

Generally, there are two functions of commissioning groups that rely on different levels of physician engagement. The first function – commissioning services outside family practice – does not necessarily require the active involvement of a large proportion of family physician members; it requires sufficient clinical expertise and input to support decision-making. The second function – primary care planning – depends on all members engaging and accepting the role of the commissioning group in improving family practice.

The evidence shows that family physician engagement in commissioning reform initiatives and primary care reform in Ontario has ranged from "highly engaged" leaders to "dissenters." Reasons for dissent are numerous but are often a combination of practical constraints and philosophical objections. A commonly cited barrier to engaging members with the work of the commissioning groups is the lack of time and capacity in family practice. Membership in commissioning groups can entail more stringent contractual arrangements, an increased demand on physician time, more paperwork and wider policy measures. There is also concern among physicians that the devolution to local commissioning may cause (or appear to cause) them to make rationing decisions, especially during times of fiscal constraint. Other general practitioners

(GPs) suggest, however, that "this concern is overstated and balancing the concerns of individual patients against a responsibility towards the wider system has always been a central part of a GP's role."

New governance structures associated with commissioning groups need to support physician buy-in and engagement. The extent to which physicians feel they have ownership of the commissioning group influences their level of engagement. A review of the system in Australia found that "there needs to be GP buy-in at both the governance and operational levels and for them to be able to see [the] benefit of their involvement." In Ontario, while this sense of buy-in was achieved in some FHTs, others have not met their full potential. According to a family physician in one FHT, "I would like to see more integration and collaboration between the physicians in the FHN [Family Health Network] and the FHT. We could do more in terms of integrated care and I don't think we have accomplished everything that we can."

In the U.K., most engagement with commissioning groups and input on decision-making is achieved through GP representation on the governing body and via practice representatives who participate in members' councils. The members' councils were designed to represent member practices within the commissioning group and were expected to play a role in setting the direction of the organization. GP representatives on the councils are to act on behalf of their practice and provide information to other members. Some constitutions hold practice representatives partially accountable for the behaviour of their practice colleagues.

Based on the evidence and experience of those implementing commissioning groups, critical factors found to support family physician engagement include the following:

• Communicating a clear vision of the reform objectives, including aspirational health system goals and a focus on quality improvement • Communicating a vision that describes how the reform and new entities are distinct from previous structures and organizations • Ensuring members understand the most important elements of the commissioning body's mandate and constitution • Prioritizing member relationships and cultivating a sense of collective ownership • Having a governance structure that supports the involvement of local clinicians in decision-making and delegates power where appropriate • Defining the roles of members, practices, the commissioning body and other governing bodies, with a clear understanding of authority and responsibility at each level • Clearly defining the role of the commissioning body in implementing quality improvement in primary care • Supporting peer-to-peer dialogue and performance review in small groups, particularly through face-to-face meetings	• Demonstrating early successes • Holding educational and other events (e.g., educational sessions, presentations by members of the governing body to the membership, forums for idea exchange and development, information sharing, presentations by other services) • Having websites or intranets with ready access to information • Enabling virtual communication with members • Enabling virtual and direct feedback mechanisms (e.g., feedback on concerns about commissioned services) • Creating telephone hotlines or other mechanisms to provide ready access to members of the governing body • Making practice visits in which commissioning body leaders meet family physicians, exchange information, seek volunteers and gain a better idea of what services are needed

Developing a foundation of integrated decision-making and collaboration

Another important lever supporting change to health system structures and delivery in a commissioning environment is having (or developing) a strong foundation for inter-organizational collaboration and working relationships with local health and social service providers. This foundation facilitates the creation of a health *system*. Levers for increased collaboration within primary care, and with the health system, include

- Aligning incentives for collaboration
- Having a sense of urgency and/or willingness to innovate
- Having positive working relationships among stakeholders
- Having support for the strategy and transformation efforts from commissioners, regulators and other organizations in the health system
- Considering participants' priorities, the dynamic of interactions and whether the focus is short or longer term
- Collaborating with other system organizations to solve specific problems (e.g., primary care and social services working to improve flow along the emergency pathway)
- Interacting with other local providers but not expending excess time and resources addressing problems beyond the particular organization's scope

Financial incentives

Several jurisdictions have used various funding models and financial incentives to spur change in primary care and much has been written on this topic. While micro-incentives have been found to result in improvements in targeted areas of care (but not wider quality improvements in non-incentivized areas), some suggest that financial incentive programs can be ill-suited to contexts of high goal ambiguity and complexity. Incentives can lead to prioritization of some goals over others and other unintended consequences.

In the U.K., GPs were thought to be trying to respond to too many different incentives at the same time and were overwhelmed by the combination – and competing priorities – of national and local incentive schemes and contractual performance measures. A report on transforming family practice in the U.K. concludes that "a different balance is needed between initiatives focused on clinical quality and outcomes and those which seek to redefine the role of primary care in whole-system changes. It is vital that policy-makers understand the impact of the various levers that they use and how they interact with each other."

Other funding levers have been shown to support change; such levers include funding for clinician training and capacity building, support for evidence-based education, and funds for family practices to contribute to redefining care pathways and reconfiguring services. This approach was referred to by an international physician leader as "paying for professionalism not performance."

Performance measurement, benchmarking and targets

The evidence is clear that data and measurement systems are critical to reforming the delivery of primary care and transforming the health-care system. Information technology use was widespread and data drove much of the planning, implementation and monitoring of commission groups internationally. Reform that incorporates data and measurement is characterized by

- Transparent measurement with simple measurement tools
- Getting the data collection and monitoring systems right
- Appropriate and supported information technology infrastructure
- Functionality that supports collating data and benchmarking
- Systems that support quality improvement efforts and the sharing of best practices
- Timely availability of data
- Regular checks and audits
- Access to data throughout the system, organization and practice

Commissioning groups in the U.K. had several mechanisms for supporting quality improvement in family practice through audit and measurement. These mechanisms include

- Setting performance targets
- Sharing comparative performance data
- Providing education and information
- Facilitating peer review and peer pressure
- Providing financial incentives
- Establishing referral pathways, protocols and management centres
- Having medical audit advisory groups and clinical audit programs
- Imposing sanctions on underperforming practices
- Organizing practice visits to discuss performance problems
- Expelling underperforming practices from the commissioning group

Organizational Development and Management

Transforming to population-based commissioning models requires significant efforts in organizational development and management at the organization and practice levels. Key areas for focus and development are outlined below.

Addressing organizational barriers to transformation

Leaders and managers need to address several barriers to transforming health-care organizations from the start. Barriers need to be acknowledged and resolved to ensure successful transition.

Managing health organizations for transformation

Another critical component of a shift to commissioning groups is the development of effective organizations at both the commissioning group and the practice/service levels. Effective management structures – including rigorous strategic approaches, governance structures, change management processes, incentives, performance metrics and accountability – are needed at start-up and beyond. The following are some of the features that support the development of strong organizations:

- Clear accountability for reform initiatives, from the board through to the front line
- Management's commitment to seeing the reform plan through, including the way boards and funders hold organizations accountable
- Strategic business plans that translate a vision into an implementation plan

- Implementation plans with strategies for organizational development, workforce development and financial viability
- A structured approach to implementation, including measurable goals, milestones and performance scorecards; these tools need to be used consistently and systematically
- Effective management structures to monitor performance, manage and track progress and hold people accountable (some organizations set up a separate governance structure for the transformation program to increase top management's level of attention and to encourage more strategic or transformational approaches)
- Skilled administrative and clinical leadership
- Clearly defined, evidence-based standards of care that are supported by clinicians and that create a focus for improvement through clear, common goals
- Multi-method training initiatives

Developing an enabling environment

An enabling environment supports and drives organizational change. Such environments are created by organizational policies, as well as national/central standards, explicit permission from central authorities and politicians to take risks and learn from mistakes, governing policies (e.g., financial incentives) that do not hinder change, and strong local relationships. The key factors that support an enabling environment in the implementation and management of commissioning models can include the following:

• External pressure for change • Central authorities that are amenable to change • Local support for change and/or local politics being addressed • Constructive relationships with authorities • Commissioners that are engaged in and support change • Cooperative inter-organizational networks • Consideration of external contexts – market, information technology, political, regulatory, social, cultural • Acknowledgement of complex, high-risk environments • Removal of obstacles • Balance of incentives and sanctions	• Alignment of organizational incentives and priorities with improvement activities • A focus on established best/good practice and any gaps between current and ideal performance • Consideration of financial context • Flexible payment structures • Navigable health-care structures • Participation seen as attractive for staff, including opportunities for career progression and role variety • Close attention to communication with all staff • Skilled strategic and operational managers executing organizational development initiatives and improvement projects effectively

Planning and change at the practice level

While many primary care practices have undergone significant reform in Ontario, most have not. The introduction of commissioning groups will likely require even more complex change processes at the front line of service delivery, including increased networking and partnering among providers. To support change, practices will need staff with business and organizational development skills and the capacity to manage the workload associated with change, and who also understand the nature and culture of family practice.

The following are examples of factors that support planning and change at the service delivery level within a population-based, commissioning environment; some were mentioned above.

• A common vision to provide community-based integrated care to enhance patient care • A dual narrative about benefits to patients and how participation in coordinated care initiatives will make the workday easier • A strong foundation of integrated work that new initiatives can build on • Leadership across primary care, community and social services, promoting joint work and collaboration • Administrative and financial support to help form networks • Increased mergers, partnerships and networks • Investments in leadership training, meetings and project management to support implementation • Regular meetings among member practices and networked practices • Workshops and "action learning sets" with family physicians, community health and social services workers, and other professional groups to develop shared goals and values and aligned working practices • Incentives to attend network, multidisciplinary and educational meetings • Improved integration of family medicine and community and specialist services	• New working relationships between GPs and specialists • Involvement of frontline staff in designing and implementing practice change • GP partners' willingness to personally invest time and financial resources • Increased career opportunities for partners and staff • Diversification of income streams with less reliance on a core contract to increase business sustainability • Shared practice resources to increase efficiency • Professional education and development of clinical and organizational skills by family physicians • Peer review • Development of shared approaches to support change and performance improvement initiatives • Incentives to practices to develop care plans, care pathways, medical directives, etc. • Adoption of best practices and of standardized clinical care and management processes across sites • Investment in information technology • Better use of data to monitor care and drive change

Hiring for cultural fit

Transitioning primary care practices and organizations need staff that reflect the aspirational vision and values of the organization. In Ontario, some FHTs experienced significant human resource challenges in this regard, which impeded their overall performance. Several FHTs altered their hiring practices based on early experiences. Some turned away potential hires or let staff go if they did not fit in with the organization's philosophy. Some FHTs left positions vacant rather than hire people they believed would be detrimental to the team and not fit into the team culture.

Standardizing clinical and management systems to support change

Some primary care practices and organizations use standardized internal processes and systems to support change and maintain quality. Poor management processes and unclear lines of accountability can detract from the organization's ability to perform consistently and efficiently. As well, some suggest that the lack of standardized operational processes within practices can reduce the time and space needed to focus on reform and practice improvement.

Internationally, primary care organizations have standardized systems in several ways. Some used jointly developed care pathways, guidelines and protocols as tools for changing clinical and referral practices within clinics and across the system. Others had standardized, systematic approaches to quality improvement and assurance across all sites and had internal "turnaround teams" to ensure all sites delivered a standard level of clinical care based on key performance indicators. Others provided standardized room layouts, clinical pathways and operational processes, and held regular meetings for peer review of treatment decisions and continuity of care during patient transitions between hospital and community.

Training and skills development

The evidence indicates that during change initiatives, individuals need skills to identify and solve problems. At least three types of skills have been identified as required for implementing change:

1. Technical skills, such as project management, clinical pathway design, change management and the use of quality improvement methodologies
2. Interpersonal skills, such as good communication, conflict management and negotiation
3. Learning skills, including collective reflection and debate

Various skills deficits have been identified in the primary care workforce that can limit its ability to deliver transformed services in an integrated, population-based environment. These deficits include the following:

- A limited understanding of population health
- Weak relationships with community health and social service professionals and poor understanding of their roles and scope
- Poor knowledge and skills for strategic planning, business case development, standardized operating systems, management of innovation, performance management and governance
- Lack of skills required to work across organizational boundaries
- Lack of familiarity with technologies that can support and transform patient care, including consultations using new media
- Limited skills in data analysis and comparison to support quality improvement and peer review
- Failure to adapt consultation style and content to individual patients' needs
- Lack of methods for care navigation

Approaches (often multifaceted) that can increase clinician capacity for implementing change and improvement include these:

• A central network to coordinate training that is consistent, replicable and responsive • Identification of core competencies and the development of a single competency framework • Development of competencies across disciplines • Accredited courses • Training hubs • Formal education and professional development • Coaching, peer support and facilitated discussions • Workshops and action learning sets • In-house mentoring, leadership and skills training programs • In-service training as part of the job description/ requirement (e.g., for management and leadership roles) • Web-based training and information resources across a network of practices	• Increased exposure to new forms of patient consultation • Creation of time and space for staff from different professions to interact and participate • Increased collaboration and interprofessional work • Job performance appraisals and balanced scorecards for individual performance • Discussions with bodies responsible for professional training about broadening their curricula • Harmonization of workforce development strategies to ensure that newly qualified practitioners are capable of integrated and interprofessional practice

Considering size of practice groups and types of arrangements

The size of practice groups and the types of arrangements that are formed can also influence success within a commissioning environment. Small practices have limited infrastructure to improve patient access and augment services. They are more vulnerable to marginal reductions in income and usually have insufficient staff to respond to new service, clinical, administrative and regulatory demands. Larger practices generally benefit more in a commissioning model.

Nonetheless, it can be challenging to keep what staff and patients of small local practices value, while achieving economies of scale and maximizing opportunities for additional contracts. A study in the U.K. found that networked (versus merged) models could take transformation only so far without compromising the autonomy of individual practices, creating conflicts of interest and slowing decision-making. Significant effort and resources were required to create larger, single practices through mergers. But closer alignment of decision-making and a shared risk/ reward approach was felt to offer more potential and better long-term sustainability. Careful analysis is needed to understand the risks and opportunities as organizations grow.

Addressing conflicts of interest

Conflict of interest has been discussed in relation to commissioning authorities. While commissioners need to work closely with GP members and provider organizations, this cooperation can create conflicts of interest. Larger primary care organizations that take on additional commissioned work and operate in a market-based environment raise a real or perceived conflict of interest between family physicians as both commissioners and care providers.

The current Australian reform removed service delivery from the role of the commissioner (except where there are no other services) because of perceived physician conflicts of interest in governance and management roles. One study in the U.K. showed awareness of and some concern about potential financial conflicts of interest. One area team manager suggested that some GPs may not yet understand the extent to which conflicts of interest could be a

constraining factor in the future. There is also some concern about the role of GPs on the commissioning governing body. Physicians with a role in the commissioning group are to adhere to explicit local policies to manage conflicts of interest when bidding for new services. In some instances, GPs adopted either a provider or commissioner role to create separation within their organization. A report on the role of commissioning groups in supporting improvement in family practice concluded that,

> If CCGs [commissioning groups] are to help foster this kind of innovation, the issue of conflicts of interest will inevitably come to the fore. For CCGs to commission enhanced primary care services from local GP-led provider organisations without risking incurring reputational damage to GPs, it will be important that conflicts of interest are managed robustly. The extent to which this becomes a constraining factor that limits the development of new forms of general practice remains to be seen

Key Findings

A number of key themes have emerged from the evidence collected and interviews conducted for this brief. The successful implementation of commissioning groups will require a strong and vocal commitment – by governments, health authorities, stakeholder groups and clinician leaders – to the aspirational goals of a high-quality, patient-centred primary health-care system. This commitment includes the development of communication strategies and a strong show of support by family medicine for – and an acknowledgement of accountability to – health system goals. A change in the culture of family medicine is needed, along with the development of a culture of change at the practice level.

As part of implementing and supporting transformational change, strong, visionary, risk-taking leadership is required at all levels. A strong voice from family medicine in design and implementation from the start will support success. This means that many family physicians will need to take on leadership and, potentially, managerial roles throughout the system and may need to further develop their skills in this regard. International and local experiences have shown that strong governance and management structures, made up of individuals with deep and diverse skills, are essential to the transition to commissioning models.

The commissioning models in the U.K., Australia and New Zealand have evolved since their inception as strengths and weakness have been assessed and governments have come and gone. The same can likely be expected in Ontario. As was learned during the implementation of these international models, and by the experience with Family Health Teams and Health Links, there needs to be an appropriate balance between clear articulation of the model and its requirements – including governance and organizational structures, performance expectations and penalties for non-conformance – and allowance for the opportunity to experiment and innovate. The tensions associated with public funding of private organizations, and between the need to ensure clinical excellence and practice autonomy, also need to be addressed.

International experience has varied in terms of the number and size of commissioning groups, jurisdictional boundaries, the role of family physicians on – and the methods of engagement with – commissioning bodies, the role of commissioning bodies as funders and service providers,

financial incentives, and how funds flow to family physicians. These elements need to be explored for the Ontario models. Potential conflicts of interest for family physicians in this regard – as well as in other areas – must be identified and addressed from the start. Additionally, the roles and responsibilities of authorities at all levels need to be clearly communicated and understood.

A critical component of this primary care system transformation is change at the practice level, including greater collaborative working relationships with other providers and sectors and a focus on high-quality clinical care and an improved patient experience. A number of models for incentivizing high performance are discussed in this document, along with their associated pros and cons. The main consideration is that the approach must be multifaceted and consider the time and resources required for change. Internationally, there has been good success with family physicians taking leadership roles in terms of accountability and peer-led models for practice improvement, including formal peer-review programs.

Introduction

In early 2015, the Expert Advisory Committee on Strengthening Primary Health Care in Ontario provided the Ministry of Health and Long-Term Care with recommendations for redesigning the primary care sector (the Price Report). The Price Report built on five position papers on improving primary care delivery developed by the Primary Health Care Planning Group in 2011. It is anticipated that the Ministry will respond to these recommendations and propose greater devolution of the primary and community-based health-care sector to the local level.

While the details of such a transformation are as yet unknown, it is assumed that organizations responsible for planning and commissioning primary care services ("patient care groups" in the Committee's report) will be formed at the sub–Local Health Integrated Network (LHIN) level. While the transition may be evolutionary, these groups would be responsible for the planning and delivery – and potentially budgeting and funding – of community-based care for a defined population of residents.

In anticipation of this announcement, and to prepare itself to support its membership, the Ontario College of Family Physicians commissioned Dale McMurchy Consulting to develop this evidence brief to provide background and information that will help the College become more knowledgeable about this type of primary care model in other jurisdictions. The brief will also help the College prepare for, contribute to and shape the coming change in Ontario.

Primary care commissioning groups are local organizations that plan, fund, oversee and sometimes deliver care for a defined population – much like LHINs do for some health-care services in Ontario. This brief focuses on the structure and experiences of primary care commissioning groups in the United Kingdom (U.K.), Australia and New Zealand. While none of these jurisdictions have models exactly like the potential Ontario model described in the Expert Advisory Committee's 2015 report, they have had fund-holding/commissioning roles in primary and community care for some time and have subsequently implemented various changes to these models. Some changes are quite recent: a different commissioning model was introduced in Australia in July 2015, and the U.K. changed part of the funding arrangements for its commissioning model in 2014.

This brief reviews the general structure and the successes and challenges related to local-level planning and commissioning models for primary and community care, as well as critical factors to consider at the initiation of change, the key levers of change, and the requirements for organizational development and management. The discussion in this document focuses on international experience. Where applicable, this discussion includes insights and parallels from the implementation of Family Health Teams (FHTs) and Health Links in Ontario.

This document is based on the published and grey literature and on government and other national reports and studies, supported by several key informant interviews. It is important to note that the structure and implementation of the commissioning models in the jurisdictions reviewed are complex and contextual and have diversity and exceptions to the rule within. The key informant interviews were invaluable in describing the structure of the models (in their various forms) and the implementation experience of various sector stakeholders, especially family physicians. As well, the key informants later validated the documentation of the models' evolution in this report.

Jurisdiction Summary

This section outlines the history and structure of local primary and community care commissioning groups in New Zealand, Australia and the U.K. It also summarizes some examples of initiatives in Canada in which primary care reform has been implemented to improve access to – and quality, integration and comprehensiveness of – services.

New Zealand

Health system reforms in New Zealand in the early 1990s aimed to introduce a market model into the health sector through contracting arrangements between providers and newly formed government-funded commissioning groups. In response, general practitioners (GPs)[1] organized themselves into local Independent Practitioner Associations (IPAs). Most GPs became members of IPAs, which ranged in size from fewer than 10 physician members to 340 in a large association in Auckland (Pro Care Health) [Cashin 2011]. These organizations were formed mainly to protect the business interests of GPs; taking a more population-based approach to primary care was a secondary objective. Some IPAs moved to a capitation funding model, although they continued to pay individual GPs per patient consultation in addition to user fees paid by patients [Gauld 2000].

Most IPAs sought to implement electronic medical records (EMRs) at each member practice. IPAs used member data to track disease patterns and develop programs accordingly. These programs included promotion and prevention programs and integrated care initiatives. Some IPAs managed the pharmaceutical and diagnostic testing budgets for their patients and pooled the savings they accrued to fund other local health programs and initiatives [Bell 1997]. IPAs also provided member education, developed and disseminated clinical and prescribing guidelines, and undertook quality monitoring and improvement [Malcolm 2002]. A national Independent Practitioners Association Council was formed to represent and coordinate member activities and share information.

In 1996, New Zealand established a single purchaser for all health services (the Health Funding Authority) and many IPAs merged to consolidate their bargaining power with the new purchaser. In 1999, the Health Funding Authority was abolished and replaced by 21 new District Health Boards (DHBs) with the aim of increasing local involvement in health-care policy and planning, improving equity in financial allocations and improving service delivery and outcomes.

In 2001, a new funding model was introduced specifically for primary and community care. Primary Health Organisations (PHOs) were established to provide primary care services either directly or through their provider members. The aim of this model was to ensure GP services were better linked with other local health services and to improve coordination of care. Unlike IPAs, PHOs were to be community-owned and -governed, with community representation on governing boards and the expectation of public consultation in their planning and decision-making. PHOs were to be multidisciplinary, including GPs and a range of other primary care providers. Many felt that PHOs were formed in a top-down fashion with minimal consultation with frontline providers [Gauld 2000]. The extent of clinical involvement in PHOs therefore varies considerably [Smith 2009].

[1] In New Zealand, Australia and the U.K. primary care physicians are universally referred to as general practitioners (GPs).

The PHOs did not replace IPAs. Many IPAs continue to provide management and support services for their members and some of the larger PHOs rely on IPAs for management services [Gauld 2008]. As well, some IPAs became PHOs, while others remained separate entities. As a result, there is a lack of clarity in the role of PHOs and how they relate to IPAs and District Health Boards in some instances [Gauld 2008, Smith 2009, Cashin 2011].

PHOs receive capitation funding via the District Health Boards to provide primary care services based on patients enrolled through GP members. There are 32 PHOs in 2015, which vary in size and structure. By mandate, they are not-for-profit organizations. PHOs compensate GPs for core services based on a government-determined capitation rate, which provides approximately half their income; patient co-payments, set by individual GPs, provide the rest. Patient registration is not mandatory, but GPs and PHOs must have a formally registered patient list to be eligible for higher government rates. (GPs who are not members of a PHO are reimbursed at a lower rate). PHOs also receive additional per capita funding for promoting health, coordinating care, improving access to care for those with financial barriers and providing additional chronic care services. In some cases, this funding has supported the development of interprofessional teams. Until July 2015, PHOs also received a small amount of funding if member GPs collectively reached quality and service delivery targets for immunizations and for cancer, diabetes and cardiovascular disease screening and follow-up. These data were reported publicly [Cashin 2011, Ashton 2015].

Clinical practice and clinical leadership structures within a PHO function separately from management and governance. Clinical leadership groups were facilitated by PHOs to gain provider input on policy and planning. These groups take different forms, but are mainly composed of clinical leaders and GPs from most member practices – and sometimes nurses and/or practice managers – who provide input and relay information to practices. PHOs with a larger number of practices also have smaller group meetings with practice staff. Clinical leadership was supported in implementing change by practice champions, the development of strategies and best practices (often linked to peer support and education) and visits to poorer-performing practices by PHO practice support teams [Smith 2009].

An assessment of the strategy found that the PHO model has helped to develop a more population-based approach to local planning and funding. However, given that the funding approach did not mitigate patient co-payments, financial barriers to access remain and the direct co-payment component of physician remuneration limits the PHOs' influence with family practice [Smith 2009].

In 2008, the New Zealand government introduced Integrated Family Health Centres (IFHCs) to promote greater integration of the care provided by District Health Boards and PHOs; IFHCs received funding from both. These services are based outside hospitals and operate through collaboration agreements. They provide chronic disease management, care coordination, after-hours services and some minor elective procedures for an enrolled population [Ryall 2008, Ministerial Review Group 2009].

Since 2013, new PHO contracts require alliance-governance arrangements between PHOs and District Health Boards modelled after the IFHC program, with an aim to improve integration of care (GP, specialist, hospital, etc.) for the population in a region. With this shift in the governance model and structure for all health services, local clinical leaders, managers and community representatives are meant to collaborate on priority-setting, decision-making,

planning, sharing resources and delivering services, with a primary focus on integration. Many alliances are creating additional clinically led "service level alliances" focused on different areas of care. Alliances also support the development and implementation of clinically supported care pathways and evidence-based guidelines for treating patients with integrated care requirements.

To support the alliances, a more flexible funding arrangement allows PHOs to allocate previously "ring-fenced funding" (such as funding for enrolled patients with chronic conditions) to new priority areas, with District Health Boards also contributing to these initiatives. In July 2015, a new Integrated Performance and Incentive Framework replaced the former primary care reporting framework. The new framework rewards performance against measures reflecting the level of integration within a region [Smith 2009, Mossialos 2015, Ashton 2015].

Australia

In Australia, federal health insurance (Medicare) and national pharmacare (the Pharmaceutical Benefits Authority) fund much of primary care. GPs receive 90% of their total payments as fee-for-service. Accredited practices also receive incentive payments for meeting the Royal Australian College of General Practitioners standards related to information technology, after-hours care, chronic disease management, teaching and other activities [Mossialos 2015, Auditor General 2010]. Care coordination is incentivized by Medicare benefits for integrated care plans for patients with complex needs. There are also incentives for having practice nurses. Interprofessional teams are found in state- and territory-funded community health centres and, increasingly, in large general practices.

Individuals are not required to register with a GP, although most people use the same practice for most of their practice visits [McRae 2010]. Physicians invoice patients after each visit. Patients can assign their Medicare benefit to a physician, who can then "bulk bill" the government for all registered patient visits if no co-payment is charged. About 80% of services are billed directly to the government. If a co-payment is charged, the patient pays the full amount and claims reimbursement.

The Government of Australia created not-for-profit Divisions of General Practice (DGPs) in the early 1990s to support family practices in quality improvement, promote integration with other health services, address population health issues within their jurisdiction and fund specific health-care programs. DGPs did not have a clinical role, but provided infrastructure support to practices in their regions and were a means by which population and public health initiatives could be implemented in primary care [Davies 2009, Russell 2002] DGPs were governed by boards of directors (predominantly GPs) and managed and run by administrative staff. Umbrella organizations supported over 120 DGPs in each state or territory and nationally (the Australian General Practice Network).

In 2011, the Australian government replaced the DGPs with Medicare Locals in order to improve coordination and integration of primary care in local communities, address service gaps and make it easier for patients to navigate the system. Medicare Locals were expected to engage the primary care sector, communities, the Aboriginal Community Controlled Health Service sector and Local Health Networks (LHNs). Medicare Locals continued much of the work of DGPs and extended their mandate to population health planning. The government also established the Australian Medicare Local Alliance to support the 61 Medicare Locals – half the number of former DGPs.

Preparing for a Devolved, Population-Based Approach to Primary Care

Medicare Locals were formed to address system fragmentation and a few had success in integrating care and improving primary care services. DGPs undertook comprehensive needs assessments. Taking a new approach, Medicare Locals completed an initial needs assessment and population health plan and then sought to develop capacity for further program planning and service development. Many worked with external partners in this regard.

Medicare Locals were responsible for distributing government after-hours incentives and a range of chronic disease programs, with some achieving a "reasonable reach," especially in mental health. As well, there were common integration strategies, such as developing information systems and single points of referral. Medicare Locals also provided practice support, continuing medical education (CME), support for information technology, improved service networks, and agreed pathways for coordination of care. Some Medicare Locals had started to collaborate with each other, but during their short tenure achieved limited coordination and collaboration at the state level [Key informant interviews 2015, Horvath 2014].

Results were mixed. According to one reviewer, "their main resource is leadership and persuasion, with little direct authority over most primary health care services, and so should perhaps be seen as coordinators of primary health care improvement rather than drivers of major change" [Key informant interviews 2015]. As well, Medicare Locals had not received clear direction on the approach to service delivery. As a result, that approach varied among Locals – they acted as coordinators or facilitators of services, purchasers and/or direct service providers. Most started mainly commissioning services, but over time developed a greater focus on direct service delivery (sometimes competing with existing services). The combined approach to service delivery by Medicare Locals caused some confusion among providers about their purpose. As well, there were challenges related to governance and conflicts of interest for the GPs involved in governance with relation to commissioning and service delivery [Key informant interviews 2015, Horvath 2014].

The transition from DGPs faced some challenges, especially where a Medicare Local was made up of more than one former DGP. Membership and board composition of the Locals was intended to better represent the primary care sector and the community than DGP membership and boards had. However, some reports indicate that governance skills and capacity were still insufficient to fulfill the mandate in several of the new organizations. GPs were well represented on boards and efforts were made to engage member GPs. Some GPs had the impression that Medicare Locals were still essentially GP organizations [Key informant interviews 2015], while others believed the more inclusive model disengaged physicians [Horvath 2015].

After no more than three years, Medicare Locals were abolished and a new model – Primary Health Networks (PHNs) – was implemented in July 2015. The PHN model differs from Medicare Locals in that there are only 30 networks. The application process to become a PHN has been more rigorous and PHNs have more explicit guidelines for governance and commissioning. The focus for implementation has been on experienced, skills-based governance and management. PHNs are meant to be leaner organizations that will use national and local data and information to define regional needs and to commission services to address them.

PHNs will not deliver services unless those services are otherwise unavailable. As well, the PHN mandate to work with Local Health Networks has been strengthened and they are expected to work with state and federal agencies to pool resources and implement services (as high-performing Medicare Locals had done). Each PHN will have a clinical council and these will be

linked to hospital councils. GPs will lead the clinical councils. In larger PHNs, there will be an umbrella council body comprising all the chairs of local clinical councils and that body will report to the board. PHNs – like many Medicare Locals and DGPs – will have community advisory committees.

United Kingdom

The U.K. has a relatively long history of health-care commissioning. The underlying motivation has been to increase efficiency through a purchaser/provider split to reduce waste in the system and better meet patient needs. GP fund-holding was introduced in 1991, after which GPs could opt to control the budget for a defined range of elective, outpatient and community health services, either as a single practice or through a group of practices. By 1997, approximately half of all family practices in the U.K had become fund-holders. In addition, 88 Total Purchasing Pilots (TPPs) were established in 1995 and 1996. In TPP sites, GP-led groups could manage the budget for all hospital and community care, although none did so in practice, choosing rather to focus on specific areas of local concern [Mays 2001].

In 1997, the new Labour government abolished GP fund-holding and total purchasing, citing concern that fund-holding was more prevalent in affluent areas, leading to unequal access to care. Primary Care Groups were established to replace GP fund-holding in 1999. These groups were composed of GPs and other professionals, as well as managerial staff from health authorities; they were meant to take over health authority responsibilities over time, ultimately becoming autonomous Primary Care Trusts (PCTs). However, in 2001, the government decided all Primary Care Groups would become PCTs and assume full commissioning and public health responsibilities, as well as directly providing community and sometimes other services (e.g., mental health).

The shift from Primary Care Groups to PCTs was associated with a reduced level of clinician influence in these organizations [Regen 2002, Smith 2004, Bate 2007]. Decisions regarding clinical services were increasingly made by managers rather than clinicians. Clinicians remained engaged through professional executive committees, although the power of these committees varied.

A national survey of Primary Care Groups/Trusts found that most had failed to win the support of their local GPs [Wilkin 2001]. In response, the government announced an adapted form of primary care commissioning known as practice-based commissioning [Department of Health 2004]. Starting in 2005, GPs formed Practice-Based Commissioning Groups and were allocated a budget by their local PCT. The extent of delegation of responsibilities varied, but formal powers, risks and accountabilities remained with the Trust. This arrangement was sometimes marked by poor working relationships between Practice-Based Commissioning Groups and the PCT [Curry 2008]. As well, these physician groups tended to focus on increasing the amount of speciality care provided within family practices.

The *Health and Social Care Act* 2012 abolished 150 PCTs and replaced them with Clinical Commissioning Groups (CCGs), of which there were about 210 across England in August 2015. The goal was that these clinically led bodies would "optimize resources in decisions about planning and purchasing a wide range of care for their local populations." CCGs now control about two-thirds of the total National Health Service (NHS) budget, including hospital, specialist and community-based services. CCGs are overseen by NHS England – a non-departmental body

accountable to the Secretary of State for Health [Mossialos 2015]. Core GP services are commissioned by NHS England.

CCGs differ from PCTs in their governance: membership is mandatory for all family practices; they are statutory bodies; they are autonomous, hold the budgets and assume full financial risk; and the governing body must be chaired by a GP and include other clinicians along with managers. A minimum number of GPs must be members of the governing body. Some, but not all, CCGs have a GP majority on the board. Member practices elect clinical leaders to the governing body, although several CCGs reported many key posts were uncontested [Naylor 2013].

The following are examples, from a CCG constitution, of governing body and member responsibilities:

Governing body's responsibilities to its members:

- Ensure members are familiar with relevant policy and guidelines
- Promote involvement of all members in the work of the CCG in securing improvements in commissioning of care and services
- Listen to the views of members in making decisions

Members' responsibilities to the CCG:

- Work collaboratively and cooperatively with the CCG to achieve its aims, as set out in the commissioning strategy and annual business plan
- Adhere to commissioning decisions made by the CCG
- Manage patient care within the budget delegated to the practice level
- Seek to improve the quality of patient care and address areas of poor practice performance or care
- Be responsible collectively and individually for the delivery of the duties and functions of the CCG [Naylor 2013]

CCG arrangements vary significantly. A number of partnership arrangements exist among CCGs (usually so smaller CCGs can achieve economies of scale in their operations), including sharing senior management positions, joint commissioning and risk-sharing protocols. The majority of CCGs have members' councils that support GP engagement and local priority-setting. Each member practice has a nominated practice representative who attends meetings on behalf of the practice. The representative could be a GP, other health-care professional or, in some cases, the practice manager.

The environment in which CCGs operate differs from past environments in a number of ways. Commissioning functions performed by PCTs are split across three organizations – CCGs, local authorities (which control the public health budget) and the 27 area teams of NHS England (responsible for commissioning primary care and specialist services and supporting CCGs and holding them to account). CCGs have two main roles: they are responsible for commissioning secondary and community care services for their local populations and they have a legal duty to support quality improvement in family practice. The latter role was somewhat challenging to fulfill when NHS England is the commissioner of GP services [Naylor 2013]. As well, CCGs have a legal obligation to consider the local needs and priorities identified by locally established

community Health and Wellbeing Boards. These boards are intended to be a forum for improving input from and accountability to the local population.

In May 2014, NHS England announced that CCGs would be invited to "co-commission" primary care and, in April 2015, the majority of CCGs took on fully delegated or joint responsibility for commissioning primary care with NHS England. New responsibilities included designing incentive payments, performance-managing GP practice contracts, and commissioning "directly enhanced services" (DES), such as chronic disease management and after-hours programs. NHS Health retains control over the GPs core contract. Co-commissioning could take one of the following forms:

1. Greater involvement in primary care decision-making and closer collaboration with NHS England area teams
2. Joint commissioning via a joint committee of the CCG and NHS England area team, with the option to pool funding for investment in primary care
3. Delegated commissioning arrangements by new CCG primary care commissioning committees, chaired by a layperson and with a majority of lay and CCG executive members [Holder 2015]

For 2015/16, CCGs opting for joint or delegated co-commissioning could have the following responsibilities:

- Reviewing or renewing existing GP contracts and awarding new ones, including designing Personal Medical Services and Alternative Provider Medical Services contracts, establishing new practices in an area and approving practice mergers
- General practice contract performance management
- General practice budget management
- Complaints management
- Designing and implementing local incentive schemes, such as new local incentives to replace the Quality and Outcomes Framework (QOF) payments and directly enhanced services
- Making decisions on discretionary payments

CCGs do not receive additional resources to fund these new responsibilities and were encouraged to share staff resources with NHS England area teams [NHS England and NHS Clinical Commissioners 2014]. NHS England has retained responsibility for commissioning dental care, eye care and community pharmacy and for managing the performance of individual GPs. With this new system, some GPs reported they were unsure about when they were accountable to their CCG or to NHS England [Holder 2015]. Although most governing body members felt positively about co-commissioning (81%), a majority of GPs and practice managers without a formal CCG role felt negatively (26%) or were neutral (43%). Many may be waiting to see how the policy is implemented before forming an opinion [Robertson 2015].

Canadian Examples

There are Canadian examples of efforts to increase access, quality, coordination and integration of care at the community level. Over the years, the provinces have introduced regional authorities to fund and oversee health-care delivery. But these efforts have largely excluded primary care. The following are examples of increased networking and integration, with a greater focus on a defined population, at the primary care level.

British Columbia

Since 2009, 35 Divisions of Family Practice representing more than 230 communities have been formed in B.C. They are non-profit organizations funded by the provincial government and Doctors of B.C. with physician membership and representation on the Division's board. Each has an executive director and a physician lead. Divisions vary across the province in terms of membership and engagement.

The Divisions of Family Practice are groups of family physicians working together within a defined geographic area to advocate, recruit physicians, initiate programs or projects, provide practice support and undertake educational initiatives. Divisions also aim to work collaboratively with community and health-care partners to enhance local patient care. A province-wide initiative – GP for Me – aims to increase patient attachment to a family physician and improve the patient-provider relationship. The program provided $60.5 million in new fee incentives to enhance practice efficiency and support doctors' capacity to take on new patients, including new fees for telephone consultations, for the extra time required for patients with chronic conditions, and for taking on new patients (with different amounts for average patients and those with complex needs). GP for Me also provided $40 million in community level funding through to March 2016 to support the Divisions in conducting research related to unattached patients and identifying the strengths and gaps in local primary care resources, in developing a plan for improving primary care capacity and linking patients with doctors, and in implementing programs to address their findings. Many of the programs funded by GP for Me include patient navigators and increased collaboration with other health-care professionals.

Quebec

Over the past decade, Quebec has initiated two main reforms that affect primary care: i) Family Medicine Groups (FMGs) and ii) 95 geographically defined Local Health Networks (LHNs) across the province. A key goal of these reforms was to improve collaboration among health-care organizations. A 2013 study of 297 primary care practices (FMGs, network clinics, local community services centres (CLSCs) and private medical clinics) in 23 LHNs looking at formal or informal arrangements among practices and with hospitals found different patterns of evolution in inter-organizational collaboration among different types of primary care practices. The LHN was found to have had an impact on "territorializing" collaborations by i) reducing collaboration outside LHN areas for all types of practice and ii) improving vertical and horizontal collaboration among health-care organizations within LHN areas for all organizations, except for private medical clinics, where collaboration decreased inside and outside the LHNs [Breton 2013].

Alberta

Primary Care Networks (PCNs) were introduced in Alberta in 2005 through a tripartite agreement with Alberta Health, Alberta Health Services and the Alberta Medical Association, using $800 million from the Primary Health Care Transition Fund. PCNs are a network of physicians who work with other health-care providers such as nurses, dietitians and pharmacists. A PCN may have one site or multiple practices. Interprofessional health-care providers (IHPs) can be co-located with physicians, but often are not. There are about 40 PCNs across the province, with over 2,900 family physicians and 700 full-time equivalent IHPs who serve about three million Albertans.

Patients are not required to roster to a PCN, but are deemed to be attached to a practice based on use. PCNs receive payments (initially $50 per capita, increased to $62 per capita early in 2012)

over and above physician fee-for-service billings to "… support enhanced staffing (including administration), premises and equipment, chronic disease management, expanded office hours, and 24/7 access to appropriate primary care" [Alberta Primary Care Networks 2015]. Each PCN has the flexibility to develop programs to meet local needs. PCNs have been supported in quality improvement initiatives by the Alberta Medical Association, the Health Quality Council of Alberta and the Primary Care Initiative. As part of improving access to comparative data, PCNs have developed their own data sharing agreement under the auspices of the Primary Care Alliance.

The results of PCNs have been mixed, with some performing at a high level and others "failing to deliver on the basic statement of intent" [Reay 2012]. A 2012 Auditor General's Report "…found weaknesses in the design and implementation of the accountability systems for the PCN program" and that "the PCN program does not have defined service delivery expectations, performance measures and targets for individual program objectives" [Auditor General 2012].

In 2012, the Government of Alberta made an election promise to "provide every Albertan with a home in the health-care system" through the creation of up to 140 Family Care Clinics (FCCs) by 2016. FCCs were to be local, team-based organizations that provide primary care services aligned with the needs of the community. Team members may include nurse practitioners, registered nurses, family physicians, dietitians, pharmacists, mental health professionals and others. These clinics coordinate the provision of a range of primary care services, including diagnosis and treatment of acute and chronic conditions, screening, immunizations and links to other health services and community agencies. They emphasize wellness, health promotion, disease and injury prevention, self-management and chronic disease management. The clinics connect patients to social supports that influence health status, such as housing and employment services.

In April 2012, three pilot FCCs began operation, in Edmonton, Calgary and Slave Lake. According to Alberta Health's website, the government has decided that the FCC program will not be expanded beyond these three operational FCCs and the new Peace River FCC announced in Budget 2015.

Ontario

In Ontario, many Community Health Centres (CHCs) and some of the higher-performing FHTs take a systematic approach to planning based on their patient profiles and take an overall population perspective both in developing their strategic plans and identifying programs and services best suited to their patients. Some FHTs have updated their strategic plans with greater reference to community needs assessments, patient demographics and disease profiles. At one large FHT, each practice developed a one-year strategic approach based on the overall FHT strategic plan, with a focus on the needs of the patients it serves. This FHT is also developing practice profiles that include patient demographics, data from the LHIN and patient data from EMRs.

CHCs and some FHTs provide intensive, tailored, collaborative services for patients with the most complex needs. Staff in some FHTs have developed skills to support program development and implementation; a few have dedicated staff roles in this area. According to staff at one FHT, "We should be using the EMR for more population medicine instead of point-to-point patient care. We can look at the FHT population through the EMR and determine health markers to see where improvements should be made" [The Conference Board of Canada 2014].

CHCs have longstanding partnerships with various community services and programs. Some FHTs have worked to improve the comprehensiveness of care they provide by expanding the services available to their patients through partnerships with organizations such as the Canadian Association for Mental Health, local diabetes programs, the Alzheimer's Society, the Heart and Stroke Foundation, Community Care Access Centres, public health units, hospitals, schools and other community organizations. Several list community resources on their websites and/or provide a list of services to their patients.

Health Links was launched in Ontario in 2013 to improve the coordination and integration of care for the most complex patients in Ontario. There are currently 82 Health Links programs in Ontario that have reached approximately 17,500 patients. Health Links aims to support patients in their transitions through the system and develop comprehensive care plans for them. While some Health Links programs have been successfully implemented and are serving numerous patients, others have struggled to get off the ground. Lack of consistency within the model and the need for a stronger performance management framework has led to variable success. There have also been missed opportunities to achieve greater collaboration and economies of scale. In the future, there will be standardization of certain elements of the model, an emphasis on the foundational role of primary care in the program, LHIN discretion over funding, and enhanced performance management and oversight by LHINs.

Start-Up Considerations

Experience and evidence indicate there are a number of key considerations for initiating and implementing primary care transformation that apply particularly to implementing commissioning groups (local organizations that plan, fund, oversee and sometimes deliver care for a defined population). When these factors are taken into account, implementation is smoother and the chances of success greater. At start-up, the guiding principles for reform need to be identified and operationalized. Key considerations include the following:

- Making a compelling case for change
- Getting the right balance between prescription and experimentation
- Governance
- The application process and requirements
- How the funds flow
- Clarity of roles and responsibilities
- The time required for change to take place
- Realistic estimates of the costs of transformation
- Geography

Making a Compelling Case for Change

Reformers need to make a "compelling case for change" [Rosen 2013, The Health Foundation 2015]. The evidence shows that the impetus for change is supported by a strong narrative indicating the potential benefits to clinicians, patients and the health-care system. International experience, as well as the recent experience with the roll out of FHTs and Health Links in Ontario, supports this. Central authorities must be clear about the vision and goals of reform – they need to take "moral leadership" and clearly set out and stand by the aspirational goals for the primary care system. These goals include an interprofessional patient medical home,

integrated care, improved patient and provider experiences (including improved patient-provider relationships), better outcomes and reduced costs. An opportunity was potentially lost with the implementation of FHTs by *not* emphasizing a broader vision for primary care and instead focusing mainly on augmenting interprofessional teams.

For clinicians, a focus on quality is part of making the case for change, including an emphasis on reducing variation and improving the quality of clinical services. In many jurisdictions, this effort has been supported by regular audits, review of practice data, peer review and initiatives to standardize care and respond to specific quality problems [Rosen 2013, Barai 2015]. Other articulated benefits found to increase the likelihood of clinicians' participation in change include a better working day, improved patient outcomes, higher incomes and recognition or peer approval for working in new ways [Casalino 2011].

The compelling case for change must speak to all involved, especially those on the front line. For example, gaps between the perceptions of boards and those of their organizations can impede recognition of the need for change. Health-care boards have often been found to rate their organizations better than frontline staff do, and various stakeholders may identify different priorities. "Clinicians and others may argue that the problem being targeted … is not really a problem, that it is not a problem 'around here' or that there are many more important problems to be addressed before this one" [Dixon-Woods 2012].

System requirements also influence a movement toward change. In the U.K., GPs moved to merged or networked practices when they perceived that increased patient demands and contractual and regulatory requirements were overwhelming small family practices. Increasing the scale and scope of practice was seen as essential to create sustainable, efficient organizations [Rosen 2013].

A well-structured implementation and change management plan includes a comprehensive communication plan for presenting the narrative for change [Rose 2015, Key informant interviews 2015]. The communication plan needs to be well-resourced and target all stakeholders, including tailored messages with a multifaceted delivery system for family physicians and other providers who need to be well apprised of and prepared for the change. Some suggest that the communication plan is one of the most important elements of reform and that for family physicians it was somewhat adequate for the launch of the FHTs, but significantly lacking for the Health Links launch [Key informant interviews 2015].

Getting the Right Balance between Prescription and Experimentation

Striking the right balance between prescribed structures/processes and experimentation has been an ongoing challenge in health-care transformation. In Ontario, this has been the case with the implementation of FHTs and Health Links. While most would agree it was important to allow these new initiatives to take a form that best reflected the local needs and environment, many argue that the Ministry of Health and Long-Term Care should have been more definitive in its expectations, including governance structures, performance expectations and penalties for non-conformance, to ensure accountability for the investment of public funds [Key informant interviews 2015, The Conference Board of Canada 2014].

The 2014 evaluation of the FHTs and the Ministry's June 2015 update on Health Links show a "lack of model consistency leading to variable success." For Health Links, the Ministry concluded that the "low rules environment" has "stimulate[d] innovation and led to pockets of

excellence rather than a cohesive model of coordinated care delivery." Flexibility in the governance structure led to a lack of role clarity and inconsistency in the type of patients targeted, making success hard to measure and best practices challenging to spread [Advancing Health Links, MOHLTC June 2015].

These challenges are discussed in relation to implementing commissioning models in the U.K., Australia and New Zealand. Descriptions of those experiences confirm that it is important for authorities to outline parameters for implementation of system transformation and to provide explicit implementation guidelines, from whole-system reconfiguration through to care pathway redesign and performance indicators. However, some experts caution against excessive policies codifying transformation (especially for such a radical change), believing the focus should instead be on "creating a permissive culture for experimenting with new approaches to primary care." They suggest "a period of permissiveness is required – in which emerging GP organizations are allowed to experiment and, at times, to fail" [Rosen 2015].

One clinician lead of a physician network, later a commissioning group, described the importance of experimentation and piloting of organizational and clinical processes, including research-based trials. But the clinician emphasized the need for regular review and to accept the need "to sacrifice your baby" if it is shown not to be effective. (This is said to be easier when experimentation is considered a pilot.) [Key informant interviews 2015]. However, "a delicate balance will be needed between this permission and freedom to test out new ways of working and proportionate governance and accountability for the investment of public funds to support change" [Rosen 2015].

In Australia, the initial mandate of the Medicare Locals was fairly flexible. However, overall mixed results have been associated with the absence of a focused mandate and, thus, variations in the interpretation of their mandate and role. Variability in the scope of activities and delivery strategies resulted in – according to a recent review – "inconsistent outcomes across Medicare Locals, dispirited stakeholder engagement, poor network cohesion, and reduced sector influence." In some instances, there was duplication of effort, especially between jurisdictional initiatives and state-based population health planning, and in some places, Medicare Locals were regarded as competitors rather than collaborators. The reviewer concluded, "variability within the context of flexibility to respond to local issues is acceptable. However, variability in intent and performance is not" [Horvath 2014].

The other balance that needs to be considered is between professional autonomy and accountability. The argument for professional autonomy is legitimate, but often goes beyond what is necessary. The boundary between professional autonomy and accountability to the public purse needs to be explicit, and courage and leadership are needed to define those boundaries that reinforce professional autonomy but stop short of denying public accountability for quality and performance [Key informant interviews 2015].

Balance during implementation also relates to the extent that reporting, and ensuring the governance requirements associated with investment in transformation, are proportionate "to avoid sapping energy and stifling progress through overly onerous reporting arrangements" [Rosen 2015]. Reporting requirements can affect the time that can be spent on implementing change. For example, Australia had separate reporting requirements for the various programs and lines of funding. Many reported that the separate funding, planning and accountability requirements for different areas of work made it more difficult to work in an integrated way. In

the U.K., GPs were overwhelmed by reporting demands and started turning down participation in incentive schemes [Lind 2013]; 71% reported that being part of the CCG negatively affected the amount of paperwork and extra meeting commitments they had [Robertson 2015].

Nevertheless, in a learning environment during reform, it is important to evaluate things rapidly to identify what works and to disseminate learnings about success quickly [Rosen 2015]. Early in the New Zealand reform, the focus was on reporting process indicators to monitor structural and organizational changes to allow oversight while the groundwork was laid. But again, it is important to have a proportionate approach so that innovators are not burdened by excessive reporting and research requirements.

Initiative to Support Innovation during Transformation

The **Integrated Care Pioneer Program** in the U.K. is a national program designed to support local innovation. It provides explicit permission – along with expert advice and limited funding for cross-program networking and learning – to allow experimentation with new approaches to the structure and delivery of services. Participants are allowed flexibility within the rules set by national bodies. Central reporting requirements are not onerous and the time required to make change is recognized. Those involved have responded positively.

"We became part of the pioneer programme as 'the badge' opens doors and gives us air cover to do what we want to do" [CCG Commissioner].

"One of the real benefits of being a pioneer has been the access to a senior national sponsor and leadership mentor. This practical central support has been invaluable in helping to unblock barriers and facilitate difficult local discussions" [CCG Commissioner].

Governance

Experience in several jurisdictions indicates that focusing on governance structures and processes is critical to the success of transformation. In the U.K., New Zealand and Australia, the nature and structure of the commissioning groups has evolved over time, often with a greater emphasis each time on corporate governance and skills-based boards and management. Several of these organizations have been said to be "maturing" in this regard. In the U.K., a recent report highlighted the need for higher-skilled and better-trained boards [Rose 2015]. Advanced skills in leadership, organizational development and change management are needed (all discussed in greater detail below). Critical to success is clarity of purpose, including well-articulated roles, goals and objectives [Australian Government 2014a, Cumming 2011].

In Australia, the guidelines for the commissioning groups (PHNs) indicate that

> at a minimum, Boards should be skills-based and managers and staff should be appropriately qualified and experienced. Boards will have accountability for the performance of the PHN in relation to outcomes, as well as clinical, financial, risk, planning, legal and business management systems. PHNs should be structured to avoid, or actively and appropriately manage conflicts of interest, particularly in relation to purchasing, commissioning [Australian Government 2014b].

One study in the U.K. found that the effectiveness of governance structures within the system and the commissioning groups affected the extent of physician engagement:

> the complex external environment, tight deadlines from NHS England and, at times, inefficient internal governance structures meant that engaging and applying the member voice in decision-making was sometimes difficult. Some of the CCGs had begun to review their governance structures to ensure that GP time was used to best effect [Holder 2015].

In Ontario, governance within FHTs has evolved. As FHTs have matured and in some cases grown, there has been a greater emphasis on formalizing governance policies that were previously missing or unwritten, including vision and mission statements, policies and procedures, planning and programming, and human resource policies. As FHTs matured, they required a corresponding evolution in the managerial abilities in their leaders. In many instances, the role of executive director advanced from that of office manager to team leader and innovator, a role requiring a wider range of administrative and managerial skills and experience. Several FHTs experienced turnover of their executive directors and took the opportunity to replace them with individuals with greater managerial skills. Some teams underwent a complete transformation of their governance and management practices.

FHTs have had a chance to reflect on their activities since inception and some have revised their strategic plans to better align with their mission, goals, objectives and patient needs. Other FHTs have not undertaken this renewal and staff in these teams reported that the lack of strategic direction affected their overall performance [The Conference Board of Canada 2014]. As well, over time as more team members became aware of and embraced the mission and vision statements – these statements were more often seen to be reflected in FHT policies, activities and team functioning. Additionally, in a couple of larger FHTs, certain disciplines developed their own mission statements, goals, objectives and action plans and met regularly to discuss their needs and progress [The Conference Board of Canada 2014].

Since implementation, many physician-led FHTs have changed their board composition to better reflect the skills and expert advice required for improving operations and/or to include broader representation by IHPs or community members. As well, some FHTs have increased the extent of patient input into FHT activities, including conducting community consultations, soliciting patient input through surveys, or involving patients on boards and subcommittees.

For example, a few larger FHTs have subcommittees through which community members provide input on FHT programs and quality improvement. These subcommittees address strategic priorities, such as chronic disease management, process improvement, the patient experience and a population health focus. The committees are reported to have placed greater emphasis on developing patient-centred policies and procedures.

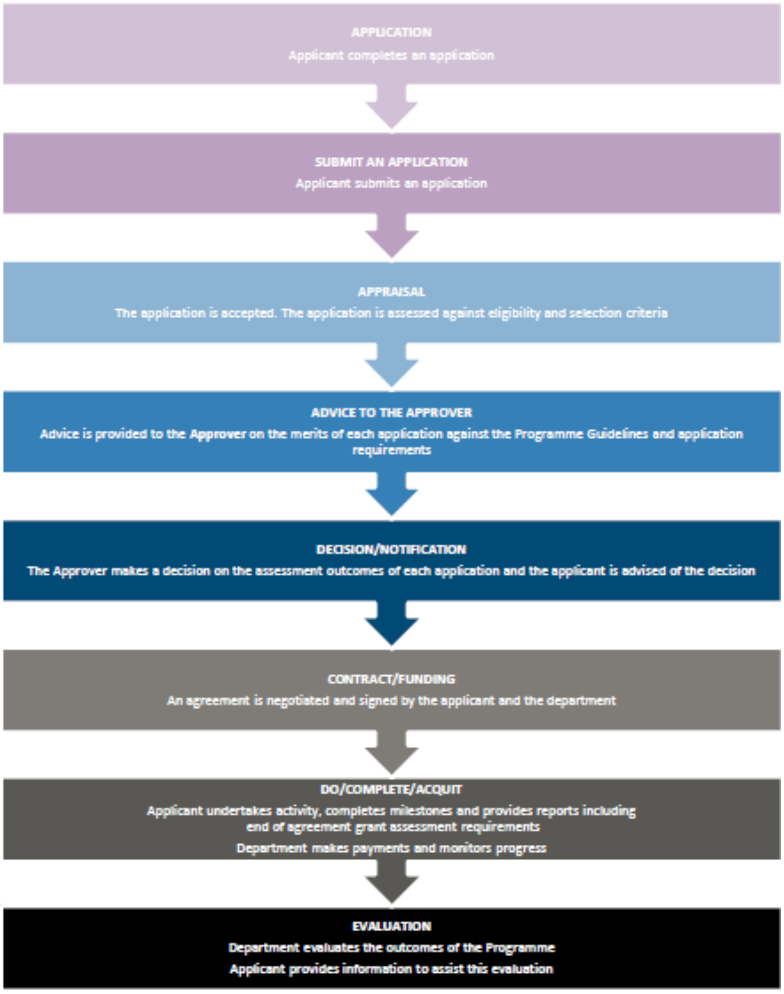
> The committee is also discussing implementation and how the resources of the FHT can be allocated to best meet the quality improvement agendas that are being developed at the practice level. … there are a number of tools that the FHT is making available to the practices such as patient surveys, care plans, and broader goals in terms of helping them [The Conference Board of Canada 2014].

The Application Process and Requirements

The process by which organizations (or groups of organizations) apply to become a commissioning group is an important consideration. Australia and the U.K. underwent extensive application processes to form and implement the most recent commissioning groups. Prior to

taking on their full responsibilities, CCGs in the U.K. had to complete an authorization process designed to test their core competencies. All 211 CCGs were eventually authorized, although 80% initially failed to meet at least some of the assessment criteria. NHS England imposed significant restrictions on a small number of CCGs, limiting their ability to function autonomously until certain conditions had been met. The authorization process was demanding on CCG leaders and some reported that it diverted energy from other core responsibilities, such as building relationships with local GP practices [Naylor 2013].

In Australia, the rigorous application process was open to private, for-profit and not-for-profit organizations and to state and territory governments. To be eligible for assessment, applicants had to be incorporated or government entities. The graphic below shows the application and review process [Australian Government 2014b].



How the Funds Flow

The way funds flow to primary care practices varies greatly across the jurisdictions studied and it can have varying effects depending on the structure and design of commissioning groups and the health-care system. Ontario's Price Report recommended incremental change, first with a separate stream of funding to family practices and then a merged system of funding flowing through the proposed sub-LHIN commissioning groups. In the international jurisdictions examined, the fund-holding and flow of funds are varied, multifaceted and complex. Usually, core funding for family physician contracts is set by the central authority, but the contracting and

accountability may lie with the commissioning group. Funding flows and mechanisms are critical to the nexus of control and to incentivizing change (and to the nature of disincentives and unintended consequences) and high performance.

In New Zealand, the funds flow through the commissioning group (the PHO) to family practices based on a capitated rate for the rostered population of practice members. (Practices may choose to pay family physicians based on a capitated or fee-for-service rate, and GPs who opt out of the model are reimbursed separately at a lower rate.) Separate funds may flow to the practices for training and additional earmarked services. A small incentive went to the commissioning group based on overall member performance on a set of practice indicators (which were recently reintroduced in order to align with system-wide indicators).

Importantly, in New Zealand the commissioning group may be run by well-established pre-existing networks of family practices (IPAs) that had previously collaborated on service delivery, clinical pathways and administrative services. Other PHOs, especially (but not exclusively) in the rural and Maori communities, are standalone entities. These two types of models have shown different levels of community engagement, population-based services and nexus of control. As well, given that a significant portion of GP remuneration comes through patient out-of-pocket payments, the commissioning groups have somewhat reduced leverage over GPs.

Another aspect for consideration is the role of the LHIN equivalent in New Zealand. The funds flow through these regional bodies to the primary care commissioning groups. However, the regional bodies were not involved in the initial negotiations and the commissioning groups do not necessarily align with their geographic boundaries. As a result, while some groups work closely with the regional body (and may even consider themselves part of one system), others work at arm's length and in a less coordinated fashion. As well, some physician-led networks (some of which are now commissioning groups as well) initiated additional fund-holding contracts traditionally outside the primary care purview.

For example, Pegasus in Christchurch negotiated holding the pharmaceutical and laboratory budgets for its patients. Through peer leadership, peer education, and audit and feedback, this group managed to save several million dollars in those areas. Later, it developed a suite of community-based services to reduce hospitalizations. The money saved did not go to the physicians but was invested back into service delivery and care pathway development, including discretionary funds for physicians to provide additional support to patients (e.g., for private dietitian services, medical devices, home care, etc.).

The funding for primary care and commissioning are equally complex in other jurisdictions. In the U.K., the way funds have flowed to primary care has changed several times since the implementation of GP fund-holding in the 1990s. Commissioning group (CCGs) now hold most of the NHS budget, *except* for primary care physician practices. However, "co-commissioning" has recently been introduced and with it, commissioners have increased control over the funding of core GP services. GPs are paid through a combination of capitation to cover essential services, optional fee-for-service payments for additional services (e.g., immunizations for at-risk populations) and the performance bonuses of the Quality and Outcome Framework (QOF). Initially a quarter of physicians' income, the proportion of income from the QOF bonuses was decreased in their 2014/15 contract with a reduced number of bonus-related services and the remaining funds reallocated to capitation payments. GPs also have financial incentives to

monitor patients with chronic conditions, such as diabetes and heart disease. About 20% of GPs are employed by practices on salary.

Each CCG is given an allowance of £25 per capita to spend on management. CCGs can decide the amount they spend internally and how much they want to outsource to Commissioning Support Units or other external organizations. The outsourced support they may receive includes health needs assessments, business intelligence services, support for service redesign, negotiating and monitoring contracts, communications and engagement, and back-office functions [NHS England 2013].

Funding flows in the U.K. are still in flux. In addition to the introduction of co-commissioning, several smaller commissioning groups are merging some of their funds to attain economies of scale. At the same time, an increasing number of formal family practice networks and large- and small-scale partnerships are emerging. Some anticipate that a greater proportion of the commissioner's administrative overhead budget could go to these practice groupings in future.

Example of Economies of Scale in Family Practice
In the U.K., the **Vitality Partnership** is a GP-led integrated care organization. The practices operate independently under the umbrella of the partnership, but have undergone "back-office" centralization to realize economies of scale and efficiencies. The organizational layer that operates above the day-to-day running of each practice through pooled funds facilitates the activity of the network, saves practices time, improves efficiency and reduces variability. Small practices have found that the clinical and administrative support "has meant they are able to enjoy general practice once again without having to worry about administrative burdens" [Rosen 2013].

In Ontario, from 2015/16 onward, rather than funds flowing to the individual Health Links initiatives, they will flow to the LHINs as a single allocation. The LHINs will then have the discretion to fund Health Links based on local and provincial priorities. According to the Ministry, this change will support stable base funding and the development of economies of scale, enable scaling up, and allow for cost savings through greater integration of care [MOHLTC June 2015].

When the funding flows through the commissioning group to family physicians and/or family practices, the role of the commissioning group is relatively greater in terms of the nature of the funding and accountability for it. In these instances, experience indicates that it is important to

- Maintain clinical engagement and avoid the perception that the commissioning groups are solely manager led
- Forge partnerships between members and managers that ensure a strong clinical voice, while managing any conflicts of interest
- Develop positive clinician-to-clinician relationships
- Focus on quality improvement to facilitate changes visible in day-to-day practice
- Maintain links with members to influence practices and avoid alienating members when performance-managing practice contracts
- Sustain clinical leadership and ensure physicians remain involved in the commissioning group's work [Holder 2015]

Important questions arising from the nature of budget holding and flow of funds include how to

- Ensure the money follows population-based needs and issues
- Promote shared resources and economies of scale and bring groups together in this regard
- Expand services using resources saved by economies of scale and other efficiencies
- Track, monitor and enforce accountability
- Define and clarify who is the funder and who is the service provider
- Address conflicts of interest, especially where family physicians have dual roles with the commissioning groups and their practices

Clarity of Roles and Responsibilities

The roles and responsibilities of the various stakeholders must be clear in the devolution of primary care to a population-based, locally commissioned model. Central authorities must provide a clear vision for primary care and other community-based health services, along with a comprehensive strategy that supports family practice and other primary care providers in extending their roles. Central authorities play a role in strategic planning that, among other things, supports family practice in operating on a larger scale [Smith 2013]. Their role is also to establish system priorities, provide guidance on quality and access standards, define the core contract and enable peer-led change [Rosen 2013].

In delegating responsibility to the local level, administrators and clinicians need to be confident that the stated roles and responsibilities and associated authority will in fact be delegated. In the U.K., there was

> substantial concern among CCG leaders that other parts of the system will revert to hierarchical relationships based on top-down control. Many saw actions taken by NHS England area teams, the Department of Health and others as illustrating that there would be a significant amount of central control in the new system and that the political narrative around local freedom and autonomy would fail to manifest itself in reality [Naylor 2013].

During transformation, local commissioning groups play an important role in helping practices manage change related to the new organizational arrangements. This support can include

- Defining expectations and contracts for service delivery
- Providing analytical and business development support to help practices create and implement business plans
- Providing professional development for the skills needed for organizational change
- Supporting priority-setting and strategic planning by developing local structures and facilitating collaborative efforts to develop local plans [Rosen 2013]

A U.K. report found the role of commissioning groups central to the successful implementation of change:

> We have argued throughout this report that if they are to achieve their goals, CCGs will need to play an active part in facilitating change in primary care. This is a contentious issue but our research suggests that most GPs acknowledge that this does fall within the remit of CCGs, and it is enshrined in the constitutions on which CCGs are founded. The debate is not about whether CCGs have a role in

> primary care development but about which parts of the agenda they take on, and how they go about it [Naylor 2013].

In relation to quality improvement, it is important to define the roles and responsibilities of the various central and regional bodies. It must be clear who is providing leadership, defining goals and targets, taking responsibility for achieving them, engaging and supporting family practices, and monitoring and responding to suboptimal performance.

The role of family physicians must also be well-defined and expectations clearly articulated. If part of the rationale for creating commissioning groups is to engage clinicians, increase their role in local decision-making and benefit from their expertise, commissioning groups need to build and sustain local family physician engagement and clearly define their roles. Family physicians can be involved in a number of ways, including dedicating administrative time to the commissioning bodies as staff or board members, acting as practice representatives, participating in local reform consultation and planning sessions, and/or acting as practice leaders and champions [Naylor 2013].

For Health Links, the Ministry of Health and Long-Term Care has laid out the following roles for itself, LHINs and the lead Health Links organization. Elaboration on the structures and processes for provider engagement and collaboration is still needed.

Ministry of Health and Long-Term Care	Local Health Integrated Network	Lead Health Links Organization
• Sets the strategic direction and provincial priorities • Provides funding to the LHINs • Leads sustainability planning • Monitors overall performance • Facilitates operations by providing provincial-level tools and supports • Oversees provincial communications	• Sets regional priorities and ensures alignment with provincial priorities • Funds Health Links in accordance with priorities • Supports regional planning • Supports implementing plans and adopting provincial tools • Identifies and implements regional supports and tools • Manages and assesses performance • Is accountable to the province for performance • Develops a sustainability plan • Ensures regional and stakeholder engagement	• Is responsible for infrastructure, business plan, project management and implementation • Engages with the LHIN • Supports patient and provider engagement • Sets targets • Establishes agreements with partner organizations • Reports to the LHIN on implementation, operations and performance • Identifies and tracks the patient cohort • Oversees care plans and coordination

[MOHLTC June 2015]

The Time Required for Change to Take Place

The evidence is clear that reform initiatives need to set realistic timeframes for achieving desired outcomes and managing risk. Commissioning groups will need to take a pragmatic and realistic approach to implementation. It takes time for providers to learn new ways of working and to implement changes that improve effectiveness and efficiency in the longer term. At a 2014 Canadian Association of Health Services and Policy Research conference, the keynote speaker (from the U.K.) indicated that when significant transformational change is introduced, it often

takes at least five years even to get back to baseline, and it is thereafter that the real impact can be seen.

Internationally, commissioning models have evolved over time. Few have remained static and most have changed significantly based on experiences during implementation (and changes in government). As well, various aspects of the models were introduced incrementally. Some started as pilot projects, while others started by focusing on a particular aspect of reform, followed by changes to other components. An important lesson from these jurisdictions is that early changes influence what can be implemented later and how the reform evolves. Thus, the first step is critical and lays the groundwork for what follows – the way reform is initiated needs to be designed with consideration of the ultimate goals and the steps that should follow.

Successful transformation of primary care and family practice requires a strong focus on "proactive support" in specific areas [Allcock 2015], along with acknowledgement of the time needed for people to engage and then participate in change. "Effective leadership and the involvement of a cadre of clinicians with the time and headspace to engage in the design and implementation of new models of care" is required [Hann 2013].This mindset includes allowing for risk-taking (not every initiative will succeed and time is needed to experiment) and patience to allow change to occur.

Individuals from British practices have described their difficulty creating the "headspace" for strategic planning and finding time away from practice workloads to develop new models and lead change. This work took place mainly on people's own time, but some also allocated specific management sessions to support organizational change. Some practices created additional capacity by hiring external management support. Another important consideration is the additional workload associated with competitive tendering. That workload can be a barrier to a family practice increasing its scope of services. Larger primary care organizations, with additional business resources, are often better positioned to do this [Rosen 2013].

Experience suggests that financial risk should be introduced gradually to avoid organizational failure. ChenMed – a capitated pre-paid health plan in the U.S. – does not take on full global risk in the first six to twelve months after taking on a new contract with insurers and starts a new risk-sharing arrangement in shadow form. This approach is used widely in the NHS and was evident in many practice-based commissioning groups when they first started. Evidence suggests that clinically led organizations holding budgets and taking financial risk can take years to gain stability and deliver change [Casalino 2011, Thorlby 2011].

In the U.S., most of the emerging Accountable Care Organizations have opted for gain-sharing contracts in their early years, rather than a mix of gain-sharing and risk-sharing [Jha 2015]. In the U.K., many GP provider organizations operate at financial risk, having Alternative Provider Medical Services contracts to run practices and practice-based commissioning contracts to run services. Some of these contracts have resulted in losses, however. International experience suggests that several will fail if they take on too much too quickly, do not conduct risk adjustment accurately and/or do not manage financial risk effectively [Rosen 2015].

Realistic Estimates of the Costs of Transformation

International experience indicates that in addition to considering the time involved in transformation, adequate attention must be given to the costs of supporting successful transformation. Many health reform initiatives have faced challenges related to not having

enough transition funding to support the process of change and one-off costs. Some suggest reformers should fully model and estimate the extent of investment needed for implementing reform in advance to support realistic resource allocation for the change (and that this projection may result in a modification of the reform initiatives in line with available resources from the start) [Allcock 2015].

The London Strategic Commissioning Framework for Primary Care Transformation estimates that between 2% and 5% of the health-care budget should be invested to support primary care transformation and at least part of this investment should go to providers to support individuals, practices, work between practices and whole-system development [NHS England 2015, Rosen 2015].

Adequately financing change can increase the likelihood of success, improved efficiency and better outcomes. The following are some considerations for funding change:

- Assessing underlying financial viability
- Assessing local funding allocations and planning for funding continuity
- Knowing the costs of setting up a new organization, infrastructure and team
- Ensuring that project management and organizational development are funded
- Securing resources for dedicated transformation teams staffed by individuals with change management skills and credibility with clinicians to manage and drive change
- Providing short-term, external support to inject energy, pace and expertise
- Securing professional time for participation in change initiatives
- Sourcing resources for skills development and leadership training
- Funding visible improvements – "quick wins" – that can build momentum, demonstrate commitment and boost morale
- Funding staff or facilities to ensure service standards
- Investing in financial incentives
- Investing in engagement and collaboration activities [Rosen 2015, The Health Foundation 2014]

Geography

In New Zealand, Australia and the U.K., commissioning groups were developed based on the individuals and groups that came together to form them; often these were groups that had historically worked together. As a result, few – except in rural areas – reflect regional geographic boundaries or the boundaries of the regional health authorities (e.g., those that commission hospital and specialist services). This approach has strengths and weaknesses. It has hindered the ability of regional authorities to streamline activities within their geographic boundaries. As well, family practices may have commissioning agreements with more than one commissioner. However, some providers have achieved economies of scale by contracting with more than one commissioning group across a wider geographical area.

In the U.K., super-partnerships – large, geographically connected group practices – are likely to be located within the boundaries of a single CCG. However, federated and networked practices can be a dispersed set of practices that span a number of CCGs [Rosen 2013, Rosen 2015, Naylor 2013]. In Australia, because boundaries between the Medicare Locals and the geographically based Local Health Networks (LHNs) (the bodies that commission and manage hospital services) did not align, a 2014 review

> found that Medicare Locals, having been established as 61 separate organisations, lacked the power and moral authority to effectively engage and negotiate with LHNs, let alone jurisdictions. There are undoubtedly instances where Medicare Locals and LHNs have proactively engaged and successfully collaborated. However, both the extent and scope of engagement has varied significantly [Horvath 2014].

As well, the

> lack of alignment has hindered governance, shared purpose and collaboration, and stymied effective strategies to integrate care, for example hindering multi-disciplinary clinical engagement to create locally relevant clinical health care pathways. Alignment of geographical boundaries is a necessity for clinical alignment and to support patient flows, as most submissions and stakeholders agreed. In some jurisdictions creative approaches may be required to achieve alignment [Horvath 2014].

Levers for System Change

The literature, and international and national experience, shows that a number of levers support the transformation of the primary care system locally, regionally and more broadly. Some approaches to implementing change in the health-care system are described in this section. The following critical levers for change are then discussed in detail:

1. Acknowledging and addressing barriers to change
2. A change in culture *and* a culture of change
3. Leadership
4. Family physician engagement
5. Developing a foundation of integrated decision-making and collaboration
6. Financial incentives
7. Performance measurement, benchmarking and targets

Approaches to Implementing Change

There is much literature on change management and incentivizing change and many approaches have been applied to health system reform. The taxonomy presented by the Health Foundation in the U.K. is relevant to the introduction of commissioning models [Allcock 2015]. They describe three approaches:

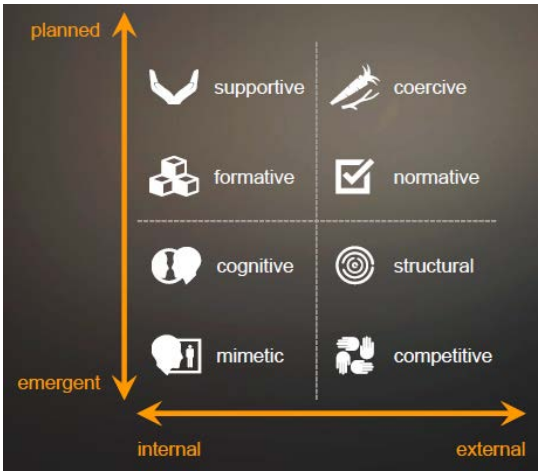
1. **Prod approaches** "direct, prod or nudge" providers to make changes. A 2015 King's Fund report provides examples of how prod approaches can be applied [Ham 2015]. These methods include the use of targets, directives and performance management frameworks; regulation; use of competition; contracting; and setting payment incentives. These are said to provide "constructive discomfort" and support "deficit management" approaches [Stevens 2004] – which allow deficiencies to be identified and services nudged (or more) to ameliorate them. Prods can play an important role and tend to have the most focus during reform. "However, taken together at a local level they have, at most, 10% impact in improving overall, rather than targeted area, performance of providers of care – including commissioning"[Allcock 2015].

With the implementation of the FHTs, some suggest that there may not have been enough prods or that the prods applied were not the most effective ones. For example, as discussed above, while implementation was allowed to be fairly flexible, FHTs had "no real tools to take corrective action for those not fulfilling FHN or FHO agreements" [Key informant interview 2015].

2. **Proactive support approaches** directly or indirectly support providers and commissioners in making changes. Described as providing "constructive comfort" or as "asset management," proactive support can target specific interventions or it can be more generic (e.g., training in management skills or leadership). External agencies can provide support and capacity building to organizations undergoing changes. Examples from the U.K. include the NHS Modernisation Agency, NHS Institute for Innovation and Improvement, NHS Improving Quality, NHS Leadership Academy, Academic Health Science Networks and Integrated Care Pioneers.

3. **People-focused approaches** are meant to influence the actions of staff directly. Through prods and proactive support that target staff rather than organizations, central authorities can strongly influence the behaviour of clinicians and administrators through contracts, professional regulation, leadership, clinical standards, training and validation. Working on the front line to improve services often lacks "hard" rewards, such as promotions, and "soft" rewards, including recognition from peers and validation of the use of clinical time for reforming service delivery. These levers have the potential to inspire and engage staff and influence change, but have received relatively less focus. In the U.K., it was observed that professional bodies do not focus enough on practice and service improvement and have a greater role to play in this regard [Allcock 2015].

The Health Foundation and King's Fund in the U.K. and work in Australia [Levesque 2015] discuss the importance of considering the balance between the various approaches to influencing change. The work from Australia provides the following framework, where multifaceted approaches support achieving the greatest impact, and illustrates how the application of various combinations of levers – such as comparative data, training and capacity building, experimentation and incentives – can influence change.



Acknowledging and Addressing Barriers to Change

When first engaging in reform, it is important to identify, discuss and address stakeholder concerns and perceived barriers to implementing change. This step includes acknowledging the change process and addressing challenges related to resources, time, resistance to change and level of effort.

The table below summarizes some of the systemic barriers to transformational change.

Area	Potential barriers
System-wide barriers	
Governing body culture	• Perspective that real improvement is not a priority • Risk-averse culture rather than willingness to change radically • Improvement not seen as everybody's business • Focus on targets rather than improvement
Stability	• Changing policy priorities and competing drivers • Lack of stability of organizations in the sector and across sectors • Lack of stability of key roles (leaders and frontline staff) • No stable group leading and coordinating change efforts
Partnership functionality	• Silo mentality, protectiveness and tribalism • Lack of involvement of all key partners, including patients, caregivers and community care
Incentives and funding	• Lack of incentives to improve • Inverse/perverse incentives • Financial constraint, meaning fewer resources are available to experiment
Initiative barriers	
Usability	• Difficult-to-use initiatives or ones that do not fit well within existing structures or processes
Resources	• Insufficient resources allocated to develop and sustain change • Lack of basic equipment or inability to acquire it quickly
Evidence base	• Lack of agreed upon evidence about how to improve • Lack of access to evidence base leading to not selecting the "right" approaches • Failure to examine learnings from other jurisdictions and sectors • Lack of resources for evaluating and sharing lessons learned

[The Health Foundation 2015]

A Change in Culture and a Culture of Change

A change in culture

Across international jurisdictions and across Ontario, many believe it is time for a transformational culture shift within family medicine and that this shift should be reinforced by a systemic structural change. Some argue that without a change in culture, any reform will be flawed and will not achieve its goals [Key informant interviews 2015]. Primary care leaders need to speak out decisively for the aspirational goals of the primary care and health-care systems, including the goal that "every Ontarian receive high-quality, coordinated, comprehensive, and continuing care" [OCFP 2014], as well as those goals discussed in numerous documents describing the fundamental attributes of primary care. All family practices need to be pushed to evolve from a "transactional" mode of thinking toward an approach that connects them more deeply with their patients and the broader community (health care, social, civic, etc.).

To ensure real transformation in Ontario, family medicine needs to strongly advocate its vision for primary care and support the voices of leaders, visionaries and younger family physicians over those of dissenters, including taking an approach that some have called "planned ignoring" [Key informant interviews 2015]. The need to change culture and own the vision was articulated in two international articles/reports published in 2015. A report on NHS leadership suggested that the NHS needs to develop a "collective vision," to portray "a values-based culture" and to

"foster a united ethos." The report suggested a need to "think collectively and act locally" [Rose 2015]. Regarding the Family Medicine for America's Health initiative, Mary Hall, President of the Society of Teachers of Family Medicine (STFM) in the U.S., wrote in the journal *Family Medicine*, "Ownership for STFM means we can't delegate or relinquish the responsibility for leading the change required to achieve the vision. STFM can't announce our belief in the vision and then disappear to let others make it happen" [Hall 2015].

A culture of change

In addition to a change in culture (or in the ethos), transformation efforts require a culture of change to be firmly in place. According to one U.K. report on transforming family practice, "the development of this kind of culture is a necessary part of the transformation itself" [UK Trans]. Change occurs in environments where the culture is open to and supports it. A culture of change has been described as "a motivated workforce that responds to the vision and 'opts in' by committing to improvement activities" [Rosen 2015]. This involvement includes "harnessing the commitment to high-quality patient care" [Dixon-Woods 2013] and engaging people in decision-making based on "co-produced organizational values" [Dixon-Woods 2012, Bate 2014]. Such an environment creates a positive attitude toward risk-taking and ensures staff feel valued [Allcock 2015].

Developing a culture of change can mean convincing people that i) there are critical issues to be addressed [Dixon-Woods 2012, de Silva 2015] and ii) the problems they believe to be intractable can in fact be fixed [The Health Foundation 2015b]. In addition to needing motivation to make change, individuals need to see value in the improvement activities over and above their usual roles and they need to be supported in taking action and overcoming the challenges they face when implementing change [Dixon-Woods 2013].

A report on accelerating change in the NHS speaks of needing "headspace to make change happen" and suggest this entails thinking beyond the day-to-day and creating the culture and attitude that "improving services [is] seen as part of their day job" [Batalden 2007]. For both large- and small-scale change, the impact of the workload and workplace environment on individuals' energy and motivation for change must also be taken into consideration [West 2012, Dixon-Woods 2013]. It is especially challenging if staff have previously been involved in poorly designed or unsuccessful reforms or if benchmarking data are not sufficient to support and confirm the areas that require reform and improvement [Allcock 2015].

Key ingredients for addressing culture

A number of key ingredients support both a change in culture and the development of a culture of change. Both can be strengthened by the following:

- A more positive tone and rhetoric about the health system and its reform goals
- A critical mass of clinicians actively supporting and advocating for change
- Support for clinicians who take leadership roles that may set them apart from, or against, their peers
- Identifying and nurturing potential clinician leaders
- Role modelling by clinical leaders
- An openness to working together
- Clinician involvement in the design and delivery of the reform initiative
- Developing and advocating for clinical standards, guidelines and performance benchmarks
- Addressing constraints imposed by external stakeholders and professional allegiances

- Central authorities working to create a common understanding and solve common problems
- Increased outreach, meetings and sharing among stakeholders
- Coordinated action across the health-care system
- Creating a sense of ownership
- A strong evidence base for change

Importantly, a culture of change is supported by a clear link between the change attempted and the professional values of and support from professional opinion leaders – who exemplify the change in culture. For example, in the U.K., commissioning groups sought clinician leaders with a desire to lead change and a mindset of going the extra mile to play various roles beyond clinical practice [Rosen 2015].

Several methods have been shown to support a culture of change in clinical practice, many of which blend organizational systems and processes with reforming frontline professional practice. A supportive context for delivering high-quality care can be achieved through the following:

• Having a shared purpose • Anchoring change in a supportive organizational culture • Organizational capacity to support change • Clinician accountability for performance • Quality having a "shared, collective meaning, value and significance within the organization" • Applying clinical standards and guidelines and performance benchmarks • Monitoring change and performance over time • Valuing innovative thinking • Promoting a learning culture and learning from others • Rewarding initiative and problem-solving • Challenging "it won't work here" attitudes, silo thinking and unwillingness to take risks • Having a willingness to try again after initial failure • Strong working relationships between management and clinicians and joint planning • New working relationships with various professional groups • Co-location of different professionals	• Staff engagement • Addressing sub-culture diversity and "tribalism" • Recognizing and celebrating team and individual efforts • Regular clinician peer review • Valuing bottom-up change • A culture focused more on support and autonomy than command and control • A positive safety environment with constructive ways to address errors • Incentives that support long-term goals (versus short-term fixes) • Reducing conflicting incentives in the health-care system • Understanding and acknowledgement, especially by central authorities, of the complexities, time and resources required to achieve sustainable change (and thus realistic demands and timelines for those on the front line) • Investment in infrastructure, such as information technology systems, data analytics and decision support tools

[Allcock 2015, Rosen 2015]

Leadership

Leadership is another critical and defining factor in supporting change in primary care discussed in the literature and by experts with field experience. Effective leaders are described as "capable," "committed," "courageous" and "respected" [Allcock 2015, Rosen 2015].
"Leadership – particularly the ability to engage people with a clear vision for change, centred on patients – is arguably the most important factor for achieving successful change. Leadership needs to be collective and distributed throughout different levels of an organisation, with leaders facilitating collaboration and sparking enthusiasm" [Allcock 2015].

Some key attributes are associated with *transformational leaders* in health care – these are unique individuals who

- Set an aspirational vision
- Inspire, energize and mobilize people
- Create an evidence-based case and urgency for change
- Are strong and courageous enough to make real changes and to take the initiative rather than waiting for permission
- Visibly commit to transformation and act as role models, exemplifying desired behaviours
- Have a clear understanding of where the sector and/or organization is going, how to get there and how to communicate this direction and inspire others
- Engage stakeholders and frontline staff early and in a genuine manner
- Solicit expertise to solve problems and make better decisions
- Learn from the experiences of others, through trial and error and by taking risks
- Convince others there is a problem and that the solution is the right one and is possible
- Can develop clear, simple goals
- Can develop a credible reform plan and enable "quick wins" to demonstrate change
- Understand how to manage stakeholders, create "headspace" and have the courage to stand their ground on what they believe is right for their sector or organization
- Can successfully navigate the "politics" of change [Rosen 2013, Allcock 2015]

Leaders with these attributes are needed at the central, regional and practice levels. Central leadership is crucial and sets the tone for reform. These leaders successfully engage those in the health sector, as well as the public and politicians, and facilitate constructive relationships among organizations. The central authority needs to take the lead and yet inspire, delegate and enable stakeholders by applying the attributes described above. Importantly, they need to avoid what some commissioners and providers reported in the U.K.: a "disconnect between words (enabling) and actions (controlling) from leaders at all levels of the system. While phrases such as 'collaborative leadership,' 'innovation' and 'taking risks to improve services' are prevalent, they are often in stark contrast to behaviours which are short-term and unduly focused on control" [Allcock 2015].

Individuals involved in the implementation of new primary care organizational models (partnerships and networks) in the U.K. agreed that leadership from both the CCG commissioners and practice leaders was essential for changing local services. But they emphasized that the motivation for transforming family practice had to come from the practice partners, who needed to take ownership of the organizational change for it to be sustainable [Rosen 2013]. Leaders needed to make a compelling case for the benefits of physician involvement in commissioning groups. "If CCGs are to succeed in engaging their members, they will need to prove the value of commissioning. Leaders will need to be able to demonstrate to their members tangible improvements for local patients within a short timeframe" [Naylor 2013].

Within large primary care practices and networks of practices, success is reported to depend on a shared vision among family physicians and their ability to communicate this vision to staff. Clinician leaders need to articulate the vision and exhibit a strong commitment to practice improvement to convince staff that change is possible and to engage in reform efforts. Practice leaders' role is said to be to "coax, encourage and enable their colleagues and peers to work in

new ways" [Rosen 2013]. However, clinicians often lack strong incentives to assume leadership roles and engage in improvement efforts. This gap needs to be overcome through support from the system and their peers [Allcock 2015].

Careful consideration must be given to the leadership capacity and pool of leaders within primary care. With the introduction of commissioning groups, family physicians are expected to play a role in the decision-making and/or operations of the commissioning group – and continue to practice. This dual role can be taxing and often the same individuals have been involved through the various reforms in Australia, New Zealand and the U.K. Growing fatigue is possible among these leaders, with few in the wings to take their place. As well, in the U.K., with the possibility of the growing influence of large primary care practices, those in CCG leadership positions may seek positions as practice leaders in the merged and networked practices instead.

Leadership can be multifaceted and evolutionary. For example, in Inner North West London, senior managers took the lead in initiating and making the case for reform. Thereafter, a system-wide leadership group was formed. It established a governance structure to introduce care planning and multidisciplinary collaboration and to secure funding for information technology. Local GP leaders played a key role in engaging other clinicians and making the case for the reform. (Small financial incentives helped to support clinician participation in multidisciplinary meetings.) As the integrated teams became more established, team managers increasingly took over leadership roles [Rosen 2015].

Reform within a primary care practice entails a focus on both quality improvement and organizational development. The nature of the leadership needed to support change and improve care can vary. During transformation, some newly integrated family practices and networks may divide their leadership roles, with some individuals focusing on organizational development and others leading in the clinical aspects of practice improvement. [The Conference Board of Canada 2014, Rosen 2013].

Quality improvement initiatives have been successful when they are peer-led. One example is peer review of clinical practice, including practice meetings to review referrals to secondary care or peer review among practices to compare clinical practice or use of hospital services. In the U.K., the Royal College of General Practitioners' Membership by Assessment of Performance is a modular approach to improving the overall organization and quality of a general practice, which is externally assessed by fellow professionals [Rosen 2015].

Leadership skills requirements

High-quality candidates for leadership and senior management are needed to support system reform and ensure success. Experts speak of the importance of having people with the right expertise leading and supporting transformation. These change specialists need both i) strong leadership skills to broker consensus and drive implementation and ii) advanced operations and managerial skills [The Health Foundation 2011].

The skills and capacities required (and that often need to be developed or augmented) include the following:

- The ability to identify and understand problems rapidly, to understand their root causes, to plan and prioritize how to solve them, and to manage implementation in a structured way (using data, staff knowledge, and experience and evidence from elsewhere)
- An understanding of how to manage and lead change, including long-term implementation
- The ability to draw on best practices and develop novel approaches to design solutions
- Practical experience in change and improvement methods and tools, and the ability to adapt and apply this experience to the specific circumstances
- The skills to manage and guide planning and implementation, including developing resource requirements, timelines, milestones, etc.
- The ability to train and empower others
- Skills for, and/or a good understanding of, data management and analytics and performance measurement [Rosen 2015]

Having leaders with the requisite skills is critical, as is developing leadership skills among clinicians, administrators and other staff. Some FHT leaders in Ontario have promoted the development of leadership, management and professional competencies among their staff. These leaders have expressed a desire for their staff to embrace innovation and change and to develop leadership and other skills. Some FHTs have contemplated formalized leadership training for current and emerging leaders. A few medium-sized and large FHTs had developed in-house training initiatives, such as a "registered nurse medical school" and lunch-and-learn sessions. Survey data have shown a significant increase in staff training in leadership, team building and skills development over time. While some FHTs had set aside funds for continuing professional development, budgets for training and education are fairly limited [The Conference Board of Canada 2014].

Example of a Leadership Training Program
GenerationQ is a part-time, fully funded leadership and quality improvement program for senior leaders working in health services to gain skills to drive change (and earn a postgraduate certificate). Fellows learn theories of leadership for quality improvement and how to apply them, and develop personal skills and strategies for resilience to allow them to address challenges. They are sponsored by a senior member of their organization who works with them throughout the fellowship. The program provides residential leadership forums, individual executive coaching, learning in facilitated peer groups with extensive feedback, opportunities to implement a project in their workplace and peer-based learning.

Family Physician Engagement

Generally, there are two functions of commissioning groups that rely on different levels of physician engagement. The first function – commissioning services outside family practice – does not necessarily require the active involvement of a large proportion of family physician members; it requires sufficient clinical expertise and input to support decision-making. The second function – primary care planning – depends on all members engaging and accepting the role of the commissioning group in improving family practice.

One evaluation on the extent to which members were aware of, involved with or supportive of the activities of the commissioning group described four groups of family physicians with differing attitudes:

1. Highly engaged leaders
2. Passive supporters agreeing with the principle of commissioning but wanting others to take the lead
3. Largely disengaged followers complying with basic requirements but doing little else
4. Dissenters objecting to the principle of commissioning [Curry 2008]

This research found that most family physicians fell into the second or third group, with fewer highly engaged leaders or active dissenters. Reasons for dissent among family physicians are numerous but are often a combination of practical constraints and philosophical objections. A commonly cited barrier to engaging members with the work of the commissioning groups is the lack of time and capacity in family practice. Membership in commissioning groups can entail more stringent contractual arrangements, an increased demand on physician time, more paperwork and wider policy measures (e.g., the requirement to register with the Care Quality Commission in the U.K. for licensing and inspection) [Smith 2013].

Reform in an environment of fiscal constraint can cause some family physicians concern that their responsibility will be to ration services, which could damage their relationship with patients and erode public trust in the profession. “The idea that it’s GP commissioning, it just doesn’t seem plausible. It seems to be about GPs taking the responsibility for horrible rationing decisions” [Naylor 2013]. Nonetheless, other family physicians suggest “this concern is overstated and balancing the concerns of individual patients against a responsibility towards the wider system has always been a central part of a GP’s role” [Regen 2002].

Other research has shown levels of engagement varying widely among members of primary care reform organizations, including the evaluation of FHTs. While in many FHT providers are working collaboratively and physicians have increasingly engaged, some physicians still have not fully embraced interprofessional practice and the extent of physician buy-in varies from FHT to FHT and within FHTs. Several physicians joined FHTs without a clear understanding of how their practice approach should change and some have not fully integrated into the FHT. As a result, referrals to IHPs and various programs are often inconsistent across FHT physicians, affecting teamwork and morale [The Conference Board of Canada 2014].

Additionally, in many FHTs, no dichotomy between Family Health Networks (FHN)/Family Health Organizations (FHO) and the FHT was observed. In some, however, FHN/FHO physicians see themselves – and operate – as an entity separate from the FHT. In these instances, some family physicians believe that better integration is needed:

> I would like to see more integration and collaboration between the physicians in the FHN and the FHT. We could do more in terms of integrated care and I don’t think we have accomplished everything that we can. I think that we could develop more programs and services if we truly used allied professionals to take away some of the responsibilities and time from the physicians. We can do this through delegated sets of responsibilities [The Conference Board of Canada 2014].

The challenges described above are less prevalent in FHTs that put greater effort into team-building and developing strategies for enhancing physician participation, and several FHTs experiencing these challenges have taken steps to address them. For example, several have an engaged physician leader or individual physicians who act as champions or mentors for other physicians to emulate. Efforts had also been made to reach out to physicians through newsletters,

websites and face-to-face meetings. To increase physician awareness and knowledge of team member competencies, some IHPs had taken the initiative to communicate their roles directly to physicians through individual or team meetings. A few IHPs had developed information sheets and newsletters related to the services they provide [The Conference Board of Canada 2014].

In one Ontario Health Links program, many family physicians in one LHIN agreed to participate. FHTs and CHCs engaged quickly and fully, whereas only about half of other physicians engaged. Engagement among the latter group increased when the Health Links program provided care coordinators who proactively identified patients, contacted the physicians and addressed patients' needs on their behalf. FHTs and CHCs have dedicated staff to perform these tasks. In another Health Links example, the initiative failed to get the requisite physician buy-in to get the program off the ground. The main barrier was that the program was implemented and managed outside primary care and the identified priority target group did not match the local family physicians' assessment of community needs and priorities [Key informant interviews 2015].

In Australia, the transition from Divisions of General Practice to Medicare Locals – with the requirement for board membership to include GPs and other providers and stakeholders, and a mandate for engagement beyond family practice – affected relationships with GPs. Some GPs felt disempowered by the new governance structures. "There needs to be GP buy-in at both the governance and operational levels and for them to be able to see benefit of their involvement" [Horvath 2014]. Nonetheless, physician engagement varied among Medicare Locals. Some established expert working groups to address issues within a specific area (e.g., mental health, aging or youth) that involved GPs along with other providers. GPs were also involved in developing clinical and care pathways within their catchment areas, received CME and training, and received practice support through visits, accreditation and collaboratives. Physicians were also engaged by the Medicare Locals through websites, social media, media, apps, newsletters and committees. These approaches are intended to continue with the new Primary Health Networks.

In the U.K., most engagement with CCGs and input on decision-making was achieved through GP representation on the governing body and via practice representatives who participate in members' councils. The members' councils were designed to represent member practices within the CCG and are expected to play a role in setting the direction of the organization. GP representatives on the councils are expected to act on behalf of their practice and provide information to other members. Some constitutions hold practice representatives partially accountable for the behaviour of their practice colleagues, stating that it is their responsibility to "ensure that their practice … adopts good practice as agreed by the group." The responsibilities delegated to members' councils differ, but often include

- Approving changes to the constitution
- Agreeing on the vision and values of the CCG
- Approving the commissioning plan, annual reports and budget
- Approving arrangements for supporting NHS England in it role to improve services [Naylor 2013]

Reports are mixed on the degree of influence GPs wield over decision-making, although most GPs feel greater influence over the CCG than the former PCT. Some of the members' councils are not well-developed nor do they wield significant influence, while others are thought to be

strongly influential. The strength and effectiveness of the council was identified as important to securing influence. "I think CCGs … are much more likely to be able to use peer pressure and influence their peers to deliver than PCTs ever could, and I think if they don't they'll fail; I think it's as stark as that" [Naylor 2013].

The extent to which physicians feel ownership of the commissioning group also influences their level of engagement. Just over half of respondents to one survey did not feel that the members "owned" their CCG, despite the fact that CCGs are meant to be membership organizations representing the views of GP practices. Some physicians expressed solidarity with other CCG members, while others were entirely disengaged from the commissioning group – both as an organization and a collective identity. Those who had not taken active roles in the CCG felt less sense of ownership of it, as did those in larger CCGs.

Some GPs cited communication problems within the CCG as barriers to engagement, including the following:

- A reliance on one individual to disseminate information from CCG meetings or distribute news bulletins, resulting in delays before all staff members received an update
- The volume of information coming from the CCG or being requested was overwhelming
- Information necessary for formal decision-making was not always easily accessible (often because of the volume of documents), sometimes resulting in decisions being made without full comprehension of all the information
- Gaps in the information provided by the CCG or information being provided in a format that was not meaningful to GPs
- No response to queries submitted by members to the governing body

There is some evidence that the size of the commissioning group is related to the level of physician engagement, with slightly lower levels of engagement in larger groups [Mays 2001, Regen 2002]. Studies have found that larger commissioning groups face greater challenges in engaging member practices and creating a culture of collective ownership [Malbon 1998, Smith 2006, Checkland 2012]. As well, smaller commissioning groups that work in formal partnership with neighbouring groups may also create barriers to engagement if physicians feel a loss of influence. Thus, it is important for all types of commissioning groups to maintain a grass roots level of engagement, which takes a great deal of time and effort [Key informant interviews 2015].

Another important consideration is ensuring that initial physician engagement is sustained. A 2015 study in the U.K. found that the proportion of GPs *highly* engaged with their CCG declined from 19% to 11% between 2013 and 2015; those who felt they could influence their CCG's work declined from 47% to 34%. Nonetheless, overall engagement was still found to be higher than in previous models. Reasons for declining engagement among GP leaders included lack of time or training to fulfill their role, CCG managers being seen as more influential in commissioning decisions than GPs on the governing body and only 21% of GPs feeling the quality of care had improved [Robertson 2015].

The table below provides the results of one study outlining reasons for family physician engagement or disengagement and highlights how divided physicians can be on clinical commissioning.

I am engaged because…	I am not engaged because…
I want to have some influence over which services are commissioned locally and how the CCG is run, as I believe this will be in the interests of my patients.	I am sceptical about the concept of CCGs and do not believe they will deliver improved services for patients. I can serve my patients best by concentrating on my core clinical duties.
It is my responsibility to get involved in the CCG's activities and to find out what is happening within the CCG.	There is a lack of communication from CCG leaders to the membership and I don't feel informed about what is going on.
As a clinician, I have a responsibility to be resource conscious and to consider how we can do the most good with finite resources.	Clinicians should not be responsible for decisions around resource allocation as this is in conflict with being the advocate for individual patients.
The CCG creates a sense of collective ownership because the governing body is made up of local GPs who represent local practices.	My potential contribution to the CCG is being overlooked because I am a practice nurse/practice manager/health-care assistant and all the attention is focused on GPs.
The CCG is a continuation of the local collaborative work that general practices were already involved in through practice-based commissioning.	The leaders of the CCG are the same individuals who were involved with the PCT – not much has changed. I am still being told what to do by a group of people.
I am familiar with and respect the clinical members of the governing body. The clinical leaders are approachable and engaging.	I do not respect the clinical members of the governing body and do not feel they represent my point of view.

[Naylor 2013]

Based on the evidence and experience of those implementing commissioning groups, critical factors found to support family physician engagement include the following:

• Communicating a clear vision of the reform objectives, including aspirational health system goals and a focus on quality improvement • Communicating a vision that describes how the reform and new entities are distinct from previous structures and organizations • Ensuring members understand the most important elements of the commissioning body's mandate and constitution • Prioritizing member relationships and cultivating a sense of collective ownership • Having a governance structure that supports the involvement of local clinicians in decision-making and delegates power where appropriate • Defining the roles of members, practices, the commissioning body and other governing bodies, with a clear understanding of authority and responsibility at each level • Clearly defining the role of the commissioning body in implementing quality improvement in primary care • Supporting peer-to-peer dialogue and performance review in small groups, particularly through face-to-face meetings	• Demonstrating early successes • Holding educational and other events (e.g., educational sessions, presentations by members of the governing body to the membership, forums for idea exchange and development, information sharing, presentations by other services) • Having websites or intranets with ready access to information • Enabling virtual communication with members • Enabling virtual and direct feedback mechanisms (e.g., feedback on concerns about commissioned services) • Creating telephone hotlines or other mechanisms to provide ready access to members of the governing body • Making practice visits in which commissioning body leaders meet family physicians, exchange information, seek volunteers and gain a better idea of what services are needed

[Naylor 2013]

Developing a Foundation of Integrated Decision-Making and Collaboration

Another important lever supporting change to health system structures and delivery in a commissioning environment is having (or developing) a strong foundation for inter-organizational collaboration and working relationships with local health and social service providers. This foundation facilitates the creation of a health *system*. Given that patient care often involves multiple providers, major priority-setting and resource allocation decisions involve commissioners and many other stakeholders. Some problems cannot be solved without primary, community, acute, mental health and social care providers working together. How the local health system functions, and the collaboration among organizations, affects what can be achieved in a transformation program.

Commissioning groups require collaborative decision-making with increased provider input; increased provider interaction (with the CCG and among themselves) is also critical. Levers for increased collaboration within primary care, and with the health system, include

- Aligning incentives for collaboration
- Having a sense of urgency and/or willingness to innovate
- Having positive working relationships among stakeholders
- Having support for the strategy and transformation efforts from commissioners, regulators and other organizations in the health system
- Considering participants' priorities, the dynamic of interactions and whether the focus is short or longer term
- Collaborating with other system organizations to solve specific problems (e.g., primary care and social services working to improve flow along the emergency pathway)
- Interacting with other local providers but not expending excess time and resources addressing problems beyond the particular organization's scope

There are examples of positive, collaborative working relationships among various services in pockets of Ontario. Although they vary greatly across the province, some FHTs have developed strong partnerships with other community-based programs to ensure greater comprehensiveness of care, optimize local resources and avoid duplication. For example, several FHTs work in close collaboration (and some are co-located) with community-based diabetes programs and several have built partnerships with local drug and alcohol services. Some FHTs, especially those in smaller communities, have formed "primary care hubs" and are co-located with pharmacy, physiotherapy, opticians, Community Care Access Centres and other providers or services.

Other examples of linkages and partnerships include FHT providers going to schools to provide counselling for diet and nutrition, sexual health and mental health; to workplaces to conduct cholesterol and blood pressure checks; and to nursing homes to provide diabetes care. As well, a few FHT providers work in close partnership with home and palliative care services when patients are unable to access services at the FHT office. One FHT has a program to respond to poor health outcomes in economically disadvantaged neighbourhoods and works with the city's department of neighbourhood planning to help connect residents with the community services they need and to identify any gaps. Fewer FHTs reported having formal relationships with their LHINs [The Conference Board of Canada 2014].

Related to Health Links, one LHIN has successfully coordinated and implemented LHIN-wide Health Links projects under the leadership of primary care. This LHIN has long had networked

primary care providers and has an established Primary Care Council that meets every two months to facilitate vertical and horizontal integration in the region. Collaboration among pockets of rural primary care providers who took a population perspective on health-care planning had predated the LHIN. This structure enabled the launch and implementation of LHIN-wide, primary care-led Health Links programs.

Participants in one U.K. study were generally positive about the commissioning group having brought individuals and practices together in a forum that had not existed before. Respondents were also positive about the clinical relationships that had developed – the greatest benefits were reported by those who had taken active roles in commissioning groups [Naylor 2013]. Many also saw the formation of CCGs as an opportunity to improve relationships between primary and secondary care, with increased clinician-to-clinician dialogue. The commissioning role can, however, also complicate the clinical relationships between primary and secondary care physicians, especially when commissioners seek to reduce specialist referrals and admissions or introduce changes to clinical pathways. Links with community care and social services were generally less well developed in the U.K., although CCGs are working to develop these further [Naylor 2013].

The changing structure and nature of family practices can also influence their interaction with other services. In the U.K., increasing the range of services offered in family practice and building larger, more influential organizations with greater physician control had to be handled sensitively with regard to the impact on other local providers. GP leaders addressed the local politics through dialogue with other local practices, commissioners, and acute care trusts, highlighting the benefits that would accrue to the local health system, not just the GP partners [Rosen 2013].

Financial Incentives

Several jurisdictions have used various funding models and financial incentives to spur change in primary care, and much has been written on this topic. For example, in the U.K., the following funding models are used:

- Micro-incentives (i.e., targeted payments for specific activities or outcomes) associated with the Quality and Outcomes Framework (QOF)
- Performance indicators for the locally negotiated Personal Medical Services contract
- Local (CCG) funding for specific interventions, such as insulin initiation and care plans
- Incentive schemes for GP participation in initiatives linked to local commissioning priorities
- Funding for enhanced primary care services beyond the scope of the GP contract (directly enhanced services)
- National incentive schemes used to achieve government priorities, such as early diagnosis of dementia or care planning for patients with complex needs
- A quality premium of up to £5 per capita paid to CCGs, to be paid directly to member practices as part of a targeted incentive scheme to support improved patient care and/or health outcomes [Naylor 2013, Rosen 2015]

While micro-incentives have been found to result in improvements in targeted areas of care (but not wider quality improvements in non-incentivized areas) in the U.K., GPs were thought to be trying to respond to too many different incentives at the same time and were overwhelmed by the combination – and competing priorities – of national and local incentive schemes and contractual

performance measures. An evaluation of the Commissioning for Quality and Innovation program found no measurable improvements because the funds were spread across too many locally defined projects, the definitions of indicators were inadequate, there was poor follow-up on projects and the program created too many targets for providers to follow [Kristensen 2013]. As well, caution must be used to ensure that performance targets are based on evidence rather than political influence, as was the case in New Zealand for cardiovascular risk testing.

Often the incentives focus on narrow clinical problems or specific clinical measures rather than broader initiatives to support strategic change across a health system. These incentive payments require clinical and administrative time and resources that potentially compete with the time required to engage in a more fundamental transformation of primary care. Some suggest abandoning targeted incentives in favour of whole-system payments in which family physicians participate in risk- and gain-sharing arrangements [Barai 2015].

Macdonald et al. (2010) suggest that financial incentive programs can be ill-suited to contexts of high goal ambiguity and complexity. Incentives can lead to prioritization of some goals over others and to other unintended consequences. They argue that "dysfunctional consequences" can often be predicted and incentives designed to reduce this risk if the various problems they are intended to solve are clearly defined [Barai 2014]. "A different balance is needed between initiatives focused on clinical quality and outcomes and those which seek to redefine the role of primary care in whole-system changes. It is vital that policy-makers understand the impact of the various levers that they use and how they interact with each other" [Rosen 2015].

New Zealand introduced a pay-for-performance program in 2006. The Performance Management Programme provided relatively small payments to commissioning groups (PHOs) based on a core set of primary care indicators. Because of its standalone and supporting role, the program may or may not be well-known among those who can affect performance – both the PHOs and primary care providers. The program is more prominent in some PHOs than others, with some PHO managers unaware of the details of how the program is implemented at the practice level, although they are able to track the indicators [Smith 2009]. An evaluation of primary care performance incentive payments to commissioning groups in New Zealand also found challenges related to the following:

- The balance between rewarding performance in high-performing commissioning groups (PHOs) and investing in those that are struggling to address issues of equity or fairness
- The balance between providing a small amount of funding to each practice and retaining funds at the PHO, where they could be used to undertake larger strategic projects or fund more staff to support practices
- Practices' differing views on whether or not to allocate individual incentive payments to physicians, nurses and other practice staff [Smith 2009]

The New Zealand performance framework has been revised and was reintroduced in July 2015 to reflect system-wide performance expectations [Aston 2015].

The evidence suggests that targeted incentives are likely to be more effective if they are

- Large-scale and high profile
- Focused on a select number of well-planned substantial change initiatives
- Attentive to the technical design of indicators and measurement methods
- Part of a multifaceted improvement strategy
- In support of an accepted mission [Kristensen 2013].

Importantly, careful consideration should be given to the design of financial incentives used for whole system goals, such as reduced emergency visits, where several factors, in addition to primary care, can have an impact.

Other funding levers have successfully supported change; such levers include funding for clinician training and capacity building, support for evidence-based education, and funds for family practices to contribute to redefining care pathways and reconfiguring services. A physician leader in New Zealand referred to this approach as "paying for professionalism not performance," based on the assumption that with the right tools physicians will want to do the best job possible [Key informant interviews 2015].

Performance Measurement, Benchmarking and Targets

The evidence is clear that data and measurement systems are critical to reforming the delivery of primary care and transforming the health-care system. Information technology use was widespread and data drove much of the planning, implementation and monitoring of commission groups internationally. Denmark, in particular, is very advanced in this regard, with data linkage throughout the system, public reporting and universal patient access to their health data.

Reform that incorporates data and measurement is characterized by

- Transparent measurement
- Simple measurement tools
- Getting the data collection and monitoring systems right
- Appropriate and supported information technology infrastructure
- Functionality that supports collating data and benchmarking
- Systems that support quality improvement efforts and the sharing of best practices
- Timely availability of data
- Regular checks and audits
- Access to data throughout the system, organization and practice[Allcock 2015]

Audit and performance data at the health authority level

Health authorities need information on the health and health-care experiences of their populations and on quality throughout the health-care system. Data are needed to support population-based assessments, clinical decision support and quality improvement. This information allows authorities to assess system performance, set goals, build the case for change, and monitor its implementation [Allcock 2015]. A strong policy commitment to quality and measurement with an emphasis on reporting (to providers and the public) can be an incentive for change [Rosen 2013].

Preparing for a Devolved, Population-Based Approach to Primary Care

Experts emphasize the need for central investment in information technology, data linkage and data analysis. Data governance rules for sharing information among providers and with patients are needed to support this investment. Some suggest that a minimum dataset for family practice is required and that the government or/and another central body should lead and monitor performance and outcomes at the population level. (In many jurisdictions, however, the roles of multiple central and local bodies – serving different but overlapping functions – in monitoring quality are often thought to be unclear, with no clear strategy for building capacity or improving quality across the system.) [Dixon-Woods 2012, OCFP 2014, Allcock 2015].

Critically, baseline data are needed to support and assess the progress of transformation in the primary care sector and within practices. Many agree that practice-level comparisons of inputs and processes are required, along with data on clinical outcomes, especially during the reform period Additionally, an effective information infrastructure is needed to identify and stratify those at risk, share clinical information among providers and support care coordination and other approaches to improving patient care [Rosen 2013, Rosen 2015, Allcock 2015].

The commissioning groups in the U.K. play a role in supporting quality improvement written into legislation and CCG constitutions. However, opinions differ on how CCGs should undertake this role. Emphasis is placed on CCGs playing a supportive role, facilitating change rather than imposing it. But CCGs must also ensure contractual requirements are fulfilled, including performance as outlined. “The challenge will be to act as a catalyst for change without damaging the relationship with member practices on which CCGs depend for their legitimacy” [Naylor 2013]. CCGs have several mechanisms for supporting quality improvement in family practice through auditing and measurement. These mechanisms include

- Setting performance targets
- Sharing comparative performance data
- Providing education and information
- Facilitating peer review and peer pressure
- Providing financial incentives
- Establishing referral pathways, protocols and management centres
- Having medical audit advisory groups and clinical audit programs
- Imposing sanctions on underperforming practices
- Organizing practice visits to discuss performance problems
- Expelling underperforming practices from the commissioning groups [Naylor 2013, Rosen 2015, Barai 2015]

When a practice is identified as underperforming, CCGs set performance targets for their resource use and develop structured recovery plans. In some cases, the practice is visited by the CCG leadership. In these instances, GP members emphasized the value of including clinical leaders in performance conversations and avoiding a paternalistic approach [Naylor 2013].

CCGs have been most successful in supporting peer review and dialogue and comparison among member practices. Peer review has been a core part of primary care commissioning since the introduction of GP fund-holding but has strengthened with the CCGs [Smith 2006]. Some participants report that the relationship between CCG clinical leads and member practices helps position CCGs “to harness the power of peer-to-peer influence.” Peer pressure has been a

powerful lever and operates well within a system based on clinical leadership and collective responsibility [Naylor 2013, Barai 2015].

Early evidence indicates that CCGs have had some impact on members' clinical practice patterns. In one survey, more than half of the practices reported that being a CCG member had changed their clinical practice in terms of prescribing patterns, referral pathways and the volume of referrals, although the scale of change has been small [Nayor 2013]. Fewer practices felt that the CCG had positively influenced the overall quality of the care they provide (21%) and the patient experience with GP services (12%), with most reporting that the CCG has had no impact in this regard [Robertson 2015]. Another study found many "bright spots" in practice and innovation, but inconsistency across CCGs and practices, which was attributed to "unclear goals, overlapping priorities that distracted attention, and compliance-oriented bureaucratized management" [Dixon-Woods 2013].

Based on experience to date, the Ministry of Health and Long Term Care has reported that the Health Links performance measurement model and oversight needs to be enhanced. Health Links started out with few performance measures to allow the program to be established and to foster innovation. But after two years, it has been difficult to quantify the program's effectiveness. In future, additional performance measures that Health Links can influence directly will be reported. As well, formal performance improvement plans, processes to identify and disseminate emerging/best practices and evaluation processes will be put in place [MOHLTC June 2015].

Related to the Quality Improvement Plan (QIP) in Ontario, some family physicians feel their perceptions of what is needed to improve the delivery of care are not aligned with the QIP indicators and that improvement priorities are determined in a top-down manner. They see no real connection between the submission of a QIP and the day-to-day reality of practice improvement. The submission of the QIP is too often seen as the end (something checked off a list) rather than the beginning of practice improvement. As a result, few clinicians feel ownership of their QIP. Some suggest there should be more incentives to support practice improvement and greater efforts to reward quality, although not necessarily through financial incentives [OCFP 2015].

Audit and performance data at the practice level

Detailed data are needed at the primary care practice level to support change. Practices need data to prioritize their improvement efforts and measure progress. This information allows frontline staff to understand and improve their care and boards to understand their organizations more fully [Allcock 2015].

Experts indicate that health-care transformation is supported by "insights from data analysis that enable a fact-based understanding of problems, inform decision making and track performance" and "tell a coherent story" [Rosen 2015]. Data acquisition and entry are time-consuming for clinical staff and they need ready access to the results of analyses of these data to see the value in collecting them. Timely data are needed, along with the requisite analytical expertise to measure and communicate impact and act on the findings.

There are challenges that need to be addressed. Many outcomes of interest are difficult to measure and track, and proving causality is difficult. Clinicians may also lack confidence in data quality, so they may focus on challenging the data rather than responding to what they show.

The evidence suggests the following are required to support the use of performance data in the practice:

- Information technology systems that allow for easy data collection and ready access to reports
- Reporting that enables clinical and management staff to easily understand what is going on and to address problems
- The use of insights from data to build a case for change, understand the root causes of problems, prioritize actions, set goals and track progress
- Trusted, high-quality data as a basis for analysis and decision-making (data quality is often improved once data are used for reporting)
- Comparison with relevant peers to understand improvement potential
- Data transparency, including reporting trends and performance comparisons among teams and individuals
- Regular practice (and broader network) meetings, troubleshooting and feedback on performance [Rosen 2015]

Example of Performance Measurement in General Practice Networks in the U.K.
"Historically, our local practices had very little to do with each other, despite being geographically close, but through network development and engagement, relationships have been forged and trust gained to enable us to create cohesion and collaboration. Shared incentives based on collective performance have helped to encourage this, but other important aspects have contributed to our onward progression, such as the creation of a network learning set involving members from each practice. Sharing and problem solving [allow] for a much better understanding of the challenges each practice has to experience and the development of mutual trust. We look at our collective performance data together and analyze how we are operating. Educational sessions and monthly multidisciplinary meetings across the network have been another key ingredient to our success" [Rosen 2013].

Organizational Development and Management

Transformation to population-based commissioning models requires significant efforts in organizational development and management. Critical areas for focus and development include those outlined below:

- Addressing organizational barriers to transformation
- Managing health organizations for transformation
- Developing an enabling environment
- Planning and change at the practice level
- Hiring for cultural fit
- Standardizing clinical and management systems to support change
- Training and skills development
- Considering size of practice groups and types of arrangements
- Addressing conflicts of interest

Addressing Organizational Barriers to Transformation

Leaders and managers need to address several barriers to transforming health-care organizations from the start. Barriers need to be acknowledged and resolved to ensure successful transition. The table below outlines some of these issues (some have been addressed above).

Focus areas	Potential barriers
Organizational barriers	
Organizational culture	• Culture of blame rather than improvement • Lack of focus on quality and improvement • Focus on "quick wins" rather than sustained change
Leadership	• Unrealistic expectations • Lack of o transformational, supportive, visible leadership o investment in leadership development o leadership buy-in o leadership ability to interpret and act on data o connection between boards, managers and frontline staff
Management skills	• Lack of project management skills • Lack of clear communication and governance processes
Use of data	• Difficulty accessing data quickly and regularly • Difficulty tracking data over time • Information technology system incompatibility between organizations and sectors
Time allocation	• Insufficient time allocated to plan for improvement • Insufficient capacity allocated to implement improvement • Time allowed for implementation is too short to show impacts
Individual barriers	
Staff attitudes	• Resistance to change • Lack of agreement that change is needed, and on the best way to improve • Different views among disciplines about the best way forward • Hierarchies in views about who should be involved
Staff skills and knowledge	• Insufficient skills in planning, implementation and dissemination • Insufficient skills in data analysis • Insufficient skills in quality improvement methodologies

[The Health Foundation 2015]

Managing Health Organizations for Transformation

Another critical component of a shift to commissioning groups is the development of effective organizations at both the commissioning group and practice/service levels. Health-care organizations often struggle to implement change. Effective management structures – including rigorous strategic approaches, governance structures, change management processes, incentives, performance metrics and accountability – are needed at start-up and beyond. The following are some features that support the development of strong organizations:

- Clear accountability for reform initiatives, from the board through to the front line
- Management's commitment to seeing the reform plan through, including the way boards and funders hold organizations accountable
- Strategic business plans that translate the vision into an implementation plan
- Implementation plans with strategies for organizational development, workforce development and financial viability
- A structured approach to implementation, including measurable goals, milestones and performance scorecards; these tools need to be used consistently and systematically, or the initiatives may weaken over time

- Effective management structures to monitor performance, manage and track progress and hold people accountable (some organizations set up a separate governance structure for the transformation program to increase top management's level of attention and to encourage more strategic or transformational approaches; others use existing governance structures)
- Skilled administrative and clinical leadership
- Clearly defined, evidence-based standards of care that are supported by clinicians and that create a focus for improvement through clear, common goals
- Multi-method training initiatives (such as the formalized programs at the Institute for Healthcare Improvement (IHI), the Institute for Innovation and Improvement's Productive General Practice program, the Modernisation Agency's initiatives in general practice, the Advancing Quality Alliance program in the U.K., primary care collaboratives, funding to stimulate innovation in family practice, and leadership development initiatives such as the Health Foundation Generation Q program) [Rosen 2013, Allcock 2015, Rosen 2015]

Developing an Enabling Environment

An enabling environment supports and drives organizational change. Such environments are created by organizational policies, as well as national/central standards, explicit permission from central authorities and politicians to take risks and learn from mistakes, governing policies (e.g., financial incentives) that do not hinder change, and strong local relationships [Allcock 2015].

The key factors that support an enabling environment in the implementation and management of commissioning models can include the following:

• External pressure for change • Central authorities that are amenable to change • Local support for change and/or local politics being addressed • Constructive relationships with authorities • Commissioners that are engaged in and support change • Cooperative inter-organizational networks • Consideration of external contexts – market, information technology, political, regulatory, social, cultural • Acknowledgement of complex, high-risk environments • Removal of obstacles • Balance of incentives and sanctions	• Alignment of organizational incentives and priorities with improvement activities • A focus on established best/good practice and any gaps between current and ideal performance • Consideration of financial context • Flexible payment structures • Navigable health-care structures • Participation is seen as attractive for staff, including opportunities for career progression and role variety • Close attention to communication with all staff • Skilled strategic and operational managers executing organizational development initiatives and improvement projects effectively

[Allcock 2015, Rosen 2015]

Planning and Change at the Practice Level

While many primary care practices have undergone significant reform in Ontario, most have not. The introduction of commissioning groups will likely require even more complex change processes at the front line of service delivery, including increased networking and partnering among providers. Mergers and partnerships will require strong management support. Corporate partnership structures and developing business plans are foreign to some family physicians, although many in Ontario now have experience in this regard. Newly networked or merged practices will have to manage the tension between collective plans and the interests of individual members. To support change, practices will need staff with business and organizational

development skills and the capacity to manage the workload associated with change, and who also understand the nature and culture of family practice. As well, experience from the U.K. and Ontario indicates that practices should ensure that staff contracts are harmonized sooner rather than later [Rosen 2013, The Conference Board of Canada 2014].

The recent experiences with FHT implementation provide numerous lessons, including the way physicians who in many cases did not know each other well came together to provide care within a single organization. Many of the participants were unfamiliar with priority-setting, governance and the planning methods required to establish the organization. In general, an environment of caution and self-protection has evolved into one of greater trust and support for a collective enterprise where the most engaged physicians are more often the voice of the FHT, rather than the sceptics. Some suggest that getting a "critical mass" of family physicians onside has helped them "break through." Among the more successful FHTs, the early days (and thereafter) were marked with regular meetings, retreats, "lots of communication" and negotiation [The Conference Board of Canada 2014, Key Informants Interviews 2015].

Shortly after implementation, a few of the larger FHTs in Ontario introduced dedicated practice facilitators whose role was to support individual practices within the FHT in clinical improvement initiatives. The facilitators were largely successful in practices that exhibited a readiness for change. (The quality improvement support role has since expanded across the model.) In hindsight, the facilitator role could have been expanded to support change management and operational development within practices, including an increased focus on building clinic staff capacity. For example, one FHT conducted an operational review in each of its practices, during which physicians were found to have limited understanding of business operations and health human resource management. Improvement efforts were undertaken based on the outcome of the reviews [The Conference Board of Canada 2014, Key informant interviews 2015].

The following are examples of factors that support planning and change at the service delivery level within a population-based, commissioning environment; some of which were discussed in greater detail above.

• A common vision to provide community-based integrated care to enhance patient care • A dual narrative about benefits to patients and how participation in coordinated care initiatives will make the workday easier • A strong foundation of integrated work that new initiatives can build on • Leadership across primary care, community and social services, promoting joint work and collaboration • Administrative and financial support to help form networks • Increased mergers, partnerships and networks • Investments in leadership training, meetings and project management to support implementation • Regular meetings among member practices and networked practices	• New working relationships between GPs and specialists • Involvement of frontline staff in designing and implementing practice change • GP partners' willingness to personally invest time and financial resources • Increased career opportunities for partners and staff • Diversification of income streams with less reliance on a core contract to increase business sustainability • Shared practice resources to increase efficiency • Professional education and development of clinical and organizational skills by family physicians • Peer review

• Workshops and "action learning sets" with family physicians, community health and social services workers, and other professional groups to develop shared goals and values and aligned working practices • Incentives to attend network, multidisciplinary and educational meetings • Improved integration of family medicine and community and specialist services	• Development of shared approaches to support change and performance improvement initiatives • Incentives to practices to develop care plans, care pathways, medical directives, etc. • Adoption of best practices and of standardized clinical care and management processes across sites • Investment in information technology • Better use of data to monitor care and drive change

[Rosen 2013, Rosen 2015, Allcock 2015]

Hiring for Cultural Fit

Transitioning primary care practices and organizations need staff that reflect the aspirational vision and values of the organization. In Ontario, some FHTs experienced significant human resource challenges in this regard, which impeded their teams' overall performance. Several FHTs altered their hiring practices based on early experiences. Some, even those experiencing physician shortages and IHP vacancies, turned away potential hires or let staff go if they did not fit in with the organization's philosophy. Some FHTs left positions vacant rather than hire people they believed would be detrimental to the team and not fit into the team culture [The Conference Board of Canada 2014].

ChenMed, a U.S. capitated health plan operating in eight states, reported that it recruits family physicians and other staff based on their attitude as much as for their skills and experience, with an emphasis on their approach to holistic, collaborative care. ChenMed invests in "developing a culture of professional responsibility for patient-centred care." It explicitly lays out expectations related to evidence-based care, shared decision-making and continuity of care. It ensures that clinical leaders are role models for desired behaviours, invests in training and development, provides decision-support tools and has formal review mechanisms to monitor clinical practice. Family physicians have 10–15% of their total income tied to performance, subject to review by their supervisors [Rosen 2015].

Standardizing Clinical and Management Systems to Support Change

Some primary care practices and organizations use standardized internal processes and systems to support change and maintain quality. Poor management processes and unclear lines of accountability can detract from an organization's ability to perform consistently and efficiently [The Health Foundation 2011, Filochowski 2013]. As well, some suggest that the lack of standardized operational processes within practices can reduce the time and space needed to focus on reform and practice improvement [Allcock 2015, The Health Foundation 2015b].

Internationally, primary care organizations have standardized systems in several ways. Some used jointly developed care pathways, guidelines and protocols as tools for changing clinical and referral practices within clinics and across the system. Others have standardized approaches to quality improvement across all sites and internal teams to ensure a standard level of clinical care. Others provided standardized room layouts, decision support and operational processes, and held regular meetings for peer review of treatment decisions and patient transitions.

Care pathways, guidelines and protocols are often used as tools for changing clinical and referral practices within clinics and across the system. These tools are viewed positively as long as providers are confident the tools are based on sound clinical evidence. Developing protocols and

pathways was a main activity of some of the IPAs/PHNs in New Zealand, where a group of local clinicians worked together to develop standardized clinical pathways across the commissioning area that were then integrated into the EMR – "with one click the information would be available and a standardized referral form could be sent directly to specialists, or for testing and procedures, as well as with a patient information sheet" [Key informant interview 2015]. This allowed for pre-existing pathway constraints to be broken down for cases that met the agreed-on criteria.

The Vitality Partnership in the U.K. was formed by the merger of nine primary care practices; it serves over 70,000 patients at 13 sites. It has a single management structure and corporate approach. Vitality has developed a standardized, systematic approach to quality improvement and assurance across all sites and has an internal "turnaround team" to ensure all sites deliver a standard level of clinical care based on key performance indicators. It also has a standardized approach to integrating new practices into the larger organization. As new practices join the partnership, they are required to adapt their working practices to the partnership's operating processes, including the standardized processes supporting change and improving clinical practice. Managerial staff follow a codified process for merging clinical and organizational information into the Vitality systems and clinical staff work to ensure that gaps in the care of incoming patients are addressed. This approach also allows staff to work in different clinical sites. Regular monitoring of the organizational dashboard allows the Partnership to track performance [Rosen 2015].

ChenMed in the U.S. uses standardized operating systems for its family physicians to support the management and delivery of care. Rather than giving physicians incentives to carry out specific interventions, ChenMed provides standardized room layouts, decision support and operational processes. This approach is said to reduce errors and maintain safety and efficiency. The organization holds weekly interprofessional team meetings and regular physician meetings to peer review treatment decisions and continuity of care during transitions between hospital and community. ChenMed does have some diversity in approach by site. It uses rapid learning cycles to test different ways of working in new locations and adapts its care coordination program to the location [Rosen 2015].

Training and Skills Development

The evidence indicates that during change initiatives individuals need skills to identify and solve problems. At least three types of skills have been identified as requisite to implementing change:

1. Technical skills, such as project management, clinical pathway design, change management and the use of quality improvement methodologies
2. Interpersonal skills, such as good communication, conflict management and negotiation
3. Learning skills, including collective reflection and debate [Gabbay 2014]

Various skills deficits have been identified in the primary care workforce that can limit its ability to deliver transformed services in an integrated, population-based environment. Many family physicians lack exposure to innovative practices and need to develop additional skills to enable new ways of working, especially those physicians working in small practices. These deficits include the following:

- A limited understanding of population health
- Weak relationships with community health and social service professionals and poor understanding of their roles and scope
- Poor knowledge and skills for strategic planning, business case development, standardized operating systems, management of innovation, performance management and governance
- Lack of skills required to work across organizational boundaries
- Lack of familiarity with technologies that can support and transform patient care, including consultations using new media
- Limited skills in data analysis and comparison to support quality improvement and peer review
- Failure to adapt consultation style and content to individual patients' needs
- Lack of methods for care navigation [Rosen 2015]

Approaches (often multifaceted) that can increase clinician capacity for implementing change and improvement include those listed below:

• A central network to coordinate training that is consistent, replicable and responsive • Identification of core competencies and the development of a single competency framework • Development of competencies across disciplines • Accredited courses • Training hubs • Formal education and professional development • Coaching, peer support and facilitated discussions • Workshops and action learning sets • In-house mentoring, leadership and skills training programs • In-service training as part of the job description/ requirement (e.g., for management and leadership roles)	• Web-based training and information resources across a network of practices • Increased exposure to new forms of patient consultation • Creation of time and space for staff from different professions to interact and participate • Increased collaboration and interprofessional work • Job performance appraisals and balanced scorecards for individual performance • Discussions with bodies responsible for professional training about broadening their curricula • Harmonization of workforce development strategies to ensure that newly qualified practitioners are capable of integrated and interprofessional practice

[Naylor 2013, Rosen 2015, Rose 2015]

Considering Size of Practice Groups and Types of Arrangements

The size of practice groups and the types of arrangements that are formed can influence success within a commissioning environment. Small practices have limited infrastructure to improve patient access and augment services. They are more vulnerable to marginal reductions in income and usually have insufficient staff to respond to new service, clinical, administrative and regulatory demands. Larger practices generally benefit more in a commissioning model. Nonetheless, it can be challenging to keep what staff and patients of small local practices value, while achieving economies of scale and maximizing opportunities for additional contracts. Careful analysis is needed to understand the risks and opportunities as organizations grow [Rosen 2013].

Commissioning groups can support the development of new models of primary care by using their commissioning powers to stimulate the growth of provider organizations and networks. Some suggest that being involved in a practice that has extended primary care service provision

as its focus may have a greater appeal for many family physicians than involvement in commissioning [Thorlby 2012].

In the U.K., three new family practice organizational models have been developed:

1. **Super-partnerships**: Large single partnerships created through formal partnership mergers
2. **Multi-practices:** Small GP partnerships managing multiple practices and services
3. **Federations or networks:** Collaborations among multiple practices through informal linkages (networks) or formal legal contracts (federations) [Smith 2013]

Based on case studies of these three models, the model chosen was influenced by the local context in which family practices operated, including the ways in which the practices had developed and the degree of trust among them. The study found that networked models could take transformation only so far without compromising the autonomy of individual practices, creating conflicts of interest and slowing decision-making. Significant effort and resources were required to create larger single practices through mergers. But closer alignment of decision-making and a shared risk/reward approach was felt to offer more potential and long-term sustainability [Rosen 2013].

Addressing Conflicts of Interest

Conflict of interest has been discussed in relation to commissioning authorities. Larger primary care organizations that take on additional commissioned work and operate in a market-based environment raise a real or perceived conflict of interest between family physicians as commissioners and care providers. The 2015 Australian reform removed service delivery from the role of the commissioner (except where there were no other services) because of physician conflicts of interest in governance and management roles.

In the U.K., while CCGs need to work closely with GP members and provider organizations, this cooperation can create conflicts of interest. Interviews conducted for one study showed awareness of and some concern about potential financial conflicts of interest. One area team manager suggested that some GPs may not yet understand the extent to which conflicts of interest could be a constraining factor in the future. There is some concern about the role of GPs on the CCG governing body [Holder 2015]. Physicians with a role in the commissioning group are to adhere to explicit local policies to manage conflicts of interest when bidding for new services. In some instances, GPs adopted either a provider or commissioner role to create separation within their organization [Rosen 2013].

> If CCGs are to help foster this kind of innovation, the issue of conflicts of interest will inevitably come to the fore. For CCGs to commission enhanced primary care services from local GP-led provider organisations without risking incurring reputational damage to GPs, it will be important that conflicts of interest are managed robustly. The extent to which this becomes a constraining factor that limits the development of new forms of general practice remains to be seen [Naylor 2013].

One study suggested that the benefits provided by the shift toward CCGs co-commissioning primary care could be compromised by greater potential conflicts of interest, reductions in overhead budgets and strained relationships with fellow GPs and NHS England. As well, with new contract management responsibilities as part of co-commissioning, CCGs, including their

clinician leads, may face difficulties maintaining good relationships with members as they try to enforce contractual performance management requirements [Holder 2015].

In the U.K., Monitor is the economic regulator of public and private providers. It licenses all providers of NHS-funded care and may investigate potential breaches of NHS cooperation and competition rules (a form of antitrust code) and investigates mergers. All constitutions must contain details about the management of conflicts of interest, outlining what constitutes a conflict and how the CCG will respond. Typical arrangements for managing conflicts include the following:

- The CCG creates and publishes a register of members' interests.
- The accountable officer ensures that for every interest declared, arrangements to manage potential conflicts are in place and agreed to in writing.
- Arrangements describe when an individual should withdraw from a specific activity and how the individual's engagement in that activity will be monitored.
- Conflicted individuals will be excluded from the relevant parts of meetings; when more than half of the members of a meeting are required to withdraw, the chair will determine whether or not the discussion can proceed.
- When insufficient individuals remain unconflicted, the decision in question will be made either by another sub-committee or group within the CCG or by an ad hoc group that could include members from another CCG or the Health and Wellbeing Board (community board).
- The governing body can seek additional scrutiny of commissioning decisions, by either the CCG's audit committee or external individuals [Rosen 2013].

Another important consideration relates to competition rules. In the U.K., issues of conflict of interest, EU competition rules and formal tendering rules have arisen. Commissioning of private health services may have wider ramifications and has created unease related to potential conflicts. These issues should be explored in relation to the North American Free Trade Agreement (NAFTA) and other Canadian trade agreements.

Summary

A number of key themes have emerged from the evidence collected and interviews conducted for this brief. The successful implementation of commissioning groups will require a strong and vocal commitment – by governments, health authorities, stakeholder groups and clinician leaders – to the aspirational goals of a high-quality, patient-centred primary health-care system. This commitment includes the development of communication strategies and a strong show of support by family medicine for – and an acknowledgement of accountability to – health system goals. As emphasized above, a change in the culture of family medicine is needed, along with the development of a culture of change at the practice level.

As part of implementing and supporting transformational change, strong, visionary, risk-taking leadership is required at all levels. A strong voice from family medicine in design and implementation from the start will support success. This means that many family physicians will need to take on leadership and, potentially, managerial roles throughout the system and may need to further develop their skills in this regard. International and local experiences have shown that

strong governance and management structures, made up of individuals with deep and diverse skills, are essential to the transition to commissioning models.

The commissioning models in the U.K., Australia and New Zealand have evolved since their inception as strengths and weakness have been assessed and governments have come and gone. The same can likely be expected in Ontario. As was learned during the implementation of these international models, and by the experience with Family Health Teams and Health Links, there needs to be an appropriate balance between clear articulation of the model and its requirements – including governance and organizational structures, performance expectations and penalties for non-conformance – and allowance for the opportunity to experiment and innovate. The tensions associated with public funding of private organizations, and between the need to ensure clinical excellence and practice autonomy, also need to be addressed.

International experience has varied in terms of the number and size of commissioning groups, jurisdictional boundaries, the role of family physicians on – and the methods of engagement with – commissioning bodies, the role of commissioning bodies as funders and service providers, financial incentives, and how funds flow to family physicians. These elements need to be explored for the Ontario models. Potential conflicts of interest for family physicians in this regard, as well as in other areas, must be identified and addressed from the start. Additionally, the roles and responsibilities of authorities at all levels need to be clearly communicated and understood.

A critical component of primary care system transformation is change at the practice level, including greater collaborative working relationships with other providers and sectors and a focus on high-quality clinical care and an improved patient experience. A number of models for incentivizing high performance are discussed in this document, along with their associated pros and cons. The main consideration is that the approach must be multifaceted and must consider the time and resources required for change. Internationally, there has been good success with family physicians taking leadership roles in terms of accountability and peer-led models for practice improvement, including formal peer-review programs.

Interviewees

Below are the key individuals interviewed via telephone and Skype for this evidence brief. Others in New Zealand, Australia, the U.K. and Canada were consulted and provided feedback and input by email.

New Zealand

Dee Mangin
Dee Mangin is an Associate Professor in the Department of Family Medicine at McMaster University; an Associate Professor and Director of Research at the University of Otago, Christchurch, New Zealand; and a family physician at the McMaster Family Health Team.

Dee moved to Canada from New Zealand in 2013. Prior to moving to Canada she was the Director of the Primary Care Unit at the University of Otago in Christchurch, as well as a Clinical Advisory Board member and Clinical Leader for Research Audit and Evaluation at the Pegasus Health Primary Healthcare Organization. She was a ministerially appointed member of the Pharmaceutical and Therapeutic Products Advisory Committee to PHARMAC (New Zealand's national pharmaceutical management agency) and served on the Southern Region Ethics Committee. She is a Fellow of the Royal New Zealand College of General Practitioners and in 2011 received its Distinguished Service Medal.

Dee's broad interests are rational prescribing; innovative models of primary care delivery; and the influences of science, policy and commerce on the nature of care. She has expertise in the effects on prescribing of pharmaceutical company promotion to consumers and physicians. She has wide clinical research experience in primary care using observational quantitative research methods, including cohort studies, cross-sectional studies and case/control studies. She has specific experience in interventional studies: in community randomized controlled trials of innovative models of care and of clinical interventions, including antidepressant use, community acquired pneumonia, antibiotics in urinary tract infection; and in "deprescribing" trials on the reduction of multiple medicines in older adults, and effective incorporation of evidence into patient-centred practice.

Toni Ashton
Toni Ashton is a Professor of Health Economics in the School of Population Health at the University of Auckland in New Zealand. Her main research interests are in the funding and organization of health systems and health-care reform, with much of her research focusing on various dimensions of health reform in New Zealand since the early 2000s. In addition to authoring numerous articles in journals and several book chapters, she has co-edited a book on health policy in New Zealand. She has also co-authored three books on superannuation. Toni has been a member of a number of government working parties and taskforces and has also undertaken a range of consultancies, including two for the World Health Organization.

Australia

Jane Gunn
Jane Gunn is Department Head, inaugural Chair of Primary Care Research and Director of the Primary Care Research Unit at the Melbourne School of Medicine. She is a general practitioner and Head of the Department of General Practice. She has worked as an academic GP since 1991 and has been heavily involved in research, teaching and curriculum development. In 2009, she was appointed to the National Health and Medical Research Council Research Committee. She was also the Chair of a Medicare Local and is working to establish the new Primary Health Network in her area.

Jane's research harnesses the patient experience to drive health-care reform. Her research interests include depression in primary care, perinatal care, women's health, cancer screening, study design, and analysis within the primary care setting. She is particularly interested in randomized controlled trials, complex interventions and combining quantitative and qualitative research methods to fully explore the questions that face the primary health-care setting.

Grant Russell
Grant Russell is a primary care clinician and health services researcher. He is Head of the School of Primary Health Care and Director of the Southern Academic Primary Care Research Unit at Monash University in Australia. He continues to work part time in a private general practice and teaches occasionally for Monash's Department of General Practice.

Grant is a graduate of the University of Western Australia and subsequently worked as a GP in Perth, setting up a small, independent general practice with colleagues prior to leaving for Canada in 2005 to work as an academic family physician and clinician investigator at the Department of Family Medicine at the University of Ottawa.

Grant's research program is directed toward understanding and measuring the impact of primary care reform on patients, clinicians and general practices. He has published extensively in journals such as the *Annals of Family Medicine*, *International Journal of Quality and Safety in Health Care*, *Family Practice* and the *Medical Journal of Australia*.

United Kingdom

Chris Naylor
Chris Naylor is a Senior Fellow in Health Policy at The King's Fund. He conducts research and policy analysis and acts as a spokesperson for The King's Fund on a range of topics. He has led several major projects, including a national evaluation exploring the development of clinical commissioning groups. He contributes to The King's Fund's work on integrated care and health system reform and has particular interests in mental health, community involvement and the environmental sustainability of health and social care.

Chris joined The King's Fund in 2007. He previously worked in research teams at the Sainsbury Centre for Mental Health and the Institute of Psychiatry; he has an MSc in public health from the London School of Hygiene and Tropical Medicine. He has also worked at the Public Health Foundation of India in Delhi.

Natasha Curry
Natasha Curry joined the Nuffield Trust in 2011 as a Senior Fellow in Health Policy. Her research interests include clinical commissioning, primary care provider models, integrated care, international health systems and NHS reform. She is currently leading the Trust's two-year program of research into the future of general practice and primary care. This mixed-methods program is tracking the development, activities and impact (on patients and professionals) of large general practice organizations. In addition, Natasha is involved in various other projects, including research into CCGs, emerging commissioning models and length of hospital stays.

Prior to joining the Nuffield Trust, Natasha was a fellow in health policy at The King's Fund. During her six years at the Fund, Natasha published widely on a number of subjects, including practice-based commissioning, the management of long-term conditions and approaches to clinical and service

integration. Previously, Natasha worked as a consultant in health at Matrix Research and Consultancy Ltd. and as the evaluations officer at the Chinese National Healthy Living Centre.

Ontario

Executive Directors, Family Health Teams

Family Physicians, Family Health Teams

Project Leads, Health Links

Project Partners, Health Links

Bibliography

Alberta Primary Care Networks. Alberta Health Services, 2015. Online at: www.pcnpmo.ca

Allcock C, Dormon F, Taunt R, Dixon J. *Constructive comfort: accelerating change in the NHS*. London: The Health Foundation, 2015.

Ashton T. Measuring health system performance: A new approach to accountability and quality improvement in New Zealand. *Health Policy*, 2015,119:999-1004.

Auditor General. *Audit Report No. 5 2010–11. Performance Audit: Practice Incentives Program*. Canberra: Australian National Audit Office, 2010.

Auditor General Alberta. *Report of the Auditor General of Alberta*. Edmonton: 2012.

Australian Government. *Department of Health National Evaluation of Medicare Locals, Final Report*. Department of Health, February 2014.

Australian Government. *Department of Health. Primary Health Networks – Grant Programme Guidelines*. Department of Health, November 2014.

Barai K. *Brief review of literature on methods for supporting change in general practice and primary care*. London: The Nuffield Trust, 2015.

Batalden PB, Davidoff F. What is 'Quality improvement' and how can it transform healthcare? *Qual Saf Health Care*, 2007,16:2-3.

Bate A, Donaldson C, Murtagh MJ. Managing to manage healthcare resources in the English NHS? What can health economics teach? What can health economics learn? *Health Policy*, 2007, 84(2-3): 249-61.

Bate P. Context is everything In: *Perspectives on context*. London: The Health Foundation, 2014.

Bell DW, Ford RPK, Slade B, McCormack SP. Immunisation Coverage in Christchurch in a Birth Cohort. *New Zealand Medical Journal*, 1997,110:440-442.

Breton M, Pineault R, Levesque J-F, Roberge D, Da Silva RB, Alexandre Prud'homme A. Reforming healthcare systems on a locally integrated basis: is there a potential for increasing collaborations in primary healthcare? *BMC Health Services Research*, 2013,13:262.

Casalino L. *GP Commissioning in the NHS in England: Ten suggestions from the United States*. London: The Nuffield Trust, 2011.

Cashin C. *New Zealand: Primary Health Organization (PHO) Performance Program*. Washington: World Bank, June 2011.

Checkland K, Coleman A, Segar J, McDermott I, Miller R, Wallace A, Petsoulas C, Peckham S, Harrison S *Exploring the Early Workings of Emerging Clinical Commissioning Groups: Final report*. London: Policy Research Unit in Commissioning and the Healthcare System, 2012.

Cumming J. Integrated care in New Zealand. *International Journal of Integrated Care*, November 2011,11(18).

Curry N, Goodwin N, Naylor C, Robertson R. *Practice-Based Commissioning: Reinvigorate, replace or abandon?* London: The King's Fund 2008.

Davies G P, Perkins D, McDonald H, Williams A. Integrated primary health care in Australia. *International Journal of Integrated Care*, October 2009, 9:e95.

de Silva D. *What's getting in the way? Barriers to change in the NHS*. London: The Health Foundation, 2015.

Department of Health. *The NHS Improvement Plan: Putting people at the heart of public services*. London: The Stationery Office, 2004.

Dixon-Woods M, Baker R, Charles K, Dawson J, Jerzembek G, Martin G, et al. Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. *BMJ Quality and Safety*, 2013,0:1-10.

Dixon-Woods M, McNicol S, Martin G. *Overcoming challenges to improving quality*. London: The Health Foundation, 2012.

Filochowski, J. *Too Good To Fail?: Why Management Gets it Wrong and How You Can Get It Right.* Harlow: Pearson UK, 2013.

Gabbay J, le May A, Connell, Klein JH. *Skilled for improvement?* London: The Health Foundation, 2014.

Gauld R. Report from the Field – The Unintended Consequences of New Zealand's Primary Health Care Reforms. *Journal of Health Politics, Policy and Law*, February 2008, 33(1).

Gauld, R. 2000. Big Bang and the Policy Prescription: Health Care Meets the Market in New Zealand. *Journal of Health Politics, Policy and Law,* 2000, 25:815-844.

Hall M, Brungardt S. Owning the FMAHealth Vision. *Fam Med,* 2015,47(8):655-7.

Ham C, Dixon A, Brooke B. *Transforming the Delivery of Health and Social Care. The case for fundamental change*. London: The King's Fund 2012.

Ham, C, Murray R. *Implementing the NHS five year forward view*. London: The King's Fund, 2015.

Hann M, McDonald J, Checkland C, Coleman A, Gravelle H, Sibbald B, Sutton M. *Seventh National GP Worklife Survey*. Manchester University, 2013.

Holder H, Robertson R, Ross S, Bennett L, Gosling J, Curry N. *Risk or reward? The changing role of CCGs in general practice*. London: The King's Fund and The Nuffield Trust, January 2015

Horvath J. *Review of Medicare Locals. Report to the Minister for Health and Minister for Sport.* Ministry of Health and Minister for Sport, March 2014.

Jha A. *US healthcare reform: lessons for the UK.* London: The Nuffield Trust, 2015.

Kristensen S, McDonald R, Sutton M. Should pay-for-performance schemes be locally designed? Evidence from the Commissioning for Quality and Innovation (CQUIN) framework. *Journal of Health Service Research and Policy*, 2013,18(2 suppl):38-49.

Levesque JF. Health System Improvement in Australia: Knowledge Organizations As Enablers. *Canadian Association of Health Services and Policy Research Conference*, Montreal: May 26, 2015.

Lind S. Revealed: GP practices face pay cut as DES uptake rates dip to 55%. *Pulse*, 23 July 2013.

Malbon G, Mays N. Total recall: what can total purchasing pilots teach PCGs? *British Journal of Health Care Management*, 1998, 4(9):428-30.

Malcolm L, Wright L, Barnett P, Hendry C. *Clinical Leadership and Quality in Primary Care Organisations in New Zealand: Report Commissioned by the Clinical Leaders Association of New Zealand for the Ministry of Health*. Auckland: Clinical Leaders Association of New Zealand, 2002.

Mays N, Wkye S, Malbon G, Goodwin N (eds). *The Purchasing of Health Care by Primary Care Organizations: An evaluation and guide to future policy*. Buckingham: Open University Press, 2001.

McRae I, Yen L, Gillespie J, Douglas K. Patient affiliation with GPs in Australia—Who is and who is not and does it matter? *Health Policy*, November 2011,103(1):16-23.

Ministry of Health and Long Term Care. *Advancing Health Links*. MOHLTC June 18, 2015.

Mossialos E, Wenzl M, Osborn R, Anderson C (eds). *International Profiles of Health Care Systems, 2014*. The Commonwealth Fund, January 2015.

Naylor C, Curry N, Holder H, Ross S, Marshall L, Tait E. *Clinical commissioning groups: Supporting improvement in general practice?* London: The King's Fund and The Nuffield Trust, 2013

NHS England *Transforming primary care in London: A strategic commissioning framework*. NHS England, 2015.

NHS England. *Towards Commissioning Excellence. A strategy for commissioning support services.* NHS England, June 2013.

Ontario College of Family Physicians. *Future Forward: 2014 to 2017*. Toronto: OCFP, 2014.

Ontario College of Family Physicians. *Advancing Practice Improvement in Primary Care: An Approach to Increase Participation and Close the Gap among Practices*. Toronto: March 2015.

Reay P, Goodrick E, Casebeer A, Hinings CR. Legitimizing New Practices in Primary Health Care. *Health Care Manage Review,* Jan-Mar 2013,38(1):9-19.

Regen E. *Driving Seat or Back Seat? GPs' views on and involvement in primary care groups and trusts*. Birmingham: University of Birmingham, Health Services Management Centre, 2002.

Robertson R, Holder H, Bennett L, Curry N, Ross S, Naylor C. *Primary care co-commissioning: a survey of members' views of their CCG and its role in primary care.* London: The King's Fund and Nuffield Trust, 2015.

Rose, Lord. *Better leadership for tomorrow - NHS Leadership Review*. National Health Service, June 2015.

Rosen R, Parker H. *New models of primary care: practical lessons from early implementers*. London: The Nuffield Trust, December 2013.

Rosen R. *Transforming general practice: what are the levers for change?* London: The Nuffield Trust, June 2015

Russell G, Mitchell G. Primary care reform – View from Australia. *Canadian Family Physician*. 2002, 48.

Smith J, Goodwin N. *Towards Managed Primary Care: The role and experience of primary care organisations*. Aldershot: Ashgate Publishing Ltd, 2006.

Smith J, Holder H, Edwards N, Maybin J, Parker H, Rosen R, Walsh N. *Securing the future of general practice: new models of primary care*. London: The King's Fund and The Nuffield Trust, July 2013

Smith J, Holder H, Edwards N, Maybin J, Parker H, Rosen R, Walsh N. *Securing the future of general practice.* London: The King's Fund and The Nuffield Trust, 2013.

Smith J, Walshe K. Big business: the corporatization of primary care in the UK and the USA. *Public Money and Management*, 2004, 24(2):87-96.

Smith J. *Critical analysis of the implementation of the Primary Health Care Strategy implementation and framing of issues for the next phase New Zealand*. Ministry of Health, March 2009.

Stevens S. Reform Strategies for The English NHS. *Health Affairs,* 2004, 23(3):37-44

The Conference Board of Canada. *Final Report: An External Evaluation of the Family Health Team (FHT) Initiative*. Ottawa: The Conference Board of Canada, June 2014.

The Health Foundation. *No. 24 What's getting in the way? Barriers to improvement in the NHS.* London: The Health Foundation, February 2015.

The Health Foundation. *In brief: Safer Clinical Systems: evaluation findings*. London: The Health Foundation, 2015b.

The Health Foundation. *Building capability to improve safety*. London: The Health Foundation, 2014.

The Health Foundation. *Evidence scan: High reliability organisations.* London: The Health Foundation, 2011.

Thorlby R, Rosen R, Smith J (2011). *GP Commissioning: Insights from medical groups in the United States.* London: The Nuffield Trust, 2011.

Thorlby R, Smith J, Mays N, Barnett P. *Primary care for the 21st century: learning from New Zealand's independent practitioner associations.* London: The Nuffield Trust, 2012.

West MA, Dawson JF. *Employee engagement and NHS performance.* London: The King's Fund, 2012.

Wilkin D, Coleman A. From primary care groups to primary care trusts in the new NHS in England. *Primary Health Care Research and Development*, 2001, 2(4): 215-22.