

The new GMS contract in primary care: the impact of governance and incentives on care

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Glossary of terms/abbreviations

Abbreviation	Term in full and explanation
BMA	British Medical Association: the professional medical association and trade union for doctors; negotiated 2004 GMS contract with the Department of Health.
CHD	Coronary Heart Disease
COPD	Chronic Obstructive Pulmonary Disease
CHP	Community Health Partnership: Scottish NHS organisation providing primary and community-based services; boundary is co-terminous with Scottish Local Authorities
CHCP	Community Health Care Partnerships: as above, but also integrated with social care
DES	Directed Enhanced Service: defined centrally and must be provided by the PCT for its population
ES	Enhanced services: additional services where local NHS organisations can commission a service not regarded as essential in the contract
GP	General Practitioner: medical practitioner who provides primary care
GMS	General Medical Services: medical services run by general practitioners; contract held with practice and local PCO
GMS contract	General Medical Services contract held by general practitioners
nGMS	New GMS contract implemented in 2004
Health Board	Health Board: Scottish NHS organisation integrating primary, secondary and community-based services
LES	Local Enhanced Service: locally developed services designed to meet local health needs
NES	National Enhanced Service: commissioned to meet local needs, but PCO must use national specifications and benchmark pricing
NHS	National Health Service
NPM	New Public Management: a management philosophy underpinning Government modernisation of the public sector; emphasis on contractual relationships and the use of incentives
PBC	Practice Based Commissioning: policy in England of allowing practices and other primary care professionals to commission services for their population

PCO	Primary Care Organisation: defined here as Primary Care Trusts in England; NHS Health Boards and Community Health Partnerships in Scotland
PCT	Primary Care Trust: an NHS Trust in England which provides some primary and community services or commissions them from other providers; also involved in commissioning secondary care
PCTMS	Primary Care Trust Medical Services: medical services run by the Primary Care Trust, where all professionals including the GPs are salaried employees of the PCT
PMS	Personal Medical Services: contract held between practice and PCO, but with local variation permitted; option for GPs to be salaried
QOF	Quality and Outcomes Framework: system of incentivised care contained within the 2004 GMS contract
RCGP	Royal College of General Practitioners

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Executive Summary

Background

Since its implementation in 2004, there has been much interest in the impact that the new GMS contract (nGMS), and in particular the Quality and Outcomes Framework (QOF), might have on practice performance, organisation and patient care. Much of the research until now has focussed on quantitative analyses of QOF performance or on qualitative insights into the impact that nGMS is having on practice teams. Much less is known about how the contract is being governed, and in particular the mechanisms that primary care organisations (PCTs in England; Health Boards and Community Health Partnerships in Scotland) are employing to monitor performance; whether these mechanisms vary depending on the service model (GMS/PMS practices; enhanced services; and out-of-hours services); the impact on staff; and, importantly, the impact on patients. This project also examined the impact of the devolving health care systems in England and Scotland, in relation to the GMS contract. These issues were informed by several theoretical approaches to governance, including Courpasson's soft bureaucracy, principal-agent analysis and accountability chains.

Aims

This study aimed to explore the governance arrangements in different models of service provision emerging from the implementation of the new GMS contract; the impact of the incentives contained within the contract on the organisation and performance of primary care; and the impact of the new contract on professional skill-mix and patients' experience.

Specific objectives were:

1. To examine the overall impact of the new GMS contract on clinical activity and patient process and outcome.
2. To describe how governance arrangements under the new contract are interpreted and implemented in the design and management of different provider organisations (practices, enhanced services and out-of-hours services).
3. To examine how governance arrangements impact on the relationships between PCOs and professionals working within different provider organisations and on the organisation of professional work.
4. To explore how new opportunities: (a) for patient and public involvement AND (b) to pursue population health or equity of care through commissioning or use of new resources, are understood and in what ways, if any, these are addressed.
5. To identify whether shared learning between provider organisations, either directly or via the PCO, occurs.

Methods

A multi-stage, multi-site study design was used utilising embedded case studies and a mixed methods approach to data collection. Four PCO case study sites were selected: two in England and two in Scotland. Within two of these sites, 6 embedded case studies were selected: 3 GMS practices; 1 PMS practice; the drug misuse enhanced service; and the out-of-hours service.

Specific methods included analyses of routinely available data on QOF performance and on workload distribution between GPs and practice nurses; interviews with 120 health care professionals working at national, regional (PCO) and practice/service level (67 in England; 53 in Scotland); case note review of patients with either diabetes or rheumatoid arthritis; and interviews with 19 patients (14 in England; 5 in Scotland).

Results

The principal contract holder in both England and Scotland for all three models of service delivery (GMS/PMS, enhanced service and out-of-hours) was the PCO. Both hard and soft mechanisms of governance were in evidence and these were inextricably linked. In England, greater weight was being given to hard mechanisms of governance, such as balanced scorecards. However, there was little evidence of punitive action being taken against poorer performers, although the enhanced and out-of-hours services acknowledged the potential for being de-commissioned.

Practices were subjected to both external monitoring, from the PCO, and internal monitoring from colleagues charged with monitoring practice performance towards QOF targets. A greater role was apparent for non-clinicians to monitor clinicians, for example in practices and in the out-of-hours services.

Practice nurses continued to take on an ever greater workload, not only in relation to QOF but also with the enhanced services. Some remained concerned about the degree to which their contribution to QOF achievement was recognised, either professionally or financially.

Evidence was equivocal in relation to unincentivised conditions. While there was no evidence of such conditions being actively neglected, the time spent on other incentivised areas left professionals and practices with little organisational slack to address these conditions fully.

Skill mix continued to develop, with evidence of a new pseudo-professional group emerging, the receptionist/health care assistant. GPs continued to deal with the most complex patients, either in terms of age, multiple morbidity and/or social circumstances, thus continuing the "hierarchy of appropriateness". However, while workload was clearly being re-distributed, there was little explicitly said about how that decision was taken. Workload was also being re-negotiated between practice nurses and community-employed staff, for example district nurses.

While gaps in QOF achievement had narrowed between the most affluent and most deprived practices, there was little evidence of QOF being used to target inequalities, despite the fact that almost all practices have opted into QOF. Despite the recent policy rhetoric in England, there was no evidence of proportionate universalism being enacted, whereby QOF could be applied globally, but with targeted approaches to increase uptake aimed at the most deprived.

Comparison of the impact of deprivation between the two countries was made more difficult due to this lack of patient-level postcode linked postcode deprivation data; the development of such a dataset in England would greatly enhance the ability to conduct local and comparative analyses of the impact of deprivation on health and health care use.

Patient care was improving year-on-year, both for patients with diabetes (selected as an example on a QOF incentivised condition), but also rheumatoid arthritis, selected as an unincentivised condition. Much of the routine monitoring was conducted by practice nurses, but GPs retained control over more complex treatment issues, such as prescribing.

Patients appeared unaware of the contract nor of changes in their care as a result of nGMS; indeed, most felt that their condition had always been monitored regularly, ever since diagnosis.

There was no evidence of patient/public involvement in monitoring and governance, with the exception of lay assessors in the QOF review visits to practices. However, increasing public involvement in governance of the contract may raise issues around contractual responsibility and probity.

Conclusions

Our research has highlighted a number of areas for policy, practitioners and for future research. We also reflect on the likely impact of changes proposed to the NHS in England by the Coalition Government in July 2010.

Policy and practice

Although nationally set, the continued devolution of health care systems in the UK may lead to renewed calls for localised approaches to the Quality and Outcomes Framework.

The central role of PCOs in monitoring and governing primary care contracts must be acknowledged, particularly in light of plans to abolish PCTs in England.

An increased reliance on bureaucratic and hierarchical systems of monitoring is likely, in time, to erode health care practitioners' autonomy which may, in turn, reduce their willingness to meet targets and incentives.

The role of service de-commissioning needs to be re-considered, as such threats de-motivate local practitioners and may prevent service providers from tendering to provide services in the future.

The negative impact of more bureaucratic and hierarchical monitoring, coupled with a more explicit role for service de-commissioning, may be destabilising in the smaller organisations, such as the proposed GP Consortia in England.

The potentially universal coverage of QOF should be strengthened and linked with enhanced services and, in England GP Consortia, to develop appropriately targeted services at underserved and disadvantaged populations.

There is a need to consider the impact of QOF on other underserved groups, such as the elderly, minority ethnic groups and those who find it difficult to attend surgeries.

There is an expressed need to review the role and remuneration of practice nurses, who are clearly a key professional group in the delivery of QOF and services related to the new contract.

The development of new services and the monitoring associated with them are falling disproportionately on practice nurses. Future policy imperatives need to be cognisant of this and recognise the implications if the practice nurse workforce dwindles.

Innovative ways of involving patients and the public in the governance of contracts is required.

Practitioners

There is a clear need to support practice nurses who are charged with mentoring other members of staff e.g. health care assistants.

New roles are developing within primary care, particularly in relation to dual roles amongst administrative staff and health care assistants. Support and training for such staff will be required.

Similarly, the development of non-clinical managerial roles need continued support and development.

Learning opportunities within and across services need to be maximised.

Research

Our findings suggest that future research should be focused on the following areas.

Research into the impact of national devolution on service delivery and organisation is required, with shared policy learning a priority.

Research will be required into the impact of abolishing PCTs and establishing GP Consortia in England.

Research into the on-going impact on unincentivised care is still required.

Further research into the impact of non-clinical monitoring of clinical roles and the impact on autonomy and professional boundaries.

The development of comparable datasets is required to allow comparative analyses on practice and service performance, taking account of the populations served.

Further research into the impact of the contract on underserved and disadvantaged populations is required.

1 Introduction

1.1 Background

Health care is under near continual re-organisation and reform, both in terms of organisational structures and the organisation of the health care professionals within those structures. In responding to such changes, the National Health Service (NHS) has gradually moved from a centrally-controlled structure of bureaucracy and hierarchy to one that is more decentralised, with greater use made of markets, quasi-markets and networks (1-3). This move towards a “New Public Management” (NPM) has led to a greater emphasis on contractual relationships, the dismantling of professional bureaucracies, greater emphasis on audit and quality improvement schemes, new ways of defining and measuring performance and increasing use of incentives (4-7). Coupled to these changes, and a more recent development, are the diverging systems of care resulting from political devolution (8-10).

This greater emphasis on NPM and changing modes of governance has implications for the National Health Service, in terms of performance and accountability, on the professionals being monitored and on outcomes for patient care. In response to these developments, the SDO commissioned three literature reviews to examine organisational factors and performance (11); the incentive effects of different forms of governance (12); and the impact of devolution and decentralisation (13). However, as quoted in the commissioning brief for this project “each [review] came to the conclusion that professionals and professional organisations within health care systems responded to differing incentives in varying circumstances and contexts”. In addition, there was little empirical evidence of the relative effectiveness of different governance and incentive mechanisms to understand “which approach works best, where, when and for whom” (14).

These issues are of particular relevance within UK primary care, where the implementation of the new General Medical Services contract in 2004 opened up opportunities for new ways of working and has placed an incentivised pay-for-performance scheme at the heart of general practice. The original SDO commissioning brief for this work outlined the need to understand the relative effectiveness of different governance and incentive mechanisms and their impact on professionals, on health care organisations and on the overall performance of the wider NHS (www.sdo.nihr.ac.uk/files/researchcall/126-brief.pdf) However, it was acknowledged that these three levels of enquiry were not mutually exclusive and that studies may address the alignment of governance arrangements between these organisational layers. It is this alignment, in particular between primary care organisations and general practices, that has been the focal point of this project, which has sought to explore and understand how these changing mechanisms of governance and incentives are impacting on primary care and to understand more fully the governance arrangements being developed in primary care from

three related perspectives: those charged with monitoring the performance and accountability of primary care professionals; health care professionals employed within primary care and general practice; and patients.

In order to fully understand the research that has taken place in this project, we must first briefly outline our understanding of the different modes of governance at play within the NHS today; relate these to the arena of primary care, with particular reference to general practice since the implementation of the new GMS contract; explore the notion of incentives and how they can impact on performance; and consider the role of professional boundaries on health care delivery. In doing this, we will pay particular heed to the devolving systems of health care in England and Scotland.

1.2 Models of governance

The rise of governance, both as a concept and as a set of processes has been intertwined with the rubric of New Public Management (4;7;15), with greater use of target setting, performance measurement, accountability, competition, incentives and the break-up of monolithic bureaucratic organisations into more manageable units. Despite this, however, there is no single agreed definition or understanding of the concept of governance (16). Gray suggested that governance should be considered less in terms of formal structural and process arrangements and more in terms of “a relationship of authority and function through which clinical policies and practices are effected and rights and obligations regulated” (17). Davies et al, in their scoping report for the SDO, defined governance in terms of individual working relationships: “ways in which organisations and the people working in them relate to each other” (12). However, what is uncontested is that governance involves accountability, monitoring, and “the nature and practice of control” (15). How this is operationalised is thus of paramount importance.

Within the framework of governance, the principal models proposed are hierarchies, markets and networks (12;18;19). To this, Newman added a fourth model: self-governance (20). Each has its own defining characteristics and key mechanisms through which it is operationalised (Figure 1). These can be mapped in two dimensions: a vertical axis illustrating the degree of centralisation or decentralisation apparent within the model; and a horizontal axis representing the extent to which governance arrangements are oriented towards continuity and stability or towards innovation. These are not, however, dichotomous but rather a spectrum of activity and, in practice, there is likely to be overlap between the models.

The **hierarchical model** is characterised by bureaucratic power and vertical relationships, which flow up and down the hierarchy. Formal accountability up the hierarchy is strong and relies on explicit standards and procedures; however, the model is also fairly inflexible and can be slow to change. Within the **market model**, power is dispersed across organisations and the model is characterised by managerial rather than

bureaucratic control. In this model, change is expedited through the use of incentives linked to performance goals and targets. Responsibility for delivering on these performance targets is devolved to local managers through contractual or quasi-contractual mechanisms. Thus competition can be engendered amongst organisations and agencies, through the use of contracts, leading to high levels of accountability through tight monitoring, inspection and audit.

In the **network model**, power is dispersed across players and is fluid. Here, networks are not contained within organisations but cut across them and across hierarchies, thus network governance is dynamic and built on horizontal relationships. This gives rise to the need for higher levels of collegiality and trust than in the previous models. Finally, in the **self-governance model**, sustainability is built up through interdependent and reciprocal relationships, delivered through mechanisms reliant on peer accountability.

This is a convenient way of categorising potential models of governance, however the distinctions are, in reality, less clear-cut. While hierarchies and markets have distinct characteristics that set them apart, the boundaries between networks and self-governance are less clear, with broadly similar monitoring mechanisms, as discussed in Chapter 1.3.

The ethos of New Public Management (NPM) has seen a move away from hierarchical models of governance towards more market and, latterly, network models and this has been as apparent within the NHS as other public sector arenas. However, this has not been a linear development. Several writers have contested the notion that the NHS has moved from one predominant model of governance to another, arguing instead that the NHS has always operated with multiple forms of governance in place. As Newman writes:

The view that we are shifting from hierarchies to markets and then to networks “forgets” a number of important changes which complicate the picture of a “from-to” dualism of past and future.

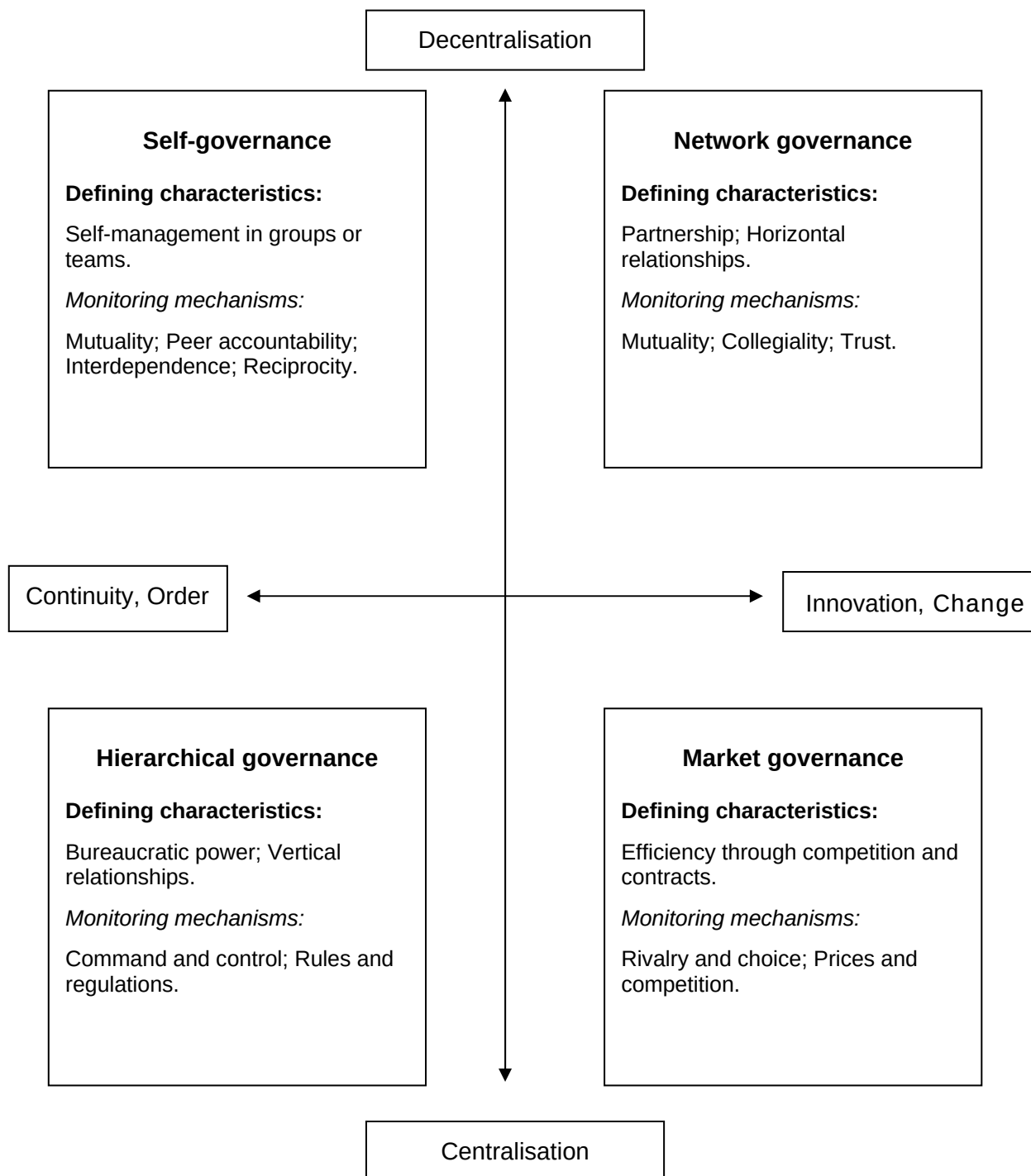
(16)

Indeed, the NHS is so large and has to meet so many different requirements, that it is inevitable that different governing structures will co-exist, depending on the context and conditions that are being met (7). This is recognised by Rhodes, who suggests that

No governing structure works for all services in all conditions. The issue therefore, is not the superiority of markets over hierarchies but the conditions under which each works best.

(18)

Figure 1. Models of governance (adapted from (17;20;(12)).



Some authors have also argued that, in reality, these models are not those of “real” markets, hierarchies or networks in the classic economic sense, but are rather “quasi” versions (1;3). For example, markets in the public sector do not function in the same way as those of the private sector, with a lack of true competition and the consumer (the patient) represented in the market by others acting as agents, for example the GP acting as a gatekeeper to secondary care through the referral process. Exworthy and his colleagues take this discussion to its natural conclusion by suggesting that, if markets in the public sector can be regarded as quasi-markets, then we must also have quasi-hierarchies

and quasi-networks in operation (1). This would imply that self-governance can also function as a quasi-model.

In addition, as suggested earlier, if these models are not mutually exclusive and overlap, it suggests that there will be blurring of the boundaries between each of the four organisational models and that the mechanisms by which governance is operationalised within each model may also overlap. This is explored in more detail next, with particular reference to the mechanisms of governance within each model.

1.3 Mechanisms of governance

The ethos of New Public Management rests on one of accountability and monitoring. In the NHS, this can be mapped by the increasing use over the last decade of centrally-derived performance indicators such as waiting times and access targets, National Service Frameworks in priority areas and payment for performance schemes, such as the Quality and Outcomes Framework in general practice (7;21). In some instances, the responsibility for monitoring rests with a national body; in other cases, this has been devolved to local level. Thus, within these different performance and accountability contexts, we may see a more hierarchical, market or network-based model in operation. However, each will require a mechanism for monitoring the activity and related performance that is under scrutiny. One way of examining this is through the four models of regulation proposed by Hood (5):

- Competition: where control is enacted through rivalry and choice.
- Oversight: where command and control techniques predominate in order to meet centrally derived targets.
- Mutuality: where control is through group processes and self-regulation.
- Contrived randomness: where control is enacted through unpredictable processes or payoffs.

Gray (17) also postulated several ideal modes of governance, which are not dissimilar to those of Hood. His typology consists of:

- Command mode: enacted through chains of “superior and subordinate authority” with control and accountability paramount.
- Communion mode: a relationship based on common values and beliefs, with a shared frame of reference.
- Contract mode: based on “inducement-contribution exchange agreed by parties”.

Some of these mechanisms can then be broadly mapped onto the governance structures described by Newman (see Figure 1). Command and contract modes, which use competition and oversight to monitor performance and accountability, are more centralised mechanisms, with performance indicators and frameworks derived centrally, e.g. from the Government. Such mechanisms are particularly apposite for hierarchical models of governance, with strong vertical relationships and

bureaucracy. Competition, where rivalry and choice predominates, is a key element of the market. These contrast with the communion mode of governance, where mutuality is a key feature – this is a more decentralised mechanism, with greater reliance on guidance from professional bodies. Thus, communion modes of governance may be more appropriate for less rigid structures of governance, as found within networks and self-governance.

However, as may be expected, these mechanisms do not map exactly onto Newman's structures – for example, the notion of contrived randomness does not map onto these structures in any clear way. One possible explanation for this lack of theoretical clarity is that, in practice, these mechanisms rarely exist in a pure form but, rather, co-exist as “complex overlays”(6) or “hybrids”(4). For example, Hood contests that, rather than the distinct entities of competition and oversight, Government uses a complex mix referred to as “comptrol”, where the elements of competition, command and control are blended (5). Thus, governance is best viewed as a complex blend of structures and mechanisms, dependent not only on the context and service under scrutiny, but also on the degree of autonomy of the professionals involved in the delivery of the service.

1.3.1 Professional autonomy

While professional autonomy is a key feature across all public sector domains, it is especially important in the field of medical care, where the medical profession has been the dominant influence (22-25). Professional autonomy reflects the degree to which professionals are free to determine the clinical care of their patients; their control over other professionals, including their workload; training, content and rewards for their work; the influence that the relationship that the profession has with the state; and, at a macro level, the dominance of the biomedical model for practice (24;26;27). Key characteristics of professional autonomy include expert knowledge and practice (23;25;28) and self-evaluation of one's own performance (29). However, the shift towards New Public Management, with its increasing emphasis on performance management, accountability and monitoring through the use of audit and performance indicators, has challenged professionalism across the public sector, most notably within the profession of medicine (7;26;29;30).

However, while professional autonomy, and in particular the autonomy of the medical profession, is a key issue, health care is provided by many professional groups working together. This raises the concepts of skill mix and professional boundaries, which may also change under different models of governance.

1.3.2 Skill mix and professional boundaries

Skill mix has been defined simply as the mix or combination of staff required in the workforce (Richardson, 1998; Richards, 2000; Jenkins-Clarke, 2001). However, others argue that the term should encompass a more dynamic entity, addressing the way in which staff interact with each other:

The term “skill mix” is usually used to describe the mix of posts, grades or occupations in an organization (strictly speaking, this is more accurately referred to as “grade mix”). It may also refer to the combinations of activities of skills needed for each job within the organization.

(31)

In relation to developments within the NHS, it is this more dynamic interpretation of skill mix that has come to the fore. The re-design of services, greater development of professional groups other than doctors, in particular nurses and allied health professionals and the move from hospital-based care to care located within primary care has led to significant changes in the composition of health care teams providing care and the way in which those teams interact. Several groups have tried to conceptualise how this skill mix change and role diversification can be defined (Box 1).

Box 1 Models of skill mix change and diversification (from (32;33))

Sibbald et al 2004	Nancarrow & Borthwick, 2005
Enhancement: where the depth of a job is increased by extending the role or skill of a particular group of workers.	Diversification: where a task not previously owned by a professional group is taken on by that group.
Substitution: where the breadth of a job is expanded, by working across professional divides or by exchanging one type of worker for another.	Specialisation: the adoption of increasing levels of expertise within a profession, often by a particular sub-group of the profession and legitimated through the use of specific titles, training and membership of a closed sub-group.
Delegation: where a task is moved up or down a traditional multidisciplinary ladder.	Horizontal substitution: when professionals with similar levels of training and expertise, but from different professional backgrounds, undertake roles that are normally undertaken by a different disciplinary group.
Innovation: where new jobs are created through the introduction of a new type of worker	Vertical substitution: the adoption or delegation of tasks across disciplinary or professional boundaries, between professionals with different levels of training or expertise. This crossing of disciplinary boundaries distinguishes vertical substitution from specialisation, which remains within a profession.

Whichever explanatory framework is preferred, there are broader issues to be considered and which may have implications for the way in which models of governance are enacted.

First, changes in the way in which professionals work together can lead to uncertainty and anxiety, particularly for the less powerful group (34). Second, the way in which professional groups delineate their own professional boundaries and then negotiate how tasks are distributed between and across these boundaries may vary depending on the governance model in which these negotiations are being enacted. Svensson suggested, in his study of hospital wards in Sweden, that the relationship between nurses and doctors was no longer one of subordination and dominance. Decisions around patient care were now negotiated between the professional groups, although nurses were still

likely to defer to the doctor when the decision was seen as “purely medical” (35). These findings were also found to apply to hospital settings in the UK (36). However, Abbott has argued that such negotiation, inter-professional collaboration and competition for roles is an inevitable factor of professional life (37). He thus contests that professional groups are engaged in a constant process of negotiation, with jurisdictional boundaries between professions in perpetual dispute and re-alignment.

These issues are particularly pertinent to UK general practice, which retained its independent contractor status when the NHS was established in 1948, but which has developed and expanded in recent years to encompass a range of professional groups, in particular general practitioners, practice nurses, community-based allied health professionals and practice-employed administrative staff. Thus, different modes of monitoring and governance may impact on the professional boundaries between each of these groups.

In order to more fully understand the impact of recent contractual changes and governance models in general practice, we must first review the development of UK general practice and the role of contracts within that.

1.4 General practice within the NHS

1.4.1 The 1966 and 1990 contracts

When the NHS was established in 1948, three groups of practitioners remained independent contractors: general dental practitioners, opticians and general medical practitioners (GPs). These groups have thus, at periodic intervals, re-negotiated their contracts with the Government. For GPs, the first major negotiation came in 1966 with The Family Doctor Charter, which introduced significant changes into general practice (38;39). GPs secured substantial pay improvements through a three-part payment system, comprising a basic practice allowance, capitation fees, and payments for designated items of service such as contraception and immunisation. Additional allowances to practices included loans and grants for the construction or improvement of practice premises, reimbursement for the practice costs of employing nursing and ancillary staff, and allowances to encourage GPs to undertake vocational training and work together in groups (Webster, 1998). The outcome of this new contract was a rapid expansion in the number of health centres and larger practices and an increasing number of employed practice staff, such as practice nurses and receptionists (40). However, there was little or no sense of governance or monitoring of these developments.

As previously described, the 1980s saw an increased focus on monitoring and accountability. Alongside this, concerns about variations in practice performance gained prominence. In response to this, The Royal College of General Practitioners produced a report titled “What Sort of Doctor”, setting out a voluntary practice-based scheme aiming to match individual

performance against defined criteria of competence (41). In the same year, “Quality in General Practice” emphasized the need to ensure quality standards in general practice (42). However despite the rhetoric of pursuing high quality care in general practice, there was little incentive in the contract to encourage GPs’ to provide high quality care and no consideration given to how these standards would be monitored nor how GPs would be held accountable for their performance. The then Conservative Government continued to focus on ways by which practice performance could be standardised leading, in 1990, to a new General Medical Services (GMS) contract that the Government imposed on GPs. This was the first major attempt to exert managerial accountability over GPs, by specifying their terms of service and linking financial incentives to the provision of certain services such as health promotion and health checks for over-75s (38;43-45). GPs saw the contractual obligations of the 1990 contract as the Government’s attempt to control their profession, challenge their clinical freedom and autonomy and threaten their status as independent contractors by delineating performance criteria (44;45). The introduction of targets and financial incentives within the contract meant that GPs were now more systematically accountable for the services provided under the 1990 contract, leading to an increase in administrative and organisational responsibilities. As well as responding to monitoring requirements in the contract, these also included developing protocols and guidelines with the Family Health Service Authorities (FHSAs), which were introduced by the 1990 NHS and Community Care Act and given managerial powers to monitor the provision of family practitioner services in general. As such, GPs felt they were being pushed into a bureaucratic chain of control, where they were managed by FHSAs, which were in turn directly accountable to the government (46).

Not everyone supports the contention that these changes challenge professional autonomy. Harrison, for example, contends that rather than challenging GP autonomy, what occurred in the early to mid-1990s was a redistribution of autonomy, both within general practice and the wider medical profession (30), with GP fundholding and the increase in the number of doctors operating within management contributing to this. While this was initially most apparent amongst the hospital-based specialties, the development of primary care organisations such as Primary Care Groups and Trusts in England and primary care organisations within Scottish Health Boards led to the rise of GP managers. These issues are considered next.

1.4.2 Governance within primary care post-1990: Soft versus hard bureaucracy

The centrality of professional autonomy has shaped how governance mechanisms can be enacted within the NHS, whichever governance model we consider. This is particularly pertinent in primary care, where the independent status of GPs is paramount. However, as discussed, with the rise of New Public Management, professionals’ expertise and autonomy have come under increasing managerial control. How this control has been enacted and enforced is key to understanding the

impact of the contract. As described previously, Hood suggested that Governments regulated professional groups through a complex mix of “comptrol”, where elements of competition, command and control were blended (5). This would fit with Gray’s contention that the modes of command, communion and contract governance can co-exist (17). There are, however, other lenses through which we can look at these issues.

One is the concept of soft bureaucracy (47). Proposed by Courpasson, soft bureaucracy addresses the question of “How rules can be imposed on members of professional elites whose [own] system of rules is based largely on autonomy?” (47). Courpasson argued that organisations dependent on professionals evolved systems of self-governance based on a number of elements, including: (i) that responsibility is clearly defined; (ii) that professionals align their behaviour to maintain their reputation; (iii) that professionals adopt standardised performance criteria, which they define; and (iv) that professionals exchange control over their autonomy for recognition of their expert effectiveness (“flexible corporatism”). In return, managers develop strategies to control professionals by developing measurable tools and by delineating personal responsibility. Courpasson argued that this was “soft” control because the standardisation of performance was accepted amongst the professionals involved without external coercion (48). However, it was possible for “harder”, more bureaucratic forms of governance to sit alongside these softer mechanisms. Several studies have examined this empirically in relation to primary care.

Sheaff et al, in a study exploring the implementation of clinical governance in English Primary Care Groups and Trusts, found that governance over frontline GPs was facilitated by local professional leaders, rather than managers, who harnessed their colleagues fears of threats to their professional autonomy and self-regulation, rather than fears of competition (49;50). This was directed essentially at clinical activity, but was difficult to sustain, to extend to non-clinical activity or to develop into harder forms of governance, if required. Others also identified this lack of “hard” or “command” governance, reporting that, while GPs commented on the increasing amount of bureaucratic paperwork associated with performance management and audit and the increasing use of financial incentives to meet performance targets, there was little or no use of sanctions for non-compliance (51). Similar views were expressed by GPs on the use of performance indicators, who felt that compliance with the “soft” approach of monitoring performance potentially prevented the harder approach of government interference (29). This view was expressed in relation to other areas as well, for example prescribing where GPs expressed disquiet about the potential threat of PCT’s monitoring their prescribing behaviour.

... it’s not quite as bad as we expected but it has the potential, the iron fist is inside the velvet glove, we know it’s there.

(52)

Thus, even before the implementation of the new GMS contract, there was evidence that multiple mechanisms of governance were developing within primary care. Although there was little evidence of hard forms of

governance being applied, GPs clearly perceived this as a potential future threat and so were happy to meet professionally driven softer forms of governance and monitoring. Financial incentives were used more frequently with respect to meeting performance indicator targets and there was evidence of a greater role for decentralised organisations such as Primary Care Trusts in monitoring performance. However, the use of incentives within contracts has been postulated to change how professionals respond in relation to governance and their professional practice.

1.4.3 Use of incentives and monitoring of incentivised behaviour

The use of incentives to change practitioner behaviour is not new – for example, the 1990 GP contract introduced incentives for immunization, cervical screening and health promotion checks, leading to an increase in the rates of these activities. The use of incentives to improve clinician performance has been shown to work in other countries and health care systems (53-56). The impact of incentives on professionals' behaviour is not, however, straightforward and several problems associated with incentivising behaviours to improve quality of care have been identified (Box 2).

Box 2 Issues associated with the incentivisation of professionals' behaviour (from (57-59))

"Crowding out" of unincentivised conditions.
Non-linear relationships between the size of the financial impact and the work that doctors will put in to meet it, i.e. doctors may have a notional income target of their own which, once met, is sufficient and they will no longer be motivated to respond further.
Detrimental impact of financial incentives on professionals' own internal motivation and professionalism.
Damage to the doctor-patient relationship through a focus on incentivised areas of care rather than on the patient's agenda.
A focus on measurable, process-related indicators rather than long-term outcomes related to health improvement.
Targeting less "difficult" patient populations, for example younger patients or patients with single conditions, rather than older, complex patients with multiple morbidities.
"Gaming" of the system by data manipulation or by removing more challenging patients from practice lists.

Once an incentivised system is in place, the predominant mechanism for monitoring its achievement is through the use of contracts. A key conceptual framework by which the relationship between the two parties in a contract is considered is that of principal-agent theory (12;21;60). The rational underpinning this theoretical model is that one party, the principal, desires an outcome that it cannot achieve itself; thus, the principal contracts with an agent, or agents, to produce the required outcome for reward, usually financial. Propper argues that, in the NHS, there are sets of overlapping principal-agent relationships (60). Baxter develops this, arguing that, where commissioning is concerned, the relationship may involve a single tier, i.e. one principal contracting with a single agent, or multiple tiers. In such a situation, agents may themselves act as principals (known as the principal-cum-agent) and

may collude with agents lower down the chain to promote their own interests rather than those of the principal at the top of the chain, especially if those in the lower chains belong to a different organisation from those in the upper chains (61). These concepts can be used to formulate accountability chains, such as those reported within primary care in England (21). It is also important, however, to consider not only the level of the payment being made, but also the way in which the payment is linked to measures of performance (62). These issues are now discussed further in relation to the 2004 GMS contract.

1.5 The 2004 General Medical Services contract

Following the imposition of the 1990 contract, GP discontent grew steadily throughout the 1990s. A survey of GPs in 2001 by the BMA found that there was low morale and many were stressed and considering leaving the profession (63). In 2002, the NHS Confederation and the BMA jointly announced plans for a major revision of the contract, designed to take into account the changing demands on primary care (64;65).

The new GMS contract (nGMS), implemented in 2004, represented a significant departure from previous contracts (66;67).

1. The NHS is no longer contracted with individual GPs but instead with practices. In principle, this made it easier for professional groups other than GPs to become practice partners, and that practices led by professionals other than GPs could be established (the latter was possible under Personal Medical Services contracts, but nGMS made it universal) (68;69).
2. Service provision was now divided into three categories: essential; additional; and enhanced services. While GMS practices had to provide essential services (Box 1), they could elect to opt out of the other two levels of service. For additional services, general practices were the preferred provider, whereas for enhanced services, Primary Care Organisations (PCOs) could commission from any provider.
3. If practices did not provide additional or enhanced services, their global sum was reduced and PCOs could use the money to secure alternative provision from other practices or other primary care providers.
4. It allowed GPs to opt out of 24-hour responsibility for their patients, with the onus for providing out-of-hours care moving from the practice to the PCO.
5. There was a major focus on the incentivisation of care within practices, through the implementation of the Quality and Outcomes Framework (QOF), which covered both clinical and organisational areas of practice.

Some of these elements will now be discussed in turn.

1.5.1 Quality and Outcomes Framework: Achievement and exception reporting

The Quality and Outcomes Framework (QOF) was described by Paul Shekelle as

an initiative to improve the quality of primary care that is the boldest such proposal attempted anywhere in the world.

(67)

As outlined in Box 3, practices are rewarded for care in both clinical and organisational areas. Clinical areas focus on chronic disease management, with the largest number of points available for coronary heart disease, hypertension and diabetes. This system does, of course, require careful monitoring and practices have to account for the number of QOF points that they are claiming for (70), which required greater computerisation of general practices (67). However, when it was implemented, it was intended that the reporting of QOF achievement to Primary Care Organisations should be “high trust, low bureaucracy” (66).

Box 3 Payment systems for general practices under the new GMS contract (68)

Type of Payment	Explanation
Weighted capitation (the “global sum”)	All practices receive a global sum payment, to pay for providing basic primary care services to registered patients (first point of contact, surgery and home visits, referral, and co-ordination - “ essential services ”). This comprises the largest part of practice income. A proportion of the global sum is optional for “ additional services ” which includes immunizations, cervical screening, maternity services, and care in the out-of hours period, when surgeries are unavailable. Where practices opt out of additional services, their payment is reduced and the reclaimed money used by the primary care organisation to provide the service elsewhere, either by commissioning another practice or an area wide organisation.
Pay for performance - the Quality and Outcomes Framework (QOF)	Payments under QOF depend on performance measured against ~150 quality indicators. Approximately half of the indicators are organizational and typically binary (e.g. have all clinical staff completed cardiopulmonary resuscitation training in the previous year); the remaining half is clinical and typically based on percentages (e.g. the percentage of patients with diabetes achieving target blood pressure). Practices are allowed to ‘exception report’ patients who are unsuitable for particular indicators (e.g. because of terminal illness, treatment intolerance or treatment refusal) or who do not attend for review after at least three invitations. Payment for binary measures is all or nothing. Payment for clinical indicators is based on a sliding scale with no payment until at least 40% of patients are compliant with the indicator and increasing linearly to a maximum threshold (typically 90% for process measures, but lower for outcomes). Achievement on each indicator is transformed to a common scale (“points”) with a maximum of 1050 points available in 2004/5. The amount earned per point for the average sized practice of ~5,500 patients and 4.5 doctors was £75 (\$106) in 2004/05 rising to £120 (\$170) in 2005/06. (In 2009, the amount earned per point was £125 (\$200)). Actual payment per practice varies with size of practice, and numbers of patients with each disease incentivised.
Specific payment for “ enhanced ”	Enhanced services are specific payments for other additional services where local NHS organisations can choose to commission a service

services”	from practices or from other providers (unlike additional services in the global sum where the practice has the right to provide the service unless they decide not to). Examples include more specialist care for alcohol and drug misuse, minor injury services and care for homeless people. Payment typically has both a lump sum element plus payment per patient with the condition, and is dependent on the practice complying with organisational and reporting requirements specified in the contract. There are three types of enhanced service. Directed Enhanced Services are defined centrally and must be provided by the local PCO for its population. Local Enhanced Services are locally developed services designed to meet local health needs. National Enhanced Services are commissioned to meet local health needs, but PCOs must use national specifications and benchmark pricing
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The QOF was thus intended to reward practices for providing high quality care, with positive outcomes anticipated such as improvements in the process of care; improved health outcomes both at the patient and population level; and an expanded role for practice nurses (70;71). However, concerns were raised that the contract might have unintended consequences (66;67;70). These included the possibility of fragmentation of care and a reduction in personal continuity; a reduction in the quality of care in those clinical areas not incentivised by the QOF; and negative impacts on the face-to-face consultation between the doctor and the patient. Another issue of concern was the explicit use of incentives within the contract, with authors postulating that incentives could lead to a lack of independent judgement on the part of GPs, risks of gaming and even the possibility of removing non-compliant patients from practice lists (72;73). These concerns were voiced by GPs themselves in a survey and interviews undertaken by Roland et al immediately prior to the implementation of the contract (74).

Since the implementation of the new contract, there has been increasing research evidence published on the impact of the QOF on clinical care, on practice organisation and on team working. Overall, practices have performed well. In the first year (2004/05), practices in England were awarded a median of 1003 points (96.7% of the 1050 points available) and 230 practices (2.8% of all practices) achieved maximum points (75). Median reported achievement for all eligible patients was 83.4% (IQR: 78.2 – 87.0%). The characteristics of the population served impacted on achievement, with lower achievement in practices with a higher proportion of patients who were in low-income or single parent households or who were aged 65 or over. Achievement was also lower in larger practices and in practices with a higher proportion of older GPs or GPs educated outside the UK. However, all of these characteristics had only a small impact on the overall variation in achievement (75). Using Scottish data, Gravelle et al found that 90.8% of practices reported levels of achievement above the upper threshold in Year 2 of the QOF (2005/06). The authors also suggested that practices could have reduced the number of patients treated by 11.8% without reducing their income (by falling below payment thresholds), suggesting “a degree of altruistic behaviour” (76).

QOF achievement was further explored in relation to a number of factors, including practice size and the socioeconomic deprivation of the practice population. While smaller practices were found to achieve lower points,

this was mostly due to difficulties acquiring high points in the organisational domain, rather than the clinical domains, leading the authors to postulate that smaller practices had less organisational capacity with which to address the QOF (77).

In general, practice population deprivation was associated with lower QOF achievement (75;76;78-80). The difference between the most affluent and most deprived practices was greatest for complex process measures, e.g. retinal screening in diabetes, for some intermediate outcome measures, e.g. glycaemic control in diabetes, and for some treatment indicators, e.g. influenza immunisation (80). Not surprisingly, QOF disease prevalence also increased with deprivation (see, for example, (81;82)).

More recently, researchers have examined the longer-term impact of QOF on performance. Campbell et al monitored a basket of performance indicators before and after the introduction of QOF (83;84). They reported that the quality of care for coronary heart disease (CHD), type 2 diabetes and asthma improved between 2003 and 2005, continuing the trend seen prior to the introduction of the QOF: this rate of improvement was statistically significant for diabetes and for asthma, but not for CHD. By 2007, however, this rate of improvement had become static or even decreased across the three conditions. QOF may also have reduced inequalities in care, for those areas that were incentivised, as the gap in QOF achievement between the most affluent and most deprived practices reduced over the first three years of its implementation (85;86).

The new contract also allowed exception reporting, where practices could exclude patients from their targets for a range of reasons (Box 4).

Box 4 Reasons for exception reporting patients (87)

Patient invited for a review 3 or more times in past year but has failed to attend.
Presence of other problems (e.g. terminal illness, extreme frailty) make chronic disease monitoring inappropriate.
Newly registered patients, whose inclusion can be delayed until the next quarter when monitoring should have been initiated.
Patients on full tolerated doses of relevant treatment, but still failing to achieve targets levels.
Patients with allergies or adverse reactions to relevant medications.
Patient for whom informed dissent from recommended treatment was recorded.
Other co-morbidity makes target treatment inappropriate.
Investigation or specialist service locally unavailable.

There were, however, concerns about the extent to which exception reporting was “gamed” and so exception reporting was the focus of several research papers. Doran et al reported that exception reporting in Year 1, for those indicators for which it could be calculated, was low with a median of 6% (IQR: 4.9-7.7%). It was, however, a strong predictor of QOF achievement in the first year, i.e. a 1% increase in exception reporting was associated with a rise of 0.31% in reported achievement (75). They also reported that around 1% of English practices exception reported over 15% of their patients. Others reported a positive

association between practice-level deprivation and exception reporting (76;81). Gravelle and colleagues examined how practices in Scotland might use exception reporting to “game” the system in their favour. They found that practices which had been below the upper payment threshold for a clinical indicator in Year 1 of the QOF, but above it in Year 2, exception reported more patients for that indicator in Year 2 compared to practices still below the upper threshold. They used these findings to estimate that practices who were below the threshold in Year 1 might have inappropriately exception reported 0.87% of their patients in Year 2, and this could account for 10.9% of all patients exception reported in Scotland.

Exception reporting also appeared to be associated with particular types of patients. Examination of patients excluded for the clinical indicators associated with stroke or TIA found that patients who were female, older, had dementia, were from deprived areas or had multiple morbidities were more likely to be exception reported (88). Practices located in densely populated areas, with small numbers of young (<16 years) or older (>64 years) patients and larger practices also had increased rates of exception reporting (89). Overall, however, the effects were small: an increase of 1000 patients in the practice population accounted for an increase of only 0.04% in the rate of exception reporting.

Only one paper reported comparative work across the four UK countries (90). Overall, both delivered care (i.e. for eligible patients) and population care (i.e. all patients, including those who could be exception reported) was highest in Scotland and Northern Ireland and lowest in Wales. Again, the largest differences were found for the most complex indicators, in particular complex process, intermediate outcome and treatment indicators.

One concern was that the QOF would have a negative impact on care for unincentivised conditions. This appears not to be the case, although care for such conditions has not improved significantly either. A case note retrieval conducted in 18 English practices found that there was a significant improvement in the achievement of 21 indicators for incentivised conditions (91), but this improvement was not observed for non-incentivised conditions. Campbell's longitudinal study explored performance for both incentivised and non-incentivised clinical indicators in CHD, asthma and diabetes (84), reporting that mean quality scores for incentivised indicators were higher than those for non-incentivised indicators for all three conditions. Indeed, in the case of CHD and asthma, quality of care had actually decreased for the non-incentivised indicators. A similar picture was observed for prescribing, where prescribing for drugs associated with QOF conditions increased significantly faster than non-QOF drugs, both before and after the implementation of the contract (92).

1.5.2 Quality and Outcomes Framework: impact of practice organisation and on staff

An increasing number of mainly qualitative studies have explored in-depth the impact of the QOF in particular, and the GMS contract more generally, on practice organisation and staff.

Whalley et al reported on a longitudinal questionnaire survey conducted with over 4000 GPs in 2004 and repeated in 2005 (93). This found that overall job satisfaction increased following implementation of the contract, with the greatest improvements being in GPs' satisfaction with their remuneration and hours of work. However, GPs also reported that the contract had increased their administrative and clinical workloads, and decreased their professional autonomy, although it was not clear in what way the contract had impacted on their autonomy.

More detailed qualitative studies with practice staff explored the impact of the QOF on practice organisation and professional boundaries. Interviews with GPs and practice nurses indicated that both the intended and unintended consequences posited prior to the implementation of the contract had, indeed, come to fruition. Both professional groups commented on improvements in teamwork, practice organisation and consistency of recording clinical data for incentivised conditions, but not for unincentivised conditions (94-96). However, both GPs and practice nurses also commented on the greatly increased workload, clinically and organisationally, felt that the need to "box-tick" interfered with the consultation and that the contract was having a negative impact on continuity of care. GPs in Campbell's study suggested that the transfer of work from themselves to practice nurses was leading to them feeling deskilled in some areas of chronic disease management, for example care of asthmatics (94).

In several studies, respondents spoke about the way in which the patient's agenda was being pushed aside by the QOF, with a lack of time to listen to patients' concerns (95;96). A particular concern of practice nurses was that of feeling unrewarded financially for their role in achieving QOF points for the practice (94;96).

Going beyond the impact on the consultation, evidence is growing that the contract is impacting on internal relationships within practices, particularly in relation to internal practice monitoring. One study, conducted in England and Scotland, carried out ethnographic research in four general practices. This work described how practitioners saw themselves as "chasers" or "chased", depending on whether they were leads for a QOF area, and so responsible for monitoring their colleagues achievement, or the professionals who were subjected to the surveillance (97-99). Practitioners working in practices which employed greater levels of surveillance were less positive about the contract and nurses were less positive about it than GPs (100;101). However, these studies were based on in-depth case studies in either two or four practices, so the wider generalisability of these findings is yet to be established.

1.5.3 Impact of the contract on other areas of care

Much less has been written about the impact of the contract on other areas of care, notably the delivery of the enhanced services and provision of out-of-hours care. In relation to the enhanced services, the House of Commons Accounts Committee noted the lack of uptake of the enhanced services in England, with many PCTs not using even the minimum allowance set aside for these services (102). In Scotland, there has been greater uptake of the enhanced services, but no studies have explored the impact of the enhanced services, either for outcomes, for patient care or on the practice.

1.5.4 Out-of-hours care

Out-of-hours care in the UK has been subject to major re-organisational change since the mid-1990s, when individual GPs were able to pass out-of-hours responsibility for their patients to other organised groups of GPs. This led to a rapid expansion in GP-led co-operatives, particularly in urban areas (103). However, control of the provision of out-of-hours care remained largely the domain of GPs.

The new GMS contract defined out-of-hours care as an additional service in the weighted capitation sum (Box 3), which allowed GPs to opt-out of 24-hour responsibility for care of their patients, for a loss in practice income of approximately £6000 per GP. The responsibility for out-of-hours care then shifted to the Primary Care Organisations (PCTs in England; NHS Health Boards in Scotland). The great majority of GPs (over 90%) opted to stop providing out-of-hours care. Three national bodies have since reported that PCTs and Health Boards were under-prepared for this responsibility and that the cost of providing such care was grossly underestimated (104-106). There has been little reported on the impact of the new contract directly on the organisation and delivery of out-of-hours care. However, a recently completed project funded by the SDO (SDO Reference 08/1519/97), in which two of the current grantholders were involved (COD & DH), examined the impact of changing workforce patterns in urgent and emergency care after the new contract. It found that new skill mix configurations were developing, with greater use of nurses and paramedics, although many GPs had returned to carry out sessional work for PCO-run organisations. The routes into urgent and emergency care were numerous and confusing for patients, although patient satisfaction appeared to be unchanged, no matter which professional group dealt with them. Instead, the generic attributes of service provision were more important, including ease of access, waiting times, continuity of care and having their expectations met about where the definitive consultation would take place (at home, in a centre or on the telephone).

1.6 The 2004 contract: what we don't yet know

The research literature on the impact of the new contract has focussed almost exclusively on quantitative analyses of the impact of the QOF on incentivised care, either generally, for specific conditions (mainly CHD

and diabetes), or for underserved populations, mainly socioeconomically deprived populations but also minority ethnic groups and the elderly. There has been little attempt to assess if the QOF has had a detrimental effect on non-incentivised conditions, with the conclusion that care for such conditions has not deteriorated, but neither has it improved. There is limited evidence of gaming and, even when it does exist, its overall impact on the variation of QOF scores appears small. Qualitative work has explored the impact on practices and staff and concluded that workload has increased, particularly for practice nurses, and professionals feel that the data collection associated with the QOF has had a detrimental impact on the practitioner-patient consultation. Many are also concerned about the increasing atmosphere of surveillance developing within practices.

There are, however, many unexplored areas post-GMS contract. In particular, there is no work exploring the types of governance and regulation that PCOs may be employing to monitor practice performance; there is no work on the way in which practices and PCOs are responding to those parts of the contract which lie out with QOF – namely the enhanced services; the impact on the governance and monitoring of out-of-hours care is under-reported; and, finally, there is little work examining the impact of the contract on the patient experience. To date, only Campbell et al have reported on the impact of QOF on patients' views of care, with no significant changes reported by patients either with regard to access to care or interpersonal elements of care, such as communication. Patients did, however, report that it was more difficult to get an appointment with a preferred GP (84). These areas thus form the major focus of the work conducted within this project.

1.7 Future developments for the NHS in England

Following the election of the Coalition Government in May 2010, a White Paper outlining the future of the NHS was released in July 2010 – *Equity and excellence: Liberating the NHS* (107). This proposes far reaching changes for the NHS in England. Of particular relevance to this work is the plan to abolish SHAs by April 2012 and PCTs by April 2013 because Practice Based Commissioning is viewed as a “flawed policy framework that confuses the respective responsibilities of GPs and PCTs, and fails to transfer real freedom and responsibility to GP practices.” (p.27) Responsibility for commissioning most health services will be devolved to consortia of general practices. However, commissioning of family health services (including general medical services), maternity services and specialist services will be the responsibility of a new body, the NHS Commissioning Board. Unlike PBC Consortia, the new GP Consortia will be allocated hard budgets from 2013/14 and membership of a consortium will be compulsory for general practices. They will be held to account by the NHS Commissioning Board for both their spending and the outcomes they achieve. The consortia will be able to purchase external support from other organisations, including from the voluntary and private sector, for some activities, such as needs assessment, contract negotiation and performance management. These consortia will

also be responsible for promoting equality and for patient and public involvement. PCTs will support GP consortia become established, but will then be abolished in 2013, when their public health functions will be transferred to local authorities. The White Paper also proposed to establish a single contractual and funding model, with funding following the patient and payments increasingly being linked to performance.

Under these proposals, a new model of monitoring and accountability has been outlined, albeit with some similarities to those currently in place. Essentially hierarchical, consortia will be accountable upwards to the NHS Commissioning Board and, through it, to the Department of Health; consortia are intended to be held accountable by the population that they will serve. Consortia will hold contracts with a range of providers, from the public and private sectors, and will monitor their performance through those contracts.

1.8 Organisation of this report

The next chapter describes the aims and objectives of this study. Then, following a discussion of the methodological approach adopted, we describe first the organisational case study sites selected for this work (Chapter 4), then the selection of embedded case studies within them (Chapter 5). Chapters 6 to 11 describe the substantive findings across a range of areas. Finally, Chapter 12 will draw these findings together, discuss the advantages and limitations of this study and make recommendations for policy, practice, GP commissioners and future research.

2 Aims and objectives

As outlined early in Chapter 1, the original commissioning brief from the SDO outlined the need to understand the relative effectiveness of different mechanisms of governance and incentives and their impact on professionals, on health care organisations and on the overall performance of the wider NHS. This project addressed these issues through the lens of the implementation of the 2004 General Medical Services (GMS) contract into UK primary care. Of particular interest were the still largely unexplored issues, namely: the types of governance and regulation that PCOs may be employing to monitor practice performance; the response of practices and PCOs to those parts of the contract which lie out with the Quality and Outcomes Framework – namely the enhanced services; the impact on the governance and monitoring of out-of-hours care; and, finally, the impact of the contract on the patient experience. These areas form the major focus of the work conducted within this project.

Here, we describe the aims and objectives of the project and indicate which strands of work address which of the objectives.

2.1 Aims

To explore the governance arrangements in different models of service provision emerging from the implementation of the new GMS contract; the impact of the incentives contained within the contract on the organisation and performance of primary care; and the impact of the new contract on professional skill-mix and patients' experience.

2.2 Objectives

1. To examine the overall impact of the new GMS contract on clinical activity and patient process and outcome (Stages 1 & 2).
2. To describe how governance arrangements under the new contract are interpreted and implemented in the design and management of different provider organisations (practices, enhanced services and out-of-hours services) (Stages 1 & 2).
3. To examine how governance arrangements impact on the relationships between PCOs and professionals working within different provider organisations and on the organisation of professional work (Stages 2 and 3).
4. To explore how new opportunities: (a) for patient and public involvement AND (b) to pursue population health or equity of care through commissioning or use of new resources, are understood and in what ways, if any, these are addressed (Stages 1, 2 and 3).
5. To identify whether shared learning between provider organisations, either directly or via the PCO, occurs (Stages 1, 2 and 3).

3 Methodological approach

3.1 *Justification for the overall study design*

In order to fully explore and understand the governance arrangements in the different models of service provision which have emerged following the implementation of the new GMS contract, a multi-stage, multi-site study design was used utilising embedded case studies and a mixed methods approach to data collection.

This approach linked the analyses of routinely collected national data with empirical data collection through comparative intensive case studies located in England and Scotland. Such an approach was chosen because it is recognised that a judicious combination of qualitative and quantitative methods can play a valuable role in health services research, providing more information and insight than one method alone (108-110).

The principal purposes for mixing methods in this study were:

1. To use routinely collected quantitative data to identify four Primary Care Organisations (PCOs) as the case study sites.
2. To enhance our understanding of the way in which these PCOs monitored practices, in relation to QOF achievement and participation in enhanced services, through the use of qualitative methods.
3. To use routinely collected quantitative data, e.g. QOF data and other practice characteristics, to construct sampling frames for the selection of embedded case study sites in two PCOs, in which further, in-depth qualitative work would be conducted.
4. To enhance our understanding of the ways in which practices organised themselves to meet the performance-related criteria of the QOF, as reported in routinely collected data, e.g. by changing the skill mix within practices or by re-delegating work from one professional group to another.
5. To explore the impact of QOF on patient care, using case note review and from the perspective of patients themselves.

In this chapter, we outline the justification for the use of embedded case studies as our principal method of empirical data collection; describe the integration of the quantitative and qualitative methods used; describe briefly the methods employed in each stage of the study; and, finally, discuss the timeline and challenges of obtaining ethical and research governance approval across multiple sites in England and Scotland. Detailed description of the actual methods used at each stage of the project will be reported in later chapters.

3.2 Case studies as a methodological approach

Yin described a case study as “an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evidenced” (111). Both Stake and Creswell defined a case study as an exploration of a bounded system, i.e. bounded by time and place, and studied through detailed in-depth data collection involving multiple sources of data (112;113).

Thus, case studies are used when context is thought to be important and highly pertinent to the phenomenon under study. Case studies are also powerful because it is a methodology able to cope with the situation of having more variables of interest than data points. As a result, the case study approach relies on multiple sources of evidence, with prior development of theoretical propositions to guide both data collection and analysis. Case studies are, therefore, intrinsically suited to the mixed methods paradigm, where the phenomenon of interest can be explored using both quantitative and qualitative data collection methods, integrated during the process of data collection and/or analyses in order to develop as full a picture as possible. However, of key importance in the development of a case study approach is consideration of the type of case study to be undertaken and the representativeness of the case study/studies selected.

3.2.1 Types of case study

Yin (111) argues that case studies can be exploratory, descriptive or explanatory. The type of case study is shaped by the research questions asked. Thus, if the research questions are predominately “what” questions, then the case study is likely to be exploratory or descriptive. If the questions tend towards “how” and “why”, the case study is more likely to be explanatory in nature. While this impacts on the way in which data collection methods are framed, the more crucial decision for researchers is whether to focus on a single case study or multiple case studies and whether such case studies are stand-alone or embedded in a wider system.

Yin provides a framework and two-by-two matrix to inform decisions on case study design (111). Case studies are considered to be either **single** or **multiple** cases; within each of these options, there can be either a **single unit of analysis** or **multiple, embedded units of analysis** (Figure 2). Within all of these options, the context in which the case is located is also of interest and, often, the boundaries between the case and its context are blurred.

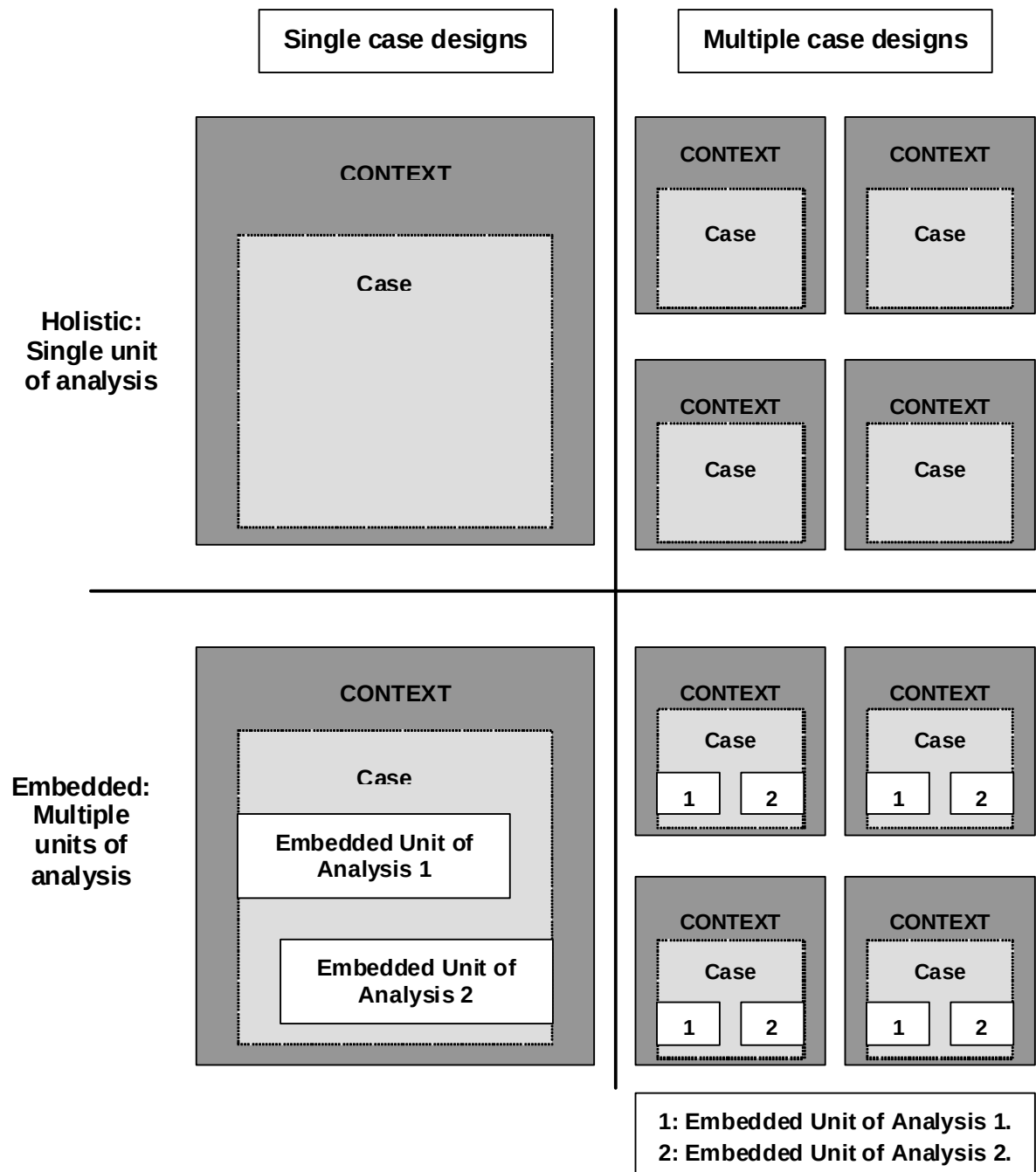


Figure 2. Yin's framework for case study design (111)

3.2.2 Single versus multiple case designs

A single case study is justifiable when it meets one of the following rationales:

- It represents a critical case with which to test a well-formulated theory.
- It represents an extreme or unique case.
- It is a representative or typical case.

- It is a revelatory case.
- It is studied longitudinally.

However, there is an inherent danger that the single case study may later turn out to be different from that assumed at the outset, and that the original research questions cannot be answered. Multiple case studies avoid some of these problems and are often considered to produce more compelling evidence, but do represent a significant increase in time and resources. Every case selected should serve a specific purpose within the overall scope of the study and follow a “replication” logic. Thus, each case is selected so that it either:

- Predicts similar results (a **literal replication**) or
- Predicts contrasting results but for predictable reasons (a **theoretical replication**).

An important step in this is the development of a rich theoretical framework. This needs to state the conditions under which a particular phenomenon is likely to be found (a literal replication) as well as conditions when it is not likely to be found (a theoretical replication).

3.2.3 Holistic versus embedded case designs

The same case study may involve more than one unit of analysis. For example, a case study may be a public programme encompassing many funded projects, which would be the embedded units. These embedded units are selected through sampling – the resulting design being an **embedded case study design**. If, however, only the global nature of the organisation or programme was studied, the design would be a stand-alone **holistic design**.

Pitfalls for the holistic design include taking too abstract an approach, resulting in a lack of clear measures or data, or that the entire nature of the case study may shift such that the original research questions cannot be answered. A major flaw of the embedded design is when the case study focuses only on the embedded unit and does not return to the larger unit of analysis, the overall case study itself. This also takes us to the key issue in case study design, that of generalisability.

3.2.4 Generalisability, validity and design quality in case study research

Given the number of cases that can be realistically selected in any project representativeness, in the statistical sense, is not achievable. Case studies should, however, be able to inform us about features present in a broader population of similar cases or, as Gerring writes “a case study is best defined as an in-depth study of a single unit ... where the scholar’s aim is to elucidate features of a larger class of similar phenomenon” (114;115).

Theory development is seen as an essential part of the design phase. Theory development not only facilitates the selection of case studies and data collection, but also informs the generalisability of the findings from

the case study. This is key, as the aim of case studies is not to reach statistical generalisability, but to aim for analytic generalization, i.e. where a previously developed theory is used as a template with which to compare the empirical results of the case study (111). Yin argues that replication may be claimed if two or more cases support the same theory and the results from the case study/case studies can be considered more potent if they do not support an equally plausible, rival theory.

Yin suggests that there are four tests related to design quality that case studies must satisfy.

- **Construct validity:** whereby researchers establish the correct operational measures for the concepts being studied e.g. data collection methods; use of multiple sources of data collection; having key informants reviewing draft case study reports.
- **Internal validity:** important for explanatory case studies, where researchers make inferences, using data to test whether an action or earlier occurrence has led to a particular outcome or response.
- **External validity:** addresses whether the findings from a study are generalisable beyond the case study in which the data were generated.
- **Reliability:** demonstrates that another investigator could repeat the study and arrive at the same findings, e.g. through transparent methods of data collection and analysis.

3.3 Justification for the use of case studies in this project

This study sought to explore and understand the governance arrangements enacted in different models of service provision which have emerged following the implementation of the new GMS contract, located in two, devolving NHS systems: England and Scotland. Based on our knowledge of the literature and on previous work, described in Chapter 1, we developed the following propositions to test out in our case studies.

1. Governance arrangements would be enacted in different ways in PCOs in England and in Scotland, due to the different ethos of the NHS in England (more market oriented) and Scotland (more professionally driven).
2. The characteristics of the practices and population served may impact on governance arrangements within PCOs.
3. Within PCOs, practices and health care professionals may be subject to different models of governance depending on the type of service being delivered. Thus, accountability for QOF performance may be governed in a different way from that of an enhanced service.
4. In order to meet these different governance requirements, practices and their staff may respond in different ways to the services being monitored

5. Out-of-hours care, as a responsibility of the PCO, may be subject to different modes of governance, with different impacts on the staff providing that service.
6. Skill mix developments may be observed within these different service models, leading to different modes of monitoring and accountability across professional groups.
7. Within practices, higher and lower QOF achieving practices may organise themselves differently, with differential impacts on both staff and patients.

To address these propositions, we first selected four PCOs as our case study sites: two in England and two in Scotland, i.e. a **multiple case design**. Within two of the case study sites (one each in England and Scotland), we then identified a range of **embedded units** for further exploration. In each case study, these embedded units were:

- Three GMS practices (n=3) selected on the basis of QOF performance;
- One PMS practice;
- One enhanced service delivered in both countries;
- One out-of-hours service.

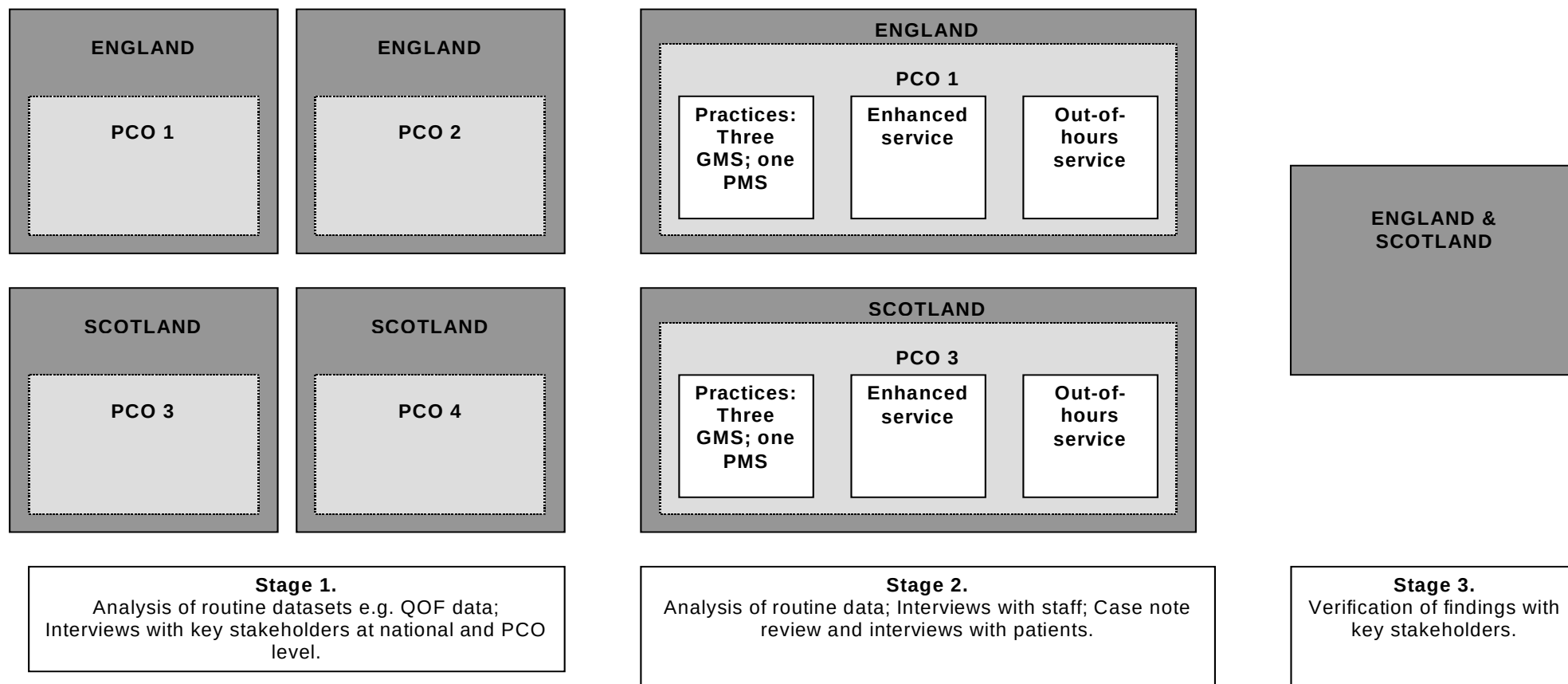
Thus, the final study design corresponded to the lower right-hand quadrant of Yin's 2X2 matrix in Figure 2. The relationship between the case studies and the stages of data collection is shown in Figure 3.

At each stage of the study, we employed and integrated multiple methods; this is discussed further in Chapter 3.4.

3.4 Justification for the integration of methods in this study

Cresswell reminds us that mixed methods research involves more than just the collection of quantitative and qualitative data within one project, but “indicates that data will be integrated, related, or mixed at some stage of the research process” (113). Bryman expanded on this and, drawing on previous literature, identified five issues that need to be considered when conducting mixed methods research (116):

Figure 3. Overall study design: relationship of case studies to stages of data collection



1. Are the qualitative and quantitative data collected simultaneously or sequentially?
2. Which approach has priority?
3. What is the function of the integration – is it, for example, for triangulation, exploration or explanation?
4. At what stage in the research process are mixed methods employed – is it, for example, at the stage of designing research questions, data collection, data analysis or data interpretation?
5. Is there more than one data strand?

Thus, consideration needs to be given not only to the purpose of mixing methods, but also to the practicalities of mixing methods.

3.4.1 The purpose of mixing methods in this study

Greene developed a useful conceptual framework outlining the purposes for which a mixed methods approach might be employed, covering the issues of triangulation, complementarity, study development, initiation and expansion (117). Bryman considered this scheme too parsimonious and so developed and expanded it to cover a wider set of purposes (116), although it overlapped substantially with Greene's. Mixed methods were used in this study to meet a number of purposes, described in Box 5 in relation to the frameworks of Greene and Bryman.

Box 5 Justification for mixed methods within this study (from (117) & (116))

Definitions according to Greene et al, 1989	Definitions according to Bryman, 2006	This study
Triangulation.		
Triangulation: convergence and corroboration of results from different methods.	Triangulation: the combination of methods to corroborate findings.	✓ Use of quantitative & qualitative methods to monitor performance and reporting over time and to explore perceptions of QOF performance; to track and monitor potential skill mix change.
Complementarity.		
Complementarity: elaboration, enhancement, clarification of the results from one method with the results from the other method.	Offsetting: the use of both methods to offset the weaknesses inherent in both and thus maximise the strengths of both.	✓ Qualitative approaches used to further our understanding about the impact of monitoring and governance on practice performance and skill mix, as measured quantitatively.
	Completeness: allows a more comprehensive account of the area of enquiry through the use of both approaches.	✓ Qualitative interviews help develop a greater understanding of performance measured quantitatively.
	Credibility: employment of	✓ Use of quantitative and

	both approaches enhances the integrity of the findings.	qualitative approaches built a more complete picture of the governance of the GMS contract.
	Context: where qualitative research provides contextual understanding of generalisable results obtained quantitatively.	✓ Qualitative data illustrates the contextual differences in health care in England & Scotland, which may impact on the quantitative data reported routinely.
	Enhancement: augmenting the qualitative or quantitative findings by gathering data using the other approach.	✓ Develop a greater understanding of performance measured quantitatively through qualitative interviews.
	Explanation: one approach helps to explain the findings generated by the other.	✓ Use of quantitative & qualitative methods to monitor performance and reporting over time and to explore perceptions of QOF performance; to track and monitor potential skill mix change and to understand the rational for potential differences.
	Illustration: the use of qualitative data to illustrate quantitative findings.	×
	Utility: the combination of the two approaches increases the usefulness of the findings for practitioners and others.	✓ A greater understanding of why the contract is being implemented and monitored in particular ways will help managers and PCOs understand how to develop and respond to that process.
Development.		
Development: the use of results from one method to develop/inform the other method.	Instrument development: where qualitative research is used to help development quantitative tools, e.g. questionnaires.	×
	Confirm & discover: the use of qualitative data to generate hypotheses, which are then tested within the same project using quantitative methods.	×
	Sampling: where one approach is used to facilitate the sampling of respondents or cases.	✓ Quantitative data used to construct a sampling frame for qualitative case study selection.
Initiation.		
Initiation: the discovery of paradox and contradiction between the methods.	Unexpected results: where surprising results generated by one approach can be understood by employing the other approach.	×
Expansion.		
Expansion: extending the breadth and range of inquiry	Process: quantitative research provides an account of	✓ Quantitative data helped to describe the structure of primary

by using different methods for different parts of the study.	structures; qualitative research a sense of process.	care; qualitative data a greater understanding of the processes.
	Different research questions: quantitative and qualitative research answers different research questions.	✓ Different research questions developed.
	Sampling: where one approach is used to facilitate the sampling of respondents or cases.	✓ Quantitative data used to construct a sampling frame for qualitative case study selection.
	Diversity of views: principally, the uncovering of relationships between variables through quantitative research while also exploring the meaning among research participants through qualitative research.	✓ Qualitative views sought from many professional groups, working at both PCO and practice level, and also from patients.
	Enhancement: augmenting the qualitative or quantitative findings by gathering data using the other approach.	✓ Develop a greater understanding of performance measured quantitatively through qualitative interviews.

However, the practicalities of mixed methods of data collection also require consideration.

3.4.2 The practicalities of mixing methods

Creswell suggests three main issues which have to be taken into consideration (113). The temporal relationship between different types of data collection (sequential or simultaneous); at which stage data integration will take place; and whether one approach has priority over the other. In this study, the methods were integrated during the construction of the study's research questions; at the data collection stage; data analysis; and in data interpretation.

In general, quantitative data were collected and analysed before the conduct of the related qualitative phase, for example in Stage 1, when quantitative data were used to develop the sampling frame for the case studies (see Chapter 4). In Stage 2, routine data on QOF performance and participation in enhanced services were used to develop a sampling frame to select embedded case study practices (Chapter 5). Case note review was also used to construct a picture of practice-based care for two selected conditions, before patients were interviewed to explore their views of their care before and after the implementation of the new contract (Chapter 11).

Although more of the study time was spent in the collection and analyses of qualitative data, principally by conducting 139 semi-structured interviews, this did not mean that qualitative methods were regarded as more important than quantitative ones. A qualitative approach was utilised more because the weight of the research objectives fell towards the qualitative paradigm. However, quantitative approaches were an

inherent and critical component of the study as, without the quantitative analyses of performance, it would not have been possible to select the case study sites nor to build a picture of practice performance prior to interviews with either staff or patients.

3.4.3 Triangulation of data collection

The use of multiple methods allowed us to fulfil one of Denzin's four types of triangulation – that of **methodological triangulation**, defined as “the use of multiple methods to study a research problem” (118;119). Denzin, however, identifies another three types of triangulation, which were also employed in this study, namely:

- **Data triangulation** – the use of a variety of sources of data within a study. Here, we used routinely available, national statistics, empirically collected interview data and data from case note retrieval.
- **Investigator triangulation** – where several different researchers are utilised. In this study three researchers, assisted by the wider project team, led data collection and analyses.
- **Theoretical triangulation** – or the use of multiple theories to inform interpretation of the study's findings. As described in Chapter 1, several different theoretical perspectives have been used to inform the analyses and interpretation of findings from this study.

Taken together, the use of multiple methods and different methods to data triangulation within the methodological approach of case studies added to the robustness and validity of the findings.

3.5 Components of the study

This project was conducted in three stages, each outlined below.

Stage 1: Understanding the development of governance and incentive arrangements at a national and primary care organisation level (Study objectives 1, 2, 4 & 5)

The aim of this stage was to explore and map perceptions of the impact of the new GMS contract on governance and incentive arrangements within primary care, including variation in the implementation of the contract across different primary care organisations (PCOs) and national jurisdictions. This work was located at national level in England and Scotland and in four PCO case study sites: two in England and two in Scotland. Data collection methods included 65 semi-structured interviews at national and PCO level and analyses of routinely available national data to explore the impact of the contract on the division of labour within general practice, and the effectiveness and equity of the new contract in terms of changes to clinical practice and patient care, in

particular comparing the effects of the Quality and Outcomes Framework on incentivised and non-incentivised conditions.

Stage 2: Understanding the creation and implementation of new governance arrangements in local contexts - comparative intensive case studies in two sites (Study objectives 2, 3, 4 & 5)

Following data analyses in Stage 1, one English and one Scottish PCO were selected as intensive case studies to examine how nationally negotiated changes in contracts were interpreted locally. Within each case study site, embedded case studies were selected for further in-depth study. These embedded sites were chosen to reflect four models of contract service delivery, reflecting different governance arrangements and incentive structures. These were:

- GMS practices (n = 3).
- PMS practice (n = 1).
- Enhanced services (n = 1).
- Out-of-hours service (n = 1).

Data collection included interviews with key stakeholders (n = 55) and patient tracker studies, which involved case note review for patients with either of two clinical conditions (diabetes or rheumatoid arthritis) followed by interviews with a sample of patients (n = 19).

Stage 3: Conceptualisation and generalisability of emergent findings (Study objectives 3, 4 & 5)

This stage of the work drew on the experience and knowledge of key informants from both the England and Scotland. Using expert task groups, emergent findings from the case studies were tested with the participants and findings from the case studies compared with emerging knowledge of the impact of governance systems and incentives within primary care in both countries.

3.6 Ethical and R&D management approval

Before data collection commenced, a Multi-site Research Ethics Committee (MREC) application was prepared for all stages of the study and submitted to the West Glasgow Multi-site Research Ethics Committee (MREC) in May 2006. This application covered work to be conducted in both England and Scotland. Initial approval was granted in August 2006, with a final letter of approval issued in October 2006. Once the four case study sites were selected, Site-Specific Information Forms (SSIs) were prepared. In order to preserve anonymity of the case study sites, these NHS Research Ethics Committees (RECs) have not been individually identified in this report.

In Scotland, SSIs were submitted to the local Research Ethics Committees (RECs) covering Case Studies 3 and 4. Approval from these sites was obtained in November 2006 (for Case Study 3) and in January

2007 (for Case Study 4). Research Management and Governance (RM&G) approval was obtained at the same time in both sites. NHS sponsorship for the whole study was granted by the R&D Directorate, NHS Greater Glasgow & Clyde as the PI (COD) already held an honorary NHS contract with that Health Board.

In England, SSI applications were submitted to two local RECs: one covering Case Study 1 and the other covering a near-by PCT which was under consideration as a case study. Approval for both sites was obtained in March 2007. However, the later choice of a different PCO as the fourth case study site (see Chapter 4.4.1) led to the need to submit another SSI application to a third REC. Approval from this Committee, covering Case Study 2, was obtained in August 2007. RM&G approval was then obtained from the relevant PCTs.

Overall, the process of obtaining both research ethics and management approval for the four sites took a total of 15 months.

4 Selection of English and Scottish primary care organisation (PCO) case study sites: a comparison of organisational structures

4.1 Introduction

Chapter 1 described the rise of governance structures within public services in general, in particular the National Health Service, leading to the overlapping models of hierarchies, markets, networks and self-governance (12;16;18;20) and the impact that different models of governance may have for professional autonomy and professional boundaries. We also discussed how governance has been enacted in primary care following successive GMS contracts and postulated on the likely effects of the 2004 contract. In order to explore this further, we selected four primary care organisation (PCO) case study sites: two in England and two in Scotland. In this chapter we describe their selection and the organisational structure of each.

In developing this work, it was necessary to acknowledge and describe the impact that devolution is having on the organisation of the NHS in England and Scotland. Scott Greer, in his critique of the impact of devolution on health care, proposes that the policy and managerial ethos is different between the two countries. In England, there has been an emphasis on central target setting, strong performance management and, latterly, the development of a market-based approach. In Scotland, NHS development has been influenced by a strong ethos of professionalism and a rejection of market-driven approaches (10;120). This is described in greater detail in Appendix 1. Here, we provide a brief resume of the organisational entities found in primary care in each country (Box 6).

Box 6 Organisational structures in primary care in England and Scotland, 2006-07

	England	Scotland
National level	Department of Health Overall responsibility for health and social care policy in England and for non-devolved health matters, such as the GMS contract. Accountable to UK Government in Westminster.	Scottish Government Health Department Overall responsibility for health and social care in Scotland. Accountable to Scottish Government in Edinburgh.
Regional level	Strategic Health Authorities (SHAs) Responsible for strategic leadership; organisational and	NHS Health Boards Responsible for all health care delivery within a geographical area, with no distinction between

	workforce development; and for delivering improved local performance in health. Reorganised in 2006 and reduced from 28 to 10. Mean population of 5,009,000. Accountable to Department of Health.	purchasing and providing. 14 Health Boards in Scotland. Mean population of 11 mainland Boards is 458,991. Accountable to Scottish Government Health Department.
	Primary Care Trusts (PCTs) Responsible for delivery health care at a local level; for improving the health of its local population; commissioning services; and directly providing services to the local population. Reorganised in 2006 and reduced from 303 to 152. Mean population of 330,000. Accountable to SHAs.	Community Health Partnerships (CHPs) Responsible for the integration of primary care and specialist services and with social care; for ensuring that local population health improvement is addressed through service delivery. In some sites, have integrated with social care to form Community Health & Car Partnerships (CHCPs). Established in 2005; 37 CHPs/CHCPs. Mean population of the mainland CHPs 155,560. Accountable to NHS Health Boards.
Practice level	General practices Responsible for delivery of general practice care to a registered population. 8540 in England. Mean list size of 6,100.	General practices Responsible for delivery of general practice care to a registered population. 1050 in Scotland. Mean list size of 5,100.

When considering the impact of the 2004 GMS contract on governance and incentives, we are here less concerned with the unit of organisation *per se* (PCTs versus CHPs) and more with the way in which governance and monitoring may be operationalised within and between organisations. Greer's concept of marketisation in England versus professionalism in Scotland raises interesting propositions for the way in which governance arrangements may be enacted in the two countries but these have been, until now, largely untested. The opportunity to conduct comparative case studies in England and Scotland offered an opportunity to test potential differences across national jurisdictions, as well as exploring the types of governance in place across the case study sites.

In this chapter, we outline the methods used to describe the population and practice characteristics of the eligible PCOs, identify the four case study sites, and provide a description of the organisational structures operational in England and Scotland at the time of data collection which provide important contextual information within which the interviews with key stakeholders took place. A more detailed descriptor of each PCO case study is contained in Appendix 2.

4.2 Methods

4.2.1 Selection of case study sites

The aim of Stage 1 of the project was to understand the development of governance and incentive arrangements at a national and primary care organisation (PCO) level, through semi-structured interviews conducted with national and regional stakeholders. However, before interviews could be conducted, it was first necessary to select the case study sites in which interviews and later, embedded case studies, would be conducted. This was informed by the analysis of routine data on practitioner and population characteristics and on recent QOF performance.

For the purposes of this study a PCO was defined as a Primary Care Trust in England and an NHS Health Board in Scotland. Characteristics known to be important to the performance of primary care, and for which comparable routine data were available in both countries, were selected with which to characterise candidate PCOs. These included:

- the supply of GPs and practices in an area;
- the percentage of female GPs;
- the percentage of GPs aged over 50;
- the total population served and the socioeconomic deprivation of the population;
- the health of the population served;
- practice performance for the first two years of the QOF.

4.2.2 Identification and analyses of routine data

Data on practice structure, GP characteristics and patient age groups for 2004-05 including the number of WTE GPs, proportion of female GPs and those aged over 50 were downloaded from the National Primary Care Research and Development Centre, University of Manchester (www.npcrdc.ac.uk/About_NPCRDC.cfm) and from the Information Services Division of NHS Scotland (www.isdscotland.org/isd/1036.html). Deprivation for England (www.communities.gov.uk/archived/general-content/communities/indicesofdeprivation/216309/) and Scotland (www.scotland.gov.uk/Topics/Statistics/SIMD/) was measured using the income domain of the Index of Multiple Deprivation (IMD) for each country. The income domain was used, rather than the overall score or other domains, because it received the highest weight in the calculation of the overall index, was highly correlated with the overall index and was the only domain calculated in a similar way for both countries (121). Deprivation was based on the income score of the practice postcode calculated by linking the postcode of the practice's main surgery to its Census Lower Layer Super Output Area (LSOA) for England and datazone level for Scotland, and then to its IMD domain score.

Health for England (www.statistics.gov.uk/census2001/census2001.asp) and Scotland (www.scot.nhs.uk/scot/common/home.jsp) was measured using data from the 2001 Census. Table CAS016 provides figures on all people by gender and age, and by combinations of self-reported limiting long-term illness and general health. The general health question has three possible categories of response: “good”, “fairly good”, and “not good”. In Table CAS016, the general health question was dichotomised into “good and fairly good” and “not good”. As the data were available by gender and age bands (0-15, 16-34, 35-49, 50-59, 60-64, 65-84, 85+), standardised variables were generated and two indirectly standardised health variables created, with a mean value of 100, measuring the ratio of patients reporting limiting long-term illness and “not good health”. A practice score was then assigned using the same procedure as for deprivation. Census data was also downloaded to calculate the percentage of the population defined as a minority ethnic group, on the basis of not being in a white ethnic origin category.

Publicly available data on QOF achievement for each practice was downloaded from the relevant national site for both England (www.qof.ic.nhs.uk/) and Scotland (www.isdscotland.org/isd/3305.html) for the years 2004-05 and 2005-06.

These data were used to construct descriptive profiles for the case study sites of interest.

4.2.3 Documentary review

Once four PCO case study sites were selected, their websites were searched to identify documents that described the re-organisation and managerial structures in each location, particularly in relation to the GMS contract. Minutes and papers from Board and Committee meetings, e.g. the Professional Executive Committee meetings in England, were retrieved if necessary and used to build a picture of the organisational structure of each PCO.

4.2.4 Interviews with key informants

Following identification of the case study sites for Stage 1 of the study, scoping meetings were held with key informants known to the study team to identify potential interviewees across each of the four case study sites. Conducted between November 2006 and spring 2007 in Scotland and June 2007 and February 2008 in England, these meetings were also used to discuss the organisational structures within each of the selected PCTs and Health Boards. This was particularly important, as at the time of data collection, primary care in both England and Scotland had undergone a period of extensive managerial re-organisation. Interviews were then conducted with both national and PCO-level key informants (described in detail in Chapter 6). Although the overall purpose of these interviews was to explore the impact of governance and incentives at a national and PCO level, the early part of each PCO interview often contained useful data on the organisational structure of the PCO in

relation to the GMS contract, enhanced services and, in England, practice-based commissioning.

4.2.5 Organisational profiles of the case study sites

Data obtained from the quantitative analyses, review of documents, scoping meetings and interviews with key informants were together used to construct a descriptive profile of each site, outlining the organisational structure and location of committees with responsibility for monitoring primary care performance within the PCO. These were later checked with one or two key informants in the PCO, as part of Stage 3 of the study.

4.3 Results

4.3.1 Selection of case study sites

Pragmatically, the geographical regions from which case study PCOs were selected was limited to northern England and mainland Scotland, given the locations of the study team researchers and the need to facilitate the later qualitative data collection at PCO, practice and patient level. Several PCOs were identified in England and in Scotland as likely sites for the location of the case studies, based on broad population and practitioner characteristics, including the level of socio-economic deprivation and GP supply. From these data, regional profiles were constructed (Table 1).

Scottish Health Boards were larger than English PCTs in terms of the number of practices and were substantially larger in terms of the population served. This highlighted an early challenge for this project - in which organisational units should be compared between England and Scotland. This is illustrated in Figure 4. The next logical unit up in size in England was the Strategic Health Authority. However, following re-organisation in 2006, these became too large in terms of the population served to compare with Scottish Health Boards (www.nhs.uk/NHSEngland/aboutnhs/Documents/MapofSHAsFeb09.pdf). An alternative considered by the project team was to scale down the unit of comparison in Scotland to that of Community Health Partnerships (CHP). However while the total population served was then broadly comparable to PCTs, the number of practices within each became smaller and not all routine data were available at the level of CHP. Thus, the unit of comparison remained PCTs in England and Health Boards in Scotland.

Table 1. Characteristics of potential regional case study sites

	England (PCTs)				Scotland (Health Boards)				
	PCT A	PCT B	PCT C	PCT D	Health Board E*	Health Board F	Health Board G	Health Board H	Health Board I
Practice supply									
Number of practices (2005-06)	104	60	39	56	210	60	99	124	72
Number of nGMS practices	67	35	34	25	206	52	93	99	70
Practice size (WTE GPs)									
% Single-handed (<= 1.0 WTE)	45.2	13.3	15.3	33.9	21.0	4.9	20.0	9.4	4.2
% Small (>1.0 – 2.0 WTE)	19.2	25.0	10.3	25.0	21.9	8.2	12.0	4.7	13.9
% Medium (>2.0 – 4.0 WTE)	21.2	38.3	46.2	26.8	31.8	36.1	34.0	25.8	34.7
% Large (>4.0 – 6.0 WTE)	12.5	20.0	25.6	10.7	15.9	27.9	25.0	29.7	27.8
% Very large (>6.0 WTE)	1.9	3.3	2.6	3.6	9.4	22.9	9.0	30.5	19.4
GP supply and characteristics									
Mean Number GPs per Practice	3.4	4.1	4.7	3.9	3.8	5.5	4.6	5.4	4.8
Mean Number WTEs per Practice	3.1	3.8	4.3	3.7	3.6	5.3	4.4	5.1	4.5
% Female GPs	34.0	43.0	36.0	31.0	46.0	34.8	42.0	52.0	41.6
% GPs age 50+	44.0	37.0	34.0	79.0	38.0	31.0	35.0	25.0	31.0

	England				Scotland				
	PCT A	PCT B	PCT C	PCT D	Health Board E*	Health Board F	Health Board G	Health Board H	Health Board I
Population characteristics									
Total Population	441800	313800	233000	282000	952758	386165	581888	837080	406933
Deprivation score (income)	31.0	21.1	10.6	18.8	24.2	16.6	17.6	12.5	14.0
65+	15	19	17	18	15	17	14	16	18
% With Limiting long-term illness	24.6	22.5	16.8	19.1	23.7	21.7	22.3	17.9	19.7
% With Not Good Health	13.8	11.4	8.1	11.4	13.7	10.5	11.9	8.5	9.0
% Minority Ethnic Population	5.7	1.7	1.8	2.1	4.5	1.1	1.3	3.3	2.4
Practice performance									
Average QOF Score per nGMS practice (2004-05)	935.4	1004.5	997.1	937.1	994.2	994.6	939.0	988.5	987.9
Average QOF Score per nGMS practice (2005-06)	1002.4	1014.3	1025.6	968.9	1031.8	1042.5	1018.9	1036.2	1031.8

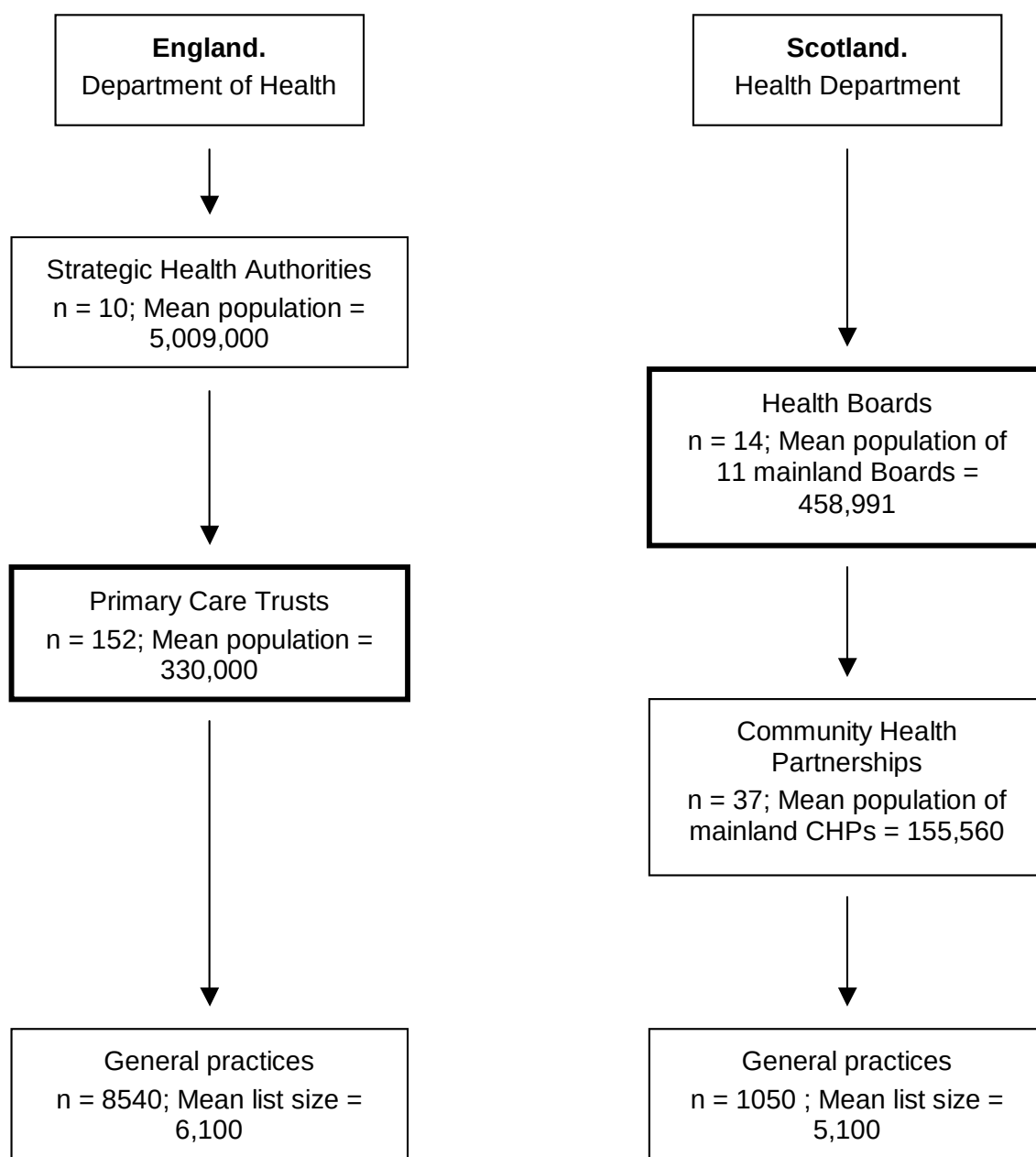
**This Health Board had recently amalgamated with part of another Board area. Data here refers only to the previous configuration of the Board.*

For data sources, see Section 4.3.2.

Columns highlighted in grey are the sites selected as case studies (see Section 4.3.1).

Figure 4. Organisational units of comparison in English and Scottish case studies, as of 2006

Boxes with heavy borders indicate levels at which PCO case study work was conducted.



PCTs A and B and Health Board E all served large, predominantly urban populations with high levels of socioeconomic deprivation, poor self-reported health in their population and with care provided by large numbers of small or single-handed practices. Practice performance, as measured by the average QOF score per GMS practice, was broadly similar across these three sites, particularly in year 2 (2005-06), although the average score in Health Board E was higher than that of PCT A. QOF performance was broadly uniform across all the sites considered, except for PCT D, which also had a high proportion of small and single-handed practices.

Thus PCT A and Health Board E were broadly similar, but with higher levels of deprivation and lower QOF achievement in the PCT site. That, plus the research teams' good links with stakeholders in both areas, led to their selection as our first case study sites.

The selection of the second two sites focused on choosing sites that provided a contrast to these two. Health Board H was selected as the Scottish comparator, as it had a much lower deprivation score, better population health and a lower percentage of single-handed and small practices, while QOF achievement was broadly similar. The selection of a second case study site in England, which could act as a comparator for PCT A, but was also broadly similar to the second Scottish case study, was more problematic. Levels of deprivation in the English sites were higher than that found in most other Health Boards in Scotland. In the end, PCT C was selected as the fourth case study site, as it had a deprivation score and geographical context similar to that found in Health Board H.

4.3.2 National context

The structure of primary care underwent substantial re-organisation in both England and Scotland around 2006. In England, there was re-organisation at both Strategic Health Authority and Primary Care Trust level, with both entities amalgamating with neighbours to form larger organisations. As well as dealing with this substantial re-organisation, PCTs were also focussed on implementing the English health policy of Practice Based Commissioning (PBC) across their catchment's area.

In Scotland, primary care was re-organised into Community Health Partnerships (CHPs) in 2004, new organisations designed to deliver community based health services, with operational and managerial responsibility devolved to a more local level. These became operational in 2005. Operationally, these organisations became the Primary Care Organisation responsible for the implementation, monitoring and governance of the nGMS contract in their area, adding an additional layer of monitoring into the system.

These re-organisations had a significant impact on the early stages of the work, particularly in the two English case study sites where it took

many months for the re-organisation and movement of personnel to settle down.

A summary of the PCO case studies selected is contained in Section 4.3.3, with a fuller descriptor of each case study site contained in Appendix 2.

4.3.3 PCO case study profiles

PCO Case Study 1 (PCT A)

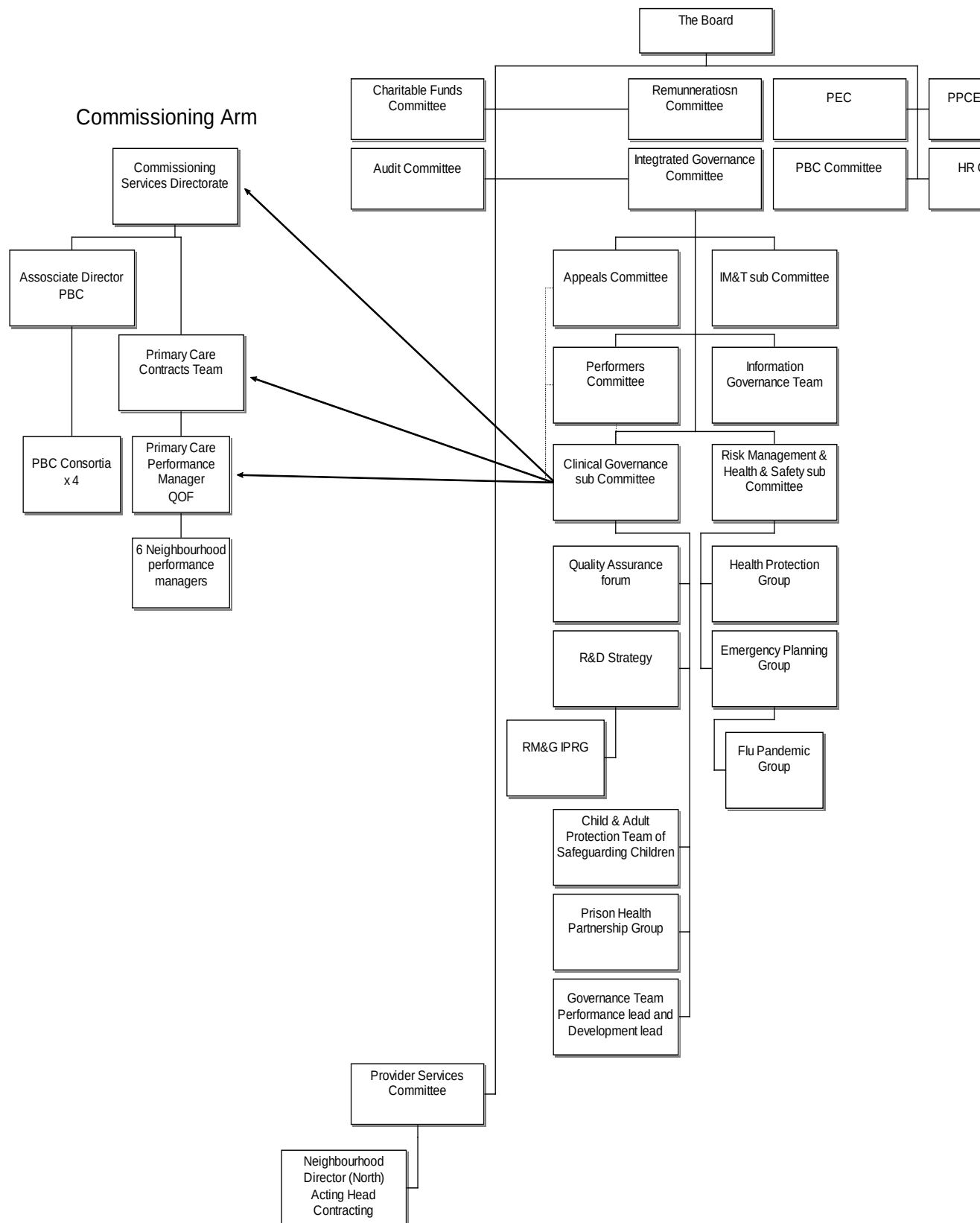
This PCT was formed on 1 October 2006, following the amalgamation of three neighbouring PCTs. In common with all PCTs in England, the PCT Board had a commissioning arm and a provider arm – both of which were still undergoing re-organisation at the time of data collection.

Key priorities for the PCT Board included tackling health inequalities; waiting times for hospital treatment; and facilitating patient choice through the use of Choose and Book. Thus, the GMS contract and QOF in particular did not directly feature in the priority areas of the PCT.

The organisational structure, at the time of data collection, is shown in Figure 5.

There were three main Committees within the commissioning arm of the PCT relevant to the governance and monitoring of the GMS contract and practice based commissioning: the **Integrated Governance Committee**, the **Professional Executive Committee** and the **Practice Based Commissioning Committee**. While the activities of the Professional Executive Committee were mainly concerned with the strategic direction of the contract, e.g. by identifying priorities and standards, the operational leadership and support for practices came from teams and individuals under the auspices of the Integrated Governance Committee. These included the **Primary Care Contracts Team**, the **Primary Care Performance Manager** (responsible for monitoring QOF performance) and the Neighbourhood Performance Managers. However, despite their operational importance, the **Neighbourhood Performance Manager** posts were being dissolved and the Primary Care Performance Manager post was moving from the Commissioning Directorate to the Medical Directorate. Thus, the organisational structure for the governance and monitoring of the GMS contract appeared to be in a constant state of flux.

Figure 5. Organisational structure of Case Study 1



As well as dealing with strategic issues in relation to the contract, the Professional Executive Committee also managed the strategic direction of the **Practice Based Consortia** and facilitated the link between the Consortia and the PCT. In late 2007, there were four PBC Consortia, with 95 of the 101 GP practices in the PCT participating. Responsibility for the monitoring and governance of the PBC Consortia resided in the **Commissioning Services Directorate** whereas responsibility for GMS and QOF was within the remit of the **Medical Directorate**. However, accountability for the PBC Consortia lay with the individual practices, not with the PEC. Each Consortia had a list of agreed priority areas, in general linked to service re-design and re-organisation and predominately focussed on chronic disease. From mid-2007, scrutiny of the PBC Consortia was undertaken by the **Practice Based Commissioning Committee**. However, there continued to be close links between this committee and the PEC. This fitted with an organisational structure described by one respondent as:

“[a] matrix type of organisation which means that it’s a flatter structure, there’s lots of linkages [across the organisation]”

Prior to amalgamation, each of the three PCTs had their own basket of **Local Enhanced Services (LES)**; after amalgamation, time had to be spent ensuring there was equivalence in service delivery and funding across the PCT. The enhanced services provided by this PCT for the period 2006-2008 are listed in Table i, Appendix 2. In general, enhanced services were delivered by general practices although some, such as the substance misuse LES and the homeless service LES, involved other community-based groups such as the homeless outreach team and, in the case of substance misuse, the NHS Trust and a third-sector charity organisation.

Monitoring of the enhanced services was the responsibility of the **Primary Care Contracts Team**. At the time of data collection (in 2007), the enhanced services were under review with the PCT conducting an annual audit to check (a) if the practice was still providing the service and (b) if yes, what the practice was providing. Some enhanced services had been passed across to PBC consortia e.g. anticoagulation monitoring, patient testing and minor surgery. In future, these were likely to still be commissioned through an enhanced service but provided on a consortia basis.

Following the implementation of the GMS contract, the PCT was responsible for **out-of-hours care** between 6.30pm and 8am, weekends and Public Holidays. Several contractors had applied to provide out-of-hours services: the group chosen was previously a GP cooperative, now an independent not-for-profit organisation. The PCT had monthly meetings with the out-of-hours service provider, who had to report against the national quality requirements and provide a financial report. An **Executive Board** ran the organisation, with an overarching **Council** to which the Executive reported. The Council included GP representatives as well as representatives of other services, such as NHS Direct, though

not a patient representative. The role of the Council was to challenge and review decisions made by the Executive, in relation to strategy and operational performance; a sub-committee reviewed clinical performance and complaints.

PCO Case Study 2 (PCT C)

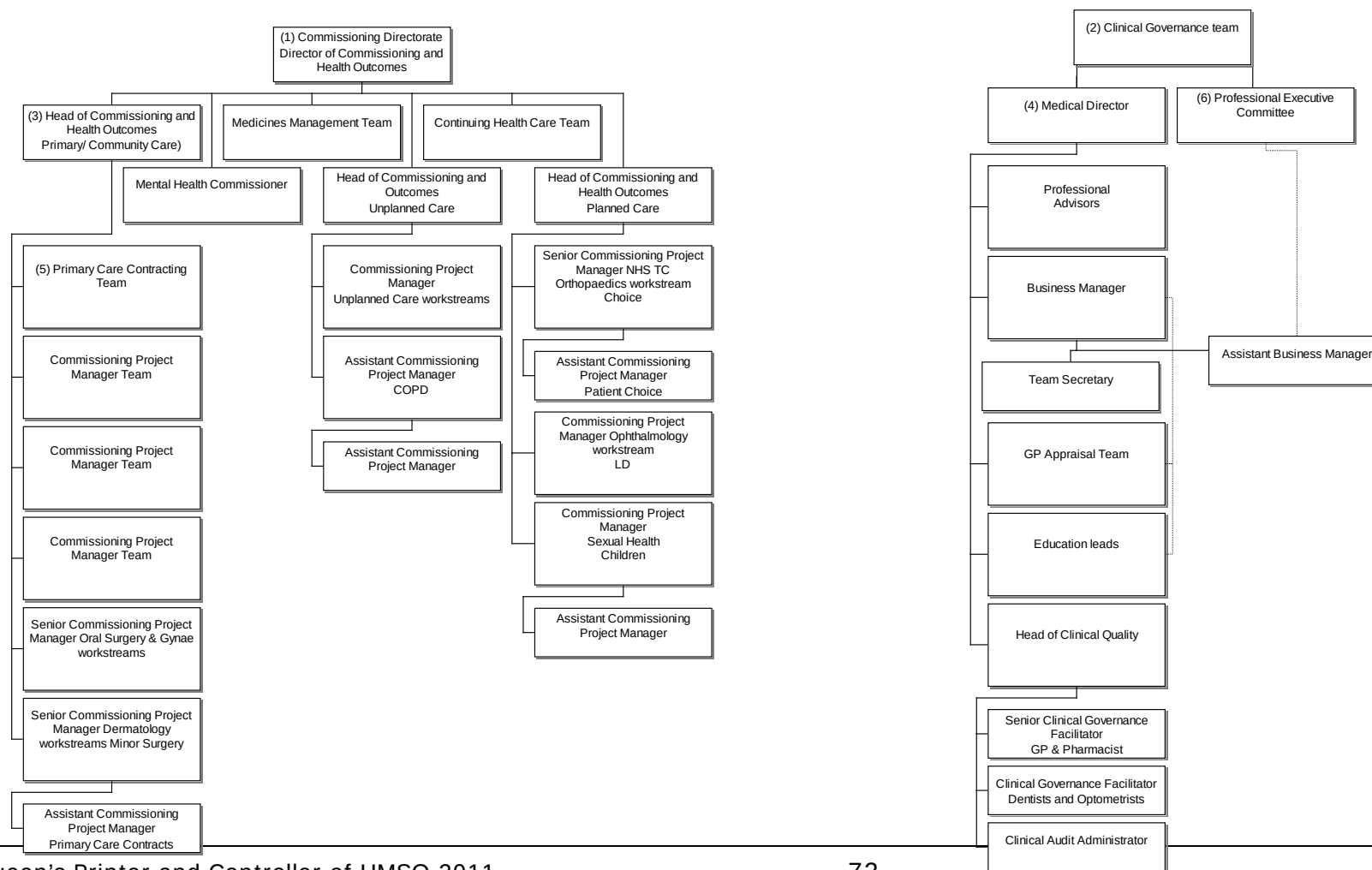
This PCT formed on 1 October 2006, when two PCTs formally merged. Again, the PCT Board had commissioning and provider arms – both still undergoing re-organisation at the time of data collection. Key priorities for the Board included the reduction of health inequalities, targeting childhood obesity, smoking cessation, reducing waiting times, developing a single system of out-of-hours care and increasing patient choice. The organisational structure is shown in Figure 6.

As with its counterpart in England, the emphasis was on the development of integrated systems (referred to as “matrix working”) for overseeing and monitoring the contract. Key strategic committees were the **Integrated Governance Committee** and the **Professional Executive Committee**. Operationally, primary care contracting and clinical governance was the province of the **Internal Primary Care Contracting and Clinical Governance Forum**, chaired jointly by the Director of Commissioning & Health Outcomes and the Medical Director. This group included the **Clinical Governance Team** and the **Primary Care Contracting Team**, which was responsible for contracting and monitoring contracts and authorising payments to all independent primary care contractors.

Practice based commissioning was less well developed here, with a single **Practice Based Commissioning Consortium** for all practices in the PCT. The PCT produced a practice based commissioning framework which set out the responsibilities of the PCT, the consortium and the participating practices. Commissioning recommendations were to be submitted to the Integrated Governance Committee through the Professional Executive Committee (PEC), which would, in turn, submit these to the PCT board. The PEC provided both clinical advice and feedback to the Integrated Governance Committee concerning the progress of PBC implementation.

The previous two PCTs in this area had invested in different **Enhanced Services**. When the two PCTs merged, there was a need to harmonise these services, which proved to be quite a difficult process. Enhanced services were monitored through a process of quarterly reconciliation, with practices submitting all their activity data to the PCT. In addition each practice had an annual contract meeting with the PCT where quality of service was discussed. Enhanced services were also linked to GPs' appraisals, with maintenance of clinical competencies being one of the topics of discussion.

Figure 6. Organisational structure of Case Study 2



Out-of-hours care underwent considerable re-organisation, with three different out-of-hours services amalgamating into a single provider organisation. This began with the rural and city systems coming together with GPs sharing the same rota and all patients going through nurse triage. Skill mix was introduced with nurse clinicians as well as doctors seeing patients in the centres and emergency care practitioners, as well as GPs, carrying out home visits. The out-of-hours service was monitored through the GP-patient survey and internal audit.

PCO Case Study 3 (Health Board E)

This was a single unified health board, with no commissioning-provider split, as outlined in Scotland's 2003 health White Paper Partnership for Care (122). As well as re-organising into this unified structure in 2005, two other major re-organisations had taken place in 2005-2006. First, the Health Board amalgamated with part of a neighbouring Health Board over a transition period of two years. Alongside this, Community Health Partnerships were established in August 2005.

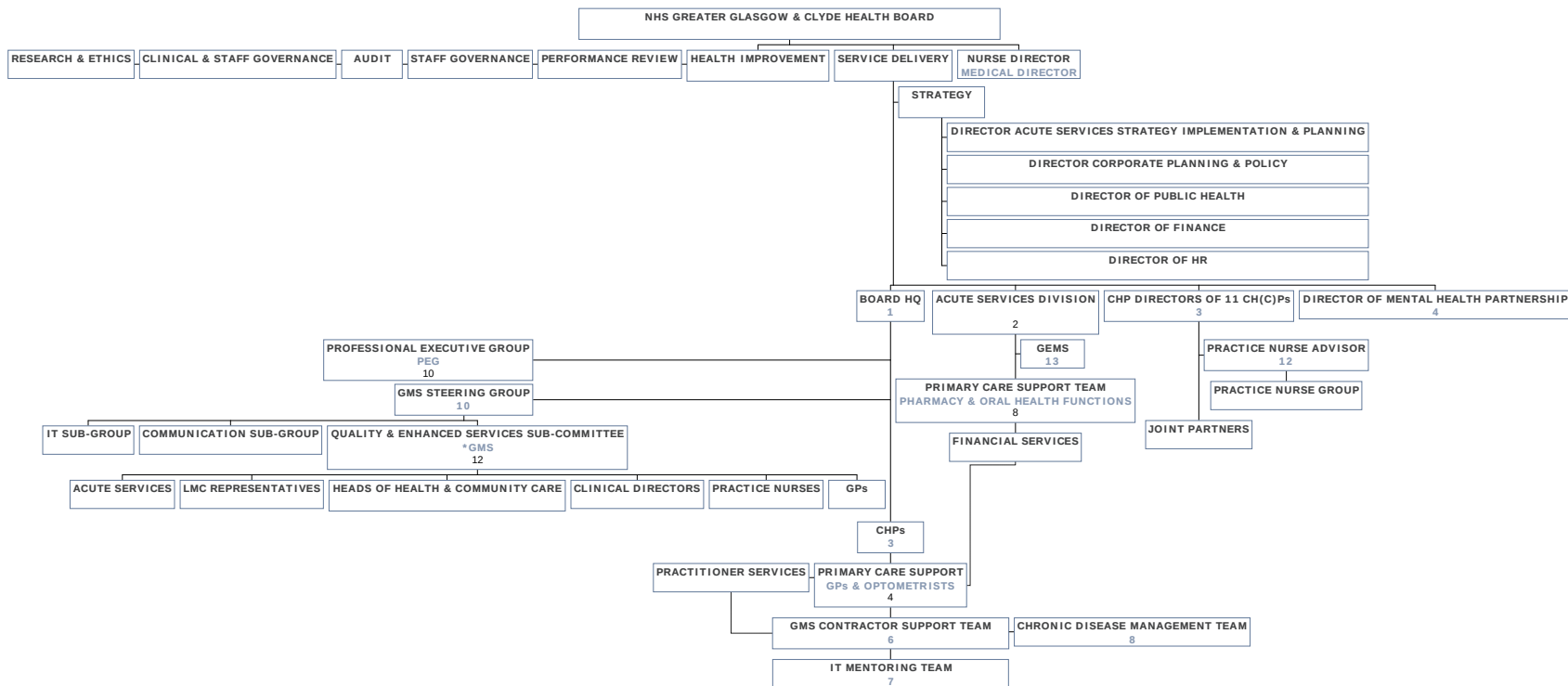
The implementation of Community Health Partnerships meant that the provision and monitoring of primary care was devolved from a single, centralised organisation (the Primary Care Trust) to 11 Community Health (and Care) Partnerships responsible for primary care, mental health and community services.

In 2007, key priorities for the Board included the reduction of health inequalities, reducing inequalities in Coronary Heart Disease mortality, tackling alcohol abuse, smoking cessation, obesity in children and adults, teenage pregnancy and sexual health and waiting times.

The organisational structure here appeared to be more hierarchical, with contract issues for GPs and optometrists dealt with by **Primary Care Support** (Figure 7). Operational support for general practices came from the **GMS Contractor Support Team**, which supported GMS practices in the areas of QOF and the enhanced services and dealt with all aspects of contract negotiation and the **IT Mentoring Team**, which supported practices' IT needs for the nGMS contract.

In relation to governance, the **GMS Contractor Support Team** had principal responsibility for the implementation of the rollout of nGMS in terms of monitoring, payment schedules and IT requirements although at the time of the Stage 1 interviews (in 2007), they were devolving some of this responsibility to the CH(C)Ps. This meant that they now had 11 organisations to deal with, rather than 1. An additional problem was that CH(C)P managers had a much wider remit, so less of an understanding of the new GMS contract and thus required more support.

Figure 7. Organisational structure of Case Study 3



Strategic direction for the GMS contract came from the **GMS Steering Group**, which included representatives from the CH(C)Ps and the Local Medical Committee. However, detailed negotiation of the contract took place within several sub-groups, who then reported back to the GMS Steering Group. Of these, the most important from a governance and monitoring perspective was the **Quality and Enhanced Services Sub-Committee**, which had wide ranging primary care representation although, at the time of data collection, no acute sector representation despite the huge implications that nGMS potentially had for acute services. So integral was this sub-committee to all matters related to the GMS contract, that one interviewee described it as

“the spider in the middle of the web that enables the system to work well”.

One on-going problem for this Committee, however, was that of communication back to CH(C)P level, because such communication now occurred across 11 organisations.

Practice nurses had their own professional lead through the **Practice Nurse Advisor**, who provided practical support for nurses in practices, as well as strategic direction and leadership on several of the above committees.

Most practices had opted into the **Directed Enhanced Services** (DES). Twelve **Local Enhanced Services** (LES) had been commissioned, some meeting particular population needs (e.g. care for the homeless population or for asylum seekers); others building on the chronic disease management programme already well established in this site. For those practices that did not wish to carry out the Chronic Disease Management LES, Primary Care Support Services had organised a team of practice nurses to carry out some of the work required.

Prior to the new contract, **out-of-hours care** had been provided by a city-wide GP out-of-hours co-operative. The separate national nurse-led telephone triage and consultation service, NHS 24, began front-ending calls for the co-operative in 2002, in line with national planning. The out-of-hours organisation was previously located within the Primary Care Division, but since re-organisation of the Board was now sited in the Emergency Medicine Directorate of the Acute Division. The majority of GPs working for this organisation were full time GP principals. There was also a minor illness nurse service, where specially trained nurses could see and treat patients triaged as having minor illnesses.

PCO Case Study 4 (Health Board H)

Like its Scottish counterpart, this Health Board also re-organised in 2003/04 to become a unified board or “Single Integrated Health System”, with the subsequent introduction of Community Health Partnerships (CHPs) in 2004/05. Originally, there were 5 CHPs but this was later reduced to 4. Again, this meant that primary care was now

devolved to four local organisations rather than one central organisation, as had previously been the case.

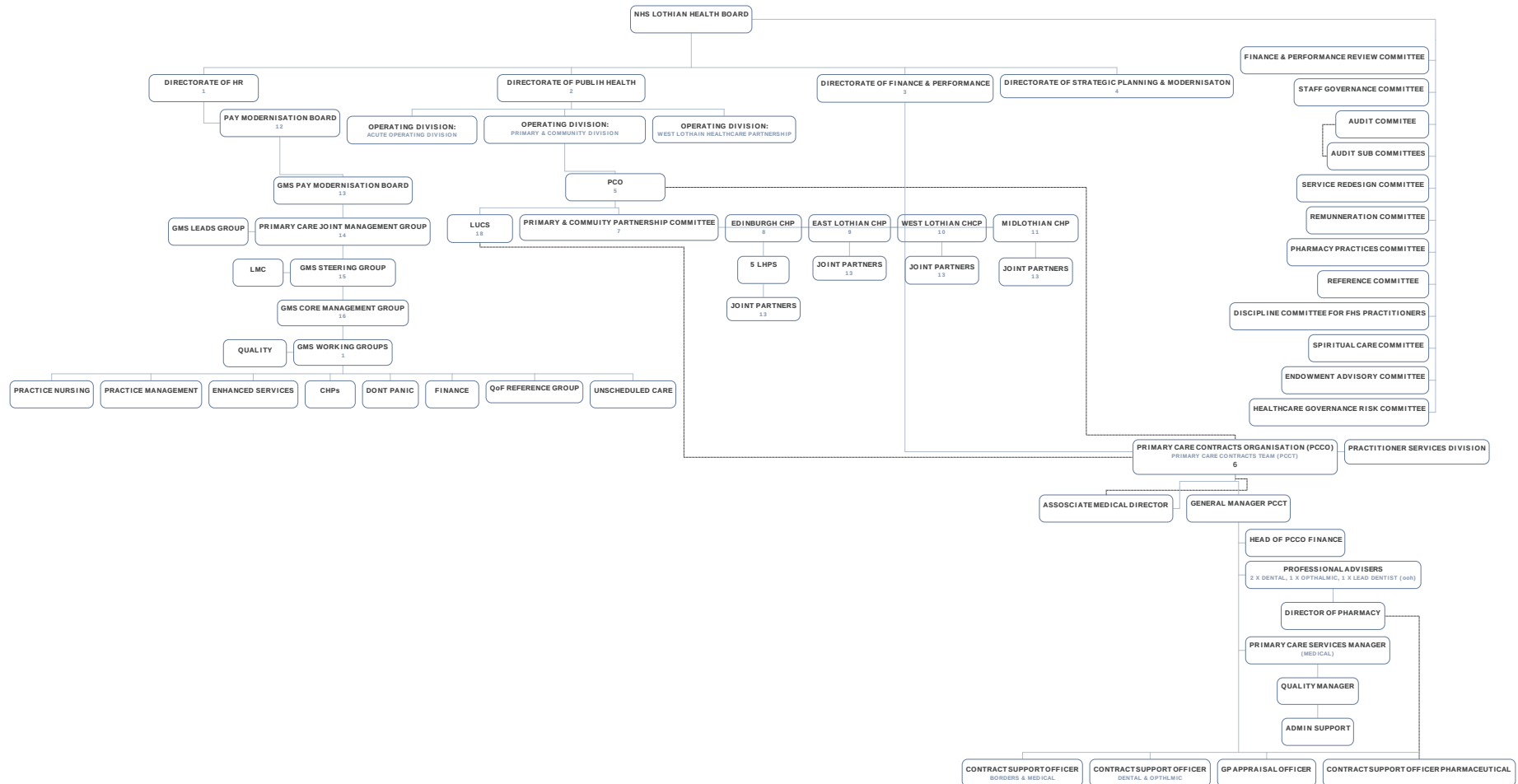
This Board's priorities were similar to those of its Scottish counterpart, including the reduction of health inequalities, reducing inequalities in Coronary Heart Disease mortality, tackling alcohol abuse, smoking cessation, obesity in children and adults, teenage pregnancy and sexual health and waiting times.

The Board adopted an integrated approach to governance, with the establishment of a single **Health Care Governance and Risk Management Committee**, with a remit to oversee all aspects of healthcare governance and risk management in primary and secondary care in order to ensure consistency and quality of clinical governance. A transitional **Primary Care Organisation** (PCO) was established to support the new CHPs, to provide expertise, reduce bureaucracy and to host the management of more complex services requiring a hosting arrangement for a defined period, until CHPs could directly manage and host the services themselves. Operationally, the **Primary Care Contracts Team**, located within the Primary Care Organisation, managed the contractual arrangements with primary care practitioners for the provision of primary care services. (See Figure 8 for the organisational structure.)

In March 2007 the PCO was dissolved and the **Primary & Community Partnership Committee (PCPC)** became the principal forum for all CHPs with co-ordinating rather than decision-making responsibilities. The remit of the PCPC was to support integration between health and other agencies and to give the four CHPs the ability to coordinate and collectively influence Board-wide strategy and decision-making while assuming an overview of primary care and CHP professional and organisational development.

A key aim of the four **CHPs** was to improve patient outcomes through the devolution of management, decision-making and resources to front-line staff. Certain services were managed in each of the CHPs, whilst others were managed in specific CHPs (see Table ii, Appendix 2). Where CHPs did not manage a service, management was provided via a hosting or partnership agreement on behalf of the CHPs through the Primary Care Organisation (PCO). CHPs therefore played a major role in the Board's Modernisation Strategy and in the negotiation and "operational delivery" (or "operational management") of additional and enhanced services with practices. Each CHP became a sub-committee of the **Primary & Community Partnership Committee** and CHPs were accountable to the executives of the Health Board.

Figure 8. Organisational structure of Case Study 4



A number of strategic and operational Committees were established to oversee GMS management and governance – these were sited with the Human Resources Directorate. A key group was the **GMS Pay Modernisation Board**, to which a number of operational groups answered, each with a particular role or responsibility. These included: the **Primary Care Joint Management Group** which approved and agreed the direction of travel for the Board in terms of national contracts; the **GMS Steering Group**, which guided the implementation of the GMS contract in partnership with the Local Medical Committee and with a wide membership from across the Board; and the **GMS Core Management Group**, which managed the process of GMS implementation. This latter group oversaw the activities of a range of GMS Working Groups, each of which led on specific areas of the contract work including practice nursing, unscheduled care, finance, links with CHPs, quality, practice management and enhanced services.

A dedicated **Clinical Nurse Manager** represented practice nursing. This role encompassed the professional leadership and also a remit for nurse prescribing, covering both community and practice nursing.

Enhanced services

Enhanced services, previously the responsibility of the Primary Care Organisation, were devolved to the **CHPs**. Monitoring of the enhanced services was carried out by the **Enhanced Services Working Group**, which in turn reported to the GMS Core Management Group. Again, a range of enhanced services relevant to local needs were commissioned.

Out-of-hours care

Out-of-hours care here was provided by the Board's **Unscheduled Care Service (LUCS)**, located within the Primary & Community Operating Division. Following the implementation of the new contract, 10 different GP out-of-hours providers scattered across the Board were brought together under a single out-of-hours service, front-ended by NHS 24. LUCS employed a combination of salaried GPs, who provided at least 35% of the shift cover, as well as 360 sessional GPs. The service also employed 29 Emergency Nurse Practitioners and 8 paramedics, shared with the Scottish Ambulance Service.

4.4 Discussion

The re-organisation of the NHS in both England and Scotland was a major challenge to the selection of the PCO case studies and later conduct of the Stage 1 regional interviews. This was a particular issue in England, as recently described by the BMA (123), where data collection was much slower due to the re-organisation, the need to wait for the new PCTs to bed down and the re-distribution and turnover of PCO staff. The continual re-organisation of the NHS meant that the organisational structure in relation to governance in general, and governance of the

GMS contract in particular, was still being developed at the time of data collection. Although we attempted to construct contextual descriptors and organisational charts for each case study, reflecting the governance arrangements for each PCO, the state of flux apparent in each site proved problematic. Thus, each descriptor and chart could only provide a snapshot of the lines of accountability at that time and were often still undergoing re-organisation, again particularly within the English case study sites. However, these did still perform a useful function in outlining broadly the governance structures within each PCO.

The case study descriptors and organisational charts highlighted some key similarities and differences across the sites and between the countries.

1. As described above, organisational re-design and re-organisation was almost the norm, with the organisations rarely reaching stability before another set of changes were introduced.
2. In keeping with national health policy, both sites in England had retained a commissioning-provider split with these arms becoming more separate and distinct; the sites in Scotland had moved to an integrated system with no such distinction. Thus, governance arrangements at a strategic level were more integrated across primary and secondary care in Scotland than they were in England, though this was not always apparent operationally.
3. All the case study sites had a hierarchical and bureaucratic structure, with many sub-groups and committees reporting upwards. This was despite the two English sites claiming to have a flatter, more matrix oriented governance structure. Operationally, there was usually one key committee in each site, however the individuals on these committees appeared to be as important as the committee itself.
4. Communication across committees was often because the same individuals sat on multiple committees e.g. the Medical Director.
5. Despite the importance of the professional group in the delivery of QOF at practice level, only the Scottish sites had a named individual responsible for practice nursing operating at a strategic, Board level.
6. In Scotland, the decentralisation of primary care to Community Health Partnerships (CHPs) was having a marked impact on the organisation, delivery and monitoring of primary care services. This was particularly apparent in Case Study 3, where care was now devolved to 11 organisations, whose remit covered primary care, community care and mental health services. This wider remit meant that the managers of CHPs often had less knowledge about the GMS contract.
7. Both countries had exerted much time and effort in developing monitoring and support systems for the strategic and operational delivery of the QOF. Each site had committees or groups responsible for the strategic development and operational monitoring of QOF and, in general, had systems in place to support practices with the IT

requirements that the QOF entailed. However, these committees and groups often sat within different parts of the organisation, e.g. with the Medical and Commissioning Directorates (Case Study 1) or within the Medical Directorate and Human Resources (Case Study 4). In Case Study 2, however, the Commissioning and Medical Directorates were jointly responsible for the monitoring and accountability of QOF. This meant that there was often a split between those responsible for strategic issues and those responsible for financial accountability.

8. The development and monitoring of the enhanced services was less clear, particularly in England, where practice based commissioning had been given greater priority. Local enhanced services (LES) had been developed to meet local needs in each site, dependent on the characteristics of the population served. However, evidence for the governance and monitoring arrangements of the enhanced services was sparse and seemed to focus on activity rather than quality or accountability.

9. In England, where practice based commissioning had been given greater priority, much of the focus of PCOs was on the development of PBC Consortia.

10. Out-of-hours care had undergone major change around the implementation of the new contract, both in terms of organisation (e.g. several services amalgamating into a single service) and skill mix to deliver care (e.g. introduction of emergency care practitioners and minor illness nurses).

11. In Case Study 1, out-of-hours care was now delivered by an independent not-for-profit organisation. In the other three sites, care was provided by an NHS organisation. In Case Study 3, the out-of-hours service now sat in the Acute Division rather than in primary care. In each, however, the PCO was still involved in the monitoring of the organisation's performance.

4.5 Conclusions

Despite very obvious differences in the organisation of the case study sites due to differences in national health policy and the despite local rhetoric about having flatter structures, all four case study sites demonstrated signs of a broadly hierarchical and bureaucratic structure for the monitoring and governance of the GMS contract. Communication across committees was often due to the presence of individuals who sat on multiple committees. Systems of monitoring and accountability were most developed for QOF, with the focus on activity for the enhanced services rather than quality or accountability. In England, the policy driver of practice based commissioning clearly took up much time and energy. Whether these organisational and contextual differences would impact on the way in which each site enacted governance in relation to the GMS contract is reported in Chapter 7.

5 Models of service delivery post-GMS contract: selection of embedded case studies in PCO case studies 1 and 3

5.1 Introduction

Several different models of service delivery are now operating within general practice since the implementation of the new GMS contract. As well as the traditional model, where practices are contracted to the General Medical Services (GMS) contract, other models include: Personal Medical Services, which have continued to develop since their inception in 1997 and give GPs the option of being salaried employees of their PCO; PCT Medical Services (PCTMS), where the PCT can deliver primary care services directly; and Alternative Providers of Medical Services (APMS), where other providers including private providers can be contracted to deliver services (124). We have hypothesised that such models of care may be subject to different mechanisms of governance and incentives, depending on who is providing the service and the degree of accountability operational within each model. These changes also impact on the experiences of staff commissioning, managing, administering and providing the services, and the patients and carers that they serve. Stage 2 of this project sought to explore these issues through studying six embedded case studies in two of our PCO case study sites.

5.2 Methods

5.2.1 Rationale for embedded case studies

In Stage 2 of this project, we identified six embedded case studies for in-depth study, in order to understand the impact of governance and incentive arrangements at the level of different models of service delivery. A pragmatic decision was made to site this work in PCO Case Studies 1 and 3, for the following reasons:

- a. Both PCOs served a broadly similar population, namely an urban, deprived population with high rates of poor self-reported health in the population.
- b. Both PCOs had a high proportion of single-handed and small practices.
- c. Both PCOs had a similar mean number of GPs per practice (approximately 3.5).

- d. Both PCOs had similar levels of QOF achievement in 2005-06 (Case Study 1 1002 points per GMS practice; Case Study 3 1032 points).
- e. The location of one in England and one in Scotland allowed us the opportunity to compare the impact of different health jurisdictions on governance and incentives.

Within each case study, **multiple embedded units** of analysis were selected. On the basis that practices with high or low QOF achievement might respond to the incentives within the QOF and to the governance arrangements established by the PCO differently, it was decided to recruit two practices in the highest quintile of QOF achievement and two in the lowest quintile, giving us **four embedded case studies** in each site. One of these practices in each site was a PMS practice. However, as practices in each case study were also involved in delivering the enhanced services, we further subdivided the selection criteria to include practices who were involved in enhanced service delivery and those who were not. The enhanced service, as a bounded system delivered jointly by practices and community-based teams, formed the **fifth embedded case study** and the out-of-hours service was the **sixth**. This is illustrated in Figure 9.

In order to inform the selection of embedded case study sites it was essential to be able to accurately characterise the general practices providing care within each site, in terms of size, deprivation of the practice population and type of contract (i.e. either GMS or PMS contract). We were able to do this through analysis of: (1) the interviews conducted as part of Stage 1; and (2) the exploratory scoping meetings with key stakeholders in each PCO. The structure and organisation of the enhanced services provided within each area was established at the same time. From this, criteria were developed to facilitate the selection and recruitment of our organisational models to Stage 2 of this project.

5.2.2 Criteria for selection of the embedded case studies

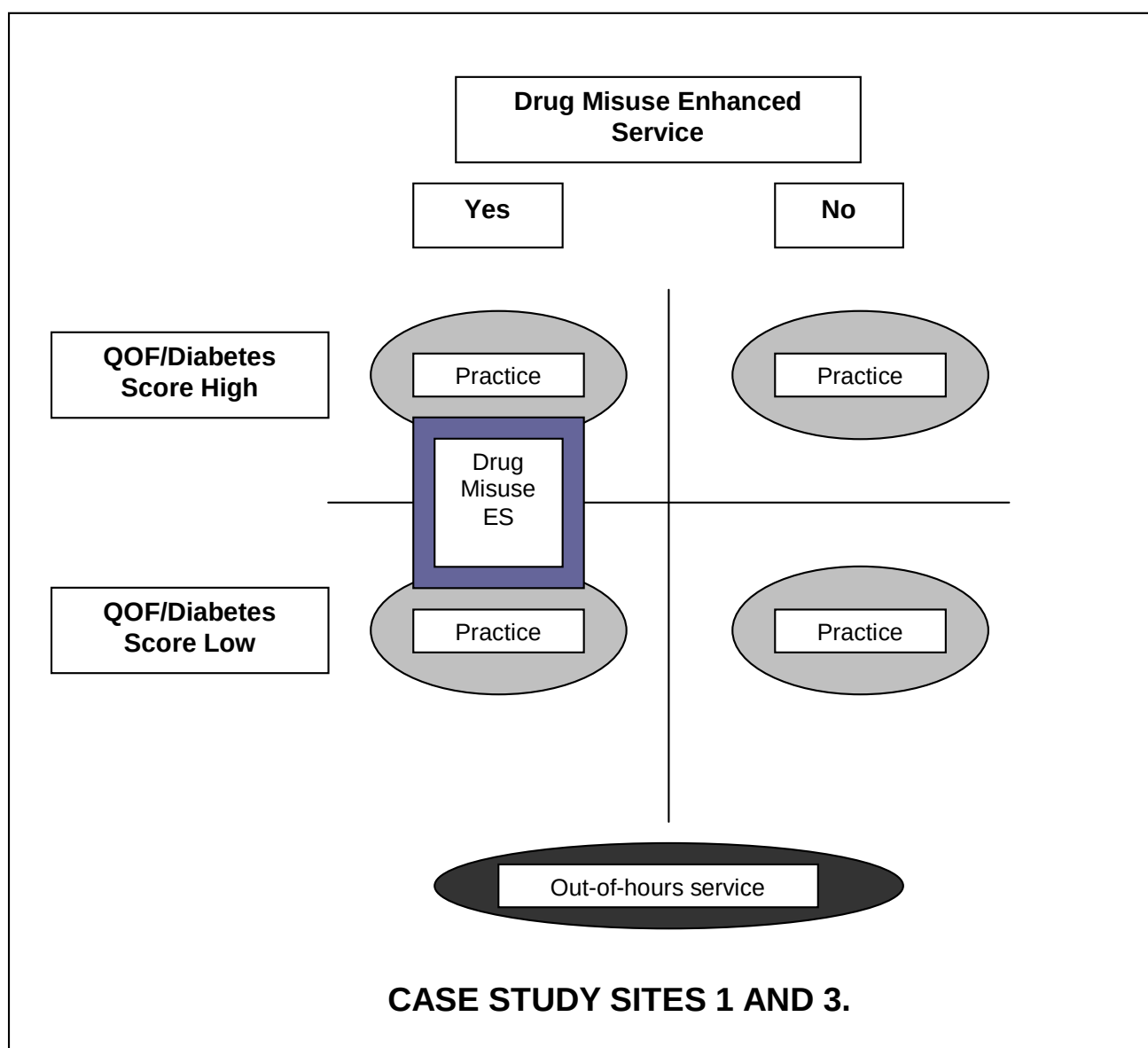
General practices

Two principal types of contract are available to general practices:

- **General Medical Services (GMS) contract:** the traditional general practice contract. Originally held between the NHS and individual GPs but, since 2004, the practice is contracted to provide a range of services for their practice population;
- **Personal Medical Services (PMS) contract:** GPs are salaried employees of the PCO and are subject to local variations in the contract specifications.

Thus, we sought to recruit practices that were examples of both models, in order to compare and contrast the governance mechanisms in operation under each contract.

Figure 9. Organisational models to be recruited as embedded case studies



Practices in Case Studies 1 and 3: 3 GMS and 1 PMS practice.

Drug misuse enhanced service: Delivered by practices and community-based services.

Based on our knowledge of the literature, it was hypothesised that the impact of governance and incentives might differ between larger and smaller practices; those serving deprived or affluent populations; and achieving high versus low QOF scores. However, as only four practices were to be selected in each case study site, the paramount criterion was that of QOF achievement. In order to explore the impact of the contract on patient care, Stage 2 also included patient tracker work focussed on an incentivised and an unincentivised condition (Chapter 3.5 and Chapter 11). The incentivised condition selected was diabetes. Therefore, we also examined practice performance in relation to diabetes QOF achievement and examined the number of patients on the practice's diabetes register.

Identification of high and low achieving practices in relation to overall QOF score and the diabetes clinical domain

Publicly available data on QOF achievement for each practice were downloaded from the relevant national site for both England (www.qof.ic.nhs.uk/) and Scotland (www.isdscotland.org/isd/3305.html) for 2006 -07. Practices were split into quintiles on the basis of QOF achievement and those in the highest and lowest achieving quintiles identified.

In relation to diabetes, a composite score was created by calculating a mean score for each practice based on percentage achievement in those indicators which applied to the whole of the diabetes register, where achievement was calculated by the numerator divided by the whole register (denominator plus those patients excepted). Again, practices were split into quintiles on the basis of this composite score and practices in the highest and lowest achieving quintiles identified. Practices appearing in the top and bottom quintiles for both overall QOF points and for the diabetes domain were identified and used as a sampling frame for recruitment. Thus, practices were identified as notional “high” and “low” achievers in relation to overall QOF performance and diabetes care in particular. The number of patients on the practice’s diabetes register was also estimated using practice QOF prevalence data for 2006-07.

Enhanced services

A list of enhanced services in each site, for 2006-07, was obtained from key stakeholders. All enhanced services provided in each case study area (directed, national and local) were then compared across the two case studies to identify a similar service delivered in both England and Scotland. After a decision was made to focus on the drug misuse enhanced service (see Section 5.3.1), a list of practices participating in the enhanced service was obtained from each PCO. As an additional check, practices were asked at the time of recruitment if they participated in the drug misuse enhanced service.

Out-of-hours service

The out-of-hours service in each area was identified during Stage 1 interviews and direct contact made with the service.

5.2.3 Recruitment of embedded case studies

General practices

A purposive sampling strategy was planned. Using the sampling frame described in 5.2.2, 12 practices were identified in each site as meeting the criteria of high/low QOF achievement and participation or not in the enhanced service. Initial contact was made with the practice manager of these selected practices, usually by one of the researchers (SG or AR) or by the lead in each area (COD or MG). If the practice expressed interest, a visit was arranged to explain the aims of the study and the workload to

the practice manager and, on some occasions, to a GP partner. This was usually followed by waiting period, while all the partners in a practice considered whether they wished to participate or not. In reality, this extended the period of recruitment significantly as it was not unusual for a practice to take up to 2 months to decide.

Once the practice was recruited, the practice manager identified members of staff willing to be interviewed. These staff members were given a copy of the information sheet and interview guide in advance. Interviews were arranged at a time suitable to the interviewee and took place within the practice. Generally, at least one GP and one practice nurse were interviewed, as well as the practice manager. Written informed consent was obtained prior to the interview.

Enhanced services

Non-practice based staff involved in the delivery of the enhanced services were approached directly and asked if they would consider participating in the study. As with practices, staff were given a copy of the information sheet and topic guide in advance; informed consent was obtained prior to the interview.

Out-of-hours service

As with the enhanced service, staff involved in the delivery of the out-of-hours service were approached through the director of the service. Staff were given a copy of the information sheet and topic guide in advance; informed consent was obtained prior to the interview.

5.3 Results

5.3.1 Characteristics of the embedded case studies

General practices

In 2006-07, Case Study 1 had 104 general practices, of which 67 were GMS practices; Case Study 3 had 210 practices, with 206 GMS practices. QOF achievement was relatively high in both sites (Table 2). There was a greater spread of QOF achievement in Case Study 1 compared with Case Study 3 between the highest and lowest achieving practices (420 points vs 178 points). However, in each site, the difference for practices in the inter-quartile range (i.e. 50% of all practices) was much smaller (92 points and 15 points respectively).

Table 2. QOF achievement in each case study site in 2006-2007

	Case Study 1	Case Study 3
Mean QOF score per GMS practice	917.9	978.6
Median QOF score per GMS practice	958.0	989.6
Range	1000.0 to 580.3	1000.0 to 752.6
Inter-quartile range	92.3	15.2

Enhanced services

Both case study sites delivered a wide range of enhanced services (Table 3).

Table 3. Enhanced service delivery in case study sites in 2005-2008

Case Study 1	Case Study 3
Directed Enhanced Services^a.	
Access to primary care	48 hour access to primary care
Childhood immunisation	Childhood immunisation
Flu and pneumococcal immunisation for over 65s	Flu and pneumococcal immunisation for over 65s
Influenza immunisation for at risk groups aged <65	Influenza immunisation for at risk groups aged <65
Minor surgery	Minor surgery
Services to deal with violent patients	Services to deal with violent patients
IM&T	
	Cardiovascular disease risk dataset
	Cancer referral
	Services for carers
	Services for adults with learning disabilities
National Enhanced Services^b.	
IUCD fitting	IUCD fitting & checking
Near patient testing	Near patient testing
	Homeless services
	Services to drug users
	Anticoagulation (one part of the Health Board only)
Local Enhanced Services^c.	
Choose & Book	
Sexual health	Sexual health
Asylum seekers	Asylum seekers & refugees
Hepatitis B immunisation for at risk groups	Diabetes
Pneumococcal immunisation for at risk groups	CHD
MMR immunisation for students	Stroke
Homeless patients	Multiple sclerosis
Travelling population	Mumps
Meningitis C immunisation for students	Carers influenza immunisation
Care of substance misusers	Contraceptive implants
Anticoagulation monitoring	Pre-chemo phlebotomy
	Care of patients with learning disabilities
	Cancer referral

a. *Directed Enhanced Services (DES): provided by the PCT for its population.*

b. *National Enhanced Services (NES): services to meet local needs, but commissioned to national specifications and benchmark pricing*

c. *Local Enhanced Services (LES): locally designed services designed to meet local health needs.*

Overall, those services delivered as Directed or National Enhanced Services, i.e. those defined centrally, were similar across England and Scotland, with a focus on access, immunisation, minor surgery, IUCD fitting and near patient testing. However, in the Scottish case study site, services for the homeless and for drug misusers were also delivered as a National Enhanced Service with nationally set specifications and pricing, whereas, in the English site, these services were delivered as Local Enhanced Services.

In both case study sites, the preferred provider for all enhanced services was general practice and almost all practices had taken up at least some enhanced service provision. However, some services were delivered across a combination of community-based service providers and general practice, for example the enhanced service for drug misusers in both sites. In Case Study 1, service provision for drug misusers was shared across general practice, the mental health trust in the area and a third-sector charity who successfully tendered for providing the specialist services within shared care for this patient group. In Case Study 3, general practice had been the main providers of care for drug misusers prior to the new contract. However, since the implementation of the new contract community addiction teams located within the CHPs had expanded. Here, the long-term strategic aim was for care of stable patients to be transferred to practices, while the community-based teams would care for those patients with more challenging and complex needs.

Delivery of a service across both general practice and community-based services raised interesting questions about how such a service would be governed. Unlike other enhanced services delivered in both case studies which were based solely in general practice, this provided opportunities to interview both practice-based staff and community-based staff about governance arrangements across the general practice-community services boundary. Given that it was also a similar model of service delivery across the two countries, the **drugs misuse enhanced service** was selected for further exploration.

Out-of-hours service

As described in Chapter 4, the PCO was responsible for the delivery of out-of-hours services in both sites. In Case Study 1, the organisation commissioned to provide out-of-hours care was a not-for-profit organisation, previously a GP co-operative. In Case Study 3, all out-of-hours calls were front-ended by NHS 24. Clinical care was provided by a GP-led organisation, again previously a GP co-operative, but which was now sited with the Emergency Medicine Directorate of the Acute Division of the Health Board.

5.3.2 Recruitment of the embedded case studies

Case Study 1

In this site, selecting practices on the basis of high and low diabetes QOF achievement resulted in a very small number of practices (n=10) eligible for the study, probably due to the smaller number of practice in this area in the first place. Therefore, here, practices were selected on the basis of overall QOF score. This resulted in the identification of 51 practices whose characteristics are outlined in Table 4.

Table 4. Characteristics of eligible practices in Case Study 1

	Highest quintile (n = 25)	Lowest quintile (n = 26)
Practice list size		
Mean (Range)	6456 (2255 – 12019)	5372 (1390 – 15658)
Median (Inter-quartile range)	5994 (3730 – 9224)	4494 (2837 – 7843)
Number of patients on diabetes disease register		
Mean (Range)	219 (55 – 429)	177 (36 – 411)
Median (Inter-quartile range)	196 (136 – 310)	164 (86 – 261)
Mean prevalence diabetes (SD)	3.47 (0.63)	3.48 (1.45)
Total QOF clinical points		
Mean (Range)	998.7 (997.0 – 1000.0)	862.0 (580.3 – 937.3)
Median (Inter-quartile range)	998.9 (997.7 – 999.8)	901.4 (828.7 – 925.4)
Type of contact (Number)		
GMS	20	17
PMS/PCT MS	5	9
Providing drug misuse enhanced service (Number)	8	6

Practices in the highest quintile had a larger mean list size and more diabetic patients than those in the lowest quintile, although diabetic prevalence was similar. From these identified practices, 12 were selected and approached sequentially to determine if they would be interested in participating in the study. Of 8 practices initially approached, 4 agreed to participate.

Case Study 3

In Case Study 3, 24 practices were identified who were in either the highest quintile for both overall QOF score and diabetes score or in the lowest quintile for both. Their characteristics are shown in Table 5.

Table 5. Characteristics of eligible practices in Case Study 3

	Highest quintile (n = 9)	Lowest quintile (n = 15)
Practice list size		
Mean (Range)	4153 (1926 – 7921)	4346 (1012 – 11775)
Median (Inter-quartile range)	3746 (2443 – 5348)	3366 (2351 – 4493)
Number of patients on diabetes disease register		
Mean (Range)	137 (48 – 264)	159 (44 – 318)
Median (Inter-quartile range)	122 (80 – 193)	170 (81 – 205)
Mean prevalence diabetes (SD)	3.17 (0.66)	4.15 (1.37)
Total QOF clinical points		
Mean (Range)	996.1 (994.9 – 1000.0)	911.9 (752.6 – 973.6)
Median (Inter-quartile range)	996.0 (995.0 – 996.0)	940.5 (881.9 – 946.9)
Total diabetic points		
Mean (Range)	89.8 (88.2 – 90.3)	79.2 (72.6 – 83.1)
Median (Inter-quartile range)	89.9 (89.5 – 91.5)	79.4 (78.0 – 80.3)
Type of contact (Number)		
GMS	15	9
PMS	0	0
Providing drug misuse enhanced service (Number)	5	10

There were no obvious differences between practices in the highest and lowest quintile of QOF achievement, although slightly more in the lowest quintile participated in the drug misuse enhanced service.

Thirteen practices were selected and approached sequentially to determine if they would be interested in participating in the study. However, no practices were recruited from this initial wave. One practice did initially express interest, but then declined to participate after deliberating for 2 months. We returned to the original sampling frame and identified several practices known to the research team, who might be willing to participate, resulting in one practice who agreed to participate.

This led to a widening of the recruitment strategy, facilitated by the Scottish School of Primary Care Research Network, who identified several practices known to be willing to participate in research and a second practice was recruited. Finally, we approached several practices

directly, which resulted in two more practices. Thus, around 20 practices had to be approached in order to recruit 4 into the study.

Unfortunately, these difficulties in recruiting practices were most apparent amongst those in the lowest quintile of QOF achievement, despite reassurances that we were not interested in their QOF score per se, but in the way that they had chosen to interpret and respond to the GMS contract in general, and QOF in particular. However, through careful selection of practices, a spread of QOF achievement was still maintained. The main characteristics of the participating practices are detailed in Table 6. To preserve practice anonymity, we assigned each practice a unique identifier.

Table 6. Organisational characteristics of the participating practices

Practice 1.	Case Study 1, England. GMS practice List size: 11731; QOF points in 2005-06: 931 (Quintile 5). Participated in substance misuse enhanced service. Staff included: 5 GPs; 2 practice nurses; 1 practice manager. Interviewed: 3 GPs; 1 practice nurse; practice manager.
Practice 2.	Case Study 1, England. PMS practice List Size: 10907; QOF points in 2005-06: 1000 (Quintile 1). Participated in substance misuse enhanced service. Staff included 6 GPs, 3 nurses, 1 practice manager. Interviewed: 2 GPs; 2 nurses; practice manager.
Practice 3.	Case Study 1, England. GMS practice List size: 10080; QOF points in 2005-06: 1000 (Quintile 1). Did not participate in substance misuse enhanced service. Staff included 4 GPs, 2 practice nurses, 1 practice manager Interviewed: 2 GPs; 1 practice nurse; practice manager; 1 administrative member of staff.
Practice 4.	Case Study 1, England. GMS practice List size: 6869; QOF points in 2005-06: 933 (Quintile 4). Did not participate in substance misuse enhanced service. Staff included 5 GPs, 1 practice nurse. Interviewed: 1 GP; practice nurse; 2 administrative members of staff.
Practice 5.	Case Study 3, Scotland. List size of 5200; QOF points in 2005-05: 1039 (Quintile 1). Participated in substance misuse enhanced service. Staff included 5 GPs; 3 nurses; 1 health care assistant; 1 practice manager. Interviewed 2 GPs; 2 practice nurse; practice manager.
Practice 6.	Case Study 3, Scotland. List size of 6800; QOF points in 2005-05: 1046 (Quintile 1). Did not participate in substance misuse enhanced service. Staff included 7 GPs; 2 practice nurses; 1 health care assistant; 1 practice manager. Interviewed: 2 GPs; 2 practice nurses; practice manager.

Practice 7.	Case Study 3, Scotland. List size of 4800; QOF points in 2005-06: 1050 (Quintile 1). Participated in drug misuse enhanced service Staff included 3 GPs; 2 practice nurses; 1 practice manager. Interviewed 2 GPs; 2 practice nurses; practice manager.
Practice 8.	Case Study 3, Scotland. List size of 3300; QOF points in 2005-05: 1038 (Quintile 2). PMS practice. Participated in substance misuse enhanced service. Staff included 4 GP partners and 1 salaried GP; 2 practice nurses; practice manager now partner in practice; office manager. Interviewed 2 GPs; 2 practice nurses; practice manager; 1 member of administrative staff.

5.4 Discussion

In this chapter, we outlined the rational and process for recruiting six embedded case studies in our two intensive PCO case study sites. A strength of this component of the project was the identification of different organisational models being delivered in primary care since the implementation of the new contract, thus affording us the opportunity of testing out how the contract is governed in these different models and the impact of that governance and the associated incentives on staff. We also developed a replication logic to the embedded case studies, testing out both literal replication (i.e. predicting similar results across the models – e.g. the response to QOF in high achieving practices will be similar in England and Scotland) and theoretical replication (i.e. predicting contrasting results for predictable reasons – e.g. less use will be made of enhanced services in England than in Scotland because of PBC).

Recruitment, particularly in relation to general practices, was slow and difficult. While a purposive sampling strategy was planned, with QOF achievement a key component, the reality was that the sampling strategy became one of convenience, where we accepted practices who were willing to participate regardless of their QOF achievement – in some cases, these were practices already known to be interested in participating in research. While this is a weakness, we did in the end obtain a spread of practices in relation to QOF achievement, ranging from the first (highest) quintile to the fifth (lowest quintile), albeit that the majority of practices were higher achieving practices.

In order to preserve the integrity of the case studies, the following chapters will report findings within each case study, including PCO and service-level views, across a number of key areas:

- Overall view of the impact of the new contract and its place in national and local primary care policy (Chapter 6).

- Development of models of governance, in particular the balance between mechanisms of hard and soft governance (Chapter 7).
- The impact of GMS incentives and monitoring on staff performance and motivation (Chapter 8).
- The impact of the contract on skill mix and professional boundaries (Chapter 9).
- The impact of the contract on inequalities (Chapter 10).
- The impact of the contract on patient care and public involvement (Chapter 11).

6 The place of the GMS contract in the devolved health systems of England and Scotland

6.1 Introduction

The new GMS contract was nationally negotiated and agreed with all general practitioners in the UK. However, as described in Chapter 4 and Appendix 1, it has been implemented into two rapidly diverging health care systems, as a result of political devolution. Greer posits that this has led to a different policy and managerial ethos in England and Scotland with an emphasis, in England, on central target setting, performance management and the development of a market-based approach. In Scotland, however, NHS development has been influenced by a strong ethos of professionalism and a rejection of market-driven approaches (10;120;123;125). This has also resulted in different structures and organisations designed to deliver primary care services: England has retained the purchaser-provider split, whereas Scotland has favoured an integrated approach to care delivery through its Health Boards and, latterly, Community Health Partnerships.

This raises the possibility that the response to the contract may be different between the two countries, particularly if Scotland has adopted a less management-driven system of accountability. Before moving on to analyse the governance and monitoring of the contract across both countries, it is first useful to consider how the contract has been viewed in each country with respect to its development, performance and its place within the wider primary care policy sphere. It is these issues that we report in this chapter.

6.2 Methods

The methods described here pertain to the findings reported in Chapters 6 to 10 and relate principally to the qualitative data. A description of the quantitative data analyses is contained in Chapters 4 and 5.

6.2.1 Setting

As described in Chapters 4 and 5, this work was set nationally, in England and Scotland; regionally in the four PCO case study sites and in the 12 embedded sites across Case Study 1 (in England) and Case Study 3 (in Scotland).

6.2.2 Selection and recruitment of interviewees

Within the national, PCO and embedded case study interviews, conducted in Stages 1 and 2, a key informant approach was adopted, with respondents selected on the basis of their knowledge of nGMS in their area and the governance and performance monitoring arrangements required to support them. Interviewees included policy makers in both England and Scotland; individuals with a knowledge of general practice at a national level; individuals involved in both commissioning and providing services in the PCOs; and frontline general practice staff.

Owing to the sensitive nature of the areas discussed and the need to preserve the anonymity of respondents, we have limited the amount of detail given about the interviewees (see Appendix 3).

National level stakeholders

In Stage 1 of this project, semi-structured interviews were conducted with stakeholders operating at a national level in both England (n=13) and Scotland (n=4). National stakeholders included those operating with the relevant Government health department (the Department of Health in England; the Scottish Government's Health Department); key leaders in national organisations; and individuals with particular knowledge of the development of the GMS contract. Interviews with SHA representatives in England were also considered part of the national group.

PCO level stakeholders

PCO level stakeholders were also interviewed during Stage 1. These included clinical and non-clinical managers operating within the PCO with responsibility for the implementation and governance of some aspect of the GMS contract, as well as individuals not directly employed by the PCO but working in that case study site, e.g. professional representatives. A total of 48 interviews were conducted: 24 in England and 24 in Scotland. Interviewees were purposively selected to ensure that both clinical and non-clinical, medical and nursing perspectives were gathered.

Initial interviewees were based on the local knowledge of the study team in relation to key people to interview. However, as described in Chapter 4.2.4, early scoping meetings held with key individuals within each PCO identified other key informants.

Interviews took place between January 2007 and June 2008.

Frontline staff

In Stage 2, six embedded case studies were selected in Case Studies 1 and to encompass GMS and PMS practices; an enhanced service; and the out-of-hours service – full details of the rationale for and selection of these is contained in Chapter 5.

A selection of staff involved in the management and delivery of these services were identified and recruited into Stage 2. Interviewees included

managers of the enhanced and out-of-hours services, general practitioners, practice nurses and practice managers. A total of 55 interviews were conducted: 30 in England and 25 in Scotland. These are also detailed in Appendix 3.

These interviews were conducted between summer 2008 and spring 2009.

6.2.3 Interview guides

Interview guides for each stage of the project were developed iteratively by the research team, informed by the empirical literature on the implementation of the GMS contract and prior research conducted by some of the grantholders into the implementation of the GMS contract (BG), delivery of out-of-hours care (COD, DH) and knowledge of developments in general practice and primary care post-GMS (COD, BG, MG, GW, FM, CC). Development of the interview guide was also informed by the theoretical literature on governance, as described in Chapter 1.

The interview guides were applied differentially, depending on the individual being interviewed, their professional background and current role in relation to the GMS contract. Topics included the participant's role and their involvement in GMS-related work; commissioning, performance monitoring and sanctioning arrangements of GMS services in their area; key governance issues pre- and post-nGMS; patient care pre- and post-nGMS; and perceived future developments in primary care. Questions concerning the techniques used to govern general practice since the start of nGMS were explored in particular depth in Stages 1 and 2, to explore the range of governance mechanisms used in relation to general practice professionals.

Interviewees were sent a copy of the interview guide, a Participant Information Sheet and a consent form prior to the interview. The researcher (SG or AR) obtained informed consent before the interview commenced.

The Stage 1 interview guide is contained in Appendix 4; the Stage 2 guide in Appendix 5.

6.2.4 Data collection and analysis

All interviews were recorded, transcribed verbatim and analysed using NVivo to store and manage the data. Preliminary themes were identified through scrutiny of the initial transcripts. A coding framework grounded in the emerging data (126) was initially developed by SG and AR. This framework then developed iteratively using the constant comparative method (127;128) until no further amendments or new categories were indicated by comparison with additional transcript data. Meetings between members of the research team were used to discuss, clarify and refine the thematic categories. During this process, the researchers coded the transcripts from their respective country. However, eight transcripts were double-coded by other members of the research team.

Any differences in interpretation of the data were resolved through discussion and consensus within the team.

Quotations are used throughout the report to illustrate salient points. Attributive statements are described according to country, stage of project, case study, pertinent information regarding role, interview number and paragraph that the quotation comes from.

6.3 Results

Here, we will report on the development of GMS as a national policy, issues pertaining to both the enhanced services and out-of-hours care and the relationship between GMS and other national policy developments, comparing and contrasting England and Scotland.

6.3.1 GMS as a national policy development

In England, the focus of the national level respondents was the development of the contract, whereas at PCO level discussions focussed predominately on the implementation and role of the national targets and specifications. In Scotland, however, both national and PCO-level interviewees discussed both the development of the contract as well as the implementation of targets and specifications. Practice and service level respondents in both countries had little to say on these wider, policy matters. While the process of implementing and monitoring the GMS contract was devolved to a Scottish level, major issues relating to contract negotiation or of changes to the QOF were dealt with at a UK level. Thus, Scottish representatives sat on the UK-level negotiating committee, led by the Department of Health, the General Practitioners Committee and the BMA.

Major components of the contract, i.e. QOF, the Global Sum and the Income Guarantee were the same across the UK, although the global sum was calculated differently in Scotland to take account of small practices operating in remote and rural areas. The QOF appeared to dominate respondents' views of the contract, regardless of what level they were working at.

..... although it's [QOF] not the whole of the contract it would appear to be to what most GPs thought the new contract was about, which was that the new contract equals QOF.....

(Scotland Stage 1, National, Interview 27, Paragraph 4)

QOF was viewed by many of the national interviewees as a great success, not only in terms of the levels of attainment, which were greater than originally anticipated, but also because it addressed both clinical and organisational areas of practice and was team-centric rather than GP-centric

So the concept of four domains, the concept of a quality based contract, the fact that GPs have achieved more than was expected of them I think is fantastic and I think its been money well spent it's the biggest quality based contract in the world and whatever cynics and grumblers say its one of the most intriguing things we have done in international terms and many other countries are intrigued by it.

(England Stage 1, National, Interview 32, Paragraph 62).

Although there was general agreement that many of the clinical indicators in the QOF were evidence-based, the process of negotiation had led to the inclusion of some targets that were not thought to be evidence-based, with much of the pressure for this coming from the Department of Health in England and from condition-specific patient support groups. Some interviewees also commented on the lack of an evidence base for the organisational and patient-centred indicators. Population-based health indicators, e.g. in relation to obesity or alcohol services, were also acknowledged as having a weaker evidence base.

Interviewee: Yes, and of course the QOF, to start with was rigorously evidence-based, or most of it, anyway, and now everybody wants to shove stuff into it, and of course all the really hard evidence has been used, and so things that people want to put in are a bit more dubious.

Interviewer: And do you think that's been political pressure?

Interviewee: Yes, and pressure groups. They want to do child obesity. No, not in a medical practice, you can't, it's society that needs to do something about that.

(Scotland Stage 2, Case Study 3 – Practice (GP), Interview 52, Paragraphs 357-361)

At Government level, the desire to involve general practice in programmes designed to tackle more upstream determinants of health, e.g. back to work schemes, also had to be addressed, as none of that was included within the QOF.

A number spoke about the use of QOF as a measure of performance in primary care, although many acknowledged that there was a need to develop a broader, more holistic way of measuring and monitoring practices. One interviewee pointed out that QOF had not been designed as a performance tool but as a payment tool, but this had led to an increase in both the quality of care and the quality of information collected nationally.

The contract was also discussed nationally in relation to plans to develop core minimum standards for all NHS providers. Meeting these core standards in general practice would be required in order to be eligible to hold a contract; however, such minimum standards were seen as only a starting point and again would be the baseline for continuous quality improvement.

It was noted that the implementation of QOF had financial repercussions. The underestimate in the level of attainment meant that the Government didn't set aside enough money to pay for QOF in the first year, leaving PCTs to pick up the shortfall.

..... their expectation in year one they'd be averaging 74% achievement and I think in year one the average achievement was something like 87% and if you think every point has a pound or two attached to it, that got very expensive

(England Stage 1, National, Interview 19, Paragraph 227)

This was an issue in both countries.

..... the problem for the Government was they didn't expect GPs to perform as well as they did. They expected the GPs to get 700 points and like all incentivised systems if you have got motivated professionals they will aim to hit the targets. Now the Government then weep and whinge and nash their teeth about that but actually it's not our fault we have over-performed. We have done what is asked of us and we have been, we should have been rewarded appropriately for it and now the Government are saying that we have overspent and are blaming the GPs and it must be one of the few professions where you get blamed for over performing against a quality standard.

(Scotland Stage 1, National, Interview 27, Paragraph 23)

One explanation for this “over-performance”, from both national and practice-based interviewees, was that the use of performance targets and specifications were not new in general practice. Antecedents of the Quality and Outcomes Framework included work on practice accreditation in Scotland, the Royal College of General Practitioners Quality Practice award scheme and SPICE – the Scottish Programme for the Implementation of Clinical Effectiveness. In each of these programmes, practices had had to meet clinical and organisational targets, most of which were evidence-based – this had required training and support and practices had been encouraged to improve their data recording, all of which laid the foundation for the high attainment observed with QOF.

Analyses of QOF data for year 1 (2004-2005), showed that achievement levels were higher in Scotland than in England across a range of QOF indicators for the four disease areas of CHD, stroke, hypertension and diabetes (Table 7). These differences were small for the simple process measures, but larger for the complex process and outcome indicators. These differences were not explained by disease prevalence, as Scotland had a higher prevalence for each disease compared to England (CHD: England 3.59%, Scotland 4.61%; Stroke: England 1.43%, Scotland 1.80%; Hypertension: England 11.32%, Scotland 11.85%; Diabetes: England 3.45%, Scotland 3.50%). This pattern remained in 2007-08, albeit the gap was narrowing. While there may be a number of explanations for this, the quality practice schemes mentioned in the preceding paragraph most likely contributed to this.

It was recognised that it was important to demonstrate that the contract was improving patient care.

..... the bit that we really need to get a handle on now is having, and we are getting under pressure nationally by the government to do this, is to say well what's the meaning for patients has patient care improved?

(Scotland Stage 1, Case Study 3 – PCO, Interview 6, Paragraph 227)

Table 7. Average population achievement by indicator category in England and Scotland, QOF 2004-05 and 2007-08

Category	England (Average % achievement)	Scotland (Average % achievement)	Scotland % point difference from England (99% CI)
"Population achievement" 2004 - 05			
Simple process (14 measures)	91.9	92.6	0.7 (0.5 to 0.9)
Complex process (3 measures)	76.4	79.1	2.7 (3.9 to 2.6)
Outcome (9 measures)	68.2	69.8	1.6 (0.7 to 2.5)
Treatment (5 measures)	72.6	72.8	0.2 (-0.4 to 0.3)
"Population achievement" 2007 - 08			
Simple process (14 measures)	94.5	95.5	1.0 (0.8 to 1.2)
Complex process (3 measures)	85.8	87.7	1.9 (1.7 to 2.1)
Outcome (9 measures)	77.1	78.6	1.5 (1.3 to 1.7)
Treatment (5 measures)	76.8	77.1	0.3 (0.1 to 0.4)

Bold type: Significant at $p < 0.01$.

Population achievement: Data for all eligible patients.

6.3.2 Enhanced services

A number of national and PCO interviewees discussed enhanced services. From the Department of Health's perspective, the Directed Enhanced Services were seen as a good way of getting a standard level of service across all English general practices. However it was generally acknowledged that this role should sit with PCTs, as commissioners of services, not with the Department of Health. In addition, at the time of interviewing, National Enhanced Services were not seen as particularly successful. As a result of both of these issues, the Department was developing a new mechanism for delivering such types of service: Primary Care Frameworks.

This led to variation in the Directed Enhanced Services and, in particular, the Local Enhanced Services, with each country pursuing its own agenda, designed to meet the needs of their populations.

.... the enhanced service component it's a shared component [across the UK] but how we actually use that component is different between the countries and reflects the policy priorities in different administrations.

(Scotland Stage 1, National, Interview 23, Paragraph 20)

Local Enhanced Services (LES) were viewed as a potentially important area for service delivery and were also seen as a mechanism by which

services could be established to care for patients in the community rather than in hospital, which was an on-going policy imperative in both countries. In the first year of the contract PCTs in England were described as being at different levels of readiness in relation to establishing LES, with many practices enrolled into LES and paid for activity that they were already providing. Since then, however, PCTs had moved on and were now reviewing what services they were commissioning, what price was being set for that service provision and who should provide that service – general practice(s) or a different provider. Again, from a Department of Health perspective, this was viewed as a way of bringing competition into primary care in England.

One interviewee suggested that the enhanced services were an under utilised resource, in both England and Scotland, partly due to a lack of expertise in developing services with clear performance criteria built in from the beginning.

I think it's eminently possible both locally and nationally to you know try patient improvements through using the enhanced services but I don't think that it's been as well utilised as it might well be and I think there's been a bit of lack of imagination at national levels about using enhanced services.

(England Stage 1, National, Interview 27, Paragraph 147)

This interviewee also commented on the financial implications of enhanced services:

I think the enhanced services are a fudge because I think they have just removed money that would have been paid to us [general practice] anyway and replaced it in a rather bureaucratic way

(England Stage 1, National, Interview 27, Paragraph 76)

Pricing of the enhanced services was an issue for many interviewees, particularly those working in PCOs in both countries, for whom negotiating local prices for enhanced services was an area of contention. PCOs found it difficult to meet the nationally agreed levels of payment.

.... national enhanced just meant that it was a kind of national standard with national prices that was more of a hindrance than a help to be honest, I think the negotiators thought that would help local systems to agree a price and agree a standard, all it did was it set in place a kind of, yes it agreed a price and a standard but it agreed a price and a standard that GPs would never move away from but they said its national so you know.

(Scotland Stage 1, Case Study 1 – PCO, Interview 6, Paragraph 191)

This was examined quantitatively using payment data. In 2005-06, Case Study 3 received higher payments for all three enhanced service types (Table 8). The biggest difference overall was for local enhanced payments where on average Case Study 3 practices received £1.65 more per patient and £3.56 more for total enhanced payments in 2005-06. In 2006-07, the overall difference fell to £0.89 per patient, largely due to a turnaround in direct payments where a large increase for Case Study 1 practices saw them receive £7.68 per patient compared to £5.23 in Case Study 3. There is little change for either case study in national enhanced payments but Case Study 3 increased the difference in local enhanced payments from £1.65 more in 2005-06 to £2.34 more in 2006-07

Table 8. Service payments to case study sites 1 and 3, 2005 to 2007

2005/06				2006/07		
	Case Study 1	Case Study 3	Difference	Case Study 1	Case Study 3	Difference
Directed	2.66	3.56	0.90	7.68	5.23	-2.45
National	1.60	2.61	1.01	1.44	2.43	0.99
Local	0.46	2.11	1.65	0.41	2.75	2.34
Total	4.72	8.28	3.56	9.52	10.41	0.89

All figures in pounds/per patient.

In Scotland, all of the enhanced services, whether Directed, National or Local, were devolved to the Health Boards – called the Scottish Enhanced Services Programme. This approach was unique in the UK, with the programme reflecting national priorities, while allowing Health Boards to develop the precise specifications. This had allowed the development of a set of Enhanced Services, which varied across Health Boards, according to the local needs of the Board. However, the lack of central control and monitoring meant that the Scottish Health Department now didn't know how much Boards were paying for the enhanced services, leading to the view that such information needed to be shared nationally.

..... there's a feeling that actually there's a lot to be said for sharing here you know across the boards about what how much they are paying for different services and how much should they be paying for that because other boards do it for free and, you know, that sort of thing.

(Scotland Stage 1, National, Interview 17, Paragraph 30)

In England too, enhanced services were viewed by some as a mechanism for developing services responsive to local needs, even if this meant regional variation in pricing.

..... having local and regional differences around enhanced work I think is fine I think that's good. Different parts of the country have very different needs so its entirely appropriate that, the PCT where I'm working in at the moment [name] is very focused on deprivation, social deprivation, inequalities, needs of ethnic minorities whereas you certainly wouldn't want my old PCT [name] to be focused on that because they aren't issues for it. you know you want some flexibility around the areas that are locally important.

(England Stage 1, National, Interview 33, Paragraph 173)

6.3.3 Out-of-hours care

Out-of-hours care, in both England and Scotland, had to respond to nationally set targets, developed from the Carson Report on standards for out-of-hours care in 2000 (129). In Scotland, these had been developed by a national body, Quality Improvement Scotland, and were a shorter version of the Carson standards. In England, by contrast, all of the Carson standards had been retained and become contractual standards for out-of-hours care – the National Quality Requirements (NQRs). These high standards and the contractual specifications put out

by the Department of Health were felt to require a new type of out-of-hours organisation, with the ability to meet such targets.

It became increasingly difficult for single GP practices or even large GP practices to consider providing that role, because they couldn't really meet the criteria that were expected from national government.

(England Stage 1, Case Study 1 – Other, Interview 63, Paragraph 3)

..... it needed a completely different model of care

(England Stage 1, Case Study 1 – Other, Interview 52, Paragraph 53)

Some interviewees commented on the paradox of having rigorous standards and monitoring in place to deal with care delivered in the out-of-hours period, but the difficulty of carrying this into the in-hours period.

..... there's some interest and debate that happens between GPs when you consider now the national quality requirements [NQRs] are very rigorous and they control the provision of out-of-hours service and the monitoring of out-of-hours services far more rigorously than anything that is monitored, far more than anything in hours so ... you have got far more awareness and control of what that service is delivering from half past 6 at night through to 8 in the morning and across weekends and then its handed over to a service you really haven't got a much handle on in terms of nothing like NQRs. You have got the QOF but that's a different thing altogether

(England Stage 1, Case Study 1 – Other, Interview 9a, Paragraph 43)

This division between in hours and out-of-hours was also felt to be impacting on the development of national policy around the provision of urgent care, due to a lack of clarity between scheduled and unscheduled care, although this was only commented on by interviewees in England.

..... I don't know how much you are aware of the urgent care strategy that the Department of Health have been trying to bring out for a couple of years now. Its just been further deferred and I, I mean a number of people believe that that is because they have tied themselves up in a bit of a knot in terms of the primary care out-of-hours and primary care in hours and tried to find a distinction between what's routine or non-routine or what's planned or what's unplanned and its all about words and how do they bring out a strategy that's covers in hours and out-of-hours without unravelling because they will never be able to bring NQRs into in hours, its too vast

(England Stage 1, Case Study 1 – Other, Interview 9a, Paragraph 47)

Like QOF, the cost of providing out-of-hours services was significantly underestimated in both countries - this was commented on by several interviewees.

I don't think we anticipated the extra costs the out-of-hours was going to bring erm you know the expectation of £6000 per GP was going to pay for out-of-hours was wildly underestimated

(England Stage 1, National, Interview 19, Paragraph 359)

.... for out-of-hours the Government priced it wrong, they definitely got it wrong I mean it shows you how much they valued out-of-hours that they priced it at approximately £6000 a GP and you know it took us a while to suddenly realise that they cost a hell of a lot more than that to deliver.

(Scotland Stage 1, National, Interview 27, Paragraph 22)

It was suggested that in Scotland, however, co-operation and knowledge sharing between those running out-of-hours services was easier, due to the small number of people involved nationally.

..... the out-of-hours community in Scotland is tiny, if you look at the people who make it happen it's tiny, and we had a kind of 24 hour conference and it had [around] 40 people there.

(Scotland Stage 1, Case Study 4 – PCO, Interview 1, Paragraph 149)

6.3.4 The GMS contract and other national policy developments

Although a national UK-wide contract, the GMS contract was being implemented into two different policy landscapes, with different policy drivers and imperatives. English interviewees had little to say about this diverging policy landscape between England and Scotland. When explicitly asked about devolution, this was usually interpreted as devolution to a local level, rather than national devolution. Interviewees in Scotland, as might be expected, had much more to say on the subject. In both countries, the GMS contract was discussed in relation to other national priorities and targets, including access targets, extended hours, quality of care and, in England patient choice and practice-based commissioning. In Scotland, the contract was discussed in relation to Scottish Government priorities such as integrated working between primary and secondary care and patient pathways.

Access was a particular issue for respondents located in England, although there was also an access target in Scotland. For some, the issue of access needed to be considered in relation to patient needs, rather than wants:

We get into difficulties around the needs and wants and I suppose that, I suppose we would think that the service isn't set up and isn't funded to provide the access that people would always want. Does it however provide the access that people need and how do we know the difference between want and need - it is all very difficult and my personal view is that I think general practices, probably on a practice by practice basis, should be looking to see how effectively they are meeting their practice needs.

(England Stage 1, National, Interview 30, Paragraph 98)

Thus, a key issue in England was to make general practice responsive to the needs of patients, rather than (as one interviewee saw it) responsive to the contract:

..... what's happening in general practice is they're responding to what's written down not to what the patient is saying in front of them, what we want them to do is to respond to the patient and to PCTs and for the contractual things to be an overall framework that we don't have to keep tweaking and changing. So one of the ways we are doing that is by introducing greater choice and competition into the system for patients, and the other way we are doing it is to try and get greater responsiveness of practices to the patients....

(England Stage 1, National, Interview 28, Paragraph 23)

For this interviewee, choice and competition were key drivers for both patients and for driving up practice performance, by encouraging a competitive environment within general practice, at least in England

.... what we are trying to do is sharpen all practices' performance up and for them to be competing with each other for patients, so that the next patient that might walk through the door and choose to register with a practice is as important as the patient that is already registered with them.

(England Stage 1, National, Interview 28, Paragraph 23)

Not everyone felt so positively about patient choice.

I think we have put far too much on the choice agenda rather than improving services locally and what I would hope that some of the devolving to PCTs would [do is] actually lessen the requirement for the choice agenda to have as much force as it's got.

(England Stage 1, National, Interview 36, Paragraph 83)

Patient choice was not a policy imperative in Scotland but, as in England, extended access was. Some in Scotland felt that the drive towards extended opening hours and 48-hour access had been driven by English policy needs, rather than Scottish ones.

Em my anxieties are is that we start messing about with an English system, which is frankly a system that talks about personalisation. Personalisation for politicians at Westminster usually means a service [which] is accessible to male, middle class, middle aged managers whether they're politicians or otherwise, in other words "I'm working late tonight and I need to see the doctor and I'd like to pop in about 9pm on my way home". Now that's expensive and in a constrained budget somebody will have to pay for that and my worry is that the people who are paying for that are the elderly and the disadvantaged who actually are getting a rather good service at the moment in terms of personalised medicine at a time that suits them during the day.

(Scotland Stage 1, Case Study 3 – PCO, Interview 24, Paragraph 317)

This view was not confined to Scottish respondents – the perceived London-centric nature of English health policy was a concern to English participants too, as typified in the following quotation.

And the reason for Advanced Access I have been told by a GP is because in London, Gordon Brown was talking to some people who work in London but lived outside London, like a lot of people do, wanting to know why they couldn't book appointments with their doctors when they got home at 7 o'clock at night. So he said right, this is wrong. But instead of making it a localised thing for London it's now national. So even though our patients are happy with the service we provide we've still got to provide an extra service.

(England Stage 2, Case Study 1 – Practice 2 (Practice Manager), Interview 42, Paragraph 258)

In Scotland, some national interviewees spoke about the challenge of implementing a UK contract across devolved systems.

..... so I always start off by saying you must remember Ministers [in Scotland] it's an English contract and that's the basis at which you have got to look at it I mean you can only imagine that it's actually always going to reflect what the big country does - that's how I would look at the Scottish - English dimension.

(Scotland Stage 1, National, Interview 23, Paragraph 32)

Where possible, steps were being taken to develop the contract in ways that met the different population needs and Ministerial priorities in Scotland, for example through the development of the Scottish enhanced services. However, Scottish interviewees discussed other possibilities too, including the potential to develop a "core" QOF, operational across

the UK, with local modules developed to meet local needs. This was seen to be an advantage, not only in Scotland, but also for SHAs in England, which generally have a population size similar to, or even larger, than that of Scotland as a whole. There was, however, also recognition of the tension between having a nationally agreed set of standards and devolving care down to a more local level.

..... because if you are running a national health service the one thing you need to do is try and make certain that there are national standards of quality and safety, of course the detail could then be negotiated locally on how you get there so I think that there's no easy answer.

(England Stage 1, National, Interview 32, Paragraph 116).

In England, enhanced services were only one mechanism by which localised services might be developed. Other options included practice-based commissioning and Alternative Medical Services Providers. At the time of interviewing, practice-based commissioning was seen as a particular route to address the English 18-week referral target to secondary care.

Its not completely free choice in the sense that the priorities are identified by the PCT so and those priorities are usually defined by a central government or the Department of Health and often relate to waiting times and 18 week targets which seems to be the overriding driver currently

(England Stage 1, Case Study 1 – PCO, Interview 4, Paragraph 19)

These were not options in Scotland particularly when, in England, private providers could potentially provide such services. Indeed, the use of private providers was seen as an area of clear difference between England and Scotland, both philosophically and strategically.

.... there's no great history in Scotland of going to the private sector, independent sector for alternatives to GP provided services. [Name] health board I think advertised a single practice 2 months ago and one private organisation was interested but didn't succeed.

(Scotland Stage 1, Case Study 4 – PCO, Interview 15, Paragraph 112)

Interestingly we are going different routes there the biggest threat in England is private providers that's a huge problem. I don't think it's as bad here....

(Scotland Stage 1, Case Study 3 – PCO, Interview 25, Paragraph 87)

England was also viewed as moving towards more performance management systems than Scotland, and this was seen as a negative development.

the problem in England, is that they are trying to apply industry management models to a system that does not work in the same way as industry management..... Mr Kipling makes apple pies, every apple pie is the same, easily measured amount of apple, amount of crust, colour of the crust, there's measurable outcomes. General practice doesn't work like that, medicine doesn't work that way, doctors patients don't appear that way, general practice [is not a] production line.

(Scotland Stage 1, National, Interview 27, Paragraph 25)

A key parameter shaping the way in which Scottish general practice and the policy community had responded to the contract was one of size.

.... well size is an obvious thing and I think the repercussions of that size are, I think they are fascinating actually just thinking about how much easier or more difficult things are because we can get all the [Health] Boards [PCOs] in one room right. We know people in you know, we know what the Boards are dealing with and we get feedback directly from the Boards, I mean we get people [from practices] emailing us - you know I get individuals who will email me about something so you are getting direct feedback right from the front line.

(Scotland Stage 1, National, Interview 17, Paragraph 22)

This economy of size also meant that, in Scotland, a number of key areas had been dealt with on a national basis including guidance for the QOF review visits and training for QOF reviewers, funded by all the Health Boards, allowing for greater consistency in the review process across the Health Boards. While the size of the country was seen as a contributing factor, another was a “cultural” factor, which was not thought to exist in other parts of the UK. One interviewee suggested that this was due to the more socialist nature of Scottish politics and the need to deal with entrenched deprivation – for others it was the sense of collegiality and collaboration.

.... that is exactly the sort of thing that I think Scotland's really good at, you know, bringing everybody together and developing something that's got national buy-in and its got of course in process approval from SGPC [Scottish General Practitioner Committee] so you know you are not, they are part of the process so its not going to be a big deal for them to sign it off at the end.

(Scotland Stage 1, National, Interview 17, Paragraph 22)

I mean it's not just scale I mean the scale means we can respond we can pilot we can, you know, discard what is not good and we can implement what is good and rapidly but it also means we can influence the culture.

(Scotland Stage 1, National, Interview 27, Paragraph 18)

There was also a suggestion that the different groups involved in the GMS process in Scotland, for example the Scottish Government Health Department and the Scottish General Practitioners Committee, got on rather better than in England – albeit that the relationship was still not always an easy one

But it does appear to me anecdotally that we do get on a bit better than say for example what happens in England and Wales. It can often depend on personalities and maturity.

(Scotland Stage 1, National, Interview 23, Paragraph 98)

Thus, the implementation of the contract in Scotland appeared to be influenced by a number of factors, including the size of the country, the different policy drivers and political philosophy, the health needs of the population and the relationships between the key players. This led some to suggestion that more, rather than less, devolution may be required.

Fundamentally, I take the view that health is a national matter and yes, we are working to a UK contract but the issue is about the health in Scotland. I wouldn't regard myself as a nationalist but I think the policy decision south of the border, particularly with practice based commissioning with the focus on trusts, primary care trusts being the commissioning agent in respect of services being delivered by and acute services are so different to the, I suppose the infrastructure that we have in Scotland and the tools that we have. And the focus in Scotland is very much on developing integration between secondary

care and primary care and trying to ensure that the patient journey is actually smooth and looking specifically at “Delivering for Health” and making it as local as possible. For that reason I remain anxious that what is developed to sort an English problem may not in fact be that which we need in Scotland and I continue to argue, up ‘til now unsuccessfully, that Scotland should in fact have a bespoke system.

(Scotland Stage 1, Case Study 4 - PCO, Interview 9, Paragraph 27)

6.4 Discussion

Greer contests that different philosophical, policy and monitoring ideologies are being pursued in England and Scotland. However, to date, there has been little empirical testing of this argument. In this chapter, we presented data that supports Greer’s argument, at least in terms of philosophy and policy development.

Although the 2004 GMS contract is a national contract, the national standards were most rigorously maintained in relation to the QOF, which could not be altered without national negotiation and agreement. Therefore, all practices across England and Scotland were measured on the same set of quality criteria. As previously reported, QOF achievement was generally high across the UK, but there were variations in the level of achievement across the four countries of the UK (90). While a lack of comparable data on key contributory factors such as practice organisation was lacking to help explain these differences, the authors did suggest that explanatory factors might include the smaller practice list sizes observed in Scotland. However, another explanation, which emerged during these interviews, was the prior work done under the auspices of other quality improvement schemes such as, in Scotland, the Quality Practice Accreditation Scheme and SPICE, the Scottish Programme for the Implementation of Clinical Effectiveness. Indeed, initiatives of this nature and the associated training that went with them were felt to help explain the well publicised high levels of QOF achievement attained across the two countries as a whole.

The contract itself, however, was viewed in Scotland, as responding to English needs and, in the English case study sites, as responding to the needs of London and the South-East. This led to suggestions that, in the future, the QOF could be modified to take account of local health needs. In this context, local generally meant at an SHA-level in England and, in Scotland, a national or Health Board level. Thus, a QOF which might be part national, part local, was viewed favourably.

A real opportunity to use the contract to develop services answering particular policy needs and local health needs appears to lie with the enhanced services. There was clear evidence that this opportunity was being taken, particularly in Scotland, although in both countries national pricing of the enhanced services was still an issue. Indeed, in England, it has recently been reported that there is an 18-fold variation in the payments made to practices for enhanced service provision across English PCTs (130). The enhanced services appeared to be used less in England as a means of developing local services at the time of data

collection, in part due to other policy initiatives such as Alternative Medical Service Providers and Practice-Based Commissioning.

In Scotland, there was a clear rejection of the use of private providers and out-of-hours care provision also remained firmly in the hands of the NHS. This appeared to offer more opportunity to develop the contract in ways which allowed for better integration of services across service providers in the community or between primary and secondary care.

There was evidence that Greer's view of a more professional and collegiate environment in Scotland was true. However, a major driver for this appears to be not just political ideology, but size. In a country with a population of around 5 million, equivalent in size to many English SHAs, it was clear that the key players at regional and national level knew each other well and were in frequent contact with each other. This appeared to be borne out even in the interviewees themselves, with respondents recruited at Health Board or even practice level, well aware of Scottish national policy and prepared to talk about national issues in a way that was less apparent in the interviews conducted in England. This also led to opportunities across Health Boards for joint working, sharing of information and piloting of approaches.

6.5 Conclusions

- Although set nationally, the GMS contract was being used to address different policy drivers in England and Scotland.
- Although the QOF was viewed as evidence-based, there was a recognition in both countries that some areas, e.g. around public health, were not well served by the QOF.
- Perceived "over-performance" in the QOF may, in part, be due to on-going programmes of quality improvement in place in primary care prior to the new contract, particularly nationally in Scotland.
- The enhanced services were seen as being one way of developing more localised services responsive to local needs.
- The use of alternative providers for enhanced services was viewed, in England, as a means of bringing competition into primary care.
- There were clear discrepancies between the two countries and within each country in payments for enhanced services.
- Scotland clearly rejected the use of a market-led approach to health care provision. While this may well be due to a more professionally-driven ethos than England, the scale of the health care system in Scotland, serving a population of 5 million, facilitates shared learning and closer relationships than is possible nationally in England.

Whether these differences led to each administration developing different ways of monitoring contract performance and whether practices and

practitioners are held accountable in the same, or different, ways is reported in the next chapter.

7 Governance and accountability in different models of health care delivery: QOF, enhanced services and out-of-hours care

7.1 Introduction

As discussed in Chapter 1, the ethos of New Public Management is one of accountability and monitoring. Within the NHS, this has led to an increase in the use of centrally derived performance indicators, monitoring, incentives and competition (7;21). Monitoring of achievement rests, in some instances, with national bodies and, at other times, is devolved locally to a regional or PCO level. The principal models of governance are:

- **Hierarchies**, characterised by bureaucratic power and vertical relationships;
- **Markets**, where power is dispersed across organisations and there is managerial rather than bureaucratic control;
- **Networks**, where power is dispersed across players and organisations;
- **Self-governance**, where sustainability is built up through interdependent and reciprocal relationships and is reliant on peer accountability.

Within these models, there is evidence to suggest that both “hard” and “soft” mechanisms of governance exist (47-49). Several studies have explored the impact of the contract, QOF in particular, on internal relationships within general practice (96;131) and on workload and monitoring within practices (97;101). However, as outlined in Chapter 1, we as yet know little about how the contract is monitored between practices and PCOs, nor whether there are different modes and mechanisms of governance at play across different models of service delivery, with respect to QOF, enhanced services and out-of-hours services. Finally, the potential impact of the devolved health systems is unknown.

Here, we report on findings from Stages 1 and 2 of this project in relation to governance and accountability. We report on data collected from national informants, as well as those working within PCOs, practices, enhanced services and the out-of-hours service to map their perceptions of the implementation of governance across the PCOs and the mechanisms by which it was enacted.

7.2 Methods

The methods pertaining to the results reported here are reported in Chapters 5 and 6.

7.3 Results

The theme of governance and accountability referred to the governance arrangements around the contract at PCO and practice level, the processes and procedures by which organisations governed various parts of the contract and the relationships between the individuals, groups and committees responsible for that monitoring. Structural aspects regarding the organisation of monitoring arrangements were used to develop the case study reports in Chapter 4. Here, we focus on the views and perceptions of the individuals interviewed.

Respondents discussed two major governance mechanisms: “hard” mechanisms which were enacted through the use of standard setting and performance management; and “soft” mechanisms, which utilised more supportive approaches, rather than punitive action, to raise practice performance. These were, however, inextricably linked. Informants at all levels (national, regional and practice-based) discussed these approaches in relation to QOF, the enhanced services and out-of-hours organisations. Here we report on the views of national respondents and those working in the English and Scottish PCO case study sites.

7.3.1 The national view

National respondents talked generally about how governance and monitoring had developed in the two countries, with a particular focus on the QOF. Some also had a more nuanced view of local and regional issues and “grassroots” general practice, due to their multiple roles, for example some had a national role but were also practising GPs.

The GMS contract is held between an individual practice and its local PCO, thus performance monitoring was a local responsibility. However, in England, SHAs monitored the processes adopted by PCTs, and monitored PCT performance in relation to agreed targets and milestones, for example progress on meeting access targets – this was generally on an ad hoc basis. As the contract bedded in, SHA monitoring focused more on improvements than absolute levels.

I wouldn't go as far as saying we performance managed them [PCTs], but we did encourage them to aim to achieve high [QOF scores] where they had a number of practices individually that were very low scores, we expected them to explain to us how they were going to recover those positions

(England Stage 1, National, Interview 19, Paragraph 123)

PCOs were the principal monitoring body in relation to the GMS contract. Monitoring of QOF achievement was meant to be “light-touch” and trust-based, but national interviewees recognised that this was far from the

case in practice, with PCOs becoming more bureaucratic in their monitoring in both countries:

I think the PCT is becoming increasingly less light touch, I think increasingly more bureaucratic. I think they should be light touch, if the practice is clearly performing well and they can use a triangulation process to show that they are a well performing practice I think they should be light touch and maybe have a heavy touch every 3-5 years.

(England Stage 1, National, Interview 31, Paragraph 97)

... it was meant to be light touch, meant to be trust based so you know it's gone from being light touch to anything but. Every practice will get a QOF visit per year and how light touch that is depends on how much of an outlier they are but you know that's an intense process and then on top of that [there] may be a payment verification visit. Now the payment verification visits are, I mean, they are quite scary....

(Scotland Stage 1, National, Interview 27, Paragraph 27)

One reason for this increased bureaucracy was the perceived need to identify practices that may be wrongly claiming reimbursement. This could, however, lead to unintended consequences:

I don't think that [impropriety in a few practices] should be an excuse for a more bureaucratic approach towards all practices. I think that would be very dangerous and very expensive and not a good use of public resources.

(England Stage 1, National, Interview 33, Paragraph 149)

Indeed, it was suggested that the amounts of money that might be wrongfully claimed were very small in comparison to the overall spend in primary care. Thus, increasing bureaucracy to detect such small amounts might not be worthwhile.

Another reason for increased monitoring was the need to identify and reduce variation in performance. This appeared particularly important for respondents in England.

..... the real issue that PCTs need to manage better is the variation and without things like QOF and access how would we know there was such variation.

(England Stage 1, National, Interview 32, Paragraph 86)

The different ethos of general practice compared to the wider PCO was raised at national level: PCT managers needed to understand the culture of primary care better, in particular its nature, in which practices operated as small businesses. For example, in relation to finance, one interviewee cogently described the different magnitude of funding that managers were used to dealing with in PCOs compared with practices, suggesting that cumbersome governance structures to monitor finances were not required in general practice, because the amounts of money being spent were much less. What was more important, from the general practice perspective, was that the information was used appropriately.

.... what we don't like doing is putting in reports [on QOF and enhanced services] for reports sake, you know, just so some manager can tick a box. What we want to do is actually have a meaning or a worth for those reports.

(Scotland Stage 1, National, Interview 27, Paragraph 33)

It appeared that the independent contractor status of general practice still posed problems for PCOs in relation to performance monitoring and accountability.

Because what the relationship between Boards and PCTs and general practice is about now is control. They do not like the fact that general practitioners are independent contractors. We are outwith the NHS as businesses but we are part of the NHS family, we contract ourselves to the NHS. It's our strength but its also a weakness

(Scotland Stage 1, National, Interview 27, Paragraph 31)

One solution mooted was to increase the number of clinicians involved in the management of the health service, for example at the level of the PCT Professional Executive Committees (PECs).

Changing rules and variation in the way in which PCTs in England interpreted the rules for practices led to difficult relationships between PCTs and GPs in some parts of the country. QOF was also seen, with succeeding years, to be getting “tougher” with the addition of new clinical indicators and an increase in the threshold levels for existing indicators. This constant changing of the QOF rules was a problem; some interviewees suggested that practices only just understood one set of rules and regulations, when they were changed the following year and could account for the submission of wrong claims.

Ways in which monitoring and accountability might be developed were discussed. A stronger link between clinical governance and the performance of individual clinicians was suggested, in particular improved triangulation across a range of activities, for example looking at individual QOF performance, prescribing and admissions, and linking this more clearly into revalidation processes. Again, this was due to the perceived unacceptable variation in the performance of individual general practitioners across the country.

Another approach being implemented in England was the balanced scorecard, which could examine practice performance over a wide range of areas including QOF – such an approach was being applied in some PCTs and to the APMS contracts in England. For one interviewee, scorecard outcomes could, in future, be linked to both incentives and sanctions within PCTs.

.... our money will be about incentivising the good to grow and incentivising the poor to get better quickly or to put them out of business basically that will be the issue, the game plan.

(England Stage 1, National, Interview 35, Paragraph 201)

For this interviewee, monitoring of practices needed to become more stringent, particularly if variation in performance was to be tackled. Thus, the relationship between PCTs and practices would have to move from a more “gentle” and supportive one to one that was:

.... more professional and more objective, more data driven and more like other contracts.

(England Stage 1, National, Interview 35, Paragraphs 229)

In relation to out-of-hours care, it was felt that there hadn't been enough forward planning in place to cover the GP opt-out – one

interviewee suggested that the focus had been on the contract itself, in particular QOF, rather than out-of-hours care. Quality standards for out-of-hours care were felt to be clear and, as a patient representative had been involved at a high level nationally, were also patient-focussed. In Scotland, out-of-hours care had been reviewed by a national body, Quality Improvement Scotland (QIS), which monitored Health Boards' progress in relation to out-of-hours targets. The same organisation also reviewed Boards' implementation of the QOF review process. As this organisation was not a national inspectorate, it relied on peer review processes rather than contractual monitoring, with Health Boards self-assessing their out-of-hours performance before a QIS review team, made up of QIS staff and peer volunteers from other Boards, visited – a process described as “a very supportive process with peers meeting up with peers”.

7.3.2 Summary of national views

- National interviewees spoke both about national governance issues and more local issues.
- Overall, there was agreement that PCOs (PCTs in England; Health Boards in Scotland) were the appropriate monitoring body for practices.
- Variation in performance in England and wrongful claims were perceived to be particular problem areas, which could be targeted by increased monitoring.
- Although the rhetoric was of “light touch” monitoring, it was recognised that practice monitoring was becoming increasingly bureaucratic through QOF visits and payment verification visits.
- In England, there was support for QOF monitoring to become part of a wider performance monitoring system, through the use of, for example, balanced scorecards. Some of these approaches were already being tested in PCTs and with other contract holders, for example APMS contracts.

However, in order to really understand the mechanisms of governance, we need to look at the impact within systems in both England and Scotland. This was conducted through the four case study sites. Case Studies 1 (in England) and 3 (in Scotland) collected data from the PCT/Health Board, enhanced service, out-of-hours service and practices, permitting us to explore the impact of governance across the PCO-practice or PCO-service boundary. Case Studies 2 (England) and 4 (Scotland) focussed principally on the PCT or Health Board perspective and enhanced the generalisability of the views collected in Case Studies 1 and 3.

7.3.3 Governance and accountability in England: Case Studies 1 and 2

QOF monitoring

In both case study sites, the PCT held the contract for all forms of service delivery (GMS and PMS practices, enhanced services and out-of-hours care). The PCT in Case Study 1 had both GMS practices and PCT-run (PCTMS) practices. Here, the commissioning arm of the Primary Care Trust was the principal performance manager for both contracts, holding contracts directly with the GMS practices and another contract with the provider arm for the PCTMS practices. Monitoring of both types of practice was the same, as both types of practice participated in QOF, allowing consistent performance standards to be developed across the PCT in relation to QOF. For one interviewee, this role for the commissioners in monitoring service performance was crucial

.... it's our role in the commissioning side of this organisation to make sure that we actually do commission high quality effective health care from all our providers and practices out there under GMS, PMS, alternative PMS are providing services against those standards and we have a duty to performance manage that to make sure they maintain those standards.

(England Stage 1, Case Study 1 - PCT, Interview 3, Paragraph 11).

In both PCTs, formal measures of performance monitoring and accountability, such as the use of practice league tables, balanced scorecards and quality practice profiles were being utilised, albeit that these were more developed in Case Study 1. These approaches were, however, closely tied to more supportive approaches such as practice visits and support for practitioners.

In Case Study 1, the three agendas of QOF monitoring, monitoring of the clinical governance framework and monitoring of other non-QOF aspects of the contract, for example enhanced service provision, were intertwined. As outlined in Chapter 4, this PCT was integrating its approaches to clinical governance, appraisal and GMS monitoring to improve primary care services overall. Indeed, there was a view amongst the interviewees in this PCT level that QOF alone was not enough to improve quality and that primary care performance had to be reviewed across a wider range of activities, such as prescribing and admissions behaviour.

The importance of performance monitoring and accountability across all of these areas was apparent, as all of the Stage 1 interviewees in both sites referred to in relation to setting clear performance standards, performance monitoring and benchmarking. Both sites had a clear programme to achieve this. All practices in Case Study 1 had received a QOF visit towards the end of the first year (2004-05) and had to produce a portfolio of evidence outlining what they had done. A QOF review team, consisting of a QOF assessor for the PCT, a GP assessor and a lay assessor, carried out this visit. In Case Study 1, however, this could also involve information from medicines management and clinical governance

– a process referred to by one interviewee in that PCT as the “softer intelligence of what was known about practices”. This presented an opportunity for the assessment team to clarify areas of practice that were unclear or not meeting the QOF criteria and to ask practices for additional information, if required. Practice performance against local PCT and national standards was to be discussed e.g. around prevalence data or exception reporting. Practices identified as outliers would be scrutinised to identify factors that may account for their position, e.g. the demographics of their practice population. After the visit, the team would draw up an agreed action plan with the practice. At the payment verification visit, the data that the practice entered onto QMAS were verified before payment was authorised. If inaccuracies were noted, the QOF assessor would re-visit the practice to discuss inconsistencies and guide the practices, before the QOF Lead for the PCT verified the data and validated payment. If practices did not meet the criteria, the principal sanction was loss of funds.

Case Study 2 underwent a very similar process of QOF review. However, both PCTs had found it difficult to maintain the momentum of annual visits due to the number of practices and so both had moved to a three-year rolling programme of visits. For both PCTs, external scrutiny was maintained through the regional internal audit agency, which also monitored performance by visiting a random 5% of practices in each PCT.

Both PCTs were making greater use of practice-level data and sharing it back with practices. In Case Study 1, the PCT provided practices information that showed their performance in relation to other practices in the PCT. Sharing data across practices was seen as a key approach to driving up quality, both in terms of data recording and delivery, for example:

it's very much integrated into the practices that the fact that, well hang on a second, how come we have only got 1% of our population that are diabetics when everybody else has got 5%. So the visits are mainly supportive and there has not been any punitive action taken at all around QOF. It still only into its third/fourth year and our experience has been that it has improved each year. The data is improving each year, the data seems to be more recognisable for each year and largely it's been supportive and productive.

(England Stage 1, Case Study 1 – PCT, Interview 1, Paragraph 62)

I think it's very useful; we enjoy looking at that. We get all these charts; it's like league tables, which produces a lot of steam, a lot of hot air.

(England Stage 2, Case Study 1 – Practice 1 (GP), Interview 41, Paragraph 187)

I don't understand how some practices can score the points they do, do you know what I mean, just don't know how they do it. So from my perspective, we scored less than our neighbouring practice down the road and that really irritated me, really irritated me.

(England Stage 2, Case Study 1 – Practice 3 (GP), Interview 47, Paragraph 664)

Information sharing, however, could have unexpected consequences as it allowed practices to see when others were receiving additional support.

And there has in the past been carrots dangled in front of the non-performing practices whereas practices who have reached their targets are just been left to get on with it and I don't think in certain circumstances it's been fair.

(England Stage 2, Case Study 1 – Practice 1 (Practice Manager), Interview 38, Paragraph 523)

A similar approach was being used by the PCT in Case Study 2. Here, the PCT was using various approaches to visualise practice performance, e.g. by the use of graphs, to highlight anomalies in performance to practices. This was used as the starting point for a supportive discussion with the practice, for example to make sure that an underlying cause for their return was not due to the demographics of the practice population, allowing the PCT to take a “lighter handed” approach with practices.

Both PCTs were trying to support the practices in their area to become more autonomous in matters relating to the contract. For example, in Case Study 1, practices were being encouraged to develop their own systems of monitoring.

Interviewee: what we are more about now is, we are trying to reassure ourselves or quality assure ourselves practices have got systems and processes in place that deliver on this. We are not about micro-managing them. I think in the past it might have been more micro managing and far more support I think in the new world there's got to be a balance between doing that.

Interviewer: So right the practices are actually developing their own systems of management and you are overseeing that.

Interviewee: That's right.

(England Stage 1, Case Study 1 – PCT, Interview 3, Paragraphs 27-31)

I think it's positive that GP practices themselves have become more autonomous and sort of self sufficient in a way, rather than it's dependency on the PCT, so you know you've got a contract, go and deliver itI think that, in transactional terms, has sort of changed from a parent-child relationship to more of an adult to adult relationship

(England Stage 1, Case Study 1 – PCT, Interview 16, Paragraph 631)

In Case Study 2, practice support was also viewed as important. Good communication between the PCT and the practices was acknowledged as crucial, particularly in the first year of the contract and built on previous relationships. Prior to the new contract, the relationship between the previous PCTs and practices in the areas had been one of support and development. This had changed, however, since the new contract and the merging of the organisations, with the PCT now more distant from the practices, albeit that there was still a lot of information sharing across practices. According to this interviewee, the ethos within the PCT had changed:

.... the PCT is very much more a performance managing organisation so it is looking at the outputs of the GMS contract, working out who are the performers and the non-performers trying to understand why has there been underperformance and of course monitoring all that through the practice visits and also in-depth audits which we have just started to roll out.

(England Stage 1, Case Study 2 – PCT, Interview 10, Paragraph 15)

The PCT in Case Study 1 had actively built local support into its monitoring systems, with Neighbourhood Performance Managers operating in localities. These individuals saw their role as supporting practices in relation to QOF, building a rapport and relationship with the practices, and sharing best practice amongst them. Some PCT interviewees felt that this supportive approach, based on local relationships and knowledge, and clearly linked to the PCT's clinical governance agenda was a key difference between this PCT and others. While some conflict was thought to be inevitable between PCT managers and practices, the local relationships and ready availability of managers to offer help and advice was felt to help reduce this tension because, in the words of this interviewee,

.... you build up the local intelligence about what's going on.

(England Stage 1, Case Study 1 - PCT, Interview 23, Paragraphs 446).

Of course, as discussed in Chapter 4.3.3, these locality posts were being disbanded, with no obvious system to replace them.

However, although interviewees in both PCTs spoke about encouraging and supporting practice autonomy, both also sent their own employees into practices to run searches on the QOF criteria, which were verified by the GPs before being used for payment purposes. This was generally felt by both practices and the PCO to be more robust, allowing mistakes to be clarified at the time. Feedback between the PCT and the practices about monitoring criteria was not always thought to be as good as it required, which could lead to practices having their performance flagged as below standard – this too required dialogue between the PCT and practice to resolve the issue.

In both PCTs, QOF was envisaged as the starting point for promoting higher quality practice and performance, with practices having to focus beyond QOF. In Case Study 2, it was anticipated that the development of such an approach would identify those practices which did not stop when QOF targets were achieved but continued to strive to improve performance in relation to local needs, with the potential to demonstrate lower use of secondary care resources.

So we are not asking them to do more to get the QOF payments, it's the QOF-plus bit so it's the promoting better practice with the QOF being the starting point.

(England Stage 1, Case Study 2 – PCT, Interview 11, Paragraph 195)

Both PCTs were thus developing systems which looked at practice performance in the round. In Case Study 2, the PCT was developing local systems that brought together QOF, practice referrals to secondary care and prescribing data – the “practice quality profile”. The information collected was used to create local benchmarks and shared with practices through the local clinical governance leads. This was viewed as a powerful driver to change practice behaviour, particularly when practices were already performing well in QOF and may not have the scope to improve much more within the QOF criteria.

.... point the GPs at a target, pay them for it [and] they will do it. I think we are in danger now of resting, where we have got to and I think we need to find mechanisms to support the GPs to go beyond the QOF. I know the QOF will continue to evolve but I think here, because we are so high in terms of current performance that won't drive the hurdle high enough - the national agreements won't be enough for us, we will want to go beyond that.

(England Stage 1, Case Study 2 – PCT, Interview 8, Paragraph 203)

In Case Study 1, this approach was being developed further, with the PCT developing a balanced scorecard approach to practice monitoring, as discussed nationally, using a traffic light system to highlight standards around performance. This encompassed the QOF but addressed wider issues too, for example practice premises, professional leadership within the practice, and HR policies and procedures – described as “the environment of the practice”. This scorecard approach was felt by some to be crucial to setting local standards, improving quality and, ultimately, patient care. A clear rationale for this process, within this PCT, was to make meeting the QOF criteria the minimum standard for practice performance, to develop local standards of performance to meet PCT population needs and to drive up standards.

.... we want to get to the position where everything is green but we also want to understand not just the relative position of practices but those practices that are improving versus those practices where standards are actually falling because what we want to drive is quality and improvement [pause] and that will be reported in a risk based way back to the [PCT] Board rather than an a league table which we don't think is terribly helpful because the whole point of doing that is to drive those quality of standards up so that everybody is over a 1000 points so that everybody is offering certainly a minimum level of primary care intervention.

(England Stage 1, Case Study 1 - PCT, Interview 20, Paragraph 127)

So we've got a standard to measure against and then once everyone's at that standard we can raise the bar.

(England Stage 1, Case Study 1 - PCT, Interview 23, Paragraph 1048)

The balanced scorecards were being reported back to practices un-anonymised, giving practices the chance to compare their performance in relation to other practices within the PCT. This was felt to be a powerful motivator to driving improvement.

... [it] is very powerful I think because practices then look over the fence and say well if they can do it that well I'll do it even better, and I think that generates motivation to improve.

(England, Case Study 1 - PCT, Interview 16, Paragraph 231)

Practices appeared to welcome the balanced scorecard approach for those areas which they felt they could control, e.g. QOF domains, vaccinations, but questioned it for areas where they had less control e.g., emergency admissions.

Interviewee: Some of them are a bit frustrating like, emergency admissions. How many of your patients have had to have emergency admissions and if too many people get sick and go into hospital you lose points, things like that. So some of them are slightly...

Interviewer: Beyond your control, really.

Interviewee: Yes.

(England Stage 2, Case Study 1 – Practice 1 (GP), Interview 41, Paragraphs 191-195)

There was little evidence of punitive action being used by the PCTs when poor performance was identified.

I think in the majority of cases the PCT has been there in a much more supportive role than anything else. Obviously it is important for the PCT has a monitoring role and we are talking about public money, we are talking about a lot of public money and it is quite correct that practices are, not performance managed but are monitored in terms of what they are doing to make sure that actually a good standard of care is being given to practices but there are practices that have had difficulties and actually the PCT in [names location] thankfully I think have bent over backwards to help those practices.

(England Stage 1, Case Study 1 – Other, Interview 2, Paragraph 69)

There was also recognition that, in the first year at least, a lack of familiarity with the IT systems had led to mistakes in data entry. Other problems tended to result from practices misinterpreting the national guidance, for example which patient survey instrument was acceptable. On the few occasions where there was felt to be a more serious problem with QOF reporting (estimated by one interviewee to be one practice per year), the area's internal audit agency checked the practice's data and verified the accuracy of the claim. Even in these cases, payment was generally not withheld – for example, in Case Study 1, some payment would be made to the practice with the rest coming once the PCT were satisfied that the claim was accurate. Thus, at the time of data collection, the principle ethos in this PCT was that of support and a recognition that some GPs might be struggling to come to terms with the new systems of monitoring and accountability contained in both the contract and practice-based commissioning:

Interviewer: Right but there have been no real punitive actions currently against practices?

Interviewee: No, I can be, I think I can be firm but I have got a heart and I do feel very much for GPs, particularly GPs in my age group and above actually because this technological age is not something that you know we take to very easily these people have struggled. The new contract, it doesn't work unless you are computerised and you know how to use it properly and some of our older GPs and our single handers have fallen foul of this and I think you know pride, not wanting to be seen to be stupid so on and so forth, I think its played its part and they find themselves in a situation now where they can't hide because we are monitoring what's going on [Break] Well we are trying to be [supportive] because at the end of the day, well I suppose the LMC would have us if, you know, we went in heavy handed and it would create hard feelings and all sorts of problems really. So I think its being sensitive to that and trying to move people on in the right way but what we won't accept is people just turning away from us. If they do that then, I'm sorry, I will get heavy handed.

(England Stage 1, Case Study 1 – PCT, Interview 3b, Paragraphs 281-283 & 295)

A similar view was expressed amongst PCT interviewees in Case Study 2. Where there were problems with performance, it was felt that this tended to be on the organisational side of the QOF, rather than in the clinical domains. Practice organisation and a lack of staff experienced in managing such a complex agenda as QOF was recognised as one contributory factor to poorer performance. However, again, even with practices that were performing less well, the ethos was one of support

rather than punitive action. Indeed, in several very small practices, this PCT had gone as far as to install a PCT-employed manager to oversee the practice management.

.... they were too small to survive on their own, and they needed that sort of more authoritative figure to actually to keep the management together, but they've got office managers in them [as well]

(England Stage 1, Case Study 2 - PCT, Interview 21, Paragraph 391).

It was also recognised that some practices found it easier to lose points on the organisational domains, rather than take the steps required to improve their organisation. Some practices chose to focus on the clinical domains rather than the organisational domains, for example the patient survey. In such cases, the PCT could provide help and access to appropriate instruments, which the practice could then use.

Again, the ultimate sanction at that time was withholding of practice payments for areas where the PCT felt the practice could not justify the claim. However, the QOF was also viewed as a positive change because it now gave the PCT more jurisdiction over practices to improve their performance whereas, previously, the PCT was reliant on practices' own motivation to improve.

In Case Study 1, there was a view from PCT interviewees that practices did not like this approach as it amounted to "prying". Practices also, at least initially, were thought to be nervous about allowing the PCT in to monitor their performance in this way, especially when guidance round some of the indicators, particularly the non-clinical indicators, was less than clear.

.... there was a lot of nervousness in some practices about them you know - what its Big Brother coming in?[Break] We were just as nervous as the practices I would say because we'd had all of this top down guidance and how to, you know, we'd implemented it the best way we could but I think the actual guidance you are given around individual indicators is a bit woolly.

(England Stage 1, Case Study 1, Stage 1 Interview - PCT, Interview 13, Paragraphs 240 & 244).

Well they're [the PCT] interfering more in practice aren't they.

(England Stage 1, Case Study 1, Stage 1 Interview - PCT, Interview 18, Paragraph 676).

This lack of clarity around the non-clinical indicators led to different interpretations of the criteria for non-clinical QOF points and so this particular PCT spent time in Year 2 devising its own set of minimum standards for practices, agreed between the PCT and the Local Medical Committee.

QOF is, of course, only one part of the GMS contract and, for one interviewee at least, the amount of effort put into monitoring QOF performance appeared to be excessive.

I mean it feels, it's a huge process [QOF visits] to coordinate and to run and to me its bizarre because the QOF is only one part of the whole contract yet we go into phenomenal detail on it and I just I suppose I don't really get it.

(England Stage 1, Case Study 1 – PCT, Interview 6, Paragraph 167)

A GP expressed a similar view:

.... before the contract came in the monitoring was fairly [light]... Every now and again you would get picked for a post verification [visit], so they would check that the claims that were made sort of matched up to what had been done, but the majority of that was all about items of service basically, which wasn't anything like as complex as QOF and the local enhanced services.

(England Stage 2, Case Study 1 – Practice 1 (GP), Interview 39, Paragraph 51)

Monitoring target achievement was important in practices too, particularly as they were only paid when targets were achieved. However, this was time consuming and took a lot of effort within the practices.

.... we spend a lot more time chasing up loose ends, looking at targets. A good portion of the day is spent actually working out what things we need to do to maintain position or improve position and the majority of that, is that we're already operating way above QOF levels anyway. I think it's in most people's nature to try and If you give them a target they'll aim for the target and that's probably how it works.

(England Stage 2, Case Study 1 – Practice 1 (GP), Interview 39, Paragraph 75)

The four practices studied organised themselves in slightly different ways and responded differently to the targets in the QOF. All four practices studied had a GP who took lead responsibility for the clinical domains of QOF. In Practice 1, the GP was also responsible for the organisational domains, whereas in Practice 3, the practice manager assumed this responsibility. Practices 1, 2 and 4 had a team-based approach, where different clinicians led on particular domains, along with practice nurses. QOF achievement was regularly monitored through multi-professional team meetings.

.... our practice approach is to take a slice of the pie and be able to take a piece each.

(England Stage 2, Case Study 1 – Practice 1 (GP), Interview 40, Paragraph 268)

The contribution of administrative staff to QOF achievement was also acknowledged by clinical staff.

So yes, I think they [the administrative staff] are much more aware that it's ultimately their jobs are dependent on us achieving a good quality of care, and being measured as well. So I think that has been a change.

(England Stage 2, Case Study 1 – Practice 4 (GP), Interview 66, Paragraph 226)

Practice 2, a PMS practice, also had staff dedicated to IT, which was thought to make the IT run more smoothly and made it more accountable. This practice also talked about occasions when they and the PCT interpreted the contract rules differently, e.g. around definitions of significant event analyses, leading to disputes about payment. Generally, these were resolved by discussion but it contributed to a view that the whole system was being monitored and interpreted ever more stringently. As described previously, the PCT carried out its own searches of the practice computerised records; this led to a sense of practices losing ownership:

....it is very different [now] because you didn't have the same amount of monitoring [pre-contract] it feels a little bit like Big Brother. It feels we don't own our patients anymore. We don't own our software anymore. I know we don't own the hardware because the PCT buys that, but we don't own our system anymore because the PCT can come in, they can change patients' medication, they write to patients and you don't know what's going on. maybe it's just a case of we need to think in a different way. I mean, this is how it's going to be now so shake off the old "yes it's yours and it's your data and you can do what you want with it". You can't anymore so accept it and move on.

(England Stage 2, Case Study 1 – Practice 2 (Practice Manager), Interview 42, Paragraph 315)

Internal monitoring, within practices, was also apparent. This was particularly apparent in Practice 2, a PMS practice, which unlike GMS practices, did not get a year-on-year uplift in salary – thus good performance was essential to securing practice income and providing staff with bonuses. This led to stringent monitoring of individual performance and a sense of all clinicians being watched and, if necessary, reprimanded.

We have the contract police if you like in the practice. I'm one of them. I'll sometimes go through in an odd moment and I'll just have a look and see who's acting on the prompts when the patient comes in and who's not.

(England Stage 2, Case Study 1 – Practice 2 (Practice Manager), Interview 42, Paragraph 15)

Indeed, in this practice, perhaps as a result of being a PMS practice, there was as clear sense of internal monitoring taking place

So we're more aware of what we're recording. Sometimes it feels a bit like points making prizes. A bit number crunching for number crunching sake.

(England Stage 2, Case Study 1 – Practice 2 (Nurse), Interview 45, Paragraph 68)

However, practitioners in all four practices commented on internal monitoring taking place, for example reminding colleagues about the need to code consultations correctly. This could happen formally, through practice meetings, or informally:

There may not be meetings, but I might get the senior partner coming in and saying, 'I'm not saying it's your fault, but we all need to make a note, we all need to be reminded'; he might say something like that. And he's not actually, and I know he's not directing the comment straight at me because the doctors fall down, as well.

(England Stage 2, Case Study 1 – Practice 4 (Practice Nurse), Interview 64, Paragraph 67)

[On targets not being met] I'm Big Brother then. Everybody is used to my e-mails. Mainly it's not the fact that they're not doing the work, it's the fact that they're not coding it really, they're not using the right code..... [Break]... If it's one particular person I tend to e-mail them and say, can you just go back and code it, using these codes please. If it's something that everybody is doing it in the practice, I'll just do a generic e-mail and most of them realise that when I'm doing QOF work, because they get about five, ten e-mails in a day saying, you've not done this, you've not done that. So it's literally checking that really.

(England Stage 2, Case Study 1 – Practice 3 (GP), Interview 47, Paragraphs 31 & 39)

This increased monitoring and emphasis on correctly coding the consultation was welcomed by most practitioners. It was seen as a way to improve patient care, even if this meant more monitoring by the PCT.

Since I started in general practicepractices worked very much in isolation, nobody from outside looked at what you were doing, or examined what you were doing. It's changed completely, the culture, you're very used to outside people auditing, looking, measuring, all sorts of things within the practice; and that's commonplace to find somebody from the PCT or the medicine management team, within the practice I would say it's, weekly or fortnightly at least. That's somebody is doing that, so that's a real big culture change since when I started in medicine, I think for the better really. It's much more open, and we're just having to much more justify what we're doing.

(England Stage 2, Case Study 1 – Practice 4 (GP), Interview 66, Paragraph 170)

All of the practices spoke about “chasing” patients more since the implementation of the new contract. In Practices 1 and 2, patients were flagged on the computer system, so they could deal with QOF indicators when that patient next attended, even if they were attending for something else. Practice 3 sent letters to patients to come in for review visits. If after three letters, the patient had not responded, they were exception reported, unless they were thought to be a difficult patient to control clinically in which case “we hassle them”.

Practice staff justified this “chasing” in terms of improved patient care and more standardised treatment across practices. Staff, particularly practice nurses, felt that patients’ care was better organised with QOF with fewer patients “slipping through the net”. Much of this monitoring fell to practice nurses:

.... depending on who the patient is seeing, at least they're getting the same standard of care, which is good, or you can see what your colleagues have done and what needs to be done that type of thing.

(England Stage 2, Case Study 1 – Practice 3 (Practice Nurse), Interview 51, Paragraph 51)

But you can understand what's behind reaching these targets, it's not all about the money in the back pocket of the GPs, it's about patient care and looking after your patients, particularly perhaps those that are on the disease registers.

(England Stage 2, Case Study 1 – Practice 4 (Practice Nurse), Interview 64, Paragraph 59)

Enhanced services

Monitoring arrangements for the additional and enhanced services were also discussed. One interviewee with a remit for enhanced services in Case Study 1 suggested that the PCT was not yet as good at monitoring these services. Citing vaccination as an example, this individual suggested that there was a lack of clarity in the national guidance as to which vaccines were part of the additional service (e.g. childhood immunisations) and which lay outside the additional service (e.g. holiday vaccines), leading to practices providing services in different ways. As with QOF, clear minimum standards laid out by the PCT were seen as the way forward:

..... really we need to actually have some performance management around what it is they are actually doing for their additional services because they are being paid for that because if they opted out of providing an additional service we can make an adjustment to the global sum to reflect that so we will just try to bottom that out a bit at the moment and make sure everybody is delivering what they are doing to a set standard.

(England Stage 1, Case Study 1 – PCT, Interview 5, Paragraph 55)

This lack of explicit performance management also existed in the enhanced services in both Case Study sites. In the first year of the contract, the PCT in Case Study 1 had paid practices a retainer and collected data to monitor what services were being provided. In the case of minor injuries, the PCT felt that practices were not providing anything over and above that considered to be essential services and so de-commissioned the provision of such services from their practices. This appeared to be the only example of de-commissioning of services occurring within this PCT.

Difficulties in monitoring enhanced service provision were also reported in Case Study 2.

Well there is a tension, isn't there, between being a business that makes money and providing a service to the NHS and monitoring this closely is a new thing, so I think that ... the QOF is probably fairly bedded now, we've really moved onto the enhanced services as the next bone of contention really.

(England Stage 1, Case Study 2 – PCT, Interview 21, Paragraph 643)

In this Case Study site, the PCT was also in the process of establishing systems to monitor practices providing enhanced services, in terms of activity undertaken. With the minor surgery service, this had moved onto measures of quality, for complications arising from procedures carried out in the practice. Here too, data were extracted directly from practice systems quarterly. This auditing of the enhanced services was being made more robust and related to payment, with the sanction of withholding payments a possibility or, ultimately, decommissioning a service from a practice. In reality, the PCT's experience so far had been that a practice either re-organised their service provision to improve care or passed the responsibility for the enhanced service to a neighbouring practice. A good example where this had taken place was in the delivery of the enhanced service for IUCD fitting, where GPs had to perform a minimum of 10-12 such procedures per annum, but where not all GPs had the necessary number of eligible patients to meet this requirement. Again, reflecting the wider need of practitioners, the provision of enhanced services had been linked into the GP's appraisal, allowing them to discuss training and competency needs to deliver the enhanced services with their appraiser.

In Case Study 1, the Drug Misuse Enhanced Service (DMS), which encompassed practices, secondary care and community-based teams, did have the same policies and care management tools across the organisation, to ensure consistency regardless of which GP was providing the care and to monitor the shared care provision between the GPs and the secondary care provider. There were monthly meetings between the

enhanced service, the secondary care provider organisation and the PCT's drug action team. Data were collected on the national Drug Treatment and Misuse Service targets, allowing national scrutiny and validation of the data, for example on the number of patients being treated. As with other services, targets were generally in the region of 80-85%, rather than 100%. The driver for these targets, however, was not the GMS contract, but other national Department of Health priorities around treatment for drug misusers.

Performance monitoring was more rigorous for the community-based arm of the service, with data on workload and audits of activity collected on all members of staff employed by service. This was reported using a traffic light system of green, amber and red and was discussed at the monthly meeting with the PCT.

... we discuss any poor performance issues in a team meeting as a team and how we can improve on that as a team.... [Break].... we also discuss any real good bits of our performance and praise the staff for attaining that level of performance and maintaining that, hopefully.

(England Stage 2, Case Study 1 – non-PCT, Interview 59, Paragraphs 67 & 71)

There was much less monitoring of the GPs who had contracted to provide services in their practice. Problems, for example around GP prescribing, were generally resolved through meeting with the GP and through training. Where problems were more serious, the case would be referred to the PCT and the contract with the GP could be removed. There was, however, an anomaly in this PCT. While the Medical Director of the enhanced service took operational responsibility for the day-to-day clinical governance of the GPs providing the service – overall responsibility formally lay with the PCT. This was described by one interviewee as “a grey area” and had arisen because the GP contracted directly with the PCT to provide drug misuse services, not with the substance misuse service organisation itself.

Training and development for the service's employed staff were met through the annual appraisal, training needs analysis and an agreed staff training plan. However, training was, at that point in time, less well organised for GPs contracted to the LES, with many not actually meeting the minimal educational requirements outlined in the LES contract.

Establishing and meeting minimum standards was deemed important to protect both the GPs and the service commissioner.

.... so if you asked me how is clinical governance in shared care, I would say really a major source of worry and anxiety to me, and for a simple process of just changing the LES to have those minimum requirements; it would make my job much easier. But I think it would also protect the commissioners, because if they don't change this and they haven't got it in and something goes wrong, then I think they'll be equally culpable.

(England Stage 2, Case Study 1 – PCT, Interview 60, Paragraph 7)

Governance standards were viewed as having been tightened, but this was not attributed to the GMS contract but instead to changes in the service's organisation.

... it is a lot tighter than it ever was, but I think that is not really the GMS contract; it is more about having a single provider and having a medical director.

(England Stage 2, Case Study 1 – PCT, Interview 58, Paragraph 67)

As with QOF, some data were collected centrally from practice computer systems, with practices signing off on the figures before the data left the practice. This was true for all the enhanced services, not just the DMS. Not all practices were happy with this.

..... a lot of them [enhanced services data monitoring] are being done off site so they are just dialling into our information, I'm not happy about it you don't know what criteria they are searching on..... [Break] you really have to keep a handle on it you know and make sure that when the enhanced services are collected that the figures are checked.

(England Stage 2, Case Study 1 – Practice 1 (Practice Manager), Interview 38, Paragraphs 76 & 88)

So, again, there was a tension between practice ownership of data and the need for centralised data for monitoring purposes.

Out of hours

Again, the contract holder for the out-of-hours organisation was the PCT. Governance and monitoring of out-of-hours care had undergone radical reform since the 2004 contract. Monitoring of the out-of-hours service was the responsibility of the organisation's Executive Board and overarching Council, with a sub-committee to review clinical performance and complaints. This was felt to be more rigorous and formalised than the system that had existed under the previous, GP-run out-of-hours co-operative, due to the stringent national targets that out-of-hours organisations had to meet since 2005. These targets were written into contracts, leading to the need for "a completely different model of care" with clear accountability frameworks and governance structures.

.... there was an attempt to be integrated at the same time as accountable and sort of rather than being a bit like the old co-op which was, like I say, a bit like a cottage industry only it was responsible for itself. [This is] our attempt to move things a bit further.

(England Stage 1, Case Study 1 – non-PCT, Interview 24, Paragraph 464)

Monthly contract monitoring meetings were held between the out-of-hours organisation and those within the PCT responsible for commissioning the service. The relationship with the PCT was described as:

..... critical friends. They have recognised that we are performing. They are recognising that we have systems in place to ensure we perform. They recognise that we've got systems in place that make sure that when we don't perform we find out why, and that we do something about it. And we have had to build up that relationship that has shown those things to them.

(England Stage 2, Case Study 1 – Other, Interview 61, Paragraph 116)

While these meetings considered financial issues and patient complaints, the principal focus was on monitoring service performance in relation to national standards laid down for all out-of-hours organisations. Most of these standards, however, focussed on processes (e.g. percentage of calls answered within a certain timeframe) rather than on clinical quality.

With the increasing focus on out-of-hours care nationally and the interface between daytime and out-of-hours provision blurring, it was felt that the new contract for out-of-services in this PCT (under negotiation at the time of the interview) was particularly stringent. The PCT was now seen as the “customer” for out-of-hours care, not local general practice. This had impacted on relationships, with the relationship with the PCT seen as stronger than that with general practice.

.... there's three in this relationship [out-of-hours organisation, PCT and general practice] where we've lost general practice, and we do need to go back and recapture those a little bit....

(England Stage 2, Case Study 1 – Other, Interview 52, Paragraph 202)

Transparent reporting, clear targets and the use of data collected within the organisation to monitor performance were all described as key elements in the governance of the out-of-hours organisation. The organisation continued to employ local doctors, not just because of their local knowledge but also because it made monitoring simpler.

We're more likely to pick up if there any other clinical governance issues about them, from outside the organisation, if they're local obviously than if they come from elsewhere.

(England Stage 2, Case Study 1 – non PCT, Interview 61, Paragraph 40)

National incidents, where patient safety had been an issue, acted as a stimulus for this PCT to work with the provider to develop rigorous performance-monitoring templates that reflected the National Quality Requirements (NQRs). A mechanism for quality inspection visits and audit existed, but these had not been enacted because, as one PCT interviewee pointed out:

... we have a series of audits and quality visits that we [could] use but we don't once the PCT is awarded a contract its not routine for then the PCT to spend the time in checking it out because its – you should commit to the contract and keep to the contract and commit to the schedules and monitoring that's identified within the contract...

(England Stage 1, Case Study 1 – PCT, Interview 9a, Paragraph 35)

As the NQRs were being met regularly, the organisation was moving to other areas. A key component of this monitoring was the development of standard operating procedures for both clinical and non-clinical staff. Non-clinical operational staff were audited regularly on their performance; similar audits were being considered for the clinical staff, the results of which could be used to establish staff development for both clinical and non-clinical staff. These were felt to be key to developing a high standard of consistency across the service. Most of the NQRs had a ceiling of 95% achievement: however, the organisation was being pushed by the PCT to reach 100% achievement on as many targets as possible, leading to more stringent monitoring of the GPs providing the service.

..... co-ops were pretty loose in a lot of their governance, we're not. We obviously, we interview, we select, we train, we tell them where they're going to work, when they're going to work, who they're going to work with, what car they will go out in, what patients they will see next. What they're free to do, obviously, is clinical care. But the rest of

the framework, in order for us to achieve our governance and our performance targets, we put a degree of control over [the GPs]

(England Stage 2, Case Study 1 – Other, Interview 52, Paragraph 137)

The organisation itself felt that the GPs had responded well to this level of monitoring, although there had been some complaints. This was also a new direction, not peer-to-peer review of clinical issues, but a non-clinician scrutinising workload performance and approaching GPs directly if there were thought to be problems. The organisation had also instituted formal performance assessment for all GPs working with them, using both paper-based documentation and telephone recordings. However, this was not always straightforward, particularly when system monitoring relied on data recorded from decision support systems, losing the professional expertise and decision-making that professionals bring to the system.

I see the professionals being managed much more than they ever used to be. I don't like it because I think that the managers who are not used to managing GPs are using the management skills they have, which is a skill to manage non-clinical people, because they're not experienced at managing clinicians just as clinicians are not used to being managed. And I think there is an awful lot of learning to go on yet about the management of general practitioners But I see it in broader terms because just as I think this decision support system diminishes the capacity of clinicians to function at their optimum, excess management will do the same and it will end up harming patients, not helping them.

(England Stage 2, Case Study 1, Interview 61 – Other, Paragraph 76)

Thus, the out-of-hours organisation was subjected to harder forms of performance monitoring driven by the national targets.

Practice-based commissioning

Although not part of the GMS contract, some respondents in Case Study 1 talked about the monitoring and accountability processes in place for dealing with practice-based commissioning. In contrast to that seen with the enhanced services, these were developing in a sophisticated manner. In the PBC Consortia, budgets were set at the start of the year and a performance-monitoring framework agreed with the participating practices. Again, the emphasis was on a minimum dataset, which practices had to attain before they received payment from the Consortium. Consortia performance was compared to the invoices they submitted to the PCT and had to tally before payment was made.

While separate from the GMS contract, at least one interviewee felt that it was crucial that standards were being met in the QOF and other parts of primary care in order to make the practice-based consortia work.

.....[routine] primary care is key you know in terms of ensuring standards are excellent across [Consortium] practices to make PBC work. It's all well and good having these services but if they haven't got the sort of you know the minimum services right then the PBC won't work.

(England Stage 1, Case Study 1 – PCT, Interview 29, Paragraph 582)

However, personal relationships were also viewed as crucial, with GPs and the Consortium managers well known to each other and respected. As with the wider PCT, this PBC Consortium utilised data from QOF, clinical governance targets and other contract targets, such as Choose and Book performance, to identify practice performing more poorly in relation to others.

I like to motivate the practices, I want [names Consortium] to be the best, I want them to have green all the way so I'll work with them on...on that and just because of my knowledge of Primary Care I can work with the practices on how to sort of develop those different targets.

(England Stage 1, Case Study 1 – PCT, Interview 29, Paragraph 610)

Less well performing practices within the PBC Consortia were offered support, with local governance leads attached to each one. While the focus was on support and guidance, it was recognised that such levels of support could not continue indefinitely. Thus, if a poorly performing practice did not improve, the ultimate sanction would be the decommissioning of services.

.... we need to accept that if a particular area in order to raise their standards needs additional resource then practices accept that and if they've not reached outcomes that we've set based on that in 12 months time and that resource will be taken from them, and we need to be clear about that.

(England Stage 1, Case Study 1 – PCT, Interview 29, Paragraph 931)

There was, therefore, clear focus on the hard governance options of performance monitoring and accountability within this PCT. However, “softer”, more supportive mechanisms were also in place.

Practices were well aware of this monitoring, but appeared unsure at that time as to how the Consortium would react to outliers. For example, in relation to being a high referring practice, one practice manager commented:

So they're [the GPs] not sure at this stage whether – they're saying do people think we're stupid because we can't look after our own patients? Or are we clever because we are thinking of things that other people haven't thought of.

(England Stage 2, Case Study 1 – Practice 3 Practice Manager), Interview 48, Paragraph 492)

7.3.4 Summary of governance and accountability in England: Case Studies 1 and 2

- The commissioning arm of the PCT held the contract for all three models of service delivery: GMS/PMS; enhanced services and out-of-hours.
- In Case Study 1, the PCT had an integrated approach to contract monitoring and wider clinical governance issues across the commissioning and providing arms of the PCT, reflected in its structural organisation.

- In both PCTs, QOF standards were viewed as the minimum requirement for primary care performance, with other activities such as referrals, admissions and prescribing just as important – the “wider practice picture”. In Case Study 2, the PCT was bringing these elements together in a “quality practice profile”.
- Although voluntary, both PCTs regarded QOF as a key mechanism for driving up quality in their area and for increasing PCT jurisdiction over practices.
- Both “hard” and “soft” mechanisms were evident in the operational monitoring, through QOF review visits; contract review visits; and payment verification visits.
- There was more emphasis on hard governance mechanisms in Case Study 1, with the PCT using target setting, performance monitoring against national and local standards and sharing of information across practices. This was evident in all the models of care delivery (GMS/PMS practices, enhanced services and out-of-hours care), as well as practice based commissioning.
- This approach was underpinned by the development of a PCT-wide balanced scorecard, used both for QOF and in the Drug Misuse enhanced service
- Softer governance mechanisms of support and guidance were, however, also clearly visible in both PCTs and included the supportive approach taken to practice visits and the development of support and training for clinicians.
- Case Study 2 had developed other supportive mechanisms, including a PCT manager supporting smaller practices with organisational issues.
- Local relationships between clinicians and managers, both clinical and non-clinical, were another important component of “softer” governance in both sites.
- Both sites used PCT-employed staff in practice to run searches and verify data entry, which may imply a lack of trust on the part of the PCT towards its general practices.
- Practices themselves did not reflect much on the impact of PCT monitoring, except for the centralised data collection. Instead, they focussed more on re-organisation within the practice to meet QOF targets.
- Practices had responded to the contract in slightly different ways: generally, responsibility for QOF was shared amongst clinicians, with one person taking overall responsibility for monitoring.
- Practice managers were a key group in monitoring performance of staff in the practices.

- There was some evidence to suggest that internal practice monitoring was more stringent in the PMS practice than in the GMS practices.
- While QOF was generally felt to have improved patient care, there was a repeated rhetoric across all practices of “chasing” patients.
- Monitoring of the enhanced services was not as well developed as that of QOF and focused on processes.
- The community-based part of the enhanced service and out-of-hours services were more aware of PCT monitoring, for example through monthly meetings to discuss target achievement.
- There was stringent monitoring in the out-of-hours service, which was judged against national standards.
- As yet, there had very little use of punitive measures to address poor performance in any service, such as withholding practice funding or decommissioning an enhanced service from a practice. However, it was clear that this was an option that may be used in the future.
- The focus within the PCT in Case Study 1 appeared to be on developing practice-based commissioning, perhaps to the detriment of the enhanced services.
- There was a clear, and developing, role for non-clinicians in the monitoring and accountability of clinicians within all service models examined.

7.3.5 Governance and accountability in Scotland: Case Studies 3 and 4

QOF monitoring

Initially in Scotland, the GMS contract was held between the Health Boards and practices. However, as described in Chapter 4, all Health Boards in Scotland had undergone substantial restructuring around the first year of the new contract, with the implementation of Community Health/Community Health and Care Partnerships (CHPs/CHCPs). (Case Studies 3 and 4 had both CHPs and CHCPs, however as there was no difference between them in term of governance, they are referred to as CHPs throughout.) Thus contracts were now held between the practices and the CHPs, who were responsible for the governance of the contract. However, while strategically they managed the contract, operationally, this had proved very difficult. Governance was thus in a state of transition in both Scottish case studies:

.... it is that this has been a transitional year in terms of that relationship building but its starting to happen they [the CHCPs] have become much more involved in the whole process they get involved in looking at contractual problems, getting involved in the contract review process they are getting more involved in the QOF review process....

(Scotland Stage 1, Case Study 3 – PCO (Health Board), Interview 6, Paragraph 41)

In Case Study 3, the Health Board was devolving its monitoring functions to its 11 CHPs. Although these organisations were relatively new, the importance of the GMS contract and the role of GPs in delivering care was recognised:

.... the core contract, it is visible to us [CHPs] in that respect - so we know each of the practices in the area, what QOF points to get and what they are delivering all that sort of stuff so that's visible to us

(Scotland Stage 1, Case Study 3 – PCO (CHP), Interview 18, Paragraph 24)

Not all CHPs had taken on monitoring functions themselves, although some were involved in the QOF review visits. Instead, as described in Chapter 4.3.3, support functions around monitoring and accountability remained centralised within the Health Board or with one CHCP, which acted as resource for the others. In Case Study 4, the Health Board had facilitated this process by establishing an interim organisation, the Primary Care Contractor's Organisation (PCCO), to monitor QOF performance until the CHPs were fully established. However, the CHP management would become involved if there were on-going performance issues.

Its more the PCCO [monitoring] because its quite a technical detailed exercise and we don't have the capacity to do it so there's a central team that does it and we get involved in things like signing off the QOF payments, we would get involved if there were issues about particular practices so if there were performance issues that became governance issues and clinical quality issues we would absolutely definitely be involved, our chief nurse or our clinical director would get involved in that too.

(Scotland Stage 1, Case Study 4 – PCO (CHP), Interview 15, Paragraph 12)

It was recognised, though, that this could remove CHPs from the monitoring process.

.... if there's any unpleasantness with primary care issues around payment verification that kind of stuff or indeed high level complaints against GPs they are actually investigated and managed by the PCCO on behalf of the CHP so I can be copied into correspondence so it's a kind of supported mechanism, although on the other hand it does, it removes us slightly from influencing delivery directly if you see what I mean.

(Scotland Stage 1, Case Study 4 – PCO (CHP), Interview 20, Paragraph 11)

An additional complication in this relationship, particularly in Case Study 3, was the apparent lack of engagement between CHPs and general practices more generally. Thus, practices did not regard the CHP as being responsible for contract monitoring. This view was supported by the practice-based interviews, where the language used was generally in relation to the Health Board, not the CHPs.

..... they [practices] are essential in terms of the services that are delivered but they don't work for us [CHPs] and I think that bit about being the independent contractor is starting to really sink home you know. They don't see us as holding the contract they see that as being held by [the Health Board]

(Scotland Stage 1, Case Study 3 – PCO (CHP), Interview 21, Paragraph 14)

Interviewer: Right, and how do you feel about the role of the CHP, in relation to the contract?

Interviewee: If I say irrelevant? The thing is it's a national contract, and it's political correctness to say that the CHP must manage the contract, but they have to manage it within the parameters that are set. I mean it may well be different in other parts of the country, but in this Health Board we have 11 or 12 CHPs. Everybody is trying to do the same thing, and they're all trying to reinvent the wheel, and that's, I think, why the management of the contract has not been devolved, because it's just been too difficult.

(Scotland Stage 2, Case Study 3 – Practice 5 (GP), Interview 52, Paragraphs 183-185)

In both case study sites, those managing the CHPs felt that of contract monitoring at a more local level would give CHPs more influence over practices. For example, greater use of benchmarking and information sharing of information could lead to a better understanding of variation in performance.

I think we should be much more involved in sharing a really mature discussion about outcomes. I think I would like to be sitting with my Clinical Director around the table with the [GP] partners and talking about their outcomes and how that's benchmarked. I'd like to be sitting there talking to them about why they're an outlier in terms of referrals not "You will do better" but "Why is it that your referrals, you know, are so out of kilter with everybody else's? What is it about your practice that is different and can you do anything"...

(Scotland Stage 1, Case Study 3 – PCO (CHP), Interview 24, Paragraph 249)

There was also recognition, however, that GPs and practices were independent contractors and that participation was a voluntary process. Thus, previous good relationships between general practice and Health Board management were seen as beneficial when establishing QOF monitoring procedures.

I think the [Health] Board do believe that the CHPs manage GPs but we don't manage them because they are independent contractors. They are all small business men who contract to deliver pieces of work for us in the CHP all within the confines of the GMS contract. If it's not on the contract they won't do it. There are enhanced services which they may opt into as part of the contract in which case they will do it - if they haven't opted in they won't do that piece of work and we can't make them do it, its entirely a free choice.

(Scotland Stage 1, Case Study 4 – PCO (CHP), Interview 20, Paragraph 15)

I think the relationships which were developed in the days of the Trust with the GP sub-committee, recognising that these are independent contractors, and that you need to negotiate with them not dictate to them, has absolutely stood us in good stead and I have to say its been about engaging what's the mutual benefit because this is not about the NHS driving general practice.

(Scotland Stage 1, Case Study 4 – PCO (Health Board), Interview 9, Paragraph 11)

In both case studies, the Health Board was beginning to discuss the use of benchmarking – this was commented on noticed by some practices in Case Study 3, who felt that there was increasing scrutiny from the Health Board, particularly in relation to the enhanced services.

..... recently it has become very much, I feel, sort of Big Brother watching you, by way of the types of information they're looking to get from practices. But they are saying, well, you don't have to return it if you don't want to, it is optional. But particularly with the whole new local enhanced services that are coming out, there's one for information management. It has become tougher.

(Scotland Stage 2, Case Study 3 – Practice 6 (Practice Manager), Interview 47, Paragraph 45)

As in England, the practices in both case study sites were monitored in three ways: QOF review visits; contract review visits, which reviewed contractual and wider practice issues including enhanced services, premises and IT; and payment verification visits to audit and check claims before payments were made. As discussed above, these visits were still conducted principally by the Health Board, rather than by the CHP.

In the first year of the contract, the Health Board in both case studies conducted a QOF review visit in all their practices, although in Case Study 4 the Health Board chose to focus on three clinical and two organisational domains, rather than on the entire QOF. Both case study sites viewed these visits as supportive rather than punitive and were important in gaining a picture of general practice delivery in the Health Board area:

..... the value really, first year round, was to enable the Board to understand how the QOF was actually being delivered, you know what practices were investing in terms of their staff and were they setting up dedicated CDM asthma clinics all this ticking boxes and I think we literally got a fair idea of how it was delivered on the ground.

(Scotland Stage 1, Case Study 4 – PCO (Health Board), Interview 5, Paragraph 59)

Contract review visits were viewed in a similar light:

.... it's not a checking or policing [visit] its more about what problems have you found, how are you getting on, what are the issues, what do you want to tell us and then what might happen is that you get a whole range of issues that come up and when you come back you say I didn't realise that they're roof was so bad, send out the premises people.

(Scotland Stage 1, Case Study 3 – PCO (Health Board), Interview 6, Paragraph 149)

Again, as in England, the number of QOF review visits decreased sharply in year 2 in both sites. A random sample of practices were visited or practices that had performed poorly in the previous year. QOF review visits were increasingly regarded by some interviewees as “light touch” - useful for establishing relationships with practices but not appropriate to deal with poorly performing practices.

I personally think it's rather light not nearly questioning enough. It's meant to be a high trust contract and I have high trust in ninety-five percent of practices but I don't have the tools, I don't think, to deal appropriately with the five percent who I don't think are satisfactory and they are after all the point of any effort.

(Scotland Stage 1, Case Study 3 – PCO (CHP), Interview 24, Paragraph 61)

Practices supported this view, although one interviewee described them as “policing”. For practices, the utility of the QOF review visits decreased as they became more knowledgeable about what they had to do.

... we found them extremely helpful and the feedback extremely helpful. And if there was a problem then it would give us the opportunity to say, well, we have had a problem here and these are the reasons why and knowing that the report is actually going to go back to the Board and hopefully things can be picked up from that.

(Scotland Stage 2, Case Study 3 – Practice 6 (Practice Manager), Interview 47, Paragraph 85)

The composition of the QOF review panel, made up of GPs, practice managers and lay assessors, who thus knew about the ethos and workload within general practice and were sympathetic towards practices, clearly contributed to positive views of these visits.

Both Health Boards collected data directly from practice systems for verification purposes. While this may not have engendered a feeling of trust between practices and the Health Board, it was recognised that this reduced the opportunity to “cheat” the system:

It's all computerised, and they suck it out of your system and they can see what you've done, so it's not as if we're saying what we've done, they can see we've done it. So there's not really much capacity for doing naughty stuff, unless you were extremely naughty, extremely devious. Most people haven't got the time to be that devious.

(Scotland Stage 2, Case Study 3 – Practice 5 (GP), Interview 52, Paragraphs 241)

Payment verification visits were viewed as “the policing visit”, designed to satisfy audit requirements and to verify claims for payment.

That was more scary because they were looking to see... they were double checking. It was like an audit.

(Scotland Stage 2, Case Study 3 – Practice 5 (Practice Manager), Interview 48, Paragraph 134)

However another interviewee, who was involved in these visits to other practices, questioned their validity and usefulness, particularly for the 5% of practices selected at random.

I do them [in other practices], and it seems absolutely daft to me. I mean the QOF points are based on what the computer says, and then you go and look at the computer, and of course the computer does say it! I've never quite worked out the point of that.

(Scotland Stage 2, Case Study 3 – Practice 5 (GP), Interview 52, Paragraph 245)

A few issues had arisen during these visits – for example, under-registration of patients on disease registers in a small number of practices. Another issue was under-performance – in such cases, the Health Board tried to support practices rather than use punitive measures. Here, there was also the view that exception reporting and gaming had not been a great problem and, when there was misuse of exception reporting, this was generally due to misinterpretation of the guidance or poor administration within the practice, rather than any intentional mis-reporting. However, it was acknowledged that there was wide variation in exception reporting levels, with a few practices exception reporting at 3-4 times the Health Board average for some indicators. In these instances, a more robust response was taken, although there was still no sign of money being withheld or of other punitive action.

..... we are having conversations at year end with before we pay the points out, that they are immediately targeted for a discussion before we sign off QMAS.

(Scotland Stage 1, Case Study 3 – PCO (Health Board), Interview 12, Paragraph 83)

It was unclear why punitive action was not utilised in this PCO, but it may have been partly due to the re-organisation taking place at the time and the devolution of power to CHPs. One interviewee – a non-clinician in a managerial role - offered the following insight:

So, it's theoretically a contractual arrangement but it's also a colleague arrangement. It's also, in some respects, people like me also have to have a servant relationship with them [clinicians]. So there's a kind of servant-leader role and it's very difficult I think it's quite complex to do it well but there comes a point when as a manager you need a stick and I don't have any, I don't think, that aren't incredibly cumbersome and require the full might of my tribe in order to use them and I think that's just maybe too clumsy and I don't think we've addressed that yet.

(Scotland Stage 1, Case Study 3 – PCO (CHP), Interview 24, Paragraph 165)

He went on to say:

At the moment accountability sits with us but the power to do anything, I think, doesn't and that's never a comfortable place for a manager to be.

(Scotland Stage 1, Case Study 3 – PCO (CHP), Interview 24, Paragraph 265)

Both case study sites felt that there had been high QOF achievement in their area. In Case Study 3, this was partly as a result of the long-standing focus on chronic disease management and high practice participation national practice accreditation scheme. This led to the view in this case study that, in future, the QOF bar should be raised, with the lower threshold for achievement raised significantly across all the indicators and more stringent use of exception codes.

However, from the practice perspective, there was a feeling that the contract and the associated increase in managerial control over the practices had focussed their attention more on targets and less on the needs of their practice populations.

I think that there, certainly, has been. Whether it's because there's been more managerial control, I don't know. But I, certainly, feel that the autonomy has been pulled away a lot from general practice. I think general practice was renowned for being quite innovative.... with the way that it dealt with things, especially in the local area, related to the community that general practitioners are working in, which, I think, we do tend to know quite well. And, I think, it's [the contract] taken away from that because I don't have the time to think about that so much because we are so much thinking about targets and things and making sure that we're putting the right codes and things in. So, whether that's due to managers I don't know.

(Scotland Stage 2, Case Study 3 – Practice 6 (GP), Interview 46, Paragraph 148)

The use of comparative data to monitor practice performance was less well developed than in England. In Case Study 3, the Health Board had released information on QOF achievement in a league table format, but very few of the interviewees, at either PCO or practice-level, discussed this. Practices could view their performance in relation to other practices, not only in the Health Board area but also across Scotland using a nationally available computerised tool, but this was not being used in any formalised sense within the PCO. For this to develop, it was felt important to acknowledge the heterogeneity of practices and the demographics of the practice population.

Each practice is different, irrespective of whether they're in the same sort of area or the same sort of client list size. Every practice will do something differently.

(Scotland Stage 2, Case Study 3 – Practice 6 (Practice Manager), Interview 47, Paragraph 57)

Our patient demographics are such that we have not got an awful lot of elderly patients and so therefore that definitely does sort of skew the work balance but we also have a massive turnover of patients students and things like that. You don't get incentivised for that, there's nothing in it really for you if you've got a turnover and neither do the sort of younger sort of patients, who may well not have a chronic disease, but they certainly have issues and problems that require a lot of consultations. So in a way, although we've not got the elderly we have other sort of problems and other issues.

(Scotland Stage 2, Case Study 3 – Practice 7 (GP), Interview 43, Paragraph 26)

Case Study 4 had developed the use of comparative data further. A standard reporting framework was established across the Health Board, which looked at a number of areas across the practice including QOF achievement, disease prevalence and exception reporting. These “practice profiles” also included the demographic of practice populations, admissions and the staffing in the practices. These data were being shared with practices and with CHPs and gave the Board a holistic view of practices:

..... a view across all the practices against their “performance” against the QOF..... so you know quite a robust process, quite an infrastructure in a sense a big bureaucracy that was set up.

(Scotland Stage 1, Case Study 4 – PCO (Health Board), Interview 4, Paragraph 2)

While GPs and practices were recognised to be working harder, this increased monitoring of practices was thought to have negative consequences for practice staff.

... the new GMS contract requires GPs to report on their performance much more so than was ever the case previously under the old contract, yes points make prizes and GPs are better paid than they were 5 years ago but they are also working in different ways and they are working harder by and large for that extra remuneration...

(Scotland Stage 1, Case Study 3 – PCO (CHP), Interview 26, Paragraph 70)

But certainly the new contract has led to, I suppose that this whole business is the Big Brother is watching you kind of attitude that, I mean I do think a degree of supervision is necessary and I don't think that people should be able to swan away doing nothing to their patients and not have some kind of action to that, but certainly I do think that this zealous over zealous monitoring has led to a lot of stress.

(Scotland Stage 2, Case Study 3 – Practice 8 (GP), Interview 33, Paragraph 75)

As in the English case study site, practices had each organised themselves in slightly different ways in response to QOF. In general, a GP took lead responsibility for the clinical domains, although in Practice 5 this was shared with the practice nurse; different GPs then took responsibility for particular clinical domains. Practice 5 took a very team-based approach to QOF: GPs worked closely with the administrative staff to contact patients; practice nurses conducted many of the annual reviews. However, for three clinical areas (mental health, dementia and epilepsy), a GP conducted the patient reviews due to the perceived

complex needs of these patients. The administrative staff had also been allocated clinical areas, so each member of the reception staff was responsible for recalling patients in particular clinical areas. The practice manager kept an overall review of progress. However, while there was a team ethos it was suggested that:

.... the doctors are obviously very keen for us to get the points but sometimes they forget to do their bit as well, so, I really, really think the onus is practically one hundred percent down to the nursing staff and the healthcare assistants and the receptionists to to get the points up and get people in ...

(Scotland Stage 2, Case Study 3 – Practice 5 (Practice Nurse), Interview 55, Paragraph 432)

Again, in each practice, the practice manager had a key role in monitoring QOF achievement over the year and for reminding clinicians to meet targets:

.... my main aim is to make sure that we get as many of the QOF points as we possibly can, in conjunction in the clinical areas with the nurses and GPs, make sure that the claims are made that need to be made and we're getting money through the practice that we should be getting.

(Scotland Stage 2, Case Study 3 – Practice 6 (Practice Manager), Interview 47, Paragraph 13)

Frankly, I just do as I'm told by our very efficient practice manager who reminds me every so often When a patient comes in, I don't think my priority is to deal with whatever boxes I have to tick for the contract. I think my priority is to deal with what the patient has come for.

(Scotland Stage 2, Case Study 3 – Practice 7 (GP), Interview 45, Paragraph 17)

The practice manager and administrative staff also took responsibility for the organisational domains of the QOF. The constantly changing demands within the QOF was viewed as problematic, as was the computer software designed to support the monitoring process.

In general, patients were contacted by letter or caught opportunistically when they came in for other appointments. Patients in Practice 5 were exception reported if they did not respond after three letters. Practice 6 had devised a “pyramid system” for patient recall, to deal with patients with more than one QOF-related condition. The patient would be recalled for the disease that was furthest up the pyramid, with diabetes at the top, but then all of their other conditions would be dealt with at the same appointment.

The workload associated with QOF was challenging particularly in the latter part of the year - checking the data and correcting missing data on the computer system was described by one GP as “bureaucratic and tedious”. However, there was now a view that:

Certainly in the first year, February and March was a complete nightmare, but we're a bit more relaxed about it now because we realise that, you know, life's too short and you can't beat yourself up about this.

(Scotland Stage 2, Case Study 3 – Practice 5 (GP), Interview 52, Paragraph 81)

Dealing with patients as they came in, and remembering about QOF targets throughout the year, were also mooted as helping to deal with the workload:

The QOF is all year round, and if you can just try and remember that and somebody is in, to tick the smoking [box] and not wait to that last three months of [QOF]

(Scotland Stage 2, Case Study 3 – Practice 6 (Practice Nurse), Interview 51, Paragraph 169)

Practice 8 was a PMS practice, so participation in QOF was not required, however:

As a PMS practice nominally we wouldn't have to get QOF points but the [Health] Board and the CHP have always made it clear that we should still be part of the, as it were, competition and certainly when we compare ourselves against others and say yes in spite of the downsides of where we are and the nature of the clientele we're dealing with, the fact that they're very high rates of DNAs etc, we are still managing to achieve quite a considerable amount.

(Scotland Stage 2, Case Study 3 – Practice 8 (GP), Interview 33, Paragraph 53)

Responsibility for QOF areas was divided up amongst the GP partners in Practice 8, working closely with the practice nurses. In this practice, the practice manager was also a partner. Her role was that of taking an overview of performance, planning ways of supporting the practice to meet its targets, financial monitoring and decisions about practice involvement in other services.

I don't tend on the whole to get very much involved in minute detail its more of an overview. I just keep an eye on things and make sure that we are going to be reaching targets. If we are not going to be reaching the targets then I'll start to ask questions to find out why, maybe plan additional clinics or you know give people additional time to do work that needs to be done.

(Scotland Stage 2, Case Study 3 – Practice 8 (Practice Manager), Interview 32, Paragraph 2)

There were different views of the increased accountability inherent in QOF and its associated “box-ticking”, even within the same practice.

As far as the new contract goes, I don't see that as being particularly managerial, ticking the boxes. When things are quantifiable and need to be quantified ticking boxes isn't a bad way of quantifying them. So, in terms of the aspect of our job that is quantifiable, it's not a bad thing to be quantifying it, so long as it doesn't push out the aspect that's not quantifiable, the relationship and so on.

(Scotland Stage 2, Case Study 3 – Practice 5 (GP), Interview 53, Paragraph 90)

..... we go through the dreadful QOF screens with them and ask them all the appropriate questions and tick all the smiley faced boxes...[laughs] you can see I'm a bit reticent about those...

(Scotland Stage 2, Case Study 3 – Practice 5 (Practice Nurse), Interview 55, Paragraph 68)

QOF was viewed as important, as long as it didn't interfere with good patient care – nor was QOF viewed as the only indicator of good patient care.

It's important as long as it's not to the detriment of the patients' quality of life because tight control [for diabetes] isn't always what's best for the patient, especially if they are elderly. Especially if they feel that they are having to come in all the time and its taking over their life, and sometimes it does feel as if it gets in the way of our normal, flowing consultation chat when you're stopping all the time and looking at numbers all the time and banging on about numbers ...

(Scotland Stage 2, Case Study 3 – Practice 8 (GP), Interview 39, Paragraph 81)

For the PMS practice, knowing where the practice “sat” in relation to other similar practices was mentioned as being interesting, but did not drive practice performance.

Performance did appear to be more important to the practice manager in the practice, both financially and professionally, but there was also recognition that the demographics of the practice population could impact on the practice's overall performance, despite its best efforts. This was particularly apparent in Practice 8, which was located in an area of severe deprivation.

[Its] very important to practice managers because we all log on to see how well everybody else has done and you know you take it as a personal slight if your practice hasn't done as well as Dr Bloggs up the road so, yes we take great pride in our QOF points. Its important because that's how we make our money that's the bottom line so whenever they try to take some of the QOF points away, as they have done this year, and we will lose out hugely on this patient questionnaire because so many of our patients, for whatever reason, they will either not open the envelope or they won't be able to read it once they do and that's 50 points and we could lose a great deal of our income this year because of that so that's the importance of it.

(Scotland Stage 2, Case Study 3 – Practice 8 (Practice Manager), Interview 32, Paragraph 74)

Enhanced services

CHPs in both case study sites felt that they had a more important role to play in deciding what the basket of enhanced services would comprise.

... more importantly it's our input or contribution to local enhanced schemes, or contribution to an engagement at the executive around new GMS funding how that will be used, what the priorities are for [name of Health Board]. So for example a common theme in all our development plans is addictions, so therefore when we are presenting our bid or our proposals for the new GMS funding. There was a local initiative, a local programme for addictions that we were keen to promote and that came out of the CHCP discussions.

(Scotland Stage 1, Case Study 3 – PCO, Interview 18 (CHP), Paragraph 24)

It was thought that the enhanced services might be useful in designing care to meet local needs, although it was recognised that not all practices would participate.

I think the trick is to know how to set targets that are meaningful and do actually influence care and that's I suppose that's where the debate around the new Scottish enhanced services come in although I would rather that we were looking at stuff that everybody had to do rather than trying to design stuff that we hope as many people as possible will buy into which is the difference really enhanced and the kind of core contract business.

(Scotland Stage 1, Case Study 4 – PCO (CHP), Interview 20, Paragraph 43)

CHPs in Case Study 3 were clear that they were now paying practices for enhanced service activity and, as such, wanted to see a return for that investment both in terms of clinical activity and quality monitoring.

.... we are paying for enhanced services and we need to be clear that we are having a return for that, so over the 2 or 3 years now that we have been developing the programme each year, year on year, we have enhanced the IT monitoring of those aspects, from a quality point of view but also from a payment point of view.

(Scotland Stage 1, Case Study 3 – PCO, Interview 2 (CHP), Paragraph 41)

In this site, some of the Local Enhanced Services, e.g. for heart disease, included elements of the QOF, thus the quality markers developed for the enhanced services were very similar to those used in QOF, as was the payment system. So, there was a sliding scale of achievement for different levels of payment and exception codes for the clinical indicators so that practices would not be penalised if patients did not attend. Practices having difficulties meeting the enhanced services targets were offered support.

..... we also have communication with the practices when we see there are areas that are being poorly done or not completed then we try to address that either with training or going to the practices. If there's a practice having a problem or whatever, do our best.

(Scotland Stage 1, Case Study 3 – PCO (Health Board), Interview 22, Paragraph 15)

A small number of practices in Case Study 3 did not participate in the Local Enhanced Services. In this situation, the Health Board sent in its own employed nurses to deliver the LES, so that patients were not disadvantaged.

Practices spoke about the impact of participating in the enhanced services. Decisions about which enhanced services to opt into were generally made by the GPs, sometimes in conjunction with the practice manager. These decisions were not taken lightly, not were decisions to opt out of a service.

I think the thing about opting out is, if you opt out there's a chance you can't opt back in, which is possibly a concern. I think the other thing is, for us as a practice, it isn't a snap decision, oh, we'll do it and see what happens - we do weigh it up.

(Scotland Stage 2, Case Study 3 – Practice 7 (Practice Manager), Interview 42, Paragraph 165)

However, one GP felt that there had been an element of coercion in getting practices to sign up to the enhanced services:

It was, probably more, "we're not doing it", type of thing! It was like, you're forcing us to do this and we don't like it, rather than being an advisory or asking our advice or anything. And I think we felt a bit held to ransom to that. And we have ended up doing it but that's more financially, because we couldn't afford not to do it, rather than anything. It wasn't something that we wanted to do.

(Scotland Stage 2, Case Study 3 – Practice 6 (GP), Interview 46, Paragraph 144)

Most of the chronic disease enhanced services were nurse-led; the time consuming nature of the data entry systems was commented on by many of the practice-based interviewees.

Interviewee: They have a hell of a time with them [the enhanced services], and they hate them.

Interviewer: And any particular reason for that?

Interviewee: The input of data, the non-logicality of the screens, and the inability to understand why we're not getting full marks. I mean seriously, every year we think is this worth it, because all I can say is we get a bad time with QOF in February and March, and that's nothing, absolutely nothing compared to the CDM [enhanced services]

(Scotland Stage 2, Case Study 3 – Practice 5 (GP), Interview 52, Paragraphs 89-93)

The diabetes LES had developed from a well-established chronic disease management programme for diabetes, with practice nurses leading on the monitoring, patient review and data entry. However, the additional areas covered by the LES (including detailed assessments of a patient's diet, exercise patterns and alcohol consumption and potential referral to community-based groups for lifestyle advice and support) and the associated data recording led one nurse to comment:

The local enhanced service is probably a lot more work for us as practice nurses, but I would say it's a lot more beneficial for patients, there's great benefit there for patients but it's a very time consuming enhanced service.

(Scotland Stage 2, Case Study 3 – Practice 6 (Practice Nurse), Interview 49, Paragraph 85)

As described in Chapter 4, the Drug Misuse Enhanced Service in Case Study 3 was, as in England, shared across general practice and community-based services. Governance accountability lay with the Health Board-wide Addiction Partnership, which helped with performance management, the development of key performance indicators and local improvement targets. Some of these were national targets, although the service had set its own targets at a higher standard. The service conducted an annual visit with the practices involved in the Drug Misuse LES, focused on the activity returns that the practice sent to the Addiction Partnership about their care of drug misusers in their practice. The fact that practices now had a contract with the Addiction Partnership was of positive benefit when it came to accountability.

... we can negotiate with the GP just to ensure that's correct and that sort of stuff and the fact that we've actually got a contract to negotiate with GPs, to ensure they are meeting that contract that's been a real benefit because before the new contract, the standard and the consistency across the Board was not the best and there was no mechanism for us to address those issues...

(Scotland Stage 2, Case Study 3 – PCO (CHP), Interview 31, Paragraph 92)

.... we've embedded the standards into the contract overnight and changed that relationship [between the service and GPs]. Yes, they're independent contractors but the bottom line is you signed up for that contract, these are the standards that are attached to them, you've got no choice - you either adhere to them or you leave the contract.

(Scotland Stage 2, Case Study 3 – PCO (Health Board), Interview 34, Paragraph 12)

This gave them the ultimate sanction of removing a practice from the drug misuse enhanced service, which had happened in one or two instances. However, if there were problems, these were again more

likely to be dealt with by offering the GP support from the service's practice support team.

This increased monitoring and accountability in the enhanced services per se was commented on by practices.

As far as the new GMS thing goes, the Enhanced Services at the Health Board level do affect us because they can be a form of micromanagement, telling us in extremely detailed ways what we should be doing.

(Scotland Stage 2, Case Study 3 – Practice 5 (GP), Interview 53, Paragraph 86)

Thus, there was a growing level of monitoring and accountability back to the Health Board and the CHCPs in the delivery of the enhanced services in this case study site.

Out of hours

In Case Study 3, the out-of-hours service had previously been a GP-run co-operative located within the Primary Care Division. With the GP opt-out, the out-of-hours organisation was moved to the Health Board's Acute Division. However, it was felt that patients were unlikely to have noticed any difference as a result of this.

We just handed over the service, lock stock and barrel to the Health Board when they started to run it, and it was essentially the same service. I mean they've developed it a bit more and got nurse practitioners in, and it probably costs twice as much, but it is essentially the same service, so we don't notice any difference. People in [name] don't notice any difference.

(Scotland Stage 2, Case Study 3 – Practice 5 (GP), Interview 52, Paragraph 125)

Governance arrangements for some issues, such as significant event handling, lay within the Acute Division. However, the organisation linked to the primary care governance structure when it came to GP performance, which was routinely monitored by checking on hospital admissions or reviewing cases that had fallen out with agreed standards. In cases of poorer performance, the GP would be interviewed by the clinical management of the out-of-hours organisation. In more serious cases, the GP might be referred to the primary care clinical support team and, if necessary, be referred on to the under-performing doctors scheme at NHS Education Scotland, who deal with issues related to qualified doctors. This monitoring was felt to be a new development. It also raised the interesting issue that GPs were acting in an explicitly managerial fashion in the out-of-hours service, monitoring their fellow GPs performance and holding them accountable. However, this raised challenges for an organisation with a small managerial structure, but with 400 GPs providing sessions.

GPs working within the service were aware that monitoring took place, although several commented that they did not know how they were monitored. One item was the number of consultations completed in per hour, leading one GP to comment:

I know that they have also audited the length of time, the number of calls that you do. That makes me quite uncomfortable. I don't like that at all because I think it's a bit unfair to look at the number of calls that you do in an hour compared with half a dozen other

doctors because you could be seeing entirely different cases. And all it takes is one psychiatric case taking two hours to sort out, by the time the police and the resident, the approved medical officer to section somebody appears, to really screw up your efficiency. So I don't think that's fair.

(Scotland Stage 2, Case Study 3 – Practice 7 (GP), Interview 45, Paragraph 97)

In Case Study 4, the out-of-hours service still sat within primary care. This service also monitored the performance of its GPs. This was fairly informal, and involved the Medical Director of the service reviewing a random sample of patient records, either on paper or on the computerised system, to ensure that data were complete and that national targets had been met, e.g. in relation to timeframes to visits. However, in the case of poor performance there were few sanctions that the organisation could bring to bear – the principle option was to suspend the GP from providing out-of-hours sessions.

Again, due to the smaller number of organisations in Scotland providing out-of-hours care, there was also a lot of shared information between all organisations nationally, for example by sharing GMC numbers, to ensure that doctors were not working in several out-of-hours organisations at once.

7.3.6 Summary of governance and accountability in Scotland: Case Studies 3 and 4

- In both case study sites, the contract for all service models GMS/PMS and the enhanced services was now with CHPs, but had previously been with the Health Board.
- Although the contractual responsibility now lay with the CHPs, this had been a relatively recent development and was yet to be fully operationalised. Monitoring remained a centralised function at Health Board level.
- Practices did not yet perceive the CHPs to be the organisation in charge of contract monitoring.
- The out-of-hours service in both case studies remained within the Health Board, which ran the service.
- As in England, QOF performance in both case studies was monitored through QOF review visits; contract review visits; and payment verification visits. Again, the frequency of these visits had decreased.
- Although hard and soft governance mechanisms were available to the PCOs in Case Studies 3 and 4, the emphasis appeared to be on the softer governance mechanisms of support and guidance; there were almost no examples of punitive action against poorly performing practices.
- There was little explicit use of comparative data to drive practice performance, particularly in Case Study 3.

- Case Study 4 was moving towards the use of quality practice profiles and comparative presentation of data back to practices, but this was not well developed.
- As in England, practices did not reflect much on the impact of being monitored by the Health Board. Again, they focussed more on internal re-organisation to meet QOF targets.
- Within practices, responsibility was shared amongst practice staff with GPs and practice managers predominantly responsible for monitoring QOF achievement.
- Practice managers were generally the key professional in monitoring individual performance within the practice.
- Monitoring and data entry was much more onerous for the enhanced services, with the onus falling to practice nurses.
- In some the drug misuse enhanced service, having an integrated PCO was an advantage as it was possible for the drug misuse service to have a contract directly with the practices to deliver the service.
- The presence of a contract for the delivery of an enhanced service raised the possibility of poorly performing practices having their contract revoked.
- Although there were national standards to meet, there was little performance monitoring within the out-of-hours service in either Case Study 3 or 4.

7.4 Discussion

The findings reported here identified a high degree of commonality across the two countries in the governance of the GMS contract, especially with regard to QOF. This was perhaps unsurprising, given that QOF is a UK-wide component of the contract. While hard and soft mechanisms of governance were inextricably linked in all four case studies, the weight placed on the mix of “hard” and “soft” mechanisms did vary between the two countries, with PCOs in England much further along the route of developing comparative systems of performance and reporting back to practices, for example in the use of balanced scorecards. There was even more apparent with respect to the enhanced services and out-of-hours care.

In all sites, the body responsible for monitoring the contracts was the PCO: the PCT in England; the NHS Health Board in Scotland. This was despite attempts in Scotland to move responsibility for contract monitoring downward to Community Health (Care) Partnerships. Indeed, this has never become a reality in Scotland and contract monitoring remains centralised with the Health Boards or with a lead CHP given the responsibility to act as principal on behalf of the Board, as had happened in Case Study 3.

With respect to practice monitoring, all of the case study sites operationalised their monitoring of practices in a similar way: QOF review visits; wider contract review visits; and payment verification visits. While the mantra of “high trust, low bureaucracy” was often repeated, interviewees at all levels and across all models of service delivery confirmed that this was far from the case. Indeed, the bureaucracy of visiting all practices in a PCO at least three times per year had led all four PCOs to review their process, with each generally dropping to one annual visit, or less. Annual QOF review visits were reserved for practices viewed as problematic, or for the 5% random sample selected each year.

Nationally, two drivers for this increased bureaucracy and monitoring were cited: first, a need to ensure that wrongful claims were kept to a minimum; and second, in England, a view that variation in practice performance had to be reduced. However, the PCOs seemed far less concerned about the potential of wrongful claims being made and rarely, if ever, mentioned variation in performance.

“Hard” mechanisms of governance, such as target setting, performance monitoring and audit were inextricably linked with “softer” mechanisms, such as peer review, support and guidance and trust. For all of the case study sites, the initial response to any identified problems with performance was to visit the practice, open up a dialogue, and offer support. Indeed, there was very little evidence of punitive action being taken in any site, or for any service. Occasionally, a proportion of funding would be withheld from a practice or some practices were “decommissioned” from providing an enhanced service. However, these instances were exceptions to the rule. One explanation might be that managers felt that they lacked appropriate tools for more punitive action – most of the available actions were quite “heavy handed”.

While this was true for both England and Scotland, it appeared that monitoring and target setting was more developed in the English sites, especially Case Study 1. Here, the balanced scorecard approach was well developed and being used across a range of practice activities. Nationally, in England, it appeared that such approaches were being favoured as a way of developing incentivised systems within primary care.

Monitoring of the enhanced services within practice was less well developed in England than in Scotland. One explanation for this might be that the implementation of practice based commissioning was clearly taking up more time and energy in the PCOs at that time. In Case Study 3 in Scotland, monitoring of the enhanced services was developing apace with a similar monitoring system to QOF in place. However, the demands of data entry were impacting on practice nurses' workload.

In the practices themselves, governance was enacted at two levels: the first was external monitoring by the contract holder – this was the PCO, the PCT in England and Health Board or CHPs in Scotland. Second was internal monitoring of practice progress towards QOF achievement.

Practices, surprisingly, had little to say on being externally monitored, beyond reflecting on the impact of QOF and payment verification visits. The only other impact that was commented on was the central extraction of practice data: in England, carried out by PCT-employed staff in the practice; in Scotland, completed electronically. This did raise tensions at times and could imply an area where trust might, in future, be eroded.

This lack of concern on the part of practices might be further explained by two factors. First, both QOF and participation in the enhanced services is voluntary – although not openly acknowledged, this was known to both practices and PCOs. Second, despite the rhetoric, there was little or no evidence of the PCOs taking punitive action against practices in any of the case study sites.

Internal monitoring of practice staff, both clinical and non-clinical, generally involved the practice manager as the main “policer” of staff performance. However, the only mechanisms open to the practice manager were fairly soft – for example, playing to clinicians sense of professionalism by telling them that they had not completed QOF targets during consultations.

A clear impact on patients was that, in order to meet QOF targets, patients were being increasingly “chased”. QOF was acknowledged to have improved patient care, but it was felt that this should not be to the detriment of other, holistic aspects of the consultation. This is explored in more detail in Chapter 11.

Out-of-hours care was subject to national targets rather than local targets, with evidence of increased monitoring of GPs providing the service becoming apparent. In England, the monitoring of the out-of-hours service had moved very much towards the harder mechanisms of governance, but this was less apparent in Scotland perhaps because the services remained within the control and operation of the Health Boards.

7.5 Conclusions

- The principal contract holder in both countries was the PCO for all three models of service delivery.
- Both hard and soft mechanisms of governance were used to monitor performance.
- In England, greater weight was given to hard mechanism of governance, especially with the development of a balanced scorecard approach.
- A greater role for non-clinicians monitoring clinicians was becoming apparent.
- The use of enhanced services was better developed in Scotland than in England, although again monitoring was softer.
- There was little evidence of punitive action being taken against poorer performance in either country.

- The monitoring of out-of-hours care was more stringent and explicit in England.

In the next two chapters the impact of this increased monitoring on staff is explored (Chapter 8) and on the way in which they organised their work (Chapter 9).

8 The impact of GMS incentives and monitoring on staff performance and motivation

8.1 Introduction

Chapter 6 explored the contribution of the GMS contract on the health system and policies of the devolved NHS administrations of England and Scotland; Chapter 7 reviewed the governance and accountability mechanisms employed in both countries across three aspects of the contract: GMS/PMS practices; enhanced services; and out-of-hours care.

A key feature of the new contract is the explicit incentivisation of care through the QOF. However, as explored in Chapter 7, the use of targets and incentives is also a feature of the enhanced services. As argued in Chapter 1, the use of incentives to improve clinician performance is not new and was, indeed, a feature of the 1990 GP contract (53-56). There are, however, well recognised problems associated with incentivising behaviours to improve quality of care, as outlined in Box 7.

Box 7 Unintended consequences of incentivisation. (Adapted from (57-59))

Crowding out of the treatment of unincentivised conditions.
Damage to doctor-patient relationship by focusing on incentivised care rather than the patients agenda.
Ceiling effect, i.e. doctors stop responding to an incentive above a certain financial level.
Non-linear relationship between size of financial impact and the work doctors will put in to meet it.
Negative impact of financial incentives on doctors' own internal motivation and professionalism.
Focus on measurable, process-related indicators rather than longer-term outcomes related to health improvement.
Targeting of less "difficult" patients at the expense of older or more complex patients.
"Gaming" of the system by data manipulation or by removing challenging patients from the list.

Marshall et al have recently argued that performance management and other levers, such as incentives and targets, are replacing the reliance on moral motivation that traditionally drove professionals (132). Many of the tasks and activities performed by professionals are driven by internal motivation – that is, activities are carried out because they are inherently satisfying, not because there is a financial reward attached to them (57). Financial incentives can, however, undermine the internal motivation of individuals (133;134) and, more importantly in this instance, de-motivate teams by producing internal conflict within the team (135)

Once an incentivised system is in place, the predominant mechanism for monitoring their achievement is, of course, through the use of contracts. As discussed in Chapter 1.4.3, a key conceptual framework by which the relationship between the two parties in a contract is considered is that of principal-agent theory (12;21;60). The relationships between a principal and agent(s) can then be visualised in accountability chains (21).

As reviewed in Chapter 1, recent studies have examined some of these issues in relation to QOF. GPs and practice nurses spoke of the data entry requirements of the new contract pushing out the patient agenda (95;96). It was also changing the nature of the relationship between professionals within practices, with internal monitoring leading practitioners to feel either “chasers” or “chased” (97-99;101). There was, however, little evidence at that time of any impact on practitioner’s own internal motivation, with most GPs at least supportive of the QOF. While accountability chains have been observed and mapped within primary care in England (21), the way in which these might differ across different models of service provision has not been explored.

There has also been much interest in exception reporting, and whether this encourages gaming. As reviewed in Chapter 1.5.1, exception reporting was introduced to ensure that practices were not financially penalised for caring for patients who either did not respond to invitations to attend for review or for patients for whom particular interventions were already contraindicated. Exceptions fall into three main categories: (a) patients who have recently joined a practice or are recently diagnosed; (b) exceptions across an entire clinical domain e.g. because the patient has declined to attend for review or for whom care in a particular domain is clinically inappropriate; or (c) exceptions in a particular indicators, e.g. because a patient declines a flu immunisation or is allergic to a particular drug.

Quantitative analyses have indicated that the actual impact of exception reporting is small (89). There is still interest, however, into how professionals use exception reporting and whether this affects their personal motivation.

In this chapter, we more fully explore the interviewees’ views of incentives in the 2004 contract, as well as the impact of monitoring both externally from the PCO and internally within the practice on motivation and performance. In addition, we examine consultation rates for incentivised versus unincentivised conditions in Scotland. Finally, we explore interviewees’ perceptions and understanding of exception reporting.

8.2 Methods

8.2.1 Qualitative data collection and analyses

The methods pertaining to the qualitative results reported here have been previously described in Chapters 5 and 6.

8.2.2 Quantitative analyses of Practice Team Information (PTI) data from Scotland

Care for incentivised versus non-incentivised conditions was examined using data available in Scotland. No equivalent dataset was routinely available to conduct this work in England.

The Practice Team Information (PTI) dataset is a Scottish national dataset data collected from a sample of general practices in Scotland on all face-to-face consultations between patients and either GPs or practice nurses, phlebotomists and health care assistants, although between 2003 and 2006, data were also collected from district nurses and health visitors. The data included all house calls and out-of-hours contacts relating to the practice's own patients but did not include telephone consultations. Clinicians were asked to record the reason for consultation, with more than one sign, symptom or condition recordable for each consultation. These were recorded using the Read clinical coding system. Currently there are 60 practices participating in PTI and these practices are broadly representative of the Scottish population in terms of age, gender, socio-economic status and the urban/rural mix. For more information on PTI, see www.isdscotland.org/isd/1044.html#Specific_conditions.

PTI records the underlying morbidities/conditions dealt with in the consultation, with relevant Read codes identified by a set of PTI-specific modifiers. Other Read codes entered into the clinical IT system are not extracted for PTI (for example, in an asthma review, the PTI dataset would include the morbidity "asthma" but not other Read codes entered as part of the review such as inhaler technique, health promotion given and so on). Data are aggregated and reported at national level.

Additional analyses were requested from ISD to compare consultation data broken down to the level of GP and practice nurse and to compare care across clinical domains. Data were obtained from ISD Scotland for three groups of conditions:

- Incentivised by QOF from April 2004 (angina, asthma, coronary heart disease [CHD], chronic obstructive airways disease [COPD], diabetes, epilepsy, hypertension, hypothyroidism)
- Incentivised by QOF from April 2006 (depression, dementia)
- Not incentivised by QOF (anxiety, back pain, multiple sclerosis, osteoarthritis).

Figures were standardised by deprivation using the Scottish Index of Multiple Deprivation.

Data were available from 59, 53, 51, 49, 48 and 58 practices for the years ending 31 March 2004, 2005, 2006, 2007, 2008 and 2009 respectively. Analyses were also conducted on the 34 practices that reported results across years 2004-2007, which showed that the substantive findings did not changed (data not shown).

In terms of comparing QOF and PTI results, it should be noted that a number of differences exist between the two datasets. PTI reflects active disease problems and is based on a count of those patients who consult for a specific condition for that particular year. In contrast, QOF includes all patients identified by the practice as having a specific condition, regardless of whether they have consulted recently for it or not. Differences also exist between PTI and the QOF in the definition of certain conditions. For more information see, www.isdscotland.org/isd/3746.html.

8.3 Results

Incentives and performance monitoring were discussed by national, PCO and practice-level interviewees. Individuals talked about responding to incentives *per se*, mainly in relation to the clinical domains of the QOF, but also discussed the broader impact of monitoring in relation to performance and motivation. This related both to individual performance, but also to organisational performance – that organisation could be a practice responding to QOF, a practice responding to an enhanced service or a larger organisational entity, such as the wider enhanced service or the out-of-hours service. Finally, interviewees spoke about the role of exception reporting and gaming.

These are now reported in turn, but with the caveat that there was considerable overlap between these areas.

8.3.1 Impact of incentives on performance and motivation

The incentives contained within the Quality and Outcomes Framework were a powerful motivator for both individual and practice performance. The QOF was seen as having motivated and energised GPs, who responded quickly to its targets.

I think certainly when the QOF came in, the new contract came in they were energised like nothing before to deliver this and that's been demonstrated by you know - point the GPs at a target, pay them for it, they will do it.

(England Stage 1, Case Study 2 – PCT, Interview 8, Paragraphs 203)

However, a number of interviewees, in both countries and across all PCOs suggested that the downside of this was that GPs and practice teams now worked “to the book” – only providing services for which they would receive payment. This raised potential conflict when new services were being planned, with PCO interviewees of the view that anything that was not defined as core or was a new service had to be delivered as an enhanced service, with payment attached.

... if clinical practice [had to change], then previously clinical practice would have changed. Now if clinical practice is changing they [GPs] are saying well we didn't used to do that before, it needs to be an enhanced service.

(England Stage 1, Case Study 2 – PCT, Interview 11, Paragraph 523)

I think its crystallised primary care into being a small business as, is it primarily about care now or is it primarily about business and I think there's been a bit of a shift towards it being much more business-like and everything is about incentives. People won't do something unless they are incentivised and incentivising is about money and I think that good will bit is what's been lost.

(Scotland Stage 1, Case Study 4 – PCO (CHP), Interview 20, Paragraph 49)

This led a small number of national-level interviewees in both countries to suggest that the proportion of practice income earned from QOF should be reduced. However, a counterview was that PCOs themselves were interpreting the contract rather too broadly:

I've been brought up to believe what's written on the paper is what you have to stick to and it's a bit unfortunate for the PCT but the contract is there and as far as I am concerned providing the practice achieves what is written down in the contract that's what gets them the points, not what the PCT might like to think is written down on the contract....

(England Stage 1, Case Study 1 – Other, Interview 2, Paragraph 57)

Concern was also expressed that the incentives contained in the QOF had led to false priorities, with a focus on the incentivised conditions and, ergo, patients with those incentivised conditions. This view was held at national, PCO and practice level. It was felt that it might become increasingly difficult to raise the profile of patient groups that did not have a “payment tariff” attached to them – for example, patients with unincentivised conditions or complex patients, such as those with multiple morbidity or the elderly. This created problems for the PCTs, in relation to issues concerning wider public health issues, for example:

I think they've [the incentives] taken our eye off the ball on some of the issues that we face that are not part of the contract and I think are dealt with very badly by doctors - like alcohol, which is probably represents 20-25% of all of our work directly or indirectly GPs are so bad at managing alcohol problems and picking up alcohol dependence or alcohol problem drinking [but] there's no room for anybody to actually go and talk to GPs because they are so busy doing all the other bits around the QOF.

(England Stage 1, National, Interview 31, Paragraph 162)

Practitioners agreed and, at times, felt that the consultation was driven by QOF. While they stressed that care for the unincentivised conditions had not deteriorated, they felt that there had not been the same focus and energy directed to those areas:

I think we're getting to the tick box era. There's a figure you're aiming for, you've done this, no you haven't. Tick the box, yes, okay. Done. And on the one hand if that's monitoring certain standards which are being done that's fine, but instead of it being a marker of how your clinical care is, I think that's become your clinical care.

(England Stage 2, Case Study 1 – Practice 1 (GP), Interview 40, Paragraph 308)

Many felt that the QOF had pushed the patient's agenda to the side during the consultation, bringing the doctor's agenda to the fore:

I think the downsides are that it's a little bit recipe book medicine and sometimes we ride roughshod over what the patient's actually come about, or wants to do, [Break] I mean, general practice has always been a bit like that, you've got your patient's agenda, the doctor's agenda, housekeeping things, it's a well-recognised thing. But I think it's certainly pushed our consultation a little bit more towards our agenda at times.

(England Stage 2, Case Study 1 – Practice 1 (GP), Interview 39, Paragraphs 379 & 383)

Some were also of the opinion that they now over-treated some patients with QOF conditions, for example by treating high blood pressure or chronic kidney disease in elderly patients where, in the past, they may have just monitored the condition. Practices also, at times, weighed up whether or not it was worth striving to achieve a particular target, particularly in relation to the organisational domain. For example, one practice, for historical reasons, experienced difficulties meeting an access target, and so had chosen to forego those points and the attached funding. Another interviewee spoke about the tensions when making decisions about which areas to focus on:

... if we're concentrating on the hypertensives, or we're concentrating on stroke or we're concentrating on one particular area, what happens to everybody else?

(Scotland Stage 2, Case Study 3 – Practice 6 (Practice Manager), Interview 47, Paragraph 40)

Thus, the incentives of QOF drove practice decision-making around particular activities, both clinical and non-clinical. This wasn't to say that the practice ignored areas, but that there was not necessarily enough organisational "stretch" for them to concentrate equally on all areas.

QOF points translated into monetary gain for the practices and this, unsurprisingly, was a powerful motivator of practice behaviour. For example, as explained in Chapter 7, Practice 2 was a PMS practice and with no year-on-year uplift in its salary budget. This clearly motivated individuals within the practice to monitor performance and QOF achievement rigorously, which impacted on other members of the practice.

.... why didn't they do the blood pressure it's 77 points, smack They don't like getting "beaten", we don't like "beating" them but it has to be done because our ethos here and you can quote this, points mean prizes, prizes mean rises because going to PMS there are very few uplifts in the money. So whereas before with GMS if we had a staff budget it would go up year on year with the cost of living, with PMS it doesn't. So the GP's now, particularly with the contract, have to find money to pay staff rises, it goes out of the pot.

(England Stage 2, Case Study 1 – Practice 2 (Practice Manager), Interview 42, Paragraph 19)

[QOF has] probably made us far too money orientated really. Just because everything is to do with money and I do feel like I'm quoting pound signs every time I talk to people.

(England Stage 2, Case Study 1 – Practice 2 (GP), Interview 46, Paragraph 876)

However, QOF achievement was also a matter of personal motivation.

Interviewer: And in terms of QOF points of achievement, how important is it for you personally to achieve a high number of QOF points?

Interviewee: Hugely. Absolutely. It's something that every year, I think any practice nurse would it's not just about achieving points, it's about best care as well. Definitely best care, first and foremost.

(Scotland Stage 2, Case Study 3 – Practice 6 (Practice Nurse), Interview 49, Paragraphs 199-201)

One unintended consequence of incentivisation is the possibility that GPs might stop targeting patients once the QOF payment threshold was achieved – the evidence for this was mixed. Some GPs spoke about going beyond QOF:

I also think that in setting the standards that's very useful but they can end up being a barrier to improve performance. If your target for diabetic control is whatever, there is no incentive to make it actually better than that because the payment kicks in at that level.

(England Stage 1, Case Study 1 – PCT, Interview 20, Paragraph 223)

..... as I say, we hit the QOF figures to start with. We're sort of now looking at trying to be above QOF. So, if you look at the blood pressure, 150/90 in hypertensives say, and QOF, they like you to be over 70%, well we're sort of saying, well actually we'd like to be 90%

(England Stage 2, Case Study 1 – Practice 1 (GP), Interview 39, Paragraph 375)

I think if there's, clinically, a reason to go beyond the targets, then we try and do that. For example, the cholesterol level being five but if someone's got a specific cardiac reason for us to really want it to be below four, then we would try and do that. We go clinically, rather than just because a target's there.

(Scotland Stage 2, Case Study 3 – Practice 6 (GP), Interview 46, Paragraph 193)

Towards the end of the QOF year, however, it was recognised that some practices prioritised activity towards those indicators and areas where they had not yet reached maximum achievement and ignored areas where they had already achieved maximum points, even if there were still patients who needed to be seen in those areas.

..... there is always a tension between what the practice managers desire to achieve as high an income for his or her practice as possible versus the clinical needs of the patients and it's very difficult to say that people are doing things that are wrong or might even be interpreted as morally wrong but there is gaming going on both in terms of which patients are called towards year end and how exception codes are applied.

(Scotland Stage 1, Case Study 3 – PCO (Health Board), Interview 12, Paragraph 89)

From an organisational perspective, the focus on national targets (QOF or the Directed and National Enhanced Services), was thought to distract practitioners from addressing local targets. Local Enhanced Services were viewed as important to redress that. However, it was clear that other non-contract areas were given less prominence, particularly in relation to health promotion or public health initiatives.

Meeting the incentives in QOF appeared to have a greater de-motivating effect on practice nurses. Nurses felt that they were asked to carry out tasks that were unnecessary clinically, in order to meet QOF targets, and that they were being used to augment GPs' salaries. Some interviewees within PCTs reported that practice nurses were increasingly dissatisfied with their job because of the constant need to "chase QOF points".

.... the nurses themselves didn't like some of the changes either, there was also a lot of animosity from nurses saying that QOF was just money making, what they were doing for QOF was just putting money into GP's pockets.

(England Stage 1, Case Study 1 – PCT, Interview 18, Paragraph 99)

[Practice nurses tell me] ... oh I'm looking for a job now because I'm, you know, I'm feeling that I need to test my skills elsewhere. [They say] I do not want to be doing COPD and

diabetes for the rest of my working life - that's the issues and the other thing is the pressures the practice nurses find themselves under. They are having pressure from the practice manager who has been asked for results and making sure that the QOF is up-to-date and all of that and sometimes I think the practice nurses feel a bit overwhelmed at what they are being asked to do.

(Scotland Stage 1, Case Study 4 – PCO (Health Board)T, Interview 4, Paragraph 95)

Practice nurses themselves felt that they were not being fully rewarded for their contribution to the practice's QOF achievement.

..... you're not rewarded the same as other professionals are. And you're doing a lot of the work for the GPs, who I know appreciate it, but you're taking a lot of the burden away from them. And I feel there should be a reward there for the nurses who really do work hard at their job, and work hard to improve patient care....

(Scotland Stage 2, Case Study 3 – Practice 6 (Practice Nurse), Interview 49, Paragraph 289)

Nurses were quick to point out that personal pride and the sense of “doing a good job” were key personal motivators for performance, but that they also wanted to feel valued:

No, absolutely not, I don't think it's about money. For me personally it's pride in my job. I really want to do the best for the patient, but it still makes you think, you're working really really hard to get points for the GPs because they know that's the way it works, it wouldn't make me want to give better care, but it would make me feel more valued by my GPs. The work we're doing is part of their income and to be recognised like that. I feel that we should be equal to our peers.

(Scotland Stage 2, Case Study 3 – Practice 6 (Practice Nurse), Interview 51, Paragraph 129)

However, if practice nurses as a professional group were feeling demoralised, so too were GPs. Some national interviewees reminded us that part of the rationale for the new GMS contract and for the Quality and Outcomes Framework has been to ensure a “well paid, well motivated workforce with people wanting to go into general practice”. While, for some, this had been achieved, there had been an unintended consequence – a hostile response to reports, particularly in the media, that GPs were now earning far more than before. This led many of the doctors interviewed, no matter whether they held national, PCO-managerial or practice roles, to comment on the impact it was having on the morale of the profession, with GPs portrayed as a problem that needed to be “controlled”. This was true in both countries and also had a knock-on effect on the morale of practice nurses.

..... it worries me the attitude stuff that comes not from the visitors [during a QOF visit] but from the Boards that you know all GPs are cheats sometimes you feel there's this assumption that you're guilty before and you've got to prove yourself and that's quite uncomfortable as a professional, to be treated in that way.

(Scotland Stage 1, National, Interview 27, Paragraph 27)

I think it is very strange because the performance related contract was introduced in order to improve patient care. And that is what it has done. And yet we are suddenly getting an awful lot of flack and an awful lot of negative publicity for actually achieving targets. So it is a disincentive

(England Stage 2, Case Study 1 – Practice 1 (GP), Interview 41, Paragraph 235)

The other thing that affects the practice nurses is, of course, the bad press about the contract because they certainly don't want to be labelled as that they are only ticking boxes or whatever and so they do talk about that at meetings - did you see the report, did you see that press, did you see that - because most practice nurses would say they are doing more than they have been asked for and they are certainly doing more than ticking boxes.

(Scotland Stage 1, Case Study 4 – PCO (Health Board), Interview 3, Paragraph 95).

This sense of demoralisation, coupled with the view that the QOF targets would become tougher in time in time, led one individual to reflect:

I think it [QOF] may have shaped what we're doing at the moment. I think we're becoming a bit more sceptical about it and we're looking at it a lot harder as to what is achievable and what's not. So, therefore, sometimes we're looking on it as is the effort worth what they're going to give us for it?

(Scotland Stage 2, Case Study 3 – Practice 6 (GP), Interview 46, Paragraph 120)

8.3.2 Impact of monitoring on performance and motivation

Practices and professionals, not surprisingly, varied in their response to the enhanced monitoring that had come with the new contract. A PCO manager commented

As varied as the individuals themselves is the way I would describe that. I think there are some GP's who are absolutely invigorated by it, there are some GP's who feel affronted by it and I would say the same thing goes for managers ... and nurses.

(England Stage 1, Case Study 1 – PCT, Interview 1, Paragraph 175)

Performance monitoring relied on good IT systems and data entry, generally at the time of the consultation. This increased data recording was welcomed at PCO level for bringing transparency into the system.

Well it does move practices in the right direction of doing the right thing and recording that they've done it, so from that point of view, at least now there is something that you can look at in the practice that gives you some idea of quality and the coverage of those services for patients which previously under items of service was really quite difficult to do.

(England Stage 1, Case Study 1 – PCT, Interview 20, Paragraph 235)

..... the level of information that's available now is much better. The levers that you have to work with practices are I think much more transparent in terms of the core elements and the enhanced services in the QOF I think it's much more transparent what you are getting for the money so the information is better the relationship with practices is more transparent because of that.

(Scotland Stage 1, Case Study 4 – PCO (CHP), Interview 15, Paragraph 192)

There were positive benefits for practices too - the use of electronic reminders, for example, easily identified patients who required their blood pressure measured or flu vaccination.

I feel very positive about it because I think it's really challenged us I mean it's made us audit it means you're doing a constant audit of what you're doing so if you look at what you're doing intelligently and honestly then with a view to try and improve it then it will improve and it has done hugely so I feel very positive about the QOF.

(England Stage 2, Case Study 1 – Practice 2 (GP), Interview 55, Paragraph 104)

These benefits extended across the practice team, with administrative staff also able to monitor patient attendance for clinical reviews. However, this meant that practitioners were using their computer more during the consultation. Many interviewees, at PCO and practice-level, talked about the impact this had on the patient consultation arguing that, while care may be more systematised for certain conditions, the consultation was now more task-driven and less patient-centred.

.... people are feeding a computer to prove that they are undertaking on a providing a quality service and losing sight of the patient who is sitting in front of them.

(England Stage 1, Case Study 1 – PCT, Interview 2, Paragraph 49)

I feel personally that I have to go through the template and fill things in as we're going along. There's no way you could go back and fill that in so you can't possibly give the patient your full attention really.

(Scotland Stage 2, Case Study 3 – Practice 7 (Practice Nurse), Interview 40, Paragraph 45)

The role of monitoring in relation to practices' care of incentivised versus unincentivised conditions was discussed. One respondent suggested that it was not clinical care *per se* that improved for the incentivised conditions, but data recording. This individual felt that GPs would not change their consultation style on the basis of whether a condition was in QOF or not:

I would just find it very difficult to imagine that a GP would look at a patient who has got a number of problems and treat them differently for different conditions depending on whether it's in the QOF or not

(England Stage 1, National, Interview 36, Paragraph 55)

As reported in Chapter 7, PCO monitoring of practice performance was increasing. This was more developed in England than in Scotland, with the use of balanced scorecards in Case Study 1 PCT and quality practice profiles in Case Study 2 PCT. In each case, reporting included QOF but also other activity such as referrals and prescribing to develop local benchmarks. This sharing of information back to the practices, allowing them to see where they lay in relation to other practices in the PCT, was felt by both PCTs to be a powerful motivator to performance.

..... it [QOF] is the measure that is used to look at your practice and say are you good, bad or indifferent and we all want to be in the very good league.

(England Stage 1, Case Study 2 – PCT, Interview 11, Paragraph 123)

Interviewee: the GPs are very keen on ... not exactly naming and shaming, but if they produce a graph, for instance, to say, I don't know, admissions to CHD, the practices will be named, so that they can see where they are and the first thing they do is ooh, where am I

Interviewer: So, sort of the peer competition drives them.

Interviewee: Absolutely, a very, very strong driver in this area.

(England Stage 1, Case Study 2 – PCT, Interview 22, Paragraphs 316-320)

However, this desire to be seen as high performing and competitive led practices, at times, to focus more on QOF areas rather than the non-QOF

“Cinderella areas”. As discussed in Chapter 7.3.3, practices in Case Study 1 expressed disquiet when measured against areas that they felt lay out with their control, for example emergency medical admissions.

Being at the bottom was supposed to act as a “disincentive”, although one GP this, suggesting it could be de-motivating for poorer performing practices.

Now, they may say well actually we’re only looking for extremes of patterns and it’s an opportunity for education or what have you, but if you’re coming bottom of the pile every time, then that must be pretty damaging.

(England Stage 2, Case Study 1 – Practice 1 (GP), Interview 39, Paragraph 99)

However, it was clear that having comparative data on performance had changed practices behaviour and motivated them to focus time and energy on areas where performance was poorer.

..... when I think about work in [names own practice] for example, we have put a focus on for example diabetes in a way that we wouldn’t have done if we hadn’t had the comparative figures. Our diabetic figures are appalling compared to other practices and we are, in a sense, trying to understand that and there are actually quite good reasons why that’s the case but there are also, probably, some issues about quality of care that we are providing to our patients and its making us think about that and try and address that. But on the other side of the coin is that there would be lots of conditions which you could actually [look at]. You have only got so much time and energy so that care will lose the focus and probably not be quite as good as it was. So I suspect that incentivising with targets has improved some areas but as a result of it, [there is a] detrimental fall in other areas.

(England Stage 1, Case Study 1 – PCT, Interview 4, Paragraph 215)

The pressure of monitoring practice performance often fell disproportionately on one or two individuals within the practice. As reported in Chapter 7, most practices had a lead GP with overall responsibility for the QOF. Overall responsibility for monitoring tended to fall on that individual. Although practice managers had a key role in motivating staff, particularly non-clinical staff, it was the GPs who oversaw the clinical monitoring.

I do feel Dr [name] at times is very pressurised because it’s him that we go to with the figures if, you know, they’re not happy with them, it’s him that checks all the figures

(England Stage 2, Case Study 1 – Practice 1 (Practice Manager), Interview 38, Paragraph 539)

.... this January gone, not this one, January gone, I literally wanted to throw everything in and just walk away, because there’s so much to do and it was my own fault, I hadn’t kept up with it, as much as I normally would have done. ... there was so much to do and I was running around again, like a headless chicken and again, because there was no protected time, I was doing it in lunchtimes, evenings. I can login from home and so I was doing all of that. I said to everybody, I’m not doing it again, somebody else can do it. But nobody volunteered and I still ended up doing it.

(England Stage 2, Case Study 1 – Practice 3 (GP), Interview 47, Paragraph 352)

The increased monitoring and administrative workload appeared to be taking its toll on practitioner’s motivation and enjoyment of their work – particularly in England:

I can see GPs getting weary. So I can see they're weary. At meetings, I can see people looking forward to retirement because of all this taking away from the focus of caring for the patient.

(England Stage 2, Case Study 1 – Practice 2 (Nurse), Interview 45, Paragraph 267)

I do think it's strange that someone my age [mid-40s] is sort of thinking well actually if I get to 55, if I'd had enough I could retire. And I think that's probably a symptom of what's going on.

(England Stage 2, Case Study 1 – Practice 1 (GP), Interview 39, Paragraph 395)

It also affected their view of the consultation. For example, a GP's view of the impact that constant monitoring had on his perceptions of a successful consultation were expressed as follows:

Even though you've done super consultation, the person has gone out saying thank you so much, you've helped so much, I feel much better, and then you know full well that you'll go to a meeting two weeks later where, why didn't you do a medication review? It would have only taken 30 seconds. And it's like aghhhh. So I certainly think it will contribute to some people leaving. It feels very onerous now; it feels like everything is gone through with a fine tooth comb and that you're never good enough.

(England Stage 2, Case Study 1 – Practice 2 (GP), Interview 46, Paragraph 263)

This impact on personal motivation to achieve the QOF targets extended to other staff, as well as the GPs.

Targets, targets, targets. And you feel - I feel like I've let everybody down if I don't reach the targets, does that make sense?

(England Stage 2, Case Study 1 – Practice 3 (IT Manager), Interview 49, Paragraph 57)

..... morale is low, staff morale, not just nurses but receptionists, GPs, morale is low all over.

(Scotland Stage 2, Case Study 3 – Practice 6 (Practice Nurse), Interview 49, Paragraph 293)

The overall feeling was that of a lack of time and energy to deal with conditions that were not, in some way, performance monitored. While most of the discussions focussed on QOF, it was recognised that other areas also gained importance if, for example, they were a PBC target:

.... if it's not in QOF, it's not in the PBC, then you're going to have to be highly dedicated to spend extra time when things are that busy anyway, to then bring up another issue. And it would be very hard to get other people following through with you.

(England Stage 2, Case Study 1 – Practice 1 (GP), Interview 40, Paragraph 187)

Indeed, particularly in England, the plethora of performance monitoring systems was taking its toll.

You've got QOF targets, you've got your LES targets, your DES targets, you've got your practice based commissioning incentive scheme and you've got your medicines management incentive scheme. I have to shift a pile of papers like that every week, just about how we're managing compared to how we were six months ago and various figures, and you've got to constantly be looking...

(England Stage 2, Case Study 1 – Practice 1 (GP), Interview 39, Paragraph 87)

Thus, performance monitoring of the QOF impacted on both an individual's intrinsic motivation and on the practice's motivation to perform well in relation to their colleagues. Monitoring of enhanced service performance had a similar impact on individual's motivation, particularly when the data collection was considered to be onerous, as in Case Study 3. Some practices were re-considering their involvement in the enhanced services.

And if the remuneration decreased because the thresholds are set too high, then you lose motivation. However hard you try you don't seem to be able to hit the target, and you can't understand why you're not hitting it, and people just shout at you, and say you're not doing it properly, but we'll see at the end of the year, we'll make a decision then.

(Scotland Stage 2, Case Study 3 – Practice 5 (GP), Interview 52, Paragraph 101)

In England, another powerful motivator existed to ensure that the enhanced and out-of-hours services strove to perform – namely de-commissioning. The drug misuse enhanced service in Case Study 1 realised that this was now a market place – if targets were not met, the PCT might not commission them to provide the service in the future. This drove their need to performance manage their staff.

.... we're in a very competitive market and we're constantly reminding the staff about the importance of our outcomes and the fact that we're in a very competitive market..... [Break] the reason we need to get these targets up is that we're now in a competitive commissioning market where we may not be re-commissioned.

(England Stage 2, Case Study 1 – Other, Interview 59, Paragraphs 147 & 153)

8.3.3 Consultation rates for incentivised and unincentivised conditions from 2003 to 2009 in a sample of Scottish practices

Overall, in 2008-2009, QOF incentivised care accounted for about one-fifth of the overall workload for GPs and practice nurses: 20.9% for QOF clinical domains versus 79.1% for non-QOF conditions. This was an increase from 2005-07, when QOF-related work comprised 13.0% of GPs and practice nurses workload.

Table 9 shows that for the first year of the contract (2004-05) consultation rates for all incentivised conditions increased. The largest increases were for asthma (22%) and epilepsy (40%). Only the stroke consultation rate fell, by 20%. In contrast, consultation rates for all of the non-incentivised conditions fell. This was greatest for dementia (-14%), depression (-12%) and osteoarthritis (-11%).

In the following years, there was no discernable pattern. An increase in one year was often followed by a fall the following year (e.g. diabetes: 10% fall in 2007-08, followed by 6% increase in 2008-09).

Dementia and depression were both incentivised in Year 3 of the QOF (2006-07). Consultation rates increased for dementia year-on-year following its incentivisation, but continued to decrease for depression.

Table 9. Consultation rates for incentivised and non-incentivised conditions between 2003-04 and 2008-09 for a sample of Scottish practices (Consultations per 1000 patients registered per year (95% Confidence Interval))

Condition	Pre-QOF (2003-04)	Year 1 (2004-05)	% Diff from Pre-QOF	Year 2 (2005-06)	% Diff from Year 1	Year 3 (2006-07)	% Diff from Year 2	Year 4 (2007-08)	% Diff from Year 3	Year 5 (2008-09)	% Diff from Year 4
Incentivised from Year 1 (2004-05).											
Angina*	16.4 (13.1-19.8)	16.7 (13.5-20.0)	1.8	13.6 (10.3-17.0)	-18.6	10.9 (8.2-13.7)	-19.9	10.2 (7.4-13.1)	-6.4	10.0 (7.6-12.5)	-2.0
Asthma	88.8 (79.2-98.4)	108.3 (98.3-118.4)	22.0	103.6 (92.4-114.8)	-4.3	101.6 (89.6-113.6)	-1.9	88.6 (78.0-99.3)	-12.8	87.6 (78.9-96.2)	-1.1
CHD*	68.9 (60.6-77.2)	76.1 (67.4-84.9)	10.5	71.9 (62.2-81.6)	-5.5	69.4 (61.5-77.3)	-3.5	58.4 (51.2-65.6)	-15.9	58.8 (53.8-63.8)	0.7
COPD	37.3 (32.3-43.1)	38.7 (33.0-44.3)	2.7	38.7 (32.3-45.1)	0	37.7 (32.3-43.0)	-2.6	37.4 (32.6-42.3)	-0.8	39.2 (35.0-43.4)	4.8
Diabetes	107.3 (94.1-120.6)	122.9 (108.7-137.1)	14.5	130.6 (116.0-145.2)	6.3	128.1 (114.7-141.4)	-1.9	115.4 (105.2-125.6)	-9.9	122.1 (109.0-135.2)	5.8
Epilepsy	8.7 (7.5-9.9)	12.2 (10.4-14.0)	40.2	9.8 (8.0-11.6)	-19.7	10.9 (7.9-13.9)	11.2	9.5 (8.1-10.9)	-12.8	10.0 (8.7-11.2)	5.3
Hypertension	219.8 (198.2-241.5)	233.3 (209.8-256.7)	6.1	222.4 (196.4-248.3)	-4.7	222.0 (197.5-246.6)	-0.2	200.1 (177.1-223.0)	-9.9	214.2 (193.6-234.7)	7.1
Hypothyroidism	22.2 (18.4-25.9)	24.3 (17.5-31.1)	9.5	21.3 (16.1-26.6)	-12.4	22.1 (17.7-26.5)	3.8	18.8 (15.4-22.1)	-14.9	23.0 (19.8-26.2)	22.3

Stroke & TIAs	18.3 (10.6- 25.9)	14.7 (12.4- 16.9)	-19.7	14.9 (12.8- 17.0)	1.4	15.0 (11.8- 18.3)	0.7	13.2 (10.0- 16.4)	-12.0	13.5 (10.5- 16.6)	2.3
Incentivised from Year 3 (2006-2007).											
Dementia	5.9 (4.8-7.1)	5.1 (3.9-6.3)	-13.6	5.1 (2.9-7.3)	0	5.3 (4.0-6.7)	3.9	5.5 (4.3-6.7)	3.8	6.5 (5.2-7.8)	18.2
Depression	158.4 (144.3- 172.4)	140.1 (124.7- 155.5)	-11.6	125.6 (110.7- 140.5)	-10.4	94.8 (82.0- 107.6)	-24.5	74.4 (60.5- 88.3)	-21.5	69.3 (56.9- 81.7)	-6.9
Non-incentivised.											
Anxiety	102.1 (92.2- 112.0)	100.1 (88.7- 111.5)	-2.0	93.0 (76.4- 109.6)	-7.1	91.3 (75.4- 107.3)	-1.8	88.3 (71.9- 104.6)	-3.3	85.4 (71.0- 99.7)	-3.3
Back pain	112.7 (105.0- 120.5)	107.9 (101.0- 114.8)	-4.3	103.9 (97.1- 110.7)	-3.7	102.6 (96.3- 108.8)	-1.3	99.2 (91.9- 106.5)	-3.3	107.9 (101.2- 114.7)	8.8
Osteoarthritis	35.5 (30.7- 40.3)	31.6 (27.8- 35.4)	-11.0	26.6 (22.9- 30.2)	-15.8	24.2 (20.8- 27.5)	-9.0	22.1 (18.6- 25.6)	-8.7	22.7 (19.9- 25.6)	2.7

Rates standardised by deprivation.

The reported prevalence rates in PTI were also examined for incentivised and non-incentivised conditions (Table 10). For this, data are only reported for the first two years of QOF.

Table 10. Prevalence rates for incentivised and non-incentivised conditions between 2003-04 and 2005-06 for a sample of Scottish practices

	Pre-QOF	Year 1	%Diff from Pre-QOF	Year 2	%Diff from Year 1
Incentivised from Year 1 (2004-05).					
Angina	10.5	11.3	7.6	9.2	-18.6
Asthma	44.1	52.8	19.7	53.2	0.8
CHD	32.9	36.6	11.2	35.4	-3.3
COPD	18.9	19.9	5.3	18.9	-5.0
Diabetes	29.1	33	13.4	34.8	5.5
Epilepsy	4.3	6.1	41.9	5.4	-11.5
Hypertension	81.7	93	13.8	93.9	1.0
Thyroid	12.4	15.2	22.6	14.1	-7.2
Stroke	7.9	9.9	25.3	9.9	0.0
Non-incentivised					
Anxiety	57.1	54.3	-4.9	50.8	-6.4
Back Pain	63.9	64.1	0.3	63.7	-0.6
Dementia	1.1	1	-9.1	0.8	-20.0
Depression	60.8	54.3	-10.7	49.1	-9.6
Osteoarthritis	22.4	20.1	-10.3	17.4	-13.4

Pre-QOF: 2003-2004; Year 1: 2004-2005; Year 2: 2005-2006

Prevalence rate is the number of patients with at least one contact for the specified condition per 1000 population during the specified year.

Based on 44 PTI practices that submitted complete PTI data.

Rates are standardised by deprivation.

Table 10 shows that that during the first year of the contract (2004-05) prevalence rates increased for all incentivised conditions compared to the previous year. The biggest increases were found for epilepsy (42%) and stroke (25%) with the smallest for COPD (5%). For unincentivised conditions, only back pain prevalence increased, albeit slightly, with the others showing falls ranging from 11% for depression to 4% for anxiety. For the second year of the contract (2005/06) falls in prevalence rates amongst the incentivised conditions were found for angina, CHD, COPD, epilepsy and hypothyroidism and all the unincentivised conditions. Of the incentivised conditions diabetes showed the largest increase in prevalence (6%) and angina and epilepsy the biggest falls (19% and

12%). The biggest fall for the unincentivised conditions was found for dementia (20%).

8.3.4 Exception reporting and gaming

Overall, there was no suggestion that exception reporting was a major, systematic problem. Even where PCTs had been “heavy on the monitoring”, only a few small anomalies were detected. Most PCO managers felt that there was little “gamesmanship” in their area. Difficulties were attributed in the first year to lack of understanding of the guidance on exception reporting and on poor administration.

To a certain extent it was a damp squib [Break] We didn't find any cases of fraud, we did find a lot of cases of poor admin practice at the practice level which was usually linked in to a misunderstanding of what the contract was requiring.

(England Stage 1, National, Interview 15, Paragraphs 175 & 359)

..... it is an area that GPs and nurses are a little hazy on about when it is appropriate to exception code and when it is not appropriate. GPs and nurses are busy people so putting a detailed explanation on a website although useful, there will always be a considerable percentage of clinicians who simply never look at the website so there is a big range in understanding within the practices and between.

(Scotland Stage 1, Case Study 3 – PCO (Health Board), Interview 12, Paragraph 83)

Nationally, there was a view that exception reporting was being used to ensure that patients received personalised care and that some variation across practices was to be expected, as it depended on the demographics of the practice population.

... the evidence is that it hasn't damaged patients one iota and it's enabled us to tailor patient care to individual patient wants and their clinical needs. There is no point insisting that someone has to have a drug that makes them ill, purely so I get paid, if it makes them ill, don't give it to them and that is tailoring care personally.

(England Stage 1, National, Interview 26, Paragraph 54)

We always knew they'll be a fair bit of variability but I don't think the evidence is there isn't a huge variability in exception reporting by and large you know from the mean.

(England Stage 1, National, Interview 27, Paragraph 175)

Some practices, however, chose not to use exception reporting, unless for exceptional reasons such as disabled patients.

So all I do is sometimes I'll just see such a person who hasn't had that done, is there a reason, because [name of GP]'s very loath for us to exemption code anyone. We only exemption code people in extreme circumstances, so whereas a lot of practices have tons of them, we don't do that unless there's a real reason.

(England Stage 2, Case Study 1 – Practice (Administrative Staff), Interview 67, Paragraph 31)

Given the time at which the interviews were conducted, it may be that PCOs were only just starting to monitor exception reporting more closely. One PCO manager suggested that:

There are two camps in exception reporting. Those who exception report everybody who fulfils the criteria for exception reporting and then there is the other camp who say we won't exception report unless it looks like it's going to affect our achievement of the

target.... [Break] So they have a sort of everybody is included unless it looks like we are only going to achieve 89% then we need to look at do we need to exception report some people?

(England Stage 1, Case Study 2 - PCT, Interview 11, Paragraphs 103 & 107)

However, it was acknowledged that such practices were the minority. Indeed, this manager ascribed variations in exception reporting not to gaming, but to different approaches to care. For example, some practices exception reported as soon as the patient failed to respond to a third letter or telephone call inviting them to attend the practice; others waited until the end of the QOF year, to give the patient every chance of responding. Indeed, another interviewee suggested that exception reporting shouldn't happen until the end of the QOF year, in order to ensure that GPs did not "give up" on patients.

I think it's been an apparent difference in rates of exception reporting but we've looked into it and it's not a gaming thing, it's a different approach to it.

(England Stage 1, Case Study 2 - PCT, Interview 11, Paragraph 131)

In terms of monitoring, PCO respondents felt that practices who were exception reporting at a higher rate than the local average were the ones to review – but that such practices were generally known to the PCO anyway. Outliers, whether above or below the average were generally targeted to receive a QOF review visit, even when the PCOs were trying to reduce the number of annual visits (as discussed in Chapter 7). During these visits issues such as the demographics of the practice population and when exception reporting occurred would be reviewed.

Another interviewee, who had been involved extensively in QOF review visits, pointed out that even with "heavy monitoring", verifying the data on the computer was next to impossible.

... what you are going to find is a computer with loads of readings in it because that is what the computer measures. There isn't a way of telling whether those readings are accurate, so light or heavy touch will not help you to do that so going and being difficult about it makes no difference.

(England Stage 1, National, Interview 37, Paragraph 39)

Overall, there was a clear view that heavy handed monitoring and bureaucracy was not worth the small amount of gain that might be made.

There is always going to be a spectrum - some GP's will push it to the very limit. Others will play fair, others won't even bother looking and won't get paid for what they should be getting paid for. That's just the spectrum of all the people isn't it? Some people tick off their Visa slips every day and other people just chuck them in the bin and assume that this is right so it's the same, I just don't think it's worth going that way for the game I mean there are lots of other things to talk about yeah.

(England Stage 1, Case Study 2 – PCT, Interview 7, Paragraph 260)

While gaming in relation to exception reporting was not perceived as an issue, some PCT interviewees suggested that there were more subtle forms of gaming. For example when GPs focussed on QOF-related issues during the consultation, regardless of what the patient's agenda was or

when processes were conducted without any longer term evidence of clinical outcomes being addressed.

.... sometimes QOF can just be [pause] you record a BP but do you do anything about it? Now that does concern me, you know, you've got your data yes I've taken that blood pressure. What have you actually done to change that blood pressure, where's your management plan to support [the patient]?

(England Stage 1, Case Study 1 – PCT, Interview 18, Paragraph 148)

8.4 Discussion

In this chapter, we report on the views of respondents on the impact of incentives and monitoring on motivation and performance, as well as their views on the possible relationship between exception reporting and gaming.

The findings presented in this chapter confirm that the QOF was motivating performance at the individual level, particularly within practices. Performing well in the QOF was a source of personal, intrinsic motivation, not only for GPs but also for practice nurses. We confirmed and developed some of the findings of other studies, namely that, within practices, some individuals were taking on the role of monitors and “chasers” of others within the practice, to ensure that QOF targets were achieved (97;98;101). This role was generally taken on by the lead GP for QOF, but there was also an important role for the practice manager in incentivising not only the non-clinical administrative staff, but also the clinical staff within practices.

Within practices, much of the responsibility for meeting QOF targets had fallen to practice nurses who as a group appeared to welcome the responsibility. However, as previously reported (96), there was also a high level demotivation amongst practice nurses, who felt that their contribution was not being well recognised, either financially or professionally.

Organisational motivation to perform well was also strong, with practices wanting to do well in relation to their peers. However, it was acknowledged that target-based approaches might de-motivate practices who failed to perform as well. In England, another powerful organisational motivator was the threat of de-commissioning of services, particularly for the enhanced services and for the out-of-hours service.

While personal and practice motivation to perform well was strong, the motivation of general practitioners and practice nurses, as professional groups, was clearly being affected by the on-going negative publicity about GP salaries since the implementation of the new contract. GPs in particular felt that they were under constant attack and found it difficult to understand why this was the case when they had done what had been asked of them by Government, namely respond to targets set by the Government in order to improve patient care. This was true in both England and Scotland.

There was a continued tension between providing care for incentivised versus unincentivised conditions. While there was no evidence to suggest that practices were deliberately ignoring or neglecting unincentivised areas, there was a recognition that the time and effort required of practices to meet the incentivised targets contained in QOF, the enhanced services and within PBC in England left little room to continue to develop care in unincentivised areas. Data from Scotland suggested that consultation rates had decreased for some unincentivised areas; however, decreases were seen in consultation rates for incentivised conditions too, after the increases associated with the first year of QOF.

Finally, no one interviewed, in either country, felt that there was evidence of systematic gaming. Difficulties in interpreting the guidance on exception reporting and poor administration were viewed as explanations for any variation in exception reporting. Indeed, some were of the opinion that exception reporting allowed practitioners to provide more personalised care for certain patients.

Overall, it was clear that the incentives and targets, which are now an integral part of the GMS contract, do affect the way that practices and related services organise themselves and respond to the performance monitoring that is part of the contract. The impact of this re-organisation of service activity on staff skill-mix and boundaries is the subject of Chapter 9.

8.5 Conclusions

- QOF was incentivising practice performance, both at the level of the organisation and the professional within the practice. This was observed in both countries.
- Within practices, the practice manager was assuming a greater role in motivating staff, particularly non-clinical administrative staff.
- Practice nurses remain concerned about the degree to which their contribution to QOF achievement was recognised professionally or rewarded financially.
- The continued negative media representation of GPs since the implementation of the new contract was de-motivating them professionally. This also appeared to be impacting on practice nurses.
- In England, another powerful motivator of performance was the threat of service de-commissioning – this was particularly true for the drug misuse enhanced service and for the out-of-hours service.
- Evidence of poorer care for non-incentivised conditions was equivocal. While there was no evidence of such conditions being actively neglected, the time spent on other incentivised areas left

professionals and practices with little organisational slack to address these conditions fully.

- No one, in either country, felt that there were any systematic attempts at gaming.

9 The impact of the GMS contract on skill mix

9.1 Introduction

The influence of general practitioner contracts on the type of staff, deployment and numbers of employed within general practice has been recognised for many years (131;136). Reimbursements in the 1990 contract for staff and the increased emphasis on chronic disease management led to a sharp increase in the number of practice nurses employed in the UK (137). The role of practice managers has also grown and developed (138). Changes to the provision of out-of-hours care has resulted in the development of new roles for nurses and for paramedics – indeed this has been the focus of a recent SDO funded study (SDO Reference 08/1519/97). With the GMS contract now held with the practice and the opportunity for other service providers to hold a GMS contract, there are clear opportunities for the skill mix within the primary care workforce to be developed and for existing roles to be redefined.

As discussed in Chapter 1.3.2, skill mix has been defined both as the mix or combination of staff required in the workforce (139-141) or as a more dynamic entity, concerned with the way in which those staff interact with each other. Thus, skill mix might lead to role enhancement; role substitution, within or across professional boundaries; specialisation; delegation; or innovation (32;33).

In developing or expanding these roles, the professionals within the existing structures need to re-assess and re-negotiate their roles with others. This re-negotiation of roles is carried out actively, within a system of work – according to Abbot “jurisdiction has to be claimed and sustained within the work arena” (37). However, to date, there has been little attention paid to the development of skill mix in primary care since the new contract. Charles-Jones et al argued, prior to the 2004 contract, that medical work was being redefined into “hierarchies of appropriateness”, with the most complex work reserved for the highly skilled professionals, doctors, while the least complex work (tasks such as taking blood) was delegated to the least qualified practitioners, including health care assistants (142).

These arguments are predicated on several assumptions, including the need to change skill mix as the workforce ages and the need to manage the rise in chronic disease (143). With so much of the QOF focussed on chronic disease management, it is timely to explore how the contract may be driving these developments. How these changes are viewed or affect the relationship with the PCO is, as yet, unknown. The way in which roles and professional boundaries are being re-negotiated within the parameters of the new contract has also been largely unexplored. For example, how is the work of meeting QOF targets being distributed

across practice staff; if nurses are taking in more tasks within the QOF, what are they giving up; and who is taking on the lower order tasks? These issues are explored in this chapter. As well as reporting on qualitative findings, we draw on data available from the Practice team Information dataset in Scotland to explore potential changes in face-to-face consultations conducted by GPs and practice nurses over the first two years of the contract.

9.2 Methods

The methods pertaining to the qualitative results reported here have been previously described in Chapters 5 and 6. A fuller description of the PTI data from Scotland is given in Chapter 8. In this Chapter, we report on workload splits between GPs and practice nurses reported from 59, 53, 51, 49, 48 and 58 practices for the years ending 31 March 2004, 2005, 2006, 2007, 2008 and 2009 respectively. Data on workload splits between GPs and practice nurses across incentivised and non-incentivised conditions were also obtained directly from ISD. For these, data were obtained from the 34 practices who returned data to ISD for the whole period between 1 April 2003 and 31 March 2006.

9.3 Results

The GMS contract was recognised, in both countries, as having an explicit focus on teams and to offer real opportunities to extend and develop the skill mix within practices.

..... the fact that practices' income is a practice income now, not an individual GP income, promotes that [team based approach] as well so I think you know by and large it's had a positive impact on the way that professionals work together in primary care.

(England Stage 1, National, Interview 33, Paragraph 121)

..... another positive side to the contract is that it has given practices the ability to introduce skill mix within the practice and that has to be a positive thing, so that you know people are working as a team

(Scotland Stage 1, Case Study 4 – PCO (Health Board), Interview 3, Paragraph 95)

However, one interviewee alluded to a tension in this arrangement – although the contract is now held with a practice, the contract negotiation remained with GPs.

You have got a contract for services not with an individual contractor and that is one of the difficulties with it, that we have only got GPs to negotiate with at the moment and that actually, it's a practice based contract so that's where a tension arises that and I don't think there is a solution to that at the moment.

(Scotland Stage 1, National, Interview 17, Paragraph 55)

For most, the key to successful QOF achievement lay in being large enough to cope organisationally with the contract by dividing up the required tasks amongst all practice staff, including GPs. This, inevitably, meant the expansion of the workforce within practices to deal with the QOF.

In terms of general practice, the more successful general practices tend to be, but not exclusively [pause], bigger groups where the GPs can split up I'll take a lead on this aspect and so on, rather than the whole thing. They tend to have invested in staff and in particular in their practice manager and nursing staff.

(England Stage 1, National, Interview 15, Paragraph 511)

We are starting to see, certainly in the innovative practices you know changes in skill mix both in terms of allowing flexible working for [GP] partners but often, you know, sessional doctors and certainly advanced skills for nurses and others and AHPs [allied health professionals] and certainly I think that we have encouraged the development of a new cohort of information and administrative assistants, who are critical to call recall systems and the ability to follow things through.

(Scotland Stage 1, Case Study 4 – PCO (Health Board), Interview 9, Paragraph 17)

Chapters 7 and 8 described how, in most of the practices studied, GPs, nurses and administrative staff worked together, often with small teams, taking responsibility for a QOF clinical domain. PCO-level interviewees were aware of this, both from a management perspective, but also through first-hand experience in practice themselves.

Yes because we are all working together there's definitely, like when I first came the GPs were there, the nurses were here, the receptionists were there. Now that's totally gone we are all literally working together.

(England Stage 1, Case Study 2 - PCT, Interview 34, Paragraph 144)

Two groups of staff clearly played a major role within practices in relation to the contract, and QOF in particular: practice nurses and the administrative staff, especially practice managers. The contract was breaking down old hierarchies within practices and giving each of these groups new and powerful responsibilities.

I would say so, yes its [team working] improved considerably, the other thing for us is within practice nursing especially, is the hierarchy has been taken away in regards to GPs, nurses and it's a much nicer environment to work with.

(England Stage 1, Case Study 2 - PCT, Interview 34, Paragraph 72)

9.3.1 Practice nurses

The implementation of the QOF within practices had enhanced the role and standing of practice nurses making them, in the words of one PCT interviewee, "more of an equal player in teams". They were now viewed by PCOs as the principal professional group involved in chronic disease management in many practices.

I mean I think their role [practice nurses] has significantly increased and in a lot of practices, though less so in this practice, they actually take the primary lead role in terms of delivering a lot of the chronic disease stuff and in fact the GPs sometimes have very little to do with that.

(England Stage 1, Case Study 1 - PCT, Interview 4, Paragraph 239)

The importance of practice nurses was recognised across all of the PCO case study sites. For example, in Case Study 1, the PCT was planning to employ a cohort of practice nurses to support small and single-handed practices who could not afford to employ full-time practice nurses

themselves. In Scotland, both Health Board case study sites had employed a practice nurse advisor – a senior nurse with responsibility for the strategic and operational development of practice nursing, as well as providing professional support to the practice nurses themselves.

Within practices, nurses were being delegated more and more QOF related work – one nurse estimated that 90% of her workload was QOF-related. One reason given for this was that nurses work to protocols and prompts better than doctors:

So, really, unless we're asked about it, the doctors leave us to it.

(England Stage 2, Case Study 1 – Practice 1 (Practice Nurse), Interview 43, Paragraph 127)

.... the nurses do take the chronic disease management on board as well and I mean they do help to improve target figures and they are more likely to take a notice of what the message on the patients' alert screen than the doctor will.

(England Stage 2, Case Study 1 – Practice 1 (Practice Manager), Interview 38, Paragraph 547)

Most nurses also felt their role had evolved and developed. For some, the role itself had not changed much since the new contract because they had previously been involved in chronic disease management, but for many it had expanded into new areas, for example COPD, which was now a QOF clinical domain. For others, the type of work they undertook had clearly changed – for example, some no longer needed to go and see patients in their home, which they had done prior to the new contract. This work had been delegated to the community-based nurses.

Yes, the role has changed, because you're doing more clinics and things, which you didn't tend to do before, and you have I suppose a greater responsibility than maybe you did years ago. You don't tend to be as much of a handmaiden to doctors, which is what you were

(England Stage 2, Case Study 1 – Practice 4 (Practice Nurse), Interview 64, Paragraph 183)

... rather than us going out and doing the housebound, say, asthmatics, diabetics, COPD patients, they're actually being taken over by the community matrons and also some of the ordinary run-of-the-mill things are taken over by the district nurses.

(England Stage 2, Case Study 1 – Practice 1 (Practice Nurse), Interview 43, Paragraph 51)

Practice nurses were seen as becoming increasingly specialised in some areas of care, in particular chronic disease management, and less skilled in other areas such as wound care. As a result these less specialised, technical tasks were being delegated to other members of staff, in particular health care assistants within the practice and district nurses in the community. This process was seen as good for patient care but did, however, lead to tensions especially with district nursing, as discussed in Section 9.3.3.

..... nurses in particular are providing a lot of the chronic disease care and that [means] health care assistants are providing a lot of things that nurses used to provide, you know technicians are much more involved in care than they used to be dealing with

spirometry or whatever investigative procedures. So I think at one level there's a much greater opportunity for skill mix using appropriate people

(England Stage 1, National, Interview 33, Paragraph 117)

It's gone into the community, which in some cases is not appropriate, because if district nurses are there to see to the housebound, there's an awful lot of patients who need wound care but are not housebound, so from that perspective it's not right, but often, because of the focus on chronic disease management, practice nurses don't have the skills to do wound management, but the district nurses do.

(England Stage 1, Case Study 2 – PCT, Interview 22, Paragraph 336)

This drive to move more routinised chronic disease care from GPs to nurses left GPs to focus on the more complex patients, either clinically (for example mental health or epilepsy) or patients with greater psychosocial needs. The GP was seen as key for these particular types of patients.

I think the aim and I'm sure this is the case across the patch is to try and move some of the straightforward chronic disease management into nurse-led clinics of course and for us to do the stuff which is a little bit more difficult.... More challenging, more complex you know, like concentrate on the difficult heart failures or something like that. Routine asthma checks and COPD monitoring and so on, diabetics checks, is mostly done by nurses.

(England Stage 1, Case Study 2 – Other, Interview 14, Paragraphs 724 & 728)

... we are left with a sort of ragbag of difficult stuff. You know, people with mental health issues, and social issues, and all the coughs and colds, as well, and undifferentiated anxiety. Sometimes you do wonder if you haven't given the best bits to the nurses, and every now and again you realise that you're hanging on to somebody with high blood pressure, and looking after them, just because it's nice to do something actually clinical

(Scotland Stage 2, Case Study 3 – Practice 5 (GP), Interview 52, Paragraph 285)

Not all of the changes to practice nursing were seen as a direct result of the contract. The shift of care from secondary to primary care meant that nurses were becoming increasingly skilled and autonomous as a result of the care they were now providing. However, the focus on the contract was driving the types of skills they needed to acquire and was leading to concerns within PCOs that other key areas of work were now less of a priority.

It's the sheer range we are so multi skilled now that you know like sometimes I look and I think my god there's not much difference between us and the GPs any more because we have become so skilled. There is because I am through and through a nurse but you know say five years ago, we weren't doing any of this and now suddenly we are prescribing meds for this, meds for that and to be able to prescribe those meds you have to be specialised in that field

(England Stage 1, Case Study 2 – PCT, Interview 34, Paragraph 205)

Lots of practice nurses worry about the core practice nurse activity because they are being tasked more with delivering all the chronic disease management and so that's important. Then again it's about saying well, sexual health for instance, is a big agenda it needs not to be dropping off you know, it needs to be kept up and practice nurses are people who deliver on that you know and they are the ones doing the cervical cytology and you know the teenage drop in clinics and that type of stuff so again that's important but if there is CHP or board development along something that isn't perhaps a priority in the contract that we are kind of saying well we can't let that all off how are we going to get that addressed.

(Scotland Stage 1, Case Study 4 – PCO (Health Board), Interview 3, Paragraph 71)

This reliance on practice nurses and the continued expansion of their remit was a growing concern. As outlined in Chapter 8, practice nurses at an individual level were often unhappy with their financial reward as a result of QOF achievement. This also translated into an organisational concern. PCO interviewees were concerned about the demands being made on practice nurses within practices.

No doubt about it practice nurses have borne a large element of the pressure and stress and I am concerned in a workforce way because the ratio of doctors, GPs to practice nurses has traditionally been 3 or 4 to 1 and I don't see that as sustainable in the real world, especially if the chronic disease management agenda expands. I don't see how we can cope with that and I think that it's only a question of time before that starts to move or cracks begin to show, if not already.

(Scotland Stage 1, Case Study 3 – PCO (CHP), Interview 2, Paragraph 221)

The downward delegation of less specialised tasks was raising the importance of another group of staff: the health care assistant. Their role was generally task-oriented, rather than concerned with the management of the patient's disease and freed up the practice nurses' time to carry out other activities, such as disease-specific clinics. As described in Section 9.3.2, health care assistants were often drawn from the ranks of the practice administrative staff.

A number of them [practices] now will tell you they have got a healthcare assistant, taking bloods, doing blood pressures, taking heights and weights and a lot of that has been the development of an existing member of staff like a receptionist who has been developed and who is now doing phlebotomy, doing other bits and pieces so I would say that's really progressed this year.

(Scotland Stage 1, Case Study 3 – PCO (CHP), Interview 8, Paragraph 86)

Health care assistants were viewed, however, as task oriented whereas practice nurses dealt with patients in a holistic fashion.

I think it's the communication with the patient and the fact that they [practice nurses] can probably, when that patient comes through the door yes they may be doing a diabetic clinic but they are holistically assessing that patient whereas if you are looking at somebody who is trained to be doing a task they are only looking at that task they have been asked to do and that's the joy and the benefit of practice nursing is you know they definitely are holistically consulting with the patients.

(Scotland Stage 1, Case Study 3 – PCO (CHP), Interview 2, Paragraph 221)

9.3.2 Practice managers and administrative staff

The other key professional group in delivering QOF were the administrative staff, in particular the practice managers. The practice manager often had the lead responsibility for all non-clinical areas of the QOF and for monitoring QOF achievement over the year. This role appeared to have been assumed by practice managers – some spoke of their practice having joint meetings with GPs, practice nurses and the practice manager to decide on how to configure themselves to best address the QOF.

We all work together, it's the GPs, myself and the practice manager here, we all work together and we involve all staff so it's a case of sitting down and looking at our weaknesses, looking at our strengths, seeing what is beneficial to patients and what isn't.

(England Stage 1, Case Study 2 - PCT, Interview 34, Paragraph 16)

The role of administrative staff had clearly also developed within practices since the contract. Often, this had led to an expansion of roles and responsibilities for existing members of staff. For example, some practices had trained a receptionist to take responsibility for QOF data entry. The increased monitoring and recalling of patients required by the QOF targets meant that having administrative staff who could deal with the IT requirements was a necessary resource. This was recognised across practices.

People's job roles have changed immensely within the practice, definitely..... we've got people summarising notes now, which we didn't used to do before. We have someone who's, that's her role. And we have a data in-putter and that's her role. She'll help out if we're sort of stuck. She'll go up stairs and everything that comes in from the hospital, their role is to scan it all and to put it all onto the computer. Then we have a summariser of all the notes that come in from the practices which are now summarised, which we didn't have before. They're new roles.

(England Stage 2, Case Study 1 – Practice 4 (Manager), Interview 67, Paragraph 493)

It was not only non-clinical administrative roles that receptionists had moved into – in some practices, they were moving into clinical roles as well. In several of the practices studied, a receptionist had been trained to carry out health care assistant tasks, such as taking blood pressure readings or taking blood. As reported in Section 9.3.1, this expansion in the role of the health care assistant saw them taking on a range of tasks previously carried out by practice nurses, in some cases even in the patient's home. As with the development of the practice nurse role, this role development was apparent in both England and Scotland.

Blood pressures, health care screening, take bloods, give flu jabs, give pneumonia jabs, and they visit patients in the house and do home visits for blood pressures, and they can do urine tests, and they also write the blood forms out. They assess to see where people are come in now, I used to do that but they; one in particular does that now.

(England Stage 2, Case Study 1 – Practice 2 (Practice Nurse), Interview 44, Paragraph 58)

..... the role that they [practice nurses] used to play is now played by a health care assistant, who does the, basically, just following the protocol, although she is very smart and she does use her initiative a lot.

(Scotland Stage 2, Case Study 3 – Practice 5 (GP), Interview 53, Paragraph 54)

9.3.3 Relationships with wider community-based teams

For PCO interviewees, the GMS contract had enhanced opportunities for other PCT or Health Board-employed staff, including community pharmacists, treatment room nurses, district nurses and, in England, community matrons.

In both countries, the new contract for pharmacists and also the external drive towards independent prescribers were seen as opportunities to develop new ways of working within primary care, reflecting the intentions of the policy drivers.

I mean pharmacy for instance they've got a, you know, they sort of work with GPs on medication reviews you know the whole sort of issue around generic prescribing all those sorts of things. I was only saying the other day that you know, we should be in our PCTMS practices. I'd like for us to employ pharmacists to carry out MURs [Medication Use Reviews] within PCTMS practices to take some pressure off primary care and hitting the...ticking the boxes for the pharmacists with their contracts as well.

(England Stage 1, Case Study 1 - PCT, Interview 16, Paragraph 607)

Within community pharmacy I think people are beginning to sit up and take notice Obviously if you are going to be implementing a new contract which will have chronic medication service what does that mean for community pharmacists and how are we going to manage all that?

(Scotland Stage 1, Case Study 4 – PCO (Health Board), Interview 13, Paragraph 45)

Greater tensions were found in the relationship between practices and community-based nursing teams. Community-based nursing staff, such as district nurses and health visitors, had generally been attached to practices, either to a single practice or split across several practices. However, within several of the case study sites, for example Case Study 1, district nursing had been reconfigured, moving from a practice-based service to larger teams serving a wider population. The contract had opened up opportunities for district nursing teams to feed into the QOF process, although it was recognised that this raised tensions. QOF was viewed by the PCT as a positive lever with which to secure practice agreement for this new configuration of the district nursing workforce.

I suppose to get cooperation and buy-in from the practices, because practices can be very focussed on just their population and their needs. [District nursing] covers whole neighbourhoods and whole cities and we have to be conscious of that, so it's how do you get the buy in from the practices to work with the Community Matrons, to work with the district nurses, to support them for those house bound patients. So that had to be linked into QOF, [it] was a really good way of getting that so I could say to them look if we're monitoring these patients in this particular way using your templates from general practice, giving you those templates back so you could put them on your systems, blood pressures, etc, the monitoring that the Community Matrons do will all feed in with your QOF requirements, so it was very much what can we do for you around QOF.

(England Stage 1, Case Study 1 - PCT, Interview 18, Paragraph 47)

Of course, it was not only the GPs who had to be convinced that this team-based approach would be beneficial. It was reported that some district nurses, not unlike some practice nurses, viewed QOF as a remuneration system solely for GPs. For both PCTs in England, the district nurses' role in completing QOF targets was about improved care of patients, particularly those who might find it difficult to attend practice, such as the housebound.

.... the [district] nurses themselves didn't like some of the changes either, there was also a lot of animosity from nurses saying that QOF was just money making, what they were doing for QOF was just putting money into GP's pockets. [Break] so there was also a lot of work with the district nurses that QOF was...is about quality and is about

management and is about best practice and its still trying to get that across to people is I think quite difficult.

(England Stage 1, Case Study 1 - PCT, Interview 18, Paragraphs 99 & 103)

... you know whatever service people get in practice they should be able to get in their own homes and therefore if there's areas with the new contract then there should also be, you know, the district nurses should be trained up to do the same in the patients homes.

(England Stage 1, Case Study 2 - PCT, Interview 22, Paragraph 31)

Meeting QOF targets, and the associated re-distribution of workload, was reported to have impacted on the relationship between practices and community-based nursing teams. For example, there were reports of tasks being passed onto PCO-employed staff, in order to free up practice nurses time to deal with the QOF, and of district nurses being asked to complete blood pressure recordings in patients unable to attend the surgery, even though there was no requirement for them to do that as part of the programme of care for the patient.

GP's actually said to me well our practice nurses can be doing other things now, so if it's not quite attached to QOF they don't want to know.

(England Stage 1, Case Study 1 – PCT, Interview 18, Paragraph 136)

..... we did start to get things like go and take a blood pressure, which as community nurses it's always got to be part of a programme of care so that caused, you know, in some instances a bit of angst because people were couldn't understand why they were being asked to do it. You know, it was about them having that discussion with the GPs, what is the rational for this what am I going out to do, not prepared to just go and do a one off and don't know what they're... you know, I'm not just going to do it because you need to meet your tick box type of thing, so it was those sort of issues.

(England Stage 1, Case Study 2 – PCT, Interview 22, Paragraph 35)

Treatment room nurses were another group who were affected by the developing role of practice nurses. Thus, there were instances of treatment room nurses being required to take on tasks that they were not trained for, for example cervical smears. This caused problems if the treatment room nurses did not want to develop their skills and had led, in Scotland, to instances of the PCO devolving the treatment room budget back to practices for them to develop the appropriate staff and skill mix.

So we are trying to meet a match of what the practice needs are, what the skills of the nurses are who are employed and work from there.

(Scotland Stage 1, Case Study 4 – PCO (CHP), Interview 19, Paragraph 28)

Because the treatment room nurses said they weren't going to do it anymore, and when the new contract came in there were still a lot more bloods getting done and cholesterols And the treatment room nurses were getting swamped, and they weren't getting paid, I mean there's no money directly going to treatment room nurses for that, and so they did it for a long time, but they didn't have time to do other work that they were specifically trained for. The boss of treatment nurses said no, we have to stop there. Our practice nurses now run phlebotomy clinics and usually there's one a day, and they're drop-in clinics for maybe an hour a day.

(Scotland Stage 2, Case Study 3 – Practice 8 (GP), Interview 39, Paragraph 65)

9.3.4 Enhanced and out-of-hours services

The new models of service delivery coming out of the contract were beginning to impact on skill mix within primary care. In Case Study 1, the drug misuse enhanced service positively supported the widening of its skill mix by sending a community-based shared care worker to participating practices – these individuals came from a variety of backgrounds, including nursing, social work and counselling. Thus patients would see the shared care worker in the practice, only needing to be seen by their GP occasionally; the shared care worker and the GP would discuss patients' care regularly in the practice

Out-of-hours care had also been reconfigured, particularly in England, where there was greater evidence of new types of roles and skill mix. These had been introduced by PCOs in response to the concern that, after the GP opt-out, many GPs might choose to stop providing out-of-hours care. In reality, however, this was not the case.

We introduced skill mix so we had nurse clinicians seeing patients in a centre as well as doctors and ECPs [emergency care practitioners] carrying out home visits as well as GPs. We felt initially that we had to go for a diversified workforce simply because there wouldn't be many doctors willing to do out of hours. The reality has been, because it is an attractive service to work for or although not as well paid as many, people actually enjoy working for it and continue to do so, so we still have this very strong group of GPs who want to do out of hours work which has been very helpful to us.

(England Stage 1, Case Study 2 – PCT, Interview 10, Paragraph 47)

In Scotland too, particularly in Case Study 3, the out-of-hours service still relied mainly on GPs.

.... younger doctors are taking up the gaps so there's been much more of a sharing of the available income if you like and that the fact that registrars have had to train in out of hours for the past 4 years I think means that they are competent and confident to continue to work out of hours in the couple of years after their training and we are more than happy to have them.

(Scotland Stage 2, Case Study 3 – PCO (Health Board), Interview 35, Paragraph 14)

There was also fluidity in the workforce models developed. The out-of-hours service in Case Study 1 still used nurses, especially for initial call triage. In Case Study 2, the out-of-hours service had previously employed nurses. However, at the time of the interviews, when the new out-of-hours service contract was being agreed and several different service providers had been amalgamated, the service had decided not to continue employing nurses as, previously, the nurses and GPs had not integrated well. A greater change was the control that non-clinical operational staff now had over the clinical staff, including the doctors.

The doctors had come from GP co-op where doctors kind of, not ran the show, but went by unchallenged and that's still going on now really. We have to say to the operating staff now you're responsible, you're going to run the shift, you're going to tell them what to do, you're going to be in charge, because that's the way it has to be.

(England Stage 2, Case Study 1 – non-PCT, Interview 53, Paragraph 71)

In Case Study 3, in Scotland, the out-of-hours service, employed nurses in two distinct roles. The first group provided assistance to the GPs, for example taking temperature and blood pressure reading, dressings and giving medication. These nurses worked in centres up to midnight. The second group were nurse practitioners, who focused on minor illness. In developing this role, the service worked with a local University to develop a minor illness training course for the practitioners, who were also supported by a GP during their training. The nurses shadowed a GP and developed their skills with GP support.

We reckon it takes about a year and a half to 2 years to fully train a nurse practitioner, we now have something like 180 hours I think per week of nurse practitioner time and they work autonomously [but] they never work on their own, they are always in a centre with a doctor but they will see treat and discharge patients without asking the doctor, if they want to ask the doctor that's fine but our idea was to have autonomous nurse practitioners.

(Scotland Stage 2, Case Study 3 – PCO (Health Board), Interview 35, Paragraph 22)

There was evidence of new, enhanced service development sitting within the PBC consortia as well, which were using new configurations of staff to deliver care to patients. This was apparent, for example, in the development of an enhanced service to provide non-urgent care in A&E, where services were being established between practices and the PCT, using salaried GPs and nurses to deliver the service. However, few interviewees spoke about these developments in detail, as they were only just being implemented.

Supporting all professional groups was seen as key. In Case Study 1, support and education sessions had been established for GPs, practice nurses and practice managers, especially in relation to practice-based commissioning. This was felt to be a valuable investment in time for the PCT as well.

I have set up sort of 6 weekly meetings with different disciplines so have a GP education session every 6 weeks, have a Practice Nurse session and also a Practice Manager sessions. So my relationship with the practices is vital to the success of practice based commissioning within [names PBC Consortium] really, to make sure that they adopt any new services but they're also involved in the decision making for what priorities that we can take forward, what services they have seen in primary care and how we can actually implement that.

(England Stage 1, Case Study 1 – PCT, Interview 29, Paragraph 7)

In general, though, learning was informal, both within practices and across services. Education for health care assistants was often ad hoc, although in some settings HCAs were assigned a practice nurse “buddy” who would mentor them.

9.3.5 Care for incentivised and unincentivised conditions by GPs and practice nurses in a sample of Scottish practices

The number of consultations generally rose year-on-year from the year prior to the introduction of the contract, 2003-04, until 2008-09 (Table 11). The exceptions were health visitors, whose total number of

consultations fell between 2003-2004 and 2005-06 and practice nurses who, despite a year-on-year increase, saw a sharp drop in the total number of consultations in Year 4 (2007-08). Total consultations again rose for practice nurses, however, in the following year.

Table 12 shows consultation rates per 1000 population for the four professional groups, although data for district nurses and health visitors were not collected after 2006-07. Consultation rates were highest for GPs; although there was a 3.4% increase in consultation rates from the year proceeding QOF to Year 5 of QOF, there was no overall trend in this increase, with rates fluctuating year-on-year. Consultation rates for practice nurses increased overall in this time period by 8.8%, although there was a drop in the last two years¹. Where data were available, consultation rates for district nurses increased (by 7.5%), but fell sharply for health visitors over the same time period (by 19.4%). Practice nurses saw approximately 30% of all GP and practice nurse consultations each year.

In 2008-09, 20.9% of all consultations with a GP or practice nurse included a QOF related conditions; 79.1% were for non-QOF related conditions. A greater proportion of practice nurse workload was QOF-related: practice nurses: 31.5% included a QOF-related condition vs 68.5% for non-QOF; GPs: 16.3% included a QOF-related condition vs 83.7% non-QOF.

Although practice nurses spoke about taking on more chronic disease management, it was not clear how this might be impacting on their care for other unincentivised conditions, nor how care was split between GPs and practice nurses. Table 13 shows that practice nurses routinely recorded more Read codes per consultation than GPs; the number of Read codes per consultation remained the same for GPs pre- and post-QOF; there was a small but steady increase for practice nurses, recording in 2005-06 an average of 2.3 Read codes compared to 1.3 for GPs. District nurses also recorded more Read codes per consultation, but there was no change for either them or health visitors over the three-year period.

Data were also requested from ISD on the breakdown of consultation rates between GPs and practice nurses by the conditions treated. These were obtained for the time period 2003-2006 and for the same 34 practices who contributed data in the years from 2003 to 2006. The findings are shown in Table 14. Results are presented in three month groupings to give a wider overview of how consultation rates may have changed over the time period.

¹ ISD suggest that this drop might be artefactual due to practices covering less holiday and other absences of nurses and due to practices changing IT systems, thereby decreasing data entry periods. See <http://www.isdscotland.org/isd/6158.html>

Table 11. Total number of contacts by professional group in a sample of Scottish practices (Number of consultations (95 % confidence interval)). From: www.isdscotland.org/isd/3678.html

Professional Group	Number of patient contacts by professional group [x1,000,000]					
	Pre-QOF (2003-04)	Year 1 (2004-05)	Year 2 (2005-06)	Year 3 (2006-07)	Year 4 (2007-08)	Year 5 (2008-09)
GPs	15.609 (14.908-16.309)	15.605 (14.918-16.293)	15.725 (15.006-16.444)	16.273 (15.411-17.135)	15.934 (15.174-16.695)	16.477 (15.769-17.185)
Practice Nurses	6.370 (5.853-6.887)	7.009 (6.465-7.552)	7.492 (6.879-8.105)	7.797 (7.095-8.500)	6.709 (5.932-7.487)	6.977 (6.364-7.590)
District Nurses	3.307 (2.825-3.788)	3.132 (2.551-3.714)	3.553 (2.657-4.449)	N/A	N/A	N/A
Health Visitors	1.726 (1.484-1.968)	1.640 (1.408-1.873)	1.395 (1.204-1.587)	N/A	N/A	N/A
GPs and PNs combined	21.979 (21.108-22.849)	22.614 (21.738-23.490)	23.217 (22.273-24.163)	24.070 (22.958-25.182)	22.643 (21.556-23.732)	23.454 (22.518-24.391)
PN consultations as a % of GP and PN consultations	29.0	31.0	32.3	32.4	29.6	29.7
Total consultations	27.012	27.386	28.165	24.070	22.643	23.454

Rates standardised for age, gender and deprivation.

Data based on the 59, 53, 51, 49, 48 and 58 participating practices in each year.

Table 12. Consultation rates per 1000 population in a sample of Scottish practices (95 % confidence intervals)

	Pre-QOF (2003-04)	Year 1 (2004-05)	Year 2 (2005-06)	Year 3 (2006-07)	Year 4 (2007-08)	Year 5 (2008-09)	Year 5 % difference from pre-QOF
GPs	2916.6 (2785.2-3048.0)	2902.6 (2774.3-3030.9)	2914.8 (2781.0-3048.6)	3008.7 (2848.9-3168.6)	2932.3 (2792.1-3072.5)	3014.8 (2885.1-3144.6)	3.4
Practice Nurses	1163.7 (1067.2-1260.2)	1282.5 (1181.3-1383.6)	1361.9 (1248.4-1475.4)	1423.2 (1293.3-1553.1)	1224.5 (1081.3-1367.7)	1266.6 (1154.4-1378.7)	8.8
District Nurses	610.3 (520.0-700.6)	579.3 (470.8-687.8)	655.8 (489.1-822.6)	N/A	N/A	N/A	7.5
Health Visitors	320.6 (275.2-366.0)	304.7 (261.4-348.1)	258.5 (222.9-294.1)	N/A	N/A	N/A	-19.4

Rates standardised for age, gender and deprivation.

Data based on the 59, 53, 51, 49, 48 and 58 participating practices in each year.

Table 13. Average number of Read codes per consultation by year and discipline in a sample of Scottish practices

	GPs	Practice Nurses	District Nurses	Health Visitors
Pre-QOF (2003/04)	1.2	2.0	2.1	1.4
Year 1 (2004/05)	1.3	2.2	2.1	1.4
Year 2 (2005/06)	1.3	2.3	2.0	1.4

Table 14. Overall consultations per 1000 of the population for incentivised and non-incentivised clinical areas in a sample of Scottish practices

	April to July 2003	Aug to Nov 2003	Dec to March 2004	April to July 2004	Aug to Nov 2004	Dec to March 2005	April to July 2005	Aug to Nov 2005	Dec to March 2006	% Change from Dec- Mar 2004 to Dec- March 2006
Incentivised from Year 1 (2004-05).										
Diabetes										
GPs	15.0	13.7	15.5	13.8	15.0	13.7	12.5	13.4	13.7	-11.6
PN	21.0	20.6	23.6	24.5	27.6	25.7	26.1	31.6	28.7	21.6
DNs & HVs	22.0	21.5	20.4	23.2	22.6	20.8	22.7	20.4	18.2	-10.8
Total	58.0	55.8	59.5	61.5	65.2	60.2	61.3	65.4	60.6	1.9
COPD										
GPs	11.3	11.3	11.6	8.5	9.5	8.9	6.9	7.9	8.3	-28.5
PN	1.6	2.0	3.5	4.1	4.7	5.0	5.5	6.0	5.8	65.7
DNs & HVs	0.6	0.5	0.6	0.5	0.3	0.1	0.6	0.7	0.5	-16.7
Total	13.5	13.8	15.7	13.1	14.5	14.0	13.0	14.6	14.6	-7.0
IHD^a										
GPs	8.3	7.6	7.9	7.8	7.4	6.1	5.8	5.6	4.8	-39.2
PN	7.0	6.7	8.1	9.9	11.2	9.1	8.1	9.8	8.3	2.5
DNs & HVs	1.2	1.0	1.6	1.8	1.4	1.3	1.2	1.5	0.8	-50.0
Total	16.5	15.3	17.6	19.5	20.0	16.5	15.1	16.9	13.9	-21.0
Stroke										
GPs	2.3	2.3	2.2	2.2	2.0	1.9	1.7	1.8	1.6	-27.3
PN	0.6	0.7	1.1	1.9	1.5	1.7	2.3	2.7	2.6	136.4
DNs & HVs	2.6	3.8	3.7	3.4	3.3	2.5	3.1	2.4	2.3	-37.8
Total	5.5	6.8	7.0	7.5	6.8	6.1	7.1	6.9	6.5	-7.1

Unincentivised.										
Back pain										
GPs	38.0	35.6	35.6	36.0	36.5	33.8	34.8	36.0	33.7	-5.3
PN	0.7	0.7	0.7	0.8	0.7	0.8	0.9	0.8	0.7	0
DNs & HVs	0.3	0.5	0.2	0.8	0.5	0.2	0.3	0.3	0.3	50.0
Total	39.0	36.8	36.5	37.4	37.7	34.8	36.0	37.1	34.7	-4.9
Depression										
GPs	53.2	53.2	52.1	48.3	48.3	45.3	42.8	43.1	42.1	-19.2
PN	0.7	0.6	0.7	0.7	0.6	0.7	0.6	0.7	0.7	0
DNs & HVs	1.6	1.4	1.7	1.3	0.5	1.5	1.3	1.1	0.9	-47.1
Total	55.5	55.2	54.5	50.3	50.4	47.5	44.7	44.9	43.7	-19.8
Psychological^b										
GPs	15.2	16.2	18.0	17.9	19.9	19.1	18.1	21.9	21.4	18.9
PN	0.5	0.6	0.4	0.5	0.4	0.5	0.6	0.6	0.5	25.0
DNs & HVs	2.0	2.1	1.8	1.9	2.3	1.2	1.9	1.9	2.0	11.1
Total	17.7	18.9	20.2	20.3	22.6	20.8	20.6	24.4	23.9	18.3

IHD (Ischaemic Heart Disease): Includes angina and myocardial infarction.

Psychological symptoms & signs includes symptoms and signs that do not necessarily have a diagnosis

Standardised for age, gender and deprivation.

In general, consultation rates were higher for GPs across all conditions than for practice nurses or district nurses and health visitors combined, especially for back pain, depression and psychological signs and symptoms. The one exception was diabetes, where both practice nurses and district nurses/health visitors had higher rates of consultation than GPs.

The percentage change over the time period immediately prior to the new contract (December 2003 to March 2004) to two years after the contract (December 2005 to March 2006) was examined across conditions and for each professional group (Table 14). GP consultation rates fell for all conditions, with the exception of psychological signs and symptoms, which rose by 19%. The greatest falls were for IHD (39% decrease); COPD (28% decrease); and stroke (27% decrease). Conversely, consultation rates for practice nurses rose or remained the same for all conditions. The greatest increases were for stroke (136% increase); COPD (66% increase); psychological signs and symptoms (25% increase); and diabetes (22% increase). Only the non-incentivised conditions back pain and depression showed no change for practice nurses.

Consultation rates generally fell for district nurses and health visitors.

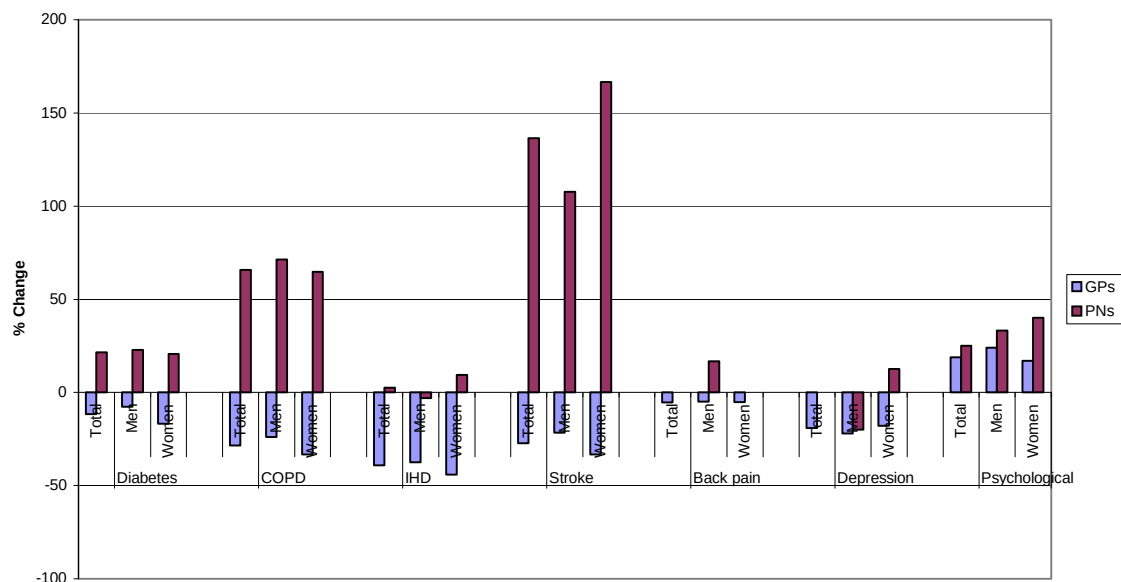
A similar pattern was seen for men and women with the exception of stroke where a small increase was found for females compared to a fall recorded for males (Figure 10). Consultations with practice nurses related to depression rose for women, but fell for men.

Consultation rates with GPs and practices across each condition were also examined by age (data not shown). Overall, consultations with GPs fell but those with practice nurses increase, regardless of the age group or condition. The principal exceptions was IHD, where consultations with practice nurses also fell for all age groups, except the 75 and over group, which rose by 44% and depression, where consultation rates rose across almost all age groups for both GPs and practice nurses.

9.4 Discussion

In this chapter, we explored the evidence, both qualitative and quantitative, to assess the impact of the new contract on skill mix, both within practices but also across practices. In particular, we looked for evidence of how this was viewed by the PCOs.

Figure 10. % Change in consultation rates for GPs and practice nurses from Dec 03-Mar 04 to Dec-05-Mar 06 by condition and gender in a sample of Scottish practices



Within practices, our work supported previous studies which have reported that nurses are increasingly focussed on QOF-related work (96;101;131). Practice nurse roles showed continued evidence of enhancement and specialisation, as described by Sibbald (32) and by Nancarrow (33), taking on more responsibility for the care of a wider group of chronic diseases, for example COPD. This qualitative view was supported by our analyses of Scottish primary care workload data. This revealed a marked increase in practice nurse COPD consultations over the first two years of the QOF.

There was, however, little or no explicit discussion about who made these decisions. Data presented in Chapter 7 showed that decisions about who leads on QOF areas were taken either by the practice team as a whole or by combinations of lead GPs, practice nurses and/or the practice manager; these decisions appear to have fed into the workload of practice nurses. However, it also appeared that, for many of the nurses interviewed (either at PCO or practice level), the focus on QOF work was also a natural extension to the role they had been playing for several years in relation to chronic disease management.

While PCO interviewees recognised the importance of practice nurses in relation to QOF achievement, they were concerned about the areas of work which they felt may now be crowded out in favour of QOF – examples cited included work on sexual health. Nurses themselves also feared that some more public health-related areas might be excluded in favour of the QOF, for example health promotion; minor illness was also felt to be crowded out. This, coupled with the increasing workload of QOF and the enhanced services, were making some in the PCOs concerned

about the long-term viability of practice nursing, as they feared that nurses may in time choose to leave rather than stay. Recent evidence has found that practice nurses in small and single-handed practices feel particularly isolated and are more likely to be thinking about leaving the profession (144). This may have, in part, underpinned the support mechanisms that some of the PCOs had put in place, either by employing their own practice nurses to support small and single-handed practices or by employing a practice nurse advisor, whose sole remit was the strategic and operational support of practice nurses.

Practice nurses were now delegating more routine tasks to health care assistants and, sometimes, PCO-employed treatment room nurses, in order to free up their time for the more complex care of chronic disease patients. However, there were some groups of patient who nurses did not care for; these included patients with complex needs, such as patients with multiple morbidity, older patients with complex needs or patients with diseases that were difficult to control, such as epilepsy. Such patients were more likely to be cared for by GPs, as were patients with complex psycho-social needs. PTI data confirmed that GPs had much higher consultation rates for depression and psychological signs and symptoms than practice nurses. Thus, the new contract appears to be embedded Charles-Jones “hierarchy of appropriateness” (142), whereby the most complex cases are reserved for the professional group at the “top” of the hierarchy, namely the GPs.

This work also highlighted the key role that administrative staff and practice managers are now playing, with evidence of their role developing in innovative ways and substituting for practise nurses in defined areas. In particular, there appears to be a new pseudo-professional group emerging - that of the receptionist/health care assistant, trained to carry out uncomplicated clinical tasks such as measurements and blood taking, but also functioning in an administrative capacity if required. Other administrative staff were also seeing their role develop and expand to meet the complex data entry and IT requirements of the QOF. Decisions about the deployment of these staff generally lay with the practice manager.

PCO staff were also aware of re-negotiation of professional boundaries between practice-employed staff and PCO-employed staff. This was most apparent with treatment room nurses and with district nurses, especially when district nursing teams were being re-organised into community-based teams rather than being practice-attached. In order to facilitate this process, PCO managers were using the QOF as a “carrot” – suggesting to practices that district nurses could assess patients in the community and help practices meet their QOF targets by conducting checks and entering data. This was not always welcomed by the district nurses, who clearly felt that such stand-alone care went against the ethos of their care of patients, which was generally more holistic.

Although there was evidence of new roles in out-of-hours care, there was less evidence of new nursing or emergency care practitioners

substituting for GPs. Indeed, in all of the case study areas, the principal provider of out-of-hours care remained GPs.

The availability of the Practice Team Information dataset in Scotland afforded a unique opportunity to further explore workload splits in primary care. There are limitations and caveats to these data. They are collected from a small proportion of Scottish practices, although are broadly representative of Scottish practices. The number of practices contributing varies in each year and it was not always possible to look at changes over time in a consistent group of practices. Data were only available at aggregate level. Nonetheless, it demonstrated that in general practice nurse consultation rates have increased since the implementation of the new contract and GP consultation rates have fallen. This confirms over a longer period of time the findings of Gemmell et al that, in the year after the contract was introduced, visits to nurses increased but visits to GPs fell(145). Here, practice nurses workload was increasing across all conditions examined, however, it was difficult to demonstrate whether QOF was “crowding out” unincentivised conditions.

The findings reported here thus confirm the centrality of practice nurses to practice performance in the QOF but also highlighted the growing importance of health care assistants and administrative/health care assistant hybrid roles.

9.5 Conclusions

- Skill mix continues to develop in practices in order to meet the requirements of QOF and enhanced service delivery.
- Practice nurse roles were continuing to develop, with evidence of enhancement and specialisation, as they took on responsibility for the care of a wider group of chronic diseases, for example COPD.
- This was reflected in the Scottish primary care workload data, which showed consultations with practice nurses generally increasing year-on-year.
- This increased workload led some PCO interviewees to express concern about the longer-term capacity in practice nursing to continue to take on a wider remit.
- GPs continued to care for the most complex cases, in term of morbidity, age and psycho-social issues, confirming that a “hierarchy of appropriateness” still exists.
- Administrative staff and practice managers were also assuming a greater role within practices.
- A new pseudo-professional group appears to be emerging - the receptionist/health care assistant, trained to carry out uncomplicated clinical tasks such as measurements and blood taking, but also functioning in an administrative capacity.

- There was little discussion, in either country, about how such decisions on workload distribution are achieved.
- Role boundary negotiations were also occurring between practice nurses and community-based nurses, with some work being delegated from practice nurses to community nurses such as health visitors. This had led to tensions in some case study sites.
- Although there was evidence of new roles in out-of-hours care, there was less evidence of new nursing or emergency care practitioners substituting for GPs. In all of the case study areas, the principal provider of out-of-hours care remained GPs.

10 The impact of the GMS contract on inequalities

10.1 *Introduction*

Tackling inequalities in health and health care is a major priority in both countries, with English and Scottish Government policy generally making the same arguments about the need to tackle health-related and wider social determinants (146;147). There are, however, different mechanisms by which interventions designed to tackle inequalities may be designed and implemented (148;149). The first focuses on health disadvantage within the poorest groups, seeking to improve absolute levels of health within a narrowly defined population group. The second focuses on the health gap, i.e. the health of poor groups, relative to other population groups – generally the poorest relative to the most affluent in the population. However, in both approaches, those who are marginally less disadvantaged are ignored and their health may actually deteriorate relative to the most disadvantaged. The final approach focuses on the health gradient across the population or, as Graham writes “the systematic relationship between socio-economic position and health” (149). This focus on systematic differences in lifestyles, living conditions and life chances recognises health improvement as a population-wide goal, although (as with all of these approaches) health must improve faster in less advantaged social groups compared to the most advantaged, if the gradient of inequality is to lessen. Smith and colleagues, in their critique of UK public health policy in relation to health inequalities argue that, despite devolving health systems, England, Scotland and Wales approach health inequalities in a broadly consistent manner, seeing inequalities as a “health gap” related to the health disadvantage of deprived communities (150). It is now recognised, however, that focussing only on the most disadvantaged will not, of itself, reduce health inequalities sufficiently. To reduce the gradient in health inequalities, “actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage - proportionate universalism” (151).

Within the new contract, one could envisage QOF to be such a universal mechanism, albeit with the caveat that only those individuals registered with a general practice participating in the QOF would be in the denominator population. However, tackling inequalities was not an explicit aim of the new contract, either generally or within the QOF. The BMA, in its submission to the House of Commons Health Select Committee on Health Inequalities, recognised this omission.

We argued actually quite strongly [for] significantly less money in QOF and more money into funding what I would call basic services, trying to improve staffing levels in the poorer practices and suchlike, so there was

more of a balance; the idea of the way you funded basic services and QOF was to have a balance between the two, so that actually practices in the more deprived, difficult areas would get bigger and better basic funding, those in the wealthier areas would get a bit less but would actually find it easier to earn the money from QOF. (152):

Previous work by members of this team highlighted the inequity in the original payment mechanism of the contract, where practices with high prevalence rates, generally found in areas of socio-economic deprivation, received less payment per patient than those with lower prevalence rates (153). This anomaly was corrected in 2009. The same group also found that while there was no systematic association between deprivation and the level of QOF payment to practices, there was a gradient in the quality of care delivered to all patients (i.e. when patients exception reported were not removed from the denominator population), with delivered quality falling with increasing deprivation. This was greatest for complex process measures, some intermediate outcome measures such as glycaemic control in diabetes and measures of treatment such as influenza immunization (80).

Other work suggests that the difference in QOF achievement between the most and least deprived practices in England has reduced over time (86;154). However, a recognised problem is that area-based socio-economic data in England are not available at patient postcode level, only at practice postcode level, raising the possibility of an ecological fallacy (155). This, along with a lack of comparable measures of deprivation, makes cross-country comparison more challenging and may explain some of the reported differences of the impact of QOF on reducing inequalities. For example, some studies reported that QOF achievement decreased with increasing deprivation in the practice population (78-80), while others reported little or no association (156;157). QOF recorded prevalence was reported to increase with increasing deprivation for diabetes and CHD (81;156); however practices in more deprived areas were more likely to exception report patients (81) or to record less data on QOF indicators (158).

Thus, it is recognised that, although not a primary aim of the QOF, there is the potential for it to be utilised to help tackle inequalities in health. However, focussing attention on QOF incentivised areas carries the risk that inequalities in the unincentivised areas may widen (155).

Here, we explore the views of stakeholders on the potential for the contract, and QOF in particular, to impact on health inequalities. We also explore in greater detail the way in which deprivation is measured may impact on our view of QOF achievement. Part of this work was recently published (121).

10.2 *Methods*

The methods pertaining to the qualitative results reported here have been previously described in Chapters 5 and 6.

For the quantitative analyses, data on QOF achievement and prevalence were obtained, as before, for each practice in England and Scotland for the period 2005-06 from The Information Centre, England (www.ic.nhs.uk/services/qof/) or from ISD Scotland (www.isdscotland.org/isd/3305.html).

QOF achievement was measured using population achievement (based on the care delivered to all patients) for CHD quality indicators where the denominator was all patients with CHD. The unadjusted prevalence rates were calculated for each individual domain by dividing the number of patients on the disease register by the practice population and multiplying by 100. We focused here on CHD as it is the QOF domain with the highest number of points attached to it (121) representing 22% of the total points available for clinical indicators. In addition, cardiovascular disease is the one the highest causes of mortality with over 193,000 deaths due to CVD in 2007 (www.heartstats.org/topic.asp?id=17).

Deprivation for England and Scotland was measured using the income domain of the Index of Multiple Deprivation (IMD) from 2004 for each country (England: www.communities.gov.uk/archived/general-content/communities/indicesofdeprivation/216309/;

Scotland: www.scotland.gov.uk/Topics/Statistics/SIMD). The income domain was used as it is calculated in a similar way in both countries; contributes, jointly with employment, the highest proportion of the overall index (22.5% in England, 29.0% in Scotland); and is highly correlated with the overall IMD score ($R=0.95$ and 0.99 for England and Scotland respectively). The income domain reports on the percentage of patients receiving state benefits on the basis of low income. Thus, the reported score correlates positively with income deprived among the practice population. For practice postcode assigned deprivation, deprivation was based on the income score of the practice postcode calculated by linking the postcode of the practice's main surgery to its Census Lower Layer Super Output Area (LSOA) for England and datazone level for Scotland, and then to its IMD domain score. For Scotland deprivation was also assigned at practice population level, based on the mean score of the registered practice population and obtained from ISD Scotland.

Data were available in total for 8167 English and 989 Scottish practices (97% and 98% of the total number of practices respectively). Practices were divided into deciles based on income and weighted by population size. We compared the mean prevalence rates for the ten QOF clinical domains and the achievement scores for the eight CHD QOF indicators for practices in the least and most deprived deciles, as measured by the income domain. Significance testing was based on practice-level data using a threshold of $p<0.01$ as our measurement of significance. The analysis was undertaken in STATA v8.2, using robust standard errors. The calculation of mean values and the regression coefficients were weighted by population size.

10.3 Results

10.3.1 Stakeholder views of the impact of QOF in inequalities

Primary care was seen as one of the most appropriate contexts in which to target inequalities in health.

Well I think we need to think seriously about global sum and MPIG I think that is key. I think we have a clear mandate from Ministers to look at health inequalities and what I've previously said is that I think the best people to deliver change in health inequalities are GP practices and contractors like them who are at the frontline. They are the gatekeepers and they have probably the best although they might say otherwise I think they have some of the best opportunities to access difficult patients.

(Scotland Stage 1, National, Interview 23, Paragraph 120)

At a national level, there was recognition that the new contract had, at the time of the interviews, "locked in" inequities into the funding arrangements that potentially disadvantaged practices serving more deprived populations.

Initially remember that Milburn [Secretary of State for Health] wanted more money shunted into QOF and we said this is ridiculous, if you do this you're going to de-fund the global sum, which was intended to deal with health inequalities, and to actually pay to look after sicker and more needy populations and they would not listen. Then having de-funded the global sum, they then had to provide a support mechanism called MPIG and that works opposite to the way it was meant to, so you've now protected historical unfairnesses, rather than [the plan] that practices looking after needy populations got more money....

(England Stage 1, National, Interview 26, Paragraph 142)

I think I would certainly change, in terms of the GMS contract, the way the global sum was worked out in terms of the Car-Hill formula which was supposed to target resources at deprived areas and that didn't happen, so I would want that to happen more effectively because I think in terms of the core services which is what the global sums about that resource allocation is really not changed I think that needs to change.

(Scotland Stage 1, Case Study 4 – PCO (Health Board), Interview 4, Paragraph 79)

However, despite inequities in the calculation of the global sum, QOF was credited, at both PCO and practice level, with reducing inequalities due to the systemization of care and the targeted nature of the recall system.

We are reducing health inequality because everybody has the opportunity to have their chronic disease managed to very high levels. It isn't just people who are demanding it, we are going out and pulling them in so I think that the new contract in our practice, and in talking with my clinicians locally, has reduced health inequality.

(England Stage 1, Case Study 2 - PCO, Interview 10, Paragraph 131)

.... I think it's good, I do think patients are benefiting from it, particularly in deprived areas.

(England Stage 2, Case Study 1 – Practice 4 (Practice Administration), Interview 53, Paragraph 50)

Although this systematized approach to chronic care was acknowledged, it was clear that not all clinical conditions were being dealt with appropriately yet.

One of the things I think we've steered away from is COPD which is probably the biggest marginal killer between areas of deprivation and areas of affluence in Scotland and it's a very difficult thing to manage I think and yet if we're to make a difference it's the one we need to manage and we haven't really addressed that.

(Scotland Stage 1, Case Study 3 – PCO (CHP), Interview 24, Paragraph 169)

PCO interviewees recognised that smaller practices were more likely to struggle with the requirements of QOF, due to a lack of organisational “stretch” and were trying to support them.

.... you find that the smaller the practice, not always the case but in the majority of cases, the smaller the practice the more they struggle with collection of data, with meeting requirements, you know, sort of their points always seem to be lower than any other practices I found. I think its [generally] because they haven't got the infrastructure in place you know....

(England Stage 1, Case Study 1 – PCO, Interview 16, Paragraph 399)

There were also concerns, however, that the contract may disadvantage those people who were less likely to respond to invitations to attend practice, perpetuating inequalities, including patients from deprived areas and housebound patients. In Case Study 3, the PCO was starting to provide home visits or transport to practices for such patients. PCO interviewees also talked about initiatives to support staff reach patients in more deprived areas. As described in previous chapters, there were also concerns that, as practice nurses focussed more and more on chronic disease management, other patient groups would be disadvantaged, for example younger patients in relation to sexual health.

..... it's like cervical cancer you know, are women being screened, and you look at the areas for cytology and you'll know that in the poorer areas that they don't we've done our utmost to get those patients in [names deprived area] to come along for the screening and they just don't want it.

(England Stage 1, Case Study 1 – PCT, Interview 23, Paragraph 594)

..... people [in affluent areas] are more willing and able to take up the offer of more systematic care and sometimes people living in more deprived areas aren't sort of concerned about inequalities and the last group in that particular aspect is the housebound. I don't think the housebound are particularly well covered by the new contract and although we are trying to remedy that in [names PCO] with our transport service and designated pilot of a designated service delivered at home, I still think that housebound patients by and large haven't done so well.

(Scotland Stage 1, Case Study 3 – PCO (CHP), Interview 2, Paragraph 239)

Several PCO interviewees were hopeful that more local forms of commissioning such as practice-based commissioning, enhanced services or, in Scotland devolution of budgets to CHPs, would help them meet the particular needs of patients in deprived areas. This extended to a view that PCT-employed services might be required in areas of severe deprivation, with a greater focus on primary prevention. However, for at

least one interviewee, the key was sustainable funding to allow long-term solutions to be developed.

[It's] difficult to get GPs to move into areas that are difficult to serve, deprived areas, difficult inner city populations and an employment model from PCTs may well be the right way to proceed for that, that sort of area....

(England Stage 1, National, Interview 12, Paragraph 308)

There was also a recognition that dealing with health inequalities required a wider, more holistic approach recognising people's lifestyles. This came through strongly in interviews with the drug misuse enhanced service in both countries and with practitioners working in areas of severe socio-economic deprivation.

You know about education starts at home, it's not just about schools and we can see the change in people and the dynamics that we use infiltrate that change because we even have food workers now you know. That's a big thing to us, going into deprived areas you know, people on low money well you can go the fish and chip shop and get chips and fish, or sausage and chips or for the same amount of money we can cook this meal and that's what food workers have done, they've had open days and it's about education, so I feel that's an important development in primary care.

(England Stage 1, Case Study 1 – PCT, Interview 23, Paragraph 974)

For us in [names area] we have got a very mixed area where we have got pockets of huge deprivation sitting next to pockets of relative affluence. The issue here is about poor health, about the social issues that go alongside the poor health issues and the employment issues and all the rest of it and here's how we need to plan services to tackle those

(Scotland Stage 1, Case Study 3 – PCO (CHP), Interview 21, Paragraph 70)

Diabetes is very socially and culturally driven. And I think what they've taken is, they've divorced it from its social and cultural context and we've very much fragmented it into the reductionist biomedical thing in the protocols. And even the enhanced services stuff about how many pieces of fruit and veg they eat a day, it's not with any sense of understanding of their culture and day-to-day life, it's just taking social stuff and reducing it to biomedical stuff.

(Scotland Stage 2, Case Study 3 – Practice 5 (GP), Interview 53, Paragraph 50)

As discussed more extensively in Chapter 6, there was a view that health care was being driven by the needs of the middle classes in England. The moves to widen access and walk-in centres, had the potential to chip away at routine daytime care, to the disadvantage of more vulnerable groups.

..... my worry is that the people who are paying for that [enhanced access] are the elderly and the disadvantaged who actually are getting a rather good service at the moment in terms of personalised medicine at a time that suits them during the day.

(Scotland Stage 1, Case Study 3 – PCO (CHP), Interview 24, Paragraph 317)

The potential for provider providers to provide health care in England was also raised, with the view that such providers would be unable to meet the needs of the most disadvantaged. That was the role of primary care.

I also worry [about] the independent providers coming in and providing health care Yeah, they will cherry pick the fit and well but again I would like to see when [private providers] are up and running in the middle of some deprived estate, seeing drug users who are dripping pus all over the floor, whether they would like to continue providing the service at the cost that we do.

(England Stage 1, National, Interview 31, Paragraph 194)

10.3.2 Measurement of deprivation and impact on reported QOF achievement

We compared deprivation levels between practice populations in England and Scotland using the mean income score domain in the Index of Multiple Deprivation (IMD) assigned to the practice postcode. Deprivation scores were similar for both countries, although Scotland tended to be marginally higher in each quintile (Table 15). For Scotland, it was also possible to compare the mean income score in each deprivation quintile assigned to the practice postcode with that assigned to the postcode of individual patients. Here, a different pattern emerged. Deprivation results based on practice population data increased the mean scores for the lowest five deprived deciles but reduced them for the five most deprived deciles. The biggest difference was found for the most deprived decile with practice postcode assigned data overestimating income deprivation by 11.4 percentage points compared to practice population assigned data (practice postcode-assigned mean of 42.5% points vs. practice population-assigned mean of 31.1% points).

Table 15. Difference in mean IMD Income levels by decile

Decile	England Deciles based on practice postcode assigned values Mean income score	Scotland Deciles based on practice postcode assigned values Mean income score	Scotland Deciles based on practice population assigned values Mean income score
Least deprived decile			
1	2.9	2.8	4.9
2	5.0	5.6	7.7
3	6.8	7.8	9.7
4	8.7	10.0	11.2
5	10.8	12.1	13.0
6	13.2	15.1	15.0
7	16.3	18.7	17.1
8	20.7	22.7	19.4
9	27.4	27.8	22.0
Most deprived decile			
10	40.7	42.5	31.1
Ratio most:least deprived	14.0	14.0	6.3

Table 16 shows the relationship between QOF prevalence rates and deprivation using practice postcode assigned data for England and Scotland and also practice population assigned data for Scotland. For most conditions, the prevalence was higher in the most deprived decile; the two exceptions in both countries were cancer and hypothyroidism. Differences between the least and most deprived deciles under practice postcode were similar (0.2% points or less) in England and Scotland for the majority of clinical domains, although there was a marked divergence for COPD (0.1% points higher in England compared to 1.1% points higher in Scotland).

With practice population assigned data (Scotland only), differences between the least and most deprived deciles increased for all clinical domains. The largest variation between practice postcode and practice population data was found for COPD where predicted prevalence was 2.2% points higher in the most deprived decile compared to the least deprived decile using population postcode assigned data, but only 1.1% points higher using practice postcode assigned data.

Table 16. Differences between least and most deprived income deciles for QOF prevalence rates for practice and population assigned data

	England: Prevalence rates based on practice postcode			Scotland: Prevalence rates based on practice postcode			Scotland: Prevalence rates based on practice population		
	Least deprived decile	Most deprived decile	Difference	Least deprived decile	Most deprived decile	Difference	Least deprived decile	Most deprived decile	Difference
CHD	3.1	3.7	0.6 [<0.001]	4.0	4.8	0.8 [<0.001]	3.7	5.0	1.3 [<0.001]
Diabetes	2.9	4.0	1.1 [<0.001]	3.0	3.6	0.6 [<0.001]	2.7	3.6	0.9 [<0.001]
Stroke	1.5	1.5	0.0 [0.79]	1.8	2.0	0.2 [0.07]	1.7	2.1	0.4 [<0.001]
Hypertension	11.5	11.3	-0.2 [0.39]	11.4	11.8	0.4 [0.50]	11.4	11.9	0.5 [0.24]
COPD	1.3	1.4	0.1 [0.04]	1.4	2.5	1.1 [<0.001]	0.9	3.1	2.2 [<0.001]
Asthma	5.8	5.7	-0.1 [0.73]	5.3	5.4	0.1 [0.19]	5.0	5.5	0.5 [0.01]
Cancer	0.7	0.6	-0.1 [<0.001]	0.8	0.7	-0.1 [0.03]	0.8	0.6	-0.2 [<0.001]
Mental health	0.6	0.7	0.1 [<0.001]	0.6	0.7	0.1 [0.10]	0.5	0.7	0.2 [<0.001]
Hypothyroidism	2.4	2.2	-0.2 [<0.001]	2.9	2.6	-0.3 [<0.001]	3.1	2.4	-0.7 [<0.001]
Epilepsy	0.6	0.6	0.0 [0.96]	0.6	0.8	0.2 [<0.001]	0.5	0.9	0.4 [<0.001]

Table 17 shows the relationship between deprivation and population achievement for CHD quality indicators. In general, QOF population achievement was lower in the most deprived decile in both countries. There was, however, greater variation between England and Scotland for

differences between the lowest and highest deprived deciles than was apparent with QOF prevalence. The biggest differences were found for CHD10, where England was 0.3% points lower for the most deprived decile compared to 3.2% points lower in Scotland; CHD06, 1.5% points lower in England compared to no difference in Scotland; and CHD12, 4.2% points lower in England compared to 3.3% points lower in Scotland.

Using practice population assigned data in Scotland, the differences increased for all the indicators with the exception of CHD10 where the difference between the least and most deprived deciles fell from 3.2% points to 2.0% points. The biggest difference using practice population assigned data was for CHD12 where the gap between the least and most deprived deciles increased from 3.3% points lower in the most deprived decile to 6.9% points lower.

Table 17. Differences between least and most deprived income deciles in CHD population achievement for practice and population assigned data

Population achievement based on practice postcode							Scotland: Population achievement based on practice population		
England:			Scotland						
	Least deprived decile	Most deprived decile	Diff	Least deprived decile	Most deprived decile	Diff	Least deprived decile	Most deprived decile	Diff
CHD 03	95.8	96.0	0.2 [0.43]	97.1	97.1	0.0 [0.95]	97.4	97	-0.4 [0.33]
CHD 05	97.6	97.1	-0.5 [<0.001]	97.2	96.6	-0.6 [0.15]	97.8	96.2	-1.6 [<0.001]
CHD 06	85.1	83.6	-1.5 [<0.001]	86.6	86.6	0.0 [0.72]	86.7	86.4	-0.3 [0.88]
CHD 07	91.5	90.9	-0.6 [0.03]	91.7	90.4	-1.3 [0.15]	92.3	90.3	-2.0 [<0.001]
CHD 08	72.4	70.9	-1.5 [<0.001]	73.8	72.2	-1.6 [0.29]	74.7	71.7	-3.0 [<0.001]
CHD 09	91.8	91.9	0.1 [0.72]	93.5	94.1	0.6 [0.30]	93.7	94.4	0.7 [0.11]
CHD 10	51.7	51.4	-0.3 [0.57]	57.4	54.2	-3.2 [<0.001]	56.1	54.1	-2.0 [0.02]
CHD 12	83.8	79.6	-4.2 [<0.001]	83.4	80.1	-3.3 [<0.001]	84.8	77.9	-6.9 [<0.001]

CHD 03: Record of smoking status in the previous 15months.

CHD 05: Record of blood pressure in previous 15 months.

CHD 06: Blood pressure recorded in previous 15 months $\leq$ 150/90.

CHD 07: Record of total cholesterol in previous 15 months.

CHD 08: Total cholesterol recorded in previous 15 months $\leq$ 5mmol/l.

CHD 09: Aspirin, alternative anti-platelet or anti-coagulant being taken.

CHD10: Treated with beta-blocker.

CHD12: Record of Influenza immunisation in previous flu season.

10.4 Discussion

This chapter reported the views of interviewees on the impact of the contract in relation to health inequalities and also examined the potential impact of different ways of measuring socio-economic deprivation.

There were interviewees at all levels (national, PCO and practice) who felt that there was a mechanism, by which the contract, in particular QOF, could impact on health inequalities. They talked about QOF having an impact on health gaps for chronic diseases, particularly CHD and diabetes. However, several felt that in one major disease area, namely COPD, less was being done to reduce the gap in health inequalities. Interviewees were cognisant that tackling inequalities in health required a broader approach and there was some evidence to suggest that the case study PCTs were developing other approaches tackling wider health behaviours, for example food workers. However, the development of these approaches did not appear to be driven by the new contract but, presumably, by other policy drivers.

There was little consideration of inequalities in our respondents' interviews, other than in relation to socio-economic disadvantage. Apart from the housebound, no other group was explicitly mentioned as being disadvantaged, for example there was no mention of ethnic minority groups. There was also a focus on either the health of the poorest groups or on the health gap between the most deprived and the most affluent. Thus, despite the opportunity afforded by QOF to practice "proportionate universalism" (151), whereby QOF is applied globally to the whole population, but with poorer or disadvantaged groups particularly targeted, there was little evidence of such approaches being considered. Certainly, there was an acknowledgement that localised approaches could be an answer to dealing with inequalities, but no clear strategies appeared to be in place.

A number of interviewees at national and PCO level discussed the perceived inequality in the funding arrangement underpinning the MPIG global sum. Indeed, members of this team reported on the anomaly, whereby practices from poorer areas were disadvantaged (153) and this was later corrected. The other issue acknowledged by these interviewees was that smaller practices were often disadvantaged by having less "organisational stretch" to deal with the administrative and organisational complexities of the QOF. Such practices were more likely to be found in areas of deprivation, thus potentially exacerbating inequalities and the inverse care law (77;159).

The limitation, in England, of having socio-economic data only at practice level and not patient level has been acknowledged (155). Here, we examined the extent to which such data impacts on associations between QOF prevalence rates, achievement for CHD quality indicators

and deprivation. Comparing Scottish data on IMD income domain at either practice postcode or practice population level showed that analyses based on data assigned at practice postcode level underestimated the relationship between deprivation and both prevalence and quality of care compared to what has been described as the “gold standard” method of assigning deprivation scores to practices based on the postcodes that the practice populations served live in (160). Indeed, assigning income deprivation at the level of the practice postcode exaggerated the variation across the deciles. The results of this study are consistent with those of Strong, which found that using data assigned to the practice postcode underestimated the association between deprivation and ill health. While the reason for this is unknown, it could be hypothesised that a contributory factor may be the positioning of the GP surgery itself, in relation to the population it serves, with practices located in areas significantly different to the areas that registered patients live – particularly in relation to socio-economic deprivation where practice populations are often spread over a wide catchment area, which may not reflect the location of the surgery (161).

Whether reported at practice postcode level or practice population level, deprivation was measured at an aggregate level rather than at the level of individual patients (for example based on patients’ occupation). Therefore it is still possible that associations identified here could differ if those associations were measured at the level of individuals, a concept referred to as the ecological fallacy or bias. The use of data based on the practice population may help to alleviate some of the difficulties encountered from the use of aggregated data. Moreover, deprivation and health have been shown to have both area level and individual level factors (162) and, as such, the use of aggregated level data may be seen as an appropriate method. Given the importance of understanding the effect of deprivation and ill health on a range of determinants related to health care, not just QOF, it may be beneficial to ensure that practice population data is available at national level in England.

10.5 Conclusions

- QOF was recognised as a mechanism that might help to tackle inequalities, particular as primary care was recognised as appropriate location for such care.
- Despite the recent policy rhetoric in England, there was no evidence of proportionate universalism, whereby QOF could be applied globally, but with targeted approaches to increase uptake aimed at the most deprived.
- The need to tackle wider social determinants of health was acknowledged in both countries. However, although there were approaches being tested in the case study sites, these could be attributed to the contract.

- There was little consideration of other disadvantaged populations, such as minority ethnic groups.
- Analyses based on practice-level postcode linked deprivation data under-estimated the relationship between deprivation and both QOF prevalence and quality of care.
- Comparison of the impact of deprivation between the two countries was made more difficult due to this lack of patient-level postcode linked postcode deprivation data; the development of such a dataset in England would greatly enhance the ability to conduct local and comparative analyses of the impact of deprivation on health and health care use.

11 The impact of the GMS contract on patients and on public involvement

11.1 Introduction

There has been relatively little research into the direct impact of the new contract on patient experience (see Chapter 1.6). Whilst studies have reported that care for some incentivised areas, in particular CHD, diabetes and asthma, have improved since QOF was implemented (83;91;163), more recent work by Campbell and his colleagues suggests that these improvements have not been sustained and are even declining for CHD and for asthma (84). The impact on unincentivised conditions is less clear. Campbell et al found that, within CHD, diabetes and asthma, quality scores were lower for unincentivised indicators than for the incentivised indicators (84). Steel and colleagues reported that while quality of care for such conditions had not worsened, it had not improved either (91), and we have reported similar findings in Chapter 8.3.3.

There is little known about patients' views of their care since the implementation of nGMS, particularly within practices. To date, only Campbell et al have reported on the impact of QOF on patients' views of care, with no significant changes reported by patients either with regard to access to care or interpersonal elements of care, such as communication. Patients did, however, report that it was more difficult to get an appointment with a preferred GP (84). Other questions remain unanswered, for example has the organisation of their care changed; what has been the impact on appointment length and frequency; and who manages their care?

We also do not know if the contract had improved the potential for patient or public involvement in the governance of health care. While patient or public involvement has been promoted in various health policy documents in both countries (164)(www.library.nhs.uk/ppi/), progress has been slow and fraught with difficulties (165;166).

In this chapter, we explore some of these issues and report, in particular, on the impact of the contract on two patient groups: patients with diabetes and patients with rheumatoid arthritis, chosen as iteratively comparable QOF and non-QOF conditions by our study team.

11.2 Methods

11.2.1 Selection of tracker conditions

In this stage of the study patients were identified and recruited into the study in order to carry out a case note review of their care for one of two

tracker conditions. A subset of patients was also interviewed about their perceptions of the care received from the practice over the previous five years. Two conditions were selected as tracker conditions:

- Diabetes (type 1 and type 2): incentivised in the QOF since the contract was implemented.
- Rheumatoid arthritis: not incentivised within QOF.

As described in Chapter 5.2.2, diabetic care, measured by the number of diabetic patients on the practice register and their QOF performance in the diabetic domain, was a secondary criterion used to select the GMS and PMS practices as embedded case studies.

11.2.2 Patient identification and recruitment

A case note review was conducted in each of the 8 practices recruited as embedded case studies. An initial search was carried out in each practice to identify eligible patients: this was conducted in England, by a member of the practice staff and verified by a GP in the practice or member of the Research Network; in Scotland, this was conducted by a Research Officer of the Scottish Primary Care Research Network and verified by a GP in the practice. Inclusion criteria were:

- Diagnosis of disease prior to 2003.
- Adult aged over 18.
- Able to give informed consent.

Patients identified from the initial search as eligible for inclusion were contacted via their practice and asked if they would consent to (a) their case notes being reviewed; and (b) the possibility of being approached for an interview about their experience of care in their practice over the past few years. Patients could consent to the case note review alone or the review and interview. The interview schedule for patients is in Appendix 6.

11.2.3 Data extraction

Data were extracted using a pro-forma designed by the research team. Data collected included patient demographics; co-morbid conditions; total number of consultations per annum and consultations for the tracker condition; and the health care professional seen. Data on a number of quality criteria were also collected (Box 8). The full pro-forma is contained in Appendix 7. All data were collected on an Access database.

Box 8 Quality criteria used in the case note review and source of evidence

Indicator	Source of evidence
General.	
Total number of consultations per annum	
Total number of consultations relating to diabetes or rheumatoid per annum	
Diabetes.	Revisions to the GMS contract 2006/07(167)
Number of patients whose blood pressure was recorded at least once in that year	QOF DM 11. The percentage of patients with diabetes who have a record of the blood pressure in the past 15 months
Number of patients whose blood pressure was 145/85 or less at least once in that year	QOF DM 12. The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less
Number of patients whose HbA1c was recorded at least once in that year	QOF DM 5. The percentage of diabetic patients who have a record of HbA1c or equivalent in the previous 15 months
Number of patients whose HbA1c was ≤ 10.0 at least once in that year	QOF DM 7. The percentage of patients with diabetes in whom the last HbA1C is 10 or less (or equivalent test / reference range depending on local laboratory) in previous 15 months
Number of patients whose HbA1c was ≤ 7.5 at least once in that year	QOF DM 20. The percentage of patients with diabetes in whom the last HbA1C is 7.5 or less (or equivalent test / reference range depending on local laboratory) in the previous 15 months
Number of patients whose cholesterol was recorded at least once in that year	DM 16. The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months
Number of patients whose cholesterol was 5 mmol/l or less at least once in that year	QOF DM 17. The percentage of patients with diabetes whose last measured total cholesterol within previous 15 months is 5 mmol/l or less
Number of patients recorded as receiving a flu immunisation in that year	QOF DM 18. The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March
Rheumatoid arthritis.	SIGN Guideline No 48(168); Chakravarty et al(169)
Number of patients prescribed/recorded as on NSAIDs in that year	The lowest NSAID dose compatible with symptom relief should be prescribed; NSAIDs should be reduced and withdrawn in possible when good response to DMARDs is achieved.
Number of patients prescribed/recorded as on DMARDs in that year	RA should be treated as early as possible with DMARDs to control symptoms and delay disease progression
Number of patients whose FBC was monitored in that year	FBC should be monitored every 4 weeks.
Number of patients whose U&Es were monitored in that year	U&Es should be monitored every 4 weeks.
Number of patients whose LFTs were monitored in that year	LFTs should be monitored every 4 weeks.

11.2.4 Data analyses

Patient demographics were compared between England and Scotland using Fisher's exact test for binary categorical variables; t-test or ANOVA for the comparison of continuous variables across groups. Using the total number of consultations for any reason as the denominator, diabetic and rheumatoid arthritis-related consultation rates per 1000 consultations were calculated for one year prior to QOF to four years after QOF for those patients included in the case note review and the percentage change calculated. Consultation rates were also compared for GPs and practice nurses and between countries. However, practice 2 was excluded from the calculation of GP and practice nurse-led diabetic consultations due to discrepancies in the coding the professional involved in these particular consultations.

Clinical variables, for example whether or not a patient had had their blood pressure measured in the previous year, were converted into a binary yes/no variable and the number of patients who fulfilled a criterion was obtained. Thus the percentage achievement for each variable was calculated using the eligible denominator population.

11.2.5 Semi-structured interviews with patients

Patients were asked if they would be willing to be interviewed by a research (AR or SG) about their experience of care in their practice. Of those who agreed, 19 were selected for interview on the basis of age, gender, condition and registered practice in order to obtain a spread of patient experience across the embedded case study practices. Interviews were transcribed and analysed thematically using NVIVO.

11.3 Results

11.3.1 Case note review

The case notes of 219 patients, who gave consent, were reviewed: 128 (58.4%) from England; 91 (41.6%) from Scotland. Patient demographics are reported in Table 18. The patient populations in England and Scotland were similar, although patients were slightly younger in Scotland, probably reflecting the larger student population in Practice 7.

Table 18. Characteristics of patients participating in case note review (Number (% of column population))

	England (n = 128)	Scotland (n = 91)	Total (n = 219)
Location			
Practice 1	38 (29.7)	-	38 (17.4)
Practice 2	53 (41.4)	-	53 (24.2)
Practice 3	25 (19.5)	-	25 (11.4)
Practice 4	12 (9.4)	-	12 (5.5)
Practice 5	-	31 (34.1)	31 (14.2)

Practice 6	-	30 (33.0)	30 (13.7)
Practice 7	-	14 (15.4)	14 (6.4)
Practice 8	-	16 (17.6)	16 (7.3)
Gender			
Male	66 (51.6)	47 (51.7)	113 (51.6)
Female	62 (48.4)	42 (46.2)	104 (47.5)
	Fisher's Exact test = 0.891.		
Age (Mean (SEM))	66.4 (1.24)	61.3 (1.25)	64.3 (0.91)
	t-test = 2.89 p = 0.004		
Tracker condition			
Diabetes	109 (85.2)	70 (76.9)	179 (81.7)
Rheumatoid arthritis	19 (14.8)	21 (23.1)	40 (18.3)
	Fisher's Exact test = 0.155.		
Co-morbidities (Median, IQR)	2.0 (1.0 – 3.0)	1.0 (0 – 1.0)	1.0 (0 – 1.0)

Overall, 179 (81.7%) patients in our sample group had diabetes; 40 (18.3%) had rheumatoid arthritis, of which 7 also had type-2 diabetes as a co-morbid condition. The length of time since diagnosis was comparable for the two tracker conditions: diabetes: mean of 9.4 years (SEM 0.56); rheumatoid arthritis: 9.3 years (SEM 1.23); t-test = 0.127, p = 0.899. Of the 179 diabetics, 19 (10.6%) had type 1 diabetes. Type 1 diabetics had been diagnosed for a significantly longer time period than type 2: 19.0 years (SEM 2.96) vs 8.3 years (SEM 0.433) vs rheumatoid arthritis 9.3 years (SEM 1.23); one-way ANOVA F (df 2) = 21.0, p < 0.0001.

There was, however, a significant difference in the length of time from diagnosis between the two countries: England: mean of 11.3 years (SEM 0.62); Scotland: 6.5 years (SEM 0.76); t-test = 4.893, p < 0.0001. This was not due to a difference in the proportion of patients diagnosed with type-1 diabetes (data not shown), but may partly reflect the younger population in the Scottish practices.

The number of major co-existing conditions, including CHD, asthma, hypertension, depression, was also calculated (Table 18). However, some patients had as many as 5 major concomitant conditions.

Consultation rates were higher for diabetes than for rheumatoid arthritis in both countries (Table 19). Within each tracker condition, consultation rates were higher for practice nurses than for GPs. Comparing the rates in each country, consultation rates were higher in England than in Scotland pre-QOF, but by Year 4 of QOF rates were higher in Scotland, for everything except GP-led diabetes consultations (England: 96.0 per 1000 consultations; Scotland: 52.8 per 1000 consultations).

Overall, consultation rates for diabetes increased over time from the year pre-QOF to Year 4 of QOF, for both GP and practice nurse consultations. Consultation rates related to rheumatoid arthritis fell over this time period, due to the almost 20% decrease in GP-led consultations. However, this masked differences observed between the

two countries. Consultations in Scotland rose more steeply from the year pre-QOF to Year 3, particularly for practice nurses, although there was a decline in Year 4 for rheumatoid arthritis (Figure 11). Over the five year time period, there was a greater increase in consultations related to diabetes in Scotland than in England. This was due to the much higher increase in practice nurse consultations in Scotland (England: 4.4% increase; Scotland: 61.4% increase).

Consultations related to rheumatoid arthritis rose in Scotland over this time period, for both GPs and practice nurses, but fell for both groups in England, particularly GPs.

The content of the consultations over time was also examined. Relevant clinical data were missing for 3 diabetic patients, so they were excluded. However, diabetes care for the 7 patients who also had rheumatoid arthritis was included in the diabetic population.

Table 20 shows that, overall, the percentage of patients meeting the quality criterion increased year-on-year for all diabetic criteria, for most of the rheumatoid arthritis criteria and for flu immunisation. Practice nurses were doing more than GPs in relation to blood pressure measurement and flu immunisation. However, for many of the other process measures, such as measurement of HbA1c and cholesterol, monitoring of U&Es and LFTs, GPs and practice nurses were splitting the workload between them. However, while GP workload in relation to these criteria had remained fairly stable over the five-year period, practice nurse contributions had increased markedly, especially over the first two years of the QOF (Figure 12). The one area that remained under the control of the GPs was prescribing for rheumatoid patients. Although the number of patients prescribed NSAIDs or DMARDS was small, this was always done by a GP, not a practice nurse. Similarly, the small number of referrals to secondary care for diabetic or rheumatoid-related reasons was always by a GP (data not shown).

Table 19. Consultation rates for patients included in the case note review per 1000 consultations per year

	Pre-QOF (2003-04)	Year 1 (2004-05)	Year 2 (2005-06)	Year 3 (2006-07)	Year 4 (2007-08)	Year 4 % difference from pre-QOF ^a
England and Scotland.						
Diabetes-related consultations ^b	202.7	214.5	243.0	260.4	269.8	33.1
Diabetes-related consultations with GP ^b	57.4	59.1	57.5	76.2	71.4	24.5
Diabetes-related consultations with PN ^b	125.9	125.9	154.3	155.9	162.3	28.9
Rheumatoid arthritis-related consultations	72.3	71.1	74.7	77.8	70.4	-2.7
Rheumatoid arthritis-related consultations with GP	26.8	30.1	29.7	23.8	21.7	-19.1
Rheumatoid arthritis-related consultations with PN	45.0	41.0	44.5	54.0	47.7	6.1
England.						
Diabetes-related consultations ^b	224.4	215.6	252.4	237.7	249.7	11.3
Diabetes-related consultations GP ^b	72.8	82.3	95.8	87.9	96.0	31.9
Diabetes-related consultations with PN ^b	147.1	126.2	156.5	149.9	153.6	4.4
Rheumatoid arthritis-related consultations	74.5	69.8	70.9	54.6	57.2	-23.3
Rheumatoid arthritis-related consultations with GP	26.7	27.0	27.4	17.3	15.0	-43.8
Rheumatoid arthritis-related consultations with PN	46.0	42.8	42.5	37.3	40.3	-12.4
Scotland.						
Diabetes-related consultations	180.9	213.6	235.7	278.7	285.0	57.6
Diabetes-related consultations with GP	41.9	39.9	28.0	66.8	52.8	26.3
Diabetes-related consultations with PN	104.6	125.6	152.6	160.8	168.9	61.4
Rheumatoid arthritis-related consultations	68.8	72.8	78.9	104.4	85.0	23.6
Rheumatoid arthritis-related consultations with GP	26.9	34.0	32.2	31.3	29.0	7.8
Rheumatoid arthritis-related consultations with PN	43.3	38.7	46.7	73.1	56.0	29.1

a. % Difference = ((Consultation rate in year 4 – Consultation rate in year 0)/ Consultation rate in year 0) x 100.

b. Excluding practice 2, due to lack of data on number of GP and practice nurse consultations for diabetes.

Figure 11. Consultation rates for each condition from 1 April 2003 to 31 March 2008

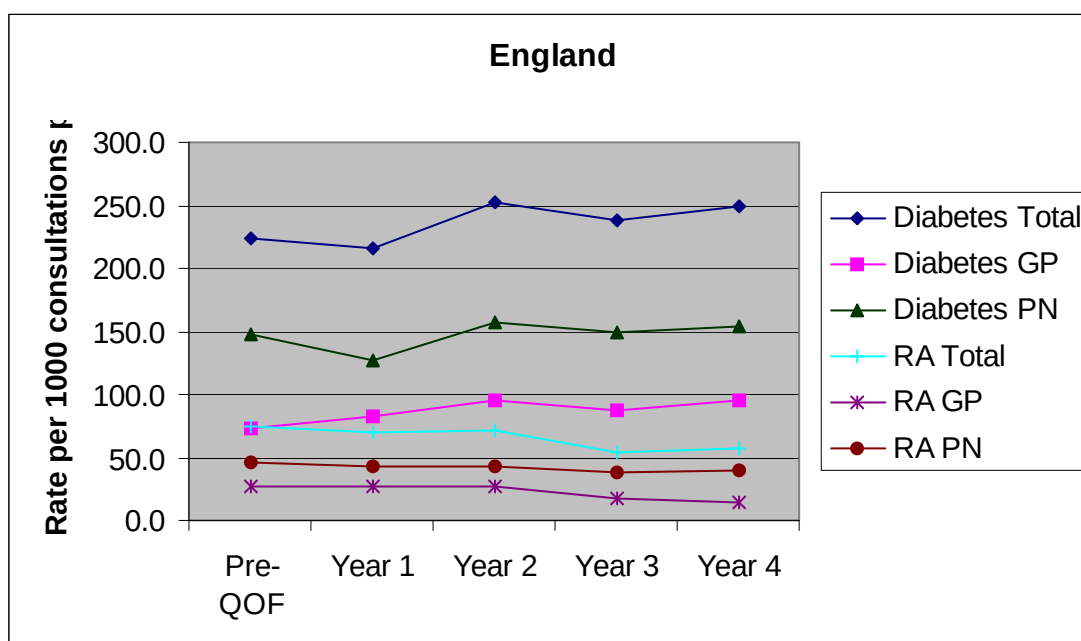
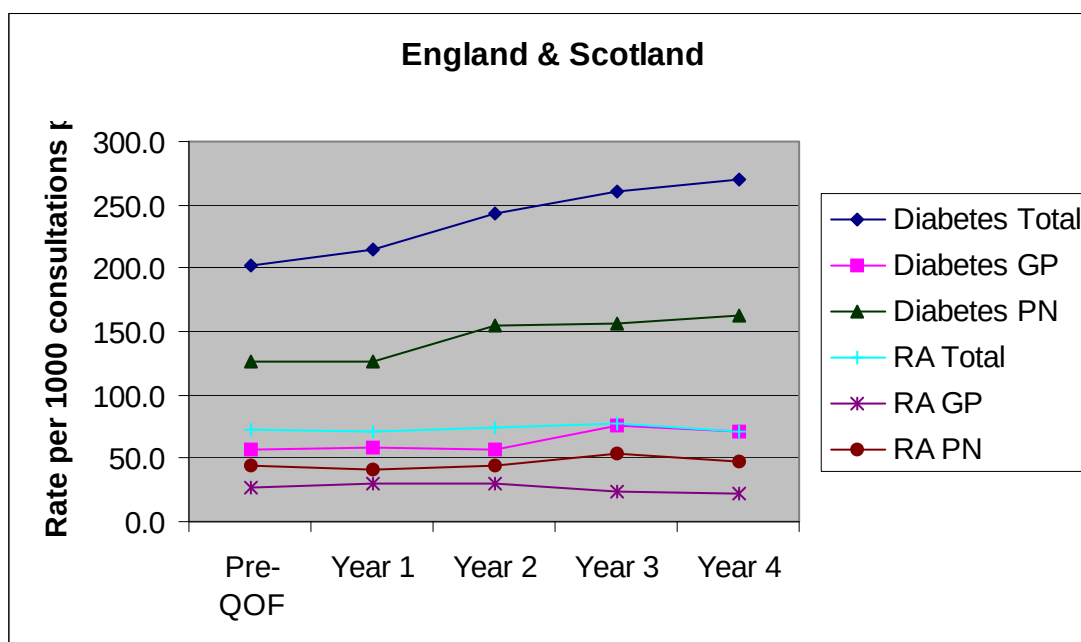
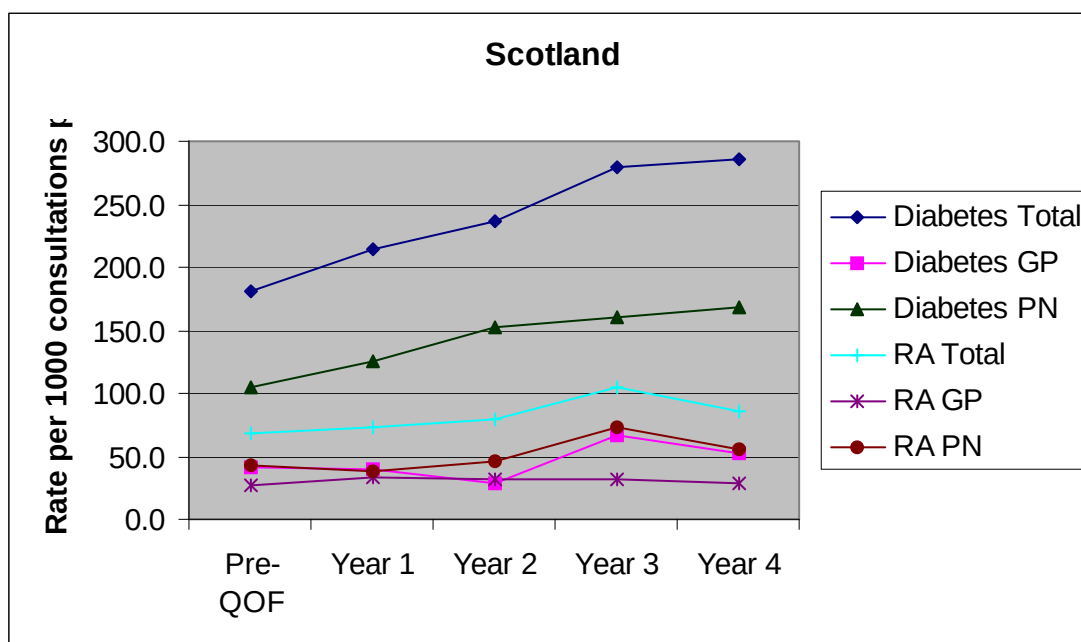


Figure 11 (cont'd)



**Table 20. Patients for whom each criterion was fulfilled in that year
(Number (%))**

	Pre-QOF (2003-04)	Year 1 (2004-05)	Year 2 (2005-06)	Year 3 (2006-07)	Year 4 (2007-08)	Absolute difference Pre-QOF to Year 4 (% points)
Care for patients with diabetes (n = 183)						
Number of patients whose blood pressure was recorded	132 (72.1)	142 (77.6)	151 (82.5)	152 (83.1)	159 (86.9)	14.8
Number of patients whose blood pressure was recorded by a GP	83 (45.4)	78 (42.6)	90 (49.2)	93 (50.8)	92 (50.3)	4.9
Number of patients whose blood pressure was recorded by a practice nurse	111 (60.7)	125 (68.3)	141 (77.0)	139 (76.0)	139 (76.0)	15.3
Number of patients whose blood pressure was 145/85 or less at least once in that year	102 (55.7)	107 (58.5)	130 (71.0)	126 (68.9)	132 (72.1)	16.4
Number of patients whose HbA1c was recorded	130 (71.0)	138 (75.4)	148 (80.9)	152 (83.1)	163 (89.1)	14.8
Number of patients whose HbA1c was recorded by a GP	89 (48.6)	83 (45.4)	81 (44.3)	91 (49.7)	94 (51.4)	4.9
Number of patients whose HbA1c was recorded by a PN	78 (42.6)	74 (40.4)	91 (49.7)	80 (43.7)	91 (49.7)	15.3
Number of whose HbA1c was ≤ 10.0 at least once in that year	102 (55.7)	104 (56.8)	108 (59.0)	109 (59.6)	116 (63.4)	16.4

Number of whose HbA1c was ≤ 7.5 at least once in that year	82 (44.8)	82 (44.8)	85 (46.4)	91 (49.7)	90 (49.2)	16.4
Number of patients whose cholesterol was measured	113 (61.7)	132 (72.1)	139 (76.0)	137 (74.9)	151 (82.5)	20.8
Number of patients whose cholesterol was measured by a GP	64 (35.0)	82 (44.8)	76 (41.5)	75 (41.0)	83 (45.4)	8.9
Number of patients whose cholesterol was measured by a PN	62 (33.9)	69 (37.7)	72 (39.3)	70 (38.3)	76 (41.5)	7.6
Number of whose cholesterol was ≤ 5.0 at least once in that year	65 (35.5)	82 (44.8)	91 (49.7)	92 (50.3)	96 (52.5)	17.0
Care for patients with rheumatoid arthritis (n = 33)						
Number of patients prescribed NSAIDs	10 (30.3)	10 (30.3)	10 (30.3)	9 (27.3)	7 (21.2)	-9.1
Number of patients prescribed NSAIDs by a GP	9 (27.3)	9 (27.3)	10 (30.3)	9 (27.3)	7 (21.2)	-6.1
Number of patients prescribed NSAIDs by a PN	0 (0)	1 (3.0)	0 (0)	0 (0)	0 (0)	0
Number of patients prescribed DMARDS	9 (27.3)	9 (27.3)	11 (33.3)	16 (48.5)	11 (33.3)	6.1
Number of patients prescribed DMARDS by a GP	8 (24.2)	9 (27.3)	11 (33.3)	16 (48.5)	11 (33.3)	9.1
Number of patients prescribed DMARDS by a PN	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0
Number of patients whose FBC was monitored	20 (60.6)	18 (54.5)	22 (66.7)	23 (69.7)	26 (78.8)	18.2
Number of patients whose FBC was monitored by a GP	15 (45.5)	14 (42.4)	15 (45.5)	17 (51.5)	18 (54.5)	9.0
Number of patients whose FBC was monitored by a PN	7 (21.2)	6 (18.2)	14 (42.4)	16 (48.5)	14 (42.4)	21.2
Number of patients whose U&Es were monitored	20 (60.6)	19 (57.6)	21 (63.6)	23 (69.7)	25 (75.8)	15.2
Number of patients whose U&Es were monitored by a GP	15 (45.5)	15 (45.5)	14 (42.4)	16 (48.5)	16 (48.5)	3.0
Number of patients whose U&Es were monitored by a PN	7 (21.2)	8 (24.2)	14 (42.4)	16 (48.5)	14 (42.4)	21.2
Number of patients whose LFT were monitored	18 (54.5)	16 (48.5)	20 (60.6)	22 (66.7)	23 (69.7)	15.2
Number of patients whose LFTs were monitored by a GP	13 (39.4)	12 (36.4)	13 (39.4)	15 (45.5)	14 (42.4)	3.0
Number of patients whose LFTs were monitored by a PN	6 (18.2)	8 (24.2)	14 (42.4)	15 (45.5)	13 (39.4)	21.2
Care for both groups of patients (n = 216)						

Number of patients recorded as receiving a flu immunisation	112 (51.9)	125 (57.9)	128 (59.3)	139 (64.4)	138 (63.9)	12.0
Number of patients recorded as receiving a flu immunisation by a GP	25 (11.6)	37 (17.1)	40 (18.5)	28 (13.0)	28 (13.0)	1.4
Number of patients recorded as receiving a flu immunisation by a PN	80 (37.0)	88 (40.7)	88 (40.7)	105 (48.6)	109 (50.5)	13.5

Figure 12. Clinical care for diabetic and rheumatoid arthritis patients

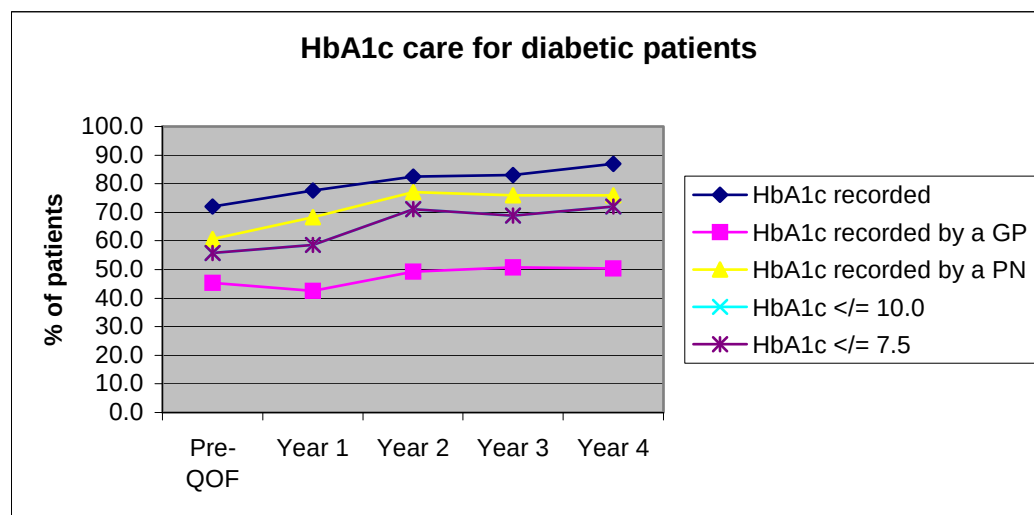
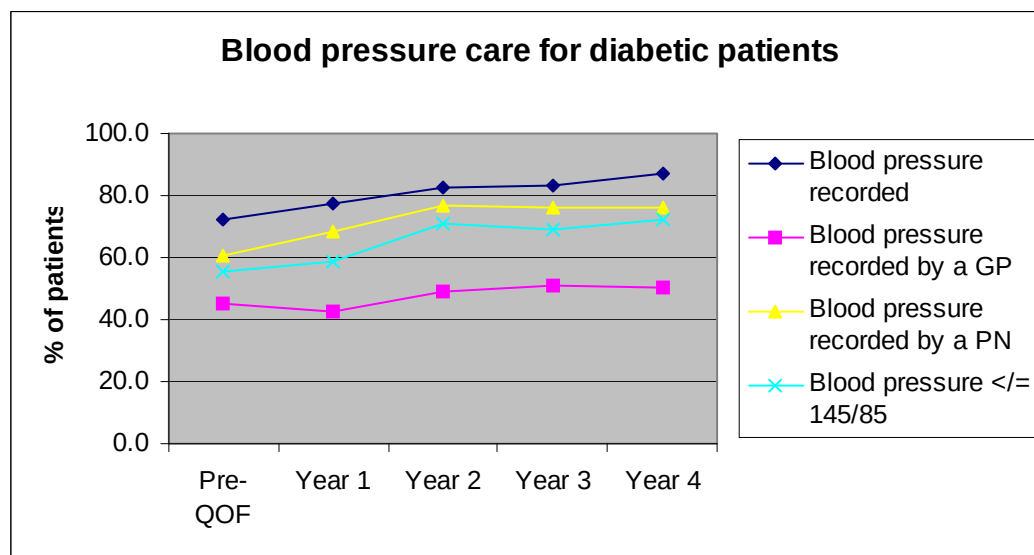


Figure 12 (cont'd)

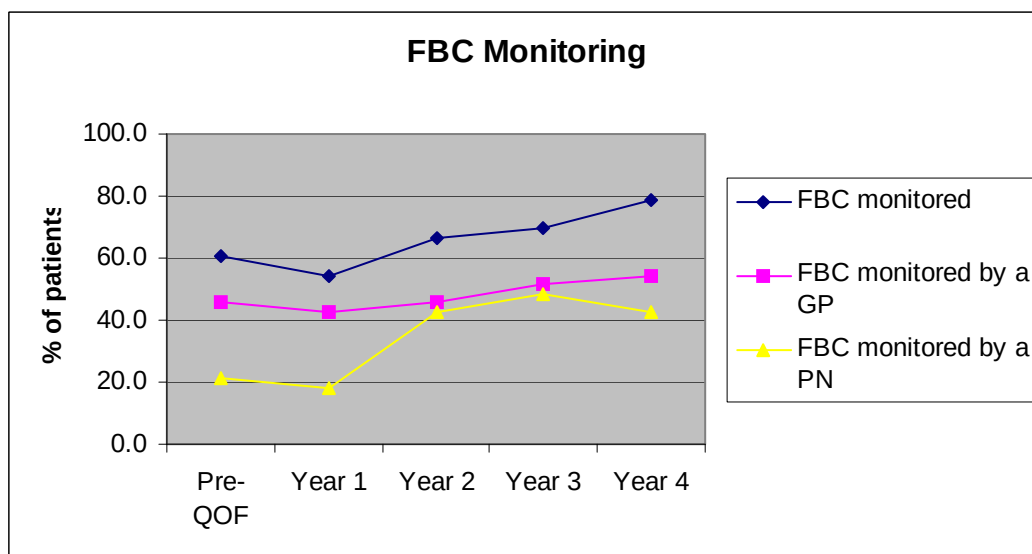
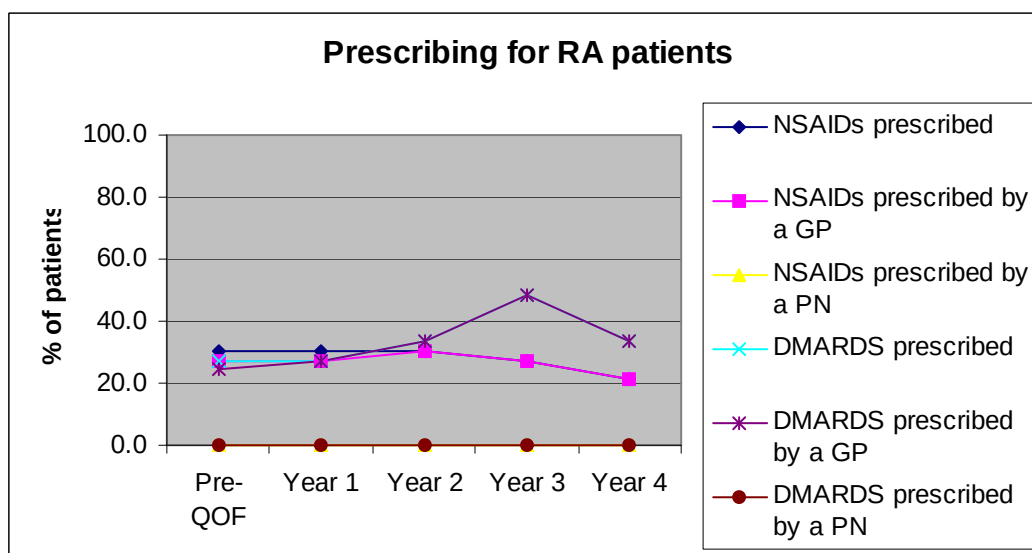
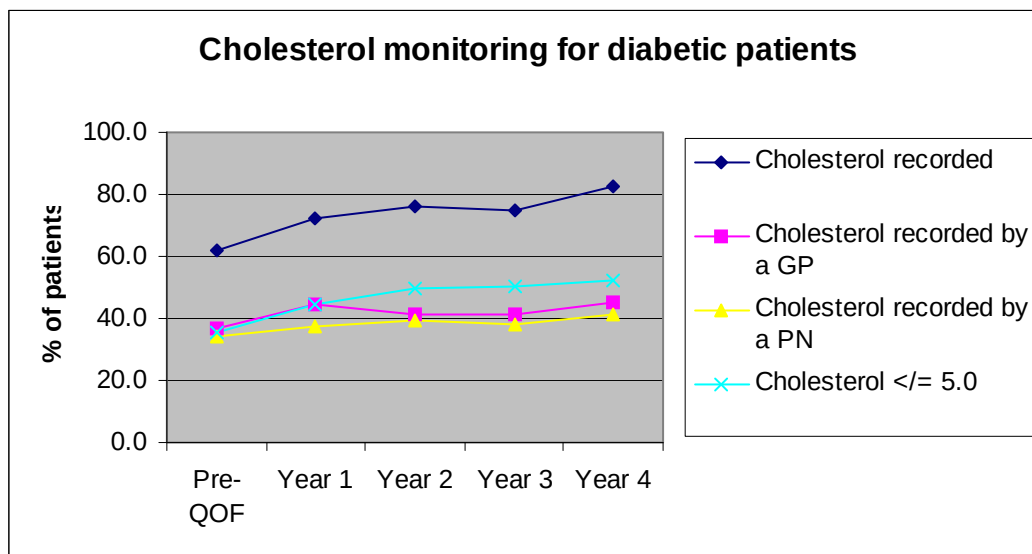
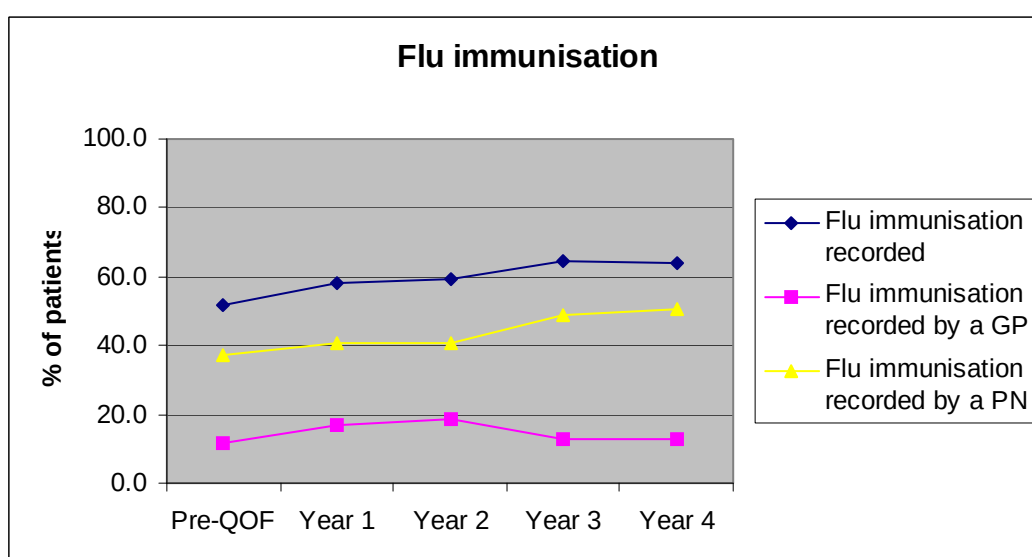
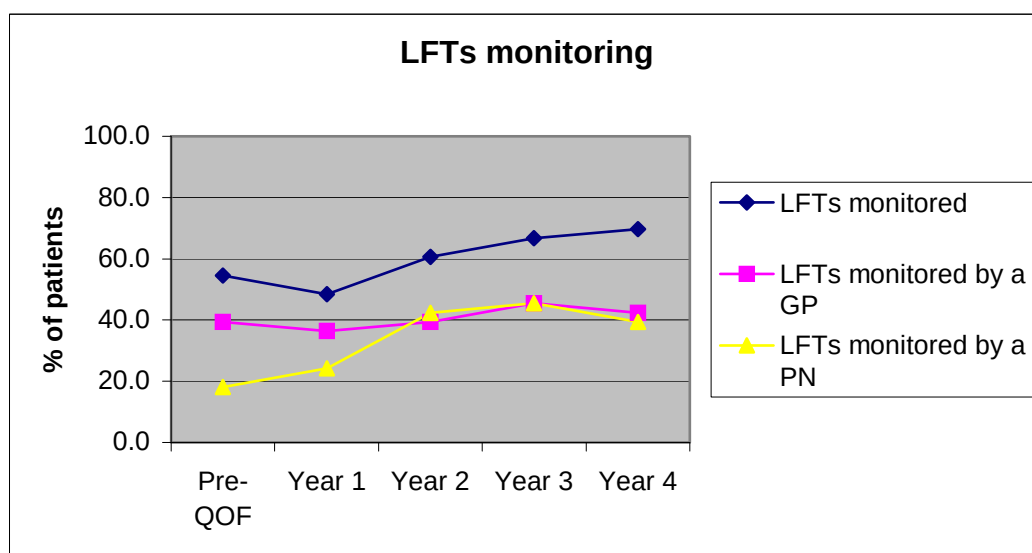
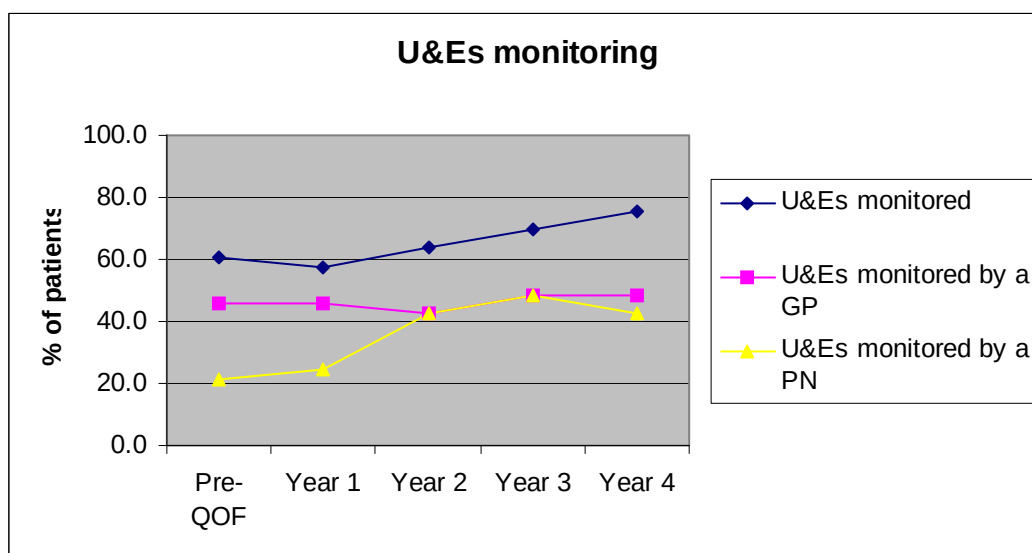


Figure 12 (cont'd)



11.3.2 Patients' views of their care

In total, 19 patients were interviewed: 14 in England; 5 in Scotland.
Patient characteristics are shown in Table 21.

Table 21. Characteristics of interviewed patients

	Tracker Condition	Practice	
England.			
Patient 1	Rheumatoid arthritis	Practice 1	Male; 60-69 year age band. Rheumatoid arthritis for 26 years. Four major co-morbidities, including CHD & hypertension
Patient 2	Rheumatoid arthritis	Practice 1	Female; 40-49 year age band. Rheumatoid arthritis for 11 years.
Patient 3	Diabetes	Practice 1	Male; 60 - 69 year age band. Diabetes for 14 years. Five major co-morbidities, including CHD & hypertension.
Patient 4	Diabetes	Practice 1	Female; 60 - 69 year age band. Diabetes for 11 years. Two major co-morbidities, including hypertension.
Patient 5	Rheumatoid arthritis	Practice 1	Male; age unknown. Rheumatoid arthritis for 20 years. Two major co-morbidities, including hypertension.
Patient 6	Rheumatoid arthritis	Practice 2	Female; 60 - 69 year age band. Rheumatoid arthritis for 18 years. Two major co-morbidities, including hypertension.
Patient 7	Diabetes	Practice 2	Male; 50 - 59 year age band. Diabetes for 19 years. Four major co-morbidities, including hypertension.
Patient 8	Rheumatoid arthritis	Practice 2	Female; 50 - 59 year age band. Rheumatoid arthritis for 5 years. One major co-morbidity.
Patient 9	Diabetes	Practice 2	Male; 60 - 69 year age band. Diabetes for 5 years. One major co-morbidity.
Patient 10	Diabetes	Practice 2	Female; 60 - 69 year age band. Four major co-morbidities, including hypertension.
Patient 11	Diabetes	Practice 2	Female; 40 - 49 year age band. Diabetes for 13 years. Two major co-morbidities.
Patient 12	Diabetes	Practice 3	Female; 50 - 59 year age band. Diabetes for 8 years. One major co-morbidity.
Patient 13	Rheumatoid arthritis	Practice 3	Female; 50 - 59 year age band. Rheumatoid arthritis for 9 years.
Patient 14	Diabetes	Practice 3	Male; 50 - 59 year age band. Diabetes for 33 years. Three major co-morbidities, including hypertension.

Scotland.			
Patient 15	Diabetes	Practice 6	Male; 60 - 69 year age band. Diabetes for 10 years.
Patient 16	Diabetes	Practice 6	Male; 60 - 69 year age band. Diabetes for 8 years.
Patient 17	Diabetes	Practice 7	Female; 60 - 69 year age band. Diabetes for 20 years. Four major co-morbidities.
Patient 18	Diabetes	Practice 7	Female; age unknown. Diabetes for 8 years.
Patient 19	Rheumatoid arthritis	Practice 8	Male; 60 - 69 year age band. Rheumatoid arthritis for 10 years. One major co-morbidity.

All patients were very satisfied with the care they received, both for the tracker condition and more generally. Most had been with the same practice for many years. Diabetic patients in particular reported having their disease reviewed on a regular basis by a practice nurse, rather than the GP. For some patients, this was a long-standing arrangement; for others, practice nurses had taken over care over the past few years, but this appeared to be unrelated to the implementation of nGMS. Rather, it appeared to be due to the development of shared care between primary and secondary care, with most practices responsible for routine monitoring. For most patients, the GP was only involved when changes were required to their medication or if there were problems related to the management of the condition.

I normally see Sister [Name] for my diabetic review yes. I mean sometimes she refers me to a doctor, obviously it's like when I went onto some medicine. Obviously if there is a question mark about a blood test or such I get referred across to the doctor, yes.

(England Stage 2, Case Study 1, Patient 12 (Diabetes; Practice 3), Paragraph 57)

With the diabetic nurse I get twice a year tests, one half yearly and then like a big MOT. With the doctor I go on an ad hoc basis when I need [to] and I don't tend to bother him all that much. If I feel I need to go then I will go but I tend to be able to cope with my diabetes on my own. I know, my body tells me whether I am coping or not coping, so I don't have too much of a problem.

(Scotland Stage 2, Case Study 3, Patient 15 (Diabetes; Practice 6), Paragraph 22)

Much of the care for rheumatoid arthritis patients remained in secondary care and several patients had little contact with their practice. Those whose care was shared between the hospital and the practice saw the practice nurse for straightforward aspects of their care, such as blood pressure measurement and taking bloods for regular checks. Again, this had been the case for a number of years and had not changed as a result of nGMS.

Interviewer: Do you have any appointments with the doctor in relation to the blood pressure management or anything like that?

Interviewee: No.... [Break].... It's always the nurse, yeah.

(England Stage 2, Case Study 1, Patient 8 (Rheumatoid arthritis; Practice 2), Paragraphs 367-374)

As with the diabetics, rheumatoid patients saw the GP for more complicated aspects of their care, for example in relation to flare-ups of the disease or for medication reviews. Specialist medications, in particular for rheumatoid arthritis, but also for other co-morbid conditions were also seen as in the domain of hospital-based “specialists”.

Interviewer: Right and are they with the nurse the medication reviews

Interviewee: No, no always with the doctor. I mean if I go to see the nurse I might say can I have a prescription and they would take it to the doctor to get it signed they will do that for me but I mean the change in medication or anything like that not the nurse always [the doctor].

(England Stage 2, Case Study 1, Patient 1 (Rheumatoid arthritis; Practice 1), Paragraphs 199-200)

And you know, the doctors [GPs] knew what, I mean they never touched those tablets because those tablets are specialist, because I was having trouble with them a few weeks ago because every so often they need topping up. [Break] And I went and they said, “well we don’t touch them because they’re specialist tablets”, so I said, “yeah I know that” so I had to go back to the hospital for them to alter them.

(England Stage 2, Case Study 1, Patient 4 (Diabetes; Practice 1), Paragraphs 333-339)

Other consultations were also used for opportunistic check-ups.

I don’t know to be honest with you I would imagine it would be at least once a year possibly twice I don’t really know because I mean sometimes I might have to go with say a chest cold and she would say while you are here do this or checked that or something

(England Stage 2, Case Study 1, Patient 1 (Rheumatoid Arthritis; Practice 1), Paragraph 189)

Generally, patients appeared to be unaware of changes in the organisation of their care over the years. Many of the patients had a long-standing relationship with the practice nurse, who was a key source of information and support as well as providing clinical care.

Interviewer: Where did you get you information on how to control it was it mainly through the practice.

Interviewee: Mainly through the practice, practice nurse was very helpful, I say in the first instance and she has been since from that time when you were sort of going into the unknown, very helpful, made sure that I was aware of everything that I should be doing and shouldn’t be doing.

(Scotland Stage 2, Case Study 3, Patient 15 (Diabetes; Practice 6), Paragraphs 64 & 65)

This was exemplified in practice 7, where patients repeatedly referred to the nurse by her first name. However, some patients were aware of being reviewed more frequently than in the past and the greater use of nurse-led clinics.

I think they do a lot more reviews; my friend goes to a blood pressure clinic..... And she has her asthma monitored as well, again usually with the nurse... So there’s a lot more nurse-led clinic, they’ve brought a nurse practitioner in.

(England Stage 2, Case Study 1, Patient 10 (Diabetes; Practice 2), Paragraph 464)

Some patients were aware of more data being collected in relation to their diabetic care, for example in relation to lifestyle advice. This was seen as beneficial.

Interviewee: They did give me that questionnaire which you fill in and put in to the computer, my sort of lifestyle issues, a lot of that stuff was already, in my case, was already there because we had gone through it and discussed it and various things.

Interviewer: How useful do you feel the lifestyle questions are?

Interviewee: Oh it is. I mean it's useful and also relates to it. The biggest problem is, the biggest problem is if in my assessment you don't require major lifestyle changes, its small lifestyle changes, to achieve those and actually do them, particularly with type 2 diabetes is more difficult.

(Scotland Stage 2, Case Study 3, Patient 16 (Diabetes; Practice 6), Paragraphs 109-111)

However, there were some concerns expressed about the increased use of targets and box-ticking within the consultation, at least by patients in Scotland.

I don't agree with that, I agree with they will obviously have some measures in place and have to meet certain standards and all the rest of it to say that they are meeting their targets but not everything in life is targetable and the Government is trying to apply targets to absolutely everything and I don't think medicine is one that necessarily can be targeted....

(Scotland Stage 2, Case Study 3, Patient 16 (Diabetes; Practice 6), Paragraph 271)

The problem I, I think, she's [the practice nurse] ticking the boxes but she's taking it onboard, as well, in a more subtle way. But I suspect, in terms of monitoring, those ... numbers with tick-boxes and things like that it must lose a lot of information if you start to aggregate it all.

(Scotland Stage 2, Case Study 3, Patient 18 (Diabetes; Practice 7), Paragraph 100)

Access and appointment availability were also issues, particularly in England. Some faced long waits to see the GP of their choice, particularly in practices where patients could not book an appointment any longer than three weeks in advance.

At one point you could book an appointment up to 6 weeks, if I went in and the doctors said come back in 6 weeks I could have booked that appointment that day. Now if I go and he says oh come back in 6 weeks, I go to the desk to book oh we can only book it 3 weeks in advance, you'll have to ring us which I find if he is giving me a date I should be able to book the appointment and they should block it off for me and say okay but the computer system only takes them to 3 weeks. Which I find is a bit of a nuisance..... [Break]....To remember to ring up and order and then they'll say oh we haven't got one for the next 3 weeks because we are already booked up.

(England Stage 2, Case Study 1, Patient 2 (Rheumatoid Arthritis; Practice 1), Paragraphs 144-152)

Thus, patients had noticed the impact of extended access. This was commented on by several patients, particularly the ability to get appointments in the evening or a Saturday morning or the provision of open surgeries where patients could turn up without an appointment and wait. This was generally regarded as a positive change and one that had occurred relatively recently:

.... they offered me a Saturday appointment. ...[Break] ... maybe it's a one off you know and when I went in, of course I said to the doctor, I said, "Oh are you working overtime?", we were laughing and he said, "Oh we work out of hours. ...[Break]So that's a good thing, especially the late one in the week for people who are working.

(England Stage 2, Case Study 1, Patient 4 (Diabetes; Practice 1), Paragraphs 400-404)

....it's [getting an appointment] improved a great deal since they've done the longer hours.

(England Stage 2, Case Study 1, Patient 7 (Diabetes; Practice 2), Paragraph 401)

At least one patient discussed the provision of open surgeries, which allowed patients to see a doctor within two days, in the light of national targets.

I should imagine the doctors have probably cut the appointments because they have the open surgery and of course it gives them more time to do their paperwork and all the other procedures so um, but from patients' point of view I mean the open surgery is a good idea; because at least you're going to see a doctor within two days, you know, as, this is what this is stipulating now isn't it? Being able to see a doctor within two days so that's when they brought it, I think it was then that came out they brought in the open surgery because that covers, covers them then. You could see a doctor.

(England Stage 2, Case Study 1, Patient 4 (Diabetes; Practice 1), Paragraph 500)

11.3.3 Patient and public involvement since the new contract

The principal means by which patients and public had been involved in the new contract was in QOF review visits, where the panel generally included a lay assessor. In England, lay assessors were drawn from the Professional Executive Committee or the Patient & Public Involvement forum, although other approaches included recruiting volunteers from local councils and local advertising. Their involvement was regarded as valuable because

they ask questions that in some cases PCT members are reluctant to because the of relationship creation and continuation.

(England Stage 1, National, Interview 19, Paragraph 303)

In England, the development of good communication methods to both involve, and inform, the public of commissioning decisions was seen as important. Communication channels, such as the Internet, were regarded as a useful medium to inform patients of their rights, for example to change practices, and to give them information on practices. However, it was recognised that releasing information on practice performance, for example QOF data, would require significant improvement in the way such information was communicated.

I think with the public it's just a completely different ball game and I don't think anybody centrally has started to play that game very well at all. I think that we pay a lip service to the patient agenda and choice and we have got patient questionnaires, we have got NHS choices, we have got so many things that are trying to make the information more accessible to the public and we are actually not that concerned about what they do with it. We are not that concerned about how, them accessing this information and what they want, changes, anything. So I think we are paying lip service to it and not very well.

(England Stage 1, National, Interview 36, Paragraph 83)

Partnership working was generally viewed positively, albeit that interviewees had few examples of practical implementation.

I think we could all benefit from working more closely with patients, go back to partnership work. I like ways of partnership when its partnership with patients and they are empowered, again another jargon word, but nonetheless they are equals as individuals and the delivery of their care and designs of care are also empowerment of partnership with communities. We are the services that they need and the services are then delivered in the most appropriate place from the most appropriate person.

(Scotland Stage 1, Case Study 3 – PCO (CHP), Interview 2, Paragraph 263)

Practices were encouraged to have patient liaison groups, however this was not mentioned by any of the practitioners in this study. The drug misuse enhanced service did have a service user's group in place and would use this forum to feedback and have a dialogue over, for example the results of client surveys.

If we can't change something then work out how we're then going to feed that back through the service user forum and say, yes we're aware, thank you for this - but for these reasons we can't change, or we can change this here, if it's a structural thing; sometimes of it's to do with user friendliness of buildings and things like that, so you can say we can deal with it here and here but we're actually waiting for a lift or whatever it is.

(England Stage 2, Case Study 1 - PCT, Interview 60, Paragraph 184)

However, it was also recognised by at least one interviewee in England that patients had particular needs from the NHS, which were probably not being met.

Patients want a local health service that is reasonably good, that is reasonably accessible, that delivers a fair standard, and what they don't want are glittering ivory tower centres that are miles away from where they are, they also want decent local service, which doesn't have to be all singing all dancing, but it has to be accessible and reasonable, and what they're getting now is more and more concentration of ivory tower medicine and I think that's poor for them.

(England Stage 1, National, Interview 26, Paragraph 122)

This interviewee went on to say:

..... patient involvement is very important, not just because it gives them a feeling of being in control or of being participants, but also because it gives them understanding, and I think we don't involve patients enough.

(England Stage 1, National, Interview 26, Paragraph 122)

There had been little or no public involvement in the development of the new contract. Public involvement would, however, have resulted in different priorities and targets within the contract.

I think the absence of lay voice a public voice in the development of the contract was deafening but and it's a big but if they had been involved how would it look different, it almost certainly would have looked different as in less evidence based because we know that the public want things that the health service is less willing to provide for example more complimentary care, how would you objectify that and attach targets to that.

(England Stage 1, National, Interview 33, Paragraph 161)

Indeed, one interviewee in Scotland commented:

I would say probably if you ask patients about the new GMS contract they wouldn't probably be able to tell you.

There was evidence of local developments in patient and public involvement. The PBC Consortia were beginning to involve patients in the design of services. One PBC Consortium was also trying to develop its diabetes care and hoped to involve patients in that process, for example by providing information on the types of routine monitoring patients should expect. There were also public representatives on the boards of the CHPs in Scotland. This, however, was raising some interesting issues in relation to their role in the governance of the GMS contract held between practices and the Health Board/CHP.

It does begin to impinge on GMS and it's interesting that there's this contractual relationship between the practices and the health board and then we are getting the public involved and really there isn't a lot of room for a public involvement role in that contractual relationship but some of the points that the public delegates raise with us are about that, they are about how, why is it that practice can have different approaches to appointment systems you know I can phone my practice and get an appointment tomorrow the next person says it takes me 6 weeks they say why is that, is that fair. We can't actually make that change through the contract because they will be fully in the terms of their contract but that's hard for the public to understand.

(Scotland Stage 1, Case Study 4 – PCO (CHP), Interview 15, Paragraph 144)

11.4 Discussion

This chapter reports on the direct impact of the contract on patients, both in relation to recorded patient care and on patients' perceptions of their care, and on patient and public involvement.

A quantitative case note review focussed on two conditions – diabetes as an incentivised condition and rheumatoid arthritis as a non-incentivised condition in QOF – found that consultation rates increased for diabetes in both countries between 2003 and 2008. GP-led consultation rates for diabetes rose more for this patient population in England than practice nurse-led consultations. However, patients reported that much of the routine monitoring was carried out by the practice nurses and this was supported by a review of the clinical content of the consultations. However, it may be that GPs are seeing diabetic patients more often in relation to reviewing their medication or that the high number of co-morbidities within the patient group means that GPs are focussed on care for more complex patients.

While consultation rates for rheumatoid arthritis patients fell in England over this time period, there was no impact on consultation rates for this group in Scotland. Thus, it was difficult to assess if care for this non-incentivised condition was truly being “crowded out”. One factor contributing to this might be the enhanced service for near patient testing, which incentivised the monitoring of a range of conditions within general practice, including rheumatoid arthritis. Indeed, a review of the clinical content of the consultation for the rheumatoid patients showed a sharp increase in number of patients being routinely monitored by practice nurses in years 1 and 2 of the QOF. Furthermore there are a range of incentives and models for sharing the management and monitoring of chronic conditions between specialists and primary care.

The history of the shift of responsibility for most diabetic patients to primary care is long-established, whereas the apparent complexity and evolving evidence and care pathways for disease modifying drugs for rheumatoid have acted as barriers to a comparable locus of care shift among these patients.

Patients themselves seemed unaware of changes to their care since the implementation of nGMS, with many reporting that practice nurses had always been integral to their care in the practice. Given the chronic nature of their conditions, this is unsurprising as practice nurses have been increasingly involved in chronic disease management over the past decade (96;131;142). However, some patients were now more aware of the use of targets to drive care and expressed mixed views of this. Access to general practice and the availability of appointments was the other area commented on, particularly in England where patients were generally supportive of initiatives to extend practice opening hours.

Thus, while there was evidence to show that the quality of care continues to improve for patients with a chronic condition, there was little evidence to suggest that patients are aware of any qualitative change in the organisation and delivery of their care.

There had also been limited involvement of patients or the public, either in the design of the new contract, or since its implementation. This reflects findings from other policy developments, including for example clinical governance (166;170). An additional barrier, however, may be contractual nature of the contract, with members of the public potentially unwilling to become involved in a setting which involves them overseeing and monitoring practices contracts with the PCO.

11.5 Conclusions

- Consultation rates for the diabetic patients included in this sample rose year-on-year since the implementation of the new contract.
- This was apparent in both countries; the consultation rate for both GPs
- and practice nurses.
- Consultation rates for rheumatoid arthritis patients in this sample decreased in England, but not in Scotland.
- There was evidence that the quality of care, as measured by the completion of quality criteria each year, improved year-on-year for both conditions.
- Much of the routine monitoring was conducted by practice nurses; GPs carried out more complex tasks, particularly prescribing.
- Patients were generally unaware of changes to the monitoring of their chronic disease over time; indeed most commented that they had always been routinely monitored over many years and, for diabetics in particular, this had usually been conducted by the practice nurse.

- Patients in England had noticed changes to their practice opening hours and in some practices, ease of getting an appointment, but did not equate this with the new contract.
- There was limited evidence of patient and public involvement in the new contract of services developing as a result of it.
- The principle exception to this was the use of lay assessors in QOF reviews.
- Increasing the role of the public in the governance of the contract may raise issues around contractual responsibility and probity.

12 Discussion and recommendations

The aims of this project were to explore the governance arrangements in different models of service provision emerging from the implementation of the new GMS contract; the impact of the incentives contained within the contract on the organisation and performance of primary care; and the impact of the new contract on professional skill-mix and patients' experience.

In addressing these aims, we had several research objectives.

1. To examine the overall impact of the new GMS contract on clinical activity and patient processes and outcomes.
2. To describe how governance arrangements under the new contract are interpreted and implemented in the design and management of different provider organisations (practices, enhanced services and out-of-hours services).
3. To examine how governance arrangements impact on the relationships between PCOs and professionals working within different provider organisations and on the organisation of professional work.
4. To explore how new opportunities: (a) for patient and public involvement AND (b) to pursue population health or equity of care through commissioning or use of new resources, are understood and in what ways, if any, these are addressed.
5. To identify whether shared learning between provider organisations, either directly or via the PCO, occurs.

These were addressed through three sequentially related stages, utilising quantitative and qualitative methodologies.

This chapter summarises the main findings and relates them back to the governance mechanisms and models discussed in Chapter 1. The findings are used to draw conclusions and to make recommendations for future policy, practice and research. First, however, we will outline the principal strengths and limitations of the work.

12.1 *Methodological considerations*

In Chapter 3 we outlined the principal methodological approach chosen for the study, that of case studies, integrating both qualitative and quantitative approaches. Here we briefly consider the strengths and limitations of these approaches.

12.1.1 **Case Studies**

PCOs are complex organisations. The literature suggests that, as a consequence, different models of governance will be enacted across PCOs (7;18;21). To explore this fully, we used a multiple case study

design with embedded units of analysis – the most complex of the options described by Yin (111). He contests that case study selection should be informed by a replication logic, i.e. cases are selected because they predict similar results (literal replication) or because they predict contrasting results, but for predictable reasons (theoretical replication). This presented a challenge because, although there was a growing body of evidence about the impact of nGMS on practices, there was little on its impact on the relationship between PCOs and practices. In addition, we also wished to compare the impact of the devolving health care systems in England and Scotland. We therefore developed theoretical propositions to test across the case studies, for example:

- That the different managerial ethos developing in each country (crudely, managerialism in England versus professionalism in Scotland) would lead to different mechanisms of governance in each country.
- That the response to QOF in high achieving practices would be similar in England and Scotland in terms of how practices responded externally to PCO monitoring and internally to the division of labour required to produce high QOF scores.
- That the policy driver of PBC in England would alter PCO and practices responses to other service delivery mechanisms, such as the enhanced services.
- That the increased external governance requirements would impact on how practices organised their care for patients in both England and Scotland.

We selected cases on the basis of theoretical replication, i.e. PCOs serving similar populations but located in different health systems, namely England and Scotland. We chose contrasting sites within countries, matched to comparison sites between countries using criteria known to impact on organisational delivery, including the level of socio-economic deprivation in the population served and the mean number of WTE GPs in a practice (Box 9). Embedded cases within each PCO were selected on the basis of literal replication, for example that practices with high QOF scores would respond similarly to monitoring and governance from their PCO, regardless of the health care system in which they were located.

Box 9 Salient features of the PCO case studies

Case Study 1. PCO in England. Accountable to the SHA. Population of 442,000; deprived population (IMD income score of 31.0) 104 general practices; 67 GMS practices. 45% of practices single-handed. Mean of 3.1 WTE GPs per practice. Mean QOF score per GMS practice in 2005-06: 1002.	Case Study 3: NHS Health Board in Scotland. Accountable to the Scottish Government Health Department. Population of 953,000; deprived population (IMD income score of 24.2) 210 general practices; 206 GMS practices. 21% of practices single-handed. Mean of 3.6 WTE GPs per practice. Mean QOF score per GMS practice in 2005-06: 1032.
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Case Study 2: PCO in England. Accountable to the SHA. Population of 233,000; fairly affluent population (IMD income score of 10.6) 39 general practices; 34 GMS practices. 15% of practices single-handed. Mean of 4.7 WTE GPs per practice. Mean QOF score per GMS practice in 2005-06: 1026.	Case Study 4: NHS Health Board in Scotland. Accountable to the Scottish Government Health Department. Population of 837,000; fairly affluent population (IMD income score of 12.5) 124 general practices; 99 GMS practices. 9% of practices single-handed. Mean of 5.1 WTE GPs per practice. Mean QOF score per GMS practice in 2005-06: 1036.
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Theory was used to test the generalisability of the findings from the case studies. This is key, as the aim of case studies is not to reach statistical generalisability, but to aim for analytic generalization, i.e. where a previously developed theory is used as a template with which to compare the empirical results of the case study (111). The analytic generalisability of our case study findings were thus tested by comparing our findings back to several of the key theoretical frameworks discussed in Chapter 1, in particular the notions of soft versus hard bureaucracy, governance mechanisms such as “comptrol” and principal-agent analysis (5;47;48;60;61).

Two principal limitations of a case study approach are that: (1) only relatively few sites are included; and (2) the potential for contexts and key questions “drifting” over the timeframe of the study. Other work in this area has also utilised a case study design (97) (101) and some of our findings, particularly from practices, complemented these studies (and added to our comparison sample). Whilst there have been some changes among QOF indicators over the span of the project, the overall ethos of the new contract has not shifted, and we are confident that our findings do have analytic generalisability.

Within the case studies, we used a mixed methods approach (Chapter 3.3), maximising integration of our mixed methods approach to data collection and analysis through actively planning complementary quantitative and qualitative approaches in the design of the study questions, study development and interpretation of findings. We used quantitative analyses to develop sampling frames for the qualitative work and qualitative data to reflect on and interpret the quantitative findings.

12.2 *Strengths and limitations*

12.2.1 *Strengths*

An overall strength of the study was its cross-jurisdictional emphasis, set in both England and Scotland. Although this raised particular practical and methodological challenges, it brought insights into the development of governance mechanisms in relation to nGMS in primary care that could not have been obtained by focussing on one country alone. It also allowed, for the first time, an empirical testing of Greer’s work (10;120)

on the impact of devolution on primary care organisation and delivery. The use of case studies encompassing the PCO, other primary care services (such as the out-of-hours organisation) and practices, as well as the national perspective, is also a particular strength of this study. Previous research has examined the impact of the contract on practices and practitioners within those individual practices (for example (96-98;101;171)), or governance in organisations (for example (21)). Ours is the first study that has encompassed both perspectives and sought to understand the interactions between them. Finally, this study also explored what impact the new contract may have on patients, both through the use of routine data and case note review within practices, but, importantly, by interviewing patients themselves.

This is also one of the largest studies of its kind to date. Ethnographic work located in four practices (two English, two Scottish) by members of this team, amongst others, interviewed 66 members of staff, including GPs, practice nurses, practice managers and other administrative staff (97;98;101). In other work, Campbell et al interviewed 21 GPs and 20 practice nurses working in 22 practices across England (94). Here, we conducted 139 interviews including 17 at national level (England and Scotland); 48 at PCO level; 15 within an enhanced service and the out-of-hours services; 40 within practices; and 19 with patients. The collection of data, analyses and interpretation were conducted by researchers and team members in both countries, adding to the robustness of the analyses and the interpretation of the findings.

12.2.2 Limitations

The use of multiple methods of data collection and multiple sources of data inevitably has limitations as well as strengths. Here we consider the main issues that may impact on the interpretation of our findings.

As discussed above, the selection of case study sites can be challenging and, if not chosen judiciously, can fail to answer the research question. This study was based on four PCO case studies, which are in themselves large organisational entities. These PCO case studies were selected pragmatically, with considerations of access and geographical proximity to the research team leading to a degree of convenience in the sampling process. There were, however, underpinning theoretical considerations: as described in Chapter 3.3, the case studies were selected to test a number of theoretical propositions and to provide a degree of theoretical replication. While the sites selected may not be geographically representative of all practices, we believe that reaching theoretical replication was an over-riding criterion for this research. In addition, the routine data presented in Chapter 4.3.1 suggest that the PCTs selected were not atypical.

All of the PCOs had experienced a period of organisational re-structuring just prior to and during the early stages of data collection, which both impacted on our ability to start the work and also to construct stable organisational charts showing where GMS governance “sat” within the wider organisation. While we tried to “sense check” these with key

informants in Stage 3 of the study, we were inevitably asking respondents to think back at least 2 years in time, in a system which is constantly evolving and changing. Therefore, although useful, the organisational charts should be thought of in a cross-sectional manner, as a picture at one point in time, rather than as a permanent structure. They provided a snapshot of organisational bureaucracy and hierarchy within each case study. The extent of organisational change also meant that individuals had, in many cases, moved onto new positions. Therefore, Stage 3, as originally planned, was difficult to execute, leading us to rely more on feedback from presentations of the work, from informal discussions with colleagues working in the respective PCTs and from the collective experience of the clinicians within the research team, who had knowledge of the changes taking place within primary care from a service perspective.

The selection of the embedded case studies, particularly general practices, inevitably involved compromise and a balancing of priorities. Despite a carefully developed set of criteria for practice selection, the reality was inevitably more pragmatic. This was especially true in Scotland where recruitment was more difficult. There was a clear reluctance for practices with lower QOF scores to participate in the study, however 2 of the 8 practices were in the lowest quintile of QOF achievement. In addition, as with all such studies, practices which participated were likely to be the better organised practices (172), regardless of QOF score, so our understanding of how QOF and the contract impacts on practices considered to be relatively poor performers may still be more limited.

The original research proposal proposed a total of 6 embedded case studies in each country, with general practices the predominant model. In retrospective, it may have been better to sample a greater number of enhanced services or out-of-hours services, as our conclusions on the governance models developing with these services were based on 2 enhanced services and 2 out-of-hours services. It is possible that exploring a wider range of enhanced service or out-of-hours models may have led to the identification of service models with alternative models of governance. However, these models of care were selected precisely because they did represent newer types of service delivery, involving both primary care/general practice and community-based services and, as such, offer unique insights into the governance systems developing in such organisations.

The identification of one incentivised and one un-incentivised tracker condition was more difficult than anticipated, particularly in relation to the non-incentivised condition. Some non-incentivised conditions that were considered when the study was initially designed, e.g. depression and anxiety, became incentivised in later iterations of the QOF, albeit in relation to other diseases. In the end, rheumatoid arthritis was selected as a disease that is readily identifiable in patients' case notes and had a large enough number of patients to make case note review worthwhile. However, the near patient testing National Enhanced Service did include testing for rheumatoid patients and, as such, may have been responsible

for increasing the monitoring of patients reported in Chapter 11. Therefore, this could not be considered as a completely non-incentivised condition. This, coupled with the small number of patients in each group as planned in the original proposal, thus gives us a partial, albeit important, view into the impact of the QOF on patient care.

Data comparability between England and Scotland was problematic and there was a general lack of data on workload distribution. Some of these issues have already been discussed in a paper published by this group, where there are difficulties in attributing socio-economic position to individuals in England (121). Analyses based on practice postcode assigned data under-estimates the relationship between deprivation and ill health for both prevalence and quality of care and leads to difficulties in comparing data from the two countries. The second limitation relates to the use of PTI data, available in Scotland. Although data were available at an aggregated level, it was not possible to obtain more fine-grained breakdowns of the data, whereby we could compare care of particular conditions between GPs and practice nurses. The availability of PTI data only at an aggregated level also prevented any significance testing of any differences found to take place. This limited our ability to fully explore, quantitatively, the distribution of workload across time.

12.3 Key findings

12.3.1 Governance arrangements in the management of different provider organisations

Overall there were many striking similarities in the governance mechanisms established within primary care in England and Scotland, despite the devolving health care systems and different ethos underpinning those systems, especially around the use of competition. Using Dowling's approach of accountability chains(21) and concept of principal-agent analysis (12;21;60), it was possible to map where accountability lay for the monitoring of the three organisational models of interest, namely GMS/PMS contracts; enhanced services; and out-of-hours services.

The de facto principal agent in the monitoring of contracts was the PCO. In relation to the organisational models of service delivery studies, there were several different agents, although general practices were a key agent in several of the systems (Box 10).

Box 10 Principals and agents in contractual monitoring in England and Scotland

Service	Principal	Agent
GMS practices	PCO. PCT in England. Health Board/CHP in Scotland	Practice
PMS practices	PCO. PCT in England.	Practice

	Health Board/CHP in Scotland	
Drugs misuse enhanced service	PCO. PCT in England. Health Board/CHP in Scotland	Practice and community-based teams (PCO & HB)
Out-of-hours service	Government and PCO. PCT in England. Health Board in Scotland	Separate not-for-profit organisation in England. NHS organisation in Scotland.

Accountability chains within primary care were shorter in Scotland, with Health Boards sitting somewhere in between PCTs and SHAs, and dealing directly with Government in a way that does not happen in England. Nonetheless, in the context of monitoring contracts within primary care and general practice, PCTs and Health Boards functioned at an equivalent level in the contractual relationships with their agents. In Scotland, there was also a policy-driven move to devolve monitoring accountability from the Health Boards to the CHPs. However, this had not happened before, nor by the end of the study, thus Health Boards remained the principal. These accountability chains are illustrated in Figure 13.

Within these accountability chains, the principal model of governance was that of a hierarchy. Both Sheaff and Dowling have argued that the principal mechanism of monitoring in GMS contracts, prior to the new contract, was more akin to that of a network or quasi-market, due to the independent contractor status of GPs under the GMS contract (21;49;50). However, evidence collected in this study suggests that nGMS, and QOF in particular, has shifted the monitoring mechanisms towards that of a hierarchy with QOF review visits, payment verification and closer monitoring of practice performance all bearing the hallmarks of a hierarchical structure rather than a more horizontal network-based governance. This was true for both GMS and PMS contracts, at least within the constraints of the embedded case studies selected for this project, with both PMS practices participating in QOF and subject to the same monitoring regimes as their GMS counterparts.

Practices, however, were subject not only to external monitoring, from the PCO, but also internal monitoring, from colleagues responsible for QOF achievement. Practices responded by enacting blended forms of governance, encompassing elements of network, self and hierarchical governance. This involved working in a collegiate manner within practices, with horizontal collaboration between small groups of clinical and administrative staff, but overlaid with a hierarchy whereby key members of the practice operated as the principals, monitoring colleagues' performance within the practice.

Figure 13. Accountability chains for primary care in England and in Scotland

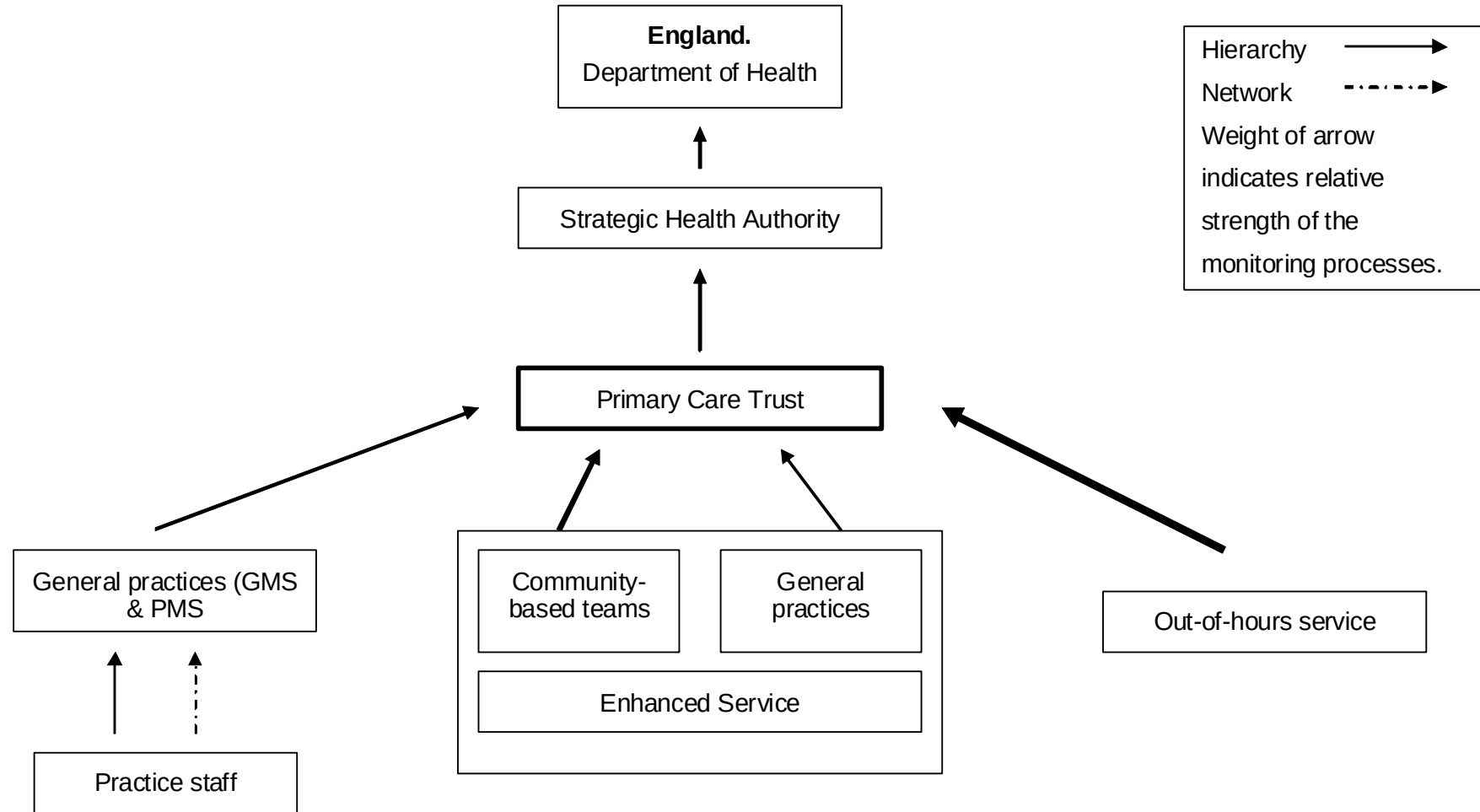
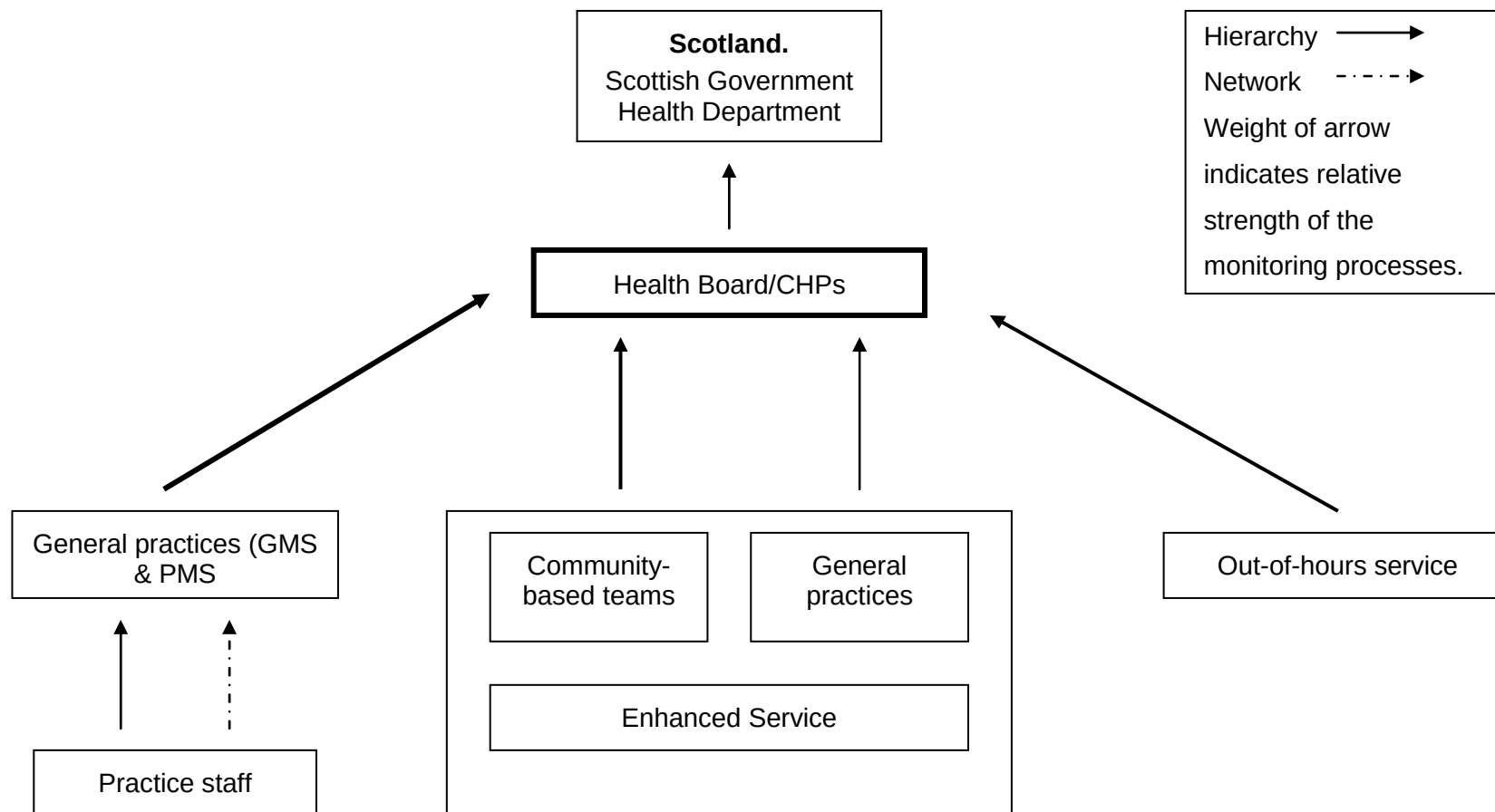


Figure 13 (cont'd)



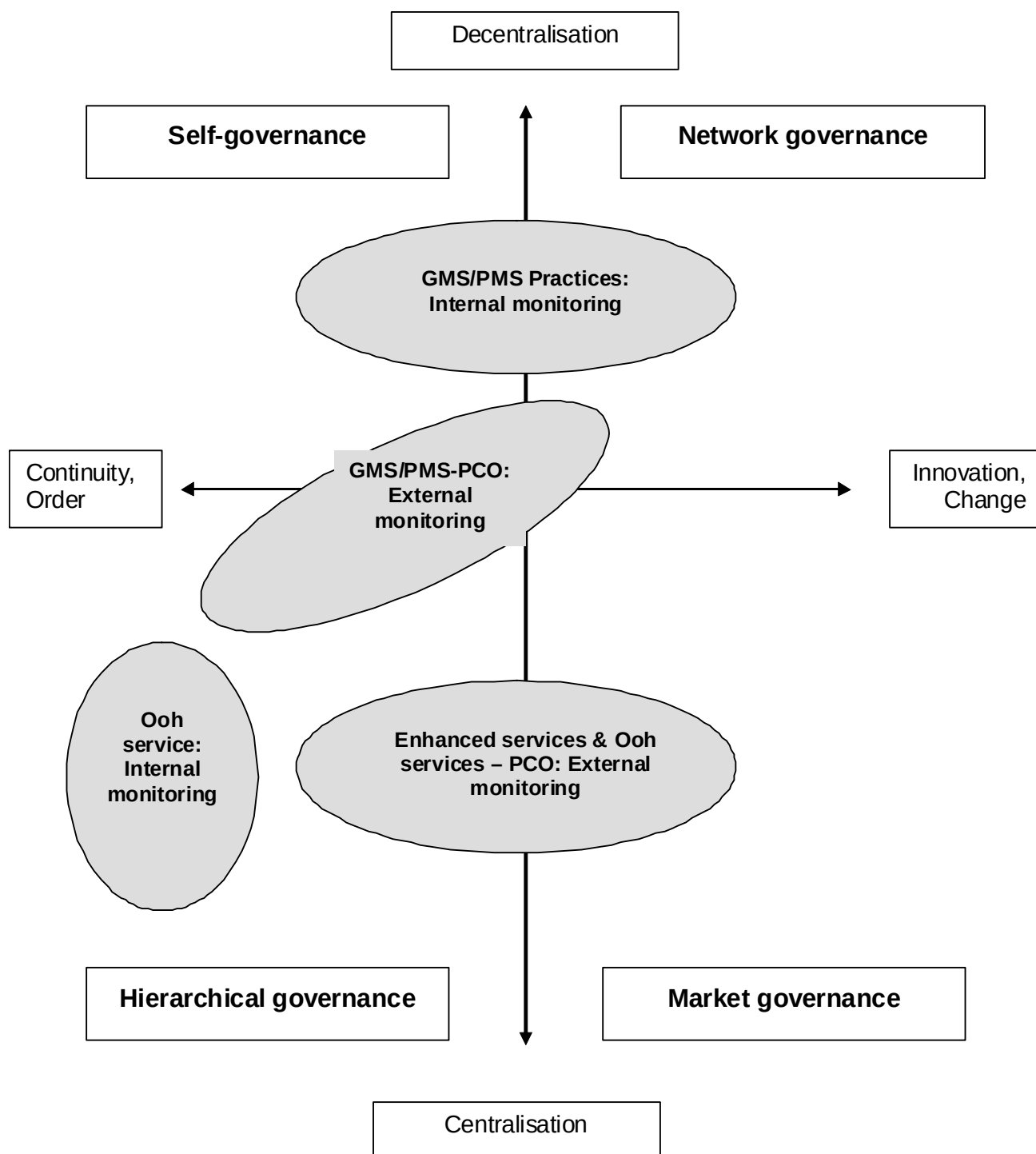
The new contract has also increased the status of non-clinical managers in monitoring clinical staff: practice managers in practices; non-clinical managerial staff in the enhanced and out-of-hours services. Thus, although professional re-stratification is continuing with clinical staff in senior monitoring roles within the PCOs (173;174), there is a growing role for non-clinicians holding clinicians accountable for their performance, both within practices, within other services and across the PCO-practice boundary.

Hierarchical governance predominated in the monitoring of both the enhanced services and out-of-hours care. Both types of service had to meet national targets and were monitored by the PCO to ensure that these were met. In both England and Scotland, the drug misuse enhanced service was delivered by a mix of general practices and community-based teams. Monitoring appeared to be more stringent and hierarchical for the community-based arm of these services. Monitoring of practice-based activity in the enhanced services, although based on hierarchical principles, was less robust and focussed mainly on evidence of activity rather than on the quality of that care.

Out-of-hours care, especially in England, was very hierarchical with stringent national targets monitored by the PCO. However, in England, market-based governance was also apparent for both of these service models. Both the enhanced service providers and the out-of-hours organisation had had to tender for their contract and were very aware that they would have to re-tender for the contract in the future. Thus, these services had to be continually aware of the potential of other service providers competing with them in the future and this also drove them to continually monitor and improve their services. This was less apparent in Scotland, as there is no policy to introduce private provider competition into the NHS in Scotland.

Thus, the nGMS contract appears to have pushed general practice-based primary care towards a more hierarchical structure, albeit with elements of both market governance in England and self/network governance within practices. These mechanisms illustrated in Figure 14. In the next Section, we discuss how the mechanisms by which this is being enacted.

Figure 14. Models of governance and the overlay of different models of service provision



12.3.2 Mechanisms of governance

Several mechanisms of governance were described in Chapter 1 and summarised again in Box 11.

Box 11 Proposed mechanisms of governance

Hood(5)	Gray(17)	Courpasson(48)
Oversight: command and control techniques used to meet centrally derived targets.	Command: governance enacted through chains of “superior and subordinate authority”; control and accountability paramount.	Soft bureaucracy: Encompasses both “hard” hierarchal forms of governance and “soft” professionally-driven collegiate forms.
Competition: control enacted through rivalry and choice.	Contract: governance based on “inducement-contribution exchange agreed by parties”.	
Mutuality: control through group processed and self-regulation.	Communion: governance based on common values and beliefs, with a shared frame of reference.	
Contrived randomness: control enacted through unpredictable processes or payoffs.		

As discussed in Chapter 1.4.2, several studies explored the governance of primary care, particularly in relation to clinical governance, prior to the new contract. These studies found that primary care was governed by a complex mix of “hard” and “soft” mechanisms, using performance management, audit and financial incentives to meet performance targets but often implemented by harnessing fellow professionals to support and drive the changes (29;49-51).

This study has found that the increased emphasis on targets enshrined within the QOF has led to a strengthening of hard governance mechanisms. PCOs not only monitor QOF performance assiduously, but the also practices monitor their performance over the year. The only group who do not appear to pay heed to QOF scores are patients, as evidenced by the patient interviews conducted here. Patients had remained with practices over many years and seemed unaware of either the contract or associated QOF scores of their practice.

PCOs, particularly in England, were also planning to develop their monitoring mechanisms, with QOF seen as only one part of the overall picture. Traffic light systems of monitoring and performance tables were being extended into other areas such as the enhanced services and, in England, practice-based commissioning. The mechanisms being

developed were those of hard governance, using centrally and PCO-derived targets and vertical chains of accountability. There was, however, also a downward sharing of performance information with all of the case studies developing reporting mechanisms back to practices so they could see their performance in relation to peers. This meant that more professionally-driven mechanisms of governance, based on shared professional values and mutuality were also utilised.

GPs were, in general, supportive of the QOF and appeared to accept the monitoring that came with it. This may also be due to the support that PCOs were giving to practices at that time – there was little evidence of PCOs taking punitive approaches to practices or providers of other services, such as the enhanced services and out-of-hours, by for example removing contracts. This threat did exist however, and drove both the drugs misuse enhanced service and the out-of-hours service in England to constantly develop and raise their standards. Such a threat did not appear to exist in Scotland, however, reflecting the clear Government commitment to rule out commercial competition in the NHS in Scotland.

While a lack of comparable data made measuring the relative effectiveness or efficiency of organisations operating under these monitoring condition, the language of GPs and practice staff in England reported in Chapter 8.3.2 reflected a greater degree of demoralisation with target setting and meeting standards amongst practitioners in England than in Scotland. Thus, continued pressure to meet targets may have longer-term impacts on the primary care workforce.

12.3.3 Impact on clinical activity and patient processes and outcomes

Much has been written about the possible impact of an incentivised system on patient care, for example by crowding out un-incentivised conditions, by impacting on professionals' internal motivation or by demotivating team members (57;132-135). Overall, we found that the impact of incentives on practice performance and on individuals' behaviour was equivocal. Data from Scotland showed no clear evidence of an decrease in consultation rates for non-incentivised conditions; it did, however, show a marked increase in workload for practice nurses for those incentivised conditions for which data were collected (diabetes, COPD, ischaemic heart disease and stroke) while GP consultation rates fell for all four conditions. There was no clear pattern, however, for those un-incentivised conditions measured. Professionals themselves spoke of being driven by a wish to provide high quality care and seemed to generally welcome more explicit reporting of performance, albeit that most of the practices included in the study were in the upper quintiles of QOF achievement. However, the use of a wider scorecard approach to monitoring being mooted in England may be problematic as professionals were clearly less happy with indicators that they felt they had less control over, such as emergency admissions.

Patients appeared unaware of changes to their care as a result of the new contract. Most talked about always being monitored by their practice, well before the implementation of nGMS. Some were aware, however, that practice nurses were playing a greater role in patient care with an increase in nurse-led clinics. The one area that patients had noticed, at least in England, was the policy driver to increase access. There was little or no impact on the care of the unincentivised condition selected, rheumatoid arthritis. This may be counterfactual however, as rheumatoid arthritis remains an area of shared care between the practice and hospital and the inception of near-patient testing as an enhanced service incentivised routine monitoring for rheumatoid patients. Indeed, this was demonstrated by the marked increase in the number of patients being monitored in the case note review. The relationship that some patients had with the practice nurse also mirrored those essential features of the GP-patient relationship, namely empathy, continuity and a long-term relationship.

Thus, overall, patient care appears to be generally improving and patients in this study continued to be positive about their care. However, this is due not only to the contract but to other policy drivers, including the shifting of care from secondary to primary care and an on-going focus on improving chronic disease care through a variety of mechanisms, of which QOF is one.

12.3.4 Professional relationships

Although the contract is pushing governance in primary care towards that of hierarchies and increased monitoring, much of this was predicated on strong professional relationships between practice-based clinicians and PCO staff. Professional re-stratification and the use of clinicians in managerial positions has continued to develop, as proposed in earlier work (173). However, as already discussed, the role of non-clinical staff is also developing and gaining prominence, especially within out-of-hours organisations, across the PCO-practice boundary and within practices. The long-term impact of such relationships on professional autonomy is still unclear but is likely to reflect a trend away from professional autonomy towards monitored and target-driven contractual relationships within a health market economy in an effort to increase cost-effectiveness and consistency of service provision.

The role of practice nurses in practice achievement has already been reported widely, for example (96;97;101;131). By looking at other service provision, in particular the enhanced services, we were able to observe how the practice nurse workload has expanded and developed. While other researchers have recognised and acknowledged this, it was clear that practice nursing appears to be reaching saturation point. This may explain why some nurses were reported to be considering leaving practice nursing (144). Many nurses appeared to be operating close to the boundaries of their speciality, with diagnosis and care of complex patients with multiple morbidities remaining with GPs. While nurses'

internal motivation remained high, external factors in particular financial remuneration remained a key issue, with many nurses in our study also feeling that they were not appropriately rewarded for their contribution to QOF achievement or the enhanced services. The level of support that practice nurses received from the PCOs also appeared to vary, although the two Scottish case study sites had acknowledged the importance of practice nurses by the appointment of a practice nurse advisor at Board level.

There was also evidence to support the development of new professional roles within general practice – supporting the concept of innovation (32) or diversification (33). This was most apparent amongst the administrative staff, where new dual roles were developing, for example administrative staff doubling up as data clerks or taking out clinical roles as health care assistants or phlebotomists. This work was delegated, in the main, from practice nurses and reinforced the notion of a hierarchy of appropriateness (142). However, it was unclear how much training or support such staff were receiving and meeting their educational and professional needs will be of paramount importance.

Charles-Jones et al, in their study of the redistribution of practice work prior to the new contracts, suggested that GPs were delegating more acute medical work to nurses (142). This appeared to be less so since the new contract was implemented, with both quantitative and qualitative evidence collected in this study pointing to the increased workload of nurses in chronic disease management.

12.3.5 Patient and public involvement

There was little evidence that the contract had stimulated a greater level of patient and/or public involvement in contractual monitoring, beyond the involvement of lay assessors in the QOF review visit. This mirrors other work that has focussed on public involvement in primary care trusts/groups, clinical governance and commissioning (166;170) which found that public involvement was often superficial. Within practices, there was a requirement for practices to conduct an annual patient survey as part of QOF. There was, however, almost no discussion, at any level, on how practices had conducted and used these surveys, nor how they had been monitored by the PCO. While partnership working with patients and the public was viewed positively, there were few examples raised of PPI in practice. There appeared to be little use made of patient fora, such as patient liaison groups, within general practices, although there was limited evidence to suggest that such approaches were being used in at least one of the enhanced services studied.

PCOs were developing ways of involving patients and the public, in both PBC in England and in Health Boards and CHPs in Scotland but, again, this was still underdeveloped. However this raises the potential difficulty of lay members, perhaps elected by the community, taking corporate responsibility for the monitoring of a clinical contract with a service provider. The new White Paper for England proposes that Consortia will

be accountable upwards, to the NHS Commissioning Board, but also downwards to their patients and the public (107). This will raise tensions and challenges for all involved in the consortia, but perhaps especially for their patient and public representatives and will warrant further investigation. The White Paper also proposes the establishment of new local bodies, called HealthWatch organisations, to replace Local Involvement Networks, with implied strengthened public scrutiny role of commissioning process and decisions.

12.3.6 Impact on inequalities

While inequalities in health is a recognised policy issue in both countries (146;147), there was little evidence that the GMS contract was being used to systematically address these issues in either country. While QOF was never intended as a mechanism with which to address health inequalities, it does afford opportunities to develop such mechanisms. QOF can be regarded as highly equitable in that, although voluntary, almost all practices participate. Indeed, evidence suggests that the gap in QOF achievement between affluent and deprived practices has reduced (86;154). However, this still does not address the underlying issues that face practices serving very deprived populations, whose populations have a range of social issues to deal with, making health a low priority in their lives (175). Bierman argues that, in order to avoid increasing inequalities, performance measures must have equity built in from the start to avoid penalising practitioners serving the most disadvantaged populations (176). There is obvious potential to develop Marmot's proposal of "proportionate universalism" (151), by which QOF is applied to all patients in a practice population, as currently happens, but with the potential to then target those in disadvantage populations through other, complementary mechanisms including enhanced services. While this has not happened under the new contract, yet, there is an on-going need to monitor health inequalities in relation to QOF and to develop services through the enhanced service route and, in England practice based commissioning, to address potential inequalities. Monitoring the impact such approaches, and comparing them across countries, would also be greatly facilitated by the development of patient-level deprivation data linked to their postcode of residence, as is available in Scotland, and the development of targeted approaches such as Marmot has recently advocated. Finally, there also needs to be greater attention paid to other sources of inequality, such as ethnicity, gender or other potentially disadvantaged groups, such as carers or the housebound as currently, most of the focus has been on socio-economic inequality.

12.3.7 Shared learning

Learning within and across practices and services appeared to be, in the main, experiential and informal rather than formal. Although interviewees talked, at various points, about formal learning, often supported by the PCO, it was informal learning that appeared to

predominate. Practitioners learned from each other, from the use of performance data and from sharing experiences with colleagues.

Learning happened in other settings, between practices or informally within the enhanced service between the practices and the community-based teams. Davies, Nutley, and colleagues suggest that, in order to fully develop organisational learning, the NHS must move from adaptive single-loop learning, to learning in which organisations reflect and build on information and data, alongside a re-shaping and re-structuring of the organisation's goals, policies and procedures (177;178). As PCOs move towards greater use of comparative performance data and the enhanced use of targets, it would be beneficial to consider how best to support practices and practitioners through this more public accountability. Rushmer et al outline three conditions that promote learning in organisations: strong, visionary leadership; empowered and involved staff; and protected time and space in which to learn (179-181). The role of PCOs, therefore, is to support, perhaps through contractual means, the development of supportive environments within practices and other services in which practitioners feel they can learn from the performance data that monitoring generates, rather than feeling overwhelmed and demoralised by it.

12.3.8 Implications for GP commissioners in England

The new White Paper for England proposes the abolition of PCTs and transfer of most of their functions to GP Consortia, who will commission services on behalf of their registered patients (107). The work reported here indicates a number of areas that commissioners operating within these Consortia will have to consider.

First, as currently configured, the *de facto* principal in monitoring contracts within primary care is the PCT. As discussed earlier in this Chapter, the PCT is central in the monitoring of general practices (both GMS and PMS practices), enhanced services and out-of-hours organisations. While the principal mode of governance used is hierarchical, it operates at differing levels of "strength" depending on the agent that the PCT holds a contract with. Thus, as illustrated in Figure 13, hierarchical monitoring was more apparent between PCTs and those organisations which had to compete to win contracts, namely the enhanced service and the out-of-hours service. Monitoring of GMS and PMS practices by the PCTs was softer and more dependent on supportive and collegiate mechanisms, albeit within a framework of targeting and performance management. Therefore, PCTs rely on mixed models of accountability and governance. Within these organisations, these different levels and approaches to monitoring and governance may be relatively straightforward to maintain; however, these may become more difficult to maintain within a smaller organisation such as a GP Consortium. This may result in a gradual move towards one model of governance over the others. Indeed, since this work was carried out there is some anecdotal evidence to suggest that this may be occurring,

with practices seen as not achieving targets within their Consortium being placed on “probation” by their fellow GPs and thus at risk of having their contract to provide primary care services removed. This suggests that GPs may be more robust in their management style on sequences of “failure” than PCTs have been. The acceptance of competition within the enhanced services and out-of-hours service will also become more dominant and will be encouraged to extend into other areas of health care provision, as outlined on page 29 of the White Paper: “Monitor and the NHS Commissioning Board will ensure that commissioning decisions [made by GP Consortia] are fair and transparent and will promote competition”.

Secondly, internal practice monitoring was a blend of network, self and hierarchical governance. If the National Commissioning Board is to be expected to take responsibility for commissioning general medical services, while GP Consortia are expected to be “increasingly influential in driving up the quality of general practice” (p.28), this raises some key questions about the monitoring and performance management of those services. Additionally, GP Consortia will be responsible for managing the combined commissioning budgets of their member GP practices. Within a larger organisation such as a PCT, it was relatively straightforward for a practising GP to take on a managerial role and to be involved in the performance monitoring of a number of practices. Indeed, McDonald has argued that this is leading to a process of professional re-stratification, with the emergence of a new GP administrative elite who are actively involved in the monitoring of colleagues within practices, PBC Consortia and PCTs (182). However, with new Government proposals expected to lead to the establishment of between 500 and 600 Consortia across England it remains to be seen whether there are sufficient GPs ready to take on such a role and, if not, what external support Consortia will seek.

Third, attempts in Scotland to devolve monitoring and governance roles from the level of the Health Boards to that of CHPs, which may be broadly to equivalent to that of GP Consortia in terms of size, have not been successful. This may suggest that there is a natural limit in terms of size of organisation which can comfortably accommodate all of the governance requirements necessary for enacting and monitoring different types of contract. At the time of this study, PBCs were in the process of being established and were generally dealing with a clearly defined number of clinical areas and contracts. Taking on the roles and responsibilities of a PCT, particularly the statutory responsibility for commissioning services within a hard budget, will require a far greater degree of administrative and organisational competence amongst the Consortia and may result in them having to pool resources over a geographical area, for example in contracting for out-of-hours care.

As already outlined in this Chapter, PCTs have not progressed as far as might be wished in either involving patients and the public in monitoring performance nor have opportunities to use the new contract to address inequalities in health been fully realised. These will be challenges for the

new GP Consortia which, again, may lack the organisational capacity to fully address these issues either.

12.3.9 Implications for policy, practice and research

Implications for policy and practice

- Although nationally set, the continued devolution of health care systems in the UK may lead to renewed calls for localised approaches to the Quality and Outcomes Framework.
- The central role of PCOs in monitoring and governing primary care contracts must be acknowledged, particularly in light of plans to abolish PCTs in England.
- An increased reliance on bureaucratic and hierarchical systems of monitoring is likely, in time, to erode health care practitioners' autonomy which may, in turn, reduce their willingness to meet targets and incentives.
- The role of service de-commissioning needs to be re-considered, as such threats de-motivate local practitioners and may prevent service providers from tendering to provide services in the future.
- The negative impact of more bureaucratic and hierarchical monitoring, coupled with a more explicit role for service de-commissioning, may be destabilising in the smaller organisations, such as the proposed GP Consortia in England.
- The potentially universal coverage of QOF should be strengthened and linked with enhanced services and, in England GP Consortia, to develop appropriately targeted services at underserved and disadvantaged populations.
- There is a need to consider the impact of QOF on other underserved groups, such as the elderly, minority ethnic groups and those who find it difficult to attend surgeries.
- There is an expressed need to review the role and remuneration of practice nurses, who are clearly a key professional group in the delivery of QOF and services related to the new contract.
- The development of new services and the monitoring associated with them are falling disproportionately on practice nurses. Future policy imperatives need to be cognisant of this and recognise the implications if the practice nurse workforce dwindles.
- Innovative ways of involving patients and the public in the governance of contracts is required.

Findings for practitioners

- There is a clear need to support practice nurses who are charged with mentoring other members of staff e.g. health care assistants.

- New roles are developing within primary care, particularly in relation to dual roles amongst administrative staff and health care assistants. Support and training for such staff will be required.
- Similarly, the development of non-clinical managerial roles need continued support and development.
- Learning opportunities within and across services need to be maximised.

Recommendations for research

Our findings suggest that future research should be focused on the following areas:

- Research into the impact of national devolution on service delivery and organisation is required, with shared policy learning a priority.
- Research will be required into the impact of abolishing PCTs and establishing GP Consortia in England.
- Research into the on-going impact on unincentivised care is still required.
- Further research into the impact of non-clinical monitoring of clinical roles and the impact on autonomy and professional boundaries.
- The development of comparable datasets is required to allow comparative analyses on practice and service performance, taking account of the populations served.
- Further research into the impact of the contract on underserved and disadvantaged populations is required.

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Appendix 1 Impact of devolution on the organisation of primary health care in England and Scotland

Although the Department of Health in London has always taken overall responsibility for UK-wide health matters such as the GP contract, territorial differences have been apparent in the way in which the four countries of the UK have organised and delivered health care (9;183). This process accelerated, however, first after the election of the Labour Government in 1997 and then with political devolution in 1999 when health became a devolved power and primary care policy in the four countries began to diverge more markedly (123). Different units of health care delivery were proposed and implemented providing, as Chris Ham has written, “a series of natural experiments in which the NHS model is adapted according to local preferences and circumstances” (9). Given the contextual location of this project, we here focus on developments within England and Scotland.

According to Greer, these natural experiments have led to a distinctly different policy and managerial ethos across the four countries of the UK. In England, there has been an emphasis on central target setting, strong performance management and, latterly, the development of a market-based approach. In Scotland, NHS development has been influenced by a strong ethos of professionalism and a rejection of market-driven approaches (10;120;123;125). Operationally, these changes have become manifest in the different structures and organisations designed to deliver primary care services. In England, the purchaser-provider split was retained post-1999 and competition favoured as a way of introducing private providers into primary care delivery. Primary Care Groups (PCGs), then Primary Care Trusts (PCTs) were established, serving between 45,000 and 225,000 patients, with the power to commission both in hours and out-of-hours services. PCTs were amalgamated and reorganised in 2006, reducing the number from 303 to 152. PCTs are monitored by, and answerable to, Strategic Health Authorities, which were themselves re-organised in 2006 and reduced in number from 28 to 10.

In contrast, Scotland abolished the purchaser-provider split and integrated all health care delivery into 14 Health Boards. The organisational unit for the delivery of community-based primary care was the Local Health Care Co-operative, with populations of 25,000 – 150,000, which although voluntary were often GP-led. These were then replaced in 2005 by Community Health Partnerships (CHPs), primary and community care organisations whose boundaries are co-terminous with Local Authorities, and with a remit to develop closer integration of health and social care (124). Indeed, in some areas, health and social care were formally integrated to form Community Health (Care) Partnerships

(CHCPs). Like England, Health Boards – the higher organisational entity – are responsible for monitoring CHPs. Except for a few services in large cities, private providers of primary health care do not generally exist, and the SNP-led Scottish Government has rejected the concept of private providers of NHS funded primary care (184;185).

Devolution has also impacted on the organisation of out-of-hours care. Both countries developed a nurse-led telephone triage service, NHS Direct in England and NHS 24 in Scotland, which patients could contact in daytime and out-of-hours periods. In England, NHS Direct developed as a franchised model, located in different organisational settings (for example Primary Care Trusts, Ambulance Service Trusts). However, in the out-of-hours period, NHS Direct remained separated from the delivery unit of out-of-hours care, generally GP-led co-operatives. In contrast, NHS 24 in Scotland was established at a national level (as a Special Health Board), integrated with GP-led out-of-hours co-operatives and linked to both the Scottish Ambulance Service and Emergency Departments. The on-going impact of devolving models of health services on urgent and emergency care has been the subject of another SDO funded project, led by Professor Val Lattimer in Southampton (SDO Reference 08/1519/97).

One of the most striking differences in the structure and organisation of general practice between England and Scotland is, however, the policy of practice based commissioning.

Practice based commissioning

Practice based commissioning (PBC) was introduced into England in 2005 with the aim of devolving responsibility for commissioning services from the Primary Care Trusts to primary care clinicians, in reality general practices. PBC could be delivered through single practices or groups operating as commissioning groups or consortia, purchasing hospital-based care and community health services for their enrolled practice population (186). Importantly, professional groups other than GPs or general practices could hold indicative commissioning budgets, raising the possibility of professional groups other than GPs being involved in PBC.

The budget of PBC groups was (and still is) indicative; the PCTs held the actual funds and were responsible for placing and managing contracts; practices were responsible for the commissioning decisions and for allocating resources. In the event of an overspend, this would be met by the PCT but persistent overspending by a PBC group could result in it losing its indicative budget (187). PCTs therefore, although not responsible for the commissioning, did have role to play in the monitoring of PBC group activity and in establishing PBC within their areas through their Professional Executive Committee.

Initially the Government target was for all practices to be involved in PBC by 2006, although it did acknowledge that “individual practices will have the option to take on commissioning to a greater or lesser extent

depending on their wishes and their capabilities" (188). However, since then, the evidence suggests that this has not happened or, where there is uptake of PBC, it is happening more slowly than first anticipated, despite PCTs making it a principal focus of their dealings with general practice (189-191).

Appendix 2 PCO Case Studies

Four Primary Care Organisations (PCOs) were selected as Stage 1 case study sites, two in England and two in Scotland, as reported in Chapter 4. This Appendix contains a detailed descriptor for each case study.

PCO Case Study 1 (PCT A)

Structural organisation

This PCT was formed on 1 October 2006, following the amalgamation of the three neighbouring PCTs. Preparations for a single organisational structure began in July 2004 when a joint management team was formed across the three PCTs, although each retained its own Board, Professional Executive Committee and other management committees.

Performance reports from the PCT Board (www.liverpoolpct.nhs.uk/Update/Main/About/pubs.asp) indicated the key priorities for the PCT in 2006-07 were:

- Targeting health inequalities by 2010, particularly around smoking cessation.
- Waiting times for cancer treatment.
- 18-week wait from GP referral to hospital treatment.
- Reductions in MRSA levels.
- Patient choice and booking, through Choose and Book.
- Sexual health and access to GUM clinics.

Thus, the GMS contract and QOF in particular did not directly feature in the priority areas of the PCT.

The PCT Board had both a commissioning arm (undergoing restructuring at the time of data collection) and a provider arm, also undergoing change at the time of data collection. The organisational structure for the commissioning arm of the PCT, in relation to the GMS contract, is shown in Figure 5.

Key committees in relation to the governance and monitoring of the GMS contract were: the **Integrated Governance Committee** (number 1 on Figure 5); the **Professional Executive Committee** (number 2); and the **Practice Based Commissioning Committee** (number 3).

The **Integrated Governance Committee** (number 1), which reported directly to the PCT Board, was responsible for the strategic development of integrated governance across the PCT, for both the commissioning and provider sides of the PCT, and oversaw the activities of several sub-committees covering performance, risk management, information governance and clinical audit.

- **Performers Committee** (number 4): reviewed serious performance issues (likely to result in suspension) across all independent providers (doctors, nurses, midwives, pharmacists and dentists).
- **Clinical Governance Committee** (number 5): chaired by the Medical Director, this key sub-committee linked to a number of different groups involved in supporting and monitoring practice performance under the new GMS contract. Representatives on the Clinical Governance Committee included the Medical Director, Director of Nursing, and PEC Chair as well as dental and pharmacology services. Three groups that reported to the Clinical Governance Committee and were of particularly relevance in the governance of the GMS contract were the **Primary Care Contracts Team** (number 6), the **Primary Care Performance Manager** (number 7) with a responsibility for QOF performance and the **Neighbourhood Performance Managers** (number 8). At the time of data collection, these teams were located within the Commissioning Services Directorate. However, both the Primary Care Performance Manager post and the Neighbourhood Performance Manager posts were again being re-organised: the Primary Care Performance Manager post was moving into the Medical Directorate, while the Neighbourhood Performance Management posts were being dissolved.

The **Professional Executive Committee** (number 2 on Figure 1) was particularly relevant to GMS-related changes. Established to provide strategic direction (e.g. by identifying priorities and standards) and clinical leadership, the PEC also supported the work of the Practice Based Commissioners (see next paragraph). The PEC was expected to recommend to the PCT Board strategic priorities for investment and disinvestment from a clinical perspective; approve business plans from PBC Consortia; manage links between the consortia and the PCT; and to provide performance management in relation to the overall achievement of outcomes. Priorities in the first year were the 18-week target for referrals, support for the four Practice Based Commissioning Consortia; and developing out-of-hospital services. Again, although important, these were not directly related to the GMS contract or to QOF.

Practice Based Commissioning

Practice Based Commissioning (PBC) Consortia (number 9): four PBC consortia were established within the PCT area, covering 95 of the 100 GP practices in the PCT area. Responsibility for the monitoring and governance of the PBC Consortia resided in the **Commissioning Services Directorate** whereas that of GMS and QOF was within the remit of the **Medical Directorate**. This was a very much 'bottom-up' process whereby practices formed their own alliances. While the PEC had a role to play in supporting these Consortia, accountability for the PBC lay with the individual practices, not with the PEC. Within the PCT, an Associate Director had responsibility for PBC, reporting back to the

Director of Strategy and working closely with commissioners, the PEC chair and PBC general managers. This individual also worked with those responsible for the primary care contracts (GMS, PMS, dental and pharmacy) and with the commissioners of secondary care services, thus providing a bridge between primary and secondary care.

Each PBC Consortium was chaired by a GP, with clinical governance leads and an interim general manager appointed to each in October 2007. Each Consortia had a list of agreed priority areas (Table i), in general linked to service re-design and re-organisation and predominately focussed on chronic disease. It was suggested that approximately 50 to 60% of practices were closely involved with PBC whilst the rest were “hanging on by their coat tails” trying to integrate PBC into their everyday working life.

From mid-2007, scrutiny of the PBC Consortia was undertaken by the **Practice Based Commissioning Committee** (number 3 on Figure 1), a committee of the PCT Board with the powers to scrutinise and approve PBC plans, agree performance targets and ensure that Consortia activity aligned with PCT strategy. However, there continued to be close links between this committee and the PEC. This fitted with an organisational structure described by one respondent as:

[a] matrix type of organisation which means that it's a flatter structure, there's lots of linkages [across the organisation].

(Interview 3, page 3)

Enhanced services

In the first year of the contract, when there were three separate PCTs across the area, each had their own basket of enhanced services. After amalgamation into one PCT, there were inevitable variations in the enhanced services, both in terms of operation and finance. In addition, the largest PCT, had been able to invest in a wider range of local enhanced services than the other two PCTs. Therefore, time had been spent in ensuring that there was equivalence in service delivery and funding across the PCT.

The enhanced services commissioned by the PCT for the period 2006-2008 are listed in Table 3 of the main report. In general, enhanced services were delivered by general practices although some, such as the substance misuse LES and the homeless service LES, involved other community-based groups such as the homeless outreach team and, in the case of substance misuse, the mental health NHS Trust and a local third-sector charity organisation.

Table i. PBC Clinical Priority Areas 2007/08. (From PBC Report to PEC, March 2007)

PBC Consortium 1	PBC Consortium 2	PBC Consortium 3	PBC Consortium 4
Achievement of 18 week wait for referral in 5 clinical areas.	Achievement of 18 week wait for referral in 6 clinical areas.	Achievement of 18 week wait for referral in 2 clinical areas.	Achievement of 18 week wait for referral in several clinical areas.
Monitoring and benchmarking of prescribing, with focus on statins & clopidogrel.	Monitoring and benchmarking of prescribing, with focus on statins & clopidogrel.	Monitoring and benchmarking of prescribing, with focus on statins & clopidogrel.	Monitoring and benchmarking of prescribing, with focus on statins & clopidogrel.
Review unplanned care provision for COPD and of in-hours A&E attendance.	Review unplanned care provision in 4 clinical areas.	Review unplanned care provision in 2 clinical areas.	Review unplanned care provision for several conditions.
Redesign of COPD services.	Improving COPD care in primary care including unplanned care.	Conduct local diabetes audit.	Conduct local diabetes audit.
To understand variation in demand for secondary care in 7 clinical areas	Reduce orthopaedic referrals by conducting more joint injections in primary care.	Improve recording in diabetes register.	Service re-design for dermatology, urology & musculoskeletal.
	Review pathways of care for patients with osteoporosis.	Improve referral and uptake of supporting services for diabetic patients.	
	Reorganise anticoagulation monitoring by moving service to primary care.		

At the time of data collection (in 2007), the enhanced services were under review with the PCT conducting an annual audit to check (a) if the practice was still providing the service and (b) if yes, what the practice was providing. The PCT was exploring ways of providing some enhanced services through the PBC consortia e.g. anticoagulation monitoring, patient testing and minor surgery had been passed across to PBC consortia to see how they might provide these services. In future, these were likely to still be commissioned through an enhanced service but driven on a consortia basis.

Monitoring of the enhanced services was the responsibility of the **Primary Care Contracts Team** (number 6 on Figure 5), although at that time the PCT was monitoring activity rather than quality. This involved the regular collection of activity data for payment purposes, but measurement of the quality of care was only likely to be carried out once every three years.

Out-of-hours services

Following the implementation of the GMS contract, the PCT was responsible for out-of-hours care between 6.30pm and 8am, weekends and Public Holidays. When GPs opted out of providing out-of-hours care, several contractors applied to provide out-of-hours services. The group chosen to provide out of hours services was one of the previous GP cooperatives, but was now an independent not-for-profit organisation. The out-of-hours contract was held with the **commissioning arm** of two of the PCTs in the region. This out of hours contract was due to end in October 2007, but had been extended for a 6-month period to avoid changes to out-of-hours services over the winter months. The out-of-hours service was monitored via both the Commissioning and Medical Directorates. Monthly contract management board meetings were attended by representatives from the two commissioning PCTs and members of the out-of-hours Board. At these the out-of-hours service provider had to report against the national quality requirements and provide a financial report. Over the first 18 months of the contract, the Commissioning Lead for Urgent Care had worked closely to the service to develop the monitoring process, including the development of locked templates to monitor compliance against the National Quality Requirements (NQRs). A bi-monthly clinical meeting also took place between Medical Directors of the out-of-hours service and the Medical Directors of the two Commissioning PCTs to discuss clinical issues.

The organisation was run by an Executive Board, with an overarching Council to which the Executive reported. The Council included GP representatives as well as representatives of other services, such as NHS Direct, though not a patient representative. The role of the Council was to challenge and review decisions made by the Executive, in relation to strategy and operational performance; a sub-committee reviewed clinical performance and complaints.

PCO Case Study 2 (PCT C)

Organisational structure

This PCT formed on 1 October 2006, when two neighbouring PCTs formally merged. As in its English counterpart, these PCTs collaborated through a joint management structure for approximately a year prior to the formal merger. While managerial structures had become more consistent across the two PCTs prior to amalgamation, there was evidence that strategic and operational approaches to the new contract had varied, with one viewed as taking a more collaborative approach with clearly defined policies around different aspects of the contract negotiated between the PCT and its practices.

At the time of the phase 1 interviews with members of the PCT, the “new” organisational structure of the PCT was in place, although some re-organisation was still taking place. Again, in line with national policy, this PCT was split into commissioning and provider arms. Although at the time of data collection the provider arm was still part of the PCT, it was

only joined at the level of integrated governance, with all of its other committees separate from the commissioning arm. The Annual Report of the PCT Board in 2007 identified a range of priorities including the reduction of health inequalities, targeting childhood obesity, smoking cessation, reducing waiting times, developing a single system of out-of-hours care and increasing patient choice (Western Cheshire Primary Care Trust 2007).

As in the other English case study, the emphasis was on the development of integrated systems (referred to as “matrix working”) for overseeing and monitoring the contract. The new Board and the Committees to the Board had been established and included: the Professional Executive Committee (PEC), Audit Committee, Remunerations Committee, Integrated Governance Committee, and the North West Specialist Commissioning Group. Beneath these main committees and groupings were a number of sub committees and task/advisory/working groups.

The **Integrated Governance Committee** was a key committee, with overarching responsibility for corporate and clinical governance. This strategic group was concerned with coordinating the PCT’s governance and risk management strategy. Sub-committees answering to this group covered a range of areas, including information governance, research and clinical audit and the implementation of NICE guidance.

Figure 6 in the main report outlines the relationship between the commissioning and governance structures at the time of data collection in 2007. There was a close working relationship between the **Commissioning Directorate** and the **Clinical Governance** team, which included the Medical Director and the Professional Executive Committee (numbers 1 and 2, Figure 6). Operationally, the Medical Director led on clinical governance and the QOF monitoring process but with the close involvement of the Director of Commissioning & Health Outcomes. The Head of Primary Care also worked closely with the Head of Clinical Quality and the Head of Clinical Standards to monitor the contract and the QOF.

Primary care contracting and clinical governance was the province of the **Internal Primary Care Contracting and Clinical Governance Forum (IPCCCGF)**, chaired jointly by the **Director of Commissioning & Health Outcomes** (number 3) and the **Medical Director** (number 4). This group included the Clinical Governance Team (number 2) and the **Primary Care Contracting Team** (number 5). This group looked at the processes and procedures around the contract and performance monitoring and how best to respond to new legislation and white paper regulations. As well as chairing the IPCCCGF the Head of Commissioning and Health Outcomes also sat on the pharmacy contract development group and the dental contract development group to ensure that there was an integrated approach to clinical governance across primary care service providers.

Commissioning of services was the overall responsibility of the Director of Commissioning, who worked closely with the Head of Commissioning for Planned Care, Head of Commissioning for Unplanned Care and the Head of Commissioning for Primary/Community Care.

The **Primary Care Contracting Team** (number 5) was responsible for contracting and monitoring contracts and authorising payments to all independent primary care contractors and sat within the commissioning team. The Director of Commissioning, the Head of Commissioning and Health Outcomes and the Medical Director met with the Local Medical Committee (LMC) on a monthly basis to discuss issues of joint interest and new developments, with the PCT seeking agreement from the LMC regarding any contractual changes with practices.

Practice Based Commissioning

This PCT had a single **Practice Based Commissioning Consortium** for all practices in the PCT. The PCT produced a practice based commissioning framework which set out the responsibilities of the PCT, the consortium and the practices in relation to practice based commissioning. PBC was a recent development here primarily because of the financial constraints imposed on the PCT whilst it addressed the financial deficit brought forward from the previous PCTs. GPs, at the time of data collection in 2007, were being paid for their clinical engagement in a number of work streams. Each GP practice had a lead GP working with GPs on the PEC and secondary care clinicians in the development of these work streams. Commissioning recommendations were to be submitted to the **Integrated Governance Committee** through the **Professional Executive Committee (PEC)**; the Integrated Governance Committee would, in turn, submit these to the PCT board. The **PEC** (number 6, Figure 2) was integral to the development of PBC, providing both clinical advice and feedback to the Integrated Governance Committee concerning the progress of PBC implementation.

Enhanced services

When the two former PCTs amalgamated, service development and governance varied widely between the two PCTs in relation to enhanced services. For example, one had invested heavily in medicines management, in particular reducing polypharmacy, identifying cost savings and working with nursing homes, whilst the other did not have a medicines management team. Payment for minor surgery was completely different in the two PCTs and the anticoagulation service also differed. One had commissioned a range of enhanced services whilst the other had not spent up to their enhanced services floor. (The enhanced services floor is the minimum amount that must be spent on enhanced services although PCOs were, and still are, free to spend more using other funding streams as appropriate.) When the two PCTs merged, there was a need to harmonise these services, which proved to be quite a difficult process. Finally it was agreed that practices in one area would receive a one off payment in recognition of services carried out but not commissioned. This was viewed as a gesture of 'good faith' and as a

means of ensuring equity across practices in the new PCT. Enhanced services were monitored through a process of quarterly reconciliation, with practices submitting all their activity data to the PCT. In addition each practice had an annual contract meeting with the PCT where quality of service was discussed. Enhanced services were also linked to GPs' appraisals, with maintenance of clinical competencies being one of the topics of discussion. The enhanced services provided are listed in Table 3 of the main report.

Out-of-hours services

Prior to the changes to out-of-hours provision in 2004 there were three different out-of-hours services operating across the two PCTs. One had a co-operative with the visiting part of the service franchised off to a private out-of-hours provider. In the other, the city area had a conventional GP co-operative with nurse triage, a Primary Care Centre and a visiting service, whilst in the rural area there were two primary care bases where patient could be seen, GPs carried out home visits and there was no nurse triage. Nine months before the new contract came in there was a gradual move towards provision of a single service. This began with the rural and city systems coming together with GPs sharing the same rota and all patients going through nurse triage, with the other providers subsequently integrated into this new system. The new service was launched on 1 July 2005 with a main centre in the city, sites across the rest of the area covered, and a shared home visiting service.

Skill mix was introduced with nurse clinicians as well as doctors seeing patients in the centres and emergency care practitioners, as well as GPs, carrying out home visits. A more diverse workforce was introduced because of the expectation that few GPs would be willing to provide out-of-hours care post 2004. However, a considerable number of GPs continued to work in the out-of-hours service after the opt-out. Because of the geographical area covered patients had a different out-of-hours arrangement, with some patients attending out-of-hours services in other PCT areas. The out-of-hours service was monitored through the GP-patient survey and internal audit.

PCO Case Study 3 (NHS Health Board E)

Organisational structure

The NHS Health Board had undergone extensive organisational restructuring over 2005-2006. First, Community Health Partnerships were established in August 2005; then the pre-existing Health Board amalgamated with part of a neighbouring Board over a transition period of two years. Finally, the previous structural organisation of hospital-based trusts and a primary care trust (which were not analogous to English Trusts) was replaced by a single unified Health Board, as recommended in Scotland's 2003 health White Paper Partnership for Care (Scottish Executive 2003) and a subcommittee structure established to cover key areas such as health improvement, performance review, clinical and staff governance, research and ethics (Figure 7 in the

main report). With this re-organisation, service delivery was devolved to four management units:

- Board Headquarters (number 1 on Figure 7).
- Acute Services Division (number 2).
- Community Health (and Care) Partnerships (number 3).
- Mental Health Partnership (number 4).

Within acute services, specialised directorates were established which cut across secondary and tertiary care, e.g. the Rehabilitation and Assessment Directorate; the Emergency Care and Medical Specialities Directorate. Primary care was devolved from a single, centralised organisation (the Primary Care Trust) to 11 Community Health (and Care) Partnerships responsible for primary care, mental health and community services.

In 2007, key priorities for the Board included the reduction of health inequalities, reducing inequalities in Coronary Heart Disease mortality, tackling alcohol abuse, smoking cessation, obesity in children and adults, teenage pregnancy and sexual health and waiting times (NHS Greater Glasgow & Clyde 2007).

From a governance perspective, a rather complicated and hierarchical model evolved (see Figure 7). **Primary Care Support** (number 5) was established in April 2006 to manage the overall coordination of primary care contracting. This centralised body worked on behalf of all CHCPs in the Health Board alongside Financial Services and Practitioner Services, with a remit to support GPs and optometrists. In terms of GPs, there were several sub-teams established to deal with particular aspects of the GMS contract:

- **GMS Contractor Support Team** (number 6): supported GMS practices in the areas of QOF and the enhanced services and dealt with all aspects of contract negotiation. This team had principal responsibility for the implementation of the rollout of nGMS in terms of monitoring, payment schedules and IT requirements although at the time of the Stage 1 interviews (in 2007), they were devolving some of the responsibility to the CH(C)Ps. This meant that the Primary Care Support team now had 11 organisations to deal with, rather than 1. An additional problem was that CH(C)P managers had a much wider remit, so less of an understanding of the new GMS contract and thus required more support.
- **IT Mentoring Team** (number 7): This team supported practices' IT needs for the nGMS contract through the placement of four IT facilitators in practices across the area – described as “foot soldiers”. As well as training practices, their role was to create a rapport with the practices to facilitate future working. In general, the facilitators dealt with GPs and practice nurses. The facilitators

also supported practices in the use of the management screens associated with the four local enhanced services (LEs).

- **Chronic Disease Management Team** (number 8): supported the implementation of its chronic disease management plan, which pre-dated the GMS contract.

Separate from the Primary Care Support team and its function, was the **Professional Executive Group** (number 9). This sub-committee represented all the independent contractors (GPs, optometrists, pharmacists and dentists). In relation to the GMS contract, this group discussed the specifications surrounding the GMS contract, but not its financial aspects. However this professional input was considered an integral aspect of the GMS and contract-support decision-making process.

Of greater importance was the **GMS Steering Group** (number 10), which discussed the policy strategies of the PCO and included members of the Local Medical Committee (all GPs) as well as the CHPs. This was the location where the Health Board could interpret and localise the policies implemented by the Scottish Executive Pay Modernisation team, although at least one respondent felt that the real negotiations took place elsewhere. For example, negotiations over issues such as rates of pay occurred within another group that met to discuss financial issues. There were also a number of sub-groups that operated below the GMS Steering Group, negotiating the detail of contract specifications then reporting back to the GMS Steering Group. These included the **IT sub-group**, the **Communication sub-group** and the **Quality and Enhanced Services Sub-Committee** (number 11). The latter group included public health representatives, IT mentoring team representatives, GPs, practice nurses, practice managers, clinical directors, two LMC representatives, representatives of the three Managed Clinical Networks, heads of health and community care and CHCP representatives, who fed the CHCP agenda into the discussions. They had, at that point, been unable to involve colleagues from the acute sector, despite the huge implications that nGMS potentially had for acute services. So integral was this sub-committee to all matters related to the GMS contract, that one interviewee described it as “the spider in the middle of the web that enables the system to work well”. One on-going problem, however, was that of communication back to CHCP level, because (as previously indicated) such communication now occurred across 11 CHCPs.

The **Practice Nurse Advisor** (number 12 on Figure 3) was the professional lead for practice nurses employed within general practices in the Health Board area. This individual met regularly with each of the CHCP senior nurses, sat on all strategic groups along with the clinical directors of the CHCPs and had regular contact with the Practice Managers Group. She also met individually with practice nurses, if required, and supported Health Care Assistants/Health Care Support Workers within GP practices. In relation to the GMS contract, the Practice

Nurse Advisor supported practice nurses, acting as a confidential sounding board in matters relating to the QOF and giving advice when required. Practice nurses were playing a major role in the Local Enhanced Services, which meant that the Health Board had to ensure that nurses were professionally competent enough to carry out their role in providing these services.

Enhanced services

Most practices had opted into the Directed Enhanced Services (DES) (see Table 3 in main report). A small number of practices decided not to carry out some of the minor surgery aspects of DESs – these were carried out by other practices on their behalf.

Twelve Local Enhanced Services (LES) had been commissioned, some meeting particular population needs (e.g. care for the homeless population or for asylum seekers); others building on the chronic disease management programme already well established in the Board area. For those practices that did not wish to carry out the Chronic Disease Management LES, Primary Care Support Services had organised a team of practice nurses to carry out some of the work required. There has been some discussion at national meetings about some Enhanced Services that could potentially be taken from practices (who were given first refusal) and provided by health boards, but this has not yet taken place.

Out-of-hours care

Prior to the new contract, out-of-hours care in the Health Board had been provided by a city-wide GP out-of-hours co-operative, which formed in 1996 and to which almost all GPs in the Board participated (number 13 on Figure 7). NHS 24 began front-ending calls for the service in 2002. The out-of-hours service was previously located within the Primary Care Division, but since re-organisation of the Board was now sited in the Emergency Medicine Directorate of the Acute Division. It operated as a “hub”, connected directly to each of the six Primary Care Emergency Centres (PCECs) and their home visiting cars. The majority of GPs working for the service were full time GP principals who also worked locally. A recent development was a minor illness nurse service, where specially trained nurses could see and treat patients triaged as having minor illnesses.

PCO Case Study 4 (NHS Health Board H)

Like its Scottish counterpart, this Health Board had also re-organised in 2003/04 to become a unified board or “Single Integrated Health System”. With the subsequent introduction of CHPs in 2004/05, it had three operating divisions:

- NHS Board.
- University Hospitals Division.
- CHPs – originally 5, but later reduced to 4.

This Board's priorities were similar to those of its Scottish counterpart, including the reduction of health inequalities, reducing inequalities in Coronary Heart Disease mortality, tackling alcohol abuse, smoking cessation, obesity in children and adults, teenage pregnancy and sexual health and waiting times (NHS Lothian 2008).

Four Directorates were established at the Board Headquarters: Human Resources; Public Health; Finance & Performance; and Strategic Planning & Modernisation (see Figure 8 – numbers 1 to 4). A global approach to governance was adopted in the Board, with the establishment of a single **Health Care Governance and Risk Management Committee**, with a remit to oversee all aspects of healthcare governance and risk management in the Operating Divisions and CHPs in order to ensure consistency and quality of clinical governance across the Board. This Committee also ensured that the Division/CHP Management teams were delivering against the NHS Quality Improvement Scotland Healthcare Governance and Risk Management Standards as well as against locally agreed Quality Improvement Programmes, carried out by individual Quality Improvement Teams in each management group/clinical team, including CHPs, clinical directorates and the Managed Clinical Networks.

A transitional organisation, the **Primary Care Organisation (PCO**, number 5 on Figure 8) was established to support the new CHPs, in order to reduce administration costs, provide expertise and reduce bureaucracy. The PCO also supported the CHPs in the management of more complex services requiring a hosting arrangement for a defined period, thus enabling the CHPs to develop increased capacity to directly manage and host the services themselves. The PCO Management team had membership from the 4 CHPs and the Board's Operating Division. It had a contract support team to coordinate the statutory PCO functions, CHP administration support, a secretariat for CHP committees and a transfer management unit for CHPs.

The **Primary Care Contracts Team (PCCT**, number 6) worked within the Primary Care Organisation, managing the contractual arrangements with primary care practitioners for the provision of primary care services to the population of the Health Board area. Here, the GMS contract was implemented alongside the contracts for other independent contractors, as well as linking GMS with both the consultant contract and Agenda for Change.

The PCCT provided the core staff for the implementation of the GMS contract, dealt with the administration of statutory contractors' lists and with enquiries from both contractors and the general public. They undertook negotiations for local contracts with the Professional Advisory Committees and with the Local Area Pharmaceutical Contractors committee and managed the NHS Complaints procedure affecting primary care practitioners, including disciplinary proceedings. Finally, they worked on the development and implementation of new contractual arrangements for primary care practitioners.

In March 2007 the PCO was dissolved and the **Primary & Community Partnership Committee (PCPC)** (number 7 on Figure 8) became the principal forum for all the area's CHPs with co-ordinating rather than decision-making responsibilities. The remit of the PCPC was to support integration between health and other agencies and to give the four CHPs the ability to coordinate and collectively influence Board-wide strategy and decision-making while assuming an overview of primary care and CHP professional and organisational development.

The four **CHPs/CHCPs** (numbers 8 to 11) were created in April 2005 in order to achieve co-terminosity with the existing NHS and Local Authority Partnerships. The key aim of the CHPs was to improve patient outcomes through the devolution of management, decision-making and resources to front-line staff. Certain services were managed in each of the CHPs, whilst others were managed in specific CHPs (Table ii). Where CHPs did not manage a service, management was provided via a hosting or partnership agreement on behalf of the CHPs through the Primary Care Organisation or its later replacement. CHPs therefore played a major role in the Board's Modernisation Strategy and in the negotiation and "operational delivery" (or "operational management") of additional and enhanced services with practices. Each CHP became a sub-committee of **Primary & Community Partnership Committee** and CHPs were accountable to the executives of the Health Board.

Table ii. Services hosted by designated CHPs on behalf of all the CHPs

CHP 1	CHP 2	CHP 3	CHCP 4
Evening and night nursing service	Learning disability specialist services	Unscheduled Care Service	Salaried community dental practitioner service
Continence service	Homeopathy	Health promotion activities with Director of Public Health	
Hospital-based services at local community hospital	Substance misuse		
Family planning	Macmillan Cancer Centre at local hospital		
Community care of the elderly			

A number of strategic and operational Committees were established to oversee GMS management and governance – these were sited with the Human Resources Directorate. These included the **Pay Modernisation Board** (number 12), responsible for leading the implementation of all the main NHS contracts (consultant contract, GMS, Agenda for Change, pharmacy and dental contracts). Of direct relevance to the monitoring of the GMS contract was the **GMS Pay Modernisation Board** (number

13), whose membership included the Chair of the GP Subcommittee of the Local Medical Committee (LMC). A number of operational groups answered to the GMS Pay Modernisation Board, each with a particular role or responsibility. These included:

- **Primary Care Joint Management Group** (number 14): Accountable to the Healthcare, Governance and Risk Committee at board level. This group incorporated all CHP general managers and clinical directors, the independent contractor groups, the health board and the acute division, and their role was to approve and agree on the direction of travel for the Board in terms of national contracts.
- **GMS Steering Group** (number 15): Guided the implementation of the GMS contract in partnership with the LMC and with a wide membership from across the CHPs, LMC, Health Council, Public Health, Medical Directors, Nursing, Practice Management and Public Relations.
- **GMS Core Management Group** (number 16): This group managed the process of GMS implementation, and was one of a series of Core Groups established for each of the independent contractors. This group oversaw the activities of a range of GMS Working Groups (number 17), each of which led on specific areas of the contract work including practice nursing, unscheduled care, finance, links with CHPs, quality, practice management and enhanced services.

Like the other Scottish site, a dedicated Clinical Nurse Manager represented practice nursing. This role encompassed the professional leadership and also a remit for nurse prescribing, covering both community and practice nursing.

Enhanced services

Enhanced services, previously the responsibility of the Primary Care Organisation, were devolved to the **CHPs**. Monitoring of the enhanced services was carried out by the **Enhanced Services Working Group** (see under 17, Figure 4), which in turn reported to the GMS Core Management Group.

Out-of-hours care

Out-of-hours care was provided by the **Local Unscheduled Care Service** (LUCS, number 18), located within the Primary & Community Operating Division. Following the implementation of the new contract, 10 different GP out-of-hours providers scattered across the Board area were brought together under a single out-of-hours service, front-ended by NHS 24. Operating from a central hub, the service operated 5 Primary Care Emergency Centres. LUCS employed a combination of salaried GPs, who provided at least 35% of the shift cover, as well as 360 sessional GPs. The service also employed 29 Emergency Nurse Practitioners and 8 paramedics, shared with the Scottish Ambulance Service.

References

NHS Greater Glasgow & Clyde 2007, Annual Review 2007.

NHS Lothian 2008, Annual review 2007/08.

Scottish Executive 2003, Partnership for care. Scotland's health White Paper, Scottish Executive, Edinburgh.

Western Cheshire Primary Care Trust 2007, Annual Report 2006/2007.

Appendix 3 Stage 1 and Stage 2 interviewees

Descriptor	Number of interviews
ENGLAND.	
National level.	13
Department of Health officials (n=2); Representatives of professional bodies, including the RCGP (n=5); Individuals involved in contract negotiations, including the NHS Confederation (n=3); Academics (n=1); Managers at Strategic Health Authority level (n=2).	13
PCO Case Study 1: PCT.	59
PCT: PCT employees with responsibility for the strategic management and operational delivery of aspect of the new GMS contract, including QOF and the enhanced services (n=9); and for commissioning within the PCT, including involvement in the PBC (n=5).	14
Other: Others working within the PCT area but not employed by them, for example strategic and operational managers from the out-of-hours service (n=6); strategic and operational managers from the enhanced service (n=5); local representatives of professional bodies (n=1).	12
Practice staff: Drawn from the four embedded case study practices and including GPs (n=8); practice nurses (n=5); practice managers (n=3); and administrative staff (n=3).	19
Patients: Patients from the four embedded case study practices, diagnosed with either diabetes (n=8) or rheumatoid arthritis (n=6).	14
PCO Case Study 2: PCT.	9
PCT: PCT employees with responsibility for the strategic management and operational delivery of aspect of the new GMS contract, including QOF and the enhanced services (n=6), and for PCT functions such as commissioning (n=2).	8
Other: Others working within the PCT area but not employed by them, for example strategic and operational managers from the out-of-hours service, local representatives of professional bodies.	1
SCOTLAND.	
National level.	4
Scottish Government Health Department officials (n=2); Representatives of professional bodies (n=2); Academics.	4
PCO Case Study 3: Health Board.	43
PCO: Health Board (n=9) and CHP (n=7) employees (with responsibility for the strategic management and operational delivery of aspect of the new GMS contract, including QOF, the enhanced services and out-of-hours service, and for service delivery; local representatives of professional bodies (n=1).	17
Practice staff: Drawn from the four embedded case study practices and including GPs (n=8); practice nurses (n=8); practice managers (n=4); and administrative staff (n=1).	21

Patients: Patients from the four embedded case study practices, diagnosed with either diabetes (n=4) or rheumatoid arthritis (n=1).	5
PCO Case Study 4: Health Board.	11
PCO: Health Board (n=7) and CHP (n=4) employees with responsibility for the strategic management and operational delivery of aspect of the new GMS contract, including QOF, the enhanced services and out-of-hours service, and for service delivery.	11

N.B. *Within each group, individuals were often able to provide insights to different aspects of the implementation of the contract, for example those working at a management level were often practising clinicians; representatives of professional bodies were also practising clinicians and/or academics.*

Appendix 4 Stage 1 interview guide

1. Interviewee Background and Current Role:

Aim: to introduce respondent and highlight any key background issues that might have a bearing on their involvement in GMS-related work.

- Current role:
 - Job title
 - Organisation
 - Length of time in post
 - Involvement on GMS-related work
 - Main contacts – nationally; at PCT/Board level
- Employment history:
 - Employment prior to start of GMS contract: details e.g. job title, title of organisation
 - Impact of GMS contract on previous role

2. Involvement in GMS-Related Work:

Aim: to establish the respondent's involvement in GMS-related work in greater depth.

- Involvement in GMS-related work, e.g.:-
 - QOF
 - Enhanced Services
 - Out of Hours Services
- What has been the wider impact on other independent contractors (dentists, pharmacists and optometrists)?
- How successful do you feel the contract implementation process has been? What could be changed?

3. Governance in Primary Care:

Aim: To explore respondent's views on the ways in which clinical governance is evolving post-GMS.

- What are the GMS governance arrangements nationally?
 - History behind current set-up
 - Relationship with SHAs/PCTs/Boards
- What do you think the key governance issues are: Nationally?
Regionally?

- What are your views on the generally 'light touch' governance approach of PCTs/Boards? Is it necessary? Was it intended?
- What are key governance issues in relation to: increased use of IM & T?; Practice Based Commissioning?
- What are your views on the issues that have surrounded exception reporting?

4. Relationships:

Aim: To establish respondent's views on the new relationships which are evolving since the start of the GMS contract.

- What do you think the key issues are in relation to the primary care workforce?
- What do you think are the best ways of involving the public in clinical governance?
- What do you think are the best ways of informing the public about quality of care they receive?

5. GMS within Devolved UK Context:

Aim: To explore respondent's views on ways GMS is evolving in UK nations (esp. England and Scotland).

- What are your views on the way the GMS contract has been devolved and the national interpretations of the contract? (ensure that views on both England and Scotland are explored)
- To what extent should GMS be devolved: (i) at a national level? (ii) at PCT/Board level?

6. Quality in Primary Care:

Aim: To explore respondent's views on the concept of 'quality' in relation to GMS within primary care context.

- Has quality improvement since start of GMS contract met your expectations?
- Has the cost of the GMS contract met your expectations?
- What went right?
- What went wrong?
- How would you define a good performer?
- How would you define a poor performer?
- Has your perception of 'quality' changed since the start of the contract?

7. Financial Investment:

Aim: To establish respondent's views on financial investment in contract.

- Do you think that the GMS contract represents good value for money and if so, in what ways?
- What parts would you change?
- What would you implement?

8. Positive and Negative Effects:

Aim: To establish more general views on effects of GMS contract.

- What have been some of the negative effects of the contract?
- What have been some of the positive effects of the contract?
- What key message would you give from your experience and involvement?

9. Future Developments:

Aim: To establish respondent's views on contract implementation process so far and their thoughts for the future.

- How do you see primary care developing in response to the GMS contract?
- Do you have any final comments?

Appendix 5 Stage 2 interview guide

1. Interviewee Background and Current Role:

Aim: To introduce respondent and highlight any key background issues that might have a bearing on their involvement in GMS-related work

- Current role:
Job title
Organisation
Length of time in post
- Employment history:
Whether working prior to start of GMS contract or not: details e.g. job title, title of organisation/name of practice

2. Involvement in GMS-Related Work:

Aim: To establish a general understanding of the respondent's involvement in GMS-related work.

- Involvement in GMS-related work, e.g.:
QOF
Enhanced Services
Administrative Systems (e.g. Practice Manager/IT Manager)

3. Contact with PCO:

Aim: To establish a general understanding of the frequency and nature of contact with the PCO.

- What role has the Health Board/PCT played in the implementation of the contract in your practice?
- How would you describe your relationship with the Health Board-CHCP/PCT? Do you think that it has changed since the start of the contract?
- Has the PCO been involved in the development of clinical governance frameworks? If yes:
Have these new frameworks been useful or not?

4. Support and Guidance:

Aim: To explore the 'softer' aspects of the practice's relationship with the PCO and any involvement with other organisations.

- What support and guidance has your practice received from the PCO prior to and during the implementation of the GMS contract?

Main contacts

Nature of contact

How useful has this been?

- Have you received any support and guidance from clinical or professional organisations (e.g. the PEC/PEG or the LMC/PBC consortia)?

Main contacts

Nature of contact

How useful has this been?

- Do you have any contact with the PCO IT Mentoring Team/equivalent?

How useful have you found them?

Have there been any particular areas of difficulty?

- Do you have involvement with other practices in the CHCP/Board/PCT?

Has the GMS implementation process had any effect on your relationship with other practices?

5. Performance Monitoring and Accountability:

Aim: To explore the 'harder' aspects of the practice's relationship with the PCO.

- Has the PCO been involved in any monitoring of services:

In relation to nGMS? If yes:

Main contacts

Nature of contact

How useful has this been?

- Have you been involved in any performance monitoring visits organised by the PCO (e.g. QOF Review Visits, Contract Review Visits)? If yes:

What was your involvement?

What has been your experience of these visits? (positive/negative, etc.)

- Has the PCO set local targets in relation to national/local priorities? If yes:

Main contacts

Nature of contact

How useful has this been?

- Has the PBC consortium been involved in any target setting or monitoring of services (England only)? If yes:

Main contacts

Nature of contact

How useful has this been?

6. Governance within the Practice:

Aim: To establish the internal governance arrangements within the practice.

- Within the practice, who is responsible for monitoring the clinical indicators of the QOF and ensuring that the work is carried out and that targets are met? What is their role? What action is taken if targets are not met?
- Within the practice, who is responsible for monitoring the organisational indicators of the QOF and ensuring the work is carried out and that targets are met? What is their role? What action is taken if targets are not met?
- Do you have team meetings to discuss GMS contract progress?

If yes:

When and where are meetings held?

Who attends?

Who leads them?

What methods are used to ensure that targets are met?

Is progress information disseminated in any other ways?

If no:

Where does QOF decision-making take place?

- Has the relationship between individuals within the practice changed as a result of the introduction of nGMS and QOF (e.g. any sense of animosity/conflict/team working etc.)?
- Have any new IT and administrative systems have been introduced to the practice since the start of the contract (e.g. recall systems, GPASS/Vision)?

Who is responsible for running these systems?

6. QOF and Enhanced Services:

Aim: To explore governance arrangements for QOF and Enhanced Services.

(i) Quality and Outcomes Framework (QOF):

- How did your practice perform under the Quality and Outcomes Framework (QOF)?

Were there any particular issues or difficulties?

Was it important for you to achieve a high QOF score (as an individual and a practice)? Why?

(ii) Enhanced Service Provision:

- Which National and Local Enhanced Services did your practice opt in or out of?

Why?

Do you see this as new work for the practice or is it a continuation of work previously carried out in these areas?

Has pricing been an issue?

Do you think that these services should be opened up to other providers?

- What impact do you think financial incentives have had on your work?

Do you think that incentives have impacted on some practice team members more than others?

Have the incentives had any impact on your desire to do a 'good job'?

7. Case Studies:

Aim: To establish how governance arrangements for diabetes, substance misuse, access and unincentivised conditions have changed since the start of contract.

1. Diabetes:

- How is diabetes care organised (e.g. hospital, GP only, shared care [and what do they mean by 'shared']; systematic clinic vs. opportunistic; nurse or GP led, or shared [and how shared])?

How long have you been doing this?

How has it changed over time?

How much impact did QOF/QOF-LES have on what you did?

- Do you have contact with any external staff in relation to diabetes (e.g. diabetes nurses provided by Health Board)?
- Have the incentives made a difference to the way that care is delivered for diabetic patients?
- How is care organised for diabetic patients with other conditions (e.g. systematic clinic vs. opportunistic; nurse or GP led, or shared [and how shared])?

How long they've doing this?

How has it changed over time?

How much impact did QOF have on what they did?

- What are the benefits of what you have put in place?
- Has it been detrimental in any way?

2. Substance Misuse:

- How is care for substance misuse patients organised (e.g. systematic clinic vs. opportunistic; nurse or GP led, or shared [and how shared])?

How long have you been doing this?

How has it changed over time?

How much of an impact has the enhanced service had on what they did?

- What contact do you have with the PCO in relation to substance misuse?
- How is substance misuse care monitored within the practice/by PCO?
- Do you have contact with any external staff in relation to substance misuse (e.g. CAT Teams/Lighthouse Project)?
- Have the incentives made a difference to the way that you deliver care for substance misuse patients?
- What have been the benefits of the changes in substance misuse care for patients/staff?
- Has it been in any way detrimental?

3. Access:

- What has been the impact of (a) access targets (b) the QOF access bonus (c) changes to the access DES on the delivery of care in your practice?
- Has the PCO issued any directives to practices regarding access targets?
- Has the PCO been involved in monitoring access to services within the practice? (How is this being done)
- How have these influenced how access is organised?
- How do these fit in with other nationally/centrally organised access improvement initiatives such as the Advanced Access collaborative?
- How do these fit in with other more local access improvement initiatives?
- What are the benefits of what you have put in place?
- Has it been detrimental in any way?

4. Unincentivised Conditions:

- Has there been any change to the delivery of care for unincentivised conditions (e.g. Rheumatoid Arthritis) since the start of the contract?
- Do you think there have been any changes in the quality of care provided for patients with unincentivised conditions (e.g. Rheumatoid Arthritis)?

8. Division of Labour: (OPTIONAL)

Aim: to explore the impact of nGMS on practice team organisation and decision-making, and the delivery of incentivised care.

- How has QOF and Enhanced Services work been distributed across the practice?

Has this changed since the start of the contract?

How are these decisions made?

- Have you employed any new staff members since the start of the contract? If yes, do you think that these changes have been necessary? If not, why not?

9. Positive and Negative Effects:

Aim: to identify respondent's views on the positive and negative effects of the QOF and Enhanced Services at practice level.

- What have been some of the benefits of the QOF and Enhanced Services at practice level?
- What have been some of the negative effects of the QOF and Enhanced Services at practice level?
- How have your relationships with PCOs changed over the last 5 years? Would you say that it was better or worse than previously? Impact?

10. Key Message:

Aim: Key Message

What key message would you give from your experience and involvement so far?

11. Future Directions:

Aim: To identify how respondents see general practice evolving over the next five years.

How do you see general practice evolving over the next five years in response to the GMS contract?

Appendix 6 Interview schedule for patients

How long have you been a patient at your current general practice?

How long have you had [insert name of condition e.g. Diabetes/Rheumatoid Arthritis]?

What treatment are you currently receiving for [insert name condition]?

Roughly how often do you go to your GP's surgery?

Who would you usually see in the practice for [insert condition] care?

Have any changes taken place in [name condition] care over the past few years e.g. seeing a different/new GP, more hospital attendances, new types of clinic within the practice, seeing the practice nurse more or less frequently.

How do you feel about the care you receive for [name condition]?

Do you attend any other clinics/services outside of the practice in relation to care for [insert name of condition e.g. Diabetes/rheumatoid arthritis]? (Name of clinic/service and length of attendance).

Do you have any other health problems?

Has the care you receive for these conditions changed over the past few years?

Appendix 7 Pro-forma for case note review

Variable to be collected	Definition / Notes
Practice Number:	Unique Identified assigned by us to identify practice: Practice 1, Practice 2, etc.
Patient Number:	Unique number assigned per patient for counting purposes only.
Patient Demographics.	
Date of birth	To allow later calculation of age.
Gender	
Postcode	Full postcode to allow later assignment of IMD/SIMD score.
Co-morbid conditions.	
Presence of other co-morbid conditions as of March 2008	Drop-down list co-morbid conditions: Angina Anxiety Asthma Atrial fibrillation Back pain Cancer Chronic kidney disease CHD COPD Dementia Depression Diabetes Epilepsy Heart failure Hypertension Hypothyroidism Multiple sclerosis Osteoarthritis Rheumatoid arthritis Stroke/TIA
Date of diagnosis of other co-morbid conditions	Date at which other condition "diagnosed" – i.e. formally documented in the notes.
Diabetes.	
Date of diagnosis	Date of diagnosis in case notes, either from practice or secondary care. Exclude patients whose date of diagnosis is later than April 2003.
Type 1 or Type 2 diabetes	Drop-down choice of Type 1 or Type 2 diabetes
Diabetes care.	
Number of consultations per annum	Number of consultations in each year for any reason
Number of diabetes-related consultations	For example diabetic reviews
Health care professional dealing with each diabetes-related consultation	GP, PN
Record of BP	Number of consultations per year in which BP was recorded

recording per year	
Number in which BP 145/85 or less	Number of consultations per year in which BP was 145/85 or less
Record of HbA1c recording per year	Number of consultations per year in which HbA1c was recorded
Number in which HbA1c was 10 or less	Number of consultations per year in which HbA1c was 10 or less
Number in which HbA1c 7.5 or less	Number of consultations per year in which HbA1c was 7.5 or less
Record of cholesterol recording per year	Number of consultations per year in which cholesterol was recorded
Number in which cholesterol was 5 mmol/l or less	Number of consultations per year in which cholesterol was 5 mmol/l or less
Record of influenza immunisation	Note of influenza immunisation in that year
Referral to secondary care	Number of times in the year where patient is referred to secondary care for diabetes care
For each of the above:	GP or PN
Rheumatoid arthritis.	
Date of diagnosis	Date of diagnosis in case notes, either from practice or secondary care.Exclude patients whose date of diagnosis is later than April 2003.
Rheumatoid arthritis care.	
Number of consultations per annum	Number of consultations in each year for any reason
Number of RA-related consultations	
Health care professional dealing with each RA-related consultation	GP, or PN

Number in which NSAIDs prescribed	Number of consultations per year in which NSAIDs were prescribed
Number in which DMARDS prescribed	Number of consultations per year in which DMARDS were prescribed
Type of DMARD	Type of DMARD prescribed
Number in which U&Es monitored	Number of consultations per year in which note of U&Es result seen
Number in which liver function monitored	Number of consultations per year in which note of liver function results seen
Referral to secondary care	Number of times in the year where patient is referred to secondary care for RA care
For each of the above	GP or PN

Addendum

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.