Strategies for Achieving Change in General Practice

Report of a Study Trip to England, August 2005

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Background

This report results from a World Health Organisation funded study tour to England in August/September 2005. The purpose of the visit was to learn what strategies have been found to be effective for facilitating change in the organisation and delivery of general practice services.

Visits were made to the National Primary Care Research and Development Centre at the University of Manchester, the Health Services Management Centre at the University of Birmingham and the Kings Fund in London. The Health Services Management Centre in Birmingham hosted the trip. Visits and interviews were also undertaken with a Strategic Health Authority, three Primary Care Trusts and four general practice teams. The general practices visited were all large, well organised practices serving populations of 15,000 to 25,000 people. All but one were serving high deprivation communities.

We share with the NHS many similarities in terms of organisation and policy in primary health care. In particular, both countries have local level primary care organisations charged with managing and governing primary health services. They also have independent general practice based on the private business model. In England the primary care organisations are Primary Care Trusts¹ (PCTs). They serve larger populations than Primary Health Organisations and are government owned.

England’s overall aims for the health service are familiar to us - achieving the best possible health outcomes and reducing health inequalities. The government is in the process of investing heavily in the health sector to modernise services and improve the standard of care. This includes investing in the primary health care infrastructure. The specific agenda for general practice includes the following:

¹ There are currently about 300 PCTs. They have a mix of commissioning (planning and funding) and provider responsibilities. Commissioning covers both primary health and secondary care. Provider responsibilities are limited to primary health and community services etc. Hospital services are provided by Trusts and Foundation Trusts, which are separate government organisations. PCTs contract with trusts through Service Level Agreements.
Waiting times for primary care to be no more than 24 hours to see a health professional and 48 hours to see a GP.

A patient-led NHS with patients having choice.

Markets should be used to improve services.

General practice to participate in purchasing of acute care and diagnostic services through Practice Based Commissioning.

The NHS has a lengthy history of active reform of general practice dating back 15 years or more. What makes it a fertile ground for learning experiences is that the reform programme has been well resourced and evaluated. Because of size there is also a diversity of experience and initiative that provides opportunities to see many different ideas put into practice.

This report considers NHS change interventions under the following headings:

1. Contracts and contracting
2. Performance management
3. Information systems initiatives
4. Community engagement processes
5. Relationships between health authorities, trusts and providers
6. Employment structures for health professionals
7. Facilitation of change using external resources
8. Practice organisation.

There are a few features of the NHS that are dissimilar to the NZ situation and which need to be taken into account. Firstly, the NHS is much more involved in the organisation of general practice than is the case in NZ. Almost 100% of general practice funding comes from the NHS and historically funding has been highly regulated through a system of entitlements and allowances. The NHS is involved in aspects of GP incomes and pensions, in Information Systems infrastructure and general practice facilities. The latest general practice contracts have extended and institutionalised the managed nature of primary health care.

The interaction is not all one way. General practice and General Practitioners (GPs) in particular appear to be extensively involved in the NHS. One PCT reported that 30% of local GPs were working on PCT projects or activities.

Despite this level of interaction, general practice is still considered to be an independent enterprise. GP ownership continues to be the dominant form of general practice although there are an increasing number of salaried principals. Most practices are considered a small business although some are medium sized.

A second point is that PCTs and general practices appear to be well resourced compared to the NZ situation. The larger practices visited had a range of management and administration resources, which gave them capability greater than what we would see in NZ. PCTs are larger than PHOs and well resourced with a range of technical and specialist resources, including for example, clinical advisors and the like. Some PCTs were providing an extensive level of operational support to their practices.

The government has been actively working to reform general practice and to incorporate it as part of overall NHS management and service improvement since the Promoting Better
Health policy of 1988. It is not yet satisfied with the gains made and consequently the reform agenda continues with initiatives at both national and district levels. At the national level government agencies continue to look for ways of shaping general practice through new policy initiatives. At the local level PCTs also see considerable scope for improving general practice services in their area. The term “organisational development” is the most commonly discussed approach within the context of discussions about practices.

1. **Contracts and contracting**

The UK provides an interesting study in how contracting and contracts can influence providers and their activities. A new General Medical Service (GMS) contract was introduced in 2004 and has had a very dramatic impact on practices. It appears to be driving a significant level of change. A number of features of the new contract are contributing to this impact:

- Contracts are now practice-based rather than with individual GPs. They provide increased autonomy to practices in terms of how practices martial resources to meet their patient’s needs.
- Practices can opt out of certain service responsibilities, including after hours cover.
- A number of obligations and risks previously carried by the practice (such as after hours coverage and responsibility for information technology investment) transfer to the PCT.
- A range of new “enhanced” primary health care services are to be contracted by PCTs, for example, minor surgery, care of the homeless, intrapartum care and depression. Some of these are specified at the national level but it is also possible for practices to collaborate to propose enhanced services to meet specific local needs.
- General practice contracts continue to be based on an enrolled register of patients. This drives the global fund, which covers most of the services provided and is the largest part of practice funding.
- Contracts focus on quality outcomes through the Quality Outcomes Framework\(^2\) (QOF), which provides additional funding for achievement of a range of organisational and service standards. It is a points-based system. Additional funding is in the order of 25%. A practice with a list of 5,000 patients would reputedly gain an additional £75,000 from the QOF.

The new GMS contract was negotiated nationally and rolled out locally by PCTs. As part of this roll out process, the PCTs visited had met with their practices and discussed implementation, agreed QOF targets, etc. Subsequently PCT staff revisited practices to audit performance.

Practices very quickly responded to the QOF framework. Among the affects mentioned by PCTs and noted in practices during visits were the following:

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\(^2\) See Appendix A for an outline of the content of the Quality Outcomes Framework.
• Practices tidied up registers, clinical notes and record keeping.

• Practices appeared to have worked hard to implement or improve their structured care programmes. All the practices reported that they already had care programmes for the key priority patient groups, but that these needed to be tidied up to meet the defined standards.

• All practices visited had taken the opportunity to opt out of the provision of after-hours care. This included one practice that had previously been participating in a satisfactory district-level collective cover arrangement. Once GPs withdrew it became the PCT’s responsibility to ensure after hours services were available. They have done this by entering into contracts with various providers. For example, with commercial enterprises set up for the purpose of providing after-hours cover.

• Several practices were talking with neighbouring practices about possible joint initiatives to take advantage of enhanced service contracts available from the PCT.

• Skill mix within practices appeared to be in a state of change. All practices had increased their nursing and administration establishment over the preceding two years. The additional nursing resources were specialist, and in some practices it appeared that most, if not all the nurses had specialist skills.

• Several practices intended to review skill mix in future, with one practice intending to reduce GPs in favour of additional specialist nursing.

All the practices visited scored very highly against the QOF, resulting in additional practice income. In one practice the additional funding was invested in extra specialist nursing resources. In another it was split between the practice directors and additional practice resources.

Nationally practices scored higher QOF points than was anticipated by authorities. This meant most PCTs paid out more in QOF payments than the funding they received, leaving a shortfall that had to be funded from elsewhere in the system.

There is debate as to whether the QOF framework really has resulted in an improvement in care as opposed to better reporting and/or manipulation of the data. Some commentators felt the NHS had set the targets too low and received very little return for the additional funding. Other commentators were concerned about “crowding out” of areas not covered by the QOF as practices work to maximize their points. Another problem reported by PCTs was that general practice has argued that certain services hitherto provided were not included in the more detailed service specification attached to the new contract. This has resulted in new funding intended to improve health status being used to contract service components that were already being delivered.

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3 PCT finances have also been hit by new contracts for NHS consultants and wider pay changes for NHS staff. NHS debt continues despite record levels of increase in NHS funding over the period 2002/2008.

4 There was suspicion that some practices had misused the exclusions policy for some of the clinical indicators. This policy allows clinicians to exclude certain patients when calculating indicators. This is for situations where it is clinically unreasonable to expect compliance. For example, because the patient is terminally ill.
Whether or not the QOF resulted in an improvement in care, there is general agreement that it has had the effect of making the provision of care more transparent and that this is a good thing.

PCTs and SHAs anticipated that QOF targets would increase in future years. Some practices did not seem to be aware that standards would rise incrementally, while others were confident about their ability to continually improve to achieve whatever standards PCTs set.

The very rapid influence achieved by the new contract appears to relate to the following features:

- It was negotiated with the British Medical Association and actively endorsed by the Association to its members. A national referendum of GPs pre-implementation supported the new contract. (Note, the majority of GPs, but not all, were supportive.)
- It built on work undertaken previously – particularly its focus on quality standards, which aligned with earlier work on clinical governance.
- It addressed specific GP issues. For example, it allowed GPs to opt out of after hours care and a range of other service components.
- The QOF indicators were evidence-based wherever possible. There seemed to be acceptance amongst practices that the indicators were incontrovertible in terms of their importance to the organization and delivery of general practice services.
- A significant level of new funding was applied to the QOF.
- Indicator targets were considered achievable by general practice, and in many cases support was provided to practices by PCTs to help them capitalise on the new funding.

The conclusion, then, is that the new contract succeeds because its logic is largely consistent with general practice priorities and interests. One commentator noted that the contract is a success not because it incentivised, but because it motivated general practice. It is inspiring to see how responsive the sector can be to this type of mechanism when all aspects are well configured.

In addition to the changes in the organization and delivery of care at practice level noted above, the new contract also seems to be supporting a subtle repositioning of general practice. The contract asserts the NHS’s service agenda for primary health care and it strengthens accountabilities. Responsibility for key strategic areas such as information technology and management (IT/M) and some facility development are assigned to PCTs. It even binds general practice to the NHS’s Human Resource strategy for primary care.

The new contract draws general practice into the NHS but it does so in the role of contractor. It engages directly with the overall unit of service delivery – the practice – rather than working through the GP as has been the case in the past. The principal-agent relationship between the PCT and the practice is clarified. The PCT’s role as commissioner is strengthened and will be strengthened further under the next wave of reforms.

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5 This strategy focuses on increasing capacity and ongoing development and support for staff.
The new contract increases the transparency of general practice services but in so doing has the effect of reducing general practice to a series of biomedical tasks. It increases the specialization of staff and encourages a narrowing (and some say fragmentation) of the scope of general practice. The overall effect of the contract seems to be to change the role of general practice from THE provider of primary health care to a community, to A provider of primary health care services within a community.

The register, another of the key foundations of general practice, is also being critically examined. Some SHAs and PCTs are suggesting that the register should be removed as the basis for contracting, presumably being replaced by some sort of output or outcome based contract, possibly tied to a geographical area. This would align with the more contractual approach to primary health care services being advocated by government. This move would have quite profound implications, not least for traditional general practice.

There are already a number of non-GP based providers delivering general practice or specialized components of care that might traditionally have been considered the prerogative of general practice – for example, nurse-led practices and specialised, community-based chronic disease programmes. Most of these at this stage are PCT or Trust run services. In future PCTs will be required to shed their provider functions and concentrate on planning and commissioning health services.

In this context it is worth noting that the GMS contract discussed above is only one of four contract forms available to PCTs to contract for primary health care services. Two others are relevant to this discussion.

- The Personal Medical Services (PMS) contract is between the PCT and a provider, which can be a non-GP practice, a PCT service division or some other agency. This contract is designed to enable innovative ways of meeting the general practice-type needs of particular populations. It predated the new GMS. Over time many general practices had already migrated to the PMS because of the greater flexibility it allowed. Up to 40% of GPs were operating under the PMS contract already. The PMS contract has been modified so it aligns with the GMS contract in terms of funding levels and to provide access to the QOF payments.

- The Alternative Provider of Medical Services (APMS) contract allows a PCT to contract with any provider (whatever type of organisation they may be) to provide primary health care services. Services may include: essential (that is, core) services, additional services where GMS/PMS practices have opted-out, enhanced services and out of hours services.

There is a perception that there are quite a number of potential innovative providers of primary health care services out there waiting to be tapped into. These include commercial enterprises, voluntary agencies, collaborative partnerships, public service bodies and NHS Trusts and Foundation Trusts. The government is keen to see PCTs tap into this resource with a more market approach to primary health care. The four contract forms available to PCTs are seen as a framework that enables PCTs to do this by providing considerable flexibility.

The government is looking to PCTs to use this framework to develop services that offer greater patient choice, improved access, and greater responsiveness to the specific needs of the community. The new contracts can be used to improve capacity, to address unmet needs
or specific population groups and to foster innovation. They can also be used to ease workload on overburdened practices, provide services where practices opt-out or to address performance issues with practices where other solutions have not worked.

2. Performance indicators and reporting

Public reporting of performance has been a key feature of the NHS and is now moving into the primary health care area with the public release of scorecards for PCTs that include primary health indicators⁶. The model uses a balanced scorecard approach and a star system driven by a points framework.

The publication of performance information fits well with the government’s intention that patients have choice in the services they access. Government would also argue that the publication of results has proven to be a very effective way of focusing agencies on the government’s key priority areas (such as waiting times) and has produced some spectacular results.

In the NHS trust sector the performance management process has been very forceful and to an extent punitive. For example, Chief Executives of trusts scoring poorly have routinely lost their jobs. Given this experience it is not surprising that both practices and PCTs were unhappy about public reporting of information relating to practice performance. The main arguments were that public reporting of performance is not effective in terms of influencing practices and does not provide information that the community wants or can do anything with. Public reporting was considered to be part of the consumer approach to health services, which was seen as inconsistent with the way patients interact with their practices. Research by the National Primary Care Research and Development Centre on the information people want about their practices identified a desire for more personal accountability from the health professionals and also indications that the practice has a willingness to learn⁷.

A number of people also felt that public reporting of practice performance was fundamentally unsound because the breadth of general practice means it is not reducible to a simple set of performance measures that the public could be expected to understand.

At the moment reporting is at the PCT level. This will only ever have limited influence on practices as long as:

- Practices consider themselves to be independent,
- Practices have a low level of identification with the PCT, and
- There are no penalties on practices for poor performance by their PCT.

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⁶ These indicators include a variety of items that relate to primary health care and general practice in particular. For example: Access times for GPs and primary health care professionals. Rates for cervical screening, diabetic retinal screening, flu vaccination, and immunisation. Assertive outreach services. Identification of learning disabilities in primary care. The indicators are detailed on the Healthcare Commission’s website: http://ratings2005.healthcarecommission.org.uk

⁷ Marshall M; Noble J; What do patients really want to know about practices? Pulse 2005 May 7; 65 18 34-35
In these circumstances PCTs will need to rely on other levers to improve the performance of practices on key indicators.

Indicators and the provision of comparative information on practice and GP performance were widely used by PCTs to effect change. This was seen as plugging into the competitiveness of GPs and the desire to be well regarded by their peers. It was seen as extremely effective by some PCTs. In some cases PCTs were using professional and clinical governance forums moderated by the professionals. In other cases PCT staff were interacting directly with practices. For example, one PCT undertook routine visits every year with every practice at which information (including comparative information) on practice performance in a range of areas was discussed. This PCT considered it important that to effectively engage with practices these visits had to be couched as organisational development rather than as performance management. Having said this, the visits were undertaken as part of the QOF assessment and performance meeting so it is highly likely the practice saw them as related to performance management.

The QOF framework is another example of an indicator system. As already discussed this has led to a very rapid change in care when coupled with strong financial incentives. The QOF indicator set is respected because it is evidence based as far as possible and because there is a reasonable level of consensus that it covers aspects of practice that should be managed well. It is also relevant that the contract itself was negotiated with the sector prior to its introduction.

Note: subsequent to this study trip, QOF indicator data has been placed in the public domain sparking a debate in the media about standards of general practice.

3. Information systems initiatives

The government believes information technology has the power to deliver significant improvements in the quality, safety and convenience of primary health care services. Information technology and management (IT/M) are also key elements in the government’s health strategy. They relate to two particular directions; information sharing as a route to integrated patient care (National Care Records), and providing an interface between primary and secondary care which then becomes a foundation on which the boundaries can be redefined.

The latter direction relates to “Choose and Book” and “Practice Based Commissioning”. The government foresees a future in which a primary health care clinician and his/her patient will use “Choose and Book” applications during a consultation to identify treatment options available at various hospitals and then to book the care and organise the necessary pre-clinic diagnostic workup\(^8\). This includes assessing treatments options at the various hospitals, the consultants available, their waiting times, etc. Policy makers see this approach as delivering choice and responsiveness to the patient.

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\(^8\) Choose and Book is supposed to be completely implemented by December 2005 but there have been major delays associated with the technology.
This is a powerful vision when combined with Practice Based Commissioning, which will see practices or groups of practices looking critically at the care pathways patients travel and accordingly making decisions about services they want hospitals to provide\(^9\). In the past general practice used this type of tool to exert considerable pressure on hospitals to reorient their services to the benefit of patients and primary health care. The NHS is hoping that this will again be the case and that Practice Based Commissioning will be a countervailing pressure to the acute sector, which is now operating under an activity-based funding system (including fixed national prices for hospital procedures) which basically encourages throughput.

Given that information technology and management have been identified as central to the health strategy, it is not surprising that the new general practice contracts moved responsibility for these elements from practices to the PCTs. NHS involvement in practice information technology has an historical precedent. In the past investment by the GP was subsidised to a significant extent through a reimbursement process.

PCTs are now responsible for both hardware and software. There is to be a National Programme for IT (NPfIT) and new Local Service Providers, which will oversee the delivery of high quality information services across all primary care organisations in the NHS in England.

In addition to the strategic advantages to the NHS mentioned above, this approach also holds potential for standardisation and cost control. General practices have mixed views. Some are enthusiastic about the potential benefits for patient care but others are concerned about risk given that information system based business applications are mission critical for general practice. Two particular concerns were expressed. Firstly, that PCTs would not be capable of organising the necessary large-scale application development programme, and secondly, that PCTs would not have the level of funding necessary to keep investment up to date. The experience to date building and implementing the Choose and Book system would confirm these concerns.

In the practices visited there was already evidence that PCTs were moving ahead on the investment programme with new generic hardware being installed. There was no evidence of new applications being rolled out, and there was some criticism about the lack of progress.

If PCTs were not directly driving new applications at this stage, this was not stopping practices from actively considering updating their core practice systems. This appears to be driven by changes in the environment. The QOF in particular places significant demands on practice systems in terms of both the extraction and reporting of data and the need to actively manage the practice register (for example, management of diabetes patients).

The “Choose and Book” system mentioned above was another factor pressuring practices to update their systems, as was the imminent development of Practice Based Commissioning. It needs to be noted that “Choose and Book” was not well regarded by the GPs interviewed on the grounds that it is rigid and impractical.

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\(^9\) Under PBC, practices will hold partial or global budgets to fund care. The budget will not be fully devolved. PCTs will still retain control.
Interestingly, practices considering changing their practice systems were also looking at alignment with systems used in other practices and even their district as a whole.

Two of the larger practices visited had their own information systems staff. One practice had two people. IS staff performed a variety of roles including information/reporting functions. In some instances at least, IS staff also undertake hardware maintenance/rebuild functions.

4. Community engagement and customer feedback processes

Community engagement and customer feedback align with the Government’s drive to achieve a “patient led” NHS. The QOF allocates points for the performance of a patient survey by the practice and the development of an action plan. All the practices visited had undertaken these surveys, apparently using external consultancies and off the shelf questionnaires to do so. They had all found the surveys to be of limited value. They were poorly integrated into the practices and into practice planning (where this occurred at all). For example, survey results seemed to have a very limited circulation within practices being confined to the partners or to one particular partner.

Practices were particularly concerned about concepts such as representativeness and relevancy, which are concepts consistent with a marketing model. For the same reasons practices did not regard advocacy, focus groups, representatives and participation in governance as acceptable options for gaining input. Despite these concerns, all practices were amenable to customer feedback and could see that it might potentially be of value.

The concerns expressed by practices were echoed by PCTs and academics. Generally the attitude was that the patient survey required by the QOF is best considered as a way for practices to get experience with consumer feedback – in other words as a learning experience and a starting point.

5. Relationships

Many PCTs employ relationships as a primary method for influencing general practice. This seems to involve two strategies. The first is to provide mechanisms that involve GPs and general practice in PCT affairs – particularly around priorities, planning and decision-making. The second is to provide support services to practices. The desired effect of both these approaches is to build up a symbiotic relationship with practices that enables the PCT to achieve its objectives.

Engagement mechanisms

There appears to be a significant level of engagement of GPs and general practice in PCT affairs. Every PCT has a Professional Executive Committee (PEC) comprising the main professional groups, including GPs (who are usually the single largest group). The PEC is
supposed to be one part of a triumvirate guiding the PCT\textsuperscript{10}. It has been described as the engine room and the navigation room of the PCT with a wide-ranging role that includes the following elements\textsuperscript{11}:

- Identifying local issues and determining priorities, policies and investment plans,
- Ensuring clinical priorities are the focus for systematic improvement in quality
- Generating and fostering active engagement with all staff and with patients and the local community so that clinical priorities are owned in common by the patient and the professional community.

An Audit Commission study in 2004\textsuperscript{12} of nine PCTs noted that all were trying to engage with general practice, with three doing it well on a systematic basis. It defined a systematic approach as including the following elements:

- A range of regular events at which PCT and practice staff and GPs come together either arising from existing mechanisms or bespoke.
- A consideration of both PCT and practice issues on the agenda
- Not overly dominated by a single organisation’s agenda or a single professional group. Seen as useful and credible by practices and by the PCT, and well attended.
- Strong leadership by and high priority for the PCT.

Some PCTs have subgroups of the PEC for particular professional groups, priority projects/issues and service areas. For example, one PCT visited had subgroups working on a primary health care development strategy, the national service framework, Practice Based Commissioning, and clinical redesign. The latter was working on a reengineering of the primary secondary interface in various specialties.

In each district there are Local Medical Committees\textsuperscript{13} representing GPs. The PCT mentioned above had regular meetings with the Local Medical Committee and found this a useful forum for dealing directly with GPs industrial issues.

Taken together the forums set out above seem to cover all the major areas of PCT and general practice activity. It meant general practice was involved comprehensively in strategy, planning and decision-making in the PCT. The extent of GP involvement in this PCT was quite significant – evidently 45 of the 123 GPs in the district were involved in some way in PCT activities. This PCT had made a strategic decision that general practice was to be the centre of primary health care in its district.

\textsuperscript{10} The other parts being the Chief Executive and the lay chair of a board providing public participation.
\textsuperscript{11} Taken from: The Strategic Leadership of Clinical Governance in PCTs: Section Three. The board and PEC roles in providing strategic leadership. http://www.cgsupport.nhs.uk/downloads/Board/strategic_leadership_CG_PCTs/Section3.pdf
\textsuperscript{12} Transforming primary care. The role of primary care trusts in shaping and supporting general practice. Audit Commission, 2004
\textsuperscript{13} Local Medical Committees are independent statutory bodies that represent GPs to a number of bodies and inform the General Practitioners Council of issues that arise locally so that they can be taken forward at national level. These committees are effectively local arms of the British Medical Association.
Supporting general practice

In addition to these formal mechanisms, this PCT also pursued a strategy of interacting on a very regular basis with practices on a range of issues so that the practices got used to working with the PCT and treated it as a source of support and resources. For example, introduction of the new contract was regarded as an opportunity to work with practices, and a significant level of assistance was provided to ensure practices got the most benefit out of the new system.

The Audit Commission noted that some PCTs were providing a wide range of support services to practices including business support functions such as HR, information management and technology, financial management, facility support, and prescribing. It further noted that on average PCTs had 1 staff to support 4 or 5 practices.

Clearly some PCTs attempt to create a partnership arrangement with general practice. This corresponds to a belief that practices and particularly GPs will respond positively when treated well and with respect. This includes, for example, paying them for meeting attendance, consulting them on issues that affect them and aligning key activities with their interests, and contracting on quality in a manner that is consistent with the way they see the world. This approach is summed up by a commentator who stated that a successful PCT is one that is good at engaging with GPs. There is support in the literature for this type of approach (Regen 2002).

Not all PCTs align so strongly with general practice. In fact, the Audit Commission noted that some PCTs are driven by strategic priorities such as acute demand management or cost control, and that this leads to a less engaging approach to general practice. The Audit Commission commented further that some PCTs felt powerless to effect change at practice level, and related this to its relationships with general practice, its knowledge of its current position, its vision of the future and ability to use resources such as networks and partnerships to get there.

If PCTs were trying hard to engage with general practice, the feeling of identification was not always reciprocated. Practices appear to relate more closely to Primary Care Groups, the precursors to PCTs, which were smaller and more focused on primary health care during the fundholding era. Fundholding was viewed nostalgically as a mechanism for allowing general practice to participate directly in the management and governance of health services, in particular to shape secondary care services and to facilitate service development within general practice. Some GPs felt alienated from PCTs and there was a view that PEC committees had become increasingly irrelevant as PCT orientation and agendas were determined by outside agencies (e.g., SHAs) and the pressures of managing acute services.

The next policy iteration sees PCTs amalgamate and shed their provider responsibilities14. GPs see this as further isolating PCTs from general practice. Some see this abstraction as being compensated for by the reintroduction of fundholding in the form of Practice Based Commissioning (PBC). These GPs see PBC as an opportunity to re-establish local participation in the management of health services. On the other hand, other GPs see it as

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14 Commissioning a Patient-Led NHS, Department of Health 2005
dominated by secondary care concerns and with little potential benefit for primary health care.

A close working relationship with general practices is not in itself a recipe for success. Prioritising relationships over results can lead to conservatism and underachievement in terms of strategy targets and health outcomes. The tension between relationships and results can be exhibited between PCTs and SHA. The PCT mentioned above that aligned strongly with general practice was not seen by its SHA as a strong performer. The alignment was seen as limiting effectiveness. This highlights a conflict between the two visions; primary health care based around general practice or primary health care delivered by a range of specialised providers.

6. Employment roles and structures

The practices visited were large with diversified multidisciplinary teams that included GPs, specialised nursing, community visitors (community health workers), clinical pharmacy, counselling. Some of them also included psychotherapy, podiatry, social work, mental health, etc. It was not uncommon to find district nursing and other PCT provided services collocated with general practice services.

It was interesting to note that these teams had often been in existence for quite some time and the resources sometimes dated back to the budget-holding era when practices had elected to use savings to develop enhanced services. In other cases the additional resources had been funded directly by the PCT or Strategic Health Authority on presentation of a business case.

The new contract and the QOF in particular were seen as encouraging the use of specialised nursing and administration skill sets because of the priority on delivering organised care for chronic conditions. Nurses seemed to be increasingly employed in specialised roles or possibly were increasingly required to have specialist expertise. For example, specialising in diabetes or cardiovascular disease.

In addition to nurses specialised in diabetes etc, there were also new roles created called Community Matrons. These nurses will essentially be case managers with responsibility for vulnerable patients with complex needs. They will coordinate general practice and social services and will work with a caseload of about 50 patients at a time. They will:

- develop a personal care plan with the patient, carers, relatives and other health professionals based on a full assessment of their needs
- keep in touch and monitor the condition of the patients regularly, though home visits or telephone calls
- work in partnership with the patient’s GP, sharing information and planning together

In some practices there are Nurse Practitioners and in others there was an interest in Physician Assistants as a way of providing front line services.

Several practices were actively looking at skill mix in the light of the new contract. One of these reported its intention to replace a GP partner with another specialist nurse at the next opportunity.

Not all practices were heading down the specialist nursing route. One practice could only be described as GP-dominated – GPs outnumbered nurses and were consciously used to provide frontline care, while nursing was limited to clinic support and structured care. The practice had found nurse triage unsatisfactorily conservative and had been investigating Physician Assistants. In this case each GP had a mix of clinical and specified leadership/management responsibilities (e.g., one GP was responsible for quality initiatives, another for implementation of Practice Based Commissioning). This practice operated in a very high deprivation community.

There was no evidence of GP specialists at any of the practices visited, although a number talked about the desirability of developing this type of service within the context of PBC\textsuperscript{16}. At an informal level there was evidence of increasing skill sets and competencies in general practice staff. For example, one practice had had a longstanding involvement with a diabetes specialist. Over a period of years the need for a visiting consultant (and for hospital referrals) had reduced as frontline practice staff became more skilled at managing diabetes clients. The need now was for a different type of relationship with the consultant. One based on liaison and advice rather than client contact.

In Manchester GPs were still in short supply but in Birmingham there were reports that GP recruitment was no longer an issue, even in high deprivation areas that had previously experienced chronic problems with GP recruitment and retention. There were also indications that the number of medical graduates wanting to enter general practice was exceeding the available training posts. On the other hand, practices reported that nursing recruitment was an ongoing problem, particularly the limited availability of nurses with specialist skills.

As mentioned above, the new contract requires general practices to abide by the NHS’s HR strategy, which focuses on capacity building, support for and development of staff. The NHS has nationally standard pay scales (currently being renegotiated) but practices, being independent, do not have to use them. PCTs can provide HR support for practices but most do not. One PCTs visited expressed a high level of frustration at its inability to influence practice employment practices, which were seen as a limiting factor on service development.

Specific mention needs to be made of the rising importance of practice managers. Both practices and PCTs highlighted the importance of this position in terms of the overall performance of a practice. The new contract, particularly the QOF, requires good practice management to maximise the funding. A number of PCTs and practices noted that there was a need to upgrade practice management in light of the new contract and in order to manage Practice Based Commissioning. In a couple of cases practices had already upgraded practice management. This was typically done within the context of normal staff turnover- i.e., it occurred as vacancies arose rather than something the practice owners actively pursued.

\textsuperscript{16} GP specialists do exist in other areas and are increasing in number.
PCTs commented that the calibre of practice managers varied markedly. Management in smaller practices tends to be more administrative in focus and more subservient to the GP partners. Two PCTs talked about getting practices to work together to employ a high quality practice manager.

The larger practices often had a quite extensive range of management resources. In addition to a practice manager who was usually a professional manager, possibly with private sector experience, there were also sometimes financial managers, human resource managers, Information Systems plus the usual complement of admin staff.

Whereas there appeared to be increasing diversity in the membership of the general practice team, there did not appear to have been much change in the structure of practices. They continued to be small to medium sized businesses owned by GP shareholders. In all the practices visited except one the directors were GPs, and only GPs. However, not all GPs were directors. Some were salaried. Nurses and practice managers do not appear to have taken up director roles.

The exception was one practice visited that was a PCT owned and operated, nurse-led practice. In this case all staff were salaried, including the GPs who were contracted on a part time basis. The manager was a nurse. She had a mixed management/clinical role. The GP input to this practice was very low given the size of the register. Alternatively, a number of specialised nursing roles were provided including two Nurse Practitioners.

There were other cases where PCTs had taken over practices. This had resulted not from a strategic decision but because the incumbent GP departed and the PCT needed the practice to continue. Taking over a practice was seen as a short-term strategy leading either to the recruitment of a new GP who would take over the practice or to amalgamation of the practice with another existing practice.

There were also instances where PCTs were employing GPs and leasing them back to practices. This appeared to be done where the practice was at the point where expansion was desirable (presumably to the PCT) but not financially viable, or where the practice was seen as an undesirable place to work (high deprivation). It was done with the idea that subsequently the practice would take over the GP. This did not necessarily accord with the views of the GP concerned. It seemed one attraction of being employed by the PCT was that you would not get trapped in an undesirable location.

7. **External facilitators**

Using external facilitators to work with practices appears to be quite common and occurs within a variety of contexts. Most often a facilitator would be brought in to work with a specific practice - either at the behest of the practice or the PCT. In some cases facilitators were funded by the practice, in others health authorities such as the PCT funded them. The latter seemed most common.

Individuals selected as facilitators are generally independent of both the practice and the PCT and are seen as having expertise in a particular area. For example, this approach was common in relation to the development of teamwork within practices. Given that good
teamwork is founded on sound organisation, work usually includes other important areas such as accountability, procedures, strategy and the outcomes towards which the team works (Peck 2005).

There was evidence that PCTs also use facilitators of various sorts as a problem solving technique. For example, to address issues with a particular service provided by a practice. One PCT, which aligned itself closely with general practice, related that it used a well respected local GP leader for this type of task. This maximised the chances that the practice would gain from the experience. It saw this type of intervention as consistent with a developmental, strengths based approach and considered it the only effective way of addressing issues with practices.

In Dundee in Scotland an attempt was made to use external facilitation on a more organised basis (Duffy, Griffin et al. 1998). It was included as part of a requirement that practices implement a Practice Development Plan. A subsequent evaluation found that many practices did not benefit from the support provided. The evaluators concluded that a practice would benefit if it was stable organisationally, coping with its workload, had a culture of change management and experience and skills which made it positively oriented to change. A model was developed to assess the status of a practice (Atkins, Duffy et al. 2001).

This finding that practices have to be ready in order to benefit from facilitation was reinforced by comments from one facilitator working on teamwork. Her feedback was that teamwork actually required fairly fundamental changes in the way practices work, and can be in conflict with practice structure and organisation. Again the facilitator reiterated the importance of using diagnostic tools to ascertain the needs of the practice. This would apply equally as well to organisational and service aspects of the practice.

The concept of a Practice Development Plan is quite enticing as a strategy for change. It involves the practice identifying its learning needs and resources being provided from within and without to meet these needs. It could include any aspect of the organisation (e.g., organisation, service delivery, staffing or finances). It contains the elements of self-directed learning and continuous service improvement. In general the experience with PDPs was that they were of limited benefit, partly for the reasons outlined above. Also, there appear to have been issues arising from the fact that Practice Development Plans were a condition of a contract and overseen by a funding agency. Theoretically PCTs could avoid the conflict by not treating PDPs as a performance issue, but this requires a very high level of trust. Also, from a practical point of view, the simplest way of instituting PDPs is to include them in a mechanism such as the QOF, in which case they are inherently associated with contracts and performance management.

8. Facility development

The process of modernising primary care has also extended to modernisation of facilities. In 2000 the government committed to increasing health spending by one third in real terms over five years. Included in this was the construction of 500 new one-stop primary care centres and the modernisation of over 3,000 general practice premises17. There seem to be a number

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17 The NHS Plan; a plan for investment, a plan for reform. NHS
of ways this has occurred, including PCT direct provision of facilities, although the most common was to use a Local Improvement Finance Trust (LIFT). This is a long term relationship with a private developer under which the PCT develops a plan of what primary health care services it wants in various locations and the LIFT manages the design, financing and construction processes. The PCT then leases the facility.

One PCT visited shared a LIFT with a neighbouring PCT. The PCT was taking an active approach to service development in its area and reported that it had five service briefs in process. These were being approached on a health needs basis. The PCT was reviewing morbidity and mortality data and community needs to identify where future services were required and what services were required. It was consulting with local authorities, communities and general practices to develop a service brief. The PCT was thinking about collocation of acute services – such as specialist outpatient services and minor ops.

Once complete, service briefs are prioritised by the LIFT and the two PCTs, after which the LIFT works on the design phase in conjunction with the relevant parties (e.g., general practices who intend participating).

In one instance the PCT had succeeded in getting two practices to occupy a single facility, although it had not, at this stage, got them to agree to amalgamate. This was seen as involving some duplication and wastage but was unavoidable in the short term.

Two of the practices visited were in newly constructed facilities. One of them had been built under the LIFT scheme. The other used an alternative private sector arrangement. Both facilities were spacious and well designed with room provided for future development. For example, both facilities had minor ops rooms that were not being used.

PCTs felt their involvement in facility development was very advantageous. The benefits included the ability to create diversified primary health care teams by collocating services, and to also pull in social services and the like, thus creating community health centres. It also enabled them to locate health centres where the need (and the benefit) was greatest, thus addressing the strategic ambition of improving access. PCTs perceived a direct benefit to health outcomes and the reduction of inequalities.

The LIFT concept has been an effective way of getting new money into primary care quickly for the modernisation of facilities. There has been some criticism that processes have been rushed and not enough thought given to a strategic assessment of future needs for primary health care and out of hospital care, resulting in a tendency to go for larger practice buildings rather than more radical options. From the practice perspective there was reportedly concern about future affordability of the new facilities.

9. Other tools for development

Obligations on practices to develop strategic and business plans have been around for a while. They do not appear to be well regarded by the PCTs as a tool for creating change. The current contract requires that all practices have a business plan which is included in their
contract with the PCT. One PCT was using the development of plans as a service improvement tool rather than as a contract performance tool.

PCTs report that they use new services as opportunities to create change in general practice. This occurs through:

- Incorporating new services into the practice, which effectively broadens the team and/or its service outlook.
- Requiring a number of practices to work together to provide a new service. This might include a number of stages. For example, developing a proposal, establishing the service, and ongoing operation.
- Looking for GPs to provide subspecialty services, with concomitant changes in the way general practice teams have related (for example, inter practice referrals).

**Next Policy steps**

The next steps in the reform process have already been mentioned in brief. The most significant changes are reform of the PCTs, which is the subject of a new NHS white paper due in late 2005, and the full implementation of Practice Based Commissioning by the end of 2006. The white paper is expected to reduce the number of PCTs from about 300 to 140 (or even 100) and to require them to shed their provider functions. The objective is to strengthen purchasing functions to make them effective in managing the health of their populations. PCTs will be funders only and they will be larger so better able to engage with acute service providers and foundation trusts.

Changes to PCTs will change the way they interact with general practices. The role will be more limited and PCTs will be more remote. GPs and general practice teams are less likely to identify with the PCT. The counter-balance to this is Practice Based Commissioning, which is a mechanism for involving general practice directly in the organisation of both primary and secondary care. Under PBC practices will be given budgets to manage (although the PCT will retain ultimate control). Some PCTs are firmly resolved that this will not be a repeat of the previous budget holding arrangement which they saw as being overly generous to general practice. In particular, they are expecting groups of practices to collectively manage budgets, and they want the practices to focus on issues such as avoidable hospital admissions and demand for acute services rather than elective and outpatient services.

If these are the parameters of PBC, it may have limited appeal to practices. However, market forces may provide a different perspective on this issue. PCTs will increasingly use the market to commission general practice and other primary health care services from a range of organisations, including corporates. These other organisations are more likely to be attracted to the potential gains to be made from savings in hospital care. In particular, they may see the gains in acute care as easier to achieve than gains in primary health care. Also, these organisations may find it easier to organise themselves to achieve the gains. In this way PBC may be a way for PCTs to increase the attractiveness of primary health care (and general practice) to non-traditional providers.
Discussion

In the UK primary health care is the subject of a reform programme that has been running for fifteen years. Terms like “modernisation”, “rejuvenation” and “organisational development” are often used, despite the fact that these terms are not very well defined. Interventions to change general practice have been multifaceted and have varied over time.

General practice appears to be changing quite quickly at present. Despite the gains made so far there is still a gap between the services delivered and the government’s aspirations for primary health care. The tools and resources available to PCTs are considerable. Among those found to be effective were the following:

- The new general practice contract appears to be strongly driving change. Its effectiveness appears to relate to its alignment with the interests of both the NHS and general practice. The additional funding it carries is certainly a factor but the response would have been quite different if GPs objected to its content. PCTs also have other contract tools allowing them the flexibility to contract with agencies to ensure their strategic objectives are covered.

- Performance indicators have been helpful, but not public reporting of PCT performance, which doesn’t seem to have an effect on practices. PCTs report that behaviour change occurs when indicators and activity information are provided within an organisational development context rather than within a contract performance framework. Some of the effectiveness of the QOF is no doubt based on the compilation of indicators and the monitoring of results.

- The IT/S investment focuses on developing the infrastructure needed to achieve the NHS’s strategic aims with respect to integration of providers and regulation of the acute sector.

- Facility investment options such as LIFT enable PCTs to take an active role in developing health service teams that meet the total health needs of communities. It gives influence over both the location of services and the composition of services. It appears to have been an effective way of grouping up practices and diversifying them through collocation of other health and social services.

- Community engagement in practices does not appear, as yet, to have had much impact although it is considered that in the medium term it will become influential.

- All PCTs attempt to engage with general practice and some PCTs actively align themselves with general practice and pursue very close working relationships. This might include providing a range of mechanisms to include general practice staff in PCT activities and providing support services to general practice. In various circumstances external facilitators were used to work with individual practices. This seems to work well where the practice was willing and ready.

- There are various options around employing general practice staff (e.g., GPs) and taking over practices. These are sometimes undertaken on a short basis to ensure service coverage and to reposition services to meet the needs of their local communities. This does not seem to have been very comfortable for PCTs. In future they will be confined to the commissioning role and will thus not have these options. PCTs use new services to augment general practice services.
- Practice managers were identified as central to the organisation and development of practices.

Practices visited showed elements of both response to change and initiation of change. Practices have taken advantage of opportunities made available to them – for example, in the diversification of the primary health care team. The timeframes for this evolutionary type of development appear to be quite long – and certainly longer than the expectations of government.

The sites visited were all medium to large diversified practices albeit in high needs communities. Feedback from PCTs and university commentators suggested that responsiveness to the mechanisms outlined above was greatest in this type of practice and least in small practices, particularly amongst sole operators. This makes intuitive sense. The average practice size is still small. In one PCT visited it was 2 GPs per practice and in another 3. Unofficially PCTs regarded sole practitioners and small practices as a risk for a variety of reasons. There was no official policy to aggregate practices, but it was noted that a number of the strategies and policies did appear to be resulting in larger practices and this was seen as a positive development.

In future the major drivers of change in the accessibility, quality and choice of general practice services are expected to be the use of market mechanisms and the selection of other types of provider organisation (including corporates). A range of new contract tools is in place already to allow PCTs to do this. To date very few PCTs have chosen to use the flexibility of the new arrangements. It has been suggested this is partly due to a lack of commissioning capacity and also to unwillingness to upset local providers, networks, and GPs. The forthcoming White Paper is expected to amalgamate PCTs to form bigger organisations and to devolve their provider functions. This may well remove both barriers.
Study Sites

Manchester Strategic Health Authority  William Greenwood
Central Manchester PCT  Michael Smith
Taneside and Glossop PCT  Anne Rothery, Medical Advisor
Walsall PCT  Paul Jennings, Chief Exec
  Phil Griffin,
  Trish Skitt
Portland Medical Practice  Kevin Harrison, GP
Blakenall Nurse Practitioner Unit  Lynda Abedin, Nurse Manager
York House Medical Centre, Stourport  Jim Goodman, GP
  Andrew Cox, GP
  Sue Bennett, Practice Manager
  Angie Sendel, Specialist nurse
Smethwick Pathfinder  Niti Pall, GP
  Dave Morris, Manager
  Hugh McLeod, GP

References


Regen, E. (2002). Driving seat or back seat: GP's views on and involvement in primary care groups and trusts, University of Birmingham, Health Services Management Centre.
Appendix  Quality Outcomes Framework

The national Quality Outcomes Framework measures achievement against a scorecard of 146 evidence-based indicators, allowing a maximum score of 1050 points. The points comprise the following:

- Clinical domain: 76 indicators in 10 areas (CHD, stroke or TIA, cancer, hypothyroidism, diabetes, hypertension, mental health, asthma, COPD and epilepsy), worth up to 550 points;

- Organisational domain: 56 indicators in 5 areas (records & information, patient communication, education & training, practice management and medicines management), worth up to 184 points;

- Patient experience domain: 4 indicators within 2 areas (patient survey and consultation length), worth up to 100 points;

- Additional services domain: 10 indicators within 4 areas (cervical screening, child health surveillance, maternity services, contraceptive services), worth up to 36 points.

- The national QOF also rewards breadth of care through (i) holistic care payments (which measure overall clinical achievement and are worth up to 100 points) and

- Quality practice payments (which measure overall achievement in the organisational, patient experience and additional services domains and are worth up to 30 points).

- Achievement against the access standards, worth up to 50 bonus points.