

**Evaluation of Second Wave Personal  
Medical Services Pilots in South East  
London - A qualitative study**



**REPORT**

## **Evaluation of Second Wave Personal Medical Services Pilots in South East London - A qualitative study.**

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## **Evaluation of Second Wave Personal Medical Services Pilots in South East London - A qualitative study.**

### **Preface:**

The Lambeth Southwark and Lewisham Health Authority (LSL) commissioned this report. LSL had established a Personal Medical Services (PMS) Evaluation Committee; and this group, whose membership is listed on the page seven, conceived the idea of this study. What they wanted was a large qualitative study, which captured the perceptions of members of each practice involved in the second wave of PMS. The study was intended to be multi-professional, with the views of nurses, managers and doctors from every practice included. This committee then evolved to become the steering committee for the project and provided support throughout its duration.

The Primary Care Informatics Group, part of the Department of Community Health Sciences at St. George's Hospital Medical School, carried out the study.

The study is reported in three ways:

- A one page summary
- An eighteen page executive summary
- The full report, 39 pages.

This document contains the summary and the full report. A companion document contains the executive summary.

These three different report formats are intended to meet different readers needs. They all cover the same ground, and are intended to convey the same message.

The views expressed in this report are the responsibility of its authors, and are not necessarily the views of the NHS, its Health Authorities or Trusts. The study team wishes to thank the participating practices and LSL for their support and interest in this project, without their commitment and enthusiasm this report would not have been possible.

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## **Evaluation of Second Wave Personal Medical Services Pilots in South East- A qualitative study.**

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## **Evaluation of Second Wave Personal Medical Services Pilots in South East London - A qualitative study.**

### **Summary:**

#### **Introduction:**

**Personal Medical Services (PMS) is a pilot scheme that general practices can volunteer to join which changes the nature of the contract with the NHS. Instead of being paid according to a complex formula of fees and allowances, practices agree to provide a minimum standard of care, with locally sensitive quality based objectives.**

#### **Aims of the evaluation:**

**To determine - from the primary care professionals in the 33 practices in Lambeth Southwark & Lewisham who became second wave PMS pilot between October 1999 and April 2000 - the factors associated with both positive outcomes and slow progress in PMS. As a result PMS can be targeted for use where it is most likely to result in health improvement.**

#### **Method:**

**The objectives set by each practice in their application for PMS status were studied, and criteria from the literature were used in the construction of a semi-structured interview schedule. Confidential, anonymous interviews were recorded with one practice nurse, practice manager and GP from each practice between May and September 2002. The interview transcripts were analysed using QSR NVIVO; emerging themes were used to produce a model to describe a successful PMS.**

#### **Results:**

**Of the target sample of 99, 81 primary care professionals were interviewed. All expressed overall enthusiasm for PMS. Critical success factors for PMS included the provision of additional clinical staff, preferably a general practitioner; and a cohesive, communicative team with a visionary leader and good management systems. Likely blocks to good progress included limited practice accommodation, and the ability to retain good staff. There were also other factors that individually did not critically affect the success or failure of the pilot, but the majority had to be favourable in order to achieve the quality improvement goals. A model was constructed that may help practices to identify whether the necessary staff, systems and resources are in place to achieve quality improvement through PMS**

#### **Conclusions:**

**PMS provides a framework for quality orientated locally sensitive care. However a variety of factors need to be considered to understand whether a particular practice is likely to achieve its objectives. The model constructed needs to be further tested to assess its usefulness as a tool to identify where resources or training need to be targeted.**

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**Evaluation of Second Wave Personal Medical Services Pilots in South East London - A qualitative study.**

**Report March 2003**

## **Evaluation of Second Wave Personal Medical Services Pilots in South East London - A qualitative study.**

### **1. Introduction:**

This evaluation examines the perceptions of primary care professionals who joined the Second Wave Personal Medical Services (PMS) pilots in Lambeth Southwark and Lewisham Health Authority (LSL.) PMS is a relatively new way of delivering primary care. Practices joined its second wave in on two dates. Wave 2(a) started in October 1999, and wave 2(b) in April 2000.

PMS has been heralded by the Department of Health<sup>1</sup> as:

"the best thing that has happened to primary care"

"a huge help in allowing us to improve services"

"we can meet the needs of our patients in a way that we couldn't"

This evaluation looks at whether becoming a PMS pilot was thought by primary care professionals on the front line as something that enabled or inhibited the achievement of locally defined quality based objectives for primary care. It documents the perceived problems, and the solutions offered by PMS; exploring which factors were important in enabling and which inhibited achievement of the targets set for quality improvement. The evaluation was formative in nature. Its intention was to set out how the processes within PMS might be improved to enable the delivery of targets set for service improvement.

LSL encouraged substantial numbers of practices to join this wave of PMS. Every General Practice who chose to participate in this wave, in this Health Authority, was able to employ additional nurses and doctors. The justification from LSL perspective for the new staff were:

1. To make general practice more attractive to new comers,
2. To help sustain existing practices and
3. Enable the development of innovative pilot projects focused around needs of the local population.

33 practices across LSL joined the second wave PMS pilot scheme.

The evaluation was carried out at the request of LSL. The Health Authority saw PMS as a mechanism for funding improvements in the quality of primary care, a stance only recently endorsed by the Audit Commission<sup>2</sup>. Table 1 sets out how LSL thought that PMS could improve primary care.

LSL set up a 'PMS Contract Development Steering Group' to encourage the second set of practices to join PMS. This second annual entry to PMS has come to be called Second Wave PMS, and went live in two phases. The first was in autumn 1999 and the second in spring 2000. LSL managed to persuade one of the largest numbers in the country to join Second Wave PMS. It had 33 (16%) of the 186 who joined nationally<sup>3</sup> within its bounds. The Health Authority wanted to understand whether this had been a worthwhile exercise and commissioned an evaluation of this group of thirty-three practices. The evaluation was to be steered by an LSL PMS Evaluation Steering Committee. This committee set a framework within which that evaluation was to be carried out. It was their wish that a nurse, practice manager and general practitioner (GP) from every practice should have the opportunity to be part of the evaluation process, and to have their say whether good or bad. The study team designed an investigation to meet this specification, which is described in greater detail within the method section. The involvement of LSL as a key stakeholder proved invaluable as the evaluation developed.

<b>Theme</b>	<b>Process change due to PMS</b>	<b>Possible outcome change</b>
<b>Roles + Responsibilities</b>	<ol style="list-style-type: none"> <li>1. Impact of PMS on teamwork</li> <li>2. Changed role of nurse</li> <li>3. Management and non-clinical support staff roles</li> </ol>	<ol style="list-style-type: none"> <li>1. Improved team work</li> <li>2. Specialist training, increased clinical responsibility</li> <li>3. New role post GMS bureaucracy</li> </ol>
<b>Organisational issues</b>	<ol style="list-style-type: none"> <li>1. Change in practice</li> <li>2. Available to register new patients</li> <li>3. Access</li> <li>4. Altered clinical services</li> </ol>	<ol style="list-style-type: none"> <li>1. Improved team working</li> <li>2. Benefit/risk to practice and population of open and closed lists</li> <li>3. More surgeries, better access</li> <li>4. To meet needs of a disease area, or population</li> </ol>
<b>Information needs</b>	<ol style="list-style-type: none"> <li>1. Information needed to evaluate progress</li> <li>2. Data collection and analysis</li> </ol>	<ol style="list-style-type: none"> <li>1. Acquired management skills to monitor and evaluate practices progress</li> <li>2. Have IT systems to automate</li> </ol>
<b>Communication</b>	<ol style="list-style-type: none"> <li>1. Within the practice team</li> <li>2. Between practices/agencies</li> </ol>	<ol style="list-style-type: none"> <li>1. Communications and learning infrastructure and processes</li> <li>2. Systems for sharing learning</li> </ol>
<b>Staff views</b>	<ol style="list-style-type: none"> <li>1. Doctors</li> <li>2. Nurses</li> <li>3. Managers</li> </ol>	<ol style="list-style-type: none"> <li>1. What new work are they doing</li> <li>2. Improved job satisfaction</li> <li>3. More likely to be retained?</li> </ol>

**Table 1: Key objectives for second wave PMS practices identified by LSL.**

In summary, the aim of the evaluation was to identify those factors which helped Second Wave PMS practices to achieve their targets, and what blocked progress. In defining which features of PMS enabled quality improvement, it was hoped it might be possible to suggest how the scheme might be improved and learn any general lessons that might be relevant for a general move towards a quality based contract across the UK.

## **2. Background:**

### **2.1 Personal Medical Services:**

#### *2.1.1 Legal and managerial framework:*

PMS pilots were established as a result of legislation within the Primary Care Act 1997. Those that take part in these pilot schemes have the right to return, after an agreed notice period to the traditional General Medical Services (GMS) arrangement for the delivery of primary care. PMS is a locally agreed quality orientated contract for general practice. So far as this study was concerned the arrangements were made between the Health Authority, LSL, and either individual general practices or groups of general practices. In the latter case it was usually grouping single-handed or small practices together to form a larger unit. The scheme and the NHS has moved on. Health Authorities no longer exist, so the agreement is with the Primary Care Trust (PCT) and the Strategic Health Authority (SHA.) A whole PCT, as well as individual or groups of practices, and nurse led services can all become PMS pilots<sup>4 5</sup>.

So far as the arrangements for the practices in the second wave were concerned in LSL each practice agreed with its local Health Authority targets for service delivery over and above a minimum standard. The practice is funded for delivering what it agrees to do. This is in contrast to the standard arrangement for general practitioners, who are independent contractors. Under the standard arrangement, practices are paid through a complex combination of allowances, fees for services done and capitation for each registered patients. These fees are set nationally. The rationale for PMS is that it is quality orientated and focussed on local needs; rather than being an administrative and service based contract set centrally.

Under PMS arrangements it was expected that LSL would carry out a local evaluation<sup>6</sup>. This guidance was followed in the design of this study<sup>7</sup>.

### 2.1.3 Why was PMS needed?

PMS can be looked on as an organisational response to a perceived problem. PMS was created because the standard arrangement between the NHS and General Practitioners, the GMS (General Medical Services) contract, has shortcomings. It lacks alignment with the day-to-day objective of general practice to deliver primary medical care. There is no value chain that links the quality of the service with remuneration, a strategically undesirable state of affairs<sup>8</sup>. Other than some target payments for performing immunisations and smears and inducements to run asthma and diabetic clinics the GMS is based on a complicated set of payments and allowances. Most of the money paid out under GMS is not related to the level of access or the quality of the service provided. There are few financial incentives within it to innovate or develop services, nor for practices to work more closely together.

## 2.2 PMS Literature Review

The Department of Health and the National PMS Development Team provide a range of useful documents accessible via their web-sites<sup>4, 9</sup>. The first attempt to explore the views of participants in PMS was the National Listening exercise<sup>10</sup>. However this really focussed on the contracting, policy, and communication issues around PMS, rather than seeking to gather front-line staff's views about what enabled the scheme to deliver successfully or not.

Subsequently there has been an interim report<sup>11</sup>, followed by a summary of the four research projects to evaluate First Wave PMS pilots<sup>12</sup>. These generally try to draw comparisons between the rate of progress between GMS and PMS. They point out that things are improving in both forms of General Practice, with slightly faster rates of improvement in PMS. The latter report describes two requisites for success; leadership and changing professional relationships within the practice.

There have also been three excellent publications from the Kings Fund<sup>13,14,15</sup>. These reflect on the potential of PMS to make primary care more quality and health outcome focussed, and less caught up in the bureaucracy of GMS. Whilst the designers of the scheme clearly intended this, the report of the listening exercise suggests that PMS contracting creates its own bureaucracy: something that may need to be carefully curtailed.

The literature on PMS is supportive of the scheme, but only reports small numbers or practices making substantial improvements within the scheme. These studies have not used the perceptions of professionals working within the scheme to explain why some practices have achieved a lot, some made only modest gains and some improved little.

An aggregated set of objectives for PMS is set out in Table 2 (page 13) This was created from the PMS literature listed above, as a first attempt to define the scope of the interviews that would be held in this evaluation.

### 2.3.1 What is evaluation?

The evaluators used Scriven's definition of evaluation<sup>16</sup>:

To determine the worth or value of *Second Wave PMS* - judging it according to appropriate criteria.

In determining the *worth and value* of Second Wave PMS the evaluators have focussed their efforts on why PMS appears to "work" (deliver outcomes) in some practices, and not in others. As

whether something "works" is very much a social construction and not an objective reality<sup>17</sup> it is readily examined by the perceptions of those that participated in the scheme.

Chemlinsky<sup>18</sup> suggests that evaluators ask three types of questions:

1. Descriptive questions. E.g. How many people are engaged in the evaluation.
2. Normative questions. The extent to which a programme operates as intended.
3. Cause-and-effect questions. To discover whether the programme has worked.

Cause-and-effect was the prime focus of this evaluation. The evaluators were keen to explore within the PMS framework what elements were associated with positive outcomes, and in what circumstances no progress was made.

### *2.3.2 The type of evaluation:*

The evaluation framework is based on research methods from the social sciences<sup>19</sup>. The purpose of the evaluation is formative, i.e. how can PMS be improved?

Scriven<sup>20</sup> divided evaluation into formative and summative. The former is carried out to provide feedback to try to improve something, and the latter, summative, which looks to examine programme effectiveness so that it can be decided whether a programme continues or not. This evaluation is primarily formative, existing to support the process of improvement and to be of use to the managers of the health service as well as the practitioners involved in PMS.

It is outcome-improvement evaluation, looking to see if the process of PMS can be improved to deliver better services for patients. Chen<sup>21</sup> built on Scriven's work suggesting that evaluators need to either focus on the process or outcomes of a programme. The focus of this evaluation was whether there had been outcomes: i.e. when the goal has been achieved; using the objectives set out in Table 2 (page 13) as its starting point. The function of the evaluation is improvement of a scheme rather than its assessment as a good or bad thing. Hence the "outcome-improvement" focus of this evaluation.

The evaluation uses a programme theory approach<sup>22</sup> i.e. developing a model of what might enable or block PMS delivering its aims. So that it is possible to suggest a mechanism whereby this programme achieves results.

## 2.3 The theoretical approach to evaluation:

In addition to looking at the PMS literature, the evaluation literature was examined to ensure that the technique adopted was appropriate,<sup>19,23</sup> and feasible.

### *2.3.3 The Social context of the evaluation:*

The social context of the evaluation was one of change and strain within primary care:

1. At a national level GPs have voted in principle to move from their old contract to a quality based one<sup>24</sup>.
2. The LSL PMS Steering Committee had ownership of the evaluation. They specified that they wanted it conducted using interviews, and that they wanted a GP, nurse and manager from each of the practices that joined PMS to be interviewed.
3. LSL, the Health Authority, as a statutory body was replaced by Primary Care Trusts (PCTs) while the evaluation was in progress. Its PMS Steering Committee continued to meet and communicate with the evaluators.
4. There were problems in recruiting practitioners into the more deprived areas of LSL, and concerns expressed in the local media about the quality of primary care<sup>25</sup>. The Department of Health GP Census illustrates the pressures that primary care in LSL is under<sup>26</sup>. It is an area with large numbers of single-handed practitioners. Many have very small lists, but there are also a substantial number of doctors with very large lists. There are a large number of very large lists, and the highest level of reported threats of violence in London.
5. Primary care professionals who wished to criticise or point out what they regard as "perverse incentives" wanted to be sure of confidentiality, and that this evaluation is not part of their performance management.

<b>OBJECTIVE</b>	<b>DESCRIPTION</b>	<b>SOURCE</b>
Improvement in patient care	High quality service	DoH KF NE
	Prioritise areas that directly affect patients	DoH NE
	Patient views, groups	LSL
Flexibility in	Service delivery new or discontinued	DoH KF LSL NE
	Roles, extension of nurse role	DoH KF LSL NE
	Skill mix	DoH KF LSL NE
	Employment opportunities	DoH LSL NE
Needs of local population	Assessment of local need	DoH KF NE
	Target local need	DoH KF NE LSL
	Addresses under- provision of service	DoH KF NE LSL
	Local primary care strategy	DoH KF NE
	Special population groups	LSL
Quality	National quality standards NSF	DoH KF NE
	Local HimP programmes	DoH KF NE
	Clinical governance	DoH KF NE
	High quality service	DoH KF NE
	Prescribing	NE
Access	Tackle social exclusion	DoH
	Reduce inequalities of health care	DoH KF NE
	Improve access	DoH KF NE
	Move away from medical model + cross health/social care divide	NE
Reduce bureaucracy	Ending link between income and service	DoH KF NE
	Impact on practice organisation	DoH NE LSL
	Data collection and analysis	DoH LSL
Monitoring outcome	Local evaluation and review	DoH
	Health outcomes	DoH KF NE
	Goals –measurable, realistic, feasible	LSL
Leadership	Strong leadership	NE
	Good management	NE
	Able to transform relationships in teams	NE
Communication	Staffing and communication issues	LSL NE
	Sharing pilot project information	LSL NE DoH
	Teamwork	LSL NE
<b>Key</b>		
<b>Abbreviation</b>	<b>Name</b>	<b>References:</b>
DoH	Department of Health	1,4,4,6,7,10
NE	National Evaluation of First Wave PMS	11.12
KF	Kings Fund	13,14.15
LSL	Lambeth Southwark and Lewisham Health Authority, PMS Evaluation Steering Committee	Personal communication

**Table 2: Objectives of PMS synthesised from the literature.**

### 2.3.4 *The relationship between the evaluators and LSL:*

The evaluation team is based externally, but there are links to members of the evaluation steering committee through STaRNet London (South Thames Primary Care Research Network - London)<sup>27</sup>. There were regular meetings during the design phase of the study, and less frequent meetings once it was underway. These enabled the evaluators to gain a good understanding about the Health Authority's aims and culture. The LSL team also facilitated contact with practices. They informed the participating practices by letter and through their network of managers about the evaluation, and compensated the practitioners for taking part, with a notional payment to cover an hour of the time of the staff interviewed.

Having good communications with the body funding of the evaluation is supported in the evaluation literature. Smith<sup>28</sup> urges the inclusion of all the stakeholders in the design process, and the importance of maintaining contact throughout the evaluation period.

## 3. Method:

### 3.1 Planning, defining objectives, and literature review

LSL is a key stakeholder within the evaluation process. They had fixed ideas that all the practices should have an input and that this should be a semi-structured interview with a practice nurse, the practice manager and the GP most active within PMS. As there were thirty-three practices this meant 99 interviews and arranging and conducting these interviews formed the bulk of the evaluative effort.

The LSL Evaluation Committee had carefully defined its reasons for this evaluation, and suggested goals for it<sup>29</sup>. These reasons and goals are set out in boxes 1 and 2, respectively.

Reasons that LSL wished to do an evaluation of their second wave PMS practices:

1. The Health Authority (and subsequently the new PCTs) have a statutory duty to evaluate PMS pilots
2. No detailed evaluation had previously been undertaken
3. Responsibility for this work will devolve to PCTs many of whom may not have the resources to undertake the detailed review now needed.
4. In terms of funding accountability, we need to know if the targets and services outlined in the practice PMS plans have been achieved
5. Practices that need extra support in terms of skills, or resources need to be identified
6. Identifying what has worked well, and what has caused problems facilitates shared learning throughout the LSL PMS pilots.
7. Lessons from this kind of evaluation can be applied to new PMS developments

### **Box 1: Reasons given by LSL for the PMS Evaluation.**

The deliverables that LSL looked for from the evaluation were:

1. The evaluation should make it possible to identify support needs of individual practices
2. The evaluation should indicate stages of development
3. Review the level of impact that the PMS pilots have had on levels of quality and services provided

### **Box 2: Goals/Objectives that LSL wanted from the PMS Evaluation.**

Through a series of meetings these goals were discussed. Initially LSL would have liked information to be reported on individual practices, but it was accepted that this might result in an unacceptable degree of bias. Practices might report what they felt their managers wanted to hear. It was agreed that the interviews would be confidential, and that anonymised collective feedback would be used to inform the health authority's goals, and that this would take place after all the data had been analysed.

The interview schedule was initially based on the list of issues that the Health Authority thought should be addressed. They had promoted PMS and had clear ideas about what it should be able to achieve. Their core ideas are set out in Table 1, in the introduction section above. This list was modified following the completion of a literature review that was going on in parallel with the discussion between the evaluators and its commissioners about what its goals should be. In addition, a consensus was developed about what should be the key objectives for a PMS practice and the basis for the evaluation were held with the head of the National PMS Development Team<sup>30</sup>. The final consensus list of PMS objectives has already been shown in Table 1. It is weighted more towards what came from the literature review, which perhaps takes a broader view.

However, the evaluation team did not lose sight of the goals/objectives of the evaluation that LSL had, listed in Box 2. Namely, that the evaluation should aim to come up with:

- a. A tool that made it possible to identify support needs of practices.
- b. Indicate the stage of development of the practice.
- c. Give some indication of the level of quality provided across the PMS pilot practices particularly focussing on whether they were finding it possible to deliver their PMS objectives.

### 3.2 Carrying out the evaluation:

The evaluation consisted of semi-structured interviews carried out in PMS practices. The first draft of the semi-structured interview sheet was piloted on staff volunteers, then on a small group of practices. The content of this prompt sheet evolved as the evaluation took place.

Prior to the interview the objectives that the practice has set for itself under PMS were studied. The goals that each practice had set, when they made their application for PMS, were made available to the evaluation team. The practice received a letter explaining that an offer to participate in the study from the Health Authority, and local PCT staff were also informed that interviews were likely to take place. The practice was then contacted by phone by the evaluation team at St. George's and booking for the interviews made. The confidentiality of the interview was stressed at the time of booking, immediately before and reinforced afterwards.

Six pilot interviews were conducted in the sample practices and the structure of the interviews adjusted as a result. Two investigators AS and VO then conducted the interviews. During the interviews a tape recording was made. They reported back to SdeL after each interview and shared the field notes that they had made.

The interviews were recorded, and subsequently transcribed verbatim by an experienced secretary used to transcribing research interviews. The transcript was then checked by AS or VO and any blanks filled in and annotation added where needed (e.g. laughing, a joke etc.). The checked interview text then underwent thematic analysis in QSR N'VIVO software, Version 1.2<sup>31</sup>. The initial analysis was based on themes that arose from the evaluation framework. A sampling frame was used to select the first 14 interviews for detailed analysis, so that they came from all parts of LSL, and represented the different size of practice, types of premises, and whether the primary care professionals involved felt they had achieved their intended goals.

From these analyses a theory or model emerged of what might need to be in place for PMS to succeed. The themes that had been identified in the first analysis were grouped into this hierarchy, and the interviews analysed thus far were re-analysed to test this theoretical model. The model, with slight modifications, stood up to this further test. The remainder of the interviews were analysed looking for new themes and to test the model.

### 3.3 Ethics and confidentiality:

The local research ethical committee stated that as there was no patient involvement, or use of patient data, ethics committee approval was not needed.

The LSL Evaluation Steering Committee agreed that they would not have access to the tapes or verbatim transcripts. However, they would have access to the final reports and drafts, but not in a way that would enable the confidentiality of the originator to be breached.

## 4. Aim and Objectives:

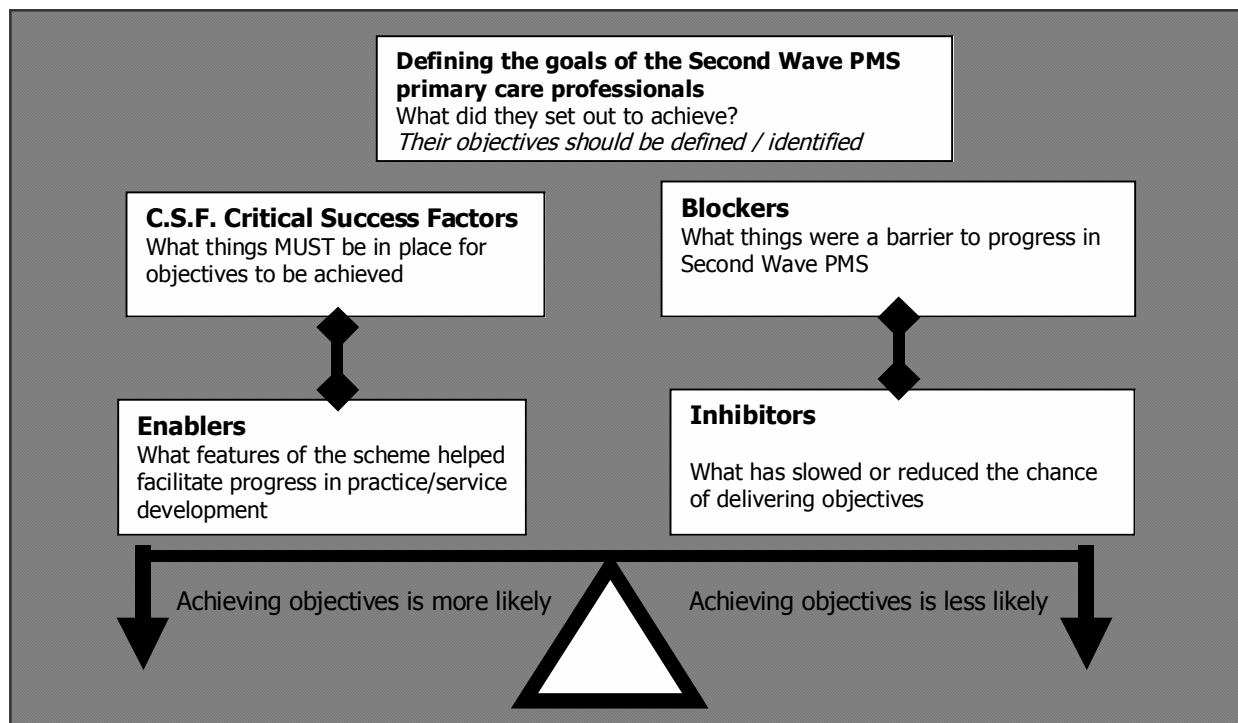
### 4.1 Aim:

**The aim of the evaluation is to examine the processes within PMS practices, and look at their perceived influences on the outcome; and report which elements are viewed by frontline primary care professionals, to be responsible for this change.**

### 4.2 Objectives:

The objectives of this evaluation are made up from the hypotheses that were generated during the interaction with the LSL Evaluation Steering Committee, reading the literature, and talking to the National PMS Development Team. It was clear that some practices made progress under PMS and others did not. We looked to gain insight into this, concentrating our efforts at looking at the process within the practice, and the primary care professionals confidential assessment of where cause and effect lay. The level of abstraction we chose to model this at was firstly to gain an understanding of what they thought achievement of goals meant. Then we sought to gain insight into the processes that were essential to achieve this, and what processes might completely block delivering their practice's intended goals. Finally, we tried to look at what the things were that might help or hinder but weren't pre-requisites and to reflect on their overview of the experience. Although this was the underlying interest the vehicle for exploring this, the interview, asked questions at a lower level of abstraction, exploring the issues set out in Table 2. The team's overall approach to the evaluation is captured in the following list of objectives:

- 4.2.1 List the factors that are pre-requisites for success. The "critical success factors."
- 4.2.2 Identify the elements of the process that collectively enable the delivery of PMS objectives, but are not pre-requisites, as defined above.
- 4.2.3 Find those elements that completely block the delivery of the objectives of a PMS pilot.
- 4.2.4 Identify the elements of the PMS process that collectively inhibit, but do not completely block delivery of the aims of PMS.
- 4.2.5 Create a model that informs whether a potential pilots portfolio is more or less likely to be able to deliver a quality based contract.
- 4.2.6 Propose how the findings of this study can be disseminated, and learnt from.
- 4.2.7 Suggest areas where further research might take place.



**Figure 1: Model of the processes that need to be in place to deliver quality improvement in PMS**

## 5. Results:

### 5.1 Sample:

The intended sample for the evaluation was to interview the lead GP, practice manager and practice nurse from all 33 practices who joined the second wave of PMS. Of these 99 intended interviews, three in each practice, a total of 18 were not available for analysis. The reasons for this were:

- Five failed to respond to at least three invitations or in one case cancelled three times in a row at short notice then failed to respond to further follow up calls.
- Ten were either on long term leave from their practices (4) or had left (6).
- Three tapes did not record sufficiently well for the text on them to be transcribed.

Of these 18 not analysed 12 (67%) were nurses, 2 (11%) were practice managers, and 4 (22%) were GPs. The group of practices not analysed was spread across the Health Authority area, and not associated with any particular size or location of the practice.

As a result of not being in a position to analyse the entire sample, a sample of 81 primary care professionals were interviewed (83%.) In one practice all three interviewees insisted on being interviewed together, and in three others interviews took place in pairs. As a result there are a total of 76 transcripts for analysis, four of which were of more than one interviewee.

The interviews took place between May and November 2002. The distribution of the interviews across the three PCTs that the original health authority area was divided into is set out in Table 3.

	<b>Total number of practices visited</b>	<b>Lambeth</b> <b>No professionals interviewed</b>	<b>Southwark</b> <b>No professionals interviewed</b>	<b>Lewisham</b> <b>No professionals interviewed</b>	<b>Total number of primary care professionals interviewed</b>
<b>Intended Sample</b>	<b>33 practices</b>	<b>33</b>	<b>42</b>	<b>24</b>	<b>99</b>
<b>Interviews not done</b>	<b>1 practice</b> not represented in the study	<b>9</b>	<b>7</b>	<b>2</b>	<b>18</b>
<b>Achieved Sample</b>	<b>32 practices</b>	<b>24</b>	<b>35</b>	<b>22</b>	<b>81</b>
<b>% of intended sample achieved</b>	<b>97%</b>	<b>73%</b>	<b>83%</b>	<b>92%</b>	<b>82%</b>

**Table 3: Target and achieved sample in the PMS evaluation**

The first group of interviews that were analysed were done so to equally reflect the diversity of practice and social class across LSL. A sampling frame was used in the first instance to ensure that interviews from each PCT area, from large and small practices, with female as well as male, old as well as young, professionals were looked at.

## 5.2 Findings:

The findings wherever possible have been captured in quotations, with a range of views expressed that present the breadth of views held among those interviewed. The intention is to present a range of views representative of the feelings of the professionals interviewed.

### 5.2.1 Trade off between GMS bureaucracy and planning to deliver a quality based service.

All of the practices that went into PMS had a clear quality agenda that they were able to articulate. They saw a trade off between time spent filling in claim forms in the old system and the need to plan how to deliver quality within the new.

*So in terms of bureaucracy you don't have to fill in all the claims so actually it has been much easier to plan and manage I think*      *Manager 8*

*I find that PMS is a good option for me in terms of like paperwork. Sort of, we don't need to send every month. Like you know, registrations and itemised claims, everything was too much for us. So PMS is sort of freedom from this that is less paperwork. So! We like less paperwork. We want to give more time; I want to give more time for my patients to solve their problems social, medical whatever it is. And then less sort of time wasting, you know paperwork. So that is my sort of reason that I joined PMS.*      *GP 29*

*I think that the dreadful, dreadful paperwork involved in making items of service claims would disappear. That was for me really just a wonderful thing that you know we wouldn't have to do. All those terrible items of service claims all the time and being so focussed on time and money. I mean obviously my job here is very money orientated but it just I think under GMS the focus was too much on money.*      *Manager 13*

*Doctors are more focussed you know, to concentrate on the patient care because of the less paperwork.*      *Manager 29*

*we were told when we went into PMS that most of the bureaucracy would disappear that's not true it hasn't proved to be true. It is just as much if not more than before and that is not just a measurement of the gradual increasing bureaucracy anyway that was going on it is also a measurement of the fact that in addition to the bureaucracy that surrounds your GMS type of work*

*you have got the new bureaucracy that comes in with the PMS work and particularly the unified budgets and monetary changes GP 11*

*you know greater flexibility, more time for patient focus you see previously with GMS you have got a sort of to take hold of the paperwork and lots of issues like claiming for itemised, and so on and then um now you can forget this. You can focus on your patient care. That's what we want you see. GP 29*

*There is much less paperwork going out .Yes. yes. yes it has freed up time for staff to do other things and there is plenty to do GP 32*

*It has clearly reduced the bureaucratic burden Manager 32*

*You sometimes need to stop and look at developments and I think PMS has allowed us to do that. It has given us the time to do it as well because of removing some of the tiers of paperwork that is going on Nurse 19*

### 5.2.2 Increased flexibility with PMS:

There was rigidity in the traditional contract for general practice, and the opportunity for more flexibility and local responsiveness in the new.

*And then another sort of aspect of why PMS I think is better than GMS is that um I am doing this pilot with neighbouring practices together sort of multi practice pilot so integration with a neighbouring sort of practice sharing our sort of um experience and I think that that is um a sort of um although I am individual single handed practice GP I can integrate my experience with the neighbouring practices GP 29*

*we were able to employ more nursing time we have been able to implement an outreach nursing service from the practice so instead of referring the patient to the community nurse one of the practice nurses who already knows the patient can go out to them at home, do a nursing assessment at home, get treatment underway, go out in an emergency situation or in a crisis so yes we have been able to change the practice nurse role and convert it to an additional outreach nursing service and this has been much appreciated and I think it is one of the reasons why the older age group have actually increased in the area because they have been attracted to the service and to the practice. So if you look at that as an accessibility aspect then it was a very positive one and it has made a big difference GP 11*

*It has given us some flexibility to look at how we deliver services, mental health is what springs to mind that was one of our objectives and we have some resources to back that up and it has given us the time you know it has been a sort of instrumental process really of looking at um how we deliver mental health services doing audits to look at that care and to clarify how we deliver the service and what the need is so it has given us that flexibility Manager 8*

*obviously we are looking at the services available here and it (PMS) has given us much more flexibility to actually you know do a needs assessment decide what the needs what the specific needs are for the local population and then perhaps move away from the more traditional services and actually have more imagination to develop an opportunity really to look at not doing things the way they always been done but to look at it with an open mind and move ahead with new ideas you know such as we have got a young person's clinic now that is set up here Nurse 15*

*Second wave gave us the opportunity to develop according to our perceptions and others' perceptions of local needs so we could do the two big projects that have taken off as a result of PMS within our own practice. GP 5*

### 5.2.3 Nobody wants to return to GMS:

None of the practices had left PMS and none of them expressed any intention of doing so, unless its benefits were made superfluous by the new GP contract. This applied right across the board, and to all the professionals interviewed.

#### 5.2.4 Freedom to develop services:

The time created by the provision of an extra pair of hands meant that for many there was the first real opportunity to develop their teams and the service that they offered. There was little consensus in the range of new services that each practice wished to develop. Having the professional freedom to develop services appeared to offer the potential for improving job satisfaction and preventing burn out. These opportunities had caused one doctor to delay retirement.

*I think that I probably would have retired earlier and that would have probably been from burn out rather than anything else. I found tremendous developments of new enthusiasm under the Fundholding scheme when it came in. We were able to perform at a very much better level for our patients as Fundholders.....*

*That was brilliant and gave us a lot of you know inclination to work um then Fundholding was written off and the PMS concept appeared. Possibly one of the reasons why we considered the PMS concept was that we had just been deprived of what was a very effective treatment system for our patients under Fundholding and we felt that we ought to explore other opportunities of providing an effective system for our patients and for our community. So yes I think that job satisfaction is an important part of the medical career and if you have got it you keep going you will provide good medicine and a good level of service and quality as well if you lose the job satisfaction I think that you risk the whole thing deteriorating and PMS was an opportunity to rekindle some of that. No we are not inherently civil servants you know; we don't like to sit at a desk and follow a set of rules. Medicine is not like that, it shouldn't be like that.*

GP 11

*"medicine is as much an art as it has ever been a science"* GP 11

*I think it has been a fantastic couple of years because really the change, the view of looking at services and service development and really I think we are much more open to new ideas looking at ways of involving patients much more in services we offer and developing services across the board with other professionals*

Nurse 15

*I think once PMS you are able to use your staff in a different way if you sort of use your imagination as a practice and you have got skills that are untapped within your staff group you can actually free up time, develop new services from the existing.*

Manager 22

The flexibility to improve quality appeared to arouse clinicians' interests in learning about best practice, and even to increase their self-esteem. They maybe have even started to achieve, what Maslow<sup>32, 33</sup> termed, self-actualisation.

*I think that it (PMS) has improved the practice services and it has kept people more on their toes we are much more conscious of trying to keep abreast of everything. I mean I have certainly felt myself that I had got into a bit of a rut, you know. Everything was just sort of routine. I was just coming in and I was doing the same old thing and I was going home. Now it is much more challenging and I find that I am, you know; I have to read my nursing journals because there are always new things coming up and, it is just, it is nice to be able to feed back, actually, sometimes because you might read something in the journal that others don't know. And, I think we do a lot more in the way of having meetings and discussing um and making sure that we are sort of keeping each other more informed.*

Nurse 8

*The (Nurse Practitioner) course has made a difference in the way I think; and, you know like different subjects that we have covered at college like sociology. I have done a locality search of where I work and, you know, that was part of the sociology project to see what the needs were of the local population. So, it has made me more aware of my practice population; more aware of communication, which was one part of the course. You know how you communicate non-verbal, verbal etc. Personally it has been a very successful part of my life in starting this course. Definitely, I am glad!*

Nurse 10

*I feel quite proud of the way the practice has improved its services over the last couple of years really and you could argue that it probably could have done that under GMS anyway but I think PMS provided*

*the driver if you like to make us do that and I suspect we wouldn't have done that quite so systematically GP 8*

*...but yes it (PMS) has certainly rejuvenated the practice I think GP 13*

### *5.2.5 Bridging the health and social care divide:*

A common feature of those reported to us is that many crossed the health-social care divide. They tended to be orientated towards groups in society. Typical of these services were: increased provision for the homeless, better care for refugees, evening clinics for teenage sexual health, or recognising that claiming Social Security Benefit can have a profound effect on the well-being of the mentally ill. This is in contrast to the targets set within many of the National Service Frameworks, which operate in a single disease area and much more within the biomedical model, e.g. setting the target of creating a "disease register" of a level of blood pressure control. There was also recognition that medical practice is about relationships and working in a patient-centred way. The traditional inter-practice barriers are starting to be broken down:

*but now (since PMS) it is a better ( mental health) service, we have got access to a counsellor, you see, and we have got access to a Benefit Adviser, in the surgery. In house! GP 29*

*I think also specific groups of patients have benefited enormously from PMS because we set certain groups as being priorities to deal with so we have the refugees, mental health, sexual health problems, (and) students. GP 8*

*Firstly we were aware of particular local community needs, which we couldn't fill under our GMS contract .....to look at the problems of teenagers particularly with their sexual health and unplanned pregnancies and also looking at problems of an increasing problem of our Asian population with significant cardiovascular disease and diabetes, again the children who were producing overt systems of disease process quite as early as their teens so we had these two areas which were not defined under our GMS contract so we felt that this was probably the best option for us to exercise and that was why we produced a pilot proposal to give it a go. GP 11*

*The mental health area is the one that has probably made most advance in that the mental health team works a lot more closely together there is a clear resource you know where to go for things and protocols that have been put together we are now looking at putting together a therapeutic garden project.....coming out of PMS that extra flexibility of manpower that allows it to happen more easily Manager 19*

*We have got a youth worker....that is starting to work quite well....we have a drop in youth clinic where we have team members counsellors, doctor, nurse youth worker and the youth worker is also going outside and into schools and covers youth organisations locally Manager 15*

### *5.2.6 Professional leadership and vision:*

It appeared that if the practice was to achieve its quality improvement goals, there had to be professional leadership and vision. This then had to be combined with effective team working if the practice was to move forward.

*You always have people in the practice who are creative with ideas and test the ideas and then you know what we have learnt is that things only work when you have control over those things and feel involved, so you try not to do things without discussion and support from people who have to carry them out just doing them, so maybe the ideas haven't come from other members of staff but they have been involved in their implementation GP 22*

*If you measure quality in terms of understanding then I would say it is something that has been greatly helped provided you involve all the staff in what you are doing they have got to understand what it is all about. With that understanding certainly comes an improvement in the quality of care GP 11*

*I mean I do have quite a lot of input with the decisions that are made within the practice I do.....but I find it difficult to have a vision as to where we are going I tend to leave that to people who have a clearer idea like the practice manager who is brilliant with that sort of stuff Nurse 13*

If new clinical staff could not be found or premises were inadequate then the practice was caught in the physical day to day needs of coping with busy surgeries. These problems were perceived to be an absolute block to developing the practice, and to delivering PMS objectives.

There were many other factors that either enabled or inhibited the ability of PMS to deliver improvements in the quality of the service. These seemed less important, although for the primary care professionals interviewed in the practice if the inhibitors were thought to be greater than the enablers then improvement did not take place.

### 5.3 Model: Pre-requisites for success and Blockers.

The model that emerged from the study is that PMS with its quality orientation and local responsiveness created a framework within which the quality of primary care can improve. The researchers formed the view that there were critical success factors, which if not in place would make it extremely unlikely that the practice would achieve its quality improvement targets. These were:

#### 5.3.1 Pre-requisite for success: 1 An extra clinician

An extra clinician, most usefully another GP, who freed up time so that systems could be changed. Single handed doctors who can't get help or cover are particularly stuck.

*rather than getting another partner, being able to get a salaried doctor, knowing that partners are so difficult to come by GP 1*

*We were able to negotiate some money for a PMS GP and the Nurse Practitioner and obviously that gave us additional clinical staff which we didn't have before and obviously that is a direct benefit to patients Manager 15*

*It gave us the opportunity to have a salaried GP which gave us the opportunity to free people up...it was as a whole approach of having time to do other things that keep GP's interest and stop them thinking I can't do this for the rest of my life. Manager 23*

*We were really short of GPs in this area.....but what has been the single biggest most important factor for this practice is the additional salaried GP's who have enabled us to do additional work. GP 8*

*On one occasion we had some protected learning time, which was an idea of the Primary Care Group, and the theory was that they would provide locums so that the doctors could be released to attend a learning session. They would provide a locum! So the only people that could attend the learning system were those in multiple doctor practices; because for the single-handers there were no locums available GP 11*

The PMS Salaried Doctor was more than a locum, they were a proper part of the team.

#### 5.3.2 Pre-requisite for success: 2 Leadership with vision, and strong management

Leadership that provided a vision of what that practice could usefully provide to improve its services and even start to address the health of its local population. The style that achieves change is that of the good communicator, with a willingness to commit to shape new and better services. This needs to be supported by sound management that can plan and then implement quality improvement. The very best of the PMS practices grasped the additional autonomy that they were given; but then channelled it into meeting local health needs.

*You have just got to have the vision and the determination to do it if you are looking at it as an (ordinary) job it is a non-starter.....it's a high level of commitment. GP 11*

*"I saw it as a real spur to the development of the practice and because we had to proactively think about where we were going and what were our priorities um set objectives in a way that we had never had to do before it was a real drive to develop the practice in areas that I really thought were useful for the practice to develop them... .. before we did used to write plans but they were aspirational rather than organisational I think.....we developed a plan with everybody in the practice and actually tried to implement it and set objectives and justify that we had achieved those objectives."* GP 8

*I am absolutely convinced that ( PMS ) has driven us to improve quality but quality in certain priority areas particularly so one of the things that happens when you are writing a Service Development Plan and you set your objectives is that you achieve those.* GP 8

*Being PMS has started us thinking as a practice into the care that we give and the care that we should give it has made us more aware. I think there has been a positive change as a practice and otherwise we might not have moved on as much as we have done, with the PMS I think we have moved forward quite a bit* Nurse 10

*Look back 10 to 15 years ago the Practice Managers were basically senior receptionists in a lot of practices... .. PMS is taking on more work and more organisational changes for strategic planning if you like you do need more than senior receptionist to take you through that so in general the way primary care is going more particularly big practices need quite high powered managers* GP 8

*We felt it ( PMS ) would make us that much more autonomous. Without the rather unpleasant political complications of fund holding..... ..we wanted our share of the cake, not for us but for our patients to be able to give a better service and I think a lot of those things have actually happened. So yes I think that's what we looked for looking for some autonomy of being able to actually implicate something from any needs assessment.* Manager 10

### 5.3.3 Pre-requisite for success 3: Teamworking with a common healthcare agenda

A cohesive primary healthcare team, able to develop a common sense of purpose and communicate effectively, was a prerequisite for success. The key function that this team is collectively responsible for managing patients' problems. In PMS this responsibility goes right "down" to the reception staff. The quality-based contract focuses them on health improvement and accessibility goals, rather than on seeing the necessary claim forms are completed as under GMS. Some GPs clearly still thought in terms of "us" and "them." And, clearly some staff were happy with this "parent-child" transaction. Berne<sup>34</sup>, reminds us these transactions are fine so long as both parties are happy. However increasingly other primary care professionals are seeing themselves as colleagues, who wish to have a more "adult-adult" transaction with their General Practitioner colleagues. The "parent-child" relationships increasingly will be things of the past.

*So more communication and so on and we do have um like um every Monday some sort of practice meeting once a week so there is more contact* GP 29

*There is very much this sort of idea that the practice is keen to have input and ideas from all the different disciplines you know and I think that really helps ...that has been great as it has been a big plus in terms of teamwork and morale and people working well together* Nurse 13

*What I have seen in patient care I see it from.....what is happening to do with morale, to do with training, to do with working as a coherent team that I didn't see before and I know that this will, it has got to impact on patient care* Manager 10

*They pull together much more as a team. The team seems much more solid. Teambuilding of course with PMS is something which has become something much more acute and much more relevant um you have got to agree amongst yourselves as to what you are doing there has got to be a sort of conformity of attitude of approach, the other thing that PMS has made us do is to involve the team right down to reception staff much more in the activity of the practice the kind of service*

*we are providing... ...there has to be an understanding of the object of the PMS project um right the way through the staff. GP 11*

*There is always... ...every GP is a lead in one of the areas that we are supposed to do as part of PMS for the National Service Framework so whoever the lead was has had to get something going on that subject and has discussed this in clinical meetings that we have every week with the other team members so we are aware of that and I think it has made us improve our or look at the care we give now and improve it. Nurse 10*

*community spirit is good ...anybody who comes to work here finds it pleasant and comfortable without this feeling oh well there's the senior partner ...no everybody has their own clinical responsibilities everybody is responsible for their own decisions but everybody is able to chat to each other am I doing this correctly am I not and that is part of the thing with our Friday meetings GP and Manager 28*

*We have tended to, I mean, a detailed look at all the different sort of staff roles and, you know, looking at the staff development. We are trying to get people interested in specific areas so that people who might be doing reception clerical admin perhaps as well as doing that on a general basis people will have particular things that they will be concentrating on, and you know particularly for example, the NSF. We are trying to sort of team up: say a doctor, a nurse, and an admin person. You know, for the different areas so that is you know clear where their responsibility lies. GP 10*

*"We wanted PMS to be in the Practice but we tried to involve everybody in the plan we were writing so everybody had the opportunity to read and it and we discussed it at several Practice meetings and redrafted it and incorporated everybody's ideas... ... the whole drive to change and the process we went through gave us a spurt in getting the whole practice involved." GP 8*

#### *5.3.4 Blockers 1: Inadequate premises:*

Two factors were blockers of progress. If these were present then progress was impossible. The first of these is inadequate premises that constrained the service that could be delivered.

*I think that we need more rooms to provide all these services so at the moment we are limited... I would like to have employment opportunities but we got because of um premises you know problems so I haven't got you know any sort of opportunity to do this employing but when we move... ...I will have my own PMS doctors, I will have a Nurse Practitioner. GP 29*

*My other concern was the ability to improve premises and I thought that if we could perhaps develop services we might get more support in terms of funding or new premises... ...the lease on this existing surgery actually runs out in 12 months time. To produce some continuity here we have to have some changes. It would not be feasible for me to fund a new lease. I wouldn't even be prepared to do it; and there has to be some shall we say joined-up thinking about providing premises and accommodation for primary care in this part of town. There have been one or two efforts in the last two years, which have all fallen through. That was to develop the premises and to purchase or develop a new site and make it big enough to introduce say two or three small practices to work together; this has all fallen through." GP 11*

*It makes sense that all the all of the new type of services on offer should come from somewhere like this but we have run out of space. You know if somebody wanted another consulting room I couldn't put them any where they would have to go on the roof so that is the downside sort of as a successful PMS practice. Manager 22*

#### *5.3.5 Blockers 2: No clinical staff*

An inability to recruit or retain clinical staff was a major problem. This applied most acutely to GPs who are in very short supply; but also to nursing staff.

*Staffing is a major, major problem and if anything is going to disintegrate the NHS and primary care in particular it is the problem of staffing. GP 11*

*The trouble is that the flexibility is being stymied because there is a complete shortage of GPs  
GP 23*

*Staff, yes because that is why I am really handicapped, I've been telling them last five years this is the thing I needed GP 27*

*I can't implement my planned programme if the pressure goes on. My purpose of doing PMS is not serving because of lack of doctors as well as a nurse. If I had doctors and nurses I could have made lots of progress.....because I am going crisis after crisis I cannot take my holidays, holiday time I had a locum here, he didn't do home visits, complaints there. GP27*

*the other half of my PMS pilot is another single handed doctor and sadly she resigned. She has actually left work she formally leaves at the end of September... ..and her reason for leaving was her inability to practice at a level at which she was happy with because of working in temporary accommodation. She was working on the 1st floor above with no lift. She had no access for the elderly or for children or for babies and she spent three years there and there was no way she was going to commit herself for the rest of her professional career without any prospect of a decent premises. GP 11*

*At the moment I am the only one here ....we had a nurse for each practice and a nurse for doing the audits ....it is very difficult ..you get agency but by the time you show them the day has gone it is very tiring having to show people what to do Nurse 30*

*No we can't be in a worse position, we are no more forward in terms of extra staff. In PMS part of the deal was that you have an extended team so that you work differently and you know work more practically, more efficiently and do new things in different ways but that part of the equation is missing so how can you be further forward GP 31*

*Unless we find the staff..... and can manage to recruit it is an up hill struggle GP 31*

*"If I was starting out as a young doctor in general practice I wouldn't want to spend a lot of time seeing and counselling girls teenagers with sexually transmitted diseases, with unplanned pregnancy with requests for termination. It's a very sort of how shall I say unbalanced medical practice and two of the girls (young doctors) who have worked here have said that they have found it very depressing to being seeing girls all the time who were doing this, that and the other and it wasn't for them. It is a problem but it is a local problem and somebody has got to address it as I see it"  
GP 11*

*Recruitment is a nightmare, it's a nightmare.. GP 16*

#### 5.4 Model: Enablers and inhibitors of the delivery of PMS objectives:

There were other factors that enabled change but were neither prerequisites for success nor complete blockers of progress. For these factors there needed to be a perception that the balance of enablers, more than counterbalanced the effect of the inhibitors.

##### 5.4.1 Trade off between a historic level of payment and good cash flow:

PMS improved cash flow, as instead of having to submit items of service claims, as under GMS; practices are paid a regular monthly amount. Even if total income did not improve it was certain and secure.

*I think the PMS budget is good cash flow for all the Practice, as such, you see. For the GMS you have to wait for quarterly payment, as such, but the PMS you have got monthly cash flow so I think it is good for the business. GP 29*

*In terms of cash flow, in terms of organising the finances it has been a vast improvement and it has really benefited GP 23*

*The cash flow is better with the PMS because every month there is money coming in and I don't have to ring ten times why this one is missing and that one missing a tremendous improvement that way GP 27*

*We especially liked the idea of having an annual contract with regular monthly payments and then streamlining our bureaucracy accordingly just giving us a bit more flexibility and control GP 22*

#### 5.4.2 Reduction in GMS claims, but information demands for PMS:

The reduction in paperwork associated with the traditional model of practice should be greater than the additional reports and information demands needed in PMS.

*I might earn a little bit more financially but I might not be able to focus on the patients because of lots of distractions from the (PMS) paperwork." GP 29*

*We had for a long time grumbled about the excessive paperwork, the enormous number of stupid forms you have to fill in order to get a stupid fee.....and that it just would be less hassle in form filling...and that hasn't been completely successful but there is certainly less form filling for simple fees GP 21*

*It's true the day to day bureaucracy might have been reduced but corresponding increase in more strategic higher level activity has more than offset any possible reductions in management activity GP 5*

*We were told when we went into PMS that most of the bureaucracy will disappear that's not true it hasn't proved to be true. It is just as much if not more than before and that is not just a measurement of the gradual increasing bureaucracy anyway that was going on. it is also a measurement of the fact that, in addition to the bureaucracy that surrounds your General Medical Services type work, you have got the new bureaucracy that comes in with the PMS work; and particularly the unified budgets, and monetary changes and things like that. The other thing is that we were given a lot of what has subsequently has proved to be erroneous information when we started PMS.. By and large as things come through, you find that that bit of information was not true, wasn't right, you have had to go back and re-do work. To give you an example with the PMS changes to PMS items of service claims were discontinued we were budgeted on our previous year's performance and given a unified budget which we negotiated and agreed. Subsequently we discover, and only recently in this case, that we should have been making returns to the Prescription Pricing Authority every month as a GMS Practice does consequently we suddenly had a big reduction in our income! GP 11*

*It (PMS) frees you from some paperwork but it also gives you more in some respects you know there is a lot more paperwork and I got the impression there was going to be less but it is not because you have to justify things at specific times rather than sending a monthly report of how many smears you have done they will say to you can you tell us what you have done and everyone is running round like a headless chicken trying to get this information together. Manager 21*

#### 5.4.2 Cynicism about NHS Management:

The lead clinical professionals within the practice must be committed to improve the quality of the service, something hard to achieve if they are disillusioned by overwork or what they perceive as too much change and too many policies and targets. Even among those who have succeeded with PMS there is cynicism that they might have been paid to succeed, and that had they got the additional resources by another route they would have made the same changes.

*"I don't know to what extent this is PMS or just these other bits of funding which I have always thought could have come anyway you know that they just didn't seem accessible under GMS I think actually that is a continual bone of contention between GMS and PMS practices really you know people just can't see why it couldn't have been done anyway but you know political imperatives being what they are you know there was a vested interest in making PMS succeed or at least appear successful you know there was a bit of numbers game going on." GP 10*

If the NHS managers appear naïve, or too keen on the scheme, it can appear that their actions are self-serving. They need to have the right balance and be supportive and encouraging of modernisation, without losing sight of the insights, or paranoia, of the workforce; depending on your viewpoint.

*I think that some of the financial advice we were given was undoubtedly wrong; and we have had to re-learn things as we go along. Yes, I mean, for instance they spent a great deal of money and invited all the new PMS pilot practices to a day on accounting procedures and at great expense. We were talked to by a group of young accountants from a large unnamed multi national accounting company; who, to put it bluntly, were teaching us like grandmother's to suck eggs. We were, you know, we were being told to produce two columns income and expenditure and how to produce a balance sheet! Most of us have been self-employed people for 20/30 years and it wasn't the kind of thing that we wanted for a day on an accounting! GP 11*

*I think that because a lot of people within Southwark went PMS as well I think that is the reason why we went in that direction as well. They made it quite it became quite advantageous at that stage to actually become PMS. GP and Manager 28*

*Lambeth, Southwark and Lewisham had I think the most pro active kind of encouragement in the UK you know and as a percentage of practices went from GMS to PMS is the highest in the country. And so that you know there was an agenda and I just wondered whether to what extent it oiled the wheels... GP 10*

#### 5.4.4 Making better use of the team's resources, especially nurses:

Making better use of nursing resources is of particular importance, given their pivotal role within the core primary healthcare team. There were incremental but important changes in the attitude towards and the level of responsibility taken, for patient's problems. Small but important initiatives to benefit patients.

*We had a special nurses away day where the practice brought a facilitator in and it was all done very professionally and we decided the way we wanted to go forward and this is how we came round to the health care assistant Nurse 8*

*I have really enjoyed going from what I call a pretty basic nurse to doing more exciting and challenging things really. Nurse 8*

*we were able to employ more nursing time we have been able to implement an outreach nursing service from the practice so instead of referring the patient to the community nurse one of the practice nurses who already knows the patient can go out to them at home, do a nursing assessment at home, get treatment underway, go out in an emergency situation or in a crisis. So yes, we have been able to change the practice nurse role and convert it to an additional outreach nursing service; and this has been much appreciated. And, I think it is one of the reasons why the older age group have actually increased in the area; because they have been attracted to the service and to the practice. So if you look at that as an accessibility aspect then it was a very positive one and it has made a big difference.... GP 11*

*We employed another nurse when we took on PMS so I think the access from the nursing point of view was made easier Nurse 19*

*I think the changes in the nurses role as well has made us become more professional and on an equal level to the GPs Nurse 19*

*Part of the pilot was to have Nurse Practitioner training funding for me as a Practice Nurse Nurse 10*

*"In the Nursing Team and nurses because of its process the nurses had an away day and sat down and thought about their own development, how they wanted the team to be configured, what roles*

*they wanted to have... ..it (PMS) was certainly a driver for nurse development; so indirectly yes nursing roles have developed through PMS." GP 8*

*One of the strongest parts of it (PMS plan) was the nursing aspect I have forgotten the jargon we use for it now but to develop a more flexible nursing approach not a generic nursing approach but a flexible one so that the nurses would look at what tasks needed to be done and sort out between themselves how best to achieve it GP 23*

*The way my role has changed: whereas, I used to do a lot of routine stuff we have now passed that on, you know. If you are a higher grade why just always be doing blood tests, which anyone can do, and so we have a health care assistant join us. We have trained them up to do the bloods, and this frees us up to do more chronic disease management. So I think in that way we have um changed quite a bit. Nurse 8*

*Obviously a phlebotomist is far, far cost effective than having a Grade G nurse taking blood so off they (two reception staff) went (to train) ...it gives the admin team or some of them new skills, a new string to their bow, not to de skill the nurses in blood taking but it gives them an opportunity to do our disease management in a more pro-active way, in a more structured way. Manager 22*

#### 5.4.5 Perverse incentives within PMS:

There are a number of perverse incentives within the scheme. The freedom to control workload by closing the practice list without it affecting practice income, meant that other practices were taking on new patients and workload but not getting an increase in income. Practices that achieved their goals felt that they were then levelled down, and were then disincentivised from continuing to develop services. Although not a quantitative study the evaluation team formed the impression that many primary care professionals were unhappy about how many practice lists were closed.

*There still has to be support based on what practices say they will do and prove that they achieve if you like people who are setting higher standards and achieving it in fact should be rewarded to enable them to keep going and the idea of levelling of all practices so giving the resources to practices that aren't doing as well in the hope that they will come up I think shouldn't happen at the expense of not resourcing practices that are achieving. I know it is a really difficult one for the PCT to sort out but I think you have to continue to encourage innovative practices provided they achieve what they say they have achieved and that is where the monitoring comes in. GP 8*

*other practices around us might have felt more of a strain. We have had to take on parts of the practice lists because of problems in the area. Because of problems recruiting and retaining doctors. So under GMS we probably wouldn't have ... Manager 13*

*It is almost impossible for any new patients to register. And, to me this is a real problem. And, we have an extra GP working and you would think that that would make life a lot easier and that we would be able to take people on. But we have not registered anyone for a year, unless they have got extenuating circumstances, or unless they have actually been allocated to us.. ..So having the extra GP I don't think has made a great deal of difference to the people who move into the area at all. Nurse 32*

*It has been a bit of a problem that if you stick your neck out in this area and practice excellence you can get swamped because you attract too many patients, so do you close your list, no, because we consciously want to keep our lists open but something at some point it has got to give it may not be possible to practise excellence for everybody and keep our lists open and face ever increasing numbers GP 5*

#### 5.4.6 The primary care - secondary care divide:

PMS, especially through the "PMS-plus" scheme, should allow practices to be paid for taking on work that is traditionally done in secondary care. The level of extra work needs to be sustainable and there needs to be an income stream to support it.

*For example: mental health. We know we look after something like 40% of our 250 psychotic patients and we should have about 20 or 30 psychotic patients in this practice. But we look after about 40% exclusively in the practice. So, in theory those patients should all be looked after in secondary care but we don't get an additional resource to look after them here. You could argue that some funding from secondary care should come to us to look after those patients and that the vehicle for that is PMS but it isn't actually in practice possible to do." GP 8*

*We are underpaid on that one (colposcopy) because we have been told there is no money available and being a secondary service we felt that once we take up some of the secondary service, money should flow from secondary service to us but it isn't GP 16*

#### 5.4.7 The prospect of a new quality based GP contract:

The ability to innovate, raise quality standards and operate flexibly to meet local needs ought provide greater rewards than the certainty and predictability of the traditional system. This could be undermined if GMS is replaced by a quality-based contract. However, national quality standards may not provide the local responsiveness achieved with PMS.

*the fly in the ointment now is that the new GMS contract is being negotiated, I mean what I don't know is whether because so many Practices have become PMS locally whether the Health Authority will take some time to consider well you know would they be able to offer some of the extensible benefits of that new GMS contracts to the existing PMS practice otherwise everybody will jump back to it." GP 10*

*The only reason I would go back (to GMS) is if the new contract turns out to be better .....we are a high quality practice and we don't get benefits for that and if the new contract reflects that we would continue on that basis GP 18*

*We looked into it (PMS) and saw what we felt what we would actually get for the practice would be advantageous to our patients. Some of the reasons, the sort of thing, was actually making applications for and doing a real needs assessment. For example, we did a needs assessment and realised that we needed a Bangladeshi Health Worker. We could never have afforded it under GMS. We got that; that is a great advantage to our patients and to the wider community... ..our Bangladeshi Health Worker, he does English classes not sort of general English classes focussing on coming to the doctors, explaining pain and also explaining the cultural differences actually educating the doctors too to understand the cultural differences Manager 10*

*It was very nice to think that through PMS we could be rewarded for meeting the very real needs of a population which didn't seem to be addressed by the Red Book GP 5*

*We were very enthusiastic about PMS we still are.....we will stay as we are until someone makes us choose I can't see any major changes until the GP contract is agreed and there's a real choice although the new contract will have many aspects of more PMS than GMS GP 22*

#### 5.4.8 Good IT and good data:

Good data about the locality and practice are needed to reduce the administrative burden of report writing, and to enable development of the case for services needed. The greater flexibility in the PMS systems allowed a broader modernisation of practice IT. However, if the IT system did not meet the needs of the end-user then it became a negative influence.

*Indeed, computers don't make life easier." Nurse 10*

*It was just planned for the local practices to have all the local practices should have the same computer system. A new system that we can use to... Well the system that we have got is not really useable. We are still using notes and we were supposed to be paperless in 2005, which is only three years away and at the moment we are still using notes and we should use the computer*

*more. We should be able to recall patients like diabetics; asthmatics every so often and we are never able to do that properly. So local practices have been offered this new computer system and hopefully it should be in place in the autumn." Nurse 10*

*"You can see that since I became a PMS now we are having new IT ..... So new IT now we are hoping that like book: admissions, with community care, with a hospital. And then several quick access: to the results blood tests, x-rays, reports through the IT side of the hospital. This is my sort of well future hope that we would achieve so there will be a good um sort of practice for the patients you see you know they get quick blood results so that we can take more actions you know quick actions if necessary." GP 29*

*PMS has enabled us to employ somebody who was solely responsible for our IT equipment. We have never had that luxury before.....I suppose he as well as the salaried doctors I would think from my point of view he is the one that has saved me an awful lot of time and has been able to develop us in the IT field in the way that we are now. Manager 22*

*It (IT) has improved excellently we bought a system in the first year of PMS, everyone got adequate training.... And since 2000 all the consultations are on the computer.....so literally for the last two years all computer data is available for us.....much more easier to grab information and look at it at the touch of a button it has made life a lot easier. GP 16*

*PMS has been almost like a catalyst to the development of other things we are now paper-light consulting on the computer system which is something that came in on the back of PMS in that it was just like a bold step that we took GP 13*

#### 5.4.9 Training and personal development:

The practice can institute the training and personal development plans to meet their patients' needs, thus underpinning the new roles and changed relationships within the team. This is contrast to the purely job-title related training that occurred previously.

*we have an in-house training scheme yeah and that in-house training scheme um is expanded from just the theoretical work of a receptionist or a secretary to something different and in come our teachers we have people from the drug dependency units, the drug treatment centres um alcohol, cannabis in particular real problems for our kids they come in we have training sessions, we have brainstorming sessions with the doctors and the nurses sit down and learn all about this and so this has been very attractive to the staff they have enjoyed it because they have been able to begin to understand the problems of the people who are coming to the desk to see them." GP 11*

*We have got one receptionist who is undergoing training as a healthcare assistant and we have got two receptionists who have learnt to be phlebotomists GP 22*

*I was offered as part of the pilot to start this Nurse Practitioner course to receive the training for three years .....so for me personally it meant a change in my job Nurse 10*

*One of the things that PMS does allow us to do is to fund courses on a generous scale than we used to before we can afford to send our nurses away and ourselves and that is extremely useful because it is good for the nurses to have extra skills, they can teach us a lot of things it is good for their morale to feel that they are respected professionals GP 21*

#### 5.4 Reflection:

Most primary healthcare professionals could see the potential benefits of PMS, even if they had not been able to realise them for their practice. Few practices felt that they had made substantial progress, though most felt there had been more good than bad. Collectively they provided a valuable insight into why this might be.

*Well I think prior to PMS we played lip service, I hope this is anonymous, to a lot of things. Not that we weren't giving a good service, we were. But, I think we paid lip service to a lot of the things that we were supposed to be doing. We did them, but now we have the time to you know create a proper structure to audit whatever particular aspect you are looking at. Audit it, see where the needs are, deal with it both clinically and non clinically well yes working out an infrastructure."*  
 Manager 10

*"I was of the opinion which unfortunately hasn't become truth that PMS would enable us to develop local services more effectively and attract in the medical manpower but it just hasn't worked out that way. I don't know the next step really except to continue hoping that we can improve things."*  
 GP 11

*"PMS definitely provided us with the tools to motivate that really. Um so I think PMS any practice can interpret it very differently I mean a practice could have gone PMS and done very little and changed very little. But, I think, we really used PMS as a tool to motivate the changes in the practice. I would say that it has been hugely successful for this practice you know and I think that we can justify that in all the reports and things we have produced."* GP 8

*We practise a high standard of medicine...we'll give as best possible care to our own registered patients but there hasn't been a sense of the needs of the whole community and what about the people registered with other practices can we have any sense of team-working and we have never really not until PMS had that sense of working as a team together* GP 5

*PMS has been useful definitely useful and it has made us all have perhaps slightly more time to look at issues that we wouldn't have had if we if we were doing GMS* Nurse 19

*Is it better under GMS or PMS is I think stems from the PCG and the lack of support from them or the lack of manpower or the lack of expertise at that level. I think that is where it stems from not necessarily from either GMS or PMS. I think that PMS could have been handled a lot better had they come down and monitored things a bit more and given us the recognition for what we were doing .....it was a case of well we're down here let's minute the meeting let's put it on file let's go on to the next trauma case but it really didn't bother with the meeting after the minutes.* GP 28

*I think PMS has the makings of a good system provided it is managed properly and you know given the budgeting is done more effectively* Manager 28

*Eighty per cent ethnic minority patients (in practice) ...so lots of problems, health education is the main thing it's time for (NSF) to have a health promotion programme, nationally they are not doing it so people are not educated, background is foreign very difficult to improve and on top of all the problem of staff budget and shortage of doctors and nurses and the purpose of doing PMS is not serving* GP 27

*I am very positive for PMS. I think within the practice it has made it possible again to re-visit and look at things we were doing....when things have been rolling for many years you sometimes need to stop and look at developments and I think PMS has allowed us to do that* Nurse23

*"Maybe if we hadn't gone into PMS we wouldn't have thought of what we needed; either for the practice, or what the population needed. So in a way it has made us think more, and focus more on those areas. Otherwise I think we would have gone on and on and on with the GMS and um not have thought of this."* Nurse

*I feel quite proud of the way the practice has improved its services over the last couple of years, really. And you could argue that it probably could have done that under GMS anyway. But, I think, PMS provided the driver; if you like to make us do that and I suspect we wouldn't probably have done it quite so um systematically. We may have focussed on particular groups, but it would have been more hand to mouth and less thought about in advance. Because we had a lot of resources in the year before PMS to help us to work the plan up.* GP 8

*I mean I think the practice and the patients on the whole are better off I mean the services are streamlined now and you know some patients are more better off than others. I think patients have you know been offered more than what they have been used to And you can see that but I think because they are better off the expectations from the patients are increased Nurse 5*

*As I said it all goes back to not having been able to recruit because with a full team that would have been possible so it takes the steam out you try and start doing these sort of things but then the bread and butter stuff, daily general practice swamps you and zaps your energy so it is very difficult GP 31*

*I think there have been issues around individual practices doing well out of PMS and how that affects other Practices that aren't PMS or who haven't done so well; and I think once or twice we have sensed that there has been some unease with the PCG. If we have asked for additional resource, the PCG say well they have already had two salaried GP's etc we need not give them anymore resource; but (instead) to give it to some other less resourced Practices. But there is always that conflict that if you have got an innovative practice you want to encourage and support them, but you also want to try and bring everybody up to the same level. It is a really difficult one to resolve because if we don't get additional support and help then we will stop being an innovative practice because we won't be able to and instead of bringing everybody up to our level you are bringing us down to a level." GP 8*

*On the whole you know I don't think it has been a bad experience at all no I think if I am absolutely honest if I really tried to think of something that has been bad about it I don't know that I could. It sounds a bit evangelical doesn't it,. It isn't meant to be...I think it has been a good experience for us as a practice. Manager 13*

*If the National Health Service has to be ethical and equitable then the needy areas will require more investment for retention and recruitment so these areas should have a premium for working in inner city areas in terms of what it costs you personally because you have to deal with the traffic and the housing problems and the muggings and violent language all the time and working with a deprived population has a personal cost. GP 31*

*So I think we have come a long way in a very short space of time and on the whole you know I think the patients are delighted with the services that they see Nurse 15*

### 5.5 What would have happened in LSL without PMS:

The interviewees were also asked how they thought things might have been had they not joined PMS.

*I think our access would not have been as good, I think our lists would have been closed for much of the time (if we had not joined PMS) because we didn't have additional salaried GP, I think we would have been working much more hand to mouth if you like meeting demand as it presented rather than proactively looking at developing services according to what was needed. I think the organisation that we have developed in the last couple of years would not be anything like it is now, the nursing team would not be as developed, I think the management structure would not be as developed, I think staff morale probably wouldn't be as good because I think those developments have improved now because communication has been better and responsibilities have been clear and you know I think I do still go back to I think most of the things that happened in this practice could in theory have happened under GMS with the exception of the additional resources but PMS has certainly been the driver that has facilitated it to happen in this Practice and I don't think it would have happened had it not been PMS because PMS made us sit down, look at our Practice priorities, national and local priorities, talk through the development plan, we had to set objectives for each year and through PMS meet those objectives. GP 8*

*I think we wouldn't have thought about our care as such we worked on and maybe with the NSFs we might have been a bit more aware but less so than being part of the PMS. Being a PMS has started us thinking as a practice into the care that we give and the care that we should give um it has made us more aware. I think there has been a positive change as a practice and otherwise we*

*might not have moved on as much as we have done with the PMS I think we have moved forward quite a bit, a big part of it. Definitely yes! Nurse 10*

*I don't think PMS has given us any freedom that we didn't have before I think in the past that we have been able to access money and I think that we traditionally had a helpful Health Authority that have the patients' interests and they have been entrusted in facilitating patient care through us, they have been very helpful. I think the PCT or PCG as it was has very often made money available through incentive schemes and I think we have benefited from that. Manager 32*

#### 5.6 Results summary and its implications:

The model for PMS created as the study developed, it is illustrated in Figure 1 (Page 20.) It works on the assumption that if barriers are removed and the right skills and enablers are in place that a PMS practice will achieve its objectives. We have termed the factors that help achieve objectives critical success factors and enablers; and the ones that hinder blockers and inhibitors.

The themes identified during the analysis, and then categorised into each area of the model is set out in Figure 2.

<b>Critical Success Factors:</b>		<b>Blockers</b>	
<b>1. Leadership</b> with <b>vision</b> combined with <b>Effective management</b>		<b>1. Inadequate premises</b>	
<b>2. Teamwork</b> with good lines of <b>communication</b>		<b>2. Shortage of clinical professionals</b>	
<b>3. Time</b>		<b>3. Lack of time</b>	

<b>Enablers and inhibitors of delivery of PMS objectives</b>			
<b>ENABLERS</b>		<b>INHIBITORS</b>	
<b>1. Regular 1/12 of contract fee</b>	vs.	<b>Based on historic payments</b>	
<b>2. Reduction GMS admin</b>	vs.	<b>PMS information demands</b>	
<b>3. Positive view of PCT motivation</b>	vs.	<b>Cynicism about managers'</b>	
<b>4. Using teams resources</b>	vs.	<b>Stuck in historic roles</b>	
<b>5. Seeing advantages in a quality based Contract</b>	vs.	<b>Unable to move beyond apparent perverse incentives</b>	
<b>6. Able to bring services from secondary to primary care</b>	vs.	<b>Can't move on from current service delivery model</b>	
<b>7. Do not want to go back to GMS</b>	vs.	<b>Could the new quality based GP contract be as attractive</b>	
<b>8. Good IT delivering good data to inform quality of service</b>	vs.	<b>Unable to understand own population health needs</b>	
<b>9. Opportunities for training and personal development</b>	vs.	<b>Training not related toward the needs of the service</b>	

**Figure 2 Themes identified during the analysis grouped into the categories defined in the model.**

It became clear during the analysis of the results that most of the themes identified were actually issues related to the level of organisational development within the practice. The following hypothesis was created as a result.

*The level of organisational development within a practice is what determines whether an objective is realistic or not. PMS pilots with sophisticated levels of organisational development can achieve a lot and those lacking can achieve far less.*

For example, it is self evident that if a practice has inadequate premises, or clinical staff vacancies it cannot deliver a complex new health intervention across the health and social care divide. What primary care professionals told us about progress under PMS was framed by what was realistic for them to achieve.

The model enabled an understanding to be developed of the reasons a PMS pilot either achieved, or failed to achieve its objectives. Where these objectives were realistic for their level of organisational development they achieved them, and when it was not, they did not. The implication from these results is that it is possible to suggest that there is a link between the level of organisational development of the practice; and what might be realistic objectives for it. Within PMS appropriate objectives can be set for practices whatever their level of organisational development. A hierarchy, based on an adaptation of Maslow's work<sup>33,32</sup>, is set out below. Level 5 has the most advanced level of organisational development, and level 1 the least.

#### **Level 5: Self-actualising practice – new services crossing the health-social divide.**

These practices have advanced levels of organisational development. The objectives that they achieve cross the Health-social care divide. This type of practice will have a multi-professional team working with an effective management structure and good relationships in its community. This level practice is likely to be able to deliver a multi-agency health improvement plan, personalised to meet the needs of the local population.

#### **Level 4: Esteemed practice – delivering effective disease management programmes**

These practices also have high levels of practice organisational development. They are able to deliver comprehensive health (and quality) improvement programmes. This appears to be the level of aspiration that exists for the new GP contract, and these practices will easily achieve these quality standards.

#### **Level 3: Social practice – individuals looking to establish innovative services.**

The problem for a practice in this category is there is no effective leadership and management. Its organisational development is therefore uncoordinated. It will have individuals with a desire for a high level of organisational development but its leadership and/or management are unable to deliver level 4 or 5. Individuals (rather than the practice) are looking to innovate and develop new services. The implication is that the practice has individuals who have the energy and enthusiasm to be developed, but that their practice does not as yet have the leadership, communication and team working for them to work at a higher level. Even if these initiatives appear to be piecemeal and the practices cannot as yet be brought to a higher level it is important that these individuals are able to develop. The risk of not doing so may be to blunt their enthusiasm, and reduce the chance that their practice will reach a higher level of organisational development. PMS provides an opportunity for these practitioners to develop and work with practices in levels 5 and 4.

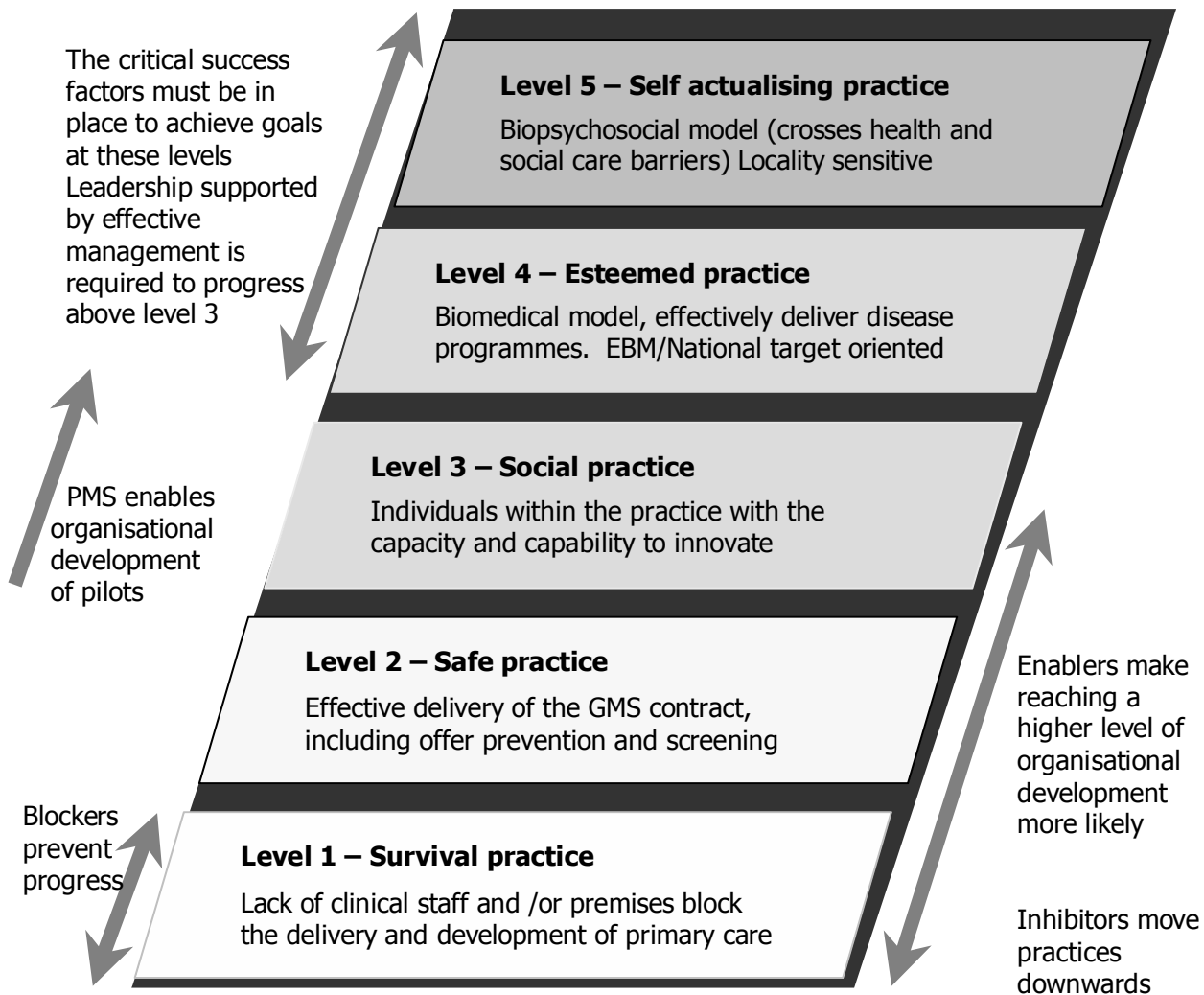
#### **Level 2: Safely delivers an illness service**

The organisational development within these practices is sufficient to run an effective illness service, and operate within the GMS contract. In this level are Practices that are busy coping with the demands of delivering GMS and serving ill patients. They lack the time to go beyond piecemeal attempts to deliver quality. The team may have self selected to work at the routine task that form the bulk of the organisational activity.

### Level 1: Struggling for survival

Here there are profound barriers to delivering the service that block organisational development. These are the practices who can't recruit or retain clinical staff. They as a result don't have the time to develop their service. Inadequate premises can also block in a practice and prevent development.

The contents of each section of the model are set out diagrammatically in Figure 3. The model represents where individual practice that were interviewed appeared to be. Like all models it exists as an abstraction of reality, and offers no more than a hypothesis of why different practices are succeeding at different levels.



**Figure 3.** The level of organisational development of a PMS pilot and its influence on which objectives are feasible. (Level titles taken from Maslow, 1954<sup>31</sup>)

## 6. Discussion:

### 6.1 Principle findings:

PMS provides a framework for quality orientated, locally responsive primary care. This is not in itself surprising, as it makes sense for PMS to be aligned with the clinical goals of general practice in that locality; rather than having to deploy a lot of management effort simply to drive the bureaucratic claims system within GMS. However for PMS to be effective there are critical success factors that must be in place, and potential blockers on progress must be removed. There are then a balance of other factors, none of which alone can block or force progress; but their combined effect must be to support the intended quality improvements.

PMS gives considerable power to the professional partnership of doctors that run the practice. Practices who operate under the GMS system are having their power and influence, as independent contractors, gradually eroded and subsumed by their PCT. A PMS practice has the opportunity to be far more influential within its own locality, and if it takes the PMS Plus option it can take on services formerly performed in secondary care. However, the practices that regard themselves as successful within PMS and had delivered new improved services had often taken this power and then given it away to broadly based teams within their practice and incorporated others outside, both within primary medical care and across the health and social care divide. A critical policy success for LSL was their offer that the scheme provided the opportunity for practices to get additional clinical staff. Those without extra clinical staff, never generated the time and space in which to move on. This decision, although taken for other reasons, set out in the introduction, was critical for progress to take place. Time was therefore both a critical success factor, if it was generated; and a blocker if you were overwhelmed already.

As set out at the end of the results, the type of objective that pilots set for themselves needed to be congruent with their state of organisational development if they were going to be likely to succeed. One of the principle output of the study is the model linking organisational development and the potential to deliver PMS targets.

LSL has set the evaluation team the objective of how to support the individual practices and how to evaluate their stage of development. The model set out in Figure 3 is a hypothesis of how that might be done. The recommendation would be that the assessment started with step one and then worked through the model. If a practice was at Step 1, then they need more time and space. Until they have this they are not going to be able to develop as a more sophisticated organisation. A practice at Step 2 may need the motivation and vision to develop beyond GMS. However the team that works there have self selected themselves as happy and efficient at collecting the forms etc. The capabilities and capacity of that team need to be developed if they are to achieve more. .., and so on...

### 6.2 Comparison with the literature:

These finding appear to the authors to be compatible with those found in the National Evaluation of First Wave PMS. However, they go beyond them suggesting a model that would allow predictions to be made about whether an individual practice or grouping would be more or less likely to succeed in delivering locally responsive quality improvements.

The style of leadership that appears to be appropriate for primary care is close to that of Senge<sup>35</sup>, who sees the new leaders' roles as designer (defining purpose and core values,) teacher (sharing models that provide insight of how to operate effectively in the current context) and steward (of the people in the organisation as well as its ideals.)

The chances of success are increased if congruence is created between primary care's contract with its core function, is widely supported within the management literature<sup>36</sup>. PMS enables

general practice to be pivotal in delivering relevant local services, rather than just implementing a national contract in the way that maximises income for the GPs in the practice.

Figure 3 owes a lot in its creation to Maslow's hierarchy of need. It became, in the view of the study team, evident that if you were stuck with no resources, or had a practice that was well adapted to GMS, that you could not progress under the PMS framework unless your practice was changed as a result of some sort of organisational development. The professionals interviewed all seemed keen to develop their pilots in a very ethical way. Maslow believed that humans tend towards growth and love, and only resort to violence etc. when they are thwarted. The view the study team took of PMS pilots is that they too wish to develop, but they needed blockers removed and the right success factors in place if that was to happen. Most of these key elements needed, related to the pilots level of organisational development.

At the base of the pyramid of practice organisational development are practices with inadequate premises who do not have the space to run a proper service, they may also lack the clinical staff to share the load and to provide the time for them to develop their service. These practices are blocked in, and can't easily progress. The next rung in the hierarchy is the bureaucratic (GMS) business model. They provide an illness service and they understand and operate under the GMS system. It is predictable; a senior receptionist can administer it, it responds slowly if at all to change. There may be little professional self-esteem in this layer.

To move beyond this there is a need for leadership, good management, team working and vision. The next layer provides what could be looked on as "biomedical systems thinking." I.e. the practice can be flexible and implement national disease targets. This implementation can take place without much change in roles, and does not require major alliances outside the professional sphere. The new quality based contract for general practice may not go beyond this layer.

The apex of the pyramid is where the practice team achieve self-actualisation. This requires "local needs system thinking." The team is prepared to work across the medical-social divide and will prioritise action where need is greatest. E.g. a Bangladeshi interpreter may be more important in this locality than a nurse facilitator to help implement another national target. Its orientation will be towards needs of groups in society rather than towards the management of single diseases.

### 6.3 Weaknesses of the study:

The specification of the study was defined by the funding body, which had very clear ideas as to how the evaluation should take place. The study context was a single health authority area within South East London, an extremely challenging environment for primary care.

The most clearly articulated views came from the GP-leads. As primary care evolves it is possible that the professional partner will be less and less likely to be the holder of the executive. If, and when this happens, it is likely that other professions in primary care will take on this role and as they do so they will be able to hold and articulate stronger opinions about the goals for quality-based primary care.

### 6.4 Call for further research:

The model proposed needs to be tested. It needs to be assessed whether it is a useful tool that would enable practices to assess whether they have a high or low chance of successfully implementing a locally sensitive quality based contract or not. It may help the managers of the service identify where extra resources or training should be applied to improve the chances of success.

Further analysis of the large amount of data collected in this study would be a worthwhile investment. Suggested topics are:

- Review of practice managers and nurses perceptions about PMS.
- To explore the relationships between the professional groups, from an examination of the narrative used.

## 7. Conclusions:

Primary care professionals are generally supportive of PMS as a quality orientated, locally sensitive contract. It appears to achieve this in the right circumstances. A model that helps explain whether a practice is more or less likely to succeed had been created to explain what these circumstances might be.

Three critical success factors were identified that need to be in place if PMS is to deliver its intended objectives. These are:

- a) Professional leadership, with vision and supported by good management
- b) A cohesive primary care team, who communicate effectively.
- c) Provision of additional clinical staff, preferably GPs to free up time;

Lack of sufficient clinical staff and inadequate premises block any chance of progress. The balance of other enabling and inhibitory factors needs to be in favour of change.

Of critical importance in LSL was that the Health Authority prioritised getting additional clinical staff into the participating practices. This was perceived by the overwhelming majority of practices to have contributed significantly to their ability to deliver PMS targets. Without this element the pilots may not have achieved as much as they did.

PMS has two elements. The first is that it is quality-driven; the second is that it is locally sensitive. The proposed new contract for general practice is quality-driven, but the quality standards are to be set nationally. The best PMS pilots carried out health needs assessments and then came up with different local priorities. It will remain to be seen whether a new "one-size-fits-all" quality based new GP contract can achieve the same level of enthusiasm that the quality driven, but locally sensitive PMS contract did?

If the model predicting the likelihood of achieving quality improvement goals can be demonstrated to be valid and reliable; it may be possible to identify those practices who can lead locality based quality based improvement in primary care, and those that may require more support.

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## 9. References:

- <sup>1</sup> Department of Health. Personal Medical Services. Part 1 Introduction to PMS. London: Department of Health, 2001.
- <sup>2</sup> Audit Commission. Personal Medical Services. A bulletin for primary care trust chairs and chief executives. London: Audit Commission (No HOT2988), 2003.
- <sup>3</sup> Department of Health. National PMS Development Team: Commonly asked questions and answers. URL: <http://www.doh.gov.uk/pmsdevelopment/qanswers.htm#many>
- <sup>4</sup> Department of Health. Primary Care Act, Personal Medical Services information site. URL: <http://www.doh.gov.uk/pricare/pca.htm>
- <sup>5</sup> Sheaff R, Holbourn A, Khong CK. Handbook - Personal Medical Services Contracts. URL: <http://www.npcrdc.man.ac.uk/PublicationDetail.cfm?ID=72>

- <sup>6</sup> Department of Health. National PMS Development Team: Evaluation and Review. URL: <http://www.doh.gov.uk/pmsdevelopment/eval.htm>
- <sup>7</sup> NHS Executive. Personal Medical Services Pilots under the NHS (Primary Care) Act 1997. A guide to local evaluation. Leeds, NHS Executive 1998.
- <sup>8</sup> Porter ME. Competitive advantage: creating and sustaining superior performance. London: Simon & Shuster/Free Press, 1985.
- <sup>9</sup> NHS Modernisation Agency. National PMS Development Team. URL: <http://www.doh.gov.uk/pmsdevelopment/index.htm>
- <sup>10</sup> Dewji M. National PMS Development Team - Listening events feedback report. URL: <http://www.doh.gov.uk/pricare/pmsdevptfeedback.pdf>
- <sup>11</sup> The PMS National Evaluation Team. National evaluation of First Wave Personal Medical Services Pilots. Integrated report from four research projects. December 2000. URL: <http://www.npcrdc.man.ac.uk/Publications/PMS2000.PDF>
- <sup>12</sup> The PMS National Evaluation Team. National evaluation of First Wave Personal Medical Services Pilots. March 2002. <http://www.npcrdc.man.ac.uk/Publications/pms2002.pdf>
- <sup>13</sup> Lewis R, Jenkins C, Gillam S. Personal Medical Services in London - Rewriting the Red book. London: Kings Fund, 1999.
- <sup>14</sup> Lewis R, Lewis S. Transforming Primary Care. Personal Medical Services in the New NHS. London: Kings Fund, 1999.
- <sup>15</sup> Lewis R, Gillam S, Jenkins C. Personal Medical Services, Modernising Primary Care? London: Kings Fund, 2001.
- <sup>16</sup> Scriven M. Evaluation Thesaurus. Newbury Park, California: Sage, 1991.
- <sup>17</sup> Wholey J.S. Formative and summative evaluation: related issues in performance measurement. *Evaluation Practice* 1996;17:145-9.
- <sup>18</sup> Chamlinsky E. Comparing and contrasting auditing and evaluation: Some notes on their relationship. *Evaluation Review* 1985;4:483-503.
- <sup>19</sup> Clarke A. Evaluation Research . An introduction to principles, methods and practice. London: Sage, 2000.
- <sup>20</sup> Scriven M. The methodology of evaluation. In Eds: Tyler RW, Gagne RM, Scriven M. Perspectives of curriculum evaluation. Chicago: Rand McNally, 1967.
- <sup>21</sup> Chen HT. A comprehensive topology for programme evaluation. *Evaluation Practice* 1996;17(2):121-30.
- <sup>22</sup> FitzGibbon CT, MorrisLL. Theory-based evaluations. *Evaluation Practice* 1996;17(2):177-84.
- <sup>23</sup> Patton MQ. How to use qualitative methods in evaluation. London: Sage, 1987.
- <sup>24</sup> McConaghie A. The GP contract, round 2: the devil is in the detail. *Pharmfocus*. October 2002. <http://www.pharmafile.com/pharmafocus/Features/feature.asp?fID=279&m=10>
- <sup>25</sup> Mullany C. A world of difference: Expert warns of borough's two tier health lottery. *Southwark News* 2002;August 15:1-4.
- <sup>26</sup> Department of Health. England and Wales: GMS & PMS Combined National Statistics Tables: 31 September 2000. URL: <http://www.doh.gov.uk/stats/gpcensus.htm>
- <sup>27</sup> STaRNet London. South Thames Primary Care Research Network. URL: <http://www.starnetlondon.org/>
- <sup>28</sup> Smith A Preston D, Buchanan D, Jordan S. When two worlds collide. *Evaluation* 1997;3(1):49-68.
- <sup>29</sup> Essex B. PMS Evaluation Project LSLHA 2001. LSL PMS Evaluation committee, draft dated 08/11/01.
- <sup>30</sup> NHS Modernisation Agency. National PMS Development Team: The Development Team. URL: <http://www.doh.gov.uk/pmsdevelopment/team.htm>
- <sup>31</sup> QSR International Pty Ltd. NUDIST VIVO software Version 1.2
- <sup>32</sup> Maslow A. Motivation and personality. New York: Harper and Row, 1954.
- <sup>33</sup> Maslow A. Towards a psychology of being. New York: John Willey and Son, 1968.
- <sup>34</sup> Berne E. Games people play: The psychology of human interaction. London: Ballantine Books, 1996.
- <sup>35</sup> Senge P. The fifth discipline. The art and Practice of the Learning Organisation. London: Random House, 1999.
- <sup>36</sup> Johnson G, Scholes K. Exploring corporate strategy, text and cases. London: Prentice Hall Europe, 1999.