

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



Executive Summary

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

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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 next page, 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. The committee 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 executive summary. A companion document contains the full report of March 2003.

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 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.

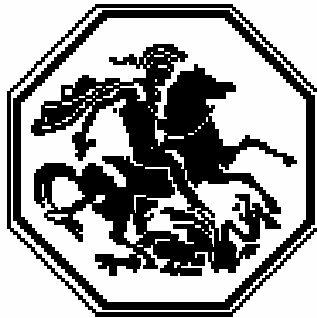
Results:

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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Executive Summary

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Executive Summary:

Introduction:

This evaluation examines the perceptions of primary care professionals who joined the Second Wave Personal Medical Services (PMS) pilots¹ in Lambeth Southwark and Lewisham Health Authority (LSL.) It looks at the effect on 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 discover how PMS might be used more effectively to achieve 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.

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

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

The use of the flexibilities of PMS by health service managers to meet the needs of the local population is something endorsed in a recent Audit Commission bulletin². 33 practices across LSL joined the second wave PMS pilot scheme³.

The evaluation aim was to identify what factors enabled Second Wave PMS practices to achieve their targets, and which 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 the implementation of a quality based contract across the UK.

Background:

PMS is a locally agreed quality orientated contract for general practice. The practice agrees with its local health service managers targets for service delivery over and above a minimum standard. The practice is funded for delivering what it agrees to do^{4,5}. This is in contrast to the standard arrangement for general practitioners, who are independent contractors. Under this standard arrangement, practices are paid through a complex combination of allowances, fees for services done and capitation for each registered patient. 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.

The literature on PMS is largely based on evaluation of the first wave of PMS pilots, who went live on 1st April 1998^{6,7,8}. These report only small numbers of 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. Developing an understanding of these differences is the focus of this study.

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

1. At a national level General Practice is poised to move to a quality based contract⁹.
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 PMS practices to be interviewed.
3. LSL Health Authority, 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. However, the shortage of GPs is also a national problem, with few areas finding it easy to recruit¹⁰.
5. There were concerns expressed in the media about the quality of primary care¹¹.
6. 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.

OBJECTIVE	DESCRIPTION	SOURCE
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
Key		
Abbreviation	Name	References:
DoH	Department of Health	1,3,4,6
NE	National Evaluation of First Wave PMS	7,8
KF	Kings Fund	12,13,14
LSL	Lambeth Southwark and Lewisham Health Authority, PMS Evaluation Steering Committee	Personal communication

Table 2: Objectives of PMS synthesised from the literature.

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).

Method:

A series of meetings were held with the LSL PMS Evaluation Steering Committee during which the criteria and standards were set where it was felt that the Second Wave PMS practices should be evaluated¹⁵. The evaluators stayed in touch with this group by face-to-face meetings and e-mail throughout the study, and provided a positive contribution.

The literature about PMS, and the information on the Department of Health and NHS websites was reviewed. Of particular value were the Kings Fund reports and the National Evaluation of First Wave PMS pilots.

The local research ethical committee stated that as there was not patient involvement or patient data involved, ethics committee approval was not needed.

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.

The goals set by each practice when they made their application for PMS, were made available to the evaluation team.

From this information a framework for the evaluation interviews was constructed. Six pilot interviews were conducted and the framework adjusted as a result. Two investigators AS and VO then conducted the interviews. They reported back to Sdel after every 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 NVIVO software, Version 1.2¹⁶. The initial analysis was based on themes that arose from the evaluation framework. A sampling frame was used to select 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.

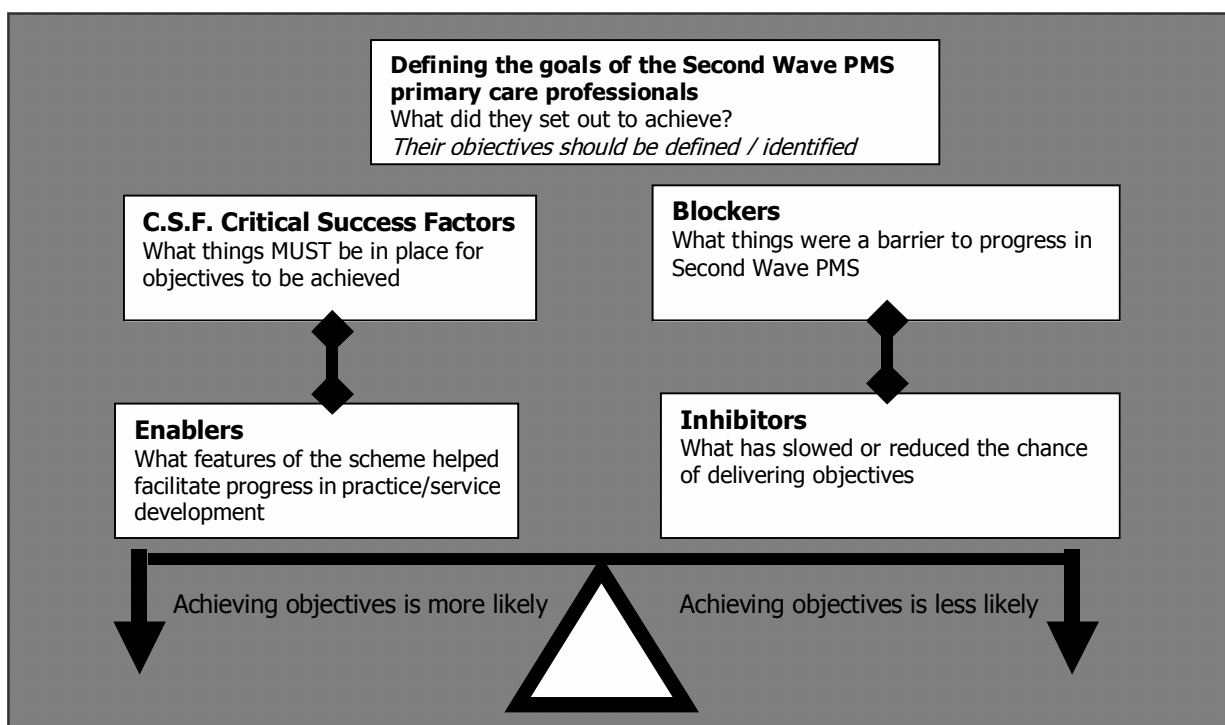


Figure 1: Model of the processes that need to be in place to deliver quality improvement in PMS

From these analyses a theory or model of what might need to be in place for PMS to succeed emerged. 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.

Results:

Sample:

The intended sample for the evaluation was 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:

1. 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.
2. Ten were either on long term leave from their practices (4) or had left (6).
3. 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.

This means that the achieved sample is 81 interviews, 82% of the intended sample. 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.

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

Table 3: Target and achieved sample in the PMS evaluation

Findings:

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

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

The time created by the provision of an extra pair of hands offered to many 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. Shifting of the managerial focus within the practice from one orientated towards making the claims and attracting the allowances, under the old GP system; to one that was disease orientated, or at its best locality need based, enabled organisational development and the creation of more effective management to take place. These developments appeared to increase self-esteem and even achieve, what Maslow termed, self-actualisation¹⁷. The locality needs based initiatives crossed the health-social care divide. They tended to be orientated towards groups in society rather than individual clinical concepts. Typical of these services were: increased provision for the homeless, better care for refugees, or evening clinics for teenage sexual health. This is in contrast to the National Service Framework targets, which largely operate in a single disease area and much more within the biomedical model.

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.

A lack of adequate premises and an inability to recruit new clinical staff were factors that left practices caught in the physical day to day needs of coping with busy surgeries in an inadequate environment.

There were many other factors that either enabled or inhibited the ability of PMS to deliver improvements in the quality of the service. If the primary care professionals perceived the effect of the inhibitors to be greater than the enablers then developments did not take place.

Model:

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.

Three critical success factors were identified, which, if not in place, would make it extremely unlikely that the practice would achieve its quality improvement targets:

1. An extra clinician, most usefully another GP, who freed up time so that systems could be changed.
2. Leadership that provided a vision of what that practice could usefully provide to improve the services and health of its local population.
3. A cohesive primary healthcare team that was able to communicate effectively.

Two factors were blockers of progress. If these were present then progress was impossible:

1. Inadequate premises that constrained the service that could be delivered.
2. An inability to recruit or retain clinical staff.

Critical Success Factors	Blockers
<ol style="list-style-type: none"> 1. Leadership with vision combined with Effective management 2. Teamwork with good lines of communication 3. Time 	<ol style="list-style-type: none"> 1. Inadequate premises 2. Shortage of clinical professionals 3. Lack of time
Enablers and inhibitors of delivery of PMS objectives	
ENABLERS	INHIBITORS
<ol style="list-style-type: none"> 1. Regular 1/12 of contract fee 2. Reduction GMS admin 3. Positive view of PCT motivation 4. Using team resources 5. Seeing advantages in a quality based contract 6. Able to bring services from secondary to primary care 7. Do not want to go back to GMS 8. Good IT delivering good data to inform quality of service 9. Opportunities for training and personal development 	<ol style="list-style-type: none"> 1. Based on historic payments 2. PMS information demands 3. Cynicism about managers' 4. Stuck in historic roles 5. Unable to move beyond apparent perverse incentives 6. Can't move on from current service delivery model 7. Could the new quality based GP contract be as attractive 8. Unable to understand own population health needs 9. Training not related toward the needs of the service

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

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

For example:

1. The costs of new services had to be more than counterbalanced by new income.
2. The reduction in paperwork associated with the traditional model of practice had to be greater than the additional reports and information demands needed in PMS.
3. 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.

4. 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. This was one of the perverse incentives within the scheme.
5. The ability to innovate, raise quality standards and operate flexibly to meet local needs has to 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.
6. 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.

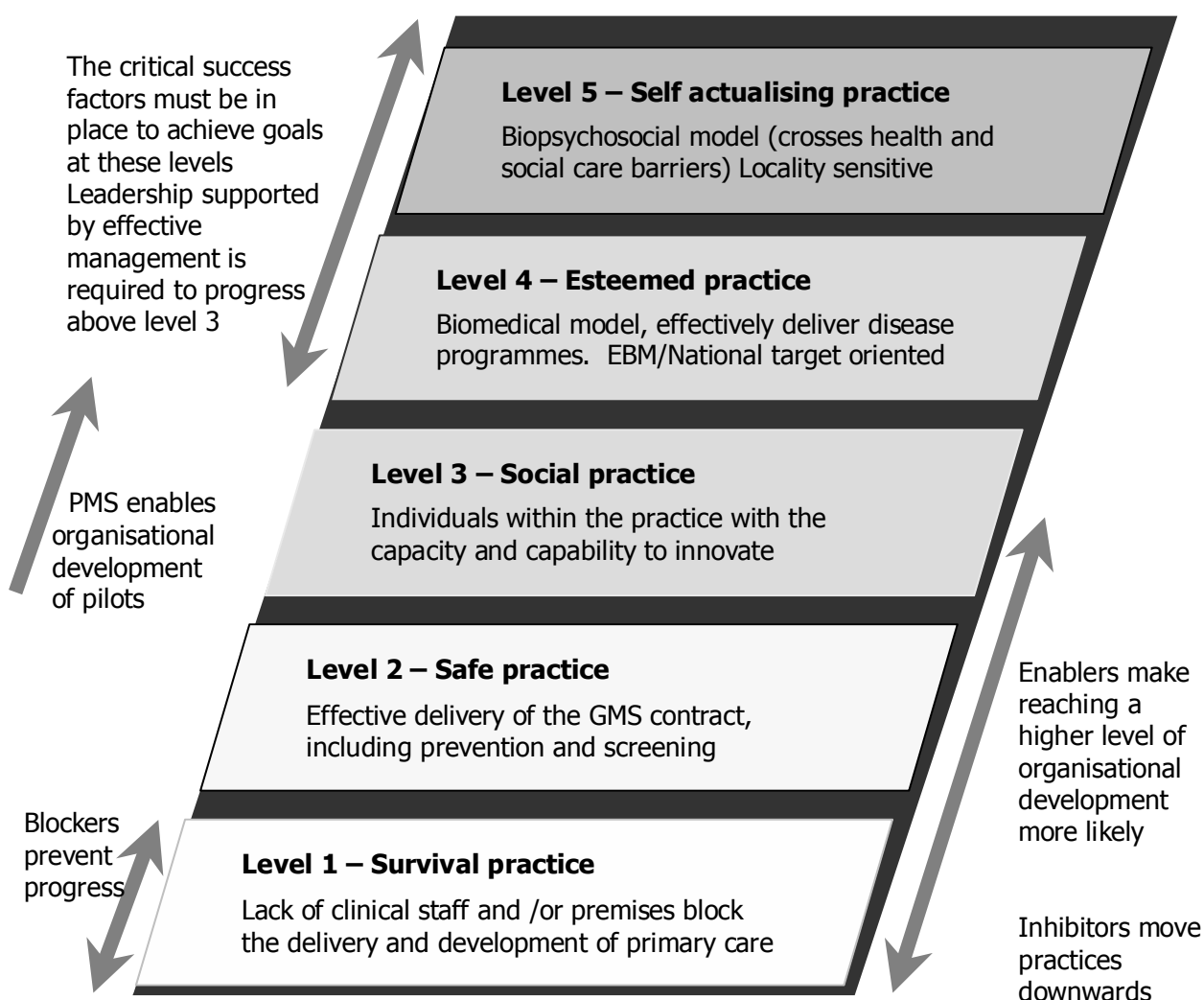


Figure 3. The level of organisational development of a PMS pilot and its influence on which objectives are feasible. (Level titles taken from Maslow, 1954¹⁷)

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.

Discussion:**Principle findings:**

PMS provides a framework for quality orientated, locally responsive primary care. However, for it to be effective there are critical success factors that must be in place, and potential blockers on progress must be removed. In addition a raft of other factors, none of which alone can block or drive progress, must be balanced in the direction of progress.

By way of contrast with the traditional GP contract, where a lot of the managerial effort within the practice is put into completing claim forms for services provided, in PMS the business and clinical functions are aligned.

PMS can give considerable power to the professional partnership of doctors who 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 to even take on services formerly performed in secondary care. However, the practices that considered themselves successful within PMS had often taken this power and then given it away to broadly based teams. Initially these teams would be within their practice; but then later would incorporate others from outside. These would be drawn from within primary medical care as well as 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. It also highlights the importance of having health service managers with vision; who also have an understanding of how the flexibility of PMS can be deployed to deliver primary care services matched to the needs of the local community.

Comparison with the literature:

These findings appear to the authors to be compatible with those found in the National Evaluation of First Wave PMS⁸. However, they go beyond 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 Senge¹⁸. He 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.)

Alignment of primary care's contract with its core function, is widely supported within the management literature. 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.

The management style of LSL, in encouraging the use of PMS to provide locally tailored services is very much in line with what is set out in the Audit Commission's Health Bulletin on PMS².

Weaknesses of the study:

The funding body, who had very clear ideas as to how the evaluation should take place, defined the specification of the study. In one sense this was a strength, in that having clear ideas is a help; its downside was that the evaluation team maybe spent too long collecting too much data, where further analysis from different view points may have produced a greater range of outputs. The study context was a single health authority area within South East London, and it is hoped that the lessons from this area are generalisable.

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 to identify where extra resources or training should be applied and to improve the chances of a PMS pilot succeeding. It also illustrates how managers might use PMS to improve services or to provide locally tailored services to meet the needs of their population or a group with special needs within it.

Conclusions:

Primary care professionals are generally supportive of PMS as a quality orientated, locally sensitive contract. They perceive it to achieve this in the right circumstances. Three critical success factors were identified that need to be in place if PMS is to deliver its intended objectives. These are:

1. Provision of additional clinical staff, preferably GPs to free up time;
2. Professional leadership and
3. A cohesive primary care team.

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.

If this model can be demonstrated to be valid and reliable it may be possible to identify those practices who can lead locality based and quality based improvement in primary care, and those that may require more support.

PMS could be strengthened as a tool for health improvement if it is deployed only to practices who are at a stage of organisational maturity that can benefit from it. It should be instituted in localities where the priorities of the local community will not be met by the "one size fits all" quality based contract for general practice.

8. Acknowledgements

This study has been funded by Lambeth Southwark and Lewisham Health Authority. Tireless enthusiasm and support has been given by the LSL PMS Evaluation Steering Committee, listed at the front of the paper. The views expressed within the paper are those of the evaluation team, and not necessarily shared by the former health authority or its sub-committees.

Thank-you to all the practices who gave up their time for the interviews, and for professional colleagues who gave their views of the manuscript at its various stages of development.

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