



Alternative Providers of Primary Care in the English National Health Service: A study of commissioning, organisation and operation. Final Project Report

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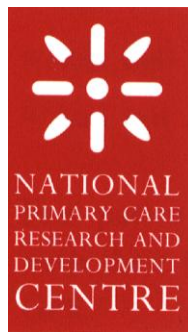
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Alternative Providers of Primary Care in the English National Health Service: A study of commissioning, organisation and operation

January 2011

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and Professor Stephen Harrison**



The research reported here was funded by the Department of Health as part of its core annual grant to the National Primary Care Research and Development Centre (NPCRDC). The views expressed are those of the authors

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Glossary

AD	Assistant Director
APMS	Alternative Provider Medical Services
APPC	Alternative Providers of Primary Care
DH	Department of Health
EAPMC	Equitable Access to Primary Medical care
FPCP	Fairness in Primary Care Procurement
FT	Foundation Trust
GMS	General Medical Services
GP	General Practitioner
HC	Health Centre
KPI	Key Performance Indicator
LMC	Local Medical Committee
NSR	Next Stage Review
PBC	Practice-based Commissioning
PCT	Primary Care Trust
PCTMS	Primary Care Trust Medical Services
PMS	Personal Medical Services
QOF	Quality and Outcomes Framework
TPP	Total Purchasing Pilots

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From January 2011 researchers undertaking this study are affiliated with the Health Policy, Politics and Organisation Group (HiPPO), Community Based Medicine, The University of Manchester.

Executive Summary

Background

Since the inception of the NHS, primary care services in the UK NHS have been delivered by groups of general practitioners, mostly working together in partnerships holding contracts with the NHS. Within this overall continuity, however, there have been a number of changes to the *types* of contracts which may be held. At the present time, there are five possible contracting routes by which a practice may provide NHS primary care services:

- GMS contract – this is the most common form of contract. It is subject to national terms and conditions
- PMS contract – this is a locally negotiated contract, which may focus upon the delivery of services specific to the needs of the local population
- PCTPMS – this contract allows PCTs to employ staff directly to deliver services
- APMS – this is a locally negotiated contract to provide services. It may be held by a provider outside the NHS, such as a private company
- SPMS – this is a contract to provide specialist services, such as those for the homeless or drug users.

In response to perceived under-provision of primary care services in some areas, the Department of Health initiated two rounds of commissioning new primary care services, using the APMS contracting route. These were called 'Fairness in Primary Care Procurement' (FPCP), and 'Equitable Access to Primary Medical Care' (EAPMC). Ten PCTs participated in FPCP, with most of these procuring a single new practice. In EAPMC a total of 112 new practices in 50 PCTs were procured. Successful bidders for these contracts included private companies, social enterprises and other mutual organisations, groups of existing GPs and organisations integrating with other NHS providers such as Foundation Trusts and providers of out of hours care. We have called these types of organisations 'Alternative Providers of Primary Care' (APPC).

Aims and objectives

- To understand how PCTs conceptualise and carry out the task of commissioning primary care services from non-traditional providers (APPCs) of primary care.
- To understand how PCTs manage primary care contracts with APPCs.
- To understand how APPCs carry out the task of providing primary medical care services.

Design and methods

We undertook a 14 month study comprising two case studies. Each case study included a geographically-defined cluster of a PCT / group of PCTs (working together for the purposes of commissioning) and some or all of its associated APPCs. These were selected purposively so as to provide a sample in which there was both (a) a variety of forms of APPC (see above) and (b) a number of common contexts in which PCTs interact with these providers. Following appropriate ethics and governance approvals, data collection included:

- Observation of 27 meetings (total approx 65 hours of observation) between PCT staff and APPC owners/employees.

- Interviews with 23 staff from both PCTs and APPCs.

Interview transcripts and observational fieldnotes were analysed together using the qualitative data analysis programme Atlas.ti

Results

1. Procurement

Both of our research Sites had undertaken the procurement of new practices under both the FPCP and EAPMC rounds of commissioning. The procurement timetables for both FPCP and EAPMC were imposed by the Department of Health (DH) and were regarded by our respondents as tight and difficult to meet. The procurement process was costly in both time and monetary terms, with costs only partially met by the resources allocated by the DH. The availability of timely guidance from the DH was regarded as a problem by some. In some local areas the procurement process was contentious, with significant opposition from local GPs and their patients, but this was not universal. There was considerable concern from both sites about the possibility of legal challenge associated with the procurement process. In Site 1, the siting of new practices was determined by the degree to which local areas were regarded as 'under-doctored' and by the need for the PCT to divest themselves of practices run under PCTPMS contracts (the latter under the FPCP round). In Site 2, the PCT were less happy with the official DH designation of some areas as 'under-doctored', arguing that the formula used to calculate this was flawed. Availability of premises was an issue in both sites, with many new practices occupying temporary accommodation initially.

2. Models of APPC

We found examples of a number of different ownership models, including:

- Commercial private companies
- Commercial private companies in partnership with local GPs
- Social enterprises
- Partnership between an out of hours provider and local GPs
- Existing GP practices tendering to provide a new practice
- Partnership between a PCT provider arm and a local GP commissioning group.

We did not find any systematic differences between these models, although a small number of respondents did comment that the larger private companies were 'more business-like' and therefore a little easier to deal with. However, it was also commented that some larger providers had failed at the bidding stage to make their bid sufficiently locally focused.

3. Contract and performance management

APMS contracts were much more tightly monitored than their GMS counterparts. In Site 1 this process was formal, involving quarterly 'preliminary meetings' followed by formal meetings (performance and reconciliation) to discuss performance against a large range of Key Performance Indicators (KPIs). In Site 2 there were similar KPIs, with regular monitoring meetings, but the process was slightly less formal. In both sites KPIs covered the following 5 domains:

- access; quality; service delivery; value for money; and patient experience.

Under each domain there were up to 21 specific indicators, and 25% of the contract value was dependent upon meeting these. There was a small amount of evidence that this tight specification could cause problems with, for example, one APPC arguing that a particularly tight definition of time taken to 'triage' walk in patients was preventing them from focusing upon the desirable goal of ensuring that all patients were seen as quickly as possible. We found a number of examples of both KPIs and contract terms which were regarded as being unclear, requiring further negotiation and discussion. In Site 1 this was compounded by the fact that a different team was involved in monitoring the contract from that which undertook the procurement. In Site 2 there was overlap between these teams, ensuring that those monitoring the contract were aware of the intentions behind individual clauses. The monitoring process was regarded as time consuming for both PCT staff and practice staff. We also found that the experience of tightly monitoring APMS contracts in this way had caused PCT staff to start to think about standard GMS performance in a different way.

4. Provider behaviour

New APMS practices sought to attract patients in a number of ways, including leafleting, setting up stalls in supermarkets and one-off themed events. This attracted some criticism from existing GPs. As the contracts progressed, recruitment was felt to come more from personal recommendations than from specific marketing events. Virtually all of the new practices that we studied had struggled to meet their target list sizes, even those in areas identified beforehand as 'under-doctored'. A number of contracts were running at a loss overall as a result of the difficulty in recruiting patients. Most of those with a contract to see 'walk in' patients were over-performing on this element of the contract. In terms of services provided and ways of working, newly set up practices did not appear to differ systematically from traditional GMS practices. However, a number in Site 2 had struggled to recruit permanent medical staff, and were employing locum cover extensively. In Site 1, by contrast, there was a financial penalty associated with using locum doctors, as the PCT regarded this as harmful to continuity of care.

5. Professional relationships, externalities and outcomes

Hostility to the new practices from existing GPs varied between areas. There were particular tensions in areas where new practices were expected to share premises with existing practices, and this had caused some problems. The APPCs that we studied had at times struggled to become involved with local collaborative working arrangement such as Practice-based Commissioning, even though it was specified in their contract that they should take part. There was some evidence that practice managers associated with the new practices were not welcome in existing local managers' groups, although previous local employment of particular individuals could mitigate this. PCT staff were asked if APMS contracts were regarded as value for money, and many said that they were not at present, mainly due to their difficulties in recruiting patients. However, some staff did feel that the existence of the new practices had caused local existing GPs to 'raise their game', by, for example, extending their opening hours, improving the local quality of service overall.

6. Impact of the 2010 Health White Paper

The main practical impact of this in our sites was that a number of the staff responsible for monitoring the AMPS contracts were being made redundant. The future of APMS contracts under the new proposals is not clear, but it seems unlikely that such a time-consuming process of contract monitoring will be possible if staff numbers are reduced.

7. Perceptions of 'success' and problems experienced

All of our respondents were asked what their definition of 'success' for an AMPS contract would be. The answers varied and often included multiple criteria, but included measures such as:

- Meeting the KPIs within the contracts to date.
- Meeting QOF
- Patient satisfaction rates
- Increasing list size / financial stability
- Renewal of contract after initial 5 year period
- Staff stability / staff morale high
- Providing services in adverse circumstances (premises etc)
- A well functioning practice
- Providing additional services to benefit local population
- Good working relationships
- The development of score cards for practice performance

Problems experienced included:

- Difficulty in attaining predicted list sizes
- Turnover of GPs within some of the contracts
- Difficulties in employing full-time GPs
- Co-location of some practices with established practices, and associated conflicts
- Definitions and interpretations of KPIs / targets etc within the contract

Conclusions

Overall, we found that both the procurement and monitoring associated with AMPS contracts were time consuming and labour intensive, and it seems unlikely that it would be feasible or desirable to extend this type of detailed performance management to existing practices. However, there was some suggestion that the experience of managing contracts in this way had encouraged PCT staff to think about GMS contracts in a different way and to be more challenging about performance. Costs per patient are high, largely due to the failure of new practices to recruit the number of patients expected, and there was some concern that the existence of walk-in facilities was stimulating demand for health care in a way that was unhelpful overall when budgets are tight. There were no clear systematic differences between the different models of APPC ownership, and there was some suggestion that the existence of APPCs in a local area had had a beneficial effect on local GPs, causing them to improve the services that they provided. Overall, whilst we found some individual examples of practices that appeared to meet a local need for additional GP services, the difficulty that most new practices had had in attracting permanent registrants suggests that the principal impact of APPC practices in the two cases that we studied was to stimulate changes in behaviour by both PCT staff and existing GPs, rather than any more direct effect in providing additional access to primary care for patients.

Background and rationale for the study

Background to the project

The National Primary Care Research and Development Centre (NPCRDC) at the University of Manchester began studying Alternative Providers of Primary Care in early 2010.

Investigators

Dr Anna Coleman, Dr Imelda McDermott, Dr Kath Checkland and Professor Stephen Harrison.

Rationale

The organisational form of National Health Service (NHS) primary care has in broad terms remained unchanged since 1948, with services delivered mainly through small organisations of self-employed GPs and GP partnerships working to the national General Medical Services (GMS) contract. Within this overall continuity, however, the contractual basis of primary care provision has been changing for some time. Perhaps most importantly, the principle (first introduced on a voluntary basis in 'PMS' contracts in 1998) that it is the general practice as a whole, rather than the individual general medical practitioner (GP) that holds a contract with the NHS became compulsory in the new GMS contract of 2004. This and other factors (such as the 'Quality and Outcomes Framework' [QOF] of incentives in the 2004 contract) have been associated with significant changes in the organisation of general practice, including more proactive approaches to chronic disease (e.g. Checkland et al 2008), more flexible approaches to 'out-of-hours' services (Richards *et al* 2008), and the greater employment of salaried GPs willing to see general medical practice as a job rather than as a business (e.g. Jones and Green 2006). However, it is the subsequent introduction of APMS ('alternative provider medical services') contracts in 2004

(http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4080264) that creates the possibility of more radical departures from the longstanding arrangements we set out above, since APMS contracts are potentially available to organisations other than traditional practices and partnerships. APMS seems originally to have been conceived as a means of increasing the supply of primary medical care in localities that were either unable to fill specific practice vacancies or were more generally 'under-doctored', and was given national prominence through the 'Fairness in Primary Care Procurement' exercise developed to deliver the commitments of the White Paper *Our Health, Our Care, Our Say* (Department of Health 2006) and implemented from April 2007 (Department of Health 2006; 2007a).

More recently, however, as the concept of World Class Commissioning (WCC) (Department of Health 2007b) has become established as the principal vehicle for NHS service and quality improvement, APMS contracts have been seen as providing the possibility for Primary Care Trusts (PCTs) to *commission* primary care in a more proactive manner than has traditionally been the case. This possibility was also emphasised by the NHS Next Stage Review (NSR – the Darzi Report, Secretary of State for Health 2008), which committed to a number of goals that will affect the organisation of primary care services. These include:

- Renewed commitment to patient access at convenient times;
- Reinforced ability for patients to choose their GP practice;

- Growing range of health services delivered in GP surgeries; and
- Better co-ordination of services between family doctors and community health services, between primary care and hospital services, and between the NHS, local government and the third independent sectors.

The NSR did not propose a national blueprint for how these goals were to be achieved, as a result of which numerous local and medical professional developments have occurred. Moreover a change of government occurred in mid-2010 (during the course of the present research) and we discuss this in greater detail below (policy context p11). At this point we can note that the new government has placed some emphasis on the need to *commission* primary care services. Thus it seems likely that over the next few years, models of primary care provision that differ from the 'traditional' model of a partnership of GP Principals practising mainly in a single location will develop. Our preliminary intelligence-gathering for the present project suggested that at least six broad varieties of such non-traditional forms of primary care provider (Alternative Providers of Primary Care – APPCs hereafter) seemed to be emerging, though these categories are by no means precise and the terms used to denote them have not become standardised. Moreover, these new forms seem to be developing at somewhat different rates and with considerable geographical unevenness. At the outset of the project, we tried to identify possible forms which included:

- Horizontal integration - ownership of multiple traditional general practices by a traditional GP partnership, though not necessarily involving spatially concentrated practices;
- The 'federated' model of several traditional practices in a defined geographical area, advocated by Royal College of General Practitioners;
- Former PCT 'provider arms', operating as social enterprises or seeking Trust and Community Foundation Trust status;
- Corporate companies;
- GP-led health centres or 'equitable access' practices (the phenomenon formerly known as polyclinics); and
- Vertical integration, i.e. Foundation Trusts or NHS Trusts providing primary care.

These new provider organisations had not prior to this research, been studied to any great extent. For instance, the ongoing Health Reform Evaluation Programme study of provider diversity by Bartlett et al (2010) was almost entirely focused on secondary care. Allen et al (forthcoming) have also been funded by the same programme to investigate the development of Community Foundation Trusts which overlaps with the third of the above categories. Moreover, few researchers have examined everyday organisation, management or commissioning processes within PCTs; most published evidence addresses more strategic questions such as PCT size (e.g. Bjork et al 2004) and the effects of mergers (e.g. Cortvriend 2004). One important exception to this general statement is the body of research about the various forms of 'clinical commissioning', from GP fundholding (e.g. Glennerster et al 1994), through 'total purchasing' (TPP) (e.g. Mays et al 1998) to practice-based commissioning (PBC) (e.g. Coleman et al 2009; Curry et al 2008). A common theme in this body of literature, at least so far as TPP (Abbott et al 2008) and PBC are concerned, is that closer relationships between GPs and PCTs have occurred, a point to which we return below. A second exception is that our own SDO-funded study (SDO 240/2008) does focus on middle management and GPs with organisational roles in PBC, so that we expect the study proposed here to be

complementary. Overall, however, the project addresses an area where research is required.

Research aims and questions

There are two major axes of potential difference between APPCs and traditional NHS primary care that may be expected to give rise to different ways of operating and different ways of relating to other NHS institutions. First, APMS contracts are designed to provide greater flexibility for PCTs to respond to the needs of their local populations (http://www.dh.gov.uk/en/Healthcare/Primarycare/Primarycarecontracting/APMS/DH_4125919#_1), so that those APPCs governed by this form of contract may (other than in relation to the Quality and Outcomes Framework) have more tightly-specified external requirements than traditional GP practices. Second, as noted above, APPCs may have a variety of ownership forms, which are also likely to impact on their methods and relationships and cannot simply be assumed to share the understandings and values of what has been referred to as the 'NHS family' (Evans 2007) of longer-standing organisations. The above developments are thus of research interest from the perspectives of both commissioning and service organisation and provision. In each case, we have an overall research aim and a number of more specific research questions that bear on, but do not exhaust the overall aim.

In relation *to commissioning*, our primary interest arises from the relative novelty of specifying the content and required standards for primary care in a context where GPs' services have traditionally been governed by a somewhat vaguely-worded contract and in which even the highly-specified requirements for performance pay (Quality and Outcomes Framework - QOF) are formally voluntary. In this respect, our overarching aim is *to understand how PCTs commission primary care*. The specific questions that the project addressed included the following:

- How do PCTs conceptualise the task of commissioning primary care?
- How do PCTs specify the primary care to be commissioned?
- What role do such specifications play in decisions to commission from particular providers?
- How do PCTs organise the subsequent performance management of relevant providers, e.g. through 'relational' or more explicit forms of contract?
- What, if any, assumptions and preferences do PCTs have in relation to particular models of APPC, and how do these relate to commissioning decisions?

In relation to service *organisation and delivery*, our overarching interest was in APPCs as new forms of organisation whose *modus operandi* may well be very different from that of traditional general medical practice at a time when improved integration between all NHS services is a central policy objective (Secretary of State for Health 2008, 2010). Our overarching research aim was *to understand how APPCs are organised and operated in the provision of primary medical care to the NHS*. More specifically, the proposed study sought to address the following questions:

- How do the different types of APPC seek to attract business in terms of both
 - marketing and
 - competitive strategy more generally?

- How do the different types of APPC organise the provision of services in terms of
 - skill-mix,
 - specification of work (e.g. in 'patient pathways' or the use of formal protocols),
 - in-house vs subcontracted care and
 - relationships with secondary care consultants etc?
- What is the impact of the different types of organisation and their choices about how to organise services on
 - the professional identity of staff and
 - relationships between staff in different professional groups?
- What are the externalities created locally by the existence of these new forms:
 - are they associated with changes in the *modus operandi* of existing traditional practices (such as extended opening hours), and
 - how do they integrate and interact with existing local professional groups such as PBC consortia or the Local Medical Committee?

As researchers of contemporary policy and organisation, we aimed both to contribute to the relevant academic literature and to inform policy (details of our dissemination strategy are given below). As noted above, contemporary developments in NHS primary care are fluid and quite fast-moving, so that we aimed to be able to provide valuable evidence about their substantive impact at grass-roots organisational level.

Design and methods

We carried out a 14 month project comprising two case studies. The duration and scale of the study were constrained by the need to complete the work within the remaining currency of the NPCRDC core grant, that is by the end of 2010. For our purposes, a 'case' is seen as a 'bounded system of interest' in respect of which the researchers seek to understand how participants enact their world but also to provide NHS policy makers and participants with 'vicarious experience' as a basis for 'naturalistic generalisation' (Stake 1994). Each case study comprised a geographically-defined cluster of a PCT / group of PCTs (working together for the purposes of commissioning) and some or all of its associated APPCs, selected purposively so as to provide a sample in which there was both (a) a variety of forms of APPC (see above) and (b) a number of common contexts in which PCTs interact with these providers. This design aimed to allow us:

- To compare different organisational forms and modes of operation of APPC in the context of a common commissioning PCT;
- To compare the primary care commissioning strategies of two PCTs in relation to a range of APPCs; and
- To observe contextual effects (externalities) of APPCs in relation to traditional forms of general medical service provider.

The *data collection* methods used were qualitative and, as with much of the research team's recent work, placed considerable emphasis on observation in addition to interviews and analyses of available documentation (e.g. Coleman *et al* 2009). It was not possible to state in advance the ratio of observational data to other forms of data that would be collected, since much depended on the type of access granted by the

organisations being studied. Although we treat the results of the triangulation of data from multiple sources as a matter of reflection rather than as a simplistic test of validity (Murphy *et al* 1998 p184), it is important to recognise that observation can lead to the identification of important matters that would otherwise be hard to detect (e.g. Coleman *et al* 2009 p36). Observation focussed mainly on two aspects of PCT and APPC operation. First, a great deal of contemporary managerial and organisational work is accomplished through oral communication and more specifically in meetings (Tengblad, 2006); they can be regarded as *constituting* work rather than simply talking about it. Thus, we have observed meetings (within and between these types of organisation) at which commissioning and/or service provision and/or the organisation of provider work are discussed. Observations were recorded by the researcher in handwritten contemporary fieldnotes, and typed up soon after the event was observed.

We also undertook semi-structured interviews with managers and professional staff from the various types of organisation. We initially identified respondents from their formal organisational positions, but supplemented this selection as result of material arising in earlier interviews or from observation that we wished to follow up. Interviews were shaped by an outline topic guide, initially developed to reflect our understanding of the main issues surrounding the development of APPC and subsequently modified to allow testing of emerging analytical themes. Interviews were audio-recorded in full with the informant's prior consent. We viewed responses as constructed objects that arise from the interaction between interviewer and interviewee in a particular context, rather than as 'straightforward' accounts of a situation. Comparing interview responses with data collected by observation of formal meetings and informal gatherings of actors allowed the development of a more nuanced understanding of the situation under investigation.

We also collected background documents (such as tender documents, business plans, discussion documents, performance reports and minutes and agendas from meetings) relating to APPC and to primary care commissioning, along with documents specifically relating to meetings that we observed. Our recent experience has been that such documents can often be provided in electronic form. We did not subject documents to a formal line-by-line analysis, but used them to provide a further point of comparison between what might be termed 'public' information disseminated in written form and more private or contingent information discussed orally.

Our approach to *data analysis* was as follows. Primary data (fieldnotes, transcripts and documents) were entered into a single hermeneutic unit in Atlas.ti software, in order both to organise the large amounts of data to be collected and to provide a space within which the team were able to work together on the analysis. First level coding (Miles and Huberman 1994) provided an initial categorisation of responses and incidents recorded in fieldnotes according to a framework developed from our research questions. Later stages of analysis used more inductive coding, enabling our analysis to address issues not directly anticipated in the research question but which may nevertheless have important policy implications. Emerging themes and theoretical ideas are discussed and refined throughout the research at research team meetings and through written memos, allowing precise definitions and use of codes to evolve.

As a consequence of the emergent and contingent nature of the data collection and analysis process, it was not possible to specify in advance the precise number of observations or interviews to be undertaken, and indeed there was no methodological

imperative to do so. During the course of the research we achieved 27 observations and 23 interviews across the two sites as shown below in Table 1.

Table 1: Fieldwork

	Interviews	Observations
Site 1	16	22
Site 2	7	5
Total	23	27*

**In terms of observations in Site 1 we observed 11 preliminary meetings (ave 2.5hrs), 9 performance reviews / reconciliation meetings (ave 2.5 hours), and 2 others (ave 2.5hrs). These include more informal discussions pre and post meetings with APPC and PCT representatives = approx 55 hours of observation. In Site 2 we observed 5 performance reviews and other meetings (ave 2 hrs) = approx 10 hours of observation.*

Site 1 was a PCT which was not affected by the 2006 reorganisations. It serves a population of over 300,000 people through over 50 GP practices and over the last few years several new practices have been commissioned. Commissioning of primary care services is located within a different Directorate (Commissioning) to monitoring of primary care services (Medical Director / Primary Care). Under the Director of Commissioning there are various Assistant Director (AD) posts including AD for Commissioning Primary Care, who with his / her team was responsible for the procurement of new practices under the two different rounds of procurement of interest during this research. The role of Deputy Director of Primary Care contracts and monitoring is located under the Medical Director and this AD and team had been responsible for monitoring the new practices and APMS contracts once they were procured. Roles within this structure were changed during late 2009 (just prior to fieldwork commencement) which resulted in different ways of working and the development of different relationships between the people involved at both the PCT and APPCs. Following the publication of the 2010 Health White Paper in the summer, roles again were beginning to change due to the monetary savings required to be made by PCTs. This included the announcement of redundancies within the team(s), general uncertainty and consequently role change. The following was a description given by the AD for Primary Care of the roles operating at the outset of the project:

Once the contract is awarded [me, PCT Officer ID 1.1] and [my] team take a step back and it is [PCT Manager ID 1.6] (Primary care contracts and monitoring) team which looks after day to day management of the contracts e.g. practice visits, preliminary meetings and quarterly meetings. However [PCT Officer ID 1.3] from [ID 1.1] team does attend these meetings. I [PCT Officer ID 1.1] only get back involved if there are problems and therefore changes needed during the contracted time (currently 5 years which then go out to re-tender).

Site 2 was reorganised about two years ago into a cluster of PCTs with a single chief executive, a single executive management team, one clinical executive and one management executive. Some directorates have an executive director lead such as procurement and contract management. The procurement and contract management directorate has 5 Assistant Directors (AD), covering such areas as procurement, acute contract management, and primary care and community. The procurement of the new APMS practices was a joint effort by these teams working together. All ADs are on grade 8D in agenda for change. Performance management of primary care contracts sits within the primary care and community team. The AD is assisted by a more senior manager, and together they oversee managers in 4 different areas - general practice, dental,

pharmacy/optometrists, and community. After the 2010 White Paper publication, the PCT is undergoing another re-organisation, as management costs are cut. Under this process, more functions are being pooled at a regional level. However, there was concern that the distances involved might deter local managers from applying for these posts:

So I suppose worst case scenario is it's too far away, you lose contract managers from this locality and you lose the knowledge and the relationship building that you've had. (PCT Officer, ID 2.3)

Project governance

The study required NHS ethical approval and research governance approval in relation to the specific sites where fieldwork has been conducted. Both were obtained before the project commenced. The main ethical issues relate to anonymity of individual informants, which we seek to preserve at all stages of reporting. The team also anonymise research sites and participating organisations within them (for instance through the use of pseudonyms in publications).

We maintain data security through anonymisation of each unit of data as soon as interview transcription or fieldnote typing (as the case may be) is completed. All data is stored in a single 'hermeneutic unit' in Atlas.ti software on a University of Manchester central computer drive, which means that all analysis involving the primary data takes place in this medium. The material is password-protected and accessible only to the named members of the research team. We never store or analyse unanonymised data on laptops or home PCs. Paper correspondence about research access, ethical and governance approval etc is stored in a locked filing cabinet at the University of Manchester.

A project Advisory Group was constituted, to include a local NHS representative, a relevant academic from another university, and a Department of Health representative. This group was convened 'virtually' at the beginning of fieldwork and used during the research period to test out emerging findings and experiences.

Policy context during the research

After the project began in January 2010, a general election resulted in a change of government and a Health White Paper (Secretary of State for Health 2010) that proposed major structural reforms in the NHS, in particular:

- The establishment of an independent and accountable Commissioning Board. At a strategic level, this board will be responsible for: allocating and accounting for NHS resources; leading on quality improvement; promoting patient involvement; promoting equality and tackling inequalities etc. At a more practical level, the NHS Commissioning Board will be responsible for commissioning primary care services, although it is not yet clear exactly how this will be managed at a local level;
- The abolition of PCTs by 2013; and
- The introduction of GP consortia to commission the majority of NHS services. All GP practices are expected to become a member of a GP commissioning consortium.

The announcement of these impending changes inevitably presented challenges to the research team in terms of access to sites (PCTs and APPCs) and individual members of staff within these. People were understandably concerned with their job status for the future and during this period several people (within PCTs) were told that they had lost their jobs. In Site 2, this appeared to affect the PCT's overall commitment to participate in the study. Numerous meetings were cancelled or postponed into the distant future during the study period and such matters are not merely difficulties for the research team; they tell us something about the impact of new policy on the implementation of existing policy, and are therefore treated as data in their own right.

Context

APMS contract

Alternative Provider Medical Services (APMS) was one of four contracting routes available to enable Primary Care trusts (PCTs) to commission or provide primary medical services within their area (see Table 2 below) at the time of the research.

Table 2: Routes for contracting primary care (adapted from Ellins 2008 Box 1 p2)

Type of contract	Description
General medical services (GMS)	Contract containing nationally agreed terms, funding allocations and service requirements. Negotiated centrally between the Department of health and BMA. Managed at local level by PCTs.
Personal medical services (PMS)	Contract negotiated locally and contains flexibility to develop services to best suit the needs of the local population. However, must provide the full range of essential primary care services.
Alternative provider medical services (APMS)	PCTs can contract with a range of providers including those external to the NHS (see list below). This is a locally negotiated contract use to commission essential primary care services and / or specific elements of service provision.
Primary care trust medical services (PCTMS)	This contract gives PCTs the option to provide services by employing staff directly.
Specialist Provider Medical Services (SPMS)	It is a Personal Medical Services (PMS) agreement but with the key difference that patients do not have to be registered with the provider to receive care [Source: Department of Health website]. It is for minority issue, which allows PCTs to procure very specific services – e.g. you could use SPMS to provide a service for drug addicts.

The introduction of the APMS contract in 2004 allowed PCTs to commission services from a wider variety of providers, including those outside the NHS. PCTs are able to contract for primary medical services with:

- commercial providers
- mutual sector providers
- public sector bodies
- GMS/PMS practices
- through a separate APMS contract with NHS Trusts and
- NHS Foundation Trusts

Under an APMS contract PCTs can specify what they require of the providers, rather than being tied to all the terms of the general medical services (GMS) contract.

Essential and additional services

Essential services include the management of patients who are ill or believe themselves to be ill, with conditions from which recovery is generally expected, for the duration of their condition, including relevant health promotion advice and referrals as appropriate, reflecting patient choice wherever practicable. Also included are the general management of patients who are terminally ill and management of chronic disease in the manner determined by the practice, in discussion with the patient.

New providers are required to provide essential primary care services currently provided by traditional GP practices but can also be expected to provide additional services. There are three types of additional services: 'directed enhanced services' are services that PCTs must provide; 'locally enhanced' services are services which are locally required and agreed; and 'national enhanced services' are services which are designed to meet local needs but which are commissioned to national specifications and with national pricing.

Examples of **Locally Enhanced Services (LES)** include:

- Asylum Seekers
- Dementia Screening
- Find and Treat
- Managing Patients with Stable Psychosis
- Depression
- Palliative Care
- Supporting Patients with Long Term Mental Health Problems
- Hib Vaccine for Young Children Catch-up (redundant from March 09)
- Programme Substance Misuse
- Continuing Healthcare
- Alcohol misuse
- Choose and Book
- IM&T

Examples of **Directed Enhanced Services (DES)** include:

- Childhood Immunisations (at 2years)
- Childhood Immunisations (at 5years)
- Childhood Pneumococcal Immunisations – routine Childhood pneumococcal and catch-up Influenza and pneumococcal immunisations
- Minor Surgery (joint injections and cutting)
- Violent patients (not specific to all contracts)

Examples of **National Enhanced Services (NES)** include:

- Anticoagulation – Level 4
- IUCD (fittings and reviews)
- Homeless (currently under review)
- Near Patient Testing – Level 2

(Source: Guide to APMS quarterly monitoring workbook, Site 1, Sept 2009).

In addition to services such as these, new providers can also be expected to provide longer opening, at least 5 additional hours a week or a minimum of 57.5 hours but often include stipulated opening hours of 8am – 8pm (Monday to Friday) and Saturday mornings (Source: Fairness in primary care brochure, Site 1). Under the 'Equitable access to Primary Medical Care Services' round of procurement each PCT was also required to commission a 'GP-led Health Centre'. These were required to open for a minimum of 84 hours per week (8am-8pm, 7 days a week), and were also required to provide facilities for 'walk in' patients. For their other procurements, PCTs were able to negotiate opening hours to suit the local need (Source: Invitation to Tender document, Site 2).

Thus, whilst the core of the APMS contract is centrally determined (and similar in scope to the standard GMS contract), some options for local variation also exist and were determined locally as part of the negotiation over the awarding of contracts.

Rounds of commissioning APMS contracts

Whilst the *possibility* of using APMS contracts to commission primary care was introduced in 2004 (Department of Health 2004), few practices were procured in this way, at least initially. Following a survey of APMS providers, Pollock et al published a paper in 2007 which provided some details of the involvement of private companies in primary care provision as of that date:

In March 2007 about 30 companies held commercial contracts to provide primary care services in England through their ownership of 74 health centres and general practices, excluding out of hours contracts (see table). The companies comprise general practitioner owned and operated companies; international healthcare corporations, including drug companies; companies with commercial links to the drug industry and healthcare corporations; companies providing catering, cleaning, and laundry services under private hospital contracts; and some joint ventures between these. (Pollock et al 2007:457)

Whilst Pollock et al (2007) describe 'about 30' private companies with involvement in primary care provision, it is clear from their accompanying table (reproduced in Appendix 1) that most of these providers were only involved in a small number of practices at this time. In 2007 the government acted to stimulate the entry of larger numbers of new providers into the primary care market by introducing the 'Fairness in Primary Care Procurement' (FPCP) process. This was followed by 'Equitable Access to Primary Medical Care (EAPMC) in 2008. Ellins et al (2009:798) describe it thus:

"PCTs were initially slow to promote choice and competition in primary medical care" despite the fact that the new process by which alternative providers of primary care were able to bid for and run APMS contracts had been available since 2004. The Department of Health's FPCP scheme (2007/08) helped to stimulate private sector involvement, which was followed by a second EAPMC scheme (2008/09).

1) **Fairness in Primary Care (2007/08)**

According to the Department of Health: “The Fairness in Primary Care procurement has been developed to deliver the commitment in the 2006 White Paper ‘Our Health, Our Care, Our Say’ to tackle inequalities in access to primary medical care services in the most under-doctored PCTs throughout England. The Fairness in Primary Care procurement is expected to provide patients with greater access and choice, including flexible opening hours, extended services and easier access to primary medical care services in their local area”.

(http://www.dh.gov.uk/en/Aboutus/Procurementandproposals/Tenders/Informationaboutprocess/DH_073435 accessed October 2010).

Under this round of procurement only a limited number of PCTs were involved across England with most of them procuring only one practice (http://www.dh.gov.uk/en/Aboutus/Procurementandproposals/Tenders/Informationaboutprocess/DH_074670 accessed January 2011). The procurement was undertaken centrally, consisting two adverts for a national tender which included a section for each participating PCT under the appropriate round. There was support for the procurement process (including help putting together procurement document and pre-qualification questionnaires) but no extra funding for the practices provided and PCTs had to meet this cost.

2) **Equitable Access to Primary Medical Care Services (2008)**

According to the Department of Health, “the NHS Next Stage Review Interim Report” (October 2007) carried out by Lord Darzi, reported that, despite sustained investment and improvement in the NHS over the last 10 years, access to primary medical care services and the quality of those services, continued to vary significantly across England. Many of the poorest communities experience the worst health outcomes and major inequalities exist within the country in indicators such as life expectancy, infant mortality and cancer mortality. In addition, the gap in life expectancy between the most deprived and least deprived areas had widened, despite improvements in life expectancy in the most deprived areas”.

The Department of Health suggested that the Equitable Access to Primary Medical Care (hereinafter referred to as EAPMC) programme would play a significant role in achieving more personalised care set out by Lord Darzi. The focus of the programme was to be on achieving the visions of a fair and personalised NHS (whilst upholding the values of safe and effective primary care service). Ministers announced that the Government would provide new investment of £250m to support PCTs in establishing at least 100 new general practices in the 25% of PCTs with the poorest provision and one new GP-led health centre in each PCT in easily accessible locations.

(http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Aboutus/Procurementandproposals/Procurement/ProcurementatPCTs/DH_086782 accessed October 2010).

There was a Government mandate for all PCTs to procure one GP-led Health Centre and an opportunity for PCTs to procure up to three new GP practices. The core criteria for the health centre and the practices were published but there was scope for considerable innovation to meet local needs.

The NHS Operating Framework 2008/09 confirmed that each PCT was expected to complete procurements during 2008/09 for (as a minimum) the GP services that form the core of these health centres. In addition to the GP-led health centre the PCT was given the opportunity to commission up to three new GP practices. These practices would be over and above those commissioned through the Fairness in Primary Care Procurement. In practice, 112 new practices were procured in 50 PCTs (Department of Health 2008).

Research Findings

1. Conceptualising the task of primary care commissioning and decisions to commission from particular providers

The study found that such decisions are local, contingent and task specific. Thus, for example, in some sites the driving motivation was to provide new services in local geographic areas identified as being under-doctored, whereas in others an additional motivation was to divest the PCT of practices owned and run by the PCT themselves (especially under the Fairness round).

A senior PCT officer described the process of contracting as driven from the Department of Health and by the complexity of the contracts:

My understanding is that they were something that's been pushed from the centre, if you like. And I think, again, going back to the first wave, I think it was something that helped us with our own difficult position. I do feel that the way of...the principal of having the extended hours and the additional services, and the demanding targets – that all sits quite comfortably with me. The bit that I struggle with, is about the complicated way in which the contracts have been designed. I don't know whether...I'm still not sure whether that's a local thing or a nationally-driven thing, with all the KPIs, but it does seem to have made it hard work for everybody. So, my interpretation is very much that we do have to respond to the department, and there are mixed feelings about that. (PCT Officer, Site 1, ID 1.2).

1.1 Under the Fairness round:

Site 1: multiple contracts (for single or multiple practices) were commissioned from multiple providers under this round. Staff, who had been employed by the PCT at existing practice locations, were transferred to work with the new providers. The following is a description of the FPCP round from a PCT officer:

This was where all PCTs in England who were considered under-doctored at that time were summoned to meet the Department of Health in London to provide reasons for this and put forward plans to overcome this in the future. Definite correlation recognised nationally regarding low numbers of GPs / quality of primary care provision / health outcomes (Site 1, PCT Officer, ID 1.1).

According to the same PCT Officer there was little competition felt between the different PCTs involved in the FPCP round and there was lots of interest from potential providers:

all PCTs involved [in this tranche of the procurement] were in same position but didn't feel they were in competition as there was a lot of interest (as there were only a select number of PCTs involved spread around the country). Each PCT within a wave were invited to an event (thinks there were 6 where she presented) where all prospective providers could attend – they provided information about the PCT area and what they were proposing to procure (Site 1, PCT Officer, ID 1.1).

Under this round (FPCP) in Site 1 there were approximately 20 interested providers and 6-8 were interviewed for each contract once the assessment procedure had been completed. This procedure looked at the quality of primary care provision proposed

against cost. If the quality element was met by multiple bidders, it was at this stage that cost became the determining factor.

According to a PCT officer, the Department of Health provided 'experts' in each of the different processes (procurement) who would work with the PCT (at the cost to the Department of Health). The PCT officer additionally said that the process was

helpful as it meant it boosted in-house ability at the time and for the future and provided outside objectivity.(Site 1, PCT Officer, ID 1.1)

There was also a perception from the PCT (Site 1, PCT Officer, ID 1.2) that this process 'killed two birds with one stone' i.e. they were an under-doctored area but the PCT was also running some practices themselves and was under pressure from the Department of Health at this time to divest themselves of their 'provider' responsibilities in order to concentrate on commissioning. The FPCP procurement gave the PCT an opportunity to become commissioners only. It also provided patients with additional choice and helped to smooth out variations in list sizes across the patch:

I think there's something in here about the fact that we were able to divest – is that the right word? – the PCT of the practices they were running. The community arm might argue that they would have quite liked to have kept them on, however, my understanding is that, actually, it's quite difficult to run a practice as a commissioning organisation so, actually, it was one less thing to worry about, almost. I think there was a silver lining in that. (Site1, PCT Officer, ID 1.2)

It is worth noting that reasons given were in keeping with some of reasons set out in Ellins et al (2008:1) for drivers to market development which included increasing capacity and access to primary care in under-doctored areas, creating new capacity in areas of increased population growth, PCTs divesting themselves of directly managed practices and stimulation of innovation.

The APMS contracts procured under the FPCP round started between May and October 2008 in Site 1.

Site 2: Only 1 practice was established under this round (FPCP), providing specialised services. According to a senior PCT Officer, in this PCT area the DH largely managed the tendering process, only passing the contract back to the PCT when it had been fully developed.

And the PCT procurement team worked directly with the Department of Health... I think in reality it was much more joint - the DH ran the procurements, with input from the PCTs. In Equitable Access it was completely the other way around; the PCTs ran the procurements with input and advice from the Department of Health. (Site 2, PCT Officer ID 2.1)

The PCT described themselves as taking the contract that they were given in good faith when it was ready to be signed. However, they told us that in practice they found that the contract they had been given was not fit for purpose, and at the time of the research were still trying to renegotiate some terms with the provider. This PCT Officer expressed it thus:

Right, that was actually, you know, before, all of that was done and dusted when I came and I got the contract and, as I say, on reflection, that contract, more than any others, has caused us some...put us in some significant financial risk in the way that it's been written but, you know, we are where we are and we've got to try and negotiate that with the provider. (Site 2, PCT Officer, ID 2.2)

1.2 Under the Equitable Access round:

Site 1: Under this round of commissioning, several new practices were established (all during December 2009) all run by one provider, two of which were co-located (with shared reception and consultation rooms). No GP-led health centre was commissioned in this site.

This procurement round's criteria were set as a balance between confidence about the ability of the provider to perform vs the cost of the service offered. Several officers at the PCT described this as a possible 'precursor' for the developing a 'balanced score card' which, was at the time of the fieldwork, being proposed to be used for all practices to monitor performance. However, during the time of the research the Local Medical Committee (LMC) was objecting to this. There were many fewer bidders for the contracts in this round of commissioning in Site 1. For one of the three practices there was only one bidder which met the criteria, and so this provider was awarded the contract by default. A PCT officer (ID 1.1) felt this could be because at the time there were more procurements taking place under EAPMC throughout the country, giving prospective providers a wider range of opportunities. The PCT had been expecting large providers such as Tesco or Virgin Health to be interested but such providers did not tender for any practices in PCT1. Bidders were generally smaller in scale and less diverse than those bidding under the previous Fairness procurement round.

Support for the bidding process was given by a central support provider to all local PCTs. This support was described as 'helpful', in that it provided clinical expertise which was objective because it came from outside the immediate area, but it also doubled the approximate cost. According to the PCT, the Department of Health provided approximately £120K for the process but PCTs had to use this to buy the support from the specified central organisation, and the hourly rate / day rate that they were expected to pay for this was seen as very expensive.

In Site 1, according to senior PCT staff, APMS contracts were drafted by lawyers working closely with the commissioning team. The main contract has a standard core but can be changed to reflect local issues (both locally for the PCT area and for individual practice sites). For example, one of the practices in Site 1 specialises in older people and therefore has some different enhanced services agreed as part of the contract. Once the invitation to tender was released, the commissioning team was involved with assessment of the tenders and interviewing prospective providers. This involved strict criteria, a scoring process and also the development of key performance indicators (KPIs) specific to the contracts. In addition there was a public consultation and presentations to the local health overview and scrutiny committee. It was stressed that the procurement process had to be transparent and able to withstand challenge (especially legal) (notes from discussion with Senior PCT representative, ID 1.1 Site 1).

For both the EMPAC and FPCP rounds in Site 1 the PCT drew up maps showing existing GP practices and identifying areas which met the criteria for a new practice. Criteria included the area being under-doctored and having poor quality primary care. This was judged upon performance indicators such as the number of people accessing health services via A&E, hospitals and out of hours services rather than via their own practices. In both procurement rounds there were obvious 'hot spots' of such deprivation. However, in the Fairness round the PCT then had to rate areas in priority order and some areas that were regarded as needing a new practice were missed as there were not enough resources to provide a new practice in all identified locations. However, these areas were subsequently prioritised in the EAPMC round, For example, the second most deprived ward in Site 1 PCT area received no new practice under the FPCP round, but did so under EAPMC.

The following is an extract from an EAPMC internal PCT report in Site 1 (Feb 2008) and describes the process to be followed when determining where newly commissioned practices should be located:

It is essential that due process be followed in determining the location of these new services. It is important that the process stands up to scrutiny and that the PCT can demonstrate that due process has been followed in all aspects of the procurement. The criteria which will be used to reach a decision will be consistent with that used for determining the location of practices as part of the Fairness in Primary Care Procurement, which included, deprivation, capacity to meet health needs based on weighted list sizes per weighted whole time equivalent health professionals (GPs, Nurse Practitioners, Practice Nurses and Health Care Assistants) indicators of effective primary care and the potential for change (potential GP retirements).

Several of the new practices were sited in old PCT-run practices although it was accepted by the PCT (and understood by the APPCs) that new premises would be sought once the contract was up and running. In some cases these new buildings were operational by the end of the research but in a few cases the practices were still in the process of trying to find suitable premises. It is the responsibility of the new providers to find their own premises, but there was an understanding that the PCT would help in this process. Other practices had found homes in buildings co-located with existing GP practices, financed under the LIFT (Local Improvement Finance Trust) system. This is a PCT-financed programme of investment in primary care premises, and in some cases in Site 1 such buildings contained unused space. The PCT required some of these practices to accept one of the new practices, into this space, but this had caused significant local tensions (see section 5.1 Externalities).

In Site 2: In Site 2 the PCT were less happy with the identification of so-called 'under-doctored areas'. There were strong feelings that the methodology used by the Department of Health had been flawed:

- Q: And then the Equitable Access, you were told how many of those?
A: We were, we were told how many practices in which PCT localities....There was challenge in the system, there was challenge from that about how had the Department of Health come to those numbers, it was challenged in action actually, not everyone was happy. We were given some explanation, but it was immovable. The explanation was based on a data set the DH felt demonstrated that there was some areas of the country that were un-doctored, and there was a

formula, which we've never seen, but a formula was used then to identify where there was perceived un-doctored areas. From memory I think it was ten altogether we had....It didn't make sense. The boards challenged it, we challenged it from a contract perspective. At that time we hadn't done procurements, so we didn't have market intelligence, but what we had was contract numbers, patient registered numbers, we knew Fairness in Primary Care had happened in [one of the PCTs in the cluster] so they were getting additional services. If anywhere was un-doctored we recognised and accepted that [one area] was, and that was what the Fairness in Primary Care pilot and initiative had grasped, but we didn't recognise the numbers between [the other areas] or we didn't recognise the scenario that there was under-doctoring, one patch versus the other. There was a lot of kickback from the cluster. There was some kickback elsewhere in the region, [Neighbouring PCT] was where there was problems and challenge particular, and for us in our area [one area] were most persistent.

Q: And that was mainly led by the GPs?

A: And that was led by the GPs, yeah. The board wasn't comfortable with the rationale as well, and I think that's a combination of the board weren't comfortable and everybody was getting a lot of heat from the GPs who had incited that patients to them also complaint. So we were starting a project that we were told we had to do.... We had no influence or control over that project; we had to do it. (Site 2, PCT Officer, ID 2.1)

Here the process ran over three rounds. Procurement was supported by an external purchasing and supply agency.. Bidders were told to submit an Invitation to Tender (ITT), which was scored based on 5 macro levels: workforce, service delivery, IM&T, premises, and finance. Each level has its own weighting. Under each of these macro-level criteria, there were 342 criteria for assessment (based on Department of Health evaluation, strategy, criteria, and score). Two people were involved in scoring each macro level criterion. These were people with a particular expertise for example, clinical issues were scored by clinicians, premises were looked at by the facilities management, etc. Besides score, risk (in terms of finance and service delivery) was also taken into account – whether the bidders were thought to be of low, medium, or high risk. Although bidders' reputation might be taken into account, they were not scored because that was considered 'perception' rather than 'fact'. Each bid was scored at an individual level by the panel and a moderator was present to ensure that there was consensus from the panel. Bidders also needed to complete a financial model template around costing, staffing, premise, rateable value, profit, and risk. The AD of Finance coordinated the finance activities across the area and made use of an external finance company to support this process. According to the a senior PCT Officer, the way the different providers filled in the tender documents could give the PCT an indication on whether they are a national/ bigger provider or local/smaller provider:

Some of it was just very...we could tell it was...And also they bid for more than one thing. So I don't know whether this is absolutely correct in terms of statistics, but the correlation between the bigger the provider and the number of procurements they went for, the higher, bigger provider went for more procurements. Whereas the smaller providers or smaller bidders were interested in a particular procurement for a particular reason, whether it was because it was near their existing practices, whether it was because of a clinical partnership, whether it because they felt it had a bigger profit than other areas, I don't know, whatever it was, there was tactically some decisions about what they went for. The bigger providers were just after gaining scale and gaining a share of the market, and as big of a share as they potentially could get. (Site 2, PCT Officer, ID 2.1)

In addition to submitting tender documents, bidders were asked to do a presentation and take part in a question and answer session with a panel member, who was not given the tender documents or the scoring. This was done deliberately partly because of time and also to get an objective view. Things that panel members had to consider include how the bidder puts themselves across, interpersonal activity, and patient feedback (which was really valued). Bidders were asked standard questions and further individual clarification questions about the bid. They had interest from both local and national companies and groups, although interest varied across the different practices being procured, with one tender receiving no viable bids at all in the first round of procurement. The procurement team were wary of the idea that a single company might procure a large number of practices, as they felt that this might make performance management of the contract more difficult. They therefore introduced their own criterion into the process by which a single company was not allowed to bid for more than a certain number of contracts. Subject to this limit, the scoring process was anonymised so as to avoid any observer prejudice influencing the process. This PCT officer explained it thus:

- Q: Did you get a sense from their documents [which one came from which provider]?
- A: Well, yes, in some way, but it didn't always happen because sometimes they forgot to change the name [of the practice they were tendering for], that happened quite a lot. So sometimes that wasn't good in practice, sometimes it was just actually, it wasn't personal enough to the particular procurement, and that didn't do them necessarily any favours. So I don't think that there was advantage to be gained from being [a big provider] in terms of the evaluation. It was about the response to the procurement that that particular panel was evaluating. (Site 2, PCT Officer, ID 2.1)

The PCT also ran a public consultation, focusing on issues such as services and location. The location was determined based on where there was the lowest ratio of patients to practice or where there was an area of greater deprivation. However, location was only used for some practices as some of the locations were pre-determined (for example the GP-led health centre) as part of strategic intent of the local authority. The PCT ran up to 2 public consultations and additional one if required. This process was quite fraught, with significant public disquiet voiced at some of the meetings:

And the consultation was ...difficult. The problem with the consultation was having to be part of the PCT panel with a very set strict, I mean very set, we didn't move off scripts, and there was a line, a communications line that we took that fitted with our strategy et cetera. To have to stay within that whilst being heckled by some very angry residents and very angry patients who have been incited to that anger by GPs who were potentially, well, not potentially, were sitting in the room alongside them, and we knew they'd put bids in. So on the one hand those individuals were creating that unnecessarily anxiety in patients, really unhelpful for patients feeling very threatened, and that confrontation while putting a bid in to get the business, just for me morally that was uncomfortable, and difficult not to go, 'ew!' 'I can't believe you're sat there...'We couldn't have moved off script, it wouldn't have been fair, it wouldn't have been appropriate, we could only discuss within the consultation the things we were consulting about, and some of the issues that patients were raising we were not consulting on those issues. What the patients wanted to talk about was Dr Bloggs who they love and like and didn't want to lose, and having to move, because all his patients have moved. But it's very difficult not to say, 'well, if you love him so much, you won't have to go anywhere because he'll still be there!' If he buys or bids for and gets the practice up the road, and decides to shut his surgery, well, that's his decision as a businessman. But we couldn't

have that kind of conversation in those [meetings]and obviously the line was much more about creating access for patients and improving services and investing in primary care, and you have a say and you can influence and we want to hear your views, and actually if you tell us what you want then we will try to make sure that happens. If you don't tell us then you will get what you're given, and that may not be what you want. (Site 2, PCT Officer, ID 2.1)

One of the managers involved (Site 2, PCT Officer, ID 2.2) described attendance at these meetings as very 'intimidating'. It also got quite 'boring', because the same people attended meetings in every area, and asked the same questions. The thrust of the argument made by those opposed to the process was that the whole thing was costing a great deal of money, and would it not have been better to give the money to the local GPs to take on more staff and improve their services? This is a point of view with which the PCT staff had some sympathy, but they described themselves as 'tied by the Department of Health rules'. They described their frustration that patients didn't seem to grasp that GPs are independent business *men* themselves, and described the GPs as 'disingenuous' in pretending that they were 'the NHS' and the bidders were 'private companies'. After a number of very acrimonious public meetings and after negotiation with the DH it was agreed that one of the new practices could be moved into a neighbouring area, serving much the same population. The GPs in the new area showed little resistance, and were described by the PCT as 'complacent' about any threat of competition from new providers.

In this site the final contracts agreed were all very similar to one another, but tended to differ with regard to expected hours of opening and in relation to the treatment of unregistered patients. Some practices were contracted to provide walk in centres for unregistered patients alongside their services for registered patients, whilst others were contracted mainly for services to registered patients. However, these latter were also allowed to see unregistered patients who booked appointments, although NOT those who walked in. This distinction proved difficult to operationalise in practice.

Decisions to award the contract were made by a procurement board which had representatives from the various localities working together.

Overall, it was clear that procurement in Site 2 took place as a result of central direction (by the Department of Health) rather than as a response to a locally determined need for new practices. The process was not used by Site 2 to divest themselves of directly run PCTMS practices, and, whilst improving services in 'under-doctored' areas was a motivation, in practice PCT managers told us that one of the main advantages of the process was the fact that it caused existing GPs to look at the services that they provided, and, in addition, gave the PCT a clearer set of criteria against which to assess all general practices.

When it came to choosing the sites for the practices, it was a matter of pragmatism (where there any suitable premises available) and looking for 'under-doctored' areas. For example, one practice is situated in an isolated community which historically had no GP practice. The local community were very supportive of this, with local councillors engaged in the consultation process.

Whilst overall the procurement process was described as being quite fraught, by the time of data collection it was acknowledged that the dust was beginning to settle.

However, there were still some ongoing conflicts. For example in Site 2, one of the APPCs was waiting at the end of the research for its purpose-built premises to be ready. In the meantime, it was occupying space in a new community hospital. This hospital contains several local GP practices, and a minor injuries unit (MIU). This APPC is allowed under its contract to see patients from other practices, but NOT on a walk-in basis – they offer bookable appointments for un-registered patients. However, as the APPC and the MIU are sharing a common reception desk, there are instances where the receptionist would send patients to the MIU instead of the APPC. At the MIU, patients would wait for about two hours before being told that they can't be treated there and ask them to go to the APPC instead, which the patients thought to be part of the hospital. Patients are not happy because they are asked to fill in further paper work after their long wait. The director of this APPC argued that the MIU is breaking restriction of trade.

In Site 2, there was another example where an APMS practice is located in an area where there were already a number of traditional practices and much concern was expressed by these practices during the consultation period that their patients would move to the walk-in centres. After negotiation, it was agreed that the APMS practice would offer only walk-in services to start with and the registration of patients would begin only when the contract had been running for a number of years.

1.3 Procurement in the longer term

Procurement is recognised in Site 1 as an ongoing process although senior PCT managers do not see the process being done on such a large scale again in the shorter term.

I suppose, an interesting question because we're in interesting times, aren't we? I mean, for the last twelve months really, we've been hearing the mantra about £20 billion needs to be saved out the NHS and, within that, I've seen little snippets of savings of ten PMS within primary care contracts. So, I don't see how that would fit with new waves of APMS, because it would be very difficult to save ten percent, and yet have new APMS practices. I think what we need to get better at, and I think we are going to get better at, is about need rather than want and demand, because they are different things. We've been doing a lot in terms of Joint Services Need Assessment (Site 1, PCT Officer, ID 1.2).

Contracts will however, come up for renewal every 5 years so the process will come around again for the APMS practices. There is some concern as to whether providers will be interested in applying for a further 5 years if recruitment to lists does not pick up (refer to section 4.2).

In Site 2, it seems that the process of EAPMC commissioning made the PCT think about primary care procurement in a different way. Instead of just taking local GP services as a fixed point, they have started to extrapolate the way in which they performance manage APMS contracts over to primary care as a whole. It has made them much more critical, and inclined to challenge existing practices. They are very keen, for example, to renegotiate some of their PMS contracts, but at the time of the data collection they had been prevented initially by the SHA and then by the election. They are keen to 'review primary care as a whole', looking at quality, and they feel as if the procurement process has given them the skills to do this. However, they say that the performance

management process for the new practices is exhaustive and time consuming, and they couldn't possibly do that for all practices.

1.4 Perceptions of the procurement process

During the research participants from both the PCTs and APPCs highlighted various issues that had to be overcome to allow the APMS practices to be procured. It may be useful to think about these issues in future procurement of such services.

Respondents were called to see the Department of Health at the outset of the Fairness round if they were seen to be an area which was under-doctored. A PCT officer from Site 1 described it thus:

"This was where all PCTs in England who were considered under-doctored at that time were summoned to meet the Department of Health in London to provide reasons for this and put forward plans to overcome this in the future, Site 1 was one PCT. Definite correlation recognised nationally regarding low numbers of GPs / quality of primary care provision / health outcomes". (Site 1, PCT Officer, ID 1.1)

Respondents talked about the level and degree of detail specified from the Department of health for the APMS contracts giving local areas little flexibility in setting out contracts that would be more beneficial to the local population.

My understanding is that they were something that's been pushed from the centre, if you like. And I think, again, going back to the first wave, I think it was something that helped us with our own difficult position. I do feel that the way of...the principal of having the extended hours and the additional services, and the demanding targets – that all sits quite comfortably with me. The bit that I struggle with, is about the complicated way in which the contracts have been designed... So, my interpretation is very much that we do have to respond to the department, and there are mixed feelings about that. (Site 1, PCT Officer, ID 1.2).

The officer went on to say:

I think, for reasons that I don't understand, there was a lot of tightness around the process to do with confidentiality and the fact that the...because these are not typical contracts, and because the costings are quite different than GMS and PMS, I think there's a lot of tightness around the whole process. (Site 1, PCT Officer, ID 1.2).

Sites also looked for guidance and clarification of issues to the Department of Health as it was a new process but at times found a lack of support. For example:

I think the other problem for us as commissioners was getting advice from the Department of Health; that was another big problem for us, because we hadn't done it before. So we were looking to the DH for advice. So things for instance, the scoring methodology, it was very, very complex, far more complex than really it needed to be. But we didn't know any different! So getting some clarification around some of the detail around that, we didn't always get it on time or the tender workshops that DH ran, well, fine, we'd do them, but they'd do them after our tender was submitted. So some very practical things like that. I think they thought we were quite, pernickety's the wrong word, but we wanted to understand some detail, maybe because we knew providers would want to understand it, and actually we'd be left contract managing. So sometimes the

level of detail that we were asking about, that seemed that they hadn't thought of that. The usual response was, 'oh, we haven't been asked that before, we haven't thought of that, we'll get back to you.' [By which time we'd have had to make a decision and sort it out. So their getting back to us was not always quick enough. Some of it was, some of the technical stuff was okay, but some of the general policy and some of the confusion around some of the documentation...because it was not the easiest documentation in the world to read, let alone fill it...(Site 2, PCT Officer, ID 2.1)

The amount of time which was taken up for the PCT was very great and included issues like preparing the initial ITTs, receiving bids, scoring bids, moderation, legal issues. In addition negotiation proved more difficult than expected:

All APMS contracts to date proved difficult to negotiate - not simple like Government said would be (i.e. could be tweaked to fit local circumstances and have needed lots of legal input each time). There was lots of interest for the 1st round (2008) fairness round BUT much less for equitable access round (providers had whole country to look at by then) (Site 1, initial mapping meeting, 15/03/10).

There were clear issues over where newly commissioned practices should be located and once a location was found, appropriate premises sought. The following is an extract that describes how suitable premises would be sought once an area had been identified:

In recognition of constraints with regard to premises for these new procurements, it is proposed to advertise locally for potential premises solutions once locations for the new GP practices and GP Led Health Centres have been agreed. (EAPMC report in Site 1, Feb 2008)

A PCT officer in Site 1 described the location of the newly established practices:

quite a number of these practices are in LIFT buildings, so there's already capacity space there to put them. And, in terms of new premises...again, you're right, there are some of these ...I think something was about existing premises and LIFT development, and then something was about areas on the map where it was, kind of, we need more practices there. So, I think there's a bit of both. A bit of opportunism with LIFT, and then a bit of "well, we have to have practices here, because there's a gap". That's my understanding of the two. Particularly, one of them, which is in [named EAMPC site], I think, is where there'd always been...not always, but I understand a big practice had a branch, and they closed their branch, and there was always a big gap where they closed their branch, and there's now one there. I think that's very positive for that population (Site 1, PCT Officer, ID 1.2).

In Site 2 the Strategic Health Authority (SHA) undertook a review of procurement process by (1) sending a questionnaire to PCT EAPMC Leads around governance arrangements, documentation and supports and (2) organising a lesson learned workshop with key personnel involve in procurements process (including the SHA, PCTs, and PASA). From the review they found that there were issues with the following which closely mirrored the issues raised in Site 1:

- Timescales - too tight and inflexible. There was no time for market analysis and no market stimulation other than informal stakeholder workshop.
- Documentation - perceived to be very complex and often made available too late to be used effectively or to meet timescales and there were some errors in template documents.

- Uncertainty - due to uncertainty around process and fear of legal challenge, PCTs were reluctant to engage or actively target potential bidders as part of market stimulation.
- Local needs - more localisation and discretion in decision making was requested as the current Invitation to Tender (ITT) was identified as being too inflexible for all needs.
- Joint working - an invaluable part of the process. When SHA advice and guidance was provided it was pivotal in achieving swift resolution to problems, legal and financial advice was perceived as weak at times, Purchasing & Supply Agency (PASA) support was recognised as invaluable.
- Pre Qualification Questionnaire (PQQ) stage – there is a different scoring mechanism and methodologies between PCTs with identical PQQ was accepted in some and rejected in others. They found that referencing process could be made more robust and there should be scope for PCTs to incorporate their knowledge of provider capability. They also found that vertical integration guidance specific to EAPMC was received late in the process and was a new concept for both PCTs and secondary care providers to understand. It was felt that Foundation Trusts either may not have fully understood vertical integration as a concept or did not pay sufficient attention to completing the vertical integration section of the PQQ as responses varied greatly in quality and content.
- Invitation to Tender (ITT) stage – having standard documentation was considered good and the bid evaluation process was robust when evaluated together (as opposed to separate evaluation of various sections of the ITT). Having a central co-ordination and administration for issuing and receiving bids was felt to be excellent. However, the ITT left little scope for innovation, for bidders to show how they could add value hence making it difficult for PCT to evaluate and benchmark bid prices. There was also some disconnection between ITT questions and interview questions and little opportunity to offer discounts for multiple bid.
- Bidder interviews stage – bidders found that panels were often not sufficiently prepared, clinical involvement seemed to make the process more difficult for private companies, and structure of the interviews did not give a full opportunity for bidder to enter discussion around innovation.
- Mobilisation - PCTs felt unprepared for conducting unsuccessful bidder debriefs and were nervous around the potential for legal challenge. There were also delays in contract signatures which were a result of lease agreement, N3 connections and legal queries on the contract itself, which were outside PCT's control.

1.5 Summary - Procurement

To date there have been two rounds of procurement, both centrally mandated by the Department of Health: Fairness in Primary Care and Equitable Access (see previous description p18). In the study areas these two rounds of procurement were seen as being separate from one another, and we found some differences between the ways in which the two rounds had been approached by different PCTs.

There were clear differences in levels of interest from alternative APPCs in bidding for new practices, with less interest shown by the bigger national companies in the EAPMC round in our research sites. Different types of APPC, with different structures and ownership models were found associated with single commissioning group (PCT).

There were much fewer bidders for the contracts in this round [EAPMC]. For one of the 3 sites there was only one bidder (who met the criteria so was awarded the contract). S/he thinks this was because there were lots of options around the country so many contractors concentrated in one locality. Had been expecting Tesco or Virgin Health to be interested but no interested locally. Bidders were generally smaller in scale and less diverse than the fairness round (Site 1, PCT Officer, ID 1.1).

Core contracts for APMS practices were the same with local flexibility for change or additions, dependant on the needs of the local population, specifications set out by the procuring PCT and offers of additional services from the APPCs.

The procurement process, including identification of practice locations , tendering, assessment of applications, interviews and final agreement of contracts was very time consuming and staff intensive for the PCTs and was carried out in a very short timescale set out by the Department of Health. The tendering, consultation and operation and monitoring of the contracts were new for both the PCTs and APPCs, and different ways of working and levels of monitoring could be identified between the sites. It was generally agreed in our sites that the whole process worked better where the PCT and APPCs could agree to work together to get the best out of the contracts for the local populations.

The different rounds were funded in different ways, both in terms of ongoing payment for practices and support for the procurement stages, resulting in PCTs having to find funding from different sources and look across their whole budget for primary care provision.

Location of and suitability of buildings were raised as issues for new practices in both sites. In Site 2, quite a number of practices started in a temporary location and only recently moved/about to move to a more permanent location.

The main problems and issues identified by respondents with rounds of commissioning included time scale, cost and getting clarification from the Department of Health on details. In Site 2 there were also some issues to do with public consultation, which was seen as very time consuming and quite confrontational. Levels of local hostility varied, and depended to some extent upon historical and geographical context. However, it was felt that they had to be seen to be fully consulting in order to avoid potential legal challenge.

2. Models of Alternative Providers of Primary Care

Throughout the research the impression given was that it mattered little to the PCTs what models of ownership or organisation were adopted by the bidders. Overall they told us that their main concern was that the bidders should be able to provide what they said they could and at a sensible and realistic price. PCT officers did not appear to conceptualise the different types of providers in the way that the research team did at the outset, and often struggled to answer questions on this topic. (Refer back to page 9 for the research team's original attempts at describing types of APPC.)

Work undertaken by Ellins et al (2008 p9) identified 3 main types of primary care provider organisation: GP-led companies, corporate providers and social enterprises.

2.1 Within Site 1

There are several different APPC's, each of which hold between 1 and 5 separate contracts for practices (single or multiple) under APMS commissioned during either / both the Fairness and Equitable access rounds. Contracts started between May 2008 and December 2009. The process by which providers in Site 1 were chosen related to a matrix of ability to provide stipulated and additional services and cost of providing the contract, as previously described. The APPCs vary in model and can be described as follows:

APPC 1 is a company established a number of years ago and working exclusively in the field of primary care. They contract with a range of NHS bodies including Primary Care Trusts (PCTs), Personal Medical Services (PMS) and General Medical Services (GMS) GP practices. It is a private limited company the shareholding consists of individuals who are General Medical Practitioners, health care professionals or employees of the PMS providers. As such the Company is a qualifying body as defined by the NHS Act 1977. This allows delivery of a number of contract models including General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider of Medical Services (APMS). Nationally APPC1 operates a growing list of practices in several SHA regions.

APPC 2 is a private company started by a group of GPs. They provide primary care services in a number of sites across the north of England. They pride themselves on retaining the core values of traditional general practice whilst addressing the specific needs of local communities through healthcare and IT innovation. This APPC decided not to participate in the research.

APPC 3 is a social enterprise started by a group of primary care professionals in Site 1. They currently deliver primary care from three sites within the same geographical area. The partnership sees itself as innovative and longer opening hours 8am to 8pm and Saturday morning have been available for some years. This APPC explicitly state that they aim to promote patient involvement in services.

We will return to questions around how different types of APPC organise the provision of service and skill mix later in this report (refer to section 4.3 onwards).

2.2 Within Site 2

APPC 4 is a partnership between a private company and local GPs. This model was devised jointly by a former PCT chief executive and a GP. According to the Executive Director of APPC 4, the ethos of the model was that ‘if you really wanted to change the way services were provided to patients that GPs were the key to that, and if you really wanted GPs to be involved and engaged in that they had to have an interest...had to have real power in designing those services and had to have an interest to make it happen’.

APPC 5 is a well established private company who have won contracts elsewhere nationally. They had previously specialised in other aspects of health and social care provision, but in response to these procurement exercises had decided to expand into primary care services.

APPC 6 is an established out-of-hours provider which started out as a GP co-op in a neighbouring area. They formed a social enterprise to provide primary care in the area in response to the procurement process

APPC 7 is a private company which has won a number of contracts in other parts of the country.

APPC 8 is a partnership between a PCT provider arm and a GP consortium. They were aiming to become a social enterprise. They are described by the PCT as being the one that “really struggled at the outset because they are a provider arm and until we [the PCT] give them a remedial notice and took money off them, they didn’t take any notice of us [the PCT]”. They are in the process of vertically integrating with a Foundation Trust.

APPC 9 is horizontal integration where a GP practice from outside the area took over a practice. A GP and a business partner (not a GP) set up this company. They are described as a small practice.

2.3 Models generally

As can be seen from this list, we found APPCs corresponding to a number of the categories that we initially established. Thus, we found horizontal integration of GPs from a practice in one area taking over a practice nearby, large, national private companies, partnerships between private companies and existing GPs and partnerships between GPs and out-of-hours providers. In addition we found APPCs who were private companies as well as those who had adopted a social enterprise model or were run by existing GP partnerships.

It was recognized in both sites that different providers have different experience in different areas of care, which may help or hinder the running of the APMS contracts. This is often due to individuals working within the APPCs and their experience as much as the structure of the APPC, as explained by a PCT monitoring officer:

It’s evident that some practices some are dealing with things better than others but I think all of them incur like problems, but I mean I suppose it’s like anybody the more experience you have at something... And you have different people and your different

partners, you've got I think [APPC1] they were pharmacy, you know, pharmaceutical and then they've got other business managers ...so some areas they will have better understanding. Then you've got like with [named GP APPC3], s/he's been in the GP for some time, so you know, and then I think a lot of it comes down to business as well, it is a business, so I think the role sort of competency, they have all got a great knowledge and some come across in different ways (Site 1, PCT Officer, ID 1.4)

Another PCT officer explained perceived differences between two of the providers in Site 1 and how they hoped that they treated all providers equally:

I do think, I think [APPC1] are much more commercial, and actually that's been very refreshing because they kind of come in, they know what the target is, they know what the contract is, and they're working to that. So they're very clear...Whereas perhaps where we've got contractors who have had a GMS or PMS contract before and have no experience of APMS I think they have struggled to acknowledge, recognise that it's a very different contract and therefore there are different mechanisms. We're going to be asking different questions, and actually I think the reaction to that has been - I don't always think it's been positive. I think they feel - they might tell you, I don't know whether you're interviewing say [APPC3] practice, but I get the feeling sometimes that - that they think that we're looking into things too intensely. Because we don't do that with PMS (Site 1, PCT Officer, ID 1.7).

The same officer went on to say:

[...] I think we treat the practices the same. But the reaction to us and how we've gone about them has differed... But I take hope in the response we get from the likes of [APPC1], that are working with numerous PCTs, so that's my benchmark if I'm honest really. As long as we apply the same principles to the other contractors then I'm confident that we're working well.... Because [APPC2] as well also work with another PCT. And they've given us that feedback as well.Because they've worked with other PCTs and they're not experiencing the same level of commitment I suppose. (Site 1 PCT Officer, ID 1.7).

In Site 2, different types and experiences of APPC did not appear to affect their performance:

Well, that was one of my worries initially because APPC 4, obviously, they're used to doing this type of thing, they've got a big workforce and they've got procedures and policies in place which cover most things and if we've got an issue with APPC 4, they're obviously very open and nip it in the bud straight away and get to the bottom of it and I thought that would be a problem with a smaller company, like APPC 9, who...there's only one GP and a business partner, but we've had no problems with this practice. They're performing well, we've had no reports from other services within the PCT about any issues with the practice, where we have with the APPC 4 practices, so... (Site 2, PCT Officer, ID 2.4)

Overall, as discussed earlier we did not find that our original distinctions between types of APPC were particularly meaningful to those on the ground, with respondents often struggling to identify the ownership or organisational model of particular practices. Local contract monitoring teams tended to develop relationships with the local managers of the practices concerned, and this seemed to be the most important factor in the monitoring process. Although some of the APPCs that we investigated were part of larger chains with a presence in a number of geographical regions, there did not seem to be much practical impact of the ownership model on the running and monitoring of the practices. The only area in which any difference was perceived was that PCT staff sometimes

commented that the larger chains appeared to have greater experience of running practices under APMS contracts, and this made the process easier. Nor did we find any noticeable differences in the ways in which the practices that we studied ran or organised themselves which were attributable to the ownership model adopted.

3. Performance management of providers

Historically in general practice 'contracts' have been fluid and flexible. The red book was a payment schedule, which set out in detail which activities would generate which payments. Whilst it was an important structuring device – you needed to have systems to show what payments were due – it didn't have a very powerful effect on what GPs did or did not do in their practices. The successive new contracts of 1990 and 2003 specified much more clearly what practices would be paid for doing, but they remain flexible and structuring rather than constraining, with many practices providing significant services over and above those set out in the contract.

In primary care overall, there has been a gradual trend towards more tightly specified contracts, especially in the form of QOF. However, APMS represents a step-change, because it is both tightly specified across a wide range of aspects of primary care, and explicitly performance managed.

3.1 Monitoring

It was consistently suggested by respondents that the APMS contracts are much more tightly monitored by the PCTs than any other GP practice contract, with more hands on day-to-day performance management.

But I don't think any, any PCT from my knowledge monitors to the extent that we do, or try to monitor the extent that we do. And we've been congratulated on it by two, two out of the [APPCs], yeah, actually, [APPC2] saying how good we do it. In fact we should market it. [APPC1] say, you know we do it very well. [APPC3] are less than enamoured (Site 1, PCT Officer ID 1.6).

It is also considered to be more formal, focussed and 'hands on' than GMS and PMS contracts as explained by various interviewees:

it's more formal, obviously, its...you can build up relationships with GMS and PMS and advise on what best practices and steer them in the right direction but with APMS you have the tools there to ensure that they're delivering in the areas that are set out in the KPI. (Site 2, PCT Officer, ID 2.4)

Monitoring of the APMS contracts is much more rigorous than PMS or GMS contracts. The PCT sees this as a good thing although it takes more time. Should provide a better service for patients ultimately. (Site 1, PCT Officer ID 1.1).

There's more hands on day to day performance management within the APMS contract. The GMS, PMS contracts are more cyclical, more annual, more monthly in its nature, whereas the APMS...the management seems sort of more hands on, more day to day. You know, it's more focused. You know, it's a definite driver of the contract. (Site 2, PCT Officer, ID 2.3)

Monitoring was undertaken by PCTs in a number of different ways. These included:

- sampling or checking. This was used for example to monitor the availability of appointments or waiting times
- face to face meetings between PCTs and contractors
- the use of formal minutes which were signed off by all involved and which included specific tasks for people to undertake
- submissions of statistics and electronic workbooks containing key performance indicators (KPIs) linked to payment.

Throughout the research period there was considerable evidence of ongoing contract renegotiation. This involved renegotiation or clarification of definitions within the contracts, with a subsequent formal sign off process. This occurred in preference to more informal flexing of contract terms, and the formal process was seen by both sides as necessary within the APMS contract.

In both sites, monitoring for Fairness and Equitable Access practices is similar – they both have same requirements for quarterly meetings and similar KPIs.

In Site 1 there was talk of using such monitoring as basis for local monitoring of other GP contracts locally. However, the local LMC had objected and the issue had not been moved forward due to the time it was taking to digest the implications of the release of the Health White Paper (Secretary of State for Health, 2010).

Additionally, towards the end of the research period there were discussions in Site 1 over the possibility of ‘toning down’ the amount of monitoring necessary as relationships between the PCT and providers developed.

Under the core APMS contract the following issues are monitored:

- Satisfactory understanding and application on all aspects of the APMS Contract
- The practice has adequate provisions in place to enable effective delivery of the contract
- There are adequate procedures and systems in place for recording services provided by the practice to the patients

In addition there were Local Enhanced Services (which can vary locally) e.g. asylum seekers, alcohol misuse, depression etc.

Key performance indicators (KPIs) are worth a monetary value of 25% of the total contract and are organised into the following areas (each worth 5%) in both Site 1 and 2:

- (a) access;
- (b) quality;
- (c) service delivery;
- (d) value for money; and
- (e) patient experience.

The domains were centrally set with detailed examples of potential KPIs provided in an APMS contract template. Within this the PCTs (input from various teams e.g. commissioning, medicines management) could specify the required KPIs and weight them according to local priorities. Each of the domains contained multiple indicators (between 1 and 21 each weighted differently between the two sites). For walk-in centres,

the KPIs are in the same domains as above apart from service delivery (for example cervical screening, immunisation, choose & book etc), which is not monitored in the same way. Additionally some PCTs chose not to give some topics a monetary value as a KPI (e.g. appointment punctuality) but still monitored these as part of the overall 'holding to account' process.

In both sites, the standard of performance required for each KPI is defined in terms of three performance Bands - A, B and C. Band A represents the desired level of performance; Band B represents the minimum acceptable level of performance; and Band C represents an unacceptable level of performance. For each performance band there is a corresponding payment band. In some cases, in recognition of the starting list size of zero the PCT allowed the provider a transition period of up to six months in which to achieve Band A performance for the KPIs. This was conditional upon the APPC being able to demonstrate reasonable progress across all the relevant KPIs by the end of the transition period. In addition, each KPI will be audited throughout the year. The Monitoring Lead will sample a selection of KPIs during each quarter. If the Provider commits a KPI failure then the PCT will be entitled to implement sanctions. These sanctions range from reducing the banding achieved (i.e. loss of revenue) to a termination of the agreement.

In Site 1 all KPIs are monitored weekly or monthly by the APPCs (for their own knowledge) and by the PCT team via spot checks to the practices (e.g. next available appointment), scheduled practice visits, sampling KPIs at preliminary meeting and more formally held to account at quarterly performance review meetings.

In Site 2, some KPIs are monitored monthly, some quarterly and some annually. In terms of access, most KPIs in this area are monitored monthly apart from equity of access (annually) and list size (quarterly). Quality (e.g. QOF) is monitored annually. Service delivery is monitored annually apart from choose and book (monthly). Similarly for walk-in centres, most areas are monitored annually apart from access, which is generally monitored monthly.

There were different perceptions from respondents about which KPIs the practices would focus on and which were easier or more difficult to achieve. A PCT Officer explained that s/he thought that the APPCs would concentrate on meeting the KPIs which would achieve the highest payment:

Well they're obviously going to give more attention to the ones that have a higher value, monetary value. So I think they probably concentrate on them first (Site 1, PCT Officer, ID 1.7)

In both Sites it was acknowledged that some KPIs are easier to achieve than others, as a PCT representative from Site 1 explained:

I don't think they'll never get there, because I don't think they've been unreasonably set high. For example, we'll go back to cytology, because that's always been one of my interests, I think it's 90 per cent. That is high, the national target is 80. However, in our area, we have at least one practice that can hit 90, so it's not an unreasonable target to expect. And that practice isn't in a particularly, shall we say, affluent area where you think "oh well, all the women will come". So, I don't think they've been unreasonably set, and the whole point of this challenging contract is to improve the care of those patients. I just think it will take them time, and I think some of them have started from a lower base

than they perhaps appreciate. Because a lot of the targets are cross-targets, if you like, but they're just set a bit higher. I should think it will take quite a lot of effort, and probably longer than they thought (Site 1, PCT Officer, ID 1.2)

Another officer perceived that the KPIs associated with the Quality and Outcomes framework (QOF) were most straightforward:

So which do I think is easiest to meet? I think QOF because of the huge section on organisational indicators. Actually I don't think the contract is rigorous enough. There is lots of greyness in it (Site 1, PCT Officer, ID 1.7)

According to PCT respondents in Site 2, KPIs which are easy to achieve are immunisations and recording of ethnicity or first language – basically anything that is directly within the providers' control or what was described as 'admin type' of KPIs. The difficult ones mentioned included walk-in centres for its 10-minutes triage time (anybody walking in to the centre would need to be seen within average 10-minutes over the month) and 20-minutes treatment time. In this area, when the contract was originally conceived, the PCT decided that triage time was important in its own right and therefore separated triage and treatment time. The contract also stipulates that patients should be assessed by an appropriate healthcare professional. This proved to be difficult to achieve and providers have tried to be creative with triage time. Providers have asked the PCT to clarify whether they can undertake assessment by telephone or whether a receptionist can do it. They also argued that if they triage people and undertake the consultation at the same time, then triage times become null or void or if the overall time from admission to treatment is 15 minutes, then why should they be concerned if they do not triage the person for example in 13 minutes because the overall journey time was 15 minutes less. This is an example in which the very tight specification of KPIs may produce perverse outcomes. Thus, if the provider continues to be strictly monitored on both triage and treatment time then they might decide that it is not worth their while to try to pursue treatment and triage simultaneously. This could result in a service which meets the letter of the performance indicators but which might be perceived by patients to be less convenient overall.

The QOF KPI is considered by one of the PCT Officer in Site 2 (ID 2.3) to be the one 'most expensive to fail on'. This is because practices must hit 98% of total QOF points to be remunerated. The PCT's recent annual review found that a lot of the practices did not hit this target. QOF made up 20% of the overall KPIs, which means that if they have not achieved it, they would lose out on 5% monetary value of the contract. At the completion of our fieldwork, the PCT was in the process of dealing with some of the providers in this site now that they have realised that they are not being paid the full amount as they missed achieving this target fully.

It was notable in Site 2, that the PCT's interpretation of which KPIs are easy or difficult to achieve can be different from the providers' own assessment. According to the providers, the difficult KPIs are around service delivery because it is not 'well defined':

So there's things around...for example, there's things around percentages of patients who have gone on whether it be weight loss or smoking cessation or whatever, et cetera, but, you know, if you have written to a patient three times and tried phoning them, et cetera, and they just refuse to respond to anything, you know, should that actually...does that count against you on your statistics or not? And actually that's a question that hasn't been answered. (Site 2, APPC 4, Executive Director, ID 2.6)

You can't force a patient to come in and have their blood pressure checked if they don't want to have it checked, or you don't have everybody...and it's within the last fifteen months. Now, you know, I don't go to my doctors, I think I've been three times in the last ten years and if you're well and you don't go to your doctors, how are you going to get that patient's weight from them? You know, so, yes we do it at the time of registering, but, you know, within fifteen months previous, you can send...and then they didn't allow you to use informed dissent sent, so within QOF, what you can do, if you have sent three invitations out and the patient doesn't come in, you can exception report that. And you can say well, you know, we've done everything, we've tried everything, we've rang them, we've sent them three invitations, three appointments then you can exception report it, the KPI doesn't allow for that so it just looks as if, you know, you've only got fifty percent of the population's weight, when really, you've contacted everybody three times and generated a list...But, you know, you've...so, it's always going to be a red figure. And it doesn't allow you to add in for the exception because then if you put the exception codes with it and then you maybe get it up to ninety percent of the people who have had it and the people who have denied to have it really. So if you add them both together that's...and, to me, that's a more reasonable way of looking at it than, I have to have everybody's weight done in the last fifteen months. And, you know, so I find that one a real difficult one. Blood pressure is maybe not so bad because people with chronic disease and everything else they have their regular checks and things. You know, a sixteen year old is not going to come in and have their weight checked and their blood pressure and things. (Site 2, APPC 4, Practice Manager, ID 2.7)

The provider has been asking the PCT to clarify this. The PCT replied that they had some meetings scheduled with the other PCT contract teams in the cluster to sit down and agree on a revision of some of the KPIs. However, the provider has yet to receive the clarification.

PCT Officers told us that they had begun to think about standard GMS performance in a different way, and were considering the possibility of using some aspects of APMS monitoring more widely. For example, a PCT representative in Site 1 explained how they hoped, in the longer term, to expand the regime of monitoring under APMS ultimately to other forms of GP contracts in the area:

The targets and KPIs in the APMS contracts are very specific to the APMS contracts. We are trying to introduce, as part of our health and equality, some stretch targets for our GMS and PMS contracts, but that's something that's just currently in process that we're trying to get worked out and agreement with the LMC on, and so forth. (Site 1, PCT Officer, ID 1.2).

3.2 Methods of monitoring

In Site 1, an electronic workbook is used, containing all KPIs and other indicators relating to the contract. This is submitted quarterly to the PCT. Preliminary meetings (quarterly between PCT and APPC) are used for checking the electronic workbook and for sampling of indicators for KPIs. Generally the business and practice managers from an APPC attend these meetings along with 2 members of the monitoring team (monitoring officer and analyst) from the PCT. The meetings are held at the practice and although it is for monitoring purposes and treated as part of the formal process, it is accepted by all participants that this type of meeting is to identify any problematic issues at the earliest possible stage as part of a supported learning process. These were introduced at the beginning of 2010 when a new head of monitoring was brought into the

team. All the PCT officers and representatives of the APPCs agreed that this system was much more productive and less stressful for all those involved than the previous monitoring regime.

At a preliminary meeting that we observed, the monitoring officer explained the function of these types of meeting to a new practice manager thus:

[PCT officer ID 1.4] then explained to [new practice manager ID 1.19] that this was an opportunity for the PCT and APPC1 / the practice to go through the submitted workbook and try to iron out any difficulties / queried etc before the more formal quarterly meeting (where people from APPC1 head office and higher up in the PCT would be present). [PCT officer ID 1.4 and business manager ID 1.12] agreed that previously when there was no preliminary meeting the quarterly meetings were 'horrible' and 'stressful' and it always felt much less supportive and more combative. Having preliminary meetings allows each side to informally make checks and learn from one another gaining insight into issues and problems. (Site 1, Observation, APPC1, Preliminary meeting, June 2010)

Additionally performance reviews which are more formal high level meetings between PCT and APPC representatives (see Box 1 below for issues discussed) are used to formally 'sign off' progress and assess performance. More people attend these meetings, representing both the PCT (monitoring, commissioning, finance, service related) and APPC (business manager, practice manager, GPs, partners from the APPC). At the outset the medical directors (or equivalent) in both the PCT and APPCs attended the performance review (set out in original contract obligations), but as time had gone on they only attend when it is thought necessary e.g. a specific clinical discussion.

The lead GP from APPC1 explained that his/ her time was probably better spent seeing patients than attending the meetings but they were more than happy to go should a specific medical issue arise:

Performance review meetings I used to go to those meetings I think for about one and a half year but then it was realised that my time probably will be consumed much more effectively if I stay here and see my patients and do other things, which I agree. Because to be honest I was going there but I was not really having a very great kind of input into those meetings. We have everyone from the head office, the accountants, the directors, the PCT's, everybody is there and [the business manager] goes there. But if there is a clinical lead only then they ask me to go and I go, if they need something clinical, then yes I go (Site 1, APPC1, GP, ID 1.20)

Box 1: Issues discussed in performance reviews

- (a) the Provider's performance of the Services*
- (b) the operation of the Performance Monitoring Regime*
- (c) reports of any relevant statutory and non-statutory bodies received by the Provider in the immediately preceding Contract Month(s) which relate to the Services;*
- (d) Patients' which relate to the Services;*
- (e) the Provider Performance Report*
- (f) the KPI Performance Summary for the Quarter*
- (g) the progress of the Provider in respect of each current Corrective Action or Rectification Plan;*
- (h) a Rectification Completion Report in respect of any Rectification Plan which has concluded;*
- (i) the results of any Provider Data Reviews*
- (j) any other relevant issues.*

Source: Schedule 7 document: Contract and Performance Management section, Site 1

From both types of meeting, formal minutes are produced, circulated, agreed and signed off by both parties within a set timescale. In addition at year end a formal reconciliation meeting is held to finalise finances. This is used to resolve if either party (APPC or PCT) owed the other any money set against the original contract stipulations.

A senior PCT officer explained how they thought the meetings held were useful to both the PCT and the APPCs:

I suppose if the meetings actually help both sides. If they help us make sure that we are managing our payments fairly, and getting value for money then, yes. And I think if it helps the practices understand what we, as a PCT, want...in fact, [named PCT officer – ID 1.6] was only telling me the other day that one of the APMS said that they value these meetings and they value the dialogue with the PCT, because they need to make sure that they are delivering what we want them to deliver (Site 1, PCT Officer, ID 1.2).

In site 1 for both rounds of contracting it has recently been agreed that performance reviews will be held every six months rather than quarterly. This is because the contracts are perceived to be working well. They will retain the option to call additional meetings when thought necessary, and will continue with quarterly preliminary meetings and sampling of KPIs / indicators of progress:

[Named PCT representative ID 1.6] proposed that future Performance review meetings should take place at mid and year end. S/he assured APPC1 that pre-meets between [named PCT officer ID 1.4] and the practice would continue and additional meetings would be arranged if deemed necessary. The proposal was accepted by APPC1. (PCT minutes, APPC1, Performance review Meeting, August 2010).

In Site 2, providers submit a monthly Exception Report & KPI report, quarterly GP practice performance report and annual reconciliation report. The contract manager reviews the report and organises performance meetings to discuss the report. The main purpose of the monthly and quarterly meeting is to look at the KPIs, making sure that the providers are performing against the KPIs. If they are not hitting band A then they will

look at why and if necessary put on an action plan to ensure that they get up to band A. They also look at the numbers of walk-ins and registered lists, average number of patients seen in a month, busiest days of the week and time of the day, patients complains, and adverse incidents (for e.g. ordered notes from Health Authority sent to the wrong address). As most of APMS practices in Site 2 are quite new (only in their first and second year of operation), the meetings would also discuss issues such as staffing (difficulty in getting full time GPs and locum sickness), problems with temporary premises (e.g. signage not clear, puddle of water after heavy rain), vandalism as the practice is located in a deprived area, and logistics for move to permanent premises. The meeting is generally attended by the contract manager from the PCT and from the APPC side the practice manager and sometimes business manager if they have one. Depending on the issues being discussed, the PCT could bring their finance manager or the APPC could bring their clinicians. Some providers will have a monthly meeting while others only a quarterly meeting. The contract stipulates that they should have quarterly performance meetings. The PCT decided to have a monthly meeting with providers who have more than one contracts to 'keep on top of any issues' and a quarterly meeting with those who only have one contract and 'no real issues'. However, this justification does not seem to be made clear to the APPC:

But it doesn't seem to be...and speaking to other managers up in the Darzi practices, not everybody has their monthly meetings so it was a case of, why are we having ours if nobody else is having theirs? (Site 2, APPC 4, Practice Manager, ID 2.7)

The PCT initially thought that they would have an admin support or a project support officer in these meetings but that hasn't been possible. It is then left to the contract manager to take notes and make sure that any actions are followed up, and, in contrast to Site 1, no formal minutes were circulated or agreed:

- M1: And that probably is a weakness because I mean there aren't any minutes that get circulated so it's a case of what notes people want to take.
- F1: Okay.
- M1: So...yeah, well, it could be. It could be problematic. And I have wondered whether I ought to take my PA along so she can take the minutes, but there seems to be something else on...
- F1: Because the contract manager involved in a meeting, taking notes as well isn't it?
- M1: Yeah.
- F1: Okay. So it's always just usually you take your own notes and people...
- M1: Yeah, people just take their own notes, yeah. So, yeah, if you wanted to rely on something that was said in a meeting there wouldn't be any documentary evidence of that discussion having taken place. (Site 2, APPC 4, Executive Director, ID 2.6)
- F2: Yeah, they're not very structured, so we don't get the minutes, or anything, you know, to feedback on so...
- F1: Yeah, that's why I didn't see the minutes.
- F2: No.
- F1: So who has to action then and how do you know what...?
- F2: Well it should be everybody really, they should have somebody from the PCT who is doing the minutes because it's the PCT will request that you have these development meetings so they should have everything minuted and that should be disseminated out to everybody and then whoever's is, you know, there to action, they should be actioning it. (Site 2, APPC 4, Practice Manager, ID 2.7)

The KPIs in APMS contracts are also seen to provide the PCT with the 'tools' for contract monitoring:

Basically, because we have the tools within APMS to monitor the contracts and the KPIs that were put into the contract were targets that the PCT wanted the practices to achieve. There was no KPI's in GMS or PMS and we have to try and work with GMS, PMS practices more to get the results, whereas APMS contracts, they have to provide it or they're in breach of the contract. (Site 2, PCT Officer, ID 2.4)

[] it's got KPI's in for a start, which the GMS and PMS contracts don't and in terms of what financial implications for penalties, that's very clear, some of them are in line with GMS but the PCT has much more strength, I think, if you like, in terms of how that contract can be managed. (Site 2, PCT Officer, ID 2.2)

However, it was also explained by respondents in both sites that monitoring so closely takes a huge amount of work in managing contracts using KPIs in this way:

The bit that I struggle with, is about the complicated way in which the contracts have been designed. I don't know whether...I'm still not sure whether that's a local thing or a nationally-driven thing, with all the KPIs, but it does seem to have made it hard work for everybody. (Site 1, PCT Officer, ID 1.2).

[] in fact, we're just pulling together work plans and performance frameworks for all of the independent contractors and that, kind of, makes it, you know, when you see something written down on paper, it, kind of, jumps out at you really that the work that we've done on APMS has been at the detriment of PMS and GMS because we haven't been able to spend the time doing PMS and GMS that we've...because we've had to do things, you know, monthly meetings, quarterly reviews and we've had issues also around system one and trying to pull the information that we need off system one. So, even now, you know, eighteen months down the line, if you like, we've still not got that quite...some of the things not quite sussed, but the monthly meetings and the quarterly reviews and actually what we've just been talking about is whether at what point do we say, actually these practices are now up and running, you know, and they should not need a monthly meeting. (Site 2, PCT Officer, ID 2.2)

Despite the tight specifications within an APPC contract, difficulties can arise over different interpretations of the wording. This has led to many lengthy discussions at monitoring meetings in Site 1 and occasionally conflict as a different interpretation may cause the practice to slip out of the top band for a KPI and as a result a loss of money. The renegotiations are complicated and a formal contract negotiation may be undertaken resulting in a contract variation signed off by both the PCT and APPC. One PCT Officer suggested that however rigorous the contract, there are always issues once it is put into operation:

Yes. Contracting's hard isn't it? You don't know all the - until you're actually working the contract you're never going to know what it's going to throw up (Site 1, PCT Officer, ID 1.7)

There have been some problems regarding contract clarity and definitions. For example a senior PCT officer in Site 1 described some issues thus:

Just some of the simple things. For instance, KPI's that 25 per cent of contracting comes dependent upon KPI's. KPI's are broken down into your various weightings and you would think they would add up to 100 per cent, wouldn't you? They don't. Also one of

the main things that came about, why APMS contracts came into being in this particular area was to increase the, increase the access times, eight till eight and Saturday mornings. There's conflicting statements within the, within the APMS contracts. One of the statements is that it's just normal core hours, which is eight till six thirty, Monday to Friday. Which is not helpful. (Site 1, PCT Officer, ID 1.6)

In addition, another PCT officer from Site 1 acknowledged that definitions within the contract are not always as clear as they should be.

- F2: I can understand from their perspective, well actually if we had a GP available eight till eight and eight till 12 on a Saturday that cost wise we couldn't afford to do that. So I can appreciate that, but just some of the contracts is just really grey and when it comes to nitty gritty stuff there's always a contradiction in the contracts that will support their argument as opposed to the first clause that we might have found that supports what the PCT are
- F1: So you can both find something to support your perspective then.
- F2: Yes because the definitions in the contract. Also if you go to definitions section, it says something like 'core hours is 8.00am until 6.30pm' Well actually we're asking them to open until 8... Yes. It doesn't define a PCP.
- F1: No, so I guess from your perspective that's very difficult to monitor and control if all the time they're coming back and saying 'yes, but in the contract it says...'
- F2: And actually where things have turned up, where we've maybe we've turned up at practices and there's nobody on reception that's easy to kind of give them a little nudge and say well actually you know... so that's right. The contract itself is rubbish.
- F1: You're not a big fan then?
- F2: No. (Site 1, PCT Officer, ID 1.7)

In Site 2, one of the APPC has been asking the PCT for clarification about the 8am-8pm opening time:

[Practice manager ID 2.7] asked for clarification about 8-8 opening time. She asked if patients were to arrive 1min before 8, do they still need to see them? She said that if this is the case then they will all have to work till midnight.

[Business manager ID 2.6] said that if he is the patient, he will insist that the doctor still see him. He said maybe if PCT has issued a letter to clarify then they can send patient away if they think they can't finish by 8pm. (Site 2, Observation, APPC 4 monthly meeting, August 2010)

[Practice manager ID 2.7] was asking about an issue that was discussed in previous meetings, which is about patients turning up at 7.55pm, just 5mins before closing time.

[PCT Officer ID 2.4] said that he has spoken to the Senior Commercial Manager and that the team have different opinions. He said that the Senior Commercial Manager suggested that he does digging around with other centres.

[PCT Officer ID 2.3] asked whether they have any number of that kind of patients within a week.

[Practice manager ID 2.7] said no.

[Business manager ID 2.6] said that if it is regular then they need to do rota but if it is not then it's ok. He said that they are just trying to get guidance on that.

[PCT Officer ID 2.4] said that he would try to get something by the end of this week. (Site 2, Observation, APPC4 monthly meeting, October 2010)

These issues have resulted in different levels of contract clarification, renegotiation and on one occasion recourse to law between the PCTs and providers.

3.3 Contract renegotiation

APMS contracts as observed in this study are extremely detailed, containing many performance measures and provisions. We found that the existence of such a detailed contract was seen by PCTs as an advantage, as it allowed them to negotiate changes or terminate the contract at a later date. This manager contrasts this with the relatively non-negotiable GMS contract:

- M1: Well, yeah, within the contract there's a change schedule and we can impose a change, the PCT can impose a change if we require. For instance, [named APPC] move, we've discussed with the provider and they've agreed to the move but if they didn't agree to the move, we can just say, in the change schedule, we require the practice to move. So, there is levers within APMS contracts for us to make any changes we require, we can terminate, we can...if they're not hitting their targets on the size, we can terminate them for under performance. We can...around the walk in centres, if they're over performing, we could cap their activity at what's in the contract so there's a lot of things we could do as a PCT.
- F1: [] Is it because its the APMS contract, that's why
- M1: Yeah, with GMS, PMS, there's no end date, there's no real levers, the practices, as long as they're not doing anything illegal, or anything, then, they can just get on with it. With APMS, there's a lot of things we can do. (Site 2, PCT Officer, ID 2.4)

In Site 1, contracts as a whole had not yet been renegotiated in this way. However, during the operation of the contracts, it also became clear in that due to specific issues (e.g. population characteristics, geographical location) certain aspects of the contracts needed to be re-examined. For example, one of the practices has been asking for a walk-in facility due to its location near sports facilities, a hotel etc which was not negotiated as part of the main contract. At the conclusion of the research, the PCT was not allowing this, and as part of contract stipulates not making a payment for immediately necessary patients:

[Named business manager ID 1.12] explained that there was an issue around patients just turning up – under current arrangements can't be treated as the practice is no a walk in centre and they don't get paid in the contract for temporary residents or immediately necessary patients (this is awkward due to proximity with hotel, college and sports facilities). Under old contracts (not APMS) used to reconcile this as end of year variation but seems to be no facility for this. [Business manager ID 1.12] would like to see this added to the contact – [PCT officer ID 1.4] was to go back to commissioning team and check this. (Site 1, Observation, APPC1, Preliminary meeting, May 2010).

3.4 Recourse to law

APMS contracts in this study were subject to legal scrutiny before they were agreed. In spite of this, and in spite of the general feeling that APMS contracts were tightly specified and monitored, it was not clear that either providers or PCTs saw them clearly as legal documents in this way. Although disputes did arise from time to time, in only one case was there discussion of having recourse to the law to solve a dispute:

- F2: And interestingly I was at an event last Thursday or Friday and [named provider] was there and it's the first time I've seen him for quite some time, tried to avoid

him but couldn't [both laugh], wasn't quite quick enough and he collared me and he said that he is going to put something in writing.

F1: Okay.

F2: Next...well this week he said, next week which is this week, although I haven't received anything yet. And sometimes [provider's] bark is worse than his bite really, so you've kind of got to know how to play him a little bit at his own game because he threatens a lot of things and he huffs and puffs and then if you kind of throw that back to him he kind of doesn't take it any further. I think his biggest gripe, you're right, is around the pharmacy and that is around the fact that on the plans that went out for...in the tender documentation said GP practice, pharmacy, although nobody...there was nowhere in the tender document that said, there will be a pharmacy co-located, he has simply made that assumption. Now I don't know how much you know about pharmacy regulations but we can't just put a pharmacy in a building, the pharmacy has to apply, it's got to go through the control of entry process, so even if we were to say we want a pharmacy there, we can't...if nobody...if a pharmacist doesn't want to be there then we can't make a pharmacy open there. And even if we did want one, if there's another one 50 yards away then it's not going to happen because they're not going to get through. So that is an issue that we've taken up with our premises people to say we should not be staying because on the one hand I can understand that he has maybe assumed that but he never asked the question.

F1: But it's not in the contract.

F2: And it is not in the contract, but that is his biggest gripe and I'm not sure that it actually holds water. He told me on Thursday that he'd taken legal advice and that he's been...the legal advice is that he's been misled, but we'll wait and see where that goes really. I mean we haven't taken legal advice as things stand, purely because of the cost of doing that that might amount to nothing. But if we need to do that then we will. But I feel quite confident that he hasn't been mis...because being misled kind of implies that that's been done deliberately and, you know, if that's been put in really as an indication I can't see that that is misleading somebody, but if we need to get legal advice then we will. But [named practice] is doing well and [named practice] are doing well, but there are particular issues around the [named practice]. []. (Site 2, PCT Officer, ID 2.2)

3.5 Summary – performance management

The main problems and issues cited by the PCTs were to do with the amount of time taken to undertake the monitoring on the PCT side, plus all the preparation time from the APPCs to pull together the required evidence weekly, monthly or quarterly. However, it was acknowledged by both PCT and APPC respondents that this generally helped to flag up issues before they became problematic, enabling issues to be resolved quickly.

In Site 1 there was an additional issue of split teams where the commissioning team undertook the procurement phase and then passed everything over to the monitoring team for checks on the contract's progress. This caused some difficulties at meetings where monitoring officers were often unable to clarify definitions as they had not been part of drawing up the contracts and generally nobody from the commissioning team attended meetings between the PCT and providers during the research period. For example it was observed at a meeting that:

[PCT officer ID 1.4] stressed to all present, but especially [practice manager ID 1.19], that when issues were raised she would be able to answer some things, the practice others and some would have to be taken back to the PCT for decisions (especially if this involved the commissioning team – e.g. wording of contract). (Site 1, Observation, APPC1, preliminary meeting, June 2010).

This was not the case in Site 2 as one of the contract managers was involved in procurement. However, the issue of clarity of contracts (definitions, appropriateness of KPIs etc) was raised as problematic at times in both sites.

Overall, contract management and monitoring was considerably more formal in site 1 than in site 2. This carried with it certain costs, in that it was time consuming and costly in monetary terms. However, it also carries with it theoretical advantages, in that it would ensure that there were no unexpected contract issues, and both parties were clearly aware of progress. Overall, the small size of this project and the short timescale means that we were not able to formally assess the advantages and disadvantages of the two different styles.

4. Provider behavior

4.1 Attracting new patients

Various mechanisms were employed by the APPCs to try to attract new patients to join their newly established practices. In Site 1 all new practices undertook leaflet drops to local housing at the outset and on other occasions as seen as necessary to publicise services. The content of leaflets was always checked by the PCT to avoid accusations of unfair competition.

A business manager from an APPC in Site 1 explained the rules about marketing:

That's a difficult one because part of the contract is that it's not detrimental to other GP practices in the area, which is really quite difficult because they're saying don't be detrimental to other practices in the area but you've got to achieve this list size. And that's a difficult one to get your head around, how do you balance that. Fine, if there were thousands of people moving into the area but there's not, so that's quite difficult, in terms of marketing you can't say we're better than the practice down the road, you can only be factual. And the PCT like to see any sort of marketing that you're going to do"[] And when you do any sort of marketing, even if it falls within the remit of what legally you're allowed to do you get some sort of flare-up from local GP practices who say this is terrible that they're doing this and this goes against regulations. I think I've been aware of one APMS contract that did something that local GPs were very unhappy about and tried to argue that it wasn't within regulations, and you just think it's another area of difficulty that makes you unpopular. (Site 1, APPC3, Business manager ID 1.25).

In Site 2, some practices did not need to do much marketing due to their premises situation in 'good' locations. However, they were allowed to market if required. Some who had real difficulty in recruiting patients undertook a 'big marketing campaign' using billboards and newspapers. In one of the APPC, there is a big sign on the street pointing to the location of the APPC. They would also use posters, banners, leaflet drops or organising local events to introduce the practice. Initially when practices went live, the

PCT supported them by running a series of newspaper and radio advertisements and informing key stakeholders such as the local councils.

In addition new patients have come to the practices (variable across the APPCs) due to some of the extra / enhanced services being offered for example, referrals from mental health services, homeless services etc.

Some of the practices in Site 1 have held more innovative and themed events to try to attract new patients e.g. stalls at local supermarkets, a seasonal event, free health checks to try to attract new business especially at the outset. As time has gone on there have been less events and the practices have relied more on word of mouth recommendations. A practice manager set out some of the things their (equitable access) practice had done to try to attract new patients:

We put notices up in local shops, clinics, chemists, there was articles in a newspaper... just before we opened and we've also had, up to now, two leaflet drops... within a three mile radius of the practice. And we also have an open day this coming Saturday. (Site 1, APPC1, Practice Manager ID 1.17).

Another suggested more novel methods which their practice had employed:

F2: I mean we have had, like, at [specified time], one Saturday – because we're open on a Saturday morning anyway – so it's one of our nurses is really quite enthusiastic and she had a sort of [themed] open day and she had us all in fancy dress, and there wasn't really a surgery on as such but it was kind of come and get your free health check, and they were just doing people's blood pressures and things and just trying to get people to register and had, like, games on for the kids and things. And quite a few people came, actually, and I don't know the exact result of how many patients we got out of it or anything like that but I know that we were all out walking round [specified town] Centre dressed [appropriately] [laughter] like, come and get your blood pressure checked. And most people were just, like, ran away, but...

F1: [laughs] Well, you would, wouldn't you, if you see a [person described] coming towards you.

F2: [laughingly] It was quite fun though. We've been to a couple of these, like, I don't think they've done one since I've been here but they've had a couple of, like, fairs, where...and they've just had a stand there and they've been doing the same thing basically, and just talking to people". (Site 1, APPC3, Admin Officer ID 1.26)

This kind of publicity can however cause issues with fellow GPs (in terms of the perception of competition for patients) as this quote illustrates:

One of the practices [not named] has had trouble within the PBC consortia which they are part of. The consortia wants to 'expel' that practice as it is publicising itself locally including a stall in the local [supermarket]. (Site 1, PCT Officer, ID 1.1)

This issue is discussed further below in the section on externalities (section 5.1).

At a meeting the PCT and APPC had a discussion about the short questionnaire several of the practices uses at registration to try to establish why new patients want to register with the practices. This was used by the APPC as part of their internal monitoring

process and was seen as extremely useful by PCT representatives in focusing future publicity:

Registration forms – PCT thanked [Business manager ID 1.12] for sending through the questionnaire used at patient registration. This asked how the patient had heard of the surgery and why they had chosen to register. Over 100 of the new registrations were due to a word of mouth recommendation, about 60 via leaflets and 50 had switched due to services offered. [No mention of longer opening hours in the discussion]. [PCT monitoring lead] said this was important as it showed marketing was only having a marginal impact and it was important for a steady list growth (even if slower than predicted at outset) to hear recommendations from others. (Site 1, Observation, APPC1, reconciliation meeting, November 2010)

Additionally a GP explained that currently (in 3rd year of contract) most were being attracted by word of mouth rather than the initial marketing (at outset of the contract) and this was seen as a success (i.e. recommendations from satisfied patients):

There are always patients keep on going and coming in any area. So that is in one way it's a good way to measure success, but only if you do a good audit which we did in the past, in the last six months. How many patients joining our practice are actually coming here because somebody else told them well go and join them because they're a good practice. So I think in May/June time last year we did an audit, and we thought okay.. Because we were looking at our marketing strategy, patients coming after leaflets, national newspaper advertisement, or the website, or head office campaign, or word of mouth. And what we found out was it was more word of mouth rather than anything else. (Site 1, APPC 1, GP, ID 1.20)

4.2 List size issues / overall contract finances

By the end of the research period, despite all their efforts in attracting new patients in Site 1 all but one of the practices were running at a lower list size (registered patients) than had been predicted at the outset - predicted growth rate of lists which, with hindsight, appeared too ambitious within the contracts. In a recent meeting between APPC1 and the PCT this was discussed and the main problem (as they saw it outlined):

There followed a brief discussion between [The APPC] and [the PCT] about the fact that all APMS practices had been given the same list growth projections at the outset and the APMS practices had not been able to change this. It did not make sense as in addition to this they were provided with practice demographics and these were highly variable so both agreed at outset they should have been able to change the projections (set by centre). (Site 1, Observation, APPC1, reconciliation meeting, November 2010).

In Site 1 two of the providers were raising issues about the overall costs of the contracts in relation to contract budget. APPC3 was having to consider *“if the contract was still viable –capitation is a particular worry”*. The contract was running at a loss and APPC3 was to decide if it was best to pay back money owed to the PCT in a lump sum or if a reduction in monthly payments made by the PCT in the future would be better in terms of cashflow (Site 1, PCT minutes, Performance review, October 2010).

APPC1 was having similar issues reporting that *“capitation and staffing were a cause for concern”* in one of the contracts (covering 2 practices). *“Staffing the 2 sites from 8-8 was adversely impacting on finances and overheads are greater than the budget”*. APPC1

therefore suggested reviewing opening times at one of the sites. Representatives of the PCT were to raise the issue with colleagues and organise a meeting between all parties to discuss the issue further.

However, in Site 2, some APPCs had reached their predicted list size number. This created difficulty in deciding whether the PCT should cap the number or come up with a re-negotiated rate if the number is over. The contract stipulates that if they are 10% over the annual number, they need a written permission from the PCT. The PCT has decided to go for the second option but it is not easy for the PCT and APPC to achieve an agreement on the rate:

- F2: So, I don't know whether you were at the thing but we mention it at every single one anyway, can we have it in writing, please, that, yes, we can go above our list size.
- F1: Yes, I remember that.
- F2: And we never get it in writing. So, obviously, I don't want to close the list because if you close the list and you tell people you're closed, it has a way of getting around, so if we ever want to open it again, you know, people just won't...it would be more difficult.
- F1: Yeah.
- F2: So, I'm just registering, at the moment, desperately hoping that we will get it in writing to say that, yes, we can, you know, because it's a shame and if people want to and it's about people's choice at the end of the day.
- F1: Exactly.
- F2: So they should be able to regardless of how many patients that we've got, if they want to register they should be able to. (Site 2, APPC 4, Practice Manager, ID 2.7)

In both sites by the end of the fieldwork there appeared to be issues with the contracts (both Fairness and Equitable access) in terms of them running at a loss against the full contract budget. This was primarily due to list size as many of the payments made to the APMS practices are based on numbers of patients. In addition there were issues of over performance on walk-in practices and APPCs not being able to provide some services (therefore receiving less or no payment) due to non-referrals of patients from PCTs (e.g. mental health, homeless services) or services being under review by PCTs:

[APPC representative] raised the issue of not being able to provide some of the services they wished to offer due to problems with non-referrals (Mental health in particular), things being put on hold by PCT etc. In year 1 the APPC had accepted this as a hit but it is now moving into year 3 and this is no longer acceptable – a discussion is required. (Site 1, Observation, APPC1, Reconciliation meeting, November 2010).

This had also been pointed out as an issue to the PCT by APPC3 at a previous meeting:

Enhanced services - PCT was still waiting for feedback from the practice. [GP] stated that the issue with most of the enhanced services is that they are getting no referrals through. Therefore there is no activity. The practice has tried to do things itself to get this up and running but it needs to be a joint process. Services included in the discussion were alcohol misuse, mental health and substance misuse. [Business manager ID 1.25] said there were significant delays and this was the 3rd year of the contract almost. (Site 1, Observation, APPC3, Performance review meeting, October 2010)

In addition there were also issues to do with the existence of multiple versions of enhanced service specifications as outlined below:

“[Business manager, ID 1.25] also raised the issue of version control on enhanced services. S/he and [GP ID 1.28] stated that it was always very difficult to tell what version of an enhanced service they were supposed to be currently working to”. (Site 1, Observation, APPC3, Performance review meeting, October 2010).

4.3 Skill mix: who are the staff at APPCs?

All APPCs in Site 1 employ a ‘business manager’ (often jointly working as a practice manager). APPC1’s business manager operates regionally across all their practices, this manager has her own personal assistant as a result. In Site 2, only one of the providers has a ‘business manager’, who is also the director of the company.

The majority of GPs employed in APMS practices in Site 1 are salaried and in the earlier stages of their careers. In Site 1 there is a specific KPI for ‘continuity of care’ means use of locums results in potential reduced banding and therefore reduced payments. However, when required locums are used (this is checked on via quarterly workbooks).

- F1: I’m assuming that the GPs here are all salaried, are they?
F2: Yeah, we do bring in locums but they’re usually just one-offs through agencies and things, we don’t have any long term. (Site 1, APPC3, Admin officer, ID 1.26)

Figures were always checked by the monitoring officer at preliminary meetings within the workbook and clarification sought if the figures were unclear as this would potentially have an impact on payment. This is illustrated by an exchanged observed at a preliminary meeting in Site 1:

[Specified GP] had taken a holiday of 4 weeks in April (2/5 to 3/5), At had looked at the number of locum hours which came to 61hrs or 14.8 sessions and questioned how the other hours had been covered. [business manager ID 1.12] stated that off the top of their head they knew all the sessions had had cover but she didn’t know the detail (couldn’t check as the computer system was currently down). S/he thought they had a long term locum (which would have been the 61 hrs) but also some cover from [another specified GP] but s/he would check.

[PCT officer ID 1.4] was concerned about the figures because they would impact on contract delivery and potentially the KPI on continuity of care.

[Business manager ID 1.12] stated that it was always difficult to get long term locum cover so this was always going to be an issue. S/he agreed to check the figures (once back from leave) and get back to A (PCT officer) by the 13th (before the performance review). (Site1, Observation, APPC1, preliminary meeting, July 2010)

In Site 2, one of the executive director noted that they need different ‘clinical skill set’ for registered patients and walk-in patients:

- F1: Is there a difference running the two different contracts?
M1: Yes, there is a difference. You need a slightly different clinical skill set for registered patients than you do for walk in patients.
F1: What kind of...?
M1: Well, if you’ve got registered patients then you have all of the...well all of the things that are associated with a registered patient probably are typified by QOF,

so, you know, managing patients with COPD or diabetes or whatever on a long term basis, you don't have any of that with a walk in patient because the patient walks in, you deal with their acute issue and, you know, advise them to go back and see their GP, you know, if they need to and that kind of ends the case in most instances. So a registered patient is quite different, so what we found quite quickly after opening the walk in centre in [named PCT] is that the practice nurse we had recruited, actually there wasn't a lot of practice nursing we had for her to do.

F1: Okay. Right. Initially when you employed her ...

M1: Yeah, yeah, we did our modelling and we thought well actually, you know, it still might be useful, et cetera, and we'd recruited a practice nurse and actually there wasn't a lot of practice nursing for her to do, and I mean she was quite keen to train up so we kept her on. We've sent her on advanced prescribing courses and different courses and so she's now, after 18 months, in a position of being able to see some of the walk in patients. So it is a different skill set for the two different patient groups, and of course the walk in patients, the vast majority are by definition walk ins, whereas registered patients, the vast majority of them are booked, although the registered patients do like to take advantage of the fact that it's a walk in centre and they can also walk in, but most of those appointments are booked and so you have a mixture of registered booked appointments and walk in appointments and trying to balance those slots through the day when you never know when you're going to get half a dozen walk in patients come in. That can be quite challenging. [] (Site 2, APPC 4, Executive Director, ID 2.6)

In most of Site 2 APPC practices locums are commonly used because of the difficulties in finding GPs who want to work full time in the area. In some APPCs where full time GPs are employed, they usually work across a number of different practices. As they use many locums, the practice managers tend to spend a lot of their time seeing or arranging locums and trying to make the rota fit around when they can get locums. This proves to be difficult in GP-led health centre where they have to be open and have a GP on premises for 84 hours per week. However, one of the benefits of using locum is that they are 'less fussed':

A lot of GPs, you know, they all have different interests and you get GPs who like the continuity of care and the greater complexity you get with the registered patient and they're just not interested with someone else walking in with a sore throat or whatever it might be. You know, it's not something they can feel particularly engaged with and so they prefer not to do that. [] Well the locums are less fussed and the locums are used to working in a variety of different settings. I mean you do get some that come in with some strange views about different things, but the locums are...it's usually the salaried GPs who are less keen on the walk in patients, who want to see the registered patients. (Site 2, APPC 4, Executive Director, ID 2.6)

In one of the APPCs in Site 2, as their GPs are less keen on walk-in patients, they are usually seen by nurses:

But hopefully, in the future, the GP will concentrate on GMS and only take walk-ins that the nurses feel they can't deal with. That's what we're aiming for. Unless there's anything very, very complex. So then myself and the GP will obviously do the QOF bits as well with the nurse, with the practice nurse. But the other nurse practitioners will solely do walk-ins as far as we can possibly. (Site 2, APPC 4, Lead Nurse, ID 2.10)

In terms of staffing for GP-led health centre in Site 2, as it also opens at the weekend, some centres decided to employ some admin staff and nurses who only come in and do

one session at a weekend. They have decided to be quite flexible in terms of the clocking in and out system due to their longer opening hours:

If a patient walks in before eight o'clock, they've got to be seen, now they might walk in at two minutes to eight, in which case, they've got to be seen, then I would expect the doctor or the nurse to see them, in which case they won't get finished until quarter past eight or ten past, quarter past eight. Quarter past eight by the time you turn everything off, say. So I would expect to see....but there again, when the rota...how we have it at the moment, there will be floating hours during the month, or a floating hour and a half, something like that, which should make up for those times when you're going to get out late. [] So, I think you've got to take the rough with the smooth. (Site 2, APPC 4, Practice Manager, ID 2.7)

Across the two sites admin / management staff have a variety of backgrounds (some primary care, some not; APPCs prefer to have the mixture). For example an admin person from APPC3 (site 1) explained about her background:

- F2: Finance background, management accounts.
F1: So what attracted you to this job then?
F2: I just wanted a change, I kind of wanted to stick to a finance-related role and then just the advert came up at the right time, it was really local and everything else and I just thought it looked interesting.
F1: So you'd never worked in primary care before?
F2: Not until this, no. (Site 1, APPC3, Admin Officer, ID 1.26)

In both Sites, as some APMS practices are not new practices i.e. take over from existing GP practices, some of the staff were TUPE¹d over. These staff has different contracts from those employed directly by the APPC:

- F2: Because I was TUPE'd over, I'm the same terms and conditions as my NHS contract, which they've got to do. Some of the reception staff, I would say, find it difficult because the original staff were TUPE'd over on the original contract, and things, but there's pros and cons to it, if you like, because they don't work after six o'clock at night, they don't work weekends, because that wasn't in the contract.
F1: Mm.
F2: But they do get paid less per hour than the [named provider] staff.
F1: Oh.
F2: But that, again, [named provider]staff work weekends, bank holidays, it's just within their contract that they work eight until eight, you know, three hundred and sixty five days a year, have no bank holidays, no Christmas, no nothing off and they don't get the NHS pension, the [named provider] staff don't get the NHS pension, so if you take the NHS pension contributions and things into account the NHS TUPE'd staff probably have a better deal but because it looks as if, on paper, they get paid more, you can understand.
F1: Yeah, I can understand.
F2: So that's one of the difficult things, is we have contracts for [named provider] staff and we have them for the original staff, which is a little bit difficult really, so there's two different employments and trying to get everybody to gel and... (Site 2, APPC 4, Practice Manager, ID 2.7)

¹ TUPE (Transfer of Undertakings) is the regulation governing the transfer of employees to another employer, whereby it protects the employees' terms and conditions.

Some problems were identified with turnover of medical staff (less so management) within practices in Site 1, especially at the early stages of the contract operation, as described by a PCT Officer:

Some alarm bells currently ringing – turnover of GPs within some of the contracts. Need to get to the bottom of this. May be list size issues or may be more fundamental issues (Site 1, PCT Officer, ID 1.1).

However, this became less problematic as time went on. In addition, some issues were raised in specific practice in Site 1 where the practice was not employing the full capacity of medical staff due to a lack of physical space. This can be seen in the following exchange between the business manager for APPC1 and a PCT officer at a performance review meeting:

[Business manager ID 1.12] stated that across the 2 contracts they were doing well and it was difficult due to them being co-located and competing for patients.

[PCT Officer ID 1.6] agreed and said that at the outset it had never been envisaged that they would be co-located.

[Business manager 1.12] We only have 4 clinical rooms so if we were running at full list size for both practices we wouldn't physically have the space. Could create some more space by moving admin upstairs and splitting the biggest consulting room but this would still not be enough.

[PCT Officer ID 1.6] agreed this was problematic and stated that it was also difficult to employ staff rationally.

[Business manager ID 1.12] No space, not Value for money. Building is not fit for purpose.

[PCT Officer ID 1.6] unsure given current climate what can be done so may be worth considering merging the 2 contracts in the future. (Site 1, Observation, APPC1, performance review meeting, August 2010)

4.4 Undertaking specific roles within APPCs

Within all the APPCs in Site 1, various members of staff (most often GPs) have taken on specific roles to help to facilitate the contract. Such roles include local medical director and practice-based commissioning lead. The medical lead (APPC 1, Site 1) is salaried but had become very involved with the practice's development and describes his time as his best and worst:

Rather than going into a practice which is already established, systems are in place and I just go and start working as a labourer really. Okay, you come in work this and go out, that's all. So that's why I came to [APPC1] and my long term aspirations I am quite happy, but we have had a few problems which I think all the general practices have had, whether it's APMS or PMS or a GMS contract. Other than that I enjoy working and I think this was probably the best learning experience of my life working for [APPC1] the last two and a half year. And it could be worst as well because it was so challenging, it was so exciting and I literally did everything, blood, sweat, tears, everything. And yes it's paid me well. When I compare myself with my other colleagues who are working in traditional PMS or GMS practices they don't have a clue what I'm talking about, when we talk about LESs, DESs, okay alcohol substance misuse, because this is part of a contract. Now whether I liked it or not in the beginning I had to do it because it was my contract, so I had to learn everything. I had to make sure what is it, what are the specifics, what is required, how do we do it, what are the services, what courses I need to attend and all those things. But I compared with myself with my other colleagues who have been at

other practices, they're just go in seeing the patients and hardly getting involved with something. (Site 1, APPC1, GP, ID 1.20)

At most of the APMS practices in Site 1, specific members of staff take on specific roles such as practice-based commissioning lead, clinical lead, lead on specified QOF / KPI indicators (these members of staff may be GPs, nurses or admin staff depending on the role). For example:

- F1: Right, okay. I understand that you've got a role within the practice that might be to do with practice based commissioning?
- F2: Yes, PBC. PBC lead
- F1: Yes. Could you tell me a little bit about what that involves?
- F2: We're quite new to the PBC actually. We just started being a member of the...I think it's South [specified town]...I can't remember which what it's called...it's the PBC...
- F1: Yes, so that's a consortium is it?
- F2: There's one nurse practitioner [named] she represents from [named practice] and I represent the [different named] practice. So what we do is...I'm basically the representative for them. We haven't started doing any PBC's as yet, so it's still new. (Site1, APPC3, GP, ID1.29).

A second GP explained that pairing medical and admin staff with specific responsibilities helped to keep on top of the targets set as otherwise it would be a full time job for individuals:

Each clinician has been allocated certain KPI's or areas of QOF where the... are taking a lead and they're paired off with admin staff so a search can be created to isolate those patients... that would be appropriate for certain pathways or certain KPI's and then that clinician makes sure that that population is brought in for recall so they can just work with the admin team and say right we've got twenty dementia patients we need to be monitoring them every six months, we could send some letters...(Site 1, APPC3, GP ID1.28)

I don't think any one clinician could know exactly what, what's needed for QOF and KPI, I mean there's a lot of overlap for both but I think if one person had to do it, it would be a full-time job (Site 1, APPC3, GP, ID1.28).

4.5 Work specification

We asked respondents from the APPC about their use of clinical protocols in their ways of working and the development of pathways for treatment of certain conditions. The clinical lead for APPC1 described this as follows:

With regards to policies and procedures I think we have standard central policies and procedures which is all over across the board same. With regards to clinical things, I think we did try but it didn't work out, and the reason for that is different practices have different contracts. Different ways of working of clinicians, clinical leads in each practice it's up to them which protocols or procedures they would want to place.. I am talking from a clinical point of view. As such we don't have a folder saying these are all out clinical protocols, this is chronic disease, this is heart failure, this is this, this and this. We have certain things from PCT or certain flow chart diagrams all these things, but I think what we do is we have encouraged the clinical teams in each practice to discuss things and come up with their own agreement on something. COPD how are you going to treat

COPD, this is how it should happen, this is what the nice guidelines say. The majority of the time in my practice here we follow the national guidelines which is nice or sign or PTS, or BHS, we follow them. So we meet very very regularly, we have our COF meetings, we discuss all these things there and if there is something that we think we should all adopt this, then we all agree on that. But as such I won't say that we have a folder of all these different areas and it's like it's pinned to my room here on the board there, okay what do I do. It's just happening. But of course because I'd have KPI's we have certain limitations there, financially or policy wise so we bring those into our national guidelines and see what's the best...(Site 1, APPC 1, GP, ID 1.20)

In another APPC (Site 1) a GP described the use of pathways and protocols as:

- F2: We're still making them (Pathways and protocols). We have one for the hypertension, and chronic kidney disease. We don't have for all...usually we follow the NICE guidelines on anything new that comes up. Because all the doctors we have here are quite young and new so we need to still go to all the meetings and teaching wherever possible, and update everybody on the...so, we try to do everything like on the protocols, we still are developing for most...it's mainly for chronic disease management so...diabetes, we didn't do one, because it's not something that the health care assistants are doing, it's mainly done by the nurses.
- F1: Right so it's mainly protocols and use of pathways when your health care assistants are...
- F2: Yes because they're obviously not medically trained...They have a list of what to do, when a patient comes, we send to them and they do...send for ECG, do what bloods they need to do, they do the bloods, and they know how to record them...and then, so things like that, we do protocols. And the nurses have their own protocols as well, for diabetes and stuff like that. I don't actually follow any... I don't actually do them, I usually look at the NICE guidelines and stuff, I sort of do that...Yes, I think as doctors you don't stick to protocols as much. We have to look at each individual patient and change it." (Site 1, APPC3, GP, ID 1.29)

Site 2 also makes use of standard protocols and procedures. However respondents highlighted the fact that they alter theirs to fit local needs:

- F1: In terms of managing the care internally, do you use protocols?
- F2: Yes, we have protocols for everything.
- F1: Can you talk to me a little bit about this protocol?,
- F2: The clinical protocols, myself and another nurse, and the lead nurse from one of the other practices in [named PCT]. We have...and also, the lead nurse from [named PCT]'s done bits as well. We've sat with the clinical protocols ourselves, reviewed them. We pass them around each other to see if they needed anything that we'd missed or anything that we want to put in. We then...
- F1: Is this initially from the kind of standard [named provider] protocol?
- F2: [named provider] do have protocols that come down to ground level. And then we sort of modify them to actually fit our practice. So yeah that's what we've done. So myself and two other lead nurses have looked at them all. And then we send them back to [named provider] to get them confirmed that yes, this is fine. Because we like to...the current NICE guidelines and things like that, so to make sure that they are evidence based and foolproof really. [named practice manager] will do all the non-clinical. There's hard copies yeah, in the policies and procedures folder. And we also have a shared drive on the computer that everybody has access to. So everybody can go in and look at the copy electronically as well.

- F1: Okay right. The locums will have that as well?
- F2: Have access to that, yeah. Our locums also have a pack as well, like an information guide, that just gives them some basic...we tend to use the same ones, the same locums all the time. But at times you might get a new one. So we do have packs and things, to tell them where to refer to for our GMS patients, bits of formulae's, drug monitoring, community instruction guides. So we do tend to put as much information, make life as easy as we possibly can for them. And for the patients, because if the GP's happy in the surroundings and happy with what's available to them, then the patients are. (Site 2, APPC 4, Lead Nurse, ID 2.10)

Some practices gave examples of being proactive in terms of audit and oversight. For example, in Site 2 APPC 4, they have developed internal audit for CQC even when they are not registered with CQC until 2012. They are also looking at safeguarding standards and how it fits with CQC.

4.6 IT systems and internal monitoring

APPC practices are expected to have good clinical IT systems. However, the standard GP computing systems are not necessarily without problems, and may not always be set up in ways which suit APMS practices:

The easiest, now that we're up and running and I'll say they were all difficult in the beginning, because it was a new computer clinical system that we were using as well. We use System One now but we used Synergy, so in the beginning there was a little bit of finding your feet and how to do things. Now, the monthly KPI's are not a problem, they're all very easy to do. We have system set up, we have Searcher set up, the only thing I will say about System One is the searching is not brilliant and it means that what happens is it gets backed up or the...it gets backed up every day at five o'clock from the main server, which is in Leeds, or somewhere, but we're open until eight o'clock so if anything is put on after five o'clock on a Friday and it doesn't do it on a weekend, so it's five o'clock on a Monday by the time it's updated, now that's a clinical problem for me, because I tend to think that if you were doing research on everybody who has had flu, on a Monday, it hasn't taken in to consideration that they could have been in on Friday evening and I've put it to System One and asked them to change it, put in a development request, and they say, no, I put it onto the chat room to see how many other people would like to have it changed, so it's an ongoing gripe, if you like, that I have with them... So I can't see what difference it would make, you know, to do it at nine o'clock at night when everybody's closed, because this must have been set up before the Darzi practices, if you like. So, lots of things we do manual here, everything's done on the case tracker, every patient that's walked through the door, we add them up, we have a sheet on a daily basis that we add how many is done, because that's the only way I know that, at least, it's done correctly because the search is, like I say, I just wouldn't trust them. So, for the likes of audit and things, for somebody to come in and audit and say, well, you've claimed for so many walk in patients but your computer is telling me that, you know, I've got my evidence there to say, we do it manually, daily, this is it and if you look on the appointments screen it's different to the open case screen, you know. (Site 2, APPC 4, Practice Manager, ID 2.7)

Additionally, there were some issues when GPs started at the APMS practices or where the APPCs employed locums in terms of IT systems which these GPs were not so familiar with.

In both sites for internal monitoring, the APPCs would have a selection of in-house meetings. These may include a full practice meeting, practice managers meeting, clinical governance meeting, and nurses meeting. Some of the issues analysed include emergency admissions, triage times (daily reporting on triage times, average triage times per day, longest triage wait per day, percentage of patients seen within the 10 minutes target), average appointment times vs average appointment lengths, productivity of individual clinicians, how many patients per hour the clinicians see, clinical audit, review of consultation notes from different clinicians, and patient satisfaction.

4.7 In-house vs subcontracted care

Many of the APMS practices chose as part of their contracts to provide additional (enhanced) services to their patients. This may include services such as minor surgery, anticoagulation services to registered and non-practice patients. Some further examples were given by the business manager of APPC3 (site 1) who explained that it was important to be proactive in providing such services:

- F1: So what kind of services would that include?
F2: There is one is on dementia; depression - mental health in general has about two or three attached to it - asylum seekers; homeless; ethnicity; osteoporosis; heart failure. There's lots of them.
F1: So a lot of work then.
F2: Yeah, a reasonable amount of work. And it's more just getting the structure in place so that you're doing something proactive as opposed to reactive. (Site 1, APPC3, Business manager, ID 1.25)

During the research we also saw some evidence of APPCs buying in services from other providers:

- F2: So we signed a contract on the thirtieth of December...
F1: And they open the next day?
F2: And that service opened on the first of January. Now no-one in their right mind would open a service on New Year's Day, but that was the DH's time frame, and actually what we did was this contracted it back to [named previous provider] for January.
F1: Right. That's interesting.
F2: Yeah, because that is the only way, it was absolutely not achievable.
F1: Not achievable, yeah.
F2: It was not achievable to sign a contract on the thirtieth of December and open a service on the first of January. That was a pilot site being run by [named previous provider] and the new provider sub-contracted to them for January, for that whole month of January. So we ticked the DH box and...
F2: ...contracts signed and the services running.
F1: Does that mean that they don't care who run?
F2: Well they never asked. So we didn't tell them.
F1: Right.
F2: But we would have failed that if it hadn't been for the fact that [named previous provider]...if that had not been a pilot site, if it had been a brand new service it would not have been deliverable. (Site 2, PCT Officer, ID 2.2)

4.8 Relationships with secondary care

Very few of the managers and clinical staff interviewed said that they had much, if any, contact, personally with secondary care staff. For example, the clinical lead at one practice described relations as follows:

In terms of communication, no there is nothing, there is no meeting or there's no forum. ...No there is no forum or platform where I am either invited or I go, or I'm aware of to be honest. But for my own appraisal I've tried to go to GP update meetings up until last year, we've been going to the meetings where you do see the consultants from the hospital, like my local hospital here [specified town]. So I know all the consultants, I've attended their talks and I have been in touch with them in the sessions the teaching sessions. The formal kind of appraisal revalidation stuff, and of course any other wards when we refer patients to them as well it's good to know them by face, so I know the majority of them in [specified town]. But as such in the pathways and things, I don't know whether it's just me or...I know quite a lot of my other colleagues working for GMS / PMS practice, I don't think so they have anything like that as well to be honest. It's probably something which is generally not there, so that is why I'm not aware of it. (Site 1, APPC1, GP, ID 1.20)

The business manager of an APPC in Site 1 described their initial contact with local hospitals / consultants and some of the problems that can arise as a newly established practice in the area:

- F2: Yeah, initially, what we do, we introduce ourselves, we write to them, speak to them, often go and meet them personally, because they have to know another practice exists because when they get a letter, their consultants get a letter, they think, who is this?
- F1: Who's that?
- F2: Yeah. And sometimes, the problem has been there that letters have gone to the old practices and that means that patient care has suffered slightly and because we've been aware of this we actually then, if we don't get the letters back by a certain turnaround we actually then, chase them. (Site 1, APPC1, Business manager, ID 1.12)

In contrast in Site 2 an APPC executive director stated:

Well, we like to talk quite often to the acute hospitals about a range of different things, not least because...because we see ourselves as a provider of community services, you know, as and when opportunities come out for us to bid for community services, we'd like to work with the local acute hospital, you know, where we can and not compete against them. So we try and have a really good relationship with them and on a service by service basis we'll sort of link in with different consultants or not. So we've got an outreach gynae pilot which we've agreed with the gynae consultants at the local acute hospital in one of the [APPC] practices. (Site 2, APPC 4, Executive Director, ID 2.6).

In one of the APPCs in Site 2, the walk-in centre was purposefully chosen to be located next to the existing hospital. The PCT's decision was taken on the plan that there would be a brand new hospital to be built in a different location and therefore as the A&E department at the current hospital would be closing, they would need something else in the area. However, the plan fell through and the A&E is still present. The APPC practice manager had developed a working relationship with the A&E manager and would meet to discuss who went to the A&E and how could that patients be seen at the walk-in centre instead. She would know if one of the patients from her registered list were to visit

the A&E. She would then write to the patients or give them a ring to find out why they would go to the A&E instead of using the walk-in centre. It was initially thought that having the walk-in centre would drop the A&E figures. However as things stand, the A&E figures has not significantly reduced. Having a walk-in centre is seen to be about giving patients more choice.

5. Professional identity, relationships and outcomes

5.1 Externalities

In terms of externalities, the PCT in Site 2 felt that the procurements had had a beneficial effect on the other GPs in the area, in that they have been 'stirred up' by the whole process, and made to think a bit more about their own services. They describe the procurements as 'giving them leverage' over GPs, and it has also created a market in alternative providers. This was obvious when they went out to tender for the local contract for Out of Hours Services: after the EAPMC process there were a number of new providers in the market. In addition, we were told that the process had prompted some GPs to increase their opening hours, for example. The PCT officers involved told us that, overall, the relationship between GPs and the PCT had changed, though it is unclear how much of that had been due to the EAPMC process, and how much had been due to the establishment of a new team responsible for managing primary care contracts. They described previous relationships in the area as 'cosy', with the GPs knowing the PCT managers well. The new team did not have those historical links, and did not know anything about managing primary care contracts, so the PCT staff were much more likely to check the letter of contracts and not rely on previous gentlemen's agreements. It also allowed them to be more challenging. This was seen by the PCT staff as being a big change for GPs, and they described it to us as 'different people, doing different things'. For example, they introduced quality visits and queried QOF scores.

In Site 1 it was acknowledged that some of the KPI targets set for the APMS contract could at some stage be rolled out and used to monitor other GP contracts locally as explained by a PCT representative:

The targets and KPIs in the APMS contracts are very specific to the APMS contracts. We are trying to introduce, as part of our health and equality, some stretch targets for our GMS and PMS contracts, but that's something that's just currently in process that we're trying to get worked out and agreement with the LMC on, and so forth (Site 1, PCT Officer, ID 1.2)

There had been some difficulties in the relationships between APPCs and other local GP practices especially where they were based in the same building. This would seem to stem from competition over patients. In Site 1 there have been allegations by APPCs that other practices have removed signage and sent patients to other locations, and in Site 2 there were allegations that staff at a minor injuries service which shared premises with a new practice had deliberately misdirected patients away from an APPC.

However, in Site 2 we also found that some APPCs would help walk-in patients arrange for an appointment with their registered GP. In APPC 4, patients would walk-in for things that cannot be seen in walk-in centres such as blood pressure tablets, referral or a

breast lump. APPC 4 would sometimes phone the patient's GP to ask if they can fit that person in:

- F2: you'll get somebody who'll say I've had this in my leg...in my knee for six weeks, and then they'll suddenly come to a walk-in centre, rather than go to their GP.
- F1: But they're registered somewhere else?
- F2: Yeah. So...and they're wanting referrals and things like that, but we don't refer...we don't refer for walk-in. Or they'll come with feeling low in mood, and there, you try to explain that the concept of walk-in and, you know, about your safety...about safe practice really, about...I would never give medication that should be ongoing. So I would never start anybody on a blood pressure tablet or a mood stabiliser, or anything like that, who isn't our patient, because I couldn't guarantee that patient's going to be followed up. So...and I try to explain to them for their safety and for my safety. And where I can, I will actually phone their GP practice, if it's during open hours, to say can you try and fit this person in because I think they really need to be seen. But I think a lot of the time, we're a bit of a scapegoat for other practices where they'll say I've been trying to get an appointment with my own surgery for a week and I can't get in, they've told me to come here....So we get a lot of that as well, which is fine, if it's something acute or if they've got a bad chest or sore throat, like your acute infections, that's absolutely fine. But sometimes, we've had ladies, because the receptionist at the other end at their own surgery hasn't actually asked what the problem is before telling them to come to us. For instance, I've had a lady with a breast lump. Now I can't do anything for that lady, and all I could say to her was that she needed to see her own GP because she needed a two-week referral. But I actually got on the phone and got the practice to get her an appointment for that day, so she could at least leave here and go straight over. Because I couldn't think of anything worse than sitting at home overnight, waiting (Site 2, APPC 4, Nurse, ID 2.10)

In both sites, the APPCs appear to have developed good working relationships with the PCT. However, there are always some difficulties due to the monitoring role of the PCT as explained by a PCT monitoring officer:

I think yes, I think they all have good relationships, but you have to bear in mind that we're doing a job and they're doing their job and something may... but we are very supportive in our team and I do help, but then I do state that we are also policing them, so, but I think the practices do have an understanding of this and I think there is one practice probably where I struggle more with and I always have done with the work group when they first started the contract getting the workbooks in and why are we doing this, but I think now when I go out we have got an understanding of what we're doing... I have a consistent approach with all practices and I hope to maintain my professionalism with all of them, but sometimes when things don't go right with what you're saying it's like me, somebody coming and saying, you don't like being said this is, you know, so you're always going to get that conflict, but I think three of the four are really, really, good and like I say, we do have our disputes and sometimes I feel, oh, but they're not that bad....(Site 1, PCT Officer, ID 1.4)

In relation to other GP practices and the local medical committee (LMC), some APPCs do not find that there is any particular hostility towards them from the LMC. One of the APPC in Site 2 described the relationship in terms of them being able to advertise jobs through the LMC. However, there have been some difficulties with established GPs as explained by two PCTs officers involved in the monitoring of the APMS contracts in Site 1:

F1: I think performance reviews, issues from performance reviews, APPC3 has experienced problems with one of their new practices and I also think APPC1 have mentioned the consortiums, the practice based commission, I think they felt a little bit hostile and I'm not sure whether, it's getting better, but I think there was a bit of hostility when they first.

F1: So a kind of wariness from the other practices?

F2: Yes and I think when they've done marketing campaigns there has been practices that have contacted [lead monitoring officer PCT] or LMC and expressed concern about that, they are distributing leaflets but they are in the right to do so, but they have a contract to work around, get the list sizes, there has been that sort, it's been my understanding there has been those sort of issues.(Site 1, PCT officer, ID 1.4)

So yes, there was animosity. Then on top of that we'd be getting telephone calls like, 'do you know that such a body has put a leaflet through our door'. And it's like, 'well they are allowed to do that'. 'Well it's not right'. But it's a new world. You can do it as well. So yes, LMC were raising things and so there were lots of things being battered away... Then there was patients complaining, MPs. I know, so it was really, really messy. So yes, it was welcomed and not welcomed (Site 1, PCT officer, ID 1.7)

Another PCT Officer (ID 1.1) in Site 1 explained that:

Other GP practices are definitely against the new APMS practices. S/he puts this down to the fact that old practices have become complacent and are worried about patients moving where they see better service provision, longer opening hours etc. In addition the old practices (and the LMC on their behalf) also seem worried about the developing balanced scorecard – an additional lever for patients. This may become more relevant if proposals to remove practice boundaries happens (Informal discussion April 2010).

Across the sites however, the level of hostility can also depend on the location and type of APPC. In areas where the local GPs provide the APPC, we found that there is not much hostility towards that APPC. However, in areas where the local GPs did not think that the procurement was necessary, the APPC is seen as a threat and as a 'waste of money', and there would be considerable hostility.

In Site 2, there was an impression that it might reduce the hostility felt by local GPs if APPCs with walk-in facilities focus upon that side of their service rather than on their registered list. For example, instead of referring to GP-led health centre as such or as a 'health centre', they are referred to or advertised as a 'walk-in centre'. Another example can be seen in an APPC practice that is moving to a new 'health village' where there will be other GP practices and healthcare facilities. This APPC had a meeting with the GP and practice manager from one of the other practices in order to reassure them that the APPC was not planning to steal patients from established practices.

However, one of the managers from APPC1 (Site 1) explained that s/he believed that tension in an area could be healthy:

Take PBC – in some areas PBC groups tried to stop APPC1 coming in. It is stacked against us from start e.g. PEC Chairs (who are GPs and have friends locally) chairing commissioning panels. However I would say you need a healthy tension in an area – this can push some practices under but those that can take the lead and make things better. (Site 1, APPC1, APPC Manager, ID 1.14).

This tension has in some cases affected the behaviour of local GPs:

- F1: And finally really, do you feel, I'm feeling that you do, but the procurement of these practices has had an impact on the existing practices...
- F2: Absolutely.
- F1: ...in terms of sharpening up their act?
- F2: It absolutely, has. I mean the noise in the system, the resistance, more so in some places than others, in my view, was about fear of competition and the threat of new business and the threat to existing service providers. Absolutely right, it has taken away some of their activity, as I say, there's concern. I question whether it's taken away some of their costs, because of the contractual arrangements. But yeah, extended access became not so much of an issue.
- F1: So everybody's opening longer hours?
- F2: Everybody's opening longer hours, everybody's opening not necessary on Saturdays, but being flexible, everybody is beginning to offer extended services and patients are seeing something better and something different.
- F1: So overall it's probably levelled up.
- F2: I think it's put some, it's put some challenge in the system. Some providers, especially the big ones, and this is where they do make a difference, are maybe looking at how they can further developer services. The cynic in me says so they can get more money, but it doesn't matter, they're driving up potentially quality through service development, so looking to try to drive up quality through service developments. (Site 2, PCT Officer, ID 2.1)

Obviously GPs were established prior to this scheme. There were a number of anxieties, as there were nationally, especially around the health centres, would they take lots of activity away from their practise, the fact that they were open longer hours and at weekends. There's no direct evidence that the practices have changed the way they're working, but anecdotally I know of practices in the vicinity of the new equitable access schemes that have modified how they look after their patients, how they have changed opening hours. They've started doing early mornings, opening late nights for people who work. Traditional GP practices already had their core hours and extended hours so they were already doing some extended hour working, but I think they're being...anecdotally they are being more responsive. I'd say equally I have to agree there are some practices who have not changed one iota. (Site 2, PCT Officer, ID 2.3)

A business manager of APPC3 (site 1) was asked about perceived issues around practice-based commissioning and their practice joining such groups locally:

Not with joining PBC groups, I get an inkling that traditional GPs have had a problem with APMS contract holders because I think they see them as private firms who are coming in and taking away the patients and the care that they've been providing. I heard a lot of talk about Virgin doing these kind of APMS contracts and this and that, and I think we got some kick-back from that when we took it, I think locally people thought there's an APMS contract holder, they're private and so on and so forth, and I think we were quite unique because we were a traditional GP who had actually gone for it. But there was quite a bit of rumblings when we came. (Site 1, APPC3, Business manager, ID 1.25).

However, a senior PCT representative perceived that initial difficulties around PBC and the APMS practices had been resolved over time:

Practice-based commissioning - I'm aware there was some resistance at first to let the APMS practices in but, as far as I understand it, all that resistance has been overcome now. I could be wrong, but that's my understanding (Site 1, PCT Officer, ID 1.2)

Even though contractually they have to be part of PBC, some APPCs are not part of the PBC group and they feel that there is nothing they can do about it:

We're not part of PBC. That's quite interesting actually because contractually we have to be part of PBC and so we started with the intent of, you know, being part of the PBC because from a contractual point of view, you know, we're required to do that. The PBC group then, supported by the PCT, said no you're not going to, we don't want you here so don't come please. And then the PCT said well if that's what they want then that's fine with us. Well I wasn't particularly fussed to be honest. I mean I see...if we can contribute to PBC then great, but, you know, if...I see us as a provider organisation and what I want to be able to do is provide good services for patients, and I'm not overly fussed whether we get involved in commissioning or not. For the future we see ourselves as providers, not commissioners, although, you know, we may need to have some role in commissioning because we have practices which will inevitably be part of GP commissioning in some form I imagine. But we very much see ourselves as a provider organisation, so, you know, the fact that they said we don't want you to be part of our PBC group, you know...fine.. You know, that's fine. I mean we won't get upset about it. (Site 2, APPC 4, Executive Director, ID 2.6)

This respondent went on to explain that, if APPC staff had previously worked in the area in a traditional practice that could ease relationships:

We, you know, try and get on with everyone and hopefully people get to know us and they realise that we're not the devil with two horns and all the rest of it. In [named PCT], again, it's a bit different because there was a practice there previously, it's the same practice manager, she's been known amongst all the practice managers for years and years and years and so this has not been a problem in [named PCT]. (Site 2, APPC 4, Executive Director, ID 2.6)

For those who are part of a local PBC group, the absence of full time GPs (working part time and / or employment of locums) can make it difficult for them to fully engage with the PBC:

Yes, that was part of the contract that I'm supposed to go to. And GP's, of course, you're supposed to have a GP lead and because we didn't have a GP, what I did was, I said that [named doctor], who is one of the GP partners in one of the practices, he was going to be our GP lead, if you like, you know, and we'd go through him, I found it really difficult to go to practice based commissioning because there's only me and to go to every single meeting with everybody else, everything else that's going on, I found it quite difficult but we do...we do participate in it, we do do the audits that requested from us, the only thing that I did fall down on, I suppose, is attending all the meetings and you've got to attend them all, but one, I think, throughout the year, which I think is a bit...oh, I think you're allowed to miss three, I think, but, you know, that's...I think I've probably been to three as opposed to missed three but that's just circumstance and, like I say, you can't plan around what happens in here. [] And it's not as if you can say to the GP, well, you know, you go, because we didn't have a GP. So hopefully, when we're fully staffed, we may be able to engage a little bit better but we do do everything that's, you know, required from us, order wise, and everything, we contribute, if you like, to it. (Site 2, APPC 4, Practice Manager, ID 2.7)

In addition, we were told that practice managers at the 'Darzi centre' are not generally welcome at local practice manager meetings. As such, these practice managers felt that there is no network to support them. However, if a practice manager was already part of

the group due to their previous role in a local GP practice, they are still seen as part of that group:

I think it would have been quite awkward for them to turn around say to me, well you're not coming any more, but as well as that, we have a registered list size as well. So, for the registered patients, under a clinical governance kind of view, yes, I should be attending because of the things that we discussed but, again, you know, from...with the other management hat on, I suppose, from a walk in patient, you know, it doesn't really matter, but everybody's been okay with me and I can't understand why they won't let them go through but from the Darzi practice managers I thought it would have been nice to have a network support in. (Site 2, APPC 4, Practice Manager, ID 2.7)

Thus, existing relationships could have a mitigating effect on local hostility.

We also found occasional examples in which the presence of an APPC practice could be put to good use by other local GP practices. For example, in one of our sites a local GP practice had closed for a day and had directed their patients to attend the nearby APPC practice.

5.2 Are APMS contracts perceived to be value for money?

We asked PCT and APPC representatives if they believed that the APMS contracts provided value for money. Many were unsure, as they suggested it was taking time for the contracts to bed in as explained by PCT officers:

- F2: I don't know. I don't think - they're very time intensive, we've got one whole time equivalent looking after seven contracts, plus an analyst, plus a finance. They're actually, the value of the contracts are much greater than, say, GMS and PMS. It really depends how you define value for money doesn't it?
- F1: It does.
- F2: If you were saying, oh well we've got a better assurance that we're delivering x, y and z, well yes we have, but actually to do that it costs us more so I really... (Site 1, PCT officer, ID 1.7).
- M1: And talks with all contractors have said they're finding it very difficult obviously to make it pay...there's I mean to make ends meet at times. And these are expensive contracts. More than on a price to patient basis, more than PMS, more than GMS which you would expect in the early days of a contract, to be honest. You would expect that. But they are expensive. Which is a shame that if they're expensive, and yet they are still struggling
- F1: Yes. Is that to do with them trying to get list sizes up and that kind of thing. Is that, is that what's really affecting them?
- M1: Of course, yeah, things like that, yeah, yeah. In the main, yeah. (Site 1, PCT Officer, ID 1.6)

When asked directly if the APMS contracts are value for money this PCT officer went on to say:

It depends, it depends why they're there. If they're to stir up the GP community to, then yeah, they're a good thing. If, if, as a strict economic model, probably not. (Site 1, PCT Officer, ID 1.6)

Others thought they were definitely not value for money:

I absolutely don't think its value for money, when you think about what a GP gets, it's sixty five quid a year per patient, and a walk in centre gets more than that per walk in. []
Every time someone walks through the door, no, I don't think it's value for money, absolutely not. [] It's very costly, it's not value for money, it just isn't value for money.
(Site 2, PCT Officer, ID 2.2)

This senior PCT Officer added that GP-led health centres are massively over-performing on their walk in contracts and were thus 'not sustainable'. In addition, with quality improvement initiatives there is a drive to look at services that can be decommissioned. He/she argued that having GP-led HC lowered the threshold for people seeking medical advice, and that this would have a negative impact on costs overall. Site 2 had done a survey and found that patients were visiting GP-led HC walk-in centres for minor ailments, that they might previously have managed themselves. In addition, they are very expensive in terms of cost per registered patients, as their list sizes have not grown as expected. GP-led HC are seen to be very vulnerable because it's 'a license to print money':

I don't think it...I don't think they think that we would have the nerve to [close them] do that because the fallout would be huge. I think the public fallout would be massive. []
But if why...to be honest, if we'd got the money from the Department of Health without any caveats we wouldn't have done [this]. We would have looked at spending that money in other ways which is what certainly the population of [local area] wanted. (Site 2, PCT Officer, ID 2.2)

6. Impact of the 2010 Health White Paper

The data collection for this research spanned the publication in 2010 of the White Paper *Equity and Excellence* (Secretary of State for Health 2010). We found that it was proving to be a difficult time for the PCT staff in both sites, as they came to terms with the fact that their employing organisations would be abolished. In Site 1, by January 2011 the AD of monitoring will have left (redundancy) and another senior member of the team is being seconded 3 days a week to a developing social enterprise:

[PCT Officer, ID 1.6] - I will be leaving in January – compulsory redundancy. We are seeing 5% cuts by Christmas and a further 20% by April 2011. BUT consortia will need best support from PCT people with experience. Consortia need skills and capacity. Encourage and support people. Enlightened consortia can see the challenges and the need for support. If they are not careful the Trusts will take GP consortia to the cleaners. (Site 1, Observation, APPC1, Performance review meeting, August 2010).

Representatives from APPC1 saw the White Paper as an opportunity to develop themselves further but also articulated that they regret what is happening to the PCT staff as a result:

So the White Paper is wonderful. Absolutely brilliant. I'd think I wrote it myself!... And what it does is it brings together a number of policy initiatives of which equitable access was one. (Site 1, APPC1, Manager, ID 1.14).

The same manager went on to say:

[The White Paper] will allow structural inhibitors to be overcome - reorder primary care. Gives the focus back to what the public wants not what the professionals want. (Site 1, APPC1, Manager ID 1.14).

This was also observed at meetings:

[Named manager, ID 1.14] stated that the White Paper proposals were providing interesting times for APPC1 but that it was upsetting to see what it was doing to individuals. Although he predicted that lots of people would be out of work and then re-employed elsewhere in the system. (Site 1, Observation, APPC1, Performance review meeting, August 2010).

In Site 2, the first round of cuts was resulting in the loss of the entire information management team:

I have no idea why they've done that, but I understand that they're getting rid of pretty much every single one of them, and I don't see how...you know, you've got to have information if you want to make a difference. I don't see how they're going to transform anything without robust information. So I think that's a mistake. And of course there are a lot of unanswered questions: who is going to manage the IT, who's going to manage all the PCT premises that there is at the moment, who's going to deal with the information management stuff that's needed? You know, some of the other things around performance management and contract management and some of the commissioning and what-have-you, you know, not wishing to downplay any of that but I mean that's basic good management to achieve all of that. You know, there are a number of other unanswered questions at the moment and we'll see how it all plays out. I don't know. But, you know, I'm optimistic because I think something dramatic has to happen and, you know, this is something dramatic (Site 2, APPC 4, Executive Director, ID 2.6)

Most of the contracting team would have left Site 2 by the end of December 2010 under a redundancy package. At the end of the research they were archiving all the documents and preparing for a handover but the new team was not yet in place. There were concerns over what will happen to the APMS contract:

I find it very difficult, one, because I don't know how it's going to affect, I don't know the contract for walk in centres for five years, I don't know whether that's going to have an impact, although, I've heard that the commissioning is going to stay with the PCT's and everything else will go out to GP practices as a consortium, kind of thing, so that's a little bit worrying, I suppose, because, you know, we're in our second year now, what's going to happen? Again, that's why I want to increase the list size, because if I increase the list size, hopefully the PCT can't come in and say that, you know, we're going to stop the contract, or the GP's, or whoever, is looking after, because of all the patients and because we were a GP practice before we were the walk in centre, so one of my aims really would be to really increase the practice list size. The white paper, I find it difficult, at the minute, because we don't have a lead GP as well and it's different with salaried GP's who come in and they get paid for what they do and then they go home again. There's nobody to take the lead on, like, in a GP practice, you will have the partners who are really, either really up for it or really, like, you know, we're not going to do anything but that's up to them to form those, kind of, you know, if it's going to be a consortium, or whatever. So, I think from here, there's not a great deal of input into the, you know, what's going to happen with the white paper. I mean, I've attended the meetings with the practice managers and everything and I know from this area what they want to do is have a consortium of all the GP practices but then [named PCT] had suggested joining with them and commissioning services and things but because [local area] may be, I don't know whether the patients are different [in different area], I don't know, but it seems to be that the services that they would want to commission wouldn't be the same on [different area]. So I think what they want to do is just have a consortium in [named PCT], one in [named PCT], which is, you know, next door really. And then maybe an overall one that would make it...that's the way things seem to be going, from here, like I say, it's quite up in the air and it's...I don't know... (Site 2, APPC 4, Practice Manager, ID 2.7)

However, a senior PCT Officer told us that they he/she believed that any future GMS contract should come to more closely resemble the APMS contract, particularly with regard to the idea of KPIs:

Well they are...there is going to be a new GP contract. I can't see that happening in the near future because whatever they do needs to be agreed with the GPs ...Uncle Tom Cobbley and all, so it's not going to be in the foreseeable future. I keep hearing rumours that it won't be a new contract, it'll just be an amendment so that they've got to do the GP consortia element of it. Excuse me, there was a hope, probably from primary care contracting people that there would be one contract that would look more like an APMS contract and would have KPIs in that gives contractors more clout, because GMS and...even PMS really don't. There was an intention that with the PMS review we would include KPIs in there, but that's been shelved because we don't want to upset GPs, do we? So that's all been shelved, given that they're going to be doing the GP...they're going to be commissioning in the future, we don't want to upset them. That is not my words, by the way.[Laughter] So that's been shelved, so my hope would be that it would be more like an APMS contract where there are key performance indicators that GPs have to achieve. Because otherwise really the GMS contracts, it's a bit because it's a contract in perpetuity, PMS practices have the right to revert to GMS if you do anything that they don't like. (Site 2, PCT Officer, ID 2.2)

7. Perceptions of success / difficulties

7.1 Perceptions of success of APMS contracts (as defined by interviewees)

All respondents were asked how they thought an APMS contract could be 'measured' in terms of success. The answers varied and often included multiple measurements such as:

- Meeting the KPIs within the contracts to date.
- Meeting QOF
- Patient satisfaction rates
- Increasing list size / financial stability
- Renewal of contract after initial 5 year period
- Staff stability / staff morale high
- Providing services in adverse circumstances (premises etc)
- A well functioning practice
- Providing additional services to benefit local population
- Good working relationships
- Use of scorecard

Most commonly responses included meeting KPIs plus some sort of broader measure(s) as illustrated by the following range of answers:

My definition of its success is improving the health of the local community, our registered patients, yes, but the local community as a whole. So I think that's a difficult one because that's just an aspiration we have we have as an organisation and not specifically related to this sort of APMS contract. (Site 1, APPC3 Business manager, ID1.25).

Well, I suppose from my perspective it's about my team's function in that, I suppose, from an organisational perspective, it is that they're getting the patients registered with them and that they're hitting many of the targets. Maybe not all, because actually I think it's a contract and a half, and I think for them - if they hit them all I'd start questioning it... But from my perspective that we've got good working relationships, that it's open, honest, transparent. (Site 1, PCT manager, ID 1.7)

Personal success is really, I suppose, just because we hit the targets and we're over performing from my point of view and I think that's down to me and the rest of the staff that's here. (Site 2, APPC 4 Practice Manager, ID 2.7)

If you define successful by the number of patients that have gone through then, yes, I guess it is, because a hundred and twenty thousand people have gone through that service that probably didn't have a service prior to that opening. [] If you define successful by we managed it within the contract budget then, no, it hasn't been successful at all. [] From a patient perspective probably, yes, from a PCT perspective probably, yes and no, yes, because patients have gone through, no, because we haven't managed it within the budget that was allocated. (Site 2, PCT Officer, ID 2.2)

Well, from a wide perspective, a successful contractor is one that achieves its KPI's and hits its list size targets, because then it's doing what was expected of it from the outset. From a personal point of view, I would say those targets were set for a reason and that was to...the KPI's were set for a reason, they were the KPI's that the PCT wanted the practice to achieve in. So if they are hitting those KPI's then that would be a successful practice in my eyes. Obviously, to ensure that there's no complaints from patients, we have a PALS service and the providers are also required to let us know of any complaints that they have receive. So, obviously, patient satisfaction would be a good factor in

deciding if it's successful or not. [] I think that's it really and just the perception of other staff in the PCT, because we meet with a number of people around the PCT and if people don't have any issues with the providers, get the information when they need to, there's no problems with them, then that wouldn't mean they're successful, I would say. (Site 2, PCT Officer, ID 2.4)

This Officer stressed the importance of staff recruitment and the responsiveness of contractors (APPCs):

Personally my sort of criteria for success are a good, solid, regular team of staff. [] It varies across all of the contracts. I would see it being positive if a contract's managed to recruit staff, if they're of a high calibre, and if they've managed to retain them throughout the first year of their contract. That gives me good vibes. That tells me that they've got good procedures in place for recruiting people, they've had a group of people that they can choose from and they've picked the best, and if they're still there after 12 months that gives me confidence there's consistency for patient care, gives me positive vibes for the future. I know that they can develop services because they've got a good start to the contract. You know, they're five year contracts so if year one is disrupted, if it's fragmented, it doesn't bode well for the next four years because, you know, you set the ground regulated foundations in the first year really. Another sort of key driver for me is how responsive the contractors are. If they're straight back to you resolving issues, answering questions, being proactive when you contact them, then I suppose I do...if they're a bit aloof, if they're forever coming back to you with reasons why that can't be achieved, that rings alarm bells to me because, you know, if this is the first year and they're not looking...if they're having problems and they're not looking to impress...you know, if I had a five year contract in the first year I'd be bending over backwards to make positive noises everywhere, showing people that I can do this and that I'm going to be here in five years rather than potentially putting anxiety in the contract manager's mind. (Site 2, PCT Officer, ID 2.3)

A PCT monitoring officer described introducing competition into the primary care market as having some positive and some negative points:

- M1: There are good elements and there are not, not good elements. The not good elements in my mind, if you introduce a profit motive in health then that's bad. Good elements are that I think there should be some sort of competition.
- F1: Because?
- M1: It should improve quality of services to patients. And make things more efficient, value for money. (Site 1, PCT Officer, ID 1.6)

One of the APPCs in Site 2 uses a balanced scorecard to measure their success:

- M1: We use score cards to measure our success. So we have four quadrants...
- F1: This is from ...
- M1: This is from us. Yeah, this is from us. We've developed it locally. So we have four quadrants. We have a quadrant which is around patients, so we do a lot of patient surveys for registered and walk in patients. Every walk in patient gets a survey which we ask them to complete... which has got a range of different questions on it and we do detailed analysis of that. So we've got a quadrant about the patient, we've got a quadrant around quality, which includes KPI reports into the PCT and other quality measures which we have. We have a quadrant which is around staff surveys; we have staff surveys which we take regularly, and, again, we do some detailed analysis of that, and staff performance management and all those sorts of things, and then we have another quadrant which is around the financial element of it. And any one of

those quadrants if it's failing, we have a failing, we have a service in trouble. So I mean clearly from a commercial point of view if we're losing money financially we have a problem with the service, it's viability, but you could be having fantastic, you know, finances but if all your staff are ready to storm off in a huff you've got a problem which you need...and equally you may have happy staff, happy patients and great finances, but if you're missing all of your clinical governance measures and KPIs and all the rest of it you're going to have a major catastrophe somewhere along the line. So each one of those quadrants is just as important and we need to be achieving all of them.

F1: Okay. So is it a score of one to ten or something? How do you score them?

M1: Well we take each measure...we set a different target within each measure as to what...it's a simple red, amber, green we use, and each measure will have a different score as to what is red, what's amber and what's green, and we'll amend that from year to year, so we want to make the targets more stretching as time goes on. Yeah, that's right. Yeah, absolutely. So our focus for the first year of the contract for [local area] certainly there wasn't quite so much of an emphasis on the financials because what we wanted to do is get the services up and running safely and to be successful from a patient and PCT perspective, and once we were confident that that was happening since then we've started taking a much more robust look at the finances. So we had much softer commercial and financial targets last year than we have now, and inevitably they'll get tougher next year as well. (Site 2, APPC 4, Executive Director, ID 2.6)

7.2 Perceptions of difficulties faced with APMS contracts (as defined by interviewees)

Interviewees were also asked what difficulties had been faced in terms of operating the APMS contracts. These included:

- Achievement of target list sizes.
- Turnover of GPs within some of the contracts
- Difficulties in employing full-time GPs
- Co-location of some practices with established practices, and associated conflicts
- Definitions and interpretations of KPIs / targets etc within the contract

Achievement of list size was by far the most often mentioned difficulty and it potentially had a large impact on the financial turnover and viability of the various contracts (as previously discussed in section 4.2). An APPC representative describes some of the issues they have faced in terms of list size:

F1: So you started at zero list size and you started your own?

F2: Yes.

F1: And can I ask what the list size is roughly now?

F2: Now you've put me on the spot, it's all right, I just haven't done research for a little while. A rough estimate is maybe 700.

F1: And is that the kind of level that you were expecting?

F2: No, it's probably less than we were expecting, but there are issues to do with our position as well, the fact that we're on the top floor, and I don't think there's actually very much new people coming into the area so it's my understanding that a lot of the patients that we're getting are basically moving from other doctors in the area. (Site 1, APPC3, Business manager, ID 1.25).

As discussed earlier, in one of the APPCs in Site 2, the APPC argued that the reason that their low registered list size is because there is no pharmacy next to their practice. However, the PCT argued that APPC 5's difficulty in getting their registered list is because there is an anti-APMS practices in that area:

- F2: Yeah, [named area where APPC 5 is located] the GPs were very anti the APMS practices and the building that [APPC 5] now occupy, there is another GP practice in [that area] and they used to be based in that building and rather than upgrade the building at the time that building was mothballed and the other practice moved to new premises. Then when the Equitable Access scheme was launched the decision was taken by the PCT to refurbish [named building where APPC 5 is located], much to the annoyance of the practice that used to be in there.
- F1: But they've moved to a new practice so...
- F2: They have, but it's not as near to the centre of town as the health centre was. So...and they used to be the only practice and now clearly there is some competition. There are some quite major relationship issues. [] I don't know which meeting you attended but [APPC 5] said that he didn't think that the practice was liable because...
- F1: Yeah, I think I was there because of the pharmacy thing, yes.
- F2: Yeah, now it...what we said to him was...clearly we kind of called his bluff a little bit and because although that practice in [local area] is a bit unique because it is a GP practice but you can do some nurse led walk-in and so the walk-in numbers...he's over performing on his contract for walk-in, but not for registered, but his argument is that because he is underperforming on the registered is not viable, but he is actually earning more than the overall contract five year period, so I'm not quite sure how he works that one out, but anyway he was adamant that it's not a viable practice and this is probably in about July he said this. So we called his bluff and said, "[named Director of APPC 5] if you don't think this is viable we need you to put something in writing and we'll take it to the board and we'll look at decommissioning if that's what you want," everything went very quiet. (Site 2, PCT Officer, ID 2.2)

This Officer suggested different issues across the different contracts caused difficulties:

- M1: There's been a mixture of issues across all of the contracts really. Obviously there's different issues between the GP practices and the health centres. Because of the nature of the health centres being open eight till eight, 24 hours a day, 365 days a year, their workforce pressures are more significant. The GP practices echo the traditional GP model and therefore the issues echo GP issues from...
- F1: The same issues.
- M1: The same issues really, just with the addition of KPIs. The health centres, you need a highly motivated workforce and you need a good, strong workforce to maintain cover 365 days for 12 hours a day, and it is demanding really. There's been similar issues in the practices. There's also been some quite individual issues and, you know, that potentially reflects on the providers and whether they're, not a small provider, but it depends on their back up and their support, whether they're part of a national group or whether they're part of a local group. You know, obviously they have their own personality and their own company ethos as well and sometimes that comes through. Sometimes that can affect how you approach resolving issues. Sometimes it's more formal that potentially it needs to be just by the nature of the provider.
- F1: So are you saying that the national bigger providers would have a more kind of formal...?

M1: Not always, but sometimes they have internal procedures and internal checks that they need to put in place before they can commit, whereas other small providers will respond instantly because they are the person at the top as it were, so you're dealing with them across the table there and then rather than having to refer to colleagues or a board. (Site 2, PCT Officer, ID 2.3)

8. Summary and conclusions

8.1 Procurement

To date there have been two rounds of procurement since 2007 (Fairness in Primary Care and Equitable Access) to increase the provision of primary care services within PCTs defined as under-doctored. The process has been driven centrally by the Department of Health within very tight timetables and stimulated the entry of new providers into the market. The procurement process has been at times contentious and it has operated within a highly specified legal framework. There were clear differences in interest, by potential providers, for the contracts between the two rounds across the two different sites, especially the larger national companies.

The commissioning of new practices was prescribed from the top and different amounts and types of help (monetary and expertise) with the procurement process and subsequent operation of the practices was available. All commissioners were expected to carry out public consultations as part of the procurement process which could include public meetings and presentations to local overview and scrutiny committees. There were different levels of support and some hostility to the new providers in local areas, often dependant on the location of the newly establishing practices – those co-located (e.g. in new LIFT funded buildings) with existing practices received greater hostility from other GPs locally who perceived themselves to be in direct competition with the new providers. There was also a degree of resentment in some areas over the fact that the EAPMS process in particular involved new investment, but this investment could not be spent to improve the services offered by existing GP practices. Some PCT Officers were in sympathy with this view, although they did perceive that the stimulation of competition may have had a beneficial effect on existing providers.

8.2 Ways of working

Different forms of APPCs are found within single PCT commissioning areas and work in different ways to meet their contract obligations, including the provision of services, the attraction of new services, the balancing of budgets and the meeting of targets. Perhaps the most striking difference that was found between the two sites was in the employment of permanent GP staff. In Site 1 the use of Locum doctors was perceived negatively and was discouraged, whilst in Site 2 a number of APPCs relied extensively on locum cover to meet their service obligations. This had a negative impact on the ability of these APPCs to engage with the wider issues relating to primary care, such as the involvement in Practice-based Commissioning.

Different mechanisms have been used by the different APPCs to attract new patient registrations and as time has gone on many have relied more heavily on word of mouth recommendations as opposed to the initial leaflet drops or on street advertising. We did not find any *systematic* differences between the different models of APPC that we had initially identified. Thus, for example, large national-level chains did not behave in ways which were systematically different from smaller local companies.

8.3 Monitoring

APMS contracts have been tightly specified and are closely monitored by commissioners. This has proved extremely time consuming for both the PCTs and providers but as relations develop locally there has been the potential to scale down the checking process. In Site 1 it was suggested that the new regime (or at least those aspects perceived to be working well) could be rolled out to monitor other primary care contracts (GMS / PMS) locally over time. Overall, the process was found to be more formal and tightly managed in site 1 than it was in site 2, but the small scale of this project means that we are unable to comment on any difference in outcomes between these two different monitoring styles.

Some difficulties have been caused by a lack of clarity of meanings within the negotiated contracts. In Site 1 this difficulty was reinforced by the splitting of responsibility for procurement and contract management between two different teams. This sometimes resulted in the need for formal contract renegotiation around specific indicators and definitions.

8.4 Outcomes

We were not able, in such a small study, to formally assess outcomes. However, we did ask all of our respondents to talk to us about their own personal definitions of success. In general we found a large number of different personal definitions of what a 'successful' APPC and APMS contract might look like. Some of these were non-specific and aspirational, with, for example, references to 'improving the health of the local community'. However, some common perceptions emerged from a number of respondents:

- The procurement process was extremely challenging, and successfully completing this within the tight timescale was regarded by many as a significant 'success'.
- Managing the contracts was very time-consuming, and it would be difficult to extend this across primary care more generally
- However, there was some consensus that thinking about primary care contracts in this way had changed attitudes to the wider field of primary care within the PCT, encouraging contract managers to be a little more challenging with existing GPs.
- There were some claims made that the existence of competition had led existing GPs to 'raise their game'
- The APMS contracts that we saw in action were generally regarded as being a relatively expensive way of providing primary care, particularly in view of the difficulties many found in recruiting permanent patients to their lists
- There was some concern that the existence of 'walk in' centres was stimulating new demand for health care services which could significantly add to overall costs.

The White Paper, *Equity and Excellence* (Secretary of Health 2010), does not contain within it any specific reference to APMS contracts in primary care. From April 2012 the new NHS Commissioning Board will be fully established, and will be responsible for

commissioning primary care contracting. However, there is as yet no detail about what this will mean and how it will operate. One thing does remain clear: policy will be based on the assumption that competition between providers is essential in any drive to improve quality:

Our aim is to free up provision of healthcare, so that in most sectors of care, any willing provider can provide services, giving patients greater choice and ensuring effective competition stimulates innovation and improvements, and increases productivity within a social market. (Secretary of State for Health, 2010:37)

Within the primary care sector, this implies that service provision by APPCs will continue. There is therefore the potential to learn from this small scale study about the procurement, operation and monitoring of such providers working under the APMS regime, and for future procurement by the soon to be formed NHS Commissioning Board.

However, it is not yet clear how any future procurements will be done, and how any existing APMS contracts will be managed by the new NHS Commissioning Board. Indeed, it seems unlikely that a central NHS Board would be able to monitor APMS contracts in the detailed way that we found to be common in this study.

Issues that seem to arise from the White Paper (or at least will require further clarification) include the following:

- Will the full range of Primary Care contracts continue to be available, or will there be a convergence between APMS, PMS and GMS contracts?
- Will the 5 year duration of contracts common under APMS remain, and will it be extended to GMS and PMS?
- How will current APMS contractors fit into developing GP Commissioning Consortia?
- The ongoing affordability of contracts? Are current APMS contracts safe and sustainable?

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Appendix 1

List of companies involved in provision of primary care as at March 2007 (Pollock et al 2007:457)

Companies with commercial contracts to provide primary and community medical services to the NHS in England (March 2007)	
Company	Service, area covered, contract type (where known)
Private health care corporations	
BK Health UK	5 medical and health centres (4 practices run under PMS in England and 1 GMS Wales)
Care UK (formerly Anglia Secure Homes)	Out of hours provision across Essex 7000 patient practice in Barking and Dagenham (APMS) HM Prison/Young Offenders Institute, Chelmsford HM Prison Wellingborough
Chilvers Mc Crea (subsidiary of Mercury)	23 general practices Prison care Out of hours care Variety of contract forms: GMS, PMS, and APMS
Concordia Health	2 general practices
Intra Health	4 general practices (PMS)
Mercury (subsidiary of Tribal Group)	1 primary care centre, City and Hackney primary care trust (integrated PMS and WIC this one not explained in footnote)
Nestor	Out of hours provider for 44 primary care trusts and 5 Welsh health boards 2 primary care centres Forensic medical services—young offender institutions, police authorities, detention centres
Serco	All out of hours care for Cornwall Out of hours care in Cardiff Cardiff and Leicester prisons
United Health care	General practice, Derby
Drug company	
Pfizer Health Solutions	Chronic disease management for North Birmingham and East Birmingham primary care trusts
Joint ventures	
Hillingdon Healthcare/ Harmoni	General practice services in Hillingdon (APMS)
Harmoni/WCI Group	Out of hours care for 11 primary care trusts 9 primary care centres
General practitioner providers	
Aston Healthcare	General practice, Mansfield
Central Surrey Health	Community nursing
Devon Doctors Cooperative	Out of hours service, Devon
GatDoc	Out of hours service, Gateshead
Hurley Group	Sternhall Lane, Peckham Riverside Medical Centre Hurley Clinic, Lambeth
Local Care Direct	Out of hours service, West Yorkshire
NEWDOC	Out of hours service, North Warwickshire and District
Northern Doctors Urgent Care	Out of hours service, North Tyneside primary care trust
On Call Care	Out of hours service, Maidstone
Rushcliffe Mutual	Provision of services and practice based commissioning in Nottinghamshire (APMS with primary care trust) 21 general practices
SELDOC	Out of hours service Lambeth, Lewisham, and Southwark
Shropdoc	Out of hours service for Shropshire, Telford and Wrekin, Powys and Wrexham
Thamesdoc	Out of hours service for Surrey primary care trust
Wayside	Surrey Heath and Woking local prison (APMS)
Wolverhampton Doctors on Call	Out of hours service for primary care trust
Wsdoc	Out of hours service for West Sussex, 7 out of hours surgeries

GMS= General medical services contract, PMS=personal medical services contract, APMS=alternative provider of medical services contract.