UNDERSTANDING STAKEHOLDER PERSPECTIVES ON THE ORGANISATION OF PRIMARY CARE: THE MEDIATING ROLE OF THE PUBLIC IN COMMUNITY GOVERNANCE

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Abstract

Aim and Objectives

The overall aim of this work was to explore the current organisation of general medical services in Scotland, and by doing so, to create evidence which would identify a more effective and acceptable organisational model for the future delivery of primary care (general medical services) within the Scottish context. There were three research objectives: to improve understanding of the views of the public in relation to the organisation of general practice (general medical services) within the wider context of primary care within Scotland; to improve understanding of the views of professionals working within primary care in relation to the organisation of primary care; and to identify and refine models of primary care, and then to test these models of primary care against the status quo with primary care staff and with representatives of the public.

Methods

Mixed methods were used to answer the research questions. These included group-work with members of the public in order to identify their priorities for the future of primary care; and semi-structured interviews with a purposive sample of primary care staff which combined members of the core practice team with Community Health Partnership and Health Board managers. Two alternative models for the provision of primary care general medical services were identified by combining the findings from the public and primary care staff with the literature. The two alternative models were then explored by public representatives and primary care staff using mixed methods which combined scoring of the models with deliberative discussion.

Results

Work with the public identified a number of specific priorities. The most important priorities included: quality of care; access to care; and holism. A number of other issues such as a desire for involvement in their own care and the importance of access were also identified. Equity was also acknowledged as being important. There was general agreement between the public and primary care staff in terms of priorities, although staff were resistant to an increased role for the public in overseeing the organisation of practices. Staff and the public agreed on the high levels of variability in general medical practice and the public were concerned about low levels of holism. Staff and managers described an emerging sense of confusion about the roles of general practice. Practice staff had very negative views of Community Health Partnerships and Health Boards in terms of governance, and there was a lack of leadership and direction across primary care. There was evidence of low levels of trust between practice staff and CHP/Board managers. Skillmix was seen as desirable, though some saw it as a means to cost reduction. The independence of practices within the NHS was overwhelmingly supported by staff, who felt that this was preferable to the difficulties encountered in the directly employed and managed system. Practice ownership and the issue of profit was contested with a number of staff being uncomfortable with the idea, but there was a recognition that removing this driver might have negative consequences. There was ambivalence about the move to a wider model of health and the impact of integration with other sectors which was seen negatively by practice staff.

Two alternative models were identified: a local contract model and a social enterprise model. These were tested by public representatives and primary care staff against the status quo. The public scored the local contract more highly on the domains of patient influence on service organisation, and on patient and carer involvement in their care. The public representatives scored the social enterprise model significantly more highly than the local contract model and the status quo. The primary care group did not score the novel models significantly higher than the status quo. The staff group were concerned about proposals to increase the involvement of the public in the organisation of services.

Conclusions

The work builds on that of others who have identified the public's priorities for primary care. It suggests that holism, patient influence in service organisation and equity are important priorities. The work with primary care staff confirms work by others relating to difficulties with the governance of primary care. Alternative independent models of provision were advanced which might address some of the current difficulties in general medical services. The author proposes that user involvement should form an important part of primary care governance, bringing together conflicting perspectives of CHP/Board managers and practice staff. The public's main role in governance is to mediate between the positions taken by health professionals and managers, creating a shared perspective which is acceptable to the public. Furthermore, the concept of conditional trust and the emergence of new forms of professionalism which foster interdisciplinary working are proposed as potential solutions to the current impasse.

Table of Contents

ABSTRACT **I**

TABLE OF CONTENTS IV

LIST OF TABLES AND FIGURES VII

DEDICATION XII

AUTHOR'S DECLARATION XIV

ABBREVIATIONS XV

CHAPTER ONE: INTRODUCTION **1**

1.1 Background *1*

1.2 Overall research aim *1*

1.3 Overview of methods *2*

CHAPTER TWO: HISTORICAL PERSPECTIVE AND LITERATURE REVIEW **4**

2.1 Objectives *4*

2.2 Methods *4*

2.3 Primary Care and General Practice *6*

2.4 Historical perspective on UK primary care *9*

2.5 The new General Medical Services Contract *16*

2.6 The impact of nGMS *20*

2.7 Scotland post-devolution *25*

2.8 England post-devolution *27*

2.9 International primary care *30*

2.10 Models for delivering primary health care in Scotland *33*

2.11 Views on the organisation of primary care *62*

2.12 Conclusion *66*

CHAPTER THREE: METHODS **67**

3.1 Research objectives *67*

3.2 Using mixed methods approaches *67*

3.3 Research objective one: to improve understanding of the views of the public in relation to the organisation of general practice (general medical services) within the wider context of primary care in Scotland. *68*

3.4 Research objective two: to improve understanding of the views of staff working within the core primary care team and of staff managing primary care in relation to the organisation of primary care. *71*

3.5 Research objective three: to identify and refine models of primary care, and to test these models of primary care against the status quo with representatives of the public and with primary care staff. 75
3.6 Justification for the specific methods chosen 81
3.7 Ethics and research governance 88
3.8 Timescale 90
3.9 Conclusion 91
CHAPTER FOUR: EXPLORING THE PUBLIC'S PRIORITIES FOR PRIMARY CARE **92**
4.1 Public participants 92
4.2 Important issues for general practice 92
4.3 Critical uncertainties for the future of general practice 96
4.3 Using scenarios to explore the public's views about the future of general practice 98
4.4 Conclusions 106
CHAPTER FIVE: EXPLORING STAFF VIEWS OF THE ORGANISATION OF PRIMARY CARE **108**
5.1 Ontology and axiology 108
5.2 Characteristics of participants 109
5.3 Organisation at the national, Health Board and Community Health Partnership levels 110
5.4 Skillmix in general practice 114
5.5 Identity and independence 116
5.6 Partnership and salaried practice 118
5.7 Organisation and health inequalities 125
5.8 Alternative models for general practice 128
5.9 Confusion 137
5.10 The patient 143
5.11 Understanding the tensions in primary care 144
CHAPTER SIX: IDENTIFYING ALTERNATIVE MODELS OF PRIMARY CARE **146**
6.1 What are the alternative models? 146
6.2 The public's priorities 147
6.3 Consensus findings from the staff interviews 147
6.4 Status quo: the General Medical Services contract (GMS) 149
6.5 Personal Medical Services Plus (PMS Plus) 151
CHAPTER SEVEN: THE PUBLIC'S ASSESSMENT OF THREE MODELS OF PRIMARY CARE **157**
7.1 Methods 157
7.2 Participants 158
7.4 Assessing the performance of the current model 162
7.5 Assessing the performance of a local contract model 164
7.6 Assessing the performance of a social enterprise model 167

7.7 Comparing the relative performance of all three models *171*

7.8 Participants views about the process of weighting priorities and scoring models *174*

7.9 Conclusions *177*

CHAPTER EIGHT: STAFF ASSESSMENT OF THREE MODELS OF PRIMARY CARE **179**

8.1 Methods *179*

8.2 Participants *180*

8.3 The priorities for the future of primary care *181*

8.4 Assessing the performance of the current model *182*

8.5 Assessing the performance of a local contract model *188*

8.6 Assessing the performance of a social enterprise model *193*

8.7 General comments *198*

8.8 Comparing the relative performance of all three models *198*

8.9 Participants views about the process of weighting priorities and scoring models *201*

8.10 Comparing public and primary care staff weighting and scoring of the models *201*

8.11 Conclusions *205*

CHAPTER NINE: DISCUSSION **206**

9.1 Findings *206*

9.2 To improve understanding of the views of the public in relation to the organisation of general practice (general medical services) within the wider context of primary care within Scotland *207*

9.3 To improve understanding of the views of professionals working within the primary care team in relation to the organisation of primary care *209*

9.4 To identify and refine models of primary care *215*

9.5 To test these models of primary care against the status quo with primary care professionals and with representatives of the public *216*

9.6 Understanding stakeholder perspectives on the organisation of primary care *220*

9.7 Limitations and strengths *223*

9.8 Reflections *231*

9.9 Possible implications of the findings *233*

9.10 Conclusions and recommendations *236*

REFERENCES **239**

APPENDIX 1 **272**

APPENDIX 2 **324**

APPENDIX 3 **335**

List of Tables and Figures

Chapter Two

Table 2.1 Primary search terms used to generate the comprehensive literature review. 5
Table 2.2 Payment elements and their descriptors as set out in the proposed nGMS contract in 2003 18
Table 2.3 Selected international examples of systems of remunerating primary health care, circa 2004. Adapted from Greβ, Delnoij and Groenewegen (136) Note: Fee-for-service (FFS). 42

Chapter Four

Table 4.1 Breakdown of public partnership fora participants by geographic area. 92
Image 4.1 Photograph showing emerging themes of importance to the future of primary care. Taken at the PPF Future for Primary Care event, November 2008. 93
Table 4.2 The PPF group's critical uncertainties for the future of general practice with two possible future states for each dimension. 98
Table 4.3 Critical uncertainties prioritised by PPF participant groups for further work 99
Figure 4.1 Orange PPF group characterisation of future scenarios for general practice using the uncertainties of access to services and resourcing of services. 99
Figure 4.2 Yellow PPF group charectarisation of future scenarios for general practice using the uncertainties of access to services and resourcing of servi.ces 100
Figure 4.3 Green PPF group characterisation of future scenarios for general practice using the uncertainties of access to services and levels of communication. 101
Figure 4.4 Red PPF group characterisation of future scenarios for general practice using the uncertainties of communication and equity. 102
Figure 4.5 Blue PPF group characterisation of future scenarios for general practice using the uncertainties of free/paid care and equity 103
Figure 4.6 Purple group characterisation of future scenarios for general practice using the uncertainties of communication and resource 105

Chapter Five

Table 5.1 Role of participants and their participant numbers 110
Table 5.2 Participants categorised by geographic area of working 110
Figure 5.1 Operational elements shaping practices. 145

Chapter Six

Table 6.1 Synopsis of the attributes of Model 1 (the status quo). 150
Table 6.2 Synopsis of the attributes of Model 2 (PMS Plus). 152

Table 6.3 Extent to which the PMS Plus model addresses the challenges identified with the extant GMS practice model 153
Table 6.4 Synopsis of the attributes of Model 3 (SEP). 154
Table 6.5 Extent to which the SEP model addresses the challenges identified with the extant GMS practice model 156

Chapter Seven

Table 7.1 Respondents categorised by geography, socioeconomic status, employment status, age-group and gender. 159
Table 7.2 Priority domains for models of general practice. 160
Table 7.3 Weighting of priority domains for general practice (second round of scoring) with median and mean scores. N=26. 161
Table 7.4 Performance scores for model 1 of general practice (second round of scoring) with median and mean scores. 162
Table 7.5 Weighted performance scores for Model 1 (participant's domain weighting score multiplied by the participant's performance score for Model 1). The cumulative score is the arithmetic sum of all 12 weighted performance scores for each participant. 163
Table 7.6 Unweighted performance scores (second round of scoring) for Model 2 (local contract) 165
Table 7.7 Weighted performance scores (second round) for Model 2 (local contract). 166
Table 7.8 Unweighted performance scores for Model 3 (social enterprise model) 168
Table 7.9 Weighted performance domains for Model 3 (social enterprise) 169
Table 7.10 Distributions of the cumulative performance scores for the 3 models. 171
Figure 7.1 Boxplot showing distributions of the cumulative weighted performance scores for Models 1, 2 and 3. 172
Table 7.11 Summary of statistical tests of significance in weighted performance scores for individual domains between models. 173

Chapter Eight

Table 8.1 Respondents categorised by geography, staff grouping and gender. 180
Table 8.2 Weighting of priority domains for general practice (second round of scoring) with median and mean scores. 181
Table 8.3 Performance scores for model 1 of general practice (second round of scoring) with median and mean scores. 183
Table 8.4 Weighted performance scores for Model 1 (participant's domain weighting score multiplied by the participant's performance score for Model 1). The cumulative score is the arithmetic sum of all 12 weighted performance scores for each participant. 184
Table 8.5 Unweighted performance scores (second round of scoring) for Model 2 (local contract) 189

Table 8.6 Weighted performance scores (second round) for Model 2 (local contract). 190
Table 8.7 Unweighted performance scores for Model 3 (social enterprise model) 194
Table 8.8 Weighted performance domains for Model 3 (social enterprise) 194
Table 8.9 Distributions of the cumulative performance scores for the 3 models. 199
Figure 8.1 Boxplot showing distributions of the cumulative weighted performance scores for Models 1, 2 and 3. 199
Table 8.10 Summary of statistical tests of significance in weighted performance scores for individual domains between models. 200
Table 8.11 Distributions for the weightings for the 12 domains of importance for both the public and staff groups 202
Table 8.12 Comparison of group scoring of priority domains of the public versus primary care staff. Independent samples Mann-Whitney U Test for each of the twelve priority domains. Using a simple Bonferroni adjustment for multiple comparisons, the level of statistical significance is reduced from 0.05 to 0.004 203
Table 8.13 Mann Whitney U Test comparing the weighting of the patient influence domain between the public (group 1) and staff (group 2). 204
Table 8.14 Cumulative weighted performance scores for all 3 models by both public representatives and staff. 205

Chapter Nine

Table 9.1 Analysis of the purposes of the mixed methodologies used in the research based upon a nosology of mixed methods purposes developed by Bryman 230

Appendix One

A1.1 Letter of invitation to PPF members to the scenario planning session 272
A1.2 Programme for the public priorities event 274
A1.3 Semi-structured interview schedule 275
A1.4 Staff letter of invitation 277
A1.5 Staff participant information sheet 279
A1.6 Staff consent form 282
A1.7 Letter of invitation to PPF participants to attend alternative models consensus panel 283
A1.8 PPF consensus panel participant information sheet 284
A1.9 PPF consensus panel consent form 287
A1.10 Scoring sheets (pre and pst discussion) for priorities and models 290
A1.11 PPF consensus panel itinerary 290
A1.12 PPF consensus panel participant questionnaire 290
A1.13 Staff email of invitation for eDelphi 290
A1.14 Staff participant information sheet for eDelphi 294

A1.15 First staff eDelphi. 297
A1.16 Second round eDelphi 305
A1.17 NHS Research Ethics Approval for Research Objective Two 322
A1.18 NHS Research Ethics Approval for Research Objective Three 323

Appendix Two

Table A2.1 Descriptive statistics for public weighting of domains (rounds 1 and 2) 325
Table A2.2 Summary of statistical tests of significance between round 1 and round 2 of weighting the domains. Ho is that there is no difference between the first and second round weighting of the domains 325
Table A2.3 Model 1 (the status quo) unweighted scores 325
Table A2.4 Summary of statistical tests of significance between round 1 and round 2 of performance scores for Model 1. Ho is that there is no difference between the first and second round performance scoring of the first model (status quo). 327
Table A2.5 Weighted performance scores for Model 1 328
Figure A2.1 Histogram showing the distribution of the cumulative weighted performance scores for Model 1 331
Table A2.6 Unweighted Performance Scores for Model 2 (Local contract) 329
Table A2.7 Summary of statistical tests of significance between round 1 and round 2 of performance scores for the second model. Ho is that there is no difference between the first and second round performance scoring of the second model (PMS Plus). 330
Table A2.8 Weighted performance scores for Model 2 (local contract) 331
Figure A2.2 Histogram of the distribution of cumulative weighted performance scores for Model 2 (local contract). 331
Table A2.9 Unweighted scores for Model 3 (social enterprise) 332
Table A2.10 Summary of statistical tests of significance between round 1 and round 2 of performance scores for the third model. Ho is that there is no difference between the first and second round performance scoring of the model (SEP). 333
Table A2.11 Weighted performance scores for Model 3 (local contract) 334
Figure A2.3 Histogram showing the distribution of the cumulative performance scores for model 3. 334

Appendix Three

Table A3.1 Descriptive statistics for public weighting of domains (rounds 1 and 2). 335
Table A3.2 Summary of statistical tests of significance between round 1 and round 2 of weighting the domains. Ho is that there is no difference between the first and second round weighting of the domains 336
Table A3.3 Model 1 (the status quo) unweighted scores. 336

Table A3.4 Summary of statistical tests of significance between round 1 and round 2 of scoring Model 1 (status quo). Ho is that there is no difference between the first and second round scoring. 338
Table A3.5 Weighted Performance Scores for Model 1 339
Figure A3.1 Cumulative weighted performance scores for Model 1 339
Table A3.6 Unweighted Performance Scores for Model 2 (Local contract) 340
Table A3.7 Summary of statistical tests of significance between round 1 and round 2 of scoring Model 2 (PMS plus). 341
Table A3.8 Weighted performance scores for Model 2 (local contract) 342
Figure A3.2 Histogram for cumulative weighted performance scores for Model 2 339
Table A3.9 Unweighted scores for Model 3 (social enterprise) 343
Table A3.10 Summary of statistical tests of significance between round 1 and round 2 of scoring Model 3 (SEP). 344
Table A3.11 Weighted performance scores for Model 3 (local contract) 345
Figure A3.3 Histogram of the cumulative weighted performance scores for Model 3 345
Table A3.12 Independent samples Mann-Whitney U Test comparing cumulative scores for Models 1,2 and 3 across two groups: public and staff. 346

Dedication

I dedicate this thesis to my children Grace and Jude and to my wife Dawn.

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Author's declaration

I declare that, except where explicit reference is made to the contribution of others, that this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Signature

John James Mallon O'Dowd

Abbreviations

A&E	Accident & Emergency
ANOVA	Analysis of Variance
APMS	Alternative Provider of Medical Services
BMA	British Medical Association
CCG	Clinical Commissioning Group
CHP	Community Health Partnership
CMO	Chief Medical Officer
COPC	Community Orientated Primary Care
CPN	Community Psychiatric Nurse
DES	Directed Enhanced Service
FFS	Fee For Service
FHG	Family Health Group
GCPH	Glasgow Centre for Population Health
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner
HMO	Healthcare Management Organisation
HMSO	Her Majesty's Stationery Office
IT	Information Technology
LES	Local Enhanced Service
LHCC	Local Health Care Co-operative
LMC	Local Medical Committee
MPIG	Minimum Practice Income Guarantee
NES	National Enhanced Service
nGMS	New General Medical Services Contract
NHS	National Health Service
NHSGGC	NHS Greater Glasgow & Clyde
OOH	Out of Hours
PbC	Practice-based Commissioning
PC	Primary Care
PCG	Primary Care Group
PCO	Primary Care Organisation
PCT	Primary Care Trust
PMS	Personal Medical Services
PPF	Public Partnership Forum

PTI	Practice Team Information
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners
SEP	Social Enterprise Partnership
SIMD	Scottish Index of Multiple Deprivations
UI	User Involvement
UK	United Kingdom
UN	United Nationals
US	United States
USA	United States of America
USSR	Union of Soviet Socialist Republics
WHO	World Health Organization
WONCA	World Organization of National Colleges, Academies and Academic Associations of General Practitioners or Family Physicians

Chapter one: introduction

This chapter sets out the author's background and motivation. It clarifies his overall research aim and introduces the general approach taken to the thesis.

1.1 Background

The organisational model underpinning the primary care system has evolved over the past 60 years. The current model for the vast majority of the UK is of GP practices acting as independent contractors to the NHS. The 2004 General Medical Services (GMS) contract brought significant changes to the contract between GPs and the NHS, detailing specific organisational and clinical objectives, which were regarded as markers of quality. The contract specifically linked attainment of these objectives with financial incentives. The contract has resulted in some success in standardising the attainment of specific objectives across the UK, but questions about how equitably these objectives are attained in disadvantaged communities still remain. Further, there is little known about how the quality framework has affected patient care in areas outside the specific objectives in the contract, and the effect of such an overtly commercial contract upon the doctor-patient relationship.

The author trained first as a GP and then as a public health doctor. This dual orientation caused him to question the current organisational arrangements for the general medical services element of primary care.

1.2 Overall research aim

The general aim of this research was to explore the current organisation of general medical services in Scotland, and to create evidence which would identify the most effective and acceptable organisational model for the future delivery of primary care (general medical services) within the Scottish context.

To accommodate the breadth of the research aim required the author to develop an extensive literature review and to employ a variety of different research

methods. This approach led to a greater understanding of the public's priorities and the views of primary care professionals. The initial findings informed the choice of alternative models of primary care. These alternative models were tested with the public and professionals using deliberative methods so that the groups could score and rank these alternatives against the status quo. This process provided a deeper understanding of the values underpinning the choices.

1.3 Overview of methods

The research aim was considered to be important but ambitious because the scope of evidence required to formulate and test alternative models of provision was substantial. The research involved five distinct elements: a literature review; a workshop with members of the public to establish their priorities for the future of primary care; a qualitative study to explore the views of primary care staff in relation to the organisation of primary care; further group work with members of the public to examine alternative models of primary care in contrast to the status quo; and an electronic Delphi method to explore the views of primary care staff in relation to the alternative models.

The detailed research objectives were:

1. To improve understanding of the views of the public in relation to the organisation of general practice (general medical services) within the wider context of primary care in Scotland.
2. To improve understanding of the views of professionals working within the primary care team in relation to the organisation of primary care.
3. To identify and refine models of primary care, and to test these models of primary care against the status quo with primary care professionals and with representatives of the public.

The initial task undertaken was a review of the existing literature. This review included the need to describe the current organisation of general medical services, taking a historical perspective which would capture the contextual influences which had shaped the organisation of primary care services in the UK and Scotland. This was followed by a summary of the international organisation of services. The review continued with a section on models of general medical

services which could be transferred into the local Scottish context and ended with a review of the literature relating to the perspectives of the public, professions and politicians on the organisation of primary care. The literature review therefore assisted with objectives one, two and three.

Given the limited literature on the public's priorities for primary care and the views of primary care staff on the organisation of primary care, research was developed to address these issues.

A greater understanding of the public's priorities for primary care was achieved through a workshop designed to explore the public's preferences for any future primary care system. This work addressed objective one.

The literature on professional's views of the organisation of primary care provided a limited perspective as organisation was rarely the main focus. Instead, most of the literature was providing a commentary upon planned or completed contract changes. Given the lack of evidence in this area, a qualitative study was developed to explore the views of primary care staff on the organisation of services. This work addressed objective two.

Using the literature findings in combination with the public's priorities and the views of primary care staff, two alternative models of provision were identified. These models were then tested with the public and primary care staff in comparison with the status quo arrangements, addressing all three objectives.

The central arguments of the research were: that although primary care was widely regarded, its organisation had been shaped by the historic influence of professionals but not by evidence or the considered views of all the stakeholders; and that the future organisation of primary care could be developed to improve the health of the population in a way which took account of these views of the public and professions, informed by an emerging evidence-base.

Chapter two: historical perspective and literature review

This chapter provided a narrative review which seeks to set the context for the research programme. It began with a historical perspective on the development of general practice and primary care within a UK context and explores international perspectives on primary care. Following this the review explored different organisational issues and models for the provision of general medical services within primary care. Finally, the chapter explored the views of the public and professionals in relation to the organisation of primary care in Scotland.

2.1 Objectives

The overarching purpose of the literature review was to identify the most effective and acceptable model of providing primary care for use within the Scottish context. This overall aim was translated into a number of more specific objectives. The objectives of the literature review were to:

- provide a historical perspective on the development of primary care in the UK;
- to identify and define models for the organisation and delivery of primary care within the UK and internationally and explore their relative strengths and weaknesses; and
- to identify the views of staff and the public on the organisation of primary care in the UK.

2.2 Methods

In order to inform both the historical perspective and wider literature review on the organisation and delivery of primary care and perspectives on the organisation, a comprehensive review of the literature was undertaken using electronic bibliographic databases. In addition to these sources, grey literature was sourced by searching the UK and Scottish Government publications databases as well as those of the King's Fund and the Nuffield Trust.

Preliminary searches suggested that evidence in this area was difficult to identify via indexing and therefore, following a number of different searches, a wide search strategy was developed. Search strategies were created to include primary (health) care within the subdomains of economics, history, manpower, methods, organisation and administration, supply and distribution. In keeping with the need to provide a historical perspective to the work, the searches were not limited to recent years.

The databases identified as being most relevant to the thesis included Medline, Embase, the Health Management Information Consortium, Emerald, The Cochrane Collaboration, Cinahl and Web of Science. The search strategy was a combination of comprehensive and targeted searches of major databases and grey literature. The main searches used are shown in Table 2.1.

Table 2.1 Primary search terms used to generate the comprehensive literature review.

Primary health care or primary care or primary medical care or general practice or family medicine limited to the subdomains of history or classification or manpower or methods or organisation and administration, or supply and distribution.
(Primary health care or primary care or primary medical care or general practice or family medicine) AND (patient satisfaction, or consumer satisfaction or patient participation, or user involvement or patient opinion)
(Primary health care or primary care or primary medical care or general practice or family medicine) AND (attitude of health personnel or professional opinion).

Whilst this methodology increased the numbers of abstracts which required further assessment, it ensured a more comprehensive literature was reviewed. Where the literature review uncovered important concepts which yielded a limited literature using the more comprehensive search strategy, targeted searches were developed. This was particularly important for organisational initiatives such as the Quality Outcomes Framework, Practice-Based Commissioning, Personal Medical Services, Community Orientated Primary Care *etc.* The literature review entailed extensive hand-searching and was guided by advice from a supervisor who was familiar with the literature being reviewed.

In addition to the search for peer-reviewed literature, the websites of the Department of Health, the Royal College of General Practitioners, the British Medical Association, the Scottish Government Health Directorate, the King's Fund and the Nuffield Trust were also searched for relevant publications. Similarly, the British Library electronic theses service was searched to identify other potentially unpublished sources of evidence.

All literature searches were screened to identify the papers which would be sought for further appraisal. Evidence identified was collated into one of the four main evidence groups: history; views; models; and comparisons/performance. Literature identified was stored in an online, electronic bibliography database (Endnote).

An initial scan of the published literature demonstrated that the evidence-base was both quantitative and qualitative, varying from personal opinion and anecdote to detailed analysis. Mays *et al* proposed a menu of methods for combining literatures in order to reach conclusions (1). Given the complexity of the research questions, the method used was that of a narrative review which would allow the emergent themes from the literature to inform further aspects of the research.

The abstracts identified were assessed by the author against the objectives of the literature review. Through reading the abstracts, the objectives were refined into a wider framework for the review. Relevant articles were then sought and reviewed and their reference lists examined to identify further literature which was assessed in the same manner. The initial literature review was carried out in late 2008. Given the high volume of primary care articles published, the database searches were repeated in early 2013.

2.3 Primary Care and General Practice

Primary (health) care, and general (medical) practice were considered to be easy to identify in everyday experience, but more difficult to define. This has resulted in problems for professionals within the sector, managers and successive

governments. A number of definitions of both general practice (family practice in some European countries and in the US) and primary health care have been used.

Primary health care has been defined by the WHO in the Declaration of Alma Ata as *"essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-determination"* (2). A more concise definition from the Institute of Medicine described primary care as having four distinguishing features. It is: accessible, co-ordinated, comprehensive and continuous, and delivered by accountable providers (3). Starfield has described primary care as "*that level of a health service system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and co-ordinates or integrates care provided elsewhere by others*"(4), often summarised as *first point of contact, comprehensive, and co-ordinated.*

The phrase primary health care was first used in the *Dawson Report* of 1920. This British parliamentary white paper was published following the First World War, at a time when politicians were beginning to recognise the limitations of a society where health care was only available to segments of the population (5). The Dawson Report, although never enacted, predicted the establishment of the National Health Service, based on regional primary health care centres. The final realisation of the NHS emerged following a further world war, some twenty-eight years later.

The phrase primary care only began being used more widely in the late 1960s and 1970s. Primary care encompassed a larger team of professionals, operating within the community, and distinct from the other sector of health care, secondary care, which encompassed almost all other provision.

Early definitions of general practice focussed on the role of the general medical practitioner: *"The general practitioner is a licensed medical graduate who gives personal, primary and continuing care to individuals, families and a practice population irrespective of age, sex and illness. It is the synthesis of these functions which is unique."(6)* Olesen *et al* have described the confusion around the definitions of general practice which

often relate to the setting, the role or the person, and it has been suggested that general practice as a medical craft has been best described by its boundaries with other disciplines, rather than by its core functions (7). In a similar fashion, Howell has suggested that general practice was "*borne out of tension with other medical care specialities.*"(8)

The Royal College of General Practitioners has endorsed European definitions of general practice as a discipline and a specialty. The discipline was described as including the following features: first contact, efficient and coordinated, is person centred and orientated to the family and community, has a unique consultation process which is based on a relationship developing over time, provides longitudinal care, takes account of prevalence and incidence of disease, manages acute and chronic needs as well as those which present in an undifferentiated way, promotes health and wellbeing, has a community health responsibility and which deals with physical, psychological, social, cultural and existential dimensions of health (abbreviated). General practitioners are described as *"specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness….in the context of their family, their community, and their culture, always respecting the autonomy of their patients. They recognise they will also have a professional responsibility to their community."(abbreviated) (9)*

One of the great strengths of primary care was its ability to be flexible and reinvent itself to meet the needs of the current time (10). This flexibility was problematic for researchers, since it meant that evaluation, comparison and analysis were complicated by the changing nature of the system, professionals and contexts being studied.

The literature often used the terms primary care and general practice interchangeably. This was not simply an issue of professional dominance or the relative size of the general practice function in comparison with other elements of primary care, but related to a confusion about the relationship between general practice and primary care, linked to location, organisation and profession. It has been said that general practice was a subset of primary care, and that primary care can be considered to be a subset of general practice. (11) Activity takes place mainly within general medical practices, but is delivered by a variety of groups

which include general practitioners. For the purpose of this thesis, general practice was used to describe both the profession practised by general practitioners (GPs) and the work carried out through general and personal medical services contracts, and salaried or alternative provider medical services. Primary care is reserved to describe a wider system of which general practice forms a significant proportion. In practice, many of the participants used these phrases interchangeably. This perspective sees general practice as the single largest subset of a wider group termed primary care. The use of general practice is not intended to imply a dominant role for the GP or to diminish the multi-professional workforce which undertakes activity within this area of primary care, but is used as a shorthand which focuses on the teams and settings in which the activity takes place.

2.4 Historical perspective on UK primary care

The current nature of general practice and primary care has been shaped by a combination of politics, professional opinion, and more recently, evidence. In order to understand models of primary care, it was first necessary to provide a historical perspective on the development of the profession and sector within the UK. In addition to bibliographic references, for the period from the inception of the NHS to 1990, the main sources drawn upon for a historical perspective on general practice and primary care organisation included Webster's *The National Health Service: A Political History. (12)*

2.4.1 General Practice and the formation of the NHS

At the inception of the NHS, medicine was divided into two crafts: specialists and generalists. Generalists functioned in the community, and referred patients when necessary to their colleagues in hospital specialist practice. General Practitioners required no formal training other than an undergraduate medical education, were considered to be less skilled and were paid considerably less than their specialist colleagues, who were members of Royal Colleges, which functioned as trades associations.

The establishment of the UK National Health Service was tortuous. During the years between the *Dawson Report* in 1920 and the period following the Second

World War, a number of different plans for an NHS were mooted, but failed to materialise due to weaknesses within Government, local authorities and the medical profession. Aneurin Bevan's appointment as Minister of Health resulted in the development of contentious plans for an integrated National Health Service which would provide medical care for the entire population, funded from general taxation, and free at the point of delivery. Bevan's relationship with the British Medical Association (BMA), which represented GPs, and the specialists' Royal Colleges, was difficult. His intended goal was a fully-salaried service covering both general practice and hospital specialty medicine. He wanted to create a centralised, politically controlled system. Bevan eventually created the NHS, but compromise was necessary to achieve this. For GPs, the compromise was that they would contract with the NHS, but retain their independence, and have this right written into an amendment to the NHS Act, thereby limiting the possibility of a salaried service at that time, although this limitation was eventually removed as discussed later (12). Independence was a recurring theme within GP history.

2.4.2 Early NHS general practice

The period between 1948 and the mid 1960s saw little further change in general practice. Most GPs operated in isolation, often in their own homes, paid largely by capitation: that is, they were given a sum of money for each patient who was registered with them, regardless of the workload associated with caring for the patient. During this period, GPs had very high workloads which they managed in relative isolation, with little or no additional staff. GPs provided round the clock care for their list of patients, with an emphasis on infectious diseases, and a significant obstetric case-load.

In addition to the burden of work absorbed by early NHS GPs, most worked with only the most basic equipment, which was very different from the technological revolution happening in hospital medicine. GPs, who prior to the inception of the NHS, were often employed as assistants in hospital practice, were now excluded from this work. Perhaps the most difficult burden for most GPs was the lack of ancillary support – staff to type letters and file notes. The *Collings Report* in 1950 described the poor state of general practice. (13) Tudor Hart has described general practice at this time as *"a primitive cottage industry"* in comparison with the developments occurring in the hospital sector. (14) There was a wide consensus

around the poor state of general practice at the time, and the government established the *Gillie Committee* to investigate and make recommendations on how the situation might be improved.

One of the consequences of the Collings Report was the foundation of the Royal College of General Practitioners (then the College of General Practitioners) in 1952. (15) Pereira Gray has set out that the purpose of the College was to provide leadership, promote quality and strengthen education and research in the field of general practice. (16)

2.4.3 1965 and the Family Doctors' Charter

The *Gillie Committee's* findings were clear: incentivise group practice, develop practice improvement loans, and help GPs with the cost of employing support staff. The report spurred the Government to engage once more with the BMA. This culminated in the BMA publishing *A Charter for the Family Doctor Service* in 1965. (17) This formed the basis for negotiation of a revised GP contract which was implemented in 1966. This contractual reorganisation promoted group practice and provided financial support for practices to employ ancillary and clinical support. (18)

Following the implementation of the revised contract, the period of the late 1960s and 1970s have been described by many as a 'golden period' for British general practice, with the specialty becoming the preferred career choice for the majority of medical graduates, and single-handed practices voluntarily merging into larger group practices, enabling some modest economies of scale, and resourcing shared ancillary support for receptionists cum secretaries. The Royal College of General Practitioners, originally established in 1952 gained influence, and promoted the unique nature of the professional generalist. In addition, there was a growth of investment in property, partly by newly enlarged practices which chose to take advantage of additional resources flowing from the contract. However, local NHS management structures also invested heavily in capital projects with the creation of new health centres, housing general practitioners as well as other community staff and providing some limited, shared access to diagnostic services such as radiology.

One further advantage of the group practice system which was being incentivised was the ability for GPs within a practice to develop shared workload agreements for the provision of out of hours care for their patients. Since the inception of the NHS, GPs had absorbed sole responsibility for their own out of hours work. Some had taken on assistants, or more junior medical staff, but the round the clock responsibility without the extensive support staff available to hospital specialists was a burden which was now more easily spread throughout larger practice teams. From the 1960s onwards, GPs, even those in group practices, relied upon deputising services to provide some of the out of hours care for their patients, allowing for a better work-life balance. Ultimately, however, the clinical responsibility for the care of patients rested with the GP. GPs could delegate care to other doctors acting on their behalf, but they could not derogate responsibility for the care of their patients.

2.4.4 1990 contract

The change of UK administration in 1979 resulted in efforts to change the relationship between agencies and the state. Rhodes has described this as an effort to *"hollow out a congested state"*. (19) This approach followed on from the implementation of the Griffiths report into NHS management which saw the establishment of general management in the health service. The approach which developed across the public sector has been described by Hood as the New Public Sector Management and was characterised by attempts to create a market-orientation in public services in order to improve their effectiveness and efficiency.

The first decade of Conservative administration brought little change for GPs. In 1989 the Conservative Government published the white paper *Working for Patients*. (20) A few prominent academic GPs published work, based on the internal market principles introduced within the secondary care system. (21, 22) Many of their proposals were included in the 1990 contract which had the overarching aims of "increasing efficiency and consumer satisfaction". Whereas the 1965 contract had changed the structure of general practice, the 1990 contract had been designed to alter processes.

The aims of the contract were to: improve consumer choice; increase the specificity of the contract (in terms of delivering activities); introduce performance-related pay; strengthen the contractual relationship with Family Health Services Authorities; and through these, to increase value for money in general practice.(23) Smith and Armstrong have pointed out the marked contrast between the Government's priorities and those of patients at the time which were: friendly staff; unhurried doctors who would listen; continuity of doctor; a nurse in the practice; good access; and short waiting times. (24) The final contract was rejected by the profession, ostensibly on the basis of a lack of evidence for specific tasks such as health improvement and reviews for those over 75, although the general consensus was that the contract eroded professional autonomy and introduced managerialism into general practice. (25) The new contract of 1990 was an attempt to define the core duties to be provided by a GP, and to use financial incentives to encourage practices to develop robust child health surveillance and vaccination, engage more fully with screening services and promote health improvement activity. A major part of the contract was an emphasis on capitation payments as the basis of remunerating GPs, since capitation was considered to be a good vehicle for cost containment. In addition, the contract encouraged a shift in activity such as minor surgery, from secondary care into primary care, and made provision to encourage GPs to work in areas of socioeconomic deprivation.

The Government also had concerns about the quality of deputising services, and incentivised practices to manage the out of hours care of their own patients. However this was unpopular with GPs and by 1995 this had been changed to permit GPs to delegate out of hours care to GP co-operatives, where groups of practices would collaborate to share out of hours work.

The 1990 contract represented the Government's first attempt at exerting significant managerial control over GPs and the first effort to use financial incentives to effect change. Practices did become more organised; employed more nurses, provided a wider array of tasks; and achieved higher levels of childhood immunisation and cervical screening than anticipated. The contract also marked the introduction of computers into practices. (26) However, there were legitimate concerns from general practice in that the evidence-base for most of the health improvement developments proposed was unsound and unsophisticated. (25)

2.4.5 Fundholding

The most significant change of the 1990 contract was the introduction of GP fundholding. This approach was part of a package of reforms referred to as the Internal Market through which community providers and hospitals were encouraged to be self-governing and to enter into arrangements which created a quasi-market in healthcare. (27) By the end of the Conservative administration fundholding was open to almost any practice, and whilst it had been initially unpopular, by the mid 90s around a third of practices had taken part. The initiative was a form of total purchasing and practices were given an indicative total sum from which they had to finance primary care, secondary care activity and prescribing for their practice population.

This form of provision, also known as integrated capitation, provided incentives to constrain both prescribing and referrals to secondary care. Since the indicative budget included allowances for all of these activities, practices were incentivised to limit expenditure by managing patients within primary care. Any residual budget remaining as a result of limiting expenditure could be reinvested in the practice to improve patient care. Fundholding also allowed individual practices to negotiate service-level agreements with secondary care Trusts. Fundholding was seen as attractive to GPs as it "*invert[ed] the power relationship"* between generalists (GPs) and specialists (Consultants). Iliffe described that it stimulated in GPs "*omniscience beneath the surface of generalism"*, or more simply that it suggests generalists always know best, even when it comes to specialist care. (23)

The threat of fundholders shifting their business (that is, patient referrals) between different hospitals resulted in inequities in access to secondary care between patients within and outwith fundholding practices. The pilot generated much division, relating to concerns about equity and transaction costs. (28, 29) Milne and Torsney's work concluded that fundholding had the effect of creating a two-tier NHS, with patients within fundholding practices being treated in a preferential manner in comparison with non-fundholders. (30) The issue of inequity made the scheme professionally and politically unpopular. The issue was contentious from the outset and the Government declined to have a pilot or official evaluation of the scheme. An independent but comprehensive attempt to evaluate the scheme suggested that claims that it improved efficiency, responsiveness and quality of care were unsubstantiated. (31)

The issue of increased transaction costs was considered to be a major unintended consequence of the internal market reforms of which GP fundholding was a major component. Webster, a historical commentator has reported that by 1997, the internal market had increased transaction costs from 5% in the late 1980s to 12%, with some commentators suggesting that "*managers talked of 17% as an eventual target*". (12) The main costs had resulted because of an increase in administration staff to facilitate the change. Between 1981 and 1991, Webster reported an 18% rise in NHS administrative staff, with a further 10% rise between 1991 and 1997. May 1997 saw a change of administration and the Labour Government published *The National Health Service*: *A service with ambition* in December 1997, reducing the prominence of the market experiment, instead promoting five themes to support the values of the NHS: a well informed public; seamless service; a highly trained workforce; evidence-based decision making; and a service which responded to the needs of patients. (32)

2.4.6 Primary care led NHS and Personal Medical Services

Fundholding was abolished by the new Labour administration elected in 1997. The new Government did, however, wish to continue with commissioning experiments started during the Conservative administration, rebranding this as 'a primary care led NHS', a concept which had been emerging as a policy direction towards the end of the Conservative administration. (33) The subsequent Bill, *A Primary Care Led NHS* sought to create services configured around patients in their communities, whilst hopefully having the additional benefit of constraining cost. (34)

1997 and 1998 saw the launch of three white papers relating to primary care across the different, soon to be devolved countries of the UK: *The New NHS, modern, dependable* in England; *Designed to Care* in Scotland; and *NHS Wales: putting patients first.* In England this paved the way for Primary Care Groups which would eventually become Primary Care Trusts; in Scotland GPs were to work together in Local Health Care Co-operatives (LHCCs) and these would combine with other community services to become Primary Care Trusts; whilst in Wales, GPs would form part of local health groups, combining input from social care and the voluntary sector. The impact of devolution for primary care is discussed later.

1997 also saw the emergence of a new form of GP contract – that of Personal Medical Services. Personal Medical Services pilots (PMS) were developed as part of the changes set out in the Primary Care Act, which attempted to introduce greater local flexibility into the contractual mechanisms being used for different sets of professionals within primary care. PMS contracts allowed a locally negotiated contract based on an assessment of local practice or area needs; permitted a wider group of professionals to form partnerships to provide services, including nurses; allowed salaried professionals to work within primary care, employed by either a practice entity or by local primary care organisations; linked finance to performance against key outcomes; and opened the debate about alternative providers of primary care, in the form of business entities other than GP partnerships. (35) Two kinds of PMS arrangements emerged: PMS and PMS Plus. PMS practice arrangements allowed greater flexibility, but the overall scope of activity was similar to that of GMS counterparts. PMS Plus practices often involved a wider scope for practice entities, such as hosting community nursing, or providing targeted services for local needs such as sexual health services.

PMS' objectives were to increase fairness, ensure efficiency, improve effectiveness, and responsiveness, promote and facilitate integration, flexibility and local accountability. Evaluation of PMS pilots after the first year suggested that initial efforts had focussed on assessing and responding to local needs (36) Shapiro suggested that the relative popularity of PMS was explained by the sense of innovation and success, combined with enhanced resources to tackle unmet need. They contrasted a managerially accountable PMS system with a professionally determined GMS (General Medical Services) approach and questioned if PMS was an innovation, or a successor to GMS. (37) Subsequent evaluation of PMS pilots in 2002 and 2006 suggested modest success of the model in comparison with GMS in terms of widening skillmix, changes in interprofessional relationships within teams, and tackling inequalities in access, but concluded that this may have been related to higher levels of investment, rather than being attributable to the model *per se*. (38) (39) PMS is discussed later in the context of payment methods.

2.5 The new General Medical Services Contract

Many GPs and the BMA did not agree with PMS, viewing it as an erosion of professional autonomy, and expressed concern at a perceived as attempt by the

Government to end the power of the nationally agreed contract which had served the profession well. This was particularly true since the Act repeated a number of elements set out in the Conservative administration's white paper *Choice and Opportunity, Primary Care: the future, (40)* particularly the possibility of commercial contracts with competition from the wider business community. Instead the profession pressed for a statement of core activity within general practice. (41) There was a belief that this would allow GPs to negotiate to be paid for an ever-increasing array of tasks being devolved to the new primary care-led NHS.

The BMA held a vote to establish the strength of feeling in general practice about current working arrangements, for both conventional general medical services and PMS contracts. In July 2001 the BMA commissioned a ballot of all 36,000 GPs in the UK to ask if they were prepared to resign if a new contract could not be agreed within a year. Two thirds of GPs voted, and of these, 86% said they would be prepared to end their NHS contracts. The Government, BMA and NHS Confederation resumed further negotiations. This resulted in the new General Medical Services contract (nGMS) 2004. (42) The shared objectives announced for nGMS were to: reduce and make workload more manageable in primary care; reward GPs appropriately for their work; address problems with recruitment and retention to general practice; and to deliver more services appropriately in primary care.

A major change was that the new contract would be between the practice partnership entity and the Primary Care Organisation,[†] rather than between individual GPs and the NHS. Further, the contract proposed the introduction of a significant element of performance-related pay, underpinned by the evidence-base for primary care in the realms of organisation and chronic disease management. The changes to the ways in which practices were to receive their income are set out in Table 2.2.

Under nGMS previous capitation, item of service and target payments from the 'red book' (regulations governing the 1990 GP contract), would end, replaced by a Global Sum, based on historic claims data. Furthermore, an epidemiologist, Professor Roy Carr-Hill was commissioned to construct a redistribution formula

[†] Primary Care Organisations referred to Primary Care Trusts in England and Wales, and Health Boards in Scotland and Northern Ireland.

which would take account of workload in practice, replacing older formulae such as the Jarman Index in order to better account for the impact of socio-economic deprivation, and thus better incentivise work in communities with greater health needs.

Table 2.2 Payment elements and their descriptors as set out in the proposed nGMS contract in 2003, adapted from O'Donnell *et al (43)*

Type of payment	Explanation
Weighted capitation (the "global sum")	All practices receive a global sum payment, to pay for providing basic primary care services to registered patients (first point of contact, surgery and home visits, referral, and co-ordination - **"essential services"**). This comprises the largest part of practice income. A proportion of the global sum is optional for **"additional services"** which includes immunizations, cervical screening, maternity services, and care in the out-of hours period, when surgeries are unavailable. Where practices opt out of additional services, their payment is reduced and the reclaimed money used by the primary care organisation to provide the service elsewhere, either by commissioning another practice or an area wide organisation.
Pay for performance - the Quality and Outcomes Framework (QOF)	Payments under QOF depend on performance measured against ~150 quality indicators. Approximately half of the indicators are organizational and typically binary (e.g. have all clinical staff completed cardiopulmonary resuscitation training in the previous year); the remaining half is clinical and typically based on percentages (e.g. the percentage of patients with diabetes achieving target blood pressure). Practices are allowed to 'exception report' patients who are unsuitable for particular indicators (e.g. because of terminal illness, treatment intolerance or treatment refusal) or who do not attend for review after at least three invitations. Payment for binary measures is all or nothing. Payment for clinical indicators is based on a sliding scale with no payment until at least 40% of patients are compliant with the indicator and increasing linearly to a maximum threshold (typically 90% for process measures, but lower for outcomes). Achievement on each indicator is transformed to a common scale ("points") with a maximum of 1050 points available in 2004/5. The amount earned per point for the average sized practice of ~5,500 patients and 4.5 doctors was £75 ($106) in 2004/05 rising to £120 ($170) in 2005/06. (In 2009, the amount earned per point was £125 ($200)). Actual payment per practice varies with size of practice, and numbers of patients with each disease incentivised.
Specific payment for **"enhanced services"**	Enhanced services are specific payments for other additional services where local NHS organisations can choose to commission a service from practices or from other providers (unlike additional services in the global sum where the practice has the right to provide the service unless they decide not to). Examples include more specialist care for alcohol and drug misuse, minor injury services and care for homeless people. Payment typically has both a lump sum element plus payment per patient with the condition, and is dependent on the practice complying with organisational and reporting requirements specified in the contract. There are three types of enhanced service. Directed Enhanced Services are defined centrally and must be provided by the local PCO for its population. Local Enhanced Services are locally developed services designed to meet local health needs. National Enhanced Services are commissioned to meet local health needs, but PCOs must use national specifications and benchmark pricing.

A second major change through nGMS was that practices had the choice of opting out of out-of-hours (OOH) care by forgoing a premium, and could opt to provide specific additional enhanced services against nationally agreed standards to meet local needs. Some of these services were mandatory (Directed Enhanced Services, DES), and some were voluntary against a national standard (Nationally Enhanced Services, NES), whilst others were Locally Enhanced Services (LES). For some services, even if a practice failed to participate, other providers in the area could tender to provide the additional services to the practice's population for a premium. (44)

Finally, a Quality and Outcomes Framework (QOF) was devised as a method to incentivise quality, which, following GPs' concerns about the health promotion targets from the 1990s contract, would be strictly evidence-based and would provide practices with an ability to increase their profit in return for evidence of improved process of care. The QOF would have four domains: organisation of the practice; patient experience; clinical care; and additional services. The profit made would be determined by performance within the practice's population, adjusted for national prevalence of conditions and practice population. (44)

The birth of nGMS was not painless. Initial projections of global sums resulted in a majority of practices having significant loss of core income. Despite assurances that such practices could compensate for this loss via the QOF, the contract was changed to include a temporary Minimum Practice Income Guarantee (MPIG) which, for an unspecified period, would make up the shortfall between historic earnings and the new global sum. This compromise significantly increased expenditure on the contract, and reduced the capacity to redistribute funds and GPs into areas of greater need. Finally, GPs voted on the contract, and despite much commentary on the commodification of health care, the emergence of a non-patient centred general practice, and the lack of a patient input into the design of the contract (45) there was a 70% turnout, with 79.4% voting in favour of nGMS.

nGMS could be seen as providing a solution to both the Government and to GPs. Previous contracts had been used to tackle structure (1966) and process (1990). The Government now created a specific, performance-related contract which began to tackle outcomes, although most of these outcomes were in fact processes of care. GPs had begun to identify core and additional roles, but in return for this commodification of care, the prospect of market involvement became greater.

2.6 The impact of nGMS

In 2009, Scotland had 88% of practices operating under the nGMS contract, with 9% still utilising PMS contracts, with the option to participate in the QOF process. 3% of practices were directly operated by NHS Boards. Since its implementation nGMS expenditure has been higher than anticipated. It was thought that practices could achieve perhaps 75% of the total QOF points available in the first year (2004/2005). In the final analysis, the average practice achievement across Scotland's 1,025 practices was 92.5%, resulting in additional quality payments of £69.8M, an average of £76,435 per practice. (46)

In 2005/2006, the average practice achieved 97.7% of the available QOF points, and since the payments per point had increased, the average attainment per practice (for QOF) rose to £134,073 per nGMS practice. In 2007/2008, average achievement was 98.2%, with nGMS practices being paid an average of £130,932 for QOF, representing a small fall from the previous year. Audit Scotland evaluated the costs of the nGMS contract to the devolved Government. It reported that the last year of the old GMS contract (2003/4) saw primary care medical services costing £503M. There was a rise of 40% over the first four years, to a total cost of £706M in 2006/7. They estimated that GP net income increased from £65,180 in 2003/4 to £90,127 in 2005/6. (47)

Audit Scotland assessed the implementation of nGMS in Scotland against the stated objectives of the stakeholders. (48) It concluded that the contract has allowed GPs to regulate their workload and manage it more effectively. The report also stated that there was evidence that GPs have been rewarded for their work, albeit at the expense of very significant growth in budgets for primary care. The conclusions around recruitment and retention of GPs were less easy to examine, since the new contracting arrangements with practice entities provided practices with discretion to decide the structure of their team, hiring salaried or temporary staff, or additional partners with different professional backgrounds and skills to provide care for patients. Specifically, the contract did not require practices to disclose the composition of their workforce. Nevertheless, Audit Scotland concluded that the contract improved recruitment. However, there has been poor measurement of prescribing activity, the appropriateness of investigations or changes in referral practice. Therefore, despite improvements in the recording of the process of care via QOF, Audit Scotland found it difficult to reach conclusions

about the range and quality of services now being provided via primary care medical services.

Some authors have questioned the underpinnings of the new contract. They have contended that although the process of care might have improved in clinical areas included in the contract, that 'orphan' areas may have suffered, with slower rates of improvement in care, or even reduction of standards in these areas. (49) Steel *et al's* observational study has explored the impact of the contract on clinical domains which were incentivised in comparison with those which were not. They concluded that the incentives led to significant improvements in the processes of care, and that areas which were not incentivised did not see significant improvements in quality. (50) In fact, work by Doran *et al* into the impact of QOF has suggested that the quality of care in non-incentivised areas was significantly lower than that initially predicted across the period 2001 to 2007. (51)

Other commentators accepted that the contract has brought evidence of population-level improvement in the quality of process of care for specific conditions; has improved the implementation of evidence-based care in practice; has improved recording of data, and that there is even some evidence of a reduction in inequalities in the process of delivered health care between the most affluent and disadvantaged in our society. (52, 53) The ability to reduce inequalities is perhaps the most contentious claim. Starfield responded to Doran *et al's* paper by stating that improvements in the process of care did not necessarily mean that there had been an improvement in meeting the individual needs of patients, and raised the issue of exception-reporting of harder to reach patients who might be more likely to be socioeconomically deprived. (54) At the inception of the new contract, there was tacit acceptance that the redistribution of funding from the global sum, via the operation of the Carr-Hill formula, was fair, because practices which cared for more affluent patients would be better placed to make up this deficit via QOF in comparison with practices in poorer communities.

Within QOF areas, patients could be excluded from the denominator of those with the risk factor of interest when calculating the proportion of patients treated against the QOF standards, so-called exception reporting. Practices could exclude patients who are unsuitable for interventions on clinical grounds, such as terminal illness, but in addition, the terms of the contract mean that the practice need only contact the patient three times to offer the QOF review. If the patient did not

attend for review after the third attempt, they can be legitimately excluded from the denominator, thus removing the impact of their non-attendance on the practice's QOF scores. Simpson *et al* have demonstrated that in an analysis of Scottish data, younger, more socioeconomically deprived patients were more likely to be excluded. (55)

McLean et al have studied both payment quality and delivered quality, which takes account of those excluded by exception reporting. (56) This work showed that delivered quality (which included those who were exception reported in the denominator) was lower in more deprived areas, with this effect being more marked for complex processes such as diagnostic tests, for glycaemic control in patients with diabetes, and for 'flu vaccination uptake. Wright *et al* have also shown the impact of socioeconomic deprivation, but in addition, suggested that settlement size was also related to QOF achievement, with villages and towns being the optimal size, and hamlets or larger urban areas being associated with lower achievement. (57)

Although practices might find it difficult to engage with particular patients, it has been suggested that exception reporting may be used to 'game' QOF scores. Doran et al 2006 found that average exception reporting was around 6%. (58) Further work suggested that around 1% of practices required further scrutiny, since patient factors alone could not account for the variation in exception-reporting found between practices. When this study was repeated in 2005/6 the authors confirmed a similar, small proportion of practices exhibiting high exception reporting.(59) Gravelle et al 2008 has shown a positive correlation between increasing QOF achievement and increased exception reporting, (60) however the scale of 'gaming', if present, was considered to be small. This work also demonstrated that practices could have decreased the number of patients reviewed by 11.8% without this reducing their incentivised income , suggesting that altruistic factors were at play as well as financial ones.

The impact of nGMS on quality improvement has been studied over time by Campbell *et al. (61, 62)* In their initial 2007 study they demonstrated an increased rate of quality improvement in terms of the processes of care for both asthma and diabetes, but not for cardiovascular disease. However, in their 2009 publication they demonstrated that the initial increases in the rate of quality improvement had not been sustained, and had in fact slowed down. The authors suggest that there

were three possible explanations: that the level of attainment was already very high, that further increases in the rate of improvement were substantially more difficult to achieve, or that the incentives were such that there was no additional incentive to improve achievement further.

An independent review of QOF commissioned by *Civitas* was critical of the approach, citing the slow improvement in other non-QOF disease areas, and states that the "patient is at risk of being crowded out" of the primary care consultation. (63) They recommended that the proportion of GP income derived from QOF was too high, and that it should be reduced to 7% (in line with a suggestion from the Health Foundation) and that the redistribution of funding to areas with greater need should be revisited. The King's Fund's review of the impact of nGMS on health inequalities concluded that QOF had differentially improved the organisation of practices operating in socioeconomically disadvantaged areas, and that there was some evidence that the process of care had improved. However, the review did not believe that there was evidence that QOF had had a measurable impact on health inequalities. They suggested that future iterations of the QOF should attempt to focus on reducing exclusions from disease registers and align the QOF more explicitly with attempts to reduce inequalities as well as tackling issues of obesity and alcohol-related illness. (64) Similarly, the Cochrane review of incentives in primary care suggested that on the basis of the published evidence, there was *"insufficient evidence to support or not support the use of financial incentives to improve the quality of primary health care."(65)*

Significant research has focussed on understanding the impact of the new contract on ways of working and relationships within practices. Roland *et al* suggested that in response to nGMS practices were: increasing the number of staff employed, particularly nurses and administrative staff and increasing the number of nurse-led chronic disease management clinics. Their survey also suggested that GPs were concerned about unintended consequences such as loss of continuity, fragmentation of care, the impact on professional motivation, and neglect of unincentivised areas of clinical activity. (66)

Work by Huby *et al* suggested that in response to the performance imperative, the nature of practice running had changed, concentrating power and decision-making within smaller numbers of staff.(67) McDonald *et al* and others have suggested that these new ways of working support the emergence of surveillance

and control around practice processes and performance, changing the *collegiate*, equal nature of professional power relationships within general practice into a more hierarchical form, a term which she has described as *professional restratification. (68-70)* They concluded that the impact of QOF had modified the model of care being provided within the practices studied. Whilst the majority of staff continued to describe a desire to provide holistic care in which the patients is treated using a wide and inclusive model of health and healthcare, there was a dominant professional narrative which focussed on the biomedical and measurable aspects of health and care.

Charles-Jones *et al*'s work suggested that such changes have been underway prior to the introduction of the contract, and they report GPs' work becoming increasingly specialised, analogous to consultants in primary care, with other routine tasks being devolved through a *hierarchy of appropriateness* to nursing and other staff. They pointed out that an increasingly biomedical gaze is at odds with the essence of general practice in terms of holism. In addition, they stated that care had been reduced to a set of tasks which have been devolved to less expensive labour groups, with the justification being that of serving a patient-centred agenda. (71) Whalley *et al's* survey suggested that despite fears around decreasing autonomy, implications for motivation and rising workload, GPs' reported increased satisfaction after the introduction of nGMS, which they attribute to reduced hours of work, rather than the increases in income which also occurred. (72)

McGregor *et al's* qualitative study focussed on the views of practice nurses. They found that there were mixed views expressed about the changing role of the practice nurse, but that many felt unrewarded for the increased workload which they had absorbed as a result of the contract. There was also a feeling that the quality of their work had changed, with an increased emphasis on *ticking boxes* and a reducing on face to face interaction with patient. (73) O'Donnell *et al's* work uncovered feelings of increasing isolation within practice nurses, especially those working within smaller practices, with these feelings being linked to a reduced likelihood of nurses to remain within practice nursing. (74)

2.7 Scotland post-devolution

The re-establishment of the Scottish parliament in 1999 saw full responsibility for health policy transferred to Edinburgh. Responsibility for the regulation of professions remained a reserved issue. The nGMS settlement was agreed at a UK national level by mutual agreement of the devolved administrations, but it has been implemented in different ways in each jurisdiction. Exworthy suggested in 1999 that primary and community care as a sector was most likely to experience divergent policy approaches as the result of devolution. (75) Devolution has seen just such a divergence in health care between Scotland and England, with consensus and professional management predominating North of the border, commissioning and purchasing being the dominant paradigm in England, public health and partnerships in Wales, whilst disruptions to the peace process in Northern Ireland have resulted in a less clear pathway. (76)

The 1997 NHS reforms saw the creation of Primary Care Trusts in England and Primary Care Divisions in Scotland. Local Health Care Co-operatives (LHCCs) were developed in Scotland. LHCCs were voluntary networks of GPs practices and other directly managed primary health staff working in co-operation with social care partnerships. Participation in these entities was optional, and the work of Simoens and Scott's nationwide survey of LHCCs in 2003 concluded that LHCCs were inconsistent across Scotland, and raised issues or representativeness, leadership and organisation. (77) In contrast, those GPs who did engage with the LHCCs found these groupings to be useful in tackling specific shared issues.

The Scottish White Paper *Partnership for Care* was published in February 2003 and proposed the dissolution of LHCCs and their overarching Primary Care Trusts (or Divisions), to be replaced with organisations which would increase partnership working between health and social care and which would be key drivers in the redesign of health services. (78) The dissolution of the 79 LHCCs and their overarching Board Primary Care Divisions in 2004 saw the emergence of 39 Community Health (and Care) Partnerships – CHPs. These CHPs all had separate schema of establishment, setting out the relationship between the NHS and other partner agencies, and devolving budgetary control, where possible, to CHPs.

CHPs developed responsibility for the management of all directly employed primary care staff and services, and had input into planning for the small parts of

the nGMS contract (such as Local Enhanced Services) which were left to the discretion of the Board. However, the nature of the nGMS contract meant that most of the funding which flowed to practices was negotiated and controlled at the UK or Scottish national level, with Boards having some discretion in the choice of local enhanced services. Audit Scotland's review of NHS performance for 2007/08 concluded that whilst there were promising developments, "*to date Community Health Partnerships have focused on structures and processes and now need to focus on delivering benefits for patients*." (47) Audit Scotland also raised concerns that whilst clinical activity has been transferred from secondary to primary care, that there had not been a reshaping of finance within boards to match these changes in activity. A Scottish Government sponsored study from 2010 suggested CHPs had made good progress in forming relationships across organisations, but concluded that effective engagement with GPs was still a challenge. (79)

Market ideology in healthcare has not been prominent in Scotland. Only one Alternative Provider of Medical Services (APMS) tender has been advertised in Scotland, at Harthill in Lanarkshire (see later under section 2.6). Following sustained pressure from the public and professionals, the contract was awarded to a traditional GP provider. Following a change of administration in 2007, the Scottish Parliament passed a bill which had the overall effect of discouraging commercial practice management. (80) This was in stark contrast to approaches within England which attempted to increase the diversity of providers within primary care (see later).

Whilst CHPs resulted in alignment of health and social care, the nature of the nGMS settlement may not have helped with joint working and the organisation of primary care. The Scottish Government has stated that it considered the English health reforms to represent a threat to the stability of the GP contract in Scotland. It intended to retain the overall structure, but to ensure that public health and quality standards are embedded with the Scottish contract. Government estimated that around three quarters of the contract will be negotiated with the BMA in Scotland. (81)

2.8 England post-devolution

Post-devolution, primary care policy in England has been characterised by continuous change, the patient choice agenda, and attempts to build upon previous fundholding experiences in the form of Practice Based Commissioning. The Scottish experience can be contrasted with that in England where Primary Care Trusts (PCTs) came into existence in 2002, but have undergone several transformations in terms of scale. PCTs have broadly similar scope across the management of primary care. In contrast to Scotland, PCTs also control the budget for, and commission both primary and secondary care services on behalf of their resident populations. The commissioning of primary care services saw the emergence of Alternative Providers of Medical Services (APMS), driven by the concept known as "*any willing provider"* which were companies or social providers who operate to a specified nGMS contract. A number of APMS have developed, including innovative models of partnership, some led by other professionals such as nurses as well as the entry of the private sector healthcare chains. Despite controversy, and questions about the ethics of private companies making profit from patient care, the Department of Health in England insisted that these arrangements differ very little from the group of GPs who operate under the same contract in established partnerships. (82)

The English NHS has also seen the development of walk-in centres to widen patient choice. These centres have been evaluated and appear to improve access for a small number of people, chiefly younger men of working age. (83)

2008 saw the publication of Lord Darzi's review High Quality Care For All: NHS Next Stage Review Final Report. This report promised a number of innovations including widening patients' choice of GP practices and the creation of a new NHS Constitution. The report sought to focus less on quality in processes such as access and waiting times, and instead improve quality of outcomes. Recommendations included an extension of choice in primary care, with increased quality indicators to inform consumers. In addition, practices would be supported to innovate and to deliver in areas of inequality. The personalisation agenda was also emphasised with the announcement of an intention to pilot personal health budgets for individuals with long-term conditions, mirroring developments in adult social care. The report also committed to GP-led centres, or 'polyclinics'. (84) The BMA has suggested that these entities would be in direct competition with traditional,

patient-centred primary care. The King's Fund has produced a report which suggested that co-location, the main advantage of the polyclinic approach, will not on its own produce integrated care. (85) It also raised concerns about continuity and co-ordination of care within these new clinics.

In response the RCGP proposed an alternative model - the development of primary care federations, based on concepts of mutuality between practices and other primary care elements such as health visitors, pharmacies and opticians. These were envisaged as alternatives to polyclinics, being smaller scale than PCTs, providing improved management of conditions within primary care federations. They argued that this solution addressed the Darzi access and choice issue, but retained the centrality of traditional practices, which would need to evolve. (86)

Practice Based Commissioning (PbC) was introduced in an attempt to increase the involvement of frontline clinicians in commissioning decisions in order to make them more aware and accountable for their treatment and referral decisions in a financial sense. The origin of PbC can be found in the 1997 white paper The New NHS: Modern, Dependable (87) and it was a recurrent theme in subsequent documents, culminating in a major policy theme in the 2006 white paper Our Health, Our Care, Our Say: a New Direction for Community Services. (88)

PbC created indicative budgets for practices to commission community and secondary care services from either themselves or other providers in order to meet the needs of their patients. Primary Care Trusts retained the funding and held the contracts. Practices were able to invest 70% of savings in patient care with 30% being retained by the PCT. PbC was initially unpopular, but an incentive payment under the Directed Enhanced Services element of nGMS led to higher levels of uptake. Most PbC took place in consortia of GP practices.

PbC was closely linked to fundholding, both being approaches to total purchasing, whereby GPs gain an understanding of the total costs borne for managing a patient. Difficulties with fundholding included reduced patient satisfaction, transaction costs and inequity (see previously). It has been suggested that PBC had similar drawbacks, and that it was not developed in ways which incorporated learning from the earlier fundholding. (89)

In late 2007 the Audit Commission suggested that despite improved uptake at a cost of £98 million in DES payments there was limited progress in PBC. (90) (This was echoed by a report by the King's Fund (91). Gillam and Lewis reported little progress in 2009, citing accepted barriers such as management support, resources and meaningful engagement, and questioned if PbC, previously described as *"the sick man of the NHS"* needed not resuscitation, but palliative care. (92)

Additional barriers to PbC included: concerns about self-interest (that GPs could commission services from themselves); lack of capability around commissioning functions; governance relationships with PCTs; a lack of timely data upon which to plan; a lack of clarity in the guidance; and that all of these barriers happened against a background of poor quality relationships between the profession and the Government. The Department of Health confirmed the status of PbC through the *Next Stage Review* which stated that *"it [PbC] has not yet lived up to its potential"* but committed to addressing the problems and implementing the initiative. *(84)*

May 2010 marked a new Conservative-Liberal administration intent on reducing NHS expenditure, but promising no *top-down* reorganisation. July 2010 brought a white paper, *Equity and Excellence: Liberating the NHS.* (93) The paper set out proposals for radical reform of the English Health Service, increasing choice, expanding the market and introducing market competition into healthcare. At the heart of the reform was the proposal to dismantle the NHS executive structures and to devolve commissioning to groups of GPs. Most commentators have questioned the wisdom of radical reform when the previous direction of change was widely considered to be delivering the outcomes being articulated, particularly given the cost of structural change at a time of economic scarcity. (94)

The administration published a *Health and Social Care Bill* in January of 2011. (95) The Bill has been substantially amended in the House of Lords, and there was widespread concern from NHS staff, both managers and healthcare professionals, about the consequences of the proposed reforms. Despite the strong GP-focus within the proposals, the BMA, the Royal College of General Practitioners (RCGP) The Faculty of Public Health and The Royal College of Nurses called for the Bill to be withdrawn due to concerns about its practicality, and concerns about the impact of open market competition on quality and safety, particularly in relation to the care of the most vulnerable. (96, 97)

The final Bill saw the creation of Clinical Commissioning Groups (CCGs) to take over the function of PCTs and hold commissioning budgets. The Bill also removed the duty on the Secretary of State to ensure the provision of comprehensive health services and widened patient choice so that there was no link between geographies and providers. Whilst the impact of these reforms on primary care and on population health remain uncertain, membership of a CCG has become a condition of practice in primary care. Furthermore, an NHS Commissioning Board has been created to allocate funding and hold CCGs to account. Further governance will include local Health and Wellbeing Boards which will have a strong local authority presence and local Health Watch organisations to protect the patient/consumer voice. One of the most contested elements of the reform has been the opening of NHS services to competitive tendering due to the future implications for any administration which might wish to reverse the changes. Commentators have also questioned how the conflicts of interest for CCGs who decide to commission themselves to provide additional services are to be addressed. (98)

2.9 International primary care

The WHO's Alma Ata declaration confirmed international commitment to the development of primary health care in order to improve health equity across the globe. Almost all developed nations have primary care sectors, although their accessibility and roles vary significantly. (99) As with the UK, many countries have a complex and contested history surrounding their primary care system. This section attempts to identify alternative models of organisation from an international perspective. The following section attempts to briefly outline primary care arrangements in the developed world. It does not represent a comprehensive review of all primary care models in operation internationally. The developing world is excluded as many of the models in place, although valid, lack a comprehensive scope. It is accepted that some of these models could provide learning for future models in Scotland.

Most European states had strong primary care sectors, which are in the main funded by the state from either general taxation (Beveridgian), or by social insurance (Bismarkian). Additional funding mechanisms at the system level include private funding, either through out-of-pocket payments for the individual,

or via a personal insurance market, and voluntary or charitable funding. A historic arrangement distinct from Beveridge was known as the Semashko system. This was the predominant system in Russia and its satellites and refers to a centrally funded, designed and governed healthcare system. Under Semashko, the state mandated all services, excluding alternative providers and private practice. Most European accession countries abandoned the Semashko system in favour of Western style Bismarkian, Beveridgian or free market systems. Some states in Europe had Beveridgian systems, predominantly the UK, Mediterranean countries and Scandinavia, whereas Bismarkian systems predominate in Germany, Austria, Luxembourg, Belgium, France and the Netherlands. Wendt developed a typology of European healthcare systems on the basis of: total expenditure; financing; provision methods; and institutional characteristics. (100) He concluded that national systems fell into one of three groups: provision-orientated (with high numbers of providers and free access); universal coverage (where access and provision were linked to social citizenship); and low budget systems with restricted access.

Gatekeeping roles[‡] were not modelled on the UK system in general. A number of countries, such as Spain, had GPs plus other specialists operating in primary care sharing the role of gatekeeper to secondary care. In Denmark, the vast majority of the population had the GP as their gatekeeper, however a small minority paid an additional premium to have the choice to refer themselves directly to secondary care specialists. In the Netherlands the GP occupied a gatekeeper role, but private system patients do not require a gatekeeper. A number of countries did not have a gatekeeper, having instead direct access to specialists and secondary care.

In Cuba, subsequent to the revolution and the resulting economic and social isolation, primary care was provided under a variant of the Semashko system. The Cuban Government mandated the system, but it had a community-orientated primary care emphasis. (101) The population must engage with their primary care doctor and nurse, who work collaboratively to provide care, with an emphasis on primary prevention. The primary care team acted as gatekeepers, controlling access to secondary care (polyclinics and hospitals) but even then, primary care teams had extensive trans-sectoral collaboration with those to whom they refer.

[‡] Gatekeeping refers to the arrangement where health systems regulate access to secondary care through referral systems from general medical practitioners.

This is facilitated by strong interprofessional relationships between primary and secondary care staff, with primary care staff having a responsibility to help their patients negotiate the transitions to secondary care, and back to their communities.

Canada's primary care system was Bismarkian. Referred to as Medicare, it was funded by a mandatory collection of 10 provincial and 3 territorial insurance schemes which provide universal coverage. Primary care physicians in Canada worked with nurse practitioners and were gatekeepers to secondary care. Recent reform in Ontario has seen the emergence of Family Health Groups (FHGs) with expanded skillmix and increased elements of capitation. Kantarevic *et al* have suggested that in comparison with traditional family medicine practices which have family physicians (analogous to GPs) who are paid by item of service, FHG practices have higher productivity, reduced referral rates and see more complex patients than their counterparts. (102)

The United States had a complex array of health care provision. Provision was historically based on private insurance or direct payment, and state Medicare for the elderly and some disabled groups and Medicaid for those who have low incomes. Medicare and Medicaid funded secondary care costs but not all primary care activity. Increasingly, Americans have been induced to join Health Management Organisations (HMOs) which function to share risk as insurers, and commission services for primary and secondary care. HMOs funded primary care delivered by a number of models and methods, including family physicians, specialists working in primary care, and sometimes nurse-only delivered primary care centres, although this was variable by state. The providers were a mix of salaried and contracted enterprises. Provision of universal primary care access for the US is very much a work in progress. Limited gatekeeping operated within HMOs, but in private practice there was no gatekeeper role, with direct referral being the norm. More recently, controversial healthcare reforms are having an impact on primary care in the US. In the reforms Medicare will be provided through Accountable Care Organisations which will attempt to integrate care. A major element of this change is the move away from item of service payment and towards capitation (see later). (103) The reforms attempt to deliver the Primary Care Medical Home (essentially co-ordinated, continuous, comprehensive primary care) through Accountable Care Organisations which utilise targets and incentives to deliver changes in practice. (104)

New Zealand and Australia have seen substantial reorganisation in primary care with the introduction of voluntary and then mandatory primary care organisations, analogous to the journey from LHCCs to CHPs in Scotland and PCTs in England. A particular strength of systems in these countries was the community governance reflected in their primary care organisations and community-based providers. (105)

2.10 Models for delivering primary health care in Scotland

Kringos has reviewed the primary care literature to define the key attributes associated with primary care. This typology builds on the work of Starfield and others, and describes ten core dimensions which are represented in most literature on primary care. These can be grouped into structural dimensions, process dimensions, and outcome dimension. The structural dimensions were: governance; economic conditions; and workforce development. Process dimensions included: access; continuity of care; co-ordination of care; and comprehensiveness of care. Finally, the outcomes dimensions were: quality; efficiency; and equity in health. (106)

Meads' case-studies of primary healthcare reform suggested six typological models for provision: the outreach franchise; reformed polyclinic; extended general practice; district health system; managed care enterprise; and the community development agency. (107) Thomas *et al* further classified these models as being three sets: those which integrated care through a mainly medical model of practice; those which intergrated via multidisciplinary teams; and those which delivered integration via networks. (108) The models which integrated through medical practice included the outreach franchise and the reformed polyclinic, which owed their origins to traditional independent general medical services providers (outreach) and a technical model which combined GPs and specialists in one site (polyclinic). Thomas suggests that this set would be strongly led my a medical profession which would integrate across primary and secondary care. The multidisciplinary integration set included extended general practice and district health systems, which they state had their origins in the post 1990 general practice model and in wider community trusts, both of which provided a stronger sense of multidisciplinary team working through which horizontal integration

was achieved (resulting in cross-sectoral working to improve health). Finally, the network integration set included managed care and community development models. Both of these approaches required a change in perspective from that of the individual to the health system, albeit through divergent methods. Managed care tends to take a managerial and enterprise approach, whilst community development tends to take a citizen-orientated, community justice approach to health and healthcare systems.

The literature contains numerous references to models of primary care. However, the word model is used in a variety of different ways, from a simple description of processes, through the variety of professional groups involved and their interaction; the scope of primary care practice; the organisation of care provision; relationships with other care sectors; and the funding and organisation of services. Given the need to relate this literature review to alternative models for use within the Greater Glasgow and Clyde area, the following elements were considered to be necessary in the search for models of primary care:

- the model should be generalisable to the whole population as is the current situation in Scotland;
- the scope of conditions covered should be universal and comprehensive, covering primary care for all those who are, or believe themselves to be ill, including acute and chronic conditions and health improvement;
- the model must specify the staff or skills necessary for operation and their inter-relationships;
- it should have a clear method of funding and provide clarity about how work is organised; and
- there should be clear governance to ensure safety and quality.

Models which failed to meet these criteria were not considered as it was thought unlikely that they would be credible alternatives for the local context. Having eliminated targeted models, and those providing a narrow scope of services, the remaining models can be described by variation in the composition of their workforce, inter-relationships and the organisation of work; their ownership; their funding mechanisms; and their governance. The models are therefore discussed under these five subheadings: workforce; funding; ownership; organisation; and governance. Given the very complex and situated nature of primary care models, it is accepted that there was some overlap between each of the model domains.

2.10.1 Workforce

Professionals cited in the contemporary literature as providing primary care of the broad scope currently offered within the UK include: GPs or family doctors; nurses, including practice nurses and nurse practitioners; medical specialists, including paediatricians; and physician assistants. Some other professionals who are defined medical specialists such as general physicians, psychiatrists and obstetricians, or specialised staff such as midwives can work within primary care, but models where these are the main providers usually have a narrowed scope or have other organisational arrangements to ensure a comprehensive service. In addition, these models represent an extended form of primary care which contains specialist elements which would normally be considered as secondary care.

2.10.1.1. GPs

Whilst in pre-NHS times a number of groups provided care, the first professional providing primary care within the UK NHS was the general practitioner. GP training has changed dramatically since 1948 where medical graduates could enter practice immediately upon leaving medical school, without any postgraduate training or further experience. Now, all GPs must now undergo supervised postgraduate training and complete postgraduate assessments of knowledge and skills in order to achieve a Certificate of Completion of Training (CCT) awarded on the advice of the Royal College of General Practitioners.

Other groups of staff are involved in providing primary care. Although the developing world has always had significant skillmix within primary care, the literature identifying skillmix as a significant policy direction within primary care for the developed world dates back to the 1980s. (109) It is difficult to ascertain if the driver behind the widening of professional groups in primary care is driven by staff shortage, the drive for professional equality with other healthcare practitioner groups, an attempt to reduce costs, or widening patient expectations, but skillmix within primary care has been a central issue within Department of Health policy since the 1990 contract. Iliffe suggested that the *industrialisation* of primary care would lead to *"large scale skill transfers, with nurse practitioners becoming alternatives to doctors and minimally trained staff (health care assistants) taking on simple nursing tasks."* (110)

2.10.1.2 Other staff groups

Nurses have always provided care within the community. However, their role in primary care was enhanced by the 1966 contract, which provided additional resources to GPs to part-fund the employment of practice nurses by groups, and the 1990 contract which required more practice nurses to provide care in newly incentivised areas. Recent years have seen a growing involvement of nurses in primary care, initially seen as a method for expanding the primary care workforce and meeting increased patient demand. Broadbent attributed the widening of nursing roles to changes in the 1990 GP contract. (111) Increasingly, practice-nurses occupy several different roles within practice groups. Sibbald *et al* have defined four roles for nurses within primary care: enhancement – extending the skills or roles of a group; substitution – of nurses for GPs; delegation – from GPs to nurses; and innovation – creating new jobs by introducing new types of worker. (112) The researchers also comment on the relative lack of robust research on the consequences of skillmix in primary care. Buchan and Poz have suggested that whilst there is limited potential for the delegation of healthcare tasks from nurses to healthcare assistant, that there is significant scope for transferring tasks from medical care practitioners to nurses. (113) Nancarrow and Borthwick have commented on the unprecendented opportunities for change in the respective roles of different health professionals in the UK context. These authors state that it is *"the first time in the history of the professions that the state has explicitly supported non-medical practitioners to encroach on traditional medical roles"*. They have suggested four ways in which professionals' roles can be changed: diversification (where a novel approach expands practice for a discipline); specialisation (resulting in a limited group taking on a role); vertical substitution (where the task is transferred to another discipline which has unequal training or expertise); and horizontal substitution (where there is a transfer of tasks to a different discipline with an equal set of training and expertise). (114)

The most common role-change identified was that of nurses being added to the professionals employed by a practice, supplementing the work of GPs. Nurses were increasingly involved in traditional roles such as treatment room work, but increasingly have moved to providing practice-based chronic disease management for patients. Other nursing staff have taken on minor injuries and minor ailments roles, enhancing their skills by becoming nurse prescribers, or developing skills as telephone triage practitioners in NHS24 or NHS Direct.

All of these roles in the UK are mainly additional to existing GP services, providing extended choice for patients. However, some models in the UK have substituted GPs with nurses, with a systematic review finding similar patient health outcomes, increased patient satisfaction, but requiring increased consultation length and reduced productivity. (115, 116)Nurse-practitioners appear to be an evolving force in primary care, with some partnerships replacing GP partners with either salaried nurse-practitioners, resulting in cost savings, or with equity nurse-partners.

In the US, the history of primary care has been characterised by competition between family practitioners (GPs) and nurse-practitioners, with state-by-state contests being played out in an attempt for each group of professionals to control the market for primary care services. In a number of US states there are primary care groups composed entirely of nurse-practitioners, who 'gatekeep' on behalf of HMOs to secondary care. (117) The UK contains a small number of nurse-led practices, (118) but thus far there have been no evaluations of their impact on quality, efficiency and effectiveness.

Further models include US-style physician assistants, who have a bachelor's degree and undergo condensed medical training to perform medical roles. (119) Health care assistants or unqualified GP assistants have also been raised as possibilities for extending the model to deliver primary care, but although financially attractive, the model lacked an evidence-base and some have suggested that such a change might undermine public confidence. (120, 121) A recent systematic review suggested that the evidence-base for nurse practitioners in primary care was secure, but that the evidence-base for other professionals such as physician assistants and pharmacists is as yet incomplete. (122) Some observers have challenged the confrontational professional paradigm, suggesting that in the main, nurses can substitute for GPs for many tasks, but that GPs need to evolve to the management of less common and more clinically complex scenarios, suggesting complementary roles within the team. (123)

2.10.1.3 Interprofessional working

Assuming that models included more than one professional group, it becomes necessary to define how the workforce might interact with each other and how

different elements of work will flow within given workforce models. The work of primary care can be divided in a number of ways: acute or chronic illness; undifferentiated problems or established conditions; biomedical versus psychosocial. By describing the work of primary care as being that of undifferentiated problems and established conditions, two patterns of working are possible: all practitioners see both undifferentiated problems (first point of contact) and differentiated problems (continuing care or chronic disease management), or different members of the practice team separate undifferentiated problems from chronic disease and continuing care management. Once again, different professionals might see either undifferentiated or differentiated problems, creating further variability in the models.

Pullon has suggested that good interprofessional relationships are mediated by trust, mutual respect, an understanding of each other's roles and evidence that they perform these competently. (124) Lanham *et al's* work has extended the attributes which need to be developed to support good interprofessional working to include: trust, mindfulness, heedfulness, respectful interactions, team diversity, a balance between social and task related focus in the team, and a balance between rich and lean communications, depending upon different contexts. (125) Frenk *et al* have recommended that the curricula of all health professionals' education should recognise the need for interprofessional working, the ability to adapt to the needs of patients and the context of the system in which they operate.(126)

McDonald *et al* have suggested that primary care health professionals have uncertain roles within a complex system. Good interprofessional working was, they contended, necessary for quality and without it there will be an adverse impact on patient experiences. In their view, professionals needed an understanding and acceptance of each others respective roles. (127) Their work also suggested that *professional restratification* (the development of novel professional hierarchies of control) described previously in relation to nGMS implementation, is a threat to good interprofessional working, but that in fact there seemed to be an acceptance of new ways of working within practices, suggesting that new norms have been established. (128)

Data from ISD's Practice Team Information programme (a representative sample of 50 practices across Scotland) suggested that GPs were more likely to see undifferentiated problems whilst practice nurses are more likely to perform tests

such as taking blood pressure, taking blood tests, or seeing patients with chronic diseases such as diabetes and asthma. (129) This suggested that the predominant model is for work to be streamed so that undifferentiated problems were seen by GPs with nurses carrying out more chronic disease management and associated monitoring tasks. Charles-Jones *et al* have described the emergence of *hierarchies of appropriateness* in the expanded practice team, where *higher-order* work is retained by the dominant profession, namely GPs. (130) As previously mentioned in relation to nGMS implementation, Grant *et al* have described professional boundaries and work in relation to QOF in English and Scottish practices. (131) In this work there was evidence of a redefined professional hierarchy where more complex, higher-order work is reserved by GPs, with protocol-driven tasks being delegated to practice nurses, who in turn created a similar hierarchy further delegating the most menial of clinical tasks to healthcare assistants. Some of this work linked with Checkland *et al's* description of the changing nature of primary care, whereby both GPs and nurses espoused a commitment to biopsychosocial *holism*, but defined an emergent hierarchy based upon increasing specialism. (69) Despite this description, a less common variant in operation within the UK uses nurse practitioners to triage, with GPs providing chronic disease management.

2.10.1.4 Team size

The size of practice teams is also a significant theme within the workforce domain of primary care models. Single-handed GPs are still common in Scotland, both in remote and urban communities. In 2007 more than 20% of GP practices in Greater Glasgow and Clyde were single-handed. (132) This model was more common in socio-economically deprived urban areas, but the nGMS model has been viewed as a significant threat to the viability of single-handed practices. (133) Some GPs may work as the only doctor within a broader multidisciplinary team, with practice nurses, reception staff, and provision from other community-operated primary care services such as district nurses, health visitors and others. A variant of this model has been the development of groups of single-handed GPs who shared resources including accommodation, ancillary and professional staff support and access to diagnostic services, but who retained their personal lists of patients. Although there have been concerns that single-handed practice reduces patient choice in terms of the potential for different perspectives and interests in comparison with a group practice, patients were often loyal to their personal

doctor. Some GPs remained single-handed through necessity, because of difficulties in recruiting staff to work with, often as a result of their practice location within an area of deprivation, rurality or both. The main concerns raised about this model were the lack of choice for patients and the lack of peer-support for the single-handed GP and potential consequences which this might have for quality and sustainability. Hippisley-Cox *et al*'s work suggested that after standardising for age, sex and socioeconomic deprivation, single-handed practices resulted in higher rates of admission for asthma and epilepsy. (134) However, to some extent the issue of quality and risk in relation to single-handed practice depends upon the perspective taken. Larger practices tended to have better developed surveillance and business processes, but lacked the advantages related to interpersonal issues. Majeed *et* al suggested that for patients with ischaemic heart disease, practice size had an impact on processes, but not on overall quality of care. (135)

Following the 1965 Family Doctor's Charter and contract, group work was incentivised, with practices being given interest-free loans to facilitate the coalescing of single-handed practitioners into larger groups (see section 2.4.3). The reasoning behind this development was the economy of sharing ancillary and other support staff including practice nurses. A further economy was that new accommodation for group practices was less expensive when practitioners were located in larger working groups.

Group practice is thus the predominant model for British general practices. The core practice team normally includes GPs, practice nurses, reception and administration staff; and a practice manager. (132) More recently, nurse practitioners have been introduced to practice team (see section 2.10.1.2). As alluded to in the previous section, most practice nurses in the UK have work delegated to them from GPs who see 'unfiltered cases'. GPs then diagnose or develop an investigation and treatment plan which can be delegated to others in the practice, including nurses. Extended nursing roles include prescribing, chronic disease management and in some instances they see 'unfiltered cases', in effect substituting for the traditional role of a GP. In most cases, even such extended nurse roles worked with a GP within the team to provide an alternative perspective on acute and chronic illness. Members of group practices collaborated, shared services, and provided shared care to patients, The advantages of group practice are increased choice and facilities for patients and increased support and

a reduction in overheads for professionals. In terms of most group practices being *de facto* partnerships, either at will (informally) or by formal agreement, there was very little literature exploring their advantages and disadvantages (but see later at section 2.10.3.1).

2.10.2 Funding

The funding and organisation of primary care were often inextricably linked as they relate to concepts of ownership and professional power relationships which determine the organisation of work.

Ways of paying primary care staff, and GPs in particular were seen as an important, historically contentious and heavily researched area. The way a system remunerated or financially rewarded its employees or contractors, was one of the main methods open to a health system to influence behaviour, but this fact does not suggest that it was the most important factor in influencing behaviour, it is simply that it was perceived as managerially simpler to consider an econometric solution than to attempt to influence values or relationships. The research in this area was often international, and an important issue was that remuneration and incentives employed in one particular health system may not have the same effects if implemented in another. Methods for health systems to remunerate GPs included: capitation; integrated capitation; fee for service (or item of service); target payments (or payment for performance); salary; and mixed payments, which might include a number of the above elements. Table 2.2 shows international methods of remunerating activity in primary health care systems in selected developed nations.

2.10.2.1 Capitation and integrated capitation

Capitation is the historic basis of the NHS system, dating back to the 1911 National Insurance Act. Under capitation systems, a doctor would be paid a specific annual sum for providing a complete package of primary care for a person. In some cases the capitation payments can be risk adjusted so that the capitation fee may be higher for groups such as the very young and the very old who require additional care. The capitation amount presupposes the development

Table 2.3 Selected international examples of systems of remunerating primary health care, circa 2004. Adapted from Greβ, Delnoij and Groenewegen (136) Note: Fee-for-service (FFS).

Country	System of remuneration
UK	Mixed
US	Mixed
Austria	Mixed
Belgium	FFS
Denmark	Mixed
Finland	Mixed
France	FFS
Germany	FFS
Greece	Salary
Ireland	Mixed
Italy	Mixed
Luxembourg	FFS
The Netherlands	Mixed
Portugal	Mixed
Spain	Mixed
Sweden	Mixed
Czech republic	Mixed
Hungary	Mixed
Poland	Capitation
Slovakia	Mixed
Slovenia	Mixed

of registered lists, once called 'panels' of patients associated with a specific doctor or group practice. Apart from risk-adjustment, the payment was independent of the quantity or complexity of care delivered. Capitation as a single method of payment is now uncommon, but as a component of mixed payment systems is present in a number of European health care systems.

Advantages of capitation were thought to include improved access to and continuity of care in combination with registration. (137) There was also some evidence that capitation encourages health promotion activity, since any effort directed into preventative care will be realised by reduced use of services, and therefore maximisation of net profit in the future. This was of course dependent on an analysis of the marginal costs of the prevention activity in comparison with the possible future utilisation costs. (138)

Disadvantages of capitation included the concepts of *over-delegation* and *risk-selection.* Over-delegation was the idea that, in order to limit care provided to a patient with high health demands, a GP may be more likely to delegate care to

another, by referring to another practitioner. (139) Risk-selection, or 'cream skimming' was the concept that, in order to limit care activity, and thus maximise profit, a GP would be more likely to register a patient who had lower demands compared with a patient with current, or future health care demands which were higher. (140) A further potential disadvantage of capitation was the capacity for GPs to expand their registration lists, thereby reducing the availability of access for each individual registered patient and thereby reducing the quality of care. This issue could be addressed through limits on list size.

Integrated capitation was a system whereby a GP gatekeeper is provided with a payment which covers the costs of both primary care and additional referrals to secondary care. This model was uncommon in Europe, but was briefly used in the UK, when under the 1990 contract, GPs could elect to become fundholding. It has been extensively used in HMO contracting arrangements in the US.

The advantages of integrated capitation were similar to the advantages of capitation – access and continuity but the important difference is that the major disadvantage of over-delegation is minimised, as there were financial consequences for such activity. Work done in the UK confirmed that fundholders limited referral activity, and constrained growth in prescribing in comparison with non-fundholders. (141) If sophisticated risk-stratification were used in the development of integrated capitation, then cream-skimming could be reduced, with a potential then for quality care to emerge, including opportunities to extend the scope of existing primary care. The disadvantages of integrated capitation included cream-skimming, which was more likely if risk-stratified payments were not used, as well as the significant transaction costs which are required to administer such a complex payment system.

Clearly the costs of a capitation or integrated capitation system are highly context dependent, and need to take account of parameters such as list sizes, risk-stratification of capitation payments, and discretion and incentives around the constraint of over-delegation behaviour. These issues notwithstanding, these methods constrain cost, provide stability, but partially limit patient freedom in comparison with non-registration systems.

2.10.2.2 Fee-for-service

Fee for service (FFS) was a simple method of payment where the GPs are paid a specific sum of money for each item of health care service delivered. It was uncommon to find this method without co-payments from patients. Fee for service was rarely found outwith mixed payment systems, except in the private sector.

Advantages of FFS included high levels of doctor and patient autonomy and choice, and FFS GPs were less likely to delegate or refer patients to others for care outwith their service, preferring to provide services themselves, increasing fees. (139) FFS also facilitated patient choice. Given the financial incentive, patients are more likely to have investigations, prescriptions or treatments provided within the practice.

However, the main disadvantages of FFS were supplier-induced demand, and the associated high costs of the system. Supplier-induced demand was the principle that as there is a fee for each service, suppliers may be incentivised to increase activity to maximise income, and there was good evidence that activity is higher in FFS compared with other systems. (137) This was particularly common when there was oversupply in primary care systems and GPs struggled to maintain or improve their income. (138)

In general, transition to FFS systems induced GPs to act to reach a target income, rather than to maximise income, although this is context dependent. (139) Possible solutions to this included the provision of strong clinical guidelines, relying on other motivations outwith the sphere of financial reward to moderate behaviour, or the development of fee-schedules which take account of the marginal costs of specific activities, thereby reducing the incentives to perform specific items of service. A further disadvantage of this method of payment was that it does not facilitate registration and subsequent continuity or co-ordination of care.

FFS incentivised activity, but the impact on health outcomes is unknown. (138) One under-investigated area was the effect which FFS has on GPs. Lichtenstein has suggested that whereas for capitation (or salaried systems), GPs tended to have fixed hours, and resentment tends to centre around patient –led demand. For FFS staff, there were incentives to work long hours to increase their financial

rewards, and the resentment fostered centred around hours of work and work-life balance. (142)

2.10.2.3 Salary

Salaried payment in primary care was the simplest method of remuneration to administer. In essence, GPs become employees of the health care system or group practice, and payment becomes independent of the volume or complexity of work performed. Salaried systems had the lowest administration costs, facilitated service planning and raised employment rights. Salaried service within group practices was uncommon in Europe before the late 1990s. Prior to this point, the majority of salaried systems operated within the constraints of the soviet-inspired Semashko system operating in Russia and its satellites. European accession countries have rapidly moved away from salaried systems, although it is unclear if this was related to experience of the salaried system per se, or the context of the Semashko paradigm which removed any choice for patients and doctors.

Salaried GPs are now considered commonplace in the UK. By the end of 2000 over half of all new PMS practices contained salaried employees. With the advent of *n*GMS, retiring partners from practices were less likely to be replaced by equity partners with high numbers of applications for each partnership advertised, and practices were far more likely to generate additional salaried roles, including salaried GPs. (143) By 2007 this trend towards salaried GPs operating in *n*GMS had seen the proportion of salaried GPs grow from 12% in 2005 to 33%. (144)

Possibly as a result of historic tensions around the desire of Bevan to salary GPs, much of the literature on salaried payment which is UK-based reflects opinion rather than evidence. The advantages of a salaried system included its simplicity to administer and plan, the capacity to break the link between outputs and payment, (145) its ability to facilitate access (146) and the fact that there was little potential for a conflict of interest since patient care is independent from income, in contrast to all other methods of payment. (147)

In the context of the UK system, independent contractor income increased from £65,180 in 2003/4 by 38% to £90,127 in 2005/6, whilst salaried GP incomes, grew by 3% between 2004/5 and 2005/6, to £46.905, representing significantly lower costs. It is not clear whether these data take account of flexible work hours, and

reduced administrative responsibilities within practice entities or if they simply reflect poorer remuneration settlements in comparison with those in partnership. (48)

Disadvantages of salaried remuneration included the tendency to over-delegate, in common with capitation systems. It has been suggested that salaried service reduces motivation to perform. (148) Even within the salaried NHS, Consultants were historically able to compete for discretionary points or distinction awards on the basis of producing high quality of higher than anticipated levels of work. There were a number of assertions in the literature that salaried practitioners have lower productivity. However, work done by Gosden *et al* within the UK, comparing conventional GMS and PMS practices suggested that the productivity of salaried GPs in comparison with independent contractor partners was similar. In fact, measures of quality and performance were slightly higher within the salaried group, although these findings did not reach statistical significance. (149)

A further form of salaried GP practice was primary care organisation (Health Board or PCT), directly-employed GPs working with a given population. This form of practice entity (known as 2C in Scotland) was uncommon in the UK, being used in areas where conventional practice is unable to attract GPs; to reach underserved groups; or where a conventional practice entity is unstable and urgent action was needed to ensure stability in the provision of care for registered patients. No literature was found looking specifically at this form of practice in isolation from salaried practitioners operating within GP-owned practices.

Some sources suggested that salaried service was synonymous with low quality. (150) Whilst this fits with the theory that resentment of rising patient demands are facilitated by a capitated or salaried system, it was difficult to separate the cultural and professional aspects of these views from objective evidence. Similarly lacking in evidence has been suggestion that salaried doctors might be more eager to please an employer than their patients. (151) Finally, it has been suggested that salaried systems do not facilitate co-ordination and continuity. (152) This was true of some historic systems which did not utilise the principle of registration or gatekeeping, but has not been corroborated in UK salaried models such as PMS.

An emergent issue in the UK has been differences in the quality of employee rights conferred on salaried doctors. Some GPs have been employed directly by

primary care organisations, whist the majority of salaried GPs are contracted to *n*GMS practices that are free to negotiate the employment contracts of their employees. Lecky's description of the state of salaried GPs provides evidence of relative professional isolation and vulnerability to exploitation. Salaried GPs also reported developing ad hoc support structures in response. Lecky also describes problems with the short term nature of salaried posts, their lack of contractual security, and practitioners' need to supplement lower incomes with multiple employment in different practices as evidence to support the development of a robust and fair model contract for salaried GPs. (153)

The Royal College of GPs and the BMA shared these concerns over some poor conditions of service being imposed on salaried doctors in terms of maternity leave, study leave and the period of notification for termination of contract. This resulted in a model contract for salaried GPs being developed by the BMA. An alternative perspective was to suggest that salaried posts provided flexibility for part time working, and freedom from administrative duties, which would appeal to sectors of the GP workforce who are willing to forego security and employment rights for these benefits. Further, it has been suggested that lack of a financial stake in the practice itself makes salaried doctors less likely to provide continuous service in one post over a period of time, in comparison with the equity partnership model. (154) Finally, Williams *et al* 2001 reviewed salaried posts within PMS pilots and concluded that they could provide a positive choice for GPs for those seeking freedom from administrative responsibilities or the financial risk of partnership. (155)

2.10.2.4 Mixed payment systems, target payments and function payments

The majority of primary health care systems globally were remunerated by mixed systems of payment which have evolved over time. In most European systems this convergence has been facilitated by the emergence of the New Public Management, (156) characterised by an attempt to improve health services' efficiency by the systematic removal of barriers between the market and public sectors. In the US, drives towards cost containment, and a growing realisation of the profound societal consequences of poor universal access to primary health care has driven private FFS businesses, HMOs and Medicare/Medicaid providers into mixed methods of remuneration, but with very high levels of heterogeneity between models within the emerging 'system'. Once more, the importance of the

cultural, professional and system features have a profound impact on any conclusions which can be drawn from evaluations of the systems of payment. In particular, the diversity of payment composition made comparison very difficult.

Mixed remuneration systems operated either at the level of the GP or practice, with components of income being drawn from salary, capitation, target or function payments, or the mixed nature of payment can operate at the level of the system, with some GPs being salaried, with others being capitated or paid via FFS.

Target payments or payment-for-performance (P4P) were financial rewards for providing an agreed level of service for a particular activity. The UK QOF is a good example of such a payment system. A function payment is a financial payment for providing additional service elements, not routinely regarded as forming part of a primary care contract. Again, the *n*GMS Enhanced Services are a good example of such payments.

A stated advantage of mixed systems of remuneration was that they can provide the advantages of each of the component parts, whilst minimising the disadvantages seen in simpler models. (152) Since mixed models exhibited so much variability, the majority of evidence represents evaluation of service changes, rather than comparisons between mixed and single payment methods. This meant that the scope of evaluations are heavily influenced by the objectives stated for the change to the service and this in turn was highly context-dependent.

An Audit Scotland report on *n*GMS evaluated the implementation of the new contract in Scotland against the shared objectives of the profession and Government, articulated in the plans for the new arrangements. These were: to reduce GP workload and make it more manageable; to reward GPs appropriately for work; to address problems with recruitment to general practice; and to deliver more services appropriately in primary care. The study found evidence that the new contract had delivered a capacity of GPs to manage their workload better, had rewarded GPs financially for specific targets achieved, resulting in a 40% growth in costs, but that there were disadvantages, such as reduced information on the primary care workforce to facilitate planning, inequalities in the terms of employment for practice-employed staff, and a lack of information to assess the system impacts in terms of the knock-on effect on secondary care, measurement of prescribing and referral activity, and no assessment of the appropriateness of

investigations being undertaken via the contract. Audit Scotland concluded that improvement had occurred, but at a significant cost, and that some of the benefits of the contract, particularly in relation to additional function payments had yet to be fully utilised by boards. Further, there was a need to overcome some of the unintended consequences of the change, particularly in relation to the lack of management information on workforce which resulted from nGMS.

The theme of improvement, but at a cost, is echoed by the independent Civitas report, (63) which concludes that significant improvements in quality of care, information management and even action on some health inequalities has been demonstrated, but that the unintended consequences resulting have been a loss in the patient-centred agenda, as well as areas of illness being 'left behind' in comparison with the improvements occurring for QOF-included conditions. The authors also expressed unease with the proportion of GP profit flowing exclusively from process-driven performance via QOF.

Target or function payments, also referred to as payment for performance (P4P) did have the capacity to change practice in primary care according to a Cochrane systematic review carried out in 2000, (157) but again, this was highly context dependent, and the financial reward only partly explains behaviours. Evidence of such discrepancies was clear. Under the 1990s contract, target payments had a profound impact in facilitating the introduction of child immunisation. In contrast, despite incentives across the GMS contracts since the 1960s, the provision of functions such as intrapartum care for women has dramatically reduced. Clearly other factors were at work. Interestingly, the most recent Cochrane review of the impact of incentives on primary care quality and performance suggested that there was insufficient evidence to recommend or not to recommend the use of P4P in primary care. (65)

The major disadvantages with target and function payments were the unintended consequences. These consequences emerge from the complex systems into which they were introduced. Gaming, or using the constraints of the system to maximise income, has been described across the history of inducement payments (59, 60) and is one particular form of unintended consequence of incentives.

Practices in deprived areas achieved similar QOF scores to practices in affluent areas. The work of Doran *et al* and Ashworth *et al* suggested that QOF payments

may have reduced some health inequalities, at the process level. This conclusion is still contested, and the longer-term impact of concentrating on QOF in practices servicing deprived populations remains unclear. (54)

The methods by which primary health care workers are remunerated is an important but complicated factor in the performance of any primary care system. Geneau *et al* interviewed GPs and studied their views of methods of remuneration, providing an analysis from a social science perspective. (158) Their conclusion was that the method of remuneration had a primary effect on the performance of activity and time management within primary care. They compared payment by item of service claims (also known as Fee For Service, FFS) with salaried service. Their conclusions about the effect of financial incentives on behaviour were enlightening. The following quotation typifies the views they encountered: *"There are some blatant injustices with FFS. I mean, it's more profitable to treat two cases of otitis than to treat one case of depression. It doesn't make sense. Bring on the otitis. Some GPs decide to do that."* They conclude that GPs are driven not only by their professional values, nor by financial incentives, but that these interact, and that GPs are ultimately driven to maximise *ontological security* in that they are driven to make their work lives more predictable, by reducing uncertainty. (159) Geneau *et al* also contend that although salaried consultations may have been longer, it was possible that this approach could be more cost effective in the longer term. (158)

Hughes work on cervical screening demonstrated the short-term effectiveness of incentive payments, but equally, demonstrated clearly that individuals then find ways to minimise the additional workload involved whilst retaining the incentives, proving that financial incentives work, but not in the manner first intended, and not necessarily in an efficient way. (160) McDonald and Roland have suggested that incentives work, but emphasise that contextual factors are crucial to their functioning on the basis of UK and US evidence. (161) The context of incentives includes the interaction between the incentive and professional values and behaviours. The work of Gravelle *et al* and Croxson *et al* provide evidence of the way in which incentives in different contexts can produce different effects. Croxson *et al* demonstrated evidence that GPs artificially inflated their clinical activity prior to the start of fundholding in order to maximise their notional budgets, suggesting that professional motives did not prevent gaming of the system. (162) On the other hand, as previously discussed, Gravelle *et al's* work

examining QOF attainment in Scottish practices suggested a degree of altruism around nGMS behaviour, since GPs could have reduced their reviews by 11.8% without incurring financial loss. (60)

The complex nature of health care systems means that the impact of changes in remuneration can be unpredictable. Part of this complex system involves other, less direct levers for behavioural change. Chaix-Coutourier has suggested that learning to develop such levers for change would provide an interesting contrast with financial incentives. (163) Scott *et al's* recent Cochrane review into the effect of financial incentives on the quality of health care provided by primary care physicians suggested that there was insufficient evidence to support or refute the use of incentives in primary care to improve quality. (65) The conclusion which seems likely is that financial incentives work, but that the frequency of *perverse consequences* is such that their use should be *rigorously evaluated with a good deal of scepticism*. (164)

2.10.3 Ownership

Iliffe has described the transformation of general practice to primary care as *industrialisation* and has used a historical framework around nineteenth and twentieth century industrialisation processes to explain changes in the models of delivery. From 1948 to 1990 the model was described as *franchise development*, which allowed general practice to grow quickly, with franchisees (GPs) absorbing most of the risk, but this led to problems with the control of quality. He has described the period 1990 to 2000 as market reforms which produced little benefit in quality, and the phase from 2000 onwards as *primary care groups*, creating *"more of an industrial market than a retail one"*. (165) Illife's framework for primary care models provides two axes: the market typology: type one markets being industrial, with work being purchased between organisations, in contrast to type 2 markets, which he describes as retail markets, where individual consumers purchased care directly. He equated type one with the UK as of 2002; and type two as the US system. On the second axis he placed a spectrum with responsible autonomy at one end, with incorporation at the other. He contended that this created a typology of models for primary care which describe how the move from professional autonomy to incorporation has developed in the UK and the US. The UK started with the *franchise* model (high autonomy in a business market) and this

gave way to *salaried state service* (high levels of incorporation in a business market). Similarly, the US, he contends, started with high autonomy in a type 2 market, producing *free practice*, and that increasing incorporation had resulted in the *HMO* (Health Management Organisation) model.

Saltman has described a classification of ownership which recognises four states: public-state ownership such as those in Greece, Germany and Portugal; public-but-not-state ownership, such as municipal health centres in Spain, Sweden and Norway; private, not-for-profit/voluntary; and private, for-profit-commercial, including the UK and he Netherlands. He recognised that this typology does not take into account complex local issues such as the fact that UK GPs still consider themselves part of the NHS and have NHS pensions, or the fact that some state systems permit GPs to practise privately within state facilities. (166)

Crampton and Starfield have proposed an alternative typology for primary care based upon ownership. They classify models as either government owned, or privately owned. Further, they classify privately owned as those which are, or are not responsible to a community-governance board. (167)

In practice, ownership is not entirely separate from governance and accountability and workforce. For the purpose of this review, we shall consider ownership using Saltman's model as the author considered that this four-state approach provided an appropriate resolution through which to classify the literature.

2.10.3.1 Private for profit

GP Partnerships in the UK are for-profit independent contractors with the NHS. This fact has been a touchstone of the profession dating back to the inception of the NHS. Sociological enquiry regards professional partnerships as a form of collegium, that is, an entity *"whose purpose is to exert control of working conditions for a profession". (168)* Defining characteristics of partnerships are: shared possession of knowledge; an exclusive professional membership; egalitarian nature; autonomous work; the capacity for peer-review of activity; and are characterised by consensus decision-making. From an economic perspective, partnerships were described as self-managing firms. Partnerships pose difficulties for economists as their structure makes the study of outcomes for a given level of effort particularly

difficult to analyse. Handy characterised partnerships as organisations which support professions which have little interest in the organisational structure. Marinker described that change in general practice partnerships was reduced to the pace of *"the slowest, least imaginative or laziest member"*. (169)

Partnerships have also been described as *"metaphors for life"*, with partners forming a psychological family or *fictive kin*. (170) Work examining the attributes within and between partnerships confirmed similarities between members of a partnership, although it is unclear if this pre or post-dated the establishment of the partnership. (171) Practices attained local reputations with their fellow GPs as "*money makers, …caring…functional…or dysfunctional*". (170) The profession has examined the nature of partnerships and their independent status on a number of occasions since the inception of the NHS. In 1977, Pereira Gray, a president of the RCGP and prominent member of the GP establishment was of the opinion that the GP's independent contractor status acted as a protection for the patient, facilitating personal doctoring rather than the doctor being answerable to the state bureaucracy. (151) This was refuted by a number of other GPs, including Julian Tudor Hart.

In 1990, Jewell stated that *"GPs are caught in the noose of the independent contractor status and are being quietly strangled"*. (172) Jewell was of the opinion that GPs absorbed all of the uncertainty of the NHS, but received no employee benefits around issues such as maternity benefit, and sickness leave. In 2000, the Royal College of General Practitioners produced a briefing which concluded that despite its limitations, partnership had protected patients and should remain the predominant model for delivering primary care in the UK, retaining an independent status. (173) A recently updated statement by the RCGP noted the dearth of partnership opportunities for younger GPs, following the advent of the *n*GMS agreement. With the additional flexibility afforded by the new contract, many retiring partners were replaced by salaried GPs, or salaried nurse practitioners. It has been suggested that this has resulted in over 100 applications for each partnership vacancy advertised. (143)

Successive GP surveys have demonstrated a shift in the nature of group practices, with salaried GPs rising from 12% of the workforce in 2005, to 33% in 2007.(144) As previously discussed, there have been concerns about the working conditions of salaried practitioners, with issues such as contractual tenure, participation in

practice development, study leave and maternity rights being issues noted in the literature. (143) However, recent evidence for the PMS pilots suggests salaried practitioners receive a lower rate of remuneration than their partner colleagues, but have improved employee benefits, including maternity, child leave, and flexibility of work, in addition to freedom from managerial tasks associated with the financial working of a partnership. (174) Work by Lester *et al* has suggested that some salaried GPs resent reduced opportunities for partnership as a result of reduced pay and the emergence of a status hierarchy, with partners at the top. (175)

2.10.3.2 Private, not-for-profit

Social enterprise has been promoted within the English NHS for a number of years. (88) It has been a theme of the previous and current administrations who see it as a way of sustaining public services at a time of reducing public finances and driving forward the contestability agenda. The Department of Health has encouraged NHS staff to request that their organisation considers becoming a social enterprise. (84, 176) The definition of social enterprise is unclear. The most widely accepted definition in the UK is that set out by the Department of Trade and Industry, which defines a social enterprise as "*a business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners." (177)* A number of sources have suggested that social enterprises should not have a single or main funding source, such as the public purse, although the Government have contested this. (178) Spear has described a number of different models of social enterprise operating within the UK: co-operatives and mutuals; voluntary organisations; intermediate labour market organisations; and community businesses. (179)

The UK Government's 2012 *Health and Social Care Bill* promotes social enterprises as a future model for service delivery, with the Health Secretary seeking to transform the NHS in England into "*the largest social enterprise sector in the world". (180)* The potential benefits of social enterprises within primary care include: better engagement with employees; staff participation; reduced bureaucracy; improved productivity; increased public satisfaction; and improved responsiveness to the public through their increased participation and a public

focus. (181) There has been a reluctance within medicine to embrace social enterprise in healthcare due to concerns about staff benefits, in particular pensions; the vulnerability of such organisations to the market; a lack of clarity about their funding and regulation; and the increasing fragmentation of health services in terms of patient care. (182)

A number of sources have commented on the lack of evidence informing the shift to deliver healthcare via social enterprise. (183, 184) Crampton has demonstrated that not-for-profit organisations in New Zealand served more disadvantaged groups, and even allowing for socio-economic confounders, were less likely to refer to secondary care than for-profit organisations, (185) but had larger, more diverse primary care teams in comparison with for-profit practices. (186) Despite reluctance in general practice (182), Government has strengthened previous guidance to encourage staff to opt to provide NHS services as a social enterprise. (187) The BMA reports that by late 2011 most PCTs had divested their directly provided community services (mainly community nursing) into a variety of different organisations, including social enterprises.

The largest literature relating to healthcare social enterprises relates to community nursing. Nurses have been more positive about social enterprise than their GP counterparts, seeing it as an opportunity to develop alternative models of primary care and to promote a role in which they substitute for GPs rather than supplementing them. (188, 189) An example of such an initiative is the Cuckoo Lane Surgery in Hanwell, London. (190) This is a nurse-led model of primary care, using social enterprise. As yet there is no comprehensive evaluation of the impact of providing NHS services as a social enterprise.

Social enterprise is a complex and contested area which has become politicised by Government and professions. Despite this, social enterprise is analogous to Crampton and Starfield's description of privately-owned organisations which have strong community governance accountability. They describe this type of organisation as providing an optimal model for primary care in New Zealand, tackling the twin problems of the market and profit on the one hand, and the perceived lack of responsiveness within government-owned healthcare. (167) It may thus offer an alternative model for providing general practice which could overcome some of the difficulties associated with GP partnerships.

2.10.3.3 Publicly owned, state-run

The most widely known system of state owned and operated primary care was the Semashko system operated in communist countries. Named after Nikoli Semashko, who designed the centrally designed, state-run health system which employed all medical staff within the USSR, the Semashko system was prevalent in all Communist-block nations. Primary care was not the model of care provided under the Semashko system. Instead, there was an emphasis of polyclinics with specialists and the provision of paediatrics, obstetrics & gynaecology and general medicine within community clinics. The focus of the Semashko system was motherhood and children, with a lesser emphasis on generalism for adults, provided through more general physicians who had lower status and training than medical and surgical specialists operating in polyclinics. (191) In Semashko countries, salaried systems were synonymous with discourteous service, with illegal co-payments by patients being the norm to incentivise a good standard of treatment. (136)

A further version of such a salaried entity is found in Cuba, where GPs are salaried, but where there is a higher level of community governance and responsibility. This approach is similar to Community Orientated Primary Care (COPC) and is covered in the section on international primary care and in the COPC section.

2.10.3.4 Public owned, non-state

This group of models would include all primary care services run by agencies on behalf of the state. It included directly employed salaried practices serving particular groups, practices where it is difficult to recruit or retain staff, or situations where more conventional models of practice are unstable. In Scotland this arrangement is called a 2C entity. In Scotland, less than 3% of practices were run in this way in 2008. (192) There was little published literature on the advantages and disadvantages of this model of practice organisation.

2.10.4 Governance

Governance of health systems is one of the most actively researched healthcare topics in Europe (193). The concepts of governance in healthcare emerged at the time of the New Public Sector Management discourse in the UK.(194) At the level of the state, governance is defined by the UN Development Programme as *"the exercise of political, economic and administrative authority in the management of a country's affairs at all levels. Governance is a neutral concept comprising the complex mechanisms, processes, relationships and institutions through which citizens and groups articulate their interests, exercise their rights and obligations and mediate their differences."* Others have described governance as a method adopted from business through which bureaucracies seek to manage the threat of rising consumerism. (195) Governance has been described as both contested and slippery by some, and even as "*promiscuous"* by others, reflecting the capacity of different groups to co-opt it for their own agendas. (196)

A number of different reasons have been attributed to the development of governance including the *"hollowing out"* of a congested state, creating a way of *"governing without government"*. (197) A number of conceptual frameworks have been described. Historical models have included governance by markets, bureaucracies and clans, sometimes referred to as markets, hierarchies, or networks. Ouchi contends that clan (network) control was most appropriate when there is limited knowledge of the process through which outcomes are being created, combined with a lack of clarity around the precise outcomes which are intended. (198)

Others have contended that within the health service, there has always been a mix of all three forms of governance, described as quasi-market, quasi-hierarchical, and quasi-network. (199) The relatively loose definition of governance has led to the development of a number of overlapping and contested forms of governance such as agency governance, corporate governance, stewardship.

Daly has suggested that the concept of governance lacked a social focus as it had its predominant focus on policy and institutions. (200) More recent concepts relevant to primary care include participatory (citizen-orientated) (201) and community-governance. (105) These approaches attempt to create a participation between healthcare providers, individuals and communities in order to bring

about the co-creation of health through agreeing approaches to change health services and to act on the wider determinants of health.

Given the prevailing context for Scottish primary care, network governance rather than the market or hierarchies was likely to be the predominant form of governance. Rhodes described network governance through which groups of individuals and organisations could work together in a self-governing manner which accommodated the diversity of the participants, but which ensured a good quality and oversight of the products and processes being produced or taking place within the network. (202)

Within the rise of the New Public Sector Management in the health service, medical staff were often ambivalent or antagonistic to the concept, with governance being seen as *"slippery….a weasel word". (203)* In contrast, in the wake of a number of high-profile medical scandals, some saw governance as the solution to problem doctors. (204)

Sheaff *et al* have developed the concept of soft, or '*subtle*' governance (205, 206), developed from Courpasson's *soft bureaucracy* which was used to describe how professional networks operated within the constraints of a wider organisation, using loose forms of coercion and persuasion, relationships and support rather than harder forms of governance, such as sanctions and the enforcement of contractual obligations. (207) In Sheaff's adaptation, it is a professional elite, created through the process of restratifiation set out earlier, which attempts to persuade or coerce the profession toward the organisational objectives, with an indirect sanction being the threat of increasing managerial intrusion into professional affairs. In this proposal, Sheaff *et al* suggested that governance was as a method to induce independent professionals to act and in which professional leaders win acceptance for specific policy and implement it, successfully maintaining their own leadership position. It has been suggested that this restratification replaced *permissive exception management* with a new form of professional regulation. (208) A number of sources have suggested that governance within primary care is relatively weak, particularly in relation to accountability issues for GMS practices. (209-212)

Phillips *et al* have reviewed the evidence-base for governance as a tool for improving quality within general practice. They concluded that the evidence-base for governance as a quality improvement tool was limited, but that the greatest

hope for success lay with approaches which recognised professional leadership and were seen as locally relevant. (213)

Smith *et al* have compared health system governance across seven European countries, using a *cybernetic* (steering) model of governance which characterised governance as consisting of three elements: priority setting, performance management, and accountability. (214) Their results suggested that there was relative agreement across performance management processes, a degree of agreement over priority setting, but wide variation in relation to the mechanisms providing accountability. They concluded that this represented the lack of a clear evidence base upon which to build such an approach. This in turn is reflected in the volume of health services research exploring governance issues. (193)

As Smith *et al's* cybernetic, or steering model suggests, one of the governential issues to be addressed is the nature of priorities for a primary care system. Starfield's work on the importance of primary care within health systems (215) is reflected in a focus on building capacity in primary care in the 2008 World Health Report. (216) In response, many governments have attempted to shift the balance of their health services towards primary care, (217) seeing this approach as a potential way of achieving the Institute for Healthcare Improvement's *Triple Aim (218)* of better health, better care and better value in response to a time of global financial adversity. (219)

Recent work by Kates *et al* has suggested that primary care would benefit from a framework to facilitate its advancement. (220) Their framework articulates primary care as a set of constituents or stakeholders, outcomes and attributes which are required to bring about these outcomes. Their conclusions are strikingly similar to those of Kringos *et al* who have set out the core dimensions based upon a comprehensive literature review. (106) Peckham has pointed out that such frameworks need to explicitly take account of additional factors such as the organisation of healthcare, local policy and accountability arrangements. (221) Labonte has suggested that the central healthcare system roles and priorities are: to act as an educator and watchdog; resource brokerage; partnership developer, communities developer; and to act as an advocate and catalyst for change.(222) In a similar fashion, Sturmberg has suggested in the Australian context, where new primary care organisations are emerging, that an adaptable framework for primary care governance should have "*less rules and more values"*, or in the words

of Smith *et al* (paraphrasing others), that we need to *"steer, not row"* the system. The elements Sturmberg suggests to counteract bureaucracy include: promoting literacies in health in the population, collaborating across organisations, leading community development, facilitating practice developments based upon assessments of need, supporting health improvement and, access to high quality care. (223)

The GMS contract has evolved over time and it has been suggested that its meaning has changed such that the state has a reduced tolerance for independence and professionalism, and instead relies upon new ways of interacting with GPs, such as increasingly specific contracts. (224) This view is consistent with the ideological underpinnings of the New Public Sector Management. Glendinning has suggested that the change is not one of the meaning of contracts *per se*, but that there has been a radical change in perspective in which NHS managers and commissioners no longer see GPs as the only way in which to provide primary care services, but regard them instead as one of a number of professions and entities with which to contract in order to meet the population's needs: a move from a general practice to a primary care focus. (225)

The GP contractual framework is a form of process governance, and although there are incentives for performance, the review process and oversight of the QOF element of the contract has been criticised as being underdeveloped. (63) Perhaps the most interesting deficiency in primary care governance is the manner in which the scope of general medical services and the QOF framework have been agreed. The nGMS contract was negotiated with the profession. Government's priorities were access and quality, but such a highly focussed contract may have acted to reduce the scope of general medical services. In particular, although patient experience does appear within the contract, there is little evidence of the kind of short-loop community governance described by Crampton and Starfield. (167)

Community Orientated Primary Care (COPC) is an approach to primary care governance which aims to ensure community-orientation and participation. The community orientated primary care model was first described by Sydney Kark, using the principles of public health to provide care for individuals as part of a community. (226) Kark described the approach as being based upon principles of epidemiology, primary care, preventative medicine and health promotion. (227) The King's Fund describes COPC as the community practice of primary care,

provided to a defined community on the basis of its assessed needs by the planned integration of public health and primary care practice. (228) Using this approach, Kark achieved significant improvements in community health in work carried out in Pholela, South Africa, and later in Israel. The US Institute of Medicine has seen COPC as a method of reaching the large proportion of the population without access to primary care services. Their operational definition saw practices being comprehensive, co-ordinated, continuous and accountable, (229) mandated a defined community for which the practice has responsibility, and described a four-step process for defining the community served, characterising the community's health problems, aligning health services to meet the health priorities, and monitoring the effectiveness of the approach on health outcomes. (229, 230) COPC can be seen as a model which facilitated community governance.

An important aspect of the US iteration of COPC was that members of the population already accessing services through primary care were excluded from the approach. The implementation of COPC has been difficult in the US, due to the cost of providing services to currently underserved communities, and because the skills required to practise COPC have proven difficult to integrate within traditional training programmes for family medicine. (231) Few examples of COPC, in its original form are found in the UK. COPC is most extensively used in the Cuban primary care system, and it prioritises health promotion and a communitarian approach to health. (101)

Socio-economically disadvantaged groups use primary and secondary care services differently. Conventional wisdom has suggested that those in disadvantage use primary care less, and have greater use of reactive services. However, the evidence is conflicting and incomplete. Pollock and Vickers demonstrated an association between deprivation and emergency admission for cancer in the UK. (232) However, Chaturvedi and Ben-Shlomo examined the consultation rates in primary care for six common conditions which required surgical referral. (233) They found that disadvantaged patients were more likely to consult with their problems, but less likely to receive surgical treatment. Furthermore, the 1991-1992 study of national morbidity statistics in general practice showed that disadvantaged patients were more likely to consult their GP about cancer than their affluent counterparts. (234) It is unclear if this increase in consultation rates was in keeping with the increased levels of some cancers associated with disadvantage, or if consultations took place at a later stage in the

course of the disease. Given these facts, using the US interpretation of COPC, which would exclude those who have had contact with services would seem unwise.

Iliffe has suggested that the principles of COPC may be more applicable at Primary Care Organisational level than at individual practice level (235), although this view further embeds the notion of the GP as a solely personal doctor, free of community perspective, in contrast to GMC guidance. Perhaps some models of social entrepreneurs, with practice being run as non-profit companies, represent a form of COPC, adapted to the predominant cultural circumstances in the English NHS. (236) Gillam has suggested that COPC might offer a model for CCGs in their new commissioning role. (237)

2.11 Views on the organisation of primary care

The vast bulk of the literature on the organisation of primary care was composed of professional opinions about the best models and methods of remunerating professionals working within primary care. The interest in this area is not new: the history of the inception of the NHS was characterised by this debate, dating back to the Dawson Report in 1920. Even when the literature is primarily evidence-informed, the effect of professional attitudes has a profound impact on the conclusions drawn. For example, the RCGP and the World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) sponsored work on funding of health systems demonstrates a significant professional disdain for salaried systems, citing them as rude, or lacking in continuity (see section on salaried employment). Whilst this might have been so in the Soviet Semashko system, there was no evidence to suggest that these facts held in a UK salaried system.
Such attitudes cannot be dismissed as mere professional protectionism or self-interest, although these attributes probably form some part of professional attitudes. The GP response to the early stages of the NHS inception was characterised by opposition to arrangements which would interfere with the independent contractor status. This was partly related to concerns about the interface between NHS and private practice, since prior to the NHS, private practice was more prevalent. However, one of the significant factors displayed was related to a fear of the impact of a state bureaucracy on GPs' autonomy- both

financially and professionally. Webster's historical analysis describes a profession which was profoundly affected by its belief that it had been wronged in negotiations significantly predating the creation of the NHS. He states that "*retribution was demanded from the government for disappointments extending back at least to the introduction of National Health Insurance. The herd memory [at the inception of the NHS] was long and retentive".(12)*

During the period of NHS formation, professionals occupied a dominant role within society, and the control of the state was seen as a threat to that role. Interestingly, despite similar concerns, specialists, later called consultants, accepted state control, but were afforded professional autonomy in clinical matters, and initially in financial matters within the new NHS hospital sector. This different approach, Webster implies, relied upon status and power. Whereas the doctors who came to be known as GPs occupied a key role in providing first-level advice and care to patients, they largely controlled the private practice of referral to specialists, who were to some extent reliant upon the favour of GPs to practice within hospitals. The Royal Colleges agreed to incorporation within a bureaucracy because it changed the status and power relationship for their specialist members, and stabilised their financial incomes, making them less dependent upon the patronage of generalists.

Professionals have also implied that GPs remaining independent from the NHS protects patients from NHS managers, as GPs' interests are in the care of their patients. However, Hickling characterises this view as inaccurate. (147) He goes on to state that the financial self-interest of GPs in the care of patients is '*an inconvenient truth*' and that GPs have managed to convince the public since the early NHS that the financial conflict of interest has not existed. The professional interests played out in primary care are not restricted to income, but relate to the widening of primary care to include nursing roles. This has created the potential for professional interests to shape delivery models since the 1960s. Professional protectionism is not limited to GPs. Pilots of the involvement of alternative workers in primary care, including Physician Assistants have generated tensions with the nursing profession. (119)

Checkland's work on the sociological roles fulfilled in primary care characterises staff as 'street-level bureaucrats', drawing on the work of Lipsky. (238)These bureaucrats are public service workers who interact "directly with citizens in the

course of their jobs, and who have substantial discretion in the execution of their work". Their roles are characterised by inadequate resources, ambiguous and multiple objectives, attempting to manage demand which exceeds supply, and making rapid decisions about patients. These factors result in workers whose interests lie in maximising and maintaining their autonomy as a defence against uncertainty. This work fits well with the conclusions of Geneau *et al*, who describe the need for GPs to maximise their ontological-security, in other words, to reduce the impact of change and uncertainty on their daily lives.(158)

From a management perspective, the history of the NHS was initially managed by professions. Despite a number of initiatives to improve management, by the early 1980s the Government had lost patience, and needed to find ways to constrain costs and improve transparency and openness in the NHS. Despite the emergence of general management (239), the independent contractor arrangement operating for the majority of entities in primary care made managerial progress particularly slow for this sector. These developments coincided with the development of the New Public Management approach characterised by convergence between private management practice and public service management. (240) The dual objectives of these initiatives have been to constrain growth in costs whilst driving up quality.

The perspectives of politicians on the NHS and primary care are complex and interesting. At its birth, the political views were of the need to divide the profession, succinctly captured by Bevan's apocryphal *"stuff their mouths with gold"* quotation. Successive Governments have attempted to improve the NHS, often using ideas from different sides of the political spectrum. However, in the last 20 years, the political approaches have all used a combination of the new public management and continued promises to keep the NHS free at the point of care delivery. This relative political stability (in terms of approach, rather than in terms of organisational continuity at the level of the NHS) is difficult to explain. A number of observers have suggested that this could represent either an emergent consensus, characterised by a centralist political approach which gains public approval, or a tacit understanding that further wholesale change in the structure of the NHS incurs high costs and delivers a low yield in terms of overall improvement in the service. (12)

There is a relatively limited literature on the public's attitudes to the organization of primary care. The British Social Attitudes Survey shows sustained satisfaction

with health services overall, (241) and this is reflected Europe-wide, where 80% of patients in all the countries surveyed rated their primary care as good or excellent. (242) Despite this high satisfaction, there is also evidence that the number of patient complaints has risen by 21% between 2010 and 2011 in the UK, according to the General Medical Council, the rise being attributed to a greater willingness of patients to complain, and rising expectations. (243)

Wensing *et al's* review of patient priorities in relation to primary care suggested that the GP's humaneness (sic), competence, involvement in decision-making, adequate time for care, access, and communication were important issues. (244) The authors had concerns about the inability to compare methods used in different studies and so they carried out a survey of patient priorities across Europe. The analysis of the surveys concluded that being given adequate time, confidentiality, access, communication, staff receiving regular updates, and a focus on preventative health were important issues. (245) The majority of studies involved had a focus on the GP consultation, rather than on organisational elements of primary care. Coulter has distinguished between the aspirations/priorities of patients and citizens and has expressed the opinion that as citizens, priorities include affordability, safety and quality, health protection and disease prevention, access, equity, responsiveness and choice, participation in service development, transparency, accountability and the opportunity to influence policy decisions. (246) Patients valued continuity, but weighed it differently depending on context, including access levels, the conditions, and patient demographic factors. (247) There is also some evidence From Wensing *et al's work* that patients prefer practices where GPs are full time and where the practice is relatively small. (245) This finding may reflect a desire for interpersonal continuity and access, but is in sharp contrast to recent trends in the UK post nGMS implementation which has seen a rise in part-time salaried working and a fall in the number of smaller single-handed practices.

Recently published work commissioned by the Scottish Government as part of the Patient Experience Programme involved interviews with more than 1,000 people from across Scotland, asking questions about the public's priorities for general practice care. (248) This work confirmed the importance of access, in terms of geography and ease of communicating with practices and obtaining appointments. In addition, most members of the public also wanted to see a health care professional who had access to their history and results of investigations, with continuity of healthcare professional being preferred by older patients,

reflecting either a generational preference/expectation, or the fact that this group were more likely to have a long-term condition. Patients felt that having time to talk, and to be listened to were also important.

There is less information on the public's views of which models of service delivery are most suitable. Experiments in the English NHS with Walk-in centres have seen their use confined to mainly working age men. (83, 249) Patients in disadvantaged areas are more likely to use their A&E department in an attempt to obtain primary care than other patients, although the use of primary care is still high in disadvantaged populations. There is little literature on the public's views of the methods by which primary care staff are remunerated. One study has reported that patient satisfaction with access through a salaried model was higher than that found in a fee-for-service model. (146) It is unlikely that the majority of patients are aware of the complexity of remuneration within primary care in the UK, with the exception being those using private general practice. (147)

2.12 Conclusion

The literature review has described the way in which professional views, governments and external factors have shaped the organisation of primary care general medical services since the inception of the NHS. It also describes the change in focus for general medical services over the years and the increasing role played by other professionals in providing services.

Assuming a common scope for general medical services, the review classified the different elements of models for the organisation of GMS as varying by workforce; funding; organisation; ownership; and governance. The review also explored the respective strengths and weaknesses of each of these constituent elements. The perspectives of professionals, NHS management, governments and the public were explored. There was little research specifically addressing professional and public views on the organisation of general practice. The findings from the literature for the basis for the next chapter in which the author sets out the methods used to improve understanding of the views of the public and professionals on the organisation of primary care in order to develop alternative models which he might test with these groups.

Chapter three: methods

This chapter opens with a statement of the research objectives and provides a detailed account of the methods chosen. The overall methodology is best described as a pragmatic mixed-methods approach in which the choice of methods was designed to create relevant answers to the research questions posed.

3.1 Research objectives

The overarching research aim was to create evidence which would identify the most effective and acceptable model of providing primary care (general medical services element) within the Scottish context.

The detailed research objectives set out were:

1. To improve understanding of the views of the public in relation to the organisation of general practice (general medical services) within the wider context of primary care in Scotland.
2. To improve understanding of the views of staff working within the primary care team in relation to the organisation of primary care.
3. To identify and refine models of primary care, and to test these models of primary care against the status quo with primary care staff and with representatives of the public.

3.2 Using mixed methods approaches

In order to answer such complex and contextual research questions a mixed methods, or multi strategy methodology was developed. Greene has described mixed methods as *"multiple ways of seeing, hearing, and making sense of the social world"(250)* More specifically, mixed methods have been defined as *"the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the purposes of breadth and depth of understanding and corroboration." (251)*

A number of authors have offered a nosology of the purposes of mixed methods. Bryman's analysis of the mixed methods literature suggested that there were 18 different rationales for the use of multi-strategy or mixed methods research. These included: triangulation of findings to improve the validity of research findings; offsetting the relative weaknesses of quantitative and qualitative methods by using a combination; completeness – providing a more comprehensive answer to the research question; providing an understanding of both structural and process issues underpinning a research question; answering different research questions; explanation – in which one methodology offers an explanation for the findings from another; to explain and explore unexpected findings; to develop a research instrument; to ensure a greater contextual understanding; to illustrate quantitative findings by using qualitative work; to improve the utility of the findings; to confirm and discover – using qualitative methods to generate hypotheses which could then be tested by quantitative methods; to ensure a diversity of views; and to enhance or build upon qualitative or quantitative findings. In addition some studies had no clear purpose or no stated purpose. (252)

Given the ambitious nature of the research, the author believed that mixed methods were the only approach which would allow a comprehensive answer to be generated. Mixed methods could involve the use of one methodology followed by another, or the concurrent use of both quantitative and qualitative methods. In this case, qualitative methods were built upon by subsequent quantitative and qualitative methods which took place concurrently. Further detailed justification for the mixed methods approach is provided in the section on strengths of the research in the discussion (chapter nine).

3.3 Research objective one: to improve understanding of the views of the public in relation to the organisation of general practice (general medical services) within the wider context of primary care in Scotland.

Although there was evidence that members of the public were satisfied or highly satisfied overall with care received via the GP practice, (253)(253)(253) the literature review uncovered little evidence of the public's priorities for primary care. Thus the purpose of the first piece of work was to explore the public's

priorities for the future of primary care. This work was undertaken as a piece of service development, supported by the Glasgow Centre for Population Health which had a role to engage with the community and support the NHS in improving services.

There are many ways in which the views of the public can be canvassed. For this study, a pragmatic decision was made to work with the Public Partnership For a (PPF), groups of interested local residents prepared to work with health staff to discuss and refine issues related to health care. Whilst all such self-selected groups raise questions of representativeness, this approach had been used to good effect locally, allowing issues to be discussed, and providing opportunities for the views of the public to be incorporated into strategy and thinking. The PPF members represented the views of their communities and were encouraged to place these views ahead of self-interest.

Through discussion, the ten PPF committees were asked to nominate up to five members each who would then attend an event to explore priorities for primary care (a maximum of 50 participants). The letter of invitation was sent to the nominated PPF members (see A1.1 in Appendix 1). 27 PPF representatives attended the event. These representatives were drawn from nine out of a possible ten local communities which form the NHS Greater Glasgow and Clyde population.

The event was introduced by the author and some colleagues from the GCPH. After a briefing about the GCPH and the overall aim of the session, participants were given a briefing on the current organisation of primary care. Following this the group listened to a presentation designed to move their focus away from the current context and towards future opportunities and threats.

The main approach used in these sessions was that of scenario planning. Andrew Lyon, a colleague from the GCPH had extensive experience in using scenario planning methods with the public. In his hands this approach had been used to help groups to explore issues of importance for the future of services. In this case, the author and Andrew Lyon worked to use elements of scenario planning. Whereas scenario planning was developed to help corporations and groups to create strategies which would withstand a number of alternative future realities, the purpose of the scenario planning in this case was to develop scenarios which

would deepen understanding of what priorities were of greatest significance to the public in terms of the future of primary care.

The participants were organised into small groups and asked to discuss and generate issues which they felt were of relevance for current and future primary care. These issues were written on notelets and these were placed on a wall of the room where the event was being held. During the course of the plenary discussion, these emergent issues were grouped together into similar themes and the sense of this checked with the group who were asked to approve or change the groupings. These groupings were then portrayed as critical uncertainties. Critical uncertainties have been described as *"a dimension of a future situation which has been prioritised by a group as being important, but which remains uncertain"*. (254) An example of this was the issue of access to appointments. This issue was translated into a critical uncertainty which would have high or ready access at one extreme, and very low or difficult access at the other.

Following plenary discussion, each group was asked to choose two *critical uncertainties* for primary care. These critical uncertainties were presented as dichotomous outcomes: presence or absence of factor A, B, *etc.* These choices created four possible scenarios: A present, B present; A absent, B present; A present, B absent; both A and B absent. The groups were then asked to discuss each scenario in detail, describing the pros and cons of each and naming each scenario. These points were captured by a scribe within each group. This was done in order to explore the beliefs and values which underpinned each scenario and to explore the preferences of the PPF group in terms of the desired outcomes for each of the critical uncertainties.

The outputs formed from the discussion of four scenarios by each group were captured and transcribed in order to allow the choices and themes to be explored by the investigator. The content created by the two-stage process was analysed by the author to seek emergent themes and reach conclusions on the values and priorities for primary care. The content was collated and independently considered by the research supervisor in order to improve the trustworthiness of the work. The itinerary for the event is found in Appendix 1, A1.2.

The author initiated and conceived the event and was involved in the planning of the event with Andrew Lyon. The author participated in the workshop, using

plenary discussion to explore the nature of primary care. He worked with Andrew Lyon to help PPF members to articulate their views about the priorities for the future of primary care. Andrew Lyon was involved with some other members of the GCPH in planning and facilitating the event, and he had a central role in using elements of scenario planning methods to facilitate the development of scenarios by the participants. The author analysed the views expressed by the PPF members and integrated these with their scenarios in order to generate the findings.

3.4 Research objective two: to improve understanding of the views of staff working within the core primary care team and of staff managing primary care in relation to the organisation of primary care.

The purpose of this section of the research was to explore the views of staff working in and through general practices in order to identify their beliefs about the way in which primary care was currently organised. The literature review yielded little formal research into this area. Most of the evidence around staff views of the organisation of primary care was anecdotal, comprising opinions expressed through journals in response to proposed organisational or contractual change. The work was therefore designed to create new knowledge in this area.

The most appropriate methodology to answer the question was considered to be that of semi-structured interviews. The purpose was to understand staff views of the organisation of general medical services within Scotland. An outline interview schedule was developed using a combination of the author's experience and views, the questions which emerged via a piece of local service development and opinion found in the literature.

The questions were designed to be open-ended and not leading. The author had previous experience of semi-structured interviewing methods. He chose to modify the language of the questions to match the style of the participant and their professional role in order to maximise the opportunities for authentic discussion of issues.

The interview schedule was developed by extending the author's initial research question and refined by piloting the schedule with a small number of colleagues who had experience of working in primary care. The interview schedule explored general views about the organisation of primary care; the current GMS contract and its impact; out of hours provision; independence; employment versus self-employment; and alternative organisations for the future. The interview schedule is shown in Appendix 1, A1.3. The interviews lasted between 45 and 60 minutes and were generally conducted at the participant's practice or at another convenient location.

Although the initial aim had been to explore the views of healthcare professionals working within general practice, it became clear that to develop a more comprehensive perspective, the views of practice managers, administration staff and those of community health staff who worked closely with the core practice team should also be included. For a similar reason, the author also sought views from primary care service managers within CHPs and those within the Health Board. Consideration was given to including policymakers at Scottish Government level, however in order to explicitly link the work to the context of a single primary care system (that of NHS Greater Glasgow and Clyde) it was agreed that primary care policy themes would instead emerge from discussions with primary care staff groups by including specific questions which explored the policy landscape.

The author considered that the initial aim would be to generate a purposive sample of between 10 and 16 participants in total, the majority being from practice teams within the NHS Greater Glasgow and Clyde area and the remainder being from NHS professional and management staff associated with primary care. The author considered that saturation of themes was likely to occur at this level, but believed that this final size of the sample would be determined by the saturation of new perspectives and knowledge.

A purposive sample was chosen in an attempt to include the views of those occupying the core roles within GP practice teams and across the system. In particular the author sought to include staff working within different types of practice (PMS, GMS and Directly Managed). Given the low numbers of non-GMS practices within the area, a representative sample would not have captured the views of those working in alternative forms of general practice.

The groups included within the sampling frame were: GP partners; salaried GPs; practice nurses; practice managers; health visitors; district nurses and practice receptionists working in or through general practices within NHS Greater Glasgow and Clyde. Whilst there are other staff groups who work through GP practices, it was felt that this initial group formed a core which would be identifiable in almost every GP practice in Scotland.

GP practice managers were identified via NHS Greater Glasgow and Clyde's practice list (accessed February 2009). The author selected practices in groups of 10 and contacted the practice managers directly to explain the purpose of the research and to request the names of practice partners or employees so that he could write to each of them to invite them to participate in the research. Letters or emails of invitation were sent to identified GPs, practice nurses, practice managers, practice reception staff, district nurses, and health visitors functioning via the practice. A reminder letter or email was sent after 14 days. No further contact was made with staff unless they responded to the invitation or reminder. The invitation and participant information sheet are shown in Appendix 1 (A1.4 and A1.5).

NHS Primary Care managers within Greater Glasgow and Clyde were identified via staff lists on the NHS Greater Glasgow and Clyde's intranet and those identified were invited in the same manner with a similar follow up method.

The majority of participants were recruited directly via letters/emails. A small number of staff, in particular those professionals who were not employed by the practice, but who worked through the practice, such as health visitors and district nurses, were recruited via snowball methods, asking practice team members who participated in the research for names and contact details to facilitate further recruitment.

When an individual had agreed to discuss participation, the author made contact via email or telephone to set up a suitable time for the interview. Interviews were always preceded by an opportunity for the participant to clarify their understanding of the research, facilitated by review of the participant information sheet and the opportunity to ask questions. In general, the main questions asked were to clarify the purpose of the research and to seek assurances around the confidentiality of the discussion which would follow. Written consent was required and in line with research governance, a copy of the consent form was

retained by the author and a further copy provided to the participant (Appendix 1, A1.6).

The participants were asked for explicit consent to audio-record the interview. All agreed to this request. The sound files created were transcribed into word files which could then be used for analysis. The author checked the transcripts against the original sound recording to ensure the accuracy of the transcription. The files were then imported into NVivo 9[§], an IT package which facilitates the recording and collation of themes identified through qualitative analysis of written material.

The interview schedules were read by the author and from this a preliminary set of codes were created. Initially the codes were not hierarchical, but were influenced by the existing structure of the interviews, which were in turn shaped by the interview guide. The author used a grounded approach using Fielding's 'coding up' methodology (255). A selection of the interviews were read by the author's supervisor and the emergent codes were discussed to develop a shared view. This process helped to improve the trustworthiness (256) of the findings and provided an opportunity for the author to clarify the reflexive issues which will have influenced the process of interpretation and analysis. Subsequent readings of the interviews permitted the author to create a quasi-hierarchical coding structure which formed the basis for the emerging themes.

Further detail on ontology and axiology is included in the opening of chapter five.

[§]NVivo 9 is an IT research tool produced by QSR International.

3.5 Research objective three: to identify and refine models of primary care, and to test these models of primary care against the status quo with representatives of the public and with primary care staff.

Having reviewed the literature, explored the public's priorities for primary care and primary care staff and managers' views about primary care organisation, the author blended these findings to create two alternative models which would contrast with the status quo. These models were chosen from approaches being used in the UK in order to explore identified shortcomings with the status quo model through work with the public and primary care staff. The purpose of creating the alternative models was two-fold. Firstly, to explore through further research if these models were considered better than the status quo. Secondly, and more importantly, by exploring the relative merits of each alternative model, it was hoped that it would be possible to obtain a deeper understanding into the priorities of the public and primary care staff and their underlying values and how these might shape the organisation of primary care.

3.5.1 The public's views of alternative models of primary care

The principle research aim for this section of work was to explore the views of members of the public in relation to the alternative models of primary care organisation. A secondary aim was to explore how these models might fit with their values. The models developed were the result of reflection on the literature, the priorities of the public and the views of primary care staff.

The approach used was a mixed methodology which contained elements of the consensus panel approach, modified using explicitly agreed and weighted priority domains through which the proposed models would be judged and discussed. This approach built on the clear consensus priorities for primary care developed through research objective one (see chapter four). A framework of priorities was developed from the themes which emerged which were combined with the methods of Edmonson-Jones. (**257**) This framework was sense-checked with the participants and the priorities were then weighted in terms of relative importance, forming a simple, transparent method through which deliberation and scoring

could take place. The approach built on prioritisation methods suggested by Edmonson-Jones in order to overcome some of the limitations of rating methods and consensus panels.[**] The consensus prioritization event had three initial purposes: to weight the relative importance of a number of previously determined priorities for any future primary care model; to present, discuss and score alternative models of primary care against the priorities in order to create a numerical ranking of the models; and to explore the participants views of each of the models. Given the novel approach being used to structure deliberation, the author added a further objective: to seek the views of the participants on the face validity and acceptability of this approach in exploring alternative service models.

The sessions were run within a meeting room at the Glasgow Centre for Population Health. The room was accessible in order to accommodate individuals with disabilities. These included lift and general access for a wheelchair user; and the use of an induction loop, assistant and large text format for an individual with sensory disabilities. Participants were seated at tables in small groups of between two and five. The author had support from a member of the Glasgow Centre for Population Health (Andrew Lyon) who helped with hosting of the event and provided brief general discussions between scoring sessions to help participants to move between sections of the event. Andrew also provided expertise in the use of elements of scenario planning and he also supported participants in providing feedback in group discussions, but did not design the research and had no part in the analysis of this work.

Public Partnership Fora were once again used as a convenience sample of interested local residents prepared to work with health staff to explore health and health service issues. A letter of invitation was sent to the ten PPF chairs across Greater Glasgow and Clyde. Through discussion, the ten PPF committees were asked to nominate up to five members each who would then attend an event to explore the alternative models (a maximum of 50 participants). The letter of invitation included a participant information leaflet and these are included as Appendix 1, A1 .7 and A1.8. The literature around consensus methods suggested

[**] Consensus panels have been described by Ryan *et al* as simplified versions of citizens' juries in which small groups are provided with limited information on specific scenarios and are then asked to make a choice and to discuss their reasoning, observed by the researcher (see reference 257).

that ten or more participants were required to ensure an adequate spread of opinion (257).

The investigator recognised that the participants recruitment was not random, since there was a degree of self-selection in both the membership of the Public Partnership Fora and those who were nominated to attend, however, he believed that more than ten participants would ensure a reasonable spread of opinion to inform the consensus. Whilst all such self-selected groups raise questions of representativeness, and the issue of citizen versus service user, this approach has been used to good effect locally for a number of years. The investigator chose to continue to use the PPF members in order to build on the work already carried out in order to determine the public's priorities for primary care. It was hoped that a significant number of the participants would have already attended the first session focused on priorities.

When PPF members attended there were provided with a further copy of the Participant Information Sheet, given the opportunity to ask questions, and asked to sign a consent form which included seeking permission for audio-recording and publication of anonymised findings in due course. These resources as well as an itinerary for the events are included within Appendix 1, A1.9.

In order to capture the scoring and written comments, the investigator developed four sets of scoring sheets. These sheets had a carbonized copy to allow collation of scores and feedback from the first round of discussion, whilst allowing the participant to retain a record of their individual scoring to which they could add a subsequent rescore and further comments. One sheet was designed to assist the weighting of the prioritisation framework, and the three subsequent sets were designed to facilitate the scoring, feedback and rescoring of the three models of primary care. An example of these sheets is included in Appendix 1, A1.10, and the itinerary is included as A1.11.

The initial portion of the meeting reminded participants of the findings from the initial event which involved public representatives and which had identified a number of priorities which should be considered for any future primary care system. Each of these priorities was discussed by the group to clarify a shared understanding of their meaning. Following this discussion, participants were asked to individually rate the importance of each of these domains from 1 (least important) to 5 (most important). Participants were free to use the same values for

each priority and were not constrained to full integers. They were also asked to write down some comments on their views. Following this the forms were collected to allow collation of the comments and weighting scores. The written comments were fed back anonymously but the numeric scores were not discussed since there is evidence from professional groups using prioritisation that a prior knowledge of the weighting of scoring instruments can lead to gaming of scoring behaviour. In the light of the discussion of written feedback, participants were asked to rescore the domains and these scores were then used to weight the prioritisation framework. The mean of the scores for each domain was used to weight each domain in the instrument.

The participants were then presented with three models for the general medical services element of primary care. The three models were entitled: the status quo; a local contract; and a social enterprise model. For each of the models the investigator presented the variables in the model in an identical manner. Each model was discussed under the headings of: the core practice team; the wider community team; the relationship with wider services; what practices *do*; quality; and cost & management issues. The author was conscious of the need to ensure that the models were presented in a way which presented the three different models in a similar manner, without emotional overlay which might influence the scoring of the participants. Participants were given the opportunity to ask questions about the models and the investigator attempted to answer in a dispassionate manner.

Following the scoring, feedback, discussion and rescoring of all three models, the weighted scores for the three models were presented to the participants. The main purpose of this was to check that the rank order reflected a valid consensus view of the participants. This presentation stimulated further discussion and debate about the merits of each of the models. In addition, the author asked the participants to complete an anonymous feedback sheet, but provided an opportunity for the participants to make general points about their reflections of the process of deliberation (Appendix 1, A1.12).

Feedback from the initial session suggested that a shorter event would aid recruitment. In response, the itinerary was altered to fit the session into a half day. The only material change made to the research was that for the second and third sessions, the weighting of the priorities was accomplished through a single stage

process rather than using feedback and rescoring. The feedback, discussion and rescoring elements remained for each of the three models discussed. An initial examination of the impact of feedback and rescoring of the priorities in the first session had shown little change in scores, so it was considered a pragmatic and valid solution to shorten this element in order to improve recruitment.

The general comments made when discussing the alternative models and the discussion which followed the presentation of the numerical results was captured and analysed for content using a grounded technique, although it was considered likely that the themes would be influenced by the prioritisation framework. Fielding's rules for coding were used. Rigour was ensured by checking the validity of the findings with the participants during the session, and by comparing the quantitative findings with the qualitative findings in terms of convergent validity. Some of the transcripts were double coded to ensure the trustworthiness of the emergent themes.

The numeric scores for the weighting of the prioritisation scorecard and the resultant scores for each of the alternative models were simply described and hypotheses tests used where appropriate to explore the significance of any variations between the three models explored. The technique used the feedback of general comments which accompanied the first round of scoring prior to the definitive second scoring round. This element was incorporated to allow a debate around the issues raised, but sought to ensure that individuals did not feel pressurised to score in a way which reflected the group view. For this reason, it was decided to examine the impact of the feedback on before and after scores for each model using paired significance tests.

3.5.2 Primary care staff views of alternative models of primary care

It was decided to develop an electronic version of a modified Delphi process, which could closely approximate many of the elements within the consensus methods used to test the alternative models with the public, but which would ensure that all staff participants were free to anonymously contribute opinions which might contradict the establishment view of the profession. It was also believed that an electronic solution would minimise paperwork and other organisational issues, simplifying the process and aiding recruitment of primary

care professionals. A web-based hosting service, SurveyMonkey was developed to facilitate the electronic Delphi. The participants were presented with the same prioritisation framework as that which was used by the public. Participants were asked to weight the domains agreed by the public and provide some written feedback. This written material, but not the numerical scores, was then fed-back to facilitate rescoring in due course. The remainder of the online session focussed on reading material on the status quo and the two alternative models of primary care, provided using the same slides as were used for the session with the public. At the end of each of the 3 models, the participants were asked for numeric scores and written comments.

Following a delay of several weeks, participants were asked to complete a further SurveyMonkey session within which they were provided with written comments from the first round of weighting and scoring and had the opportunity to rescore and provide additional comments.

Traditional Delphi methods often require more than two rounds to achieve consensus. In this case two rounds were set in order to mirror the approach taken with the public. Whilst the creation of clear consensus is considered central to the working of Delphi, the addition of the structured criteria-based scoring made this a less critical objective. Nevertheless, the feedback of opinions and opportunities to rescore and comment offered some opportunity for deliberation.

A colleague within the NHS organisation who was trained to create content on SurveyMonkey assisted with uploading the investigator's slides and questions onto the SurveyMonkey platform. This colleague played no part in designing the content or process around the research.

The purpose of this work was to explore primary care staff views of alternative ways of organising primary care and to create new knowledge. Although transferability was considered desirable, engagement and understanding of the participants was considered to be more important. For this reason, the investigator sought permission from the NHS research ethics service to re-approach the original participants from the qualitative study on professionals' views of the organisation of primary care, in order to seek their views of the alternative models which had been developed through a synthesis of the literature, their views and the views of the public.

The 20 original participants were approached via an email with an attached Participant Information Sheet which can be found in Appendix 1, A1.13 and A1.14. If no reply was received, a reminder email was sent two weeks later. Those who agreed to participate were asked via email if they had read the participant information leaflet, had been given the opportunity to ask questions and have them answered, and therefore gave informed consent to participate. Those who consented were sent an identification number. This number permitted the investigator to link the responses from each participant through both the initial scoring and the subsequent rescoring submission without requiring the participants to enter any identifiable data. Screen shots from both SurveyMonkey sessions are included at Appendix 1, A1.15 and A1.16.

The approach taken to analysis was similar to that taken for the analysis of the public participants' prioritisation sessions.

3.6 Justification for the specific methods chosen

3.6.1 The public's priorities for the future of primary care

As this piece of work was part of service development, the choice of methods was constrained by the need to create meaningful engagement with the NHS Board's Public Partnership Fora: groups of people drawn from their local communities who came together to be consulted on proposals to change and improve services. Group consensus methods were considered as possible ways in which the investigator could explore the public's priorities for primary care. However, the investigator's experience was that few members of the public would have much knowledge of the structure of primary care beyond that of their own personal experience of their GP. This was confirmed by the lack of literature in this area. Therefore, the investigator believed that the process used to explore the public's priorities would need to be supportive in order to help the participants to generate views and priorities. Following general discussion at the Glasgow Centre for Population Health, the methodology agreed incorporated elements from scenario planning.

Scenario planning had been widely used in public and private sectors following its use by Royal Dutch Shell to plan for future uncertainties.[††] As with a number of management techniques, their heuristic nature had resulted in limited use of the tools in academic work. Schoemaker has studied the use of scenario planning and their effect on behavioural psychology. (258) He has suggested that scenarios generate sufficient uncertainty and complexity to help participants to *"…deepen [their] realization as to what is significant versus ephemeral."* Scenario planning was believed to provide a flexible and engaging way of generating *critical uncertainties* in primary care. Critical uncertainties have been defined as *"a dimension of a future situation which has been prioritised by a group as being important, but which remains uncertain"*. (254) It was believed that scenario planning methods could permit some exploration of the relative merits of combinations of different uncertainties. It was hoped that these discussions would then create a group consensus on the public's priorities and values as they related to primary care. Scenario planning has been used by public services (259) and specifically by health services to facilitate planning processes. (260-262) In general the approach was designed to result in decisions which withstand multiple possible future scenarios. In this case, the scenario planning methodology was only used to help participants to take a future-focus on primary care, creating for them the possibility of other possible models of primary care, and to assist with the development of potential future scenarios. These scenarios were intended as a method to explore priorities.

This section of work was supported by a colleague from the Glasgow Centre for Population Health, Dr Andrew Lyon, who had used scenario planning in health services research in the past. The methods for the Public event were developed in collaboration with Dr Lyon. The analysis and findings were developed only by the author.

[††]Royal Dutch Shell was a petrochemical company where scenario planning was popularised in the 1970s. The work was led by Pierre Wack, who developed the work of Herman Kahn (RAND Corporation) and Gaston Berger (Centre d'Etudes Prospectives). Prior to this point, scenario planning had been dismissed by many sectors because of its complexity and lack of academic favour. The company withstood unpredictable changes in the price of oil (the 1973 oil shock, and the 1979 collapse in value) far more effectively than their competitors. Wack and others attributed this to the use of scenario planning.

3.6.2 Staff views on the organisation of primary care

Questionnaire, focus groups and interviews were considered as possible methods to explore staff understanding and beliefs around the organisation of primary care.

Questionnaires were considered as a method of identifying the views of a large group of primary care professionals. This methodology would have provided quantitative information on professionals' beliefs around the organisation of primary care. The method was also considered to be flexible in that it could provide the option for participants to generate alternative views not included in the questionnaire. The main reasons for rejecting the questionnaire methodology related to the existing state of knowledge around the views of primary care staff, a lack of understanding of the underpinnings of staff views on this topic and the author's observation that professionals had a tendency to revert to an acceptable position when facing unfamiliar questions.

Focus groups were considered as they would have allowed an exploration of the views of professionals. The group dynamic would have allowed debate and discussion to test and refine views and beliefs both within and between different professions. Focus groups were considered to have the advantage of being more efficient in that they permitted the views of a larger number of professionals to be expressed in a shorter time than would be required for one-to-one interviews. Focus groups might also have encouraged participation by those who would be uncomfortable in one-to-one interviews about topics seen as complex or unfamiliar. (263) The main reason for rejecting focus groups was the concern that professionals would be reluctant to share views which challenged the status quo or were seen to erode the standing of one profession in relation to another. The author's experience was that in a number of group venues where the organisation of primary care had been discussed, the group dynamic had not acted to create dissent, but may have instead stifled alternative opinions.

Structured; semi-structured; and in-depth interviews were considered. (264) Structured interviews would have had the advantage of using a standardised interview schedule supporting a rigorous approach. In-depth interviews were rejected due to their time consuming nature and the inability to compare and contrast opinions on a given topic between interviews.

Semi-structured interviews had the advantage that they retained a framework of general topics and questions which the author could explore during the interview, but permitted the flexibility to discuss unanticipated areas raised by the participant (264). In addition, semi-structured interviewing provided the author with the ability to tailor the questions and ask them in the language of the participant (265) with the aim of ensuring an *'authentic sharing of beliefs and opinions'* and the ability to challenge pre-existing beliefs (266). The author considered this to be a significant advantage for semi-structured interviewing as his previous experience when discussing the organisation of primary care had led him to believe that professionals were unwilling to express views contrary to the prevailing model. The author hoped that a semi-structured approach might permit him to gain *'an insider's perspective' (267)*. The main disadvantage of one-to-one interviews is that they could be very time-consuming.

Generalisability was not considered to be a suitable goal for this piece of work,. since the aim was not one of hypothesis testing. Indeed many researchers have stated that the highly contextual nature of qualitative work makes generalisability unrealistic. It was, however, considered feasible to attempt to ensure the transferability of the work. Transferability suggests that in spite of the highly situated nature of the research, that meticulous attention to detail and recording of researcher assumptions (268) and that actions will allow some findings to be transferred from one situation to another (269). In line with this thinking, the sample required to answer the research question should be purposive in nature, reflecting the staff working in and through general practice.

The shape of general practice is essentially similar across the UK, although the impact of devolution has resulted in a divergence of policy (76) and the author believed that this might have resulted in some variation in the priorities articulated through the GMS contract. In order to maximise the relevance of the research to the local policy context and to improve the shared experience of the extant model of primary care between the author and those interviewed, the author chose to limit the sampling frame to professionals working in primary care within NHS Greater Glasgow and Clyde.

In order to identify and approach staff working in NHS practices, the author considered using historical data for GP principals which predated the nGMS contract. However, this approach would have excluded changes in GP partners

over the past 5 years. Moreover, it would exclude nurses and practice salaried medical staff whom the author wished to include in the purposive sample.

The author also explored the possibility of contacting practice managers to ask them to distribute letters of invitation to staff working in their practices as this would reduce the need to hold this information centrally. However, evidence suggested that unnamed invitations were likely to compound difficulties with recruitment. Mapstone and colleagues performed a Cochrane sponsored systematic review which identified lack of recognition for professionals as a barrier to participation in research (270) Perhaps more importantly, it was likely that practices who agreed to distribute unnamed invitations were more likely to have been different from most general practices. Experience has shown that certain practice characteristics, including practice size have a significant impact on participation in optional activities such as research. (271) Such an approach would therefore have unacceptably compromised the spectrum of staff experiences contributing to the sample.

3.6.3 The public's views of two alternative models of primary care

The purpose of this section of work was to explore the public's views of alternative models of primary care and built upon previous work with the public and with primary care staff. Little was known about the public's attitudes to models of primary care. Therefore, the concepts being explored required a high level of engagement with participants. This precluded the use of a more generalisable method such as a survey. In addition, the investigator believed that deliberation and discussion was a necessary part of the process in order to deepen the understanding of the participants' underlying beliefs.

Previous work to establish the priorities of the public in relation to the future organisation of primary care was considered to form the basis through which the public would be able to form views of the alternative models. Although a number of qualitative and quantitative methods of assessing the public's views of healthcare interventions were in use, including surveys and focus group techniques, there was relatively little evidence of effectiveness of methods which allow sufficient engagement to permit complex concepts to be addressed.

A number of methods, both qualitative and quantitative have been proposed in order to elicit the public's preferences for healthcare. Ryan *et al* have reviewed the methodologies. (272) Quantitative methods were classified as ranking, rating or choice-based approaches. Qualitative methods included individual and group-based processes. Group based processes included focus groups, concept mapping, citizens' juries, consensus panels,public meetings and nominal group techniques.

Ryan *et al* conclude that in terms of quantitative methodologies, ranking scales were of limited use. Rating scales were widely used, but many did not consider the strength of preference of alternative options or allow different components of choice to be explored. Standard gamble, conjoint analysis and willingness to pay approaches were also considered. From a qualitative perspective, one to one interviews and focus groups were most popular and performed well against their criteria for validity. The authors also suggested that Delphi and citizens' juries met the criteria for quality and validity.

Citizens' juries and deliberative processes such as consensus panels have been increasingly used as a method of citizen involvement. The concept for such forms of participative democracy evolved from a German approach called *plannungzelle,* or *planning cells* which supported local and national government in addressing planning issues. Citizens' juries have been popular in the UK since early work was performed by the Institute for Public Policy Research in the 1990s. (273) The approach has been criticized, however, because although the individual participants are asked to be impartial, they are inherently self-interested as citizens, tax payers and service users. (274) In addition, citizens' juries have been criticised on the basis of their cost.

In response, more focused deliberative panels have been suggested. These panels are brief and less resource intensive, providing more limited information and latitude to the participants. Coulter *et al* have demonstrated that the composition of such a panel has an impact on the outcome. Their study demonstrated that a multidisciplinary team was more likely to conclude that a treatment was inappropriate than a team composed of professionals who routinely used the technique. (275) Stronks *et al* studied the use of a deliberative panel to explore healthcare cuts. They concluded that a major difficulty with the technique was the need to ensure that the public had sufficient information and time in which to come to a conclusion. (276)

Reports by Edmonson-Jones suggested that a structured deliberative approach could be successfully used to allow groups, including members of the public, to prioritise service developments (257). This scorecard approach was developed by Edmonson-Jones as a framework to permit a variety of alternative service developments to be compared using an agreed, common framework of priorities. This approach is related to other more established approaches such as Nominal Group Technique and it included a transparent mathematical method of criteria weighting to allow a scoring and thus, a ranking of alternatives which in turn stimulated debate and facilitated the emergence of a consensus view. The author had prior experience of using such an approach to service development. In his experience, the use of clear criteria which were developed by the stakeholders overcame many of the difficulties with rating methods suggested by Ryan *et al*, since they facilitated comparisons and relative components to be explored.

3.6.4 Staff views of two alternative models of primary care

The main aim of this section of the research was to describe alternative models for primary care to staff working within primary care and to seek their views on the strengths and weaknesses of the models in comparison with the status quo. The work built upon the findings from the staff interviews and the public's priorities.

As with the section on the public's views of alternative models of primary care, deliberative methods were considered to be the most appropriate method to explore the professionals' views of primary care models in order to provide a deeper understanding of the participants' beliefs. Ryan *et al's* work suggested that approaches might include one to one interviews, consensus techniques such as nominal group technique, focus groups, consensus panels or the Delphi method.

Previous experience by the investigator in the west of Scotland context had led him to believe that professionals were reluctant to share their views openly within groups of primary care professionals. His experience was that an acceptable professional position based on the status quo emerged rapidly, and that this often acted to stifle alternative views. Given this experience, the investigator elected to use deliberative methods which might reduce this tendency. The Delphi method was considered to be a suitable methodology because it reduced the possibility of

a professionally valid view emerging which might stifle alternative opinion in face to face techniques such as focus groups, and even within NGT groups.

3.6.5 Statistical analysis

Descriptive and analytic statistics were carried out using SPSS 20. The *a priori* hypotheses being tested included examination of first and second round scoring and weighting for the public and staff groups using paired tests both parametric and non-parametric, depending upon the distribution of the data. To explore differences in the cumulative scores between the three models, Repeated Measures Analysis of Variance or Friedman's Two-way Analysis of Variance by Ranks were used, again determined by the distributions of the data. When comparing the cumulative scores for each model between both groups or comparing the weighting of the domains between groups, the independent Mann Whitney U Test was used to reflect the nature of the data.

3.7 Ethics and research governance

The research took place with members of the public who participated in the NHS Board's Public partnership Fora, and with primary care staff and managers who worked for or contracted with the Board. The major ethical issues related to issues around rigour, confidentiality, consent and privacy, and opportunity cost.

3.7.1 Rigour

The rigour of the methods was tested through the author's evaluation of the current literature, through discussion with his supervisors and by testing the methods either through a Research Ethics Committee or with peers and the local NHS Research and Development Service.

Work focussed on research objective two on staff views on the organisation of primary care was approved by the local Primary Care Research Ethics Committee.

The work focussed on research objective three was approved by Glasgow University's Medical Faculty Research Ethics Committee. Research Objective One on the public's priorities for primary care took place prior to the author registering for the degree of M.D; however the ethics of this work were still afforded consideration. Following review, this work was considered to be service development by the National Research Ethics Service, thus research ethics committee approval was not required. Rigour for this element was ensured via peer discussion within the GCPH and through discussion with local services. Letters of ethical approval are contained within Appendix 1, A1.17 and A1.18.

3.7.2 Confidentiality, consent and privacy

Informed consent was considered important for all of the elements of the research. For each piece of work a Participant Information Leaflet was created. This included information to help the potential participant understand the purpose of the research, what it might mean for them if they chose to participate and how to contact the author if they had any further questions. In addition, it provided information about who was sponsoring the research, how personal data would be stored and how the findings would be disseminated. Consent forms were created for Research Objectives Two and Three. For Research Objective One, attendance was taken to imply consent.

In line with the Data Protection Act, and NHS and Glasgow University's Research Governance, all personal data was stored in locked data cabinets within the GCPH or on NHS computers which were password protected.

Confidentiality was considered particularly important for those managers and primary care staff who participated. A number of participants sought guarantees of anonymity because expressing personal opinions was considered difficult given the issues being discussed. Therefore great care was taken to protect the identity of participants in the results chapters and to ensure the security of the file which links participants to individual's identities.

The right to privacy was an important issue which was in tension with the need to recruit and retain participants. This was resolved through ethical review of the importance and rigour of the research being balanced against the individual's

right to privacy. The protocol for recruitment was designed to ensure that after an initial approach and one reminder, no subsequent contact would be made. Further, in the eDelphi, where ethical permission was sought to reapproach the original staff participants, the invitation email was designed to protect staff privacy and to make it clear that staff could refuse to participate.

3.7.3 Opportunity cost

The most significant ethical issue was that of opportunity cost. This was considered an issue for both the members of the public, NHS staff and contractors. The issue of opportunity cost was related to that of research rigour. Given the commitment of participants to the various elements of this research, the rigour of the work was considered central in ensuring that the time spent on the research was a worthwhile investment in comparison with the alternative uses of this time either personally or in terms of NHS work forgone.

In addition, measures were developed within the research to reduce the opportunity cost. Firstly, the interviews with primary care staff were organised to take place at a time and place which would create minimal disruption for the member of staff involved. When staff were involved in follow-up work to test the alternative models in the light of their previous comments, this was accomplished via an eDelphi to reduce the amount of time required and to increase flexibility in terms of the location and timing. With the follow-up work with PPF members, learning from the first event designed to test the alternative models suggested that participants would have preferred a half-day event. Subsequent events were modified to take account of this request.

3.8 Timescale

The research took place over a period of two and a half years from early 2009 to mid 2011. The work with the public on priorities preceded the registration of the research for a higher degree (Research Objective One). This was followed by a more comprehensive literature review and the qualitative research with primary care staff (Research Objective Two). The findings from these elements of research

were then combined to create two alternative models for general medical services. These models were then tested with both the public and the primary care staff using mixed methods (Research Objective Three).

3.9 Conclusion

The research employed mixed methods to build upon initial elements of research and to improve the rigour of the work. The issue of rigour in relation to the mixed methods involved is discussed further under the section on strengths of the research within chapter nine. There were three major research objectives which related to four pieces of research:

Research Objective One: to improve understanding of the views of the public in relation to the organisation of general practice (general medical services) within the wider context of primary care within Scotland. This was achieved through a study using methods adapted from scenario planning to identify and explore the public's priorities for primary care (chapter four) and through findings from testing alternative models of service provision with the public (chapter seven).

Research Objective Two: to improve understanding of the views of staff working within the primary care team in relation to the organisation of primary care. This was achieved through a qualitative study using semi-structured interviews to explore staff views of the organisation of primary care (chapter five) and through testing alternative models of primary care (chapter eight).

Research Objective Three: to identify and refine models of primary care, and to test these models of primary care against the status quo with primary care staff and with representatives of the public.

This was explored through two pieces of work: a study using both qualitative and quantitative components to identify the public's views of two alternative models for the provision of general medical services in comparison with the status quo; and a study using both quantitative and qualitative components to explore staff views of two alternative models for the provision of general medical services in comparison with the status quo (chapters seven and eight).

Chapter four: exploring the public's priorities for primary care

This chapter provided a detailed account of the findings of a public involvement event carried out in October of 2008 to establish the public's priorities for the future of primary care. The work was carried out in collaboration with Dr Andrew Lyon from the Glasgow Centre for Population Health and used group discussion and scenario planning techniques to explore the public's priorities for a future primary care system.

4.1 Public participants

50 members of NHS Greater Glasgow & Clyde's Public Partnership Fora were invited to attend a half day workshop entited *Opportunities for General Practice.* 27 members attended the event which was held in The Lighthouse venue in Glasgow City Centre. The representation from the different Community Health Partnership areas is shown in Table 4.1 with at least one participant from each area.

Table 4.1 Breakdown of public partnership fora participants by geographic area.

Community Health Partnership area	Number of participants
East Dunbartonshire	2
West Dunbartonshire	7
East Renfrewshire	4
Renfrewshire	2
Inverclyde	4
North Glasgow	3
West Glasgow	2
South East Glasgow	2
South West Glasgow	1
TOTAL	27

4.2 Important issues for general practice

Participants identified a series of issues which were considered important for the future of general practice. This was achieved through group and plenary discussion, with identified issues being written down and added to emerging themes on a wall adjacent to the group-work area. A photographic image of these issues shown in Image 4.1. In addition to the analysis of these themes, the plenary discussion from the groups was recorded, transcribed and analysed.

Image 4.1 Photograph showing emerging themes of importance to the future of primary care. Taken at the PPF Future for Primary Care event, November 2008.

4.2.1 Access: rights and expectations

Six participants made separate comments about access as a critical uncertainty. There was discussion about the importance of physical accessibility to premises, or access to information, but in the main the focus was on ready access to a GP when

needed. A number of participants felt that GPs should provide better access, in particular at evenings or weekends. In contrast, some participants felt that patient expectations might be too high and that access might be distorting the prioritisation of work:

> *"If you go back to years ago when there was no appointment times and everybody just knew they had to sit and wait, and I think people are expecting too much now. I think it is just what everybody expects, that they have got a time and they should be taken at that time and they have to realise that that's not always possible…there should be an understanding that the culture of the GP is one in which emergencies do occur and we expect tolerance from the people using the services."*

4.2.2 Continuity, holism and roles

Participants raised the issue of continuity as important and uncertain. Some perceived continuity as being about continuity of information, *"a GP that knows the family history of that person"*. One participant provided a compelling example of when this had not happened, and one member of practice staff had not known about a bereavement within the immediate family. Some participants spoke about continuity of information and wanted to see better links to other services. Other participants challenged this view, seeing the critical issue being continuity of person, believing that *"seeing the same GP"* was central.

The majority of participants considered that holism was important, and uncertain. Many questioned if this was achievable under existing time constraints but there was a desire to see GPs working within a far broader social model of health. For some participants, holism embodied a traditional view of family medicine:

> *"House calling. When people do need house calls, you should not need to beg for them to get a house call."*

For others, the role described was one which saw the GP as co-ordinating activity across health and social care:

"I think also that GPs should be able to refer people to social work and other services and benefits, and that once this happens, social work should keep them informed of what services they [the patients] are getting, because otherwise GPs just assume you are getting the correct services."

Some participants raised the need for practices to involve carers in decision-making and to be aware of the health needs of carers as a whole.

The idea of a wider social model of health for general practice was developed by some participants who described the importance of equity, providing fair services which met the needs of specific groups such as the old, those with social needs, and those with learning disabilities.

A number of participants raised the issue of patient empowerment which they saw as central to the role of the GP. They linked the idea of empowerment to that of taking personal responsibility for health:

"GPs should encourage people and empower them to take responsibility. You know. It's not just down to the GP, we are human beings. We all have a responsibility to look after our own health too."

Participants wanted involvement and empowerment in their own care, but also wanted practices to listen to their views about the provision of services designed to meet their health needs. The idea of action in response to engagement was a clear emergent theme.

4.2.3 The role of the GP in business

Participants discussed the issue of cost and the role of the GP practice as a small business. Some participants believed that having a role as both GP and small business-person was an unnecessary distraction from the core role of caring for people:

"GPs acting as a business and the question of all the complexity comes from their capability in that role as agents for the NHS."

The issue of how decisions around the allocation of resources were made within practices raised two opposing viewpoints. A large number of participants believed that issues around cost could lead to conflicts of interest:

> *"I don't think GPs should be concerned about cost, because it's not necessary…because the GP can decide what services to offer rather than [provide] a total service."*

This idea was linked to the idea that *"treatment should be need, not resource-led".*

A contrasting view suggested that there was no alternative to having GPs involved in allocating and managing costs:

> *"Doctors have got to have responsibility for costs today*. It would be irresponsible [for them] not to."*

An advantage of the small business model was thought to be the GP contract as it was considered that this could be used to hold GPs to account:

> *"[There are] important example[s where] GPs are not doing [it] as part of their contract when they are actually getting paid for it."*

Another concern raised in the context of the GP as a business-person was that of co-payment or user charges. Participants reflected that previously free NHS services in dentistry had evolved in this manner and there was universal agreement that such charges were undesirable:

> *"The worry is the possibility of a financial cost eventually. The dentists now charge a certain amount, so [there is] a possibility about GPs charging."*

4.3 Critical uncertainties for the future of general practice

The participants used group discussion and plenary discussions to refine their ideas and concerns and to develop the issues discussed in the first part of the workshop into critical uncertainties. Critical uncertainties have been described as a dimension of a future situation which has been prioritised by a group as being

important, but which remain uncertain (254). For each of the uncertainties, it is then possible to create future scenarios where the critical issue is present in two states, for example, payment for GP services: free at the point of delivery, or user co-payment. A number of critical uncertainties were identified by building on group and plenary discussions (see Table 4.2). These critical uncertainties were generated by the PPF participants.

As previously stated, the author was supported by Andrew Lyon who had experience of using elements of scenario planning to help participants move from present concerns to future possibilities. Andrew introduced the concept of future scenarios. He worked with the author to develop the participants' stated priorities in plenary discussion. The participant groups then developed their own scenarios by choosing two critical uncertainties.

The group focussed on communication as it was considered central to good general practice. They saw two possible future outcomes which they wished to explore: good communication or poor communication. For the issue of confidentiality, the group believed that the GP practice would either provide high levels of confidentiality, or low levels of confidentiality. Access to a GP would either be good or it would be limited in the future. The group thought that continuity of services, both within the practice and across other services would either be good, with joined-up care in the future, or it would be limited, leading to fragmented care. The way in which GP services were funded was a concern, with some of the group believing that this would remain free at the point of use, and others believing that the future would involve user charges or co-payment. The overall level of resource within general practice was also considered an important uncertainty, with the two possible scenarios being resource-rich or resource-poor practices. The GP's role was also considered to be uncertain, with two possible scenarios considered possible: the GP remained as both doctor and business-person, allocating and managing the practice, or the GP focused exclusively on the care of patients, with managerial and allocation elements being undertaken separately. Out of hours care was considered to be an important issue. A number of participants expressed a view that the NHS24 out of hours arrangements could be more effective, and so the two possible ends of the spectrum for this uncertainty were effective or ineffective out of hours care. Finally, the issue of fairness or equity of services for vulnerable groups was considered to be uncertain. The outcomes considered possible were a high equity system with

resources being tailored to group and individual need, or a low equity system where some groups and individuals would be marginalised and underserved.

Table 4.2 The PPF group's critical uncertainties for the future of general practice with two possible future states for each dimension.

Critical uncertainty	State 1	State 2
Communication	Poor communication	Good communication
Confidentiality	Low level of confidentiality in practice	High level of confidentiality in practice
Access to GP	Poor access to GP	Good access to GP
Patient involvement	Ineffective patient involvement	Effective patient involvement
Continuity of services	Services are fragmented	Services are joined-up
Cost/payment	Services are paid for by user	Services are free at the point of use
GP resources	Resource poor	Resource rich
GP role	GP as doctor and small business-person	GP as doctor
Out of hours care	Ineffective, fragmented out of hours care	Effective, comprehensive out of hours care
Equity/fairness	Services are unfair/inequitable	Services are fair or equitable

4.3 Using scenarios to explore the public's views about the future of general practice

Having identified the critical uncertainties for the future of general practice from a public perspective, participants were asked to work in groups to select two critical uncertainties which would be used as scenario dimensions. Combining two sets of these scenario dimensions would create four potential future scenarios for general practice. For each of the scenarios, they were asked to discuss the advantages and disadvantages of each and if possible, to provide each scenario with a name which would identify their reaction to the scenario. Table 4.3 shows the sets of critical uncertainties which each subgroup chose in order to create their future scenarios for discussion. All of the scenarios which emerged were generated from the two critical uncertainties chosen and then developed by the PPF groups.

Table 4.3 Critical uncertainties prioritised by PPF participant groups for further work

Group name	Critical uncertainty 1	Critical uncertainty 2
Orange	Good/bad access	High/low NHS resources
Green	Good/bad access	Good/bad communication
Yellow	High/low NHS resources	Good/bad access
Red	Good/bad communication	High/low equity
Blue	Free/user payment GP	High/low equity
Purple	Good/bad communication	High/low NHS resources

4.3.1 Travelling in style? Access versus NHS resources

The orange and the yellow groups chose to explore access versus NHS resource availability as critical uncertainties which might shape future scenarios for general practice. The orange group participants characterised these scenarios by labelling them with a travel theme: the *Five Star Cruise*; the *Queen Mary*; *Ryanair*; and *Titanic*. The group findings are summarised in Figure 4.1. The yellow group described the four future scenarios as *Valhalla; Fort Knox; Florence Nightingale*; and *DIY healthcare*. The characteristics of these scenarios are shown in Figure 4.2.

Figure 4.1 Orange PPF group characterisation of future scenarios for general practice using the uncertainties of access to services and resourcing of services.

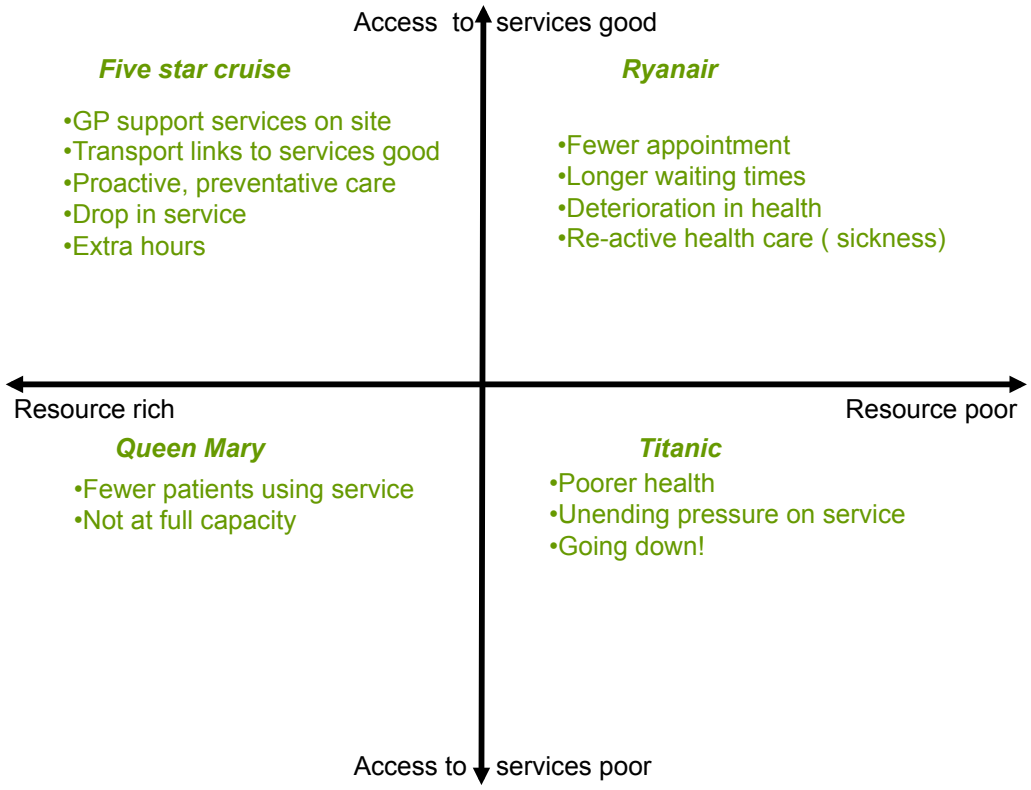
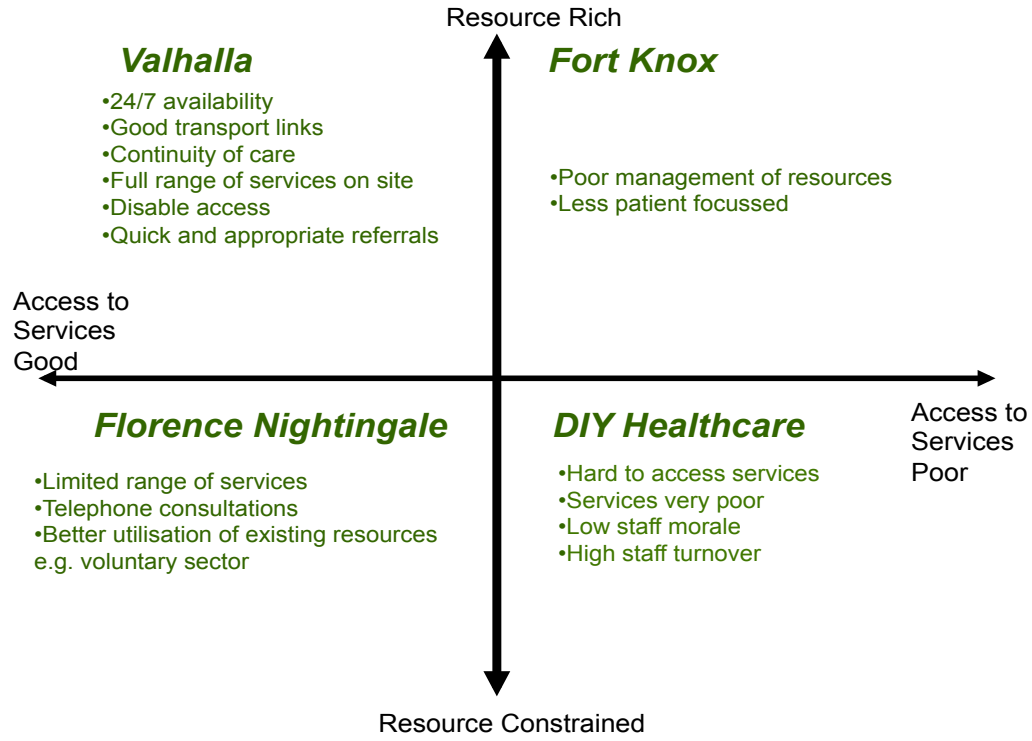


Figure 4.2 Yellow PPF group characterisation of future scenarios for general practice using the uncertainties of access to services and resourcing of services.



As expected there was a clear preference for good access and high levels of resource for general practice. In this scenario, described as the Five Star Cruise option, GPs and their support services were located on the same site, with enhanced access through extended opening hours and drop-in clinics. The yellow group included these themes within their scenario which they called Valhalla. In addition, participants believed that this scenario would offer opportunities to address access through improving transport for those who found it difficult to reach their GP. There was also a focus on preventative care.

In contrast, a resource poor, but good access system was described using the analogy of a budget airline, Ryanair. There seemed to a belief that limited resources would in fact mean that access could not be independently high (reflected in the comment about waiting times). In addition, there was a feeling that health overall would deteriorate as a result of more limited resources in the system. The yellow group labelled this scenario as Florence Nightingale: providing a limited range of services and relying on the voluntary sector.

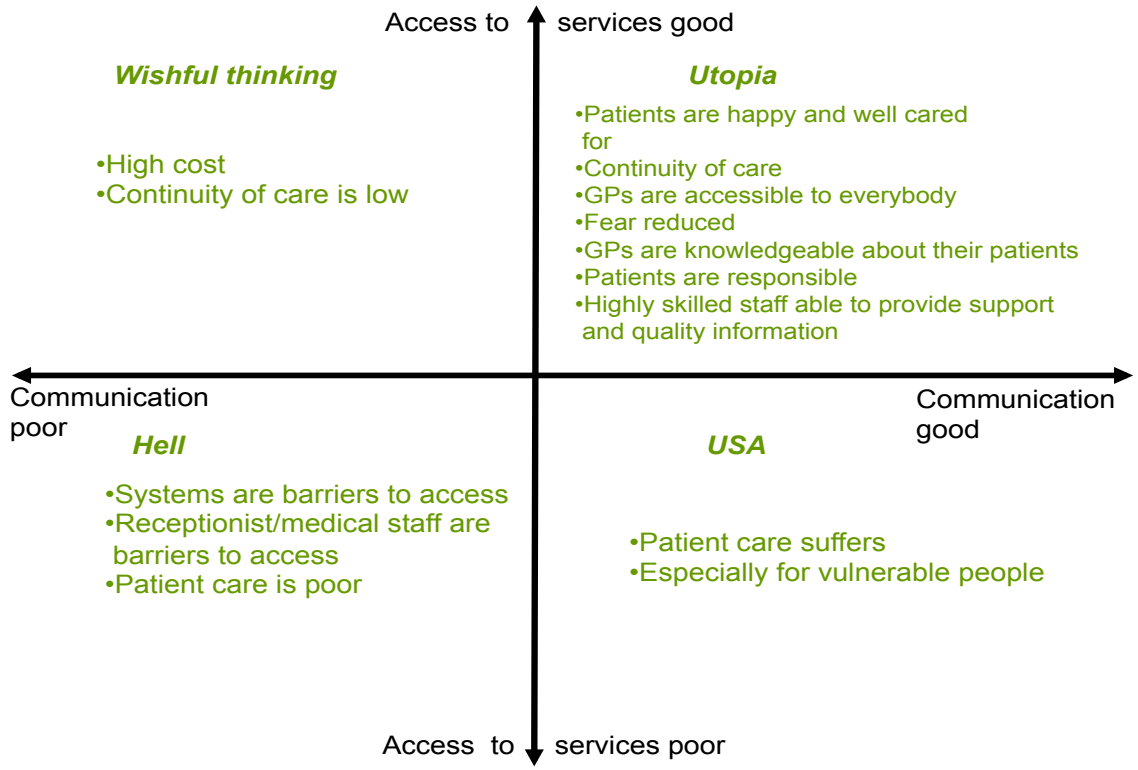
The Queen Mary cruise liner was used to describe a resource high, but low access system – high quality, but where few could afford to use the service. The yellow group described this scenario as Fort Knox, again reflecting the high quality but

low access which they believed represented a poor management of resources. Finally, the poor resource and poor access solution was named as Titanic as it was considered an undesirable future, which was likely to sink! The yellow group described this as DIY healthcare, where people were left to their own devices.

4.3.2 Utopia: access versus communication

The green group chose to explore the uncertainties around access and communication in relation to future general practice. The group described the four scenarios as utopia; wishful thinking; USA; and Hell. The group's reflections on these scenarios are shown in Figure 4.3.

Figure 4.3 Green PPF group characterisation of future scenarios for general practice using the uncertainties of access to services and levels of communication.



The group believed that the utopian scenario was one where there was good communication and good access. They felt that this would provide continuity of care; greater patient responsibility and reduced fear; and greater patient satisfaction. If access was good, but communication poor they felt that it was wishful thinking to believe that this would provide good outcomes. They believed that this model would be costly and would provide little continuity of care. The group named the good communication, low access scenario USA, reflecting their beliefs that this represented the state of primary care in that country. The group

believed that this was a particularly inequitable solution for vulnerable groups. Finally, the low access and low communication solution was labelled Hell.

4.3.3 Who cares? equity and communication

The red group chose equity and communication as their critical uncertainties. They described four scenarios entitled: it's your job; use your loaf; it's not my job; and who cares. These are shown in Figure 4.4.

Figure 4.4 Red PPF group characterisation of future scenarios for general practice using the uncertainties of communication and equity.

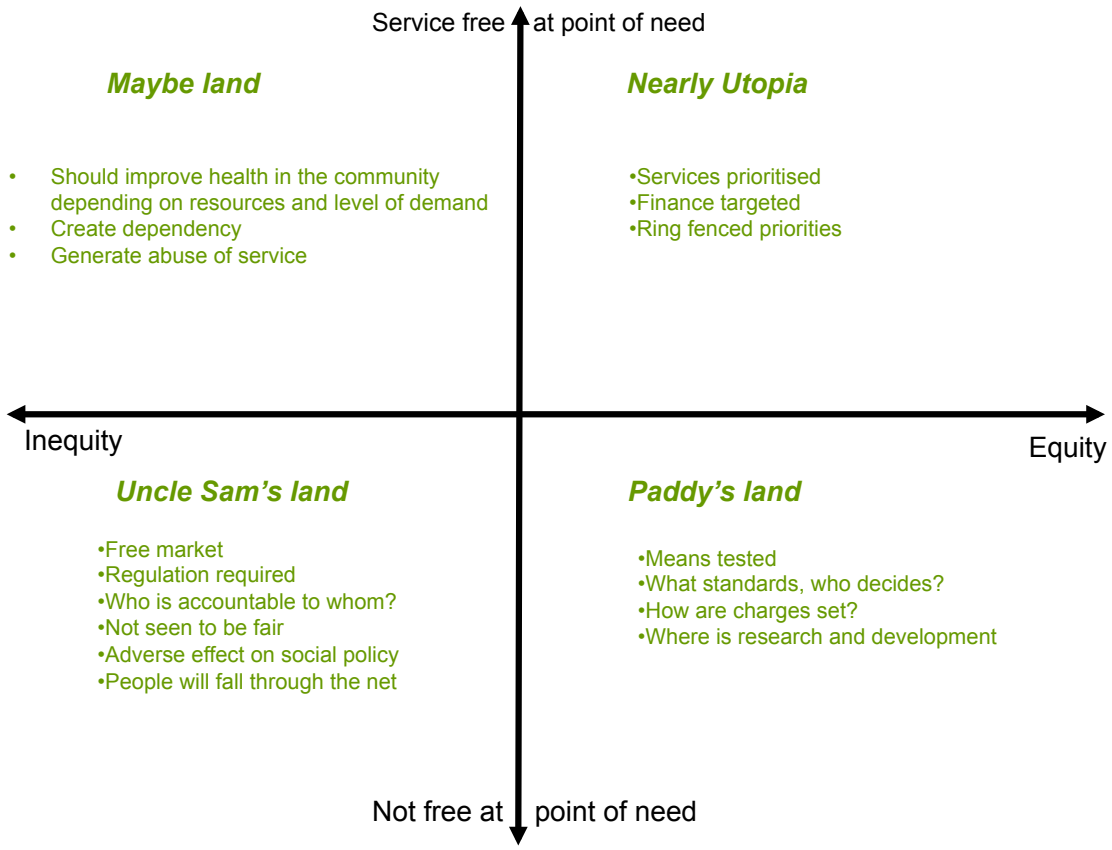
Use your loaf represented the scenario with high levels of equity and good communication. Communication was tailored towards patients' individual needs with GPs taking time to explain. When equity remained high, but communication was poor the scenario was described as *it's not my job*. This was characterised by the creation of resources which could tackle inequalities, but the group felt that these would be ineffective because no-one used them as a result of poor communication. When communication was good, but the system was inequitable, there were standardised, but not tailored forms of communication and

information, often using media such as mobile apps which had the potential to widen inequalities in access to information. Finally,
with poor communication and inequity was a system in which the quality of care was so poor that it was described as *who cares.*

4.3.4 Uncle Sam: free care or paying for care and equity

The blue group chose the uncertainties of free/paid GP care and equity in order to develop their four future scenarios. These were labelled Uncle Sam's Land; Paddy's Land; Nearly Utopia; and Maybe Land. These are shown in Figure 4.5.

Figure 4.5 Blue PPF group characterisation of future scenarios for general practice using the uncertainties of free/paid care and equity



Nearly utopia (high equity and free access) was characterised by targeting of resources to meet needs, with prioritisation on the basis of needs. The group also mentioned targets to drive healthcare.

Maybe land was described as free access but inequitable provision. The group believed that it should improve the health of the population overall, but the inequity could create dependency culture and abuse of services.

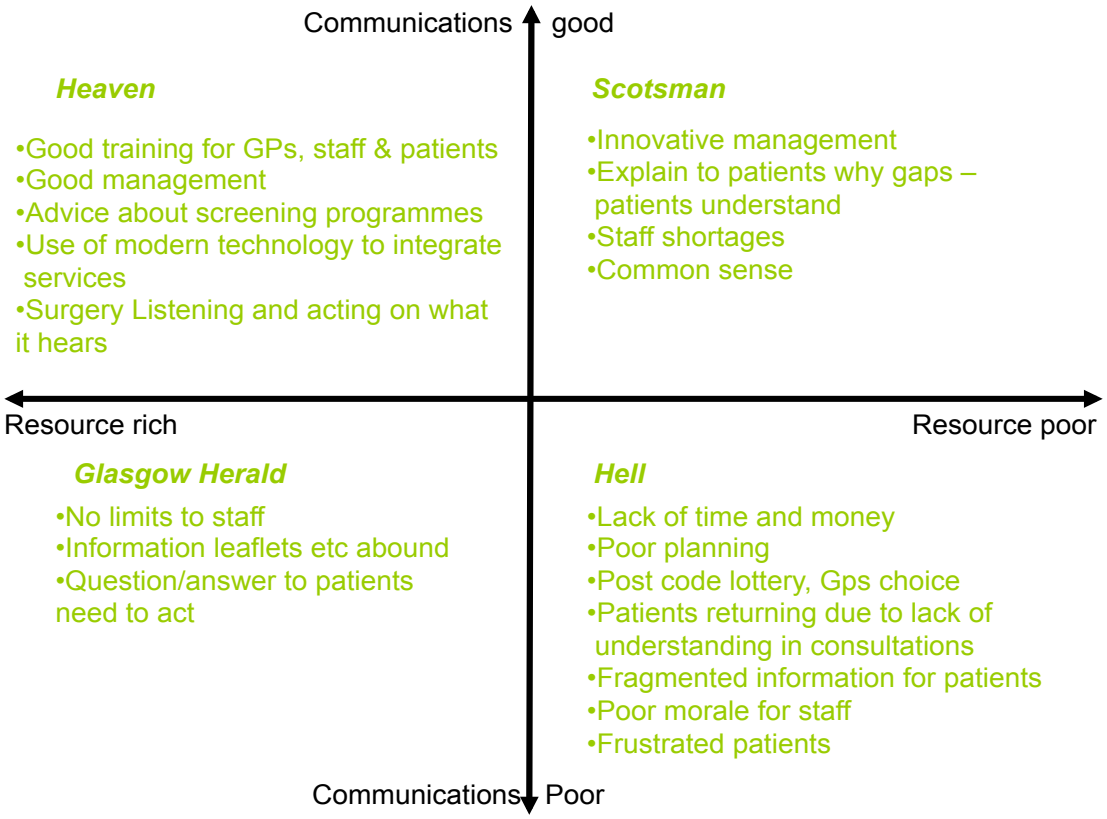
Uncle Sam's land described the US system of fee for service combined with an inequitable approach in which there was no real attempt at fairness. It was considered that people's health would suffer as they *"fall through the net"*. The group believed that this system would have a markedly negative effect on society.

Paddy's land was based on a discussion about the Irish GP system with co-payment which was means-tested. The group had serious reservations about this system in terms of accountability and governance with questions being asked such as *"who sets the charges?"*

4.3.5 Newspapers: communications and resources

The purple group used a theme of newspapers and their quality, reflecting the focus on communication which they explored in combination with the level of resources available to general practice. They described four potential scenarios: Heaven (high resource and good communication); the Scotsman newspaper (good communication with low resources); the Glasgow Herald (poor communication despite good resource levels); and Hell (poor resources and poor communication). The findings are shown in Figure 4.6

Figure 4.6 Purple group characterisation of future scenarios for general practice using the uncertainties of communication and resource



Heaven was characterised by the provision of good advice to patients by well trained staff, including tailored advice and information on issues such as screening programmes. In this scenario the participants believed there would be good management and that practices would listen and respond to issues raised.

The Scotsman scenario was so named because the participants felt that it produced good quality communication on a very limited budget. The group felt that this model would use good communication to explain to all concerned about the shortages.

The Glasgow Herald scenario was considered resource-rich and communication-poor, with a large number of staff, but relatively poor communication with frustrated patients, but little evidence of engagement.

The final Hell scenario was based upon poor communication and low levels of resource. This was considered to be very fragmented and frustrating for patients, with high levels of return appointments, poor planning and low levels of staff morale.

4.4 Conclusions

The issues raised by the participants, their prioritised critical uncertainties and their ultimate choice of which of these to use as scenario dimensions provides an opportunity to understand what was valued by the public. The focus on better communication, access, resources, attaining value for money and ensuring that services remained free were expected and fitted well with the results from surveys of general practice and patient- satisfaction.

The prominence given to equity within general practice was unexpected. The group, plenary and scenarios provided a number of insights which corroborated the view that fairness and providing services which could meet the needs of marginalised groups and individuals was seen as very important for the future of general practice.

The participants' views about the role of the GP as a business-person as well as the doctor role was also unexpected. There is little published about the public's understanding of or attitudes to the organisational roles occupied by GPs and the investigator believed that most of the participants would simply view the GP in the doctor-role. Despite the emergence of discussion about the dual roles, there was no agreement in this area, with some participants being uncomfortable that GPs were making decisions about the allocation of resource and availability of services, whilst others felt that this was inevitable and desirable.

Participants had a clear view that holism was an important issue for future practice. Some saw this through a traditional family practice lens of the GP knowing the patient personally, and providing personal continuity and house visits when needed. Others saw holism as a move to a wider social model of health with GPs integrating care across health, social care and the third sector, providing a more joined-up experience.

The issue of quality and staff training was mentioned by a number of staff across their discussion of the scenarios, reflecting the need to develop good communication skills and the ability of staff not only to tailor information and treatment to individuals, but also for GPs to empower patients to become involved in their own care and to encourage them to take responsibility for their health. The involvement of carers where appropriate, and the provision of

adequate care for their additional needs was also considered important. In addition to the them of seeking to be to be more involved in their own care, the scenarios clearly demonstrated a desire for meaningful engagement between patients and practices so that patients' collective views about service issues could have an impact on the provision of services.

Through the scenarios, the participants also sought an emphasis on preventative care, described as not being simply *reactive fire-fighting* which included the issue of taking personal responsibility, and which also encompassed discussions about other prevention programmes such as screening.

Chapter five: exploring staff views of the organisation of primary care

This chapter provides a detailed account of the findings of qualitative research conducted with staff who work in and with GP practices in the West of Scotland. 20 staff were interviewed. The chapter sets out the ontological position taken, characteristics of the participants and their views of the organisation of general practice; the national, board and CHP layers of organisation; skillmix; identity and independence; partnerships and salaried general practice; inequalities; and their views of alternative models of general practice. It sets out a disordered system of primary care, with absent leadership, problematic relationships between professionals and management and a lack of focus on outcomes.

5.1 Ontology and axiology

For the qualitative research, the overall ontological approach taken was critical realism (277). The author's ontological perspective was of *'subtle realism'*, in which there was acceptance of the existence of multiple perspectives rather than the relativist view of multiple realities (278). In keeping with a subtle realist ontology, the epistemological view taken was a modified dualism/objectivism (279). In essence this meant that although it was desirable to separate the roles of the author and participant, this situation was rarely possible. Given this fact, the role of the author's values, beliefs and perspectives were important, influencing the findings and in turn being influenced by them. In order to account for this fact, the author needed to provide a *'faithful rendition of [his] own experiences' (256)* and clearly record his thinking and decision-making in order to improve the rigour of the research and assist future researchers to clarify in what way the assumptions and actions of the author had shaped the findings. These views had to be expressed prior to interpretation of the findings of research.

The axiological assumption taken was that the values of the researcher were likely to have an impact on the findings. This was considered likely and although the author made efforts to reduce the impact of his values and *a priori* hypotheses influencing the findings, it was considered that a clear account of the experiences and hypotheses of the researcher should be set out in order to assist the reader in establishing the impact that these values might have had on the findings.

The researcher was a 40 year old male medical practitioner who had spent the majority of his adult life in medical training and practice within the west of Scotland. He has experience as a general practitioner, hospital doctor, public health registrar and as a consultant in public health medicine, with concurrent experience as both a GP and a public health doctor. This experience led him to question the current organisation of general practice. His *a priori* hypothesis was that a primary care system based on an independent contractor model might be less efficient than a salaried model and that the current system has emerged through a series of complex circumstances rather than being designed in a manner which was effective and acceptable to all. Further, he held a view that recent changes to the independent contractor model as a result of a new contract, had increased the potential for the profit motive to reduce the comprehensive nature of general practice. The author's values centre around the importance of primary healthcare being universal, free at the point of use, effective and efficient.

5.2 Characteristics of participants

Through a combination of purposive and snowball sampling, 20 staff working in and with general practices or managing primary care within CHPs or the Health Board were identified and interviewed. 30 practices were contacted using a systematic approach and of these, participants were recruited from 12, meaning that 40% of practice entities approached agreed to participate.

Seven groups of staff were included within the interviews: practice managers; NHS Board or CHP primary care managers; GP partners; salaried GPs; practice nurses; and community nurses (including a Health Visitor and a District Nurse). Of the 14 members of staff operating within practice entities (excluding community nursing staff and Board primary care managers), 10 were working within practices with '17j '(General Medical Services) contracts; 2 were working within '17c' (Personal Medical Services) contracts; and 2 were working within '2c' (directly provided medical services) entities. The characteristics of participants by role and location are shown in Table 5.1 and 5.2.

Table 5.1 Role of participants and their participant numbers

Role	Participant Numbers	Numbers in each staff group
Practice manager	1, 5, 7 and 8	4
Primary care manager	2, 4, 13 and 18	4
GP partner	6, 14 and 16	3
Salaried GP	3, 10, 11 and 15	4
Practice nurse	12 and 17	2
Community nurse	19 and 20	2
Practice receptionist	9	1

Table 5.2 Participants categorised by geographic area of working‡‡

Geographic area	Number of Participants
Whole board area	6
North West Glasgow*	2
North East Glasgow*	3
South Glasgow*	6
Renfrewshire	1
East Dunbartonshire	1
West Dunbartonshire	1

5.3 Organisation at the national, Health Board and Community Health Partnership levels

The participants supported the practice-based organisation of primary care, but identified a number of challenges which included: a lack of leadership for primary care; tensions between UK and Scottish Governments and between Scottish Government and the Board; a lack of a shared vision for the future; low levels of trust between practices and Board managers; and difficulties with prioritisation within CHPs.

The majority of the respondents expressed a positive view of general practice organisation overall, although they acknowledged that there were some problematic issues.

*During the course of the study the five Glasgow Community Health and Care Partnerships were reorganised into three CHP areas: North West, North East and South Glasgow. The participants are described according to their revised geographic area.

> *"I think overall it's good, I think the main parts of it are very good. There's parts of it that could be done better and there's parts of it that seem to be forced upon us that I would say are maybe not in the best interest of the patient."*
>
> *Participant 12 (Practice Nurse), paragraph 17*

A number of staff believed *"that in primary care, the practice is the building block."* Whilst the majority of staff viewed work around inequalities and determinants as important within primary care, there was a feeling that attempts in Glasgow to integrate primary and social care had compromised attempts to integrate primary and secondary care. A primary care manager summed this up:

> *"The whole point was actually it was improving that primary/secondary care interface and not the local authority primary care interface, and in Glasgow we've gone down a completely different route from what they've done elsewhere and you could actually say that maybe the primary care interface secondary care interface hasn't really changed."*
>
> ***Participant 13 (Primary Care Manager), line 119***

Participants were asked to comment on the organisation of primary care at the national (UK and Scottish), Health Board, and CHP level.

5.3.1 Government and the Health Board

A primary care manager described substantial tensions between the UK and Scottish Governments around primary care. He observed that structural change within primary care across Boards had resulted in a reduced focus upon the sector at a national and local level:

> *"I think one of the consequences of the major structural transformational change has been to lose some of the focus on primary care, partly because you haven't had an organisation called the Primary Care Trust or Division….I think that it's disappeared as… it doesn't seem to resonate in government policy."*
>
> ***Participant 18 (Primary Care Manager), line 18***

The theme of contest between different levels of management was picked up by another primary care manager who offered the opinion that a lack of clarity between levels of organisation was a root cause of many of the problems facing primary care. In contrast to primary care managers, few staff working within primary care had specific views about the nature of national primary care organisation. GPs and community staff described the national organisation as being outside their influence, and consequently, being outside their interest.

In terms of the Board level organisation, staff either felt there was a deficit or had little understanding of the role the Board played in primary care. A primary care manager believed that responsibility for the deficit in organisation lay in part with Scottish Government's attempt to operationalise things, and a lack of communication back to Government at the Board level.

5.3.3 CHP organisation

The majority of participants held negative views about the value of CHPs, irrespective of their staff group. One of the main difficulties was that of communication and engagement between practices and CHPs.

> *"Our GPs want to talk to the CHP and we want to be more involved and they're not being, they're being the last to know about things and not being included in things and they feel isolated from it."*
>
> Participant 12 (GP Partner), line 497

In contrast, a community nurse suggested that some of the responsibility for difficulties with CHPs lay with GPs, suggesting that politically motivated GPs had little interest in CHPs because they had little influence and power within it. There was a view from within primary care managers that CHPs didn't really understand general practice (as opposed to primary care), and that engagement had been problematic:

> *"I think we have a number of [CHP managers] who simply do not understand the way of working and the complexity and the challenge …if you don't understand that, you won't get it right."*

Participant 18 (Primary Care Manager), line 37

A community nurse was ambivalent about CHPs, and suggested that there were factors which influenced the success of CHPs in terms of levels of need, and size. The participant gave examples of experience within two different CHPs; one serving a largely affluent area, and the other serving a very deprived area. In this example he commented upon the things which made the more affluent CHP work. He believed that this included a smaller size; the ability to intervene at a lower threshold of need, adequate resources, and good communication:

> *"it's the size, the communication is poorer, they are more…I suppose it is lax about the levels, thresholds were much lower where they would take action. I don't know whether it's because of the amount of need that there was in the area that I'd come to, so again it's lack of resources, and lack of continuity, all the things that we recognise as being indicators that it's difficult to work."*

Participant 19 (Community Nurse), line 55

A practice nurse described the invisibility of CHPs, but still felt their influence on some aspects of general practice working. When prompted, the same participant did not feel that the CHP structure should be retained in terms of size and cost, although she accepted the need for some form of oversight. She was also ambivalent about the value of social care and health integration.

> *[Interviewer: If you could change the organisation of primary care would the CHP look the same? Would it be there, would it not be there? It's up to you.]*
>
> *"No it wouldn't be there. I don't think I like it. I don't think I like it."*

Participant 12, line 396

A primary care manager confirmed that the integrated health and social care model had created problems without addressing fundamental issues such as a move to more holism, better resource allocation across sectors or tackling health inequalities. He also stated that, paradoxically non-integrated partnerships had developed a wider model of health:

> *"The integrated model has for a whole series of reasons of personalities and everything else, limped along. My observation would be it's not radically dealt differently with the issues of inequity and the realignment or resource, whereas some CHPs equally [have] not had a narrow health model"*
>
> ***Participant 18 (Primary Care Manager), line 78***

In contrast to the negative comments on CHPs, one community nurse defended their value in terms of providing structure for staff and attempting to engage with communities, but stated that continuous change was problematic.

In summary, there was a limited understanding of the role of national or board structures in the organisation of primary care, with some managers suggesting that stronger primary care leadership in Government and better relationships between Government and Boards were necessary. Views of CHPs were mostly negative, with challenges being related to communication and engagement; understanding of primary care; difficulties with unmet need and size of organisation; and problems with cultural integration between health and social care. A small number of staff saw the CHP entity as valuable for health professionals.

5.4 Skillmix in general practice

Staff were asked for their attitudes towards skillmix within general practice. The majority of staff were supportive of skillmix within practices. Most staff interpreted skillmix as referring to the balance between GPs and nurses within practice, with a smaller number referring to the increasing involvement of practice managers as partners, extended roles for reception and administrative staff, and some suggesting the need for wider skillmix to be employed through the practice in order to address population needs.

The majority of staff felt that skillmix was a welcome development which had been overlooked in some practices. A number of staff reflected on negative attitudes to skillmix from GPs, believing that skillmix was often seen as

threatening to the GP's role. A primary care manager felt that an important driver for skillmix was the search to reduce costs.

Whilst there was consensus for nurses to become involved in chronic disease management, there was an emphasis on this being a protocol-driven form of care. There were divergent views about nurses seeing undifferentiated illness (triage). A practice nurse expressed frustration in not participating in triage work:

> *"[One of our nurses] did the minor illness course and I got really frustrated because we couldn't find a way out of the contract to allow [them] to do some of the acute stuff, minor ailments."*
>
> ***Participant 1 (Practice Manager), line 786***

A number of staff reflected on the change in skillmix which had already taken place in general practice. This view was typified by comments from a primary care manager who reflected on the shift in work towards nurses, and the way in which this skillmix had altered the balance of power between practice nurses and GPs, with a significant portion of practice income being linked to chronic disease management tasks carried out by practice nurses:

> *"Within practices it has changed the nature of the relationship between practice nurses, practice managers and the GPs. "*
>
> ***Participant 4 (Primary Care Manager), line 768***

A number of staff were keen to see additional staff roles embedded within, rather than aligned around GP practices. An example of this was the discussion around accessing Community Psychiatric Nurses (CPNs) based within the practice. She saw this as being an attempt to align staff resources with practice needs:

> *"I think you still need the GP's, you still need the practice nurses. And I suppose I think what I would like to see is …a wee bit back to a wee bit of choice depending on what your practice needs.... like when you look at the profile of your practice you are the best person to identify the needs, and if you need something to be there you should be able to get enough service into that*

practice rather than having to go through the whole [process] to get a referral which can take months."

Participant 20 (Community Nurse), line 145

5.5 Identity and independence

Participants were asked if they felt part of the NHS, given that most were employed by independent contractor practices. All of the staff employed within GP practices had strong views that they were part of the NHS, but that they were also independent. A number of staff working outwith general practice felt that practice staff didn't feel that they were part of the NHS; that they were independent, and that the NHS attempted to impose the sense of identity upon them:

[Interviewer: Do you think practices feel part of the NHS?]

"I don't think they do, I think they see themselves as very much independent. I think we think that they you know... they are..they see themselves as self-regulating, self-funding, they are independent contractors."

Participant 19 (Community Nurse), line 106

The majority of practice staff were in favour of the independent contractor status, believing it conferred advantages such as responsiveness and flexibility of service change which was far greater than that which could be achieved in the managed NHS; that it supported innovation in service delivery and that it gave a sense of ownership and achievement. In particular, a GP partner believed that the sense of control provided by the independent contractor model was related to better staff health compared to colleagues working within the managed service. He recounted a comment from a psychiatrist colleague who stated that the higher locus of control experienced by GPs at work was linked with better mental health levels in comparison with hospital doctors and some other groups:

"I was at a meeting years ago a psychiatrist who specialises in depression in doctors, a quite well known guy who does the talks and he said that, you know,

GPs have a low level of mental illness purely because they are in charge of their own lives and they can make changes and they can change things compared to, e.g., hospital doctors or people out with the medical practice."

Participant 16 (GP Partner), line 120

Some practice staff acknowledged that independence led to variability, so that staff might be more exposed to suboptimal employment practices, where individuals could be exploited. One practice nurse described that the lack of oversight associated with the independent contractor status left little recourse for staff when they felt that they had been treated unfairly. The result she believed was the staff had to choose the practice they worked for very carefully as there was relatively little regulation:

"It depends on the practice. It's good for me because I'm in a nice practice it's a good practice and they make me feel valued, but I know a lot of practice nurses that are very, very unhappy they feel they are being totally exploited…basically it's more and more and more things put on their plate without any more pay or without any reward or anything like that so it just varies from practice to practice. Very difficult because obviously they're independent contractors and they can do what they like so at the end of the day you are at their mercy just depending on how they think things should be run and everything. You just, for us we have to make sure you find a good practice."

Participant 12 (Practice Nurse), line 221

One primary care manager explored the impact which independent contractor status had on patients. He felt that patients were not aware that GPs were independent. He went on to describe some of his own beliefs as a manager about the disadvantages of the independent contractor arrangement, including the fact that this made general practice more of a business than an occupation, a lack of managerial levers to ensure that GPs provided appropriate hours of work in which to see patients, and his belief that there was little accountability for the effectiveness of the services provided:

"I don't think many patients will see this [being independent] as being a benefit or not, it will just be the GP they've gone to. The average patient if you said, "who employs GPs?" They would say "the NHS." They wouldn't know that GPs essentially are private business people who own that business, who often don't/won't work full-time because they've got other income sources, and there is no direct accountability to the body of the NHS for the clinical effectiveness of the service that they provide."

Participant 18 (Primary Care Manager), line 107

5.6 Partnership and salaried practice

This section was designed to seek staff views of GP partnerships, that is, the business partnerships through which groups of GPs co-operate and contract with the NHS, sharing profit and risk. The majority of participants supported partnership over direct employment, either within a practice or as a health board employee. Additional themes explored included the changing nature of partnership; concerns about the nature of profit within partnerships, the fact that partnerships lacked transparency and other issues of autonomy and accountability; and the variability of partnerships.

5.6.1 Partnerships

Salaried GPs demonstrated a preference for partnership to salaried employment. One GP described the change from being a trainee to being a salaried GP and described that the transition was not an easy one. She believed that partners were treated better and had greater job security:

"I want a partnership and I think, certainly, most people who are around about my stage want something more permanent than 6 months to a year… I need job security and I believe that most people in my position also want that. I took this job, not because I don't want a partnership, but because there was nothing else."

Participant 3 (Salaried GP), line 404

Some practice managers and GPs held the belief that partners demonstrated a greater commitment towards the practice, delivering added value and taking additional responsibility within the practice in terms of management. Some practice staff expressed a preference for partners in comparison with salaried staff because partners were more committed to the practice:

> *"I don't think if you get a salaried GP you've got the commitment that you have from a partner in a practice. They get their salary come and do their work and go, but they are not committed and they could easily leave."*
>
> ***Participant 5 (Practice Manager), line 564***

One practice manager, however, held a divergent view. He believed that partnership and independence were unnecessary, and favoured a directly salaried model analogous to that for hospital staff.

A major theme was the changing nature of partnerships following the introduction of the nGMS contract in 2004. One primary care manager spoke of the increasingly business-like operation of practices, and that this required choices to be made to improve business expertise by recruiting a practice manager as a partner. The primary care manager believed that this was because medical staff often lacked the prerequisite business skills. A practice nurse offered the view that some practices were recruiting nurses as partners, which would improve their remuneration and which they saw as fairer, allowing a better financial reward for responsibility and for their contribution to the practice.

A primary care manager described that within partnerships, the new contract had generated a more explicit business framework, forcing clear decisions about the configuration of services. She gave the example of how her practice had made choices about which local enhanced services to adopt. She explained that the decision to participate or reject the enhanced service wasn't made on the basis of clinical needs alone, but that it involved an analysis of the financial return for the time invested by the practice. She stated that a number of practices had rejected enhanced services on the basis that the financial reward was too low:

> *"So there is a balance to be struck that isn't just workload and ability to deliver on a clinical basis; there is also a balance to be struck on if I see this hundred patients before year end I will generate another £2000, or if I see that other 100 patients perhaps equally deserving, then I don't generate any more … So there are those tensions, which are more financially explicit in our current independent contractor status that would not appear if people were managed, there would be other tensions, but there wouldn't be those ones because you would get paid your salary whatever level of service you deliver."*
>
> ***Participant 4 (Primary Care Manager), line 324***

A number of GP partners spoke of the variability in partnerships, in terms of their motivation and functioning. One GP partner described the different characteristics of partnerships. Some were run to maximise profit, with profit *"clearly going straight to the pocket of bosses"*, with others being run as *"communes"* with profit sharing. Another GP pointed out the high levels of autonomy within practices who effectively *"run their own little kingdom"*. One GP pointed out that profit sharing was all very well, but for staff on lower pay, there were issues to be addressed as conventionally, members *"all share the profits and losses of the partnership."*

One salaried GP provided evidence of the variability between partnerships and described his experiences of two practices, one generally positive, but the other negative, being part of an unhealthy relationship. He described how isolating this experience was and reflected on the lack of transparency which prevented others from really appreciating his predicament, and also prevented others from providing effective assistance:

> *"My experience of partnership was a bad thing for me. One was a partnership of five very, very different people and probably fairly driven by maximising profit, but I mean good people, but…the second partnership I was in there was two people: myself and another person and it was a very unhappy arrangement because the other person I think it would be fair to say was quite a controlling individual…So there was nobody really, when that dissolved the only people that were of help were the LMC [Local Medical Committee] who were a little bit of help, but not a lot of help so there was no protection really, it was very, it's just sort of behind closed doors in a partnership nobody really sees the*

dynamics in what are going on, it's very difficult to go anywhere for help I think."

Participant 15 (Salaried GP), line 213

One salaried GP believed that partnership provided independence and autonomy, which ultimately benefitted patients by being more agile: making it easier to adapt services to meet needs. She believed that in comparison, directly managed services were bureaucratic and slow to react:

"It's good for GPs [partnerships and independence] because it does give them, as I said, a degree of autonomy and it allows them to provide a service geared to the particular group of patients that they serve and I think that's a good thing."

Participant 10 (Salaried GP), line 109

In contrast, most GPs suggested that a GP's status as salaried or partner didn't directly affected the quality of patient care that they could deliver. There was a belief that clinical decision-making was separate from managerial and organisational responsibility.

Most staff were uncomfortable with the notion of practices making a profit from patient care. This was particularly true of nursing staff, some primary care managers and some GPs. Some staff accepted the inevitability of profit as a way of remunerating independent contractors, but felt that profit beyond a reasonable salary should go back into the practice to fund better patient care. One GP partner wondered if there was a way to make partnerships more transparent in a financial sense, protecting the public purse from profiteering and providing some sense of protection for staff who might otherwise be exploited:

"I wonder if there is some way of working within partnerships to stop the kind of, I don't know is abuse too strong a work, for partnerships to function in a better way or a more fairer way. I mean I do think that partnerships where they employ salaried GPs and knock off all the profits seems wrong and I think there should be some way of practices having to, the internal workings of them

should be more visible and should be scrutinised and there should be some degree of protection within the partnerships."

Participant 15 (Salaried GP), line 397

Another GP suggested that profit sharing with the local community might be a more acceptable way of constraining excesses whilst retaining the financial incentive associated with profit, as a form of social enterprise, with a degree of profit sharing across all the staff within the practice.

In contrast, a minority of participants agreed with profit as a means of payment, seeing it as a fair return on work and recognising the profit was a reward for the risk of making a loss, which some suggested was not uncommon within general practice. Some staff saw profit as an important financial incentive to drive innovation and efficiency.

5.6.2 Salaried general practice

Salaried GP participants were asked to provide their perspectives on salaried employment. The salaried GPs included staff working within nGMS practices (17j); PMS practices (17c); and directly provided services managed by the Board (2c). Themes explored included general attitudes towards salaried employment, issues of involvement and status; autonomy; performance issues; and the impact on learning.

The majority of salaried GPs preferred partnership to salaried employment. Despite this, most were supportive of salaried employment, often as a short-term solution for those for whom job security and mortgages were less of a concern. The advantages included a lack of responsibility for management decisions, and the understanding that *"at the end of the day I can go home and that's the end of it for me."*

One salaried GP who had also been a partner provided these thoughts on problems with salaried employment including the idea that it might promote

reduced productivity in staff who were guaranteed a salary irrespective of their work-rate or clinical quality, concern about a lack of independence, and the relatively low remuneration of salaried employment in comparison with partnership:

> *"I personally would have preferred a salary for good, you know, a good salary for being a doctor, but that would have been abused by doctors not being good and taking the money. Lack of independence, what else…well it's a minor issue, I mean, the salary is poor so I'm earning for 9 out of 10 sessions what I used to earn for 5 [as a partner]."*
>
> ***Participant 10 (Salaried GP), line 18***

In contrast, another salaried GP felt that salaried service promoted productivity, due to the increased employer scrutiny, leaving *"nowhere to hide" i*n comparison with partnership. A primary care manager believed that a Board salaried service would improve quality and afford greater protection for patients, by addressing issues of transparency. A primary care manager gave an example of how, from a managerial perspective, salaried service was linked to the concept of power:

> *"I think the salaried bit certainty you can look more at the quality of what you're giving and it's not the ticking of the boxes it's going back and saying well lets pull out the record, lets look at the, you can drill a bit deeper...because we can get the records. People don't want to share information cause information is …they just see it as a negative rather than actually looking at it as a positive."*
>
> ***Participant 13 (Primary Care Manager), line 125***

All the salaried GPs felt that they had clinical autonomy. One salaried GP commented on the cultural issues around managing GPs, where staff from different professional backgrounds found the degree of clinical discretion problematic:

> *"I do have clinical autonomy, but I'm also very closely monitored. There have been several managers with backgrounds in social work or nursing and they I think are freaked out to an extent by the professional autonomy that GPs have and they attempt to control and attempt to put that into some sort of box that*

they can feel comfortable that you're not going out too far on a limb or that they've got some sort of idea of what you are doing."

Participant 10 (Salaried GP), line 41

Despite the comments about clinical autonomy, all of the salaried GPs described a lack of involvement within the practice. This was linked to the idea of status and equality with partners. Most staff did not think that being salaried or being a partner would make a difference to patients:

"I'm not sure that patients would know and whether they would be aware that there is any difference and whether they would see any difference."

Participant 15 (Salaried GP), line 153

Two participants were concerned about the safety of a move towards a fully salaried service, because in their experience, salaried work tended to attract less experienced staff, and there was a feeling that this was dangerous because GPs needed to work with more experienced colleagues in order to practice safely and learn:

"I think salaried services can become quite dangerous because I think what, my experience is I have learnt so much from the experience of different levels of experience in the team like one of the partners has been here for over 20 years and if you look at pure salaried service...that is run mainly by doctors so younger, not age meaning, but less experience and I think you don't learn from each other as much any more or you can't learn from each other because you are all at the same level and I think that's a huge disadvantage and I would be very careful recommending services like that."

Participant 6 (GP Partner), line 642

5.7 Organisation and health inequalities

The participants were asked to reflect on how the organisation of practice services impacted upon health inequalities. Responses demonstrated a wide variety of knowledge and understanding around inequalities. Many staff believed that the way services were organised did affect health inequalities, but that inequalities were hard to tackle. There was evidence that inequality- sensitive approaches were also practitioner-dependent, and finally, a minority showed a disinterest in this topic.

Some participants demonstrated a sophisticated understanding of the impact of primary care organisation on health inequalities. This included the insight that the independent practice-based model might be responsible in part for creating or sustaining health inequalities:

> *"So I think, you know, that independent contractual status makes it difficult to sort of unify a service if you like and I think there would be winners and losers out of that."*

Participant 11 (Salaried GP), line 109

A number of staff described a strong relationship with the patient as central to tackling inequalities, and contrasted this with the demands of more affluent patients. A number of staff commented on the need for flexible access to tackle inequalities, but that this was challenging because of different partner perspectives within the practice.

Participants also described pragmatic approaches to inequalities so that patients who didn't attend for QOF chronic disease management checks wouldn't necessarily be excluded from further recall if they failed to attend following a third letter (as per the conditions set out in the nGMS contract which permitted exclusion of those whose care was scrutinised for QOF payments). There was also an attempt to identify patients who needed chronic disease checks opportunistically, and to combine the checks for multimorbidity into a single contact:

> *"There's none of this 3 strikes and you're out business because we know that there are patients who just live such chaotic lives and they can't cope with that."*

Participant 16 (GP Partner), line 108

Additional factors mentioned around inequality-sensitive approaches within the practice were the importance of bridging services which could have an impact on some determinants of health, and the need for additional time:

> *"You need a lot more time with these people primarily, and money to help, you know, with these kind of referrals and we need more people, we need more food workers, we need people to show them how to cook, we need people to tell them that's a healthy diet and that's not and show them what that means. It's all right telling them, but they haven't got a clue it's showing them it, it's demonstrating it, it's showing them how to go shopping and pick the right things and food demonstrations and, you know, showing them how you can exercise without having to pay a fortune to go to a gym, actually showing them which I know it's basic, but that's what they need."*

Participant 12 (Practice Nurse), line 397

In contrast, some staff had a rudimentary understanding of health inequalities, confusing it with monitoring of equalities:

> *"Well we treat every patient that comes in the door the same, it doesn't matter, you know, what race, religion, whatever they are they get treated the same as long as they live in our area. We feel that all the patients get dealt with exactly the same it doesn't matter who they are, what age they are."*

Participant 5 (Practice Manager), line 654

There was a variable approach to providing inequality-sensitive services for excluded groups such as the housebound, and this issue was linked to the cost of providing such a service. Some practices provided good evidence of outreach services, whilst others simply excluded the patients from these chronic disease management activities:

> *"…the people that are excluded are the housebound because there's no, because they don't count towards your targets. Now good practices will then say, well actually that doesn't matter they are potentially our most vulnerable therefore*

we would build our services around those individuals, but you will have others that will say well actually if you are housebound it doesn't really count."

Participant 13 (Primary Care Manager), line 21

Whilst the majority of staff were concerned by health inequalities, one participant rejected the concept, believing it to be a health service managerial or political construct which had little relevance for general practice.

"By the time people reach doctors they are already ill or already set in their life path: we're a reactive service. If you want to improve health inequalities you've got to look at housing, education, you know, jobs, taxation, it's nothing to do with doctors."

Participant 16 (GP Partner), line 31

A number of staff reflected on how difficult it was to have an impact on inequalities, and that some elements of organisation, such as the nGMS contract, and in particular, the QOF, were a challenge for populations living in permanent crisis. Staff also described the uphill challenge of dealing with vulnerable populations, where prevention was well down the list of priorities. One participant explained that organisation and resources were not the only issues which needed to be addressed to tackle health inequalities in primary care. A further important area was the need for adequate staff training in order to intervene and tackle inequalities:

"I think the main message is that general practice can deliver things and even in the most deprived areas, I remember the dentist saying at the meeting even if you pay people highly they won't go to these areas. I think if you train people according to deprivation issues, it is possible to deliver a good model of care. It won't be cheap, but I think in the long term it will be cheaper than dealing with all our delinquent patients and chronic diseases."

Participant 5 (GP Partner), line 941

5.8 Alternative models for general practice

This section describes the participants' views of what issues should be considered when considering alternative models for general medical services in the future. All the participants were supporters of general practice in its widest sense, but were encouraged to think how it might be improved.

The themes which emerged were of the need to widen skillmix; optimise practice size and infrastructure; retain independence versus a centralised service, promote holistic and generalist practice; develop staff understanding of local needs and provide adequate skills to tackle inequalities; consider the issue of profit and incentives; and the need to improve the whole health system.

5.8.1 Skillmix

All of the participants were enthusiastic about skillmix within general practice. Most nurses and managers saw a need for an extension to the nursing role within general practices, with nurse practitioners functioning at a high level with their own patients. Many GPs agreed with the need to widen skillmix, but saw this as being achieved through the practice being able to access a greater number of healthcare roles than simply GPs and nurses, including healthcare assistants, pharmacists, health visitors and district nurses. An important issue raised was the need not only to develop the skillmix, but also to identify how this new skillmix might be negotiated by the patient, ensuring that the right needs were matched with the right skills:

> *"I think it's again educating your receptionists to be able to signpost people the right way and educating the patients if they go into the GP this time because they've got conjunctivitis or a sore throat or things like that saying to them well, you know, fine okay I've seen you today but if this happens again here are the list of things that, actually the nurse can deal with."*
>
> ***Participant 1 (Practice Manager), line 810***

There was a strong sense that skillmix required a strong practice team although there was a spectrum of views about the nature of the preferred relationship between staff and the practice to enable optimal working. This varied from the view that staff should be employed by the practice through being practice-based, that they could be practice attached, or most distantly of all, practice aligned. In general, GPs had a strong view that the wider team should be embedded within the practice to improve working.

5.8.2 Based on the independent practice team

Almost all participants wanted to retain the independence of the current model, seeing it as simpler and of great value. One GP Partner summed up the high regard in which the independent practice team was held:

> *"when it works well, you know, a practice based team is a beautiful thing."*
>
> ***Participant 14 (GP Partner), line 249.***

The majority of participants believed that the practice unit concept worked very well and that any future method of delivering primary care should be based upon the practice concept, using the practice unit to integrate the delivery of services for the patient. One primary care manager gave an example of visiting another European country where primary care was more fragmented, where patients self-referred to secondary care. He made a compelling case to retain generalism within practices:

> *"…the downside of that is that nobody has got an absolute overview of the care of that individual …it's very difficult to control what medication they're on and all of that, that type of stuff and I don't think, you don't get that in our system. I think people have got faith in their GP and I think in itself is a good building block…"*
>
> ***Participant 17 (Primary Care Manager), line 57***

In contrast, one practice manager had a radically different model in mind, based not upon the practice system, but on the hospital system. In this model, he envisaged salaried primary care, with shift working. He felt that additional constraints would need to be introduced to discourage improper use of the system by patients, with greater use of nurses to see less complex cases.

> *I'd do away with partnerships altogether and make it very much a hospital based type system, …you'd maybe have 2 or 3 shifts a day…you would have GPs, doctors and nurses working … differently so that, you know, the cheaper nurse would be the majority of the patients and the more expensive doctor would be seeing the referrals from the nurse or the obvious patients [coming] straight in."*
>
> ***Participant 7 (Practice manager), line 351, 356 and 368***

5.8.3 Focus on local needs and inequalities

Some participants described the desire to configure practices in a manner which would better meet local needs, giving examples of the kinds of skillmix which might be required to address specific local practice factors such as diversity or social problems:

> *"I would build it up from, based on the population, what do you actually need… If you work in a multilingual area you would have bilingual workers as part of your core team. I think if you wanted to bring in some of that social care component you would embed that within that kind of structure."*
>
> ***Participant 13 (Primary Care Manager), line 243***

Another GP described that changing the configuration of the practice was possible under the current arrangements, but that the adherence to a standard framework meant that change only happened in a long-term manner, rather opportunistically, rather than being a planned process. She gave the example of how skillmix could be changed to meet the needs of the population:

> *"That's the kind of stuff that allows you...from your population base to say we've got it wrong, and see the next time we've got a vacancy that's coming up in our district nurse, actually what this practice needs is something else."*
>
> ***Participant X (GP Partner), line 294***

A number of staff raised the importance of configuring alternative models in order to tackle health inequalities. Staff appreciated that engagement was a major challenge and that there were limits to what could be done within the existing arrangements to tackle this issue, through opportunistic chronic disease management which combined a number of health checks into one. Some staff felt that there were limits to what should be done with engagement, fearing that it was possible to become too intrusive into patients' lives. Despite this concern, there was a feeling that an alternative model should address some of the difficulties with the current arrangements, for example ensuring that chronic disease management was available for the housebound. Some staff felt that the model should include additional staff focussed upon outreach, tackling health behaviours and other determinants of health, such as poverty:

> *"I think it should be…a complete spectrum from looking after the severely ill right the way across to encouraging better living."*
>
> ***Participant 3 (Salaried GP), line 842***

5.8.4 Size and location

Many staff believed that in a future model, the size of a practice entity would matter. Some staff expressed this in terms of the limits for the number of GPs, or as a size of population served. There was a consensus that practices could be too small or too large.

Staff believed that single-handed general practice was undesirable, despite the potential advantages offered in terms of continuity of care. In general the reasons cited included difficulties in providing a sufficient breadth of service, governance and an absence of mutual professional support:

> *"Because there's nobody to keep an eye, you know, you need somebody else to have an opinion to bounce things off, bounce ideas off. I think one's not enough."*
>
> ***Participant 12 (Practice Nurse), line 285***

A primary care manager described an optimum size of practice as serving 12,000 patients, having six or seven partners, 3 or 4 nurses and a good quality manager. He believed that this size optimised costs, and enhanced the ability of the practice to perform, allowing for cross-cover for clinical staff absence, and the range of skills facilitated clinical competition to ensure quality:

> *"…there'll be enough of them there to cross-cover…within the clinicians and between these larger practices there will be an element of clinical competition to do well."*
>
> ***Participant 18 (Primary Care Manager), line 1054***

Other staff emphasised that just as single-handed practice was undesirable, that practices could become too large. The main reason cited for this was a lack of continuity for patients.

In addition to the optimum size of practices, the issue of ideal premises was raised. There was a clear professional difference between nurses and GPs in relation to GP premises. A number of nursing staff expressed a preference for health centre working, with a number of practices being co-located with access to additional services and facilities. An important theme which emerged was the need for professional support and mutual assistance. This was summed up by one practice nurse who described the professional support advantages of co-locating practices:

> *"…if there are any second opinions you need with other practice nurses it's easy to pop through and ask their opinion or borrow something, or support."*
>
> ***Participant 12 (Practice Nurse), line 297***

In contrast, a GP partner described the pride associated with having been able to design and build the premises for his practice:

> *"It's a lovely practice with a new building which we built from scratch so we've got a real sense of ownership from it because, you know, the architect was a friend so we sat and designed it, individual rooms."*
>
> ***Participant 16 (GP Partner), line 110***

Other GPs cited the greater freedom which independent premises gave them in terms of their ability to react to needs and change services.

5.8.5 Profit, partnership and other incentives

A number of views were expressed by staff in relation to the desirability of profit as an incentive within an alternative model of primary care. The majority of respondents were uncomfortable with the notion of profit being made as a result of healthcare activity. Staff expressed a spectrum of views which ranged from those who rejected the need for an independent contractor settlement and the notion of profit, preferring instead a salaried service, through to those who believed that profit was an inevitable consequence of the model, but who favoured a more acceptable means of distributing and dealing with profit. A minority of participants were comfortable with profit in its current form as an acceptable incentive.

Although a number of staff were uncomfortable with the notion of profit and the need for financial incentives, feeling that *"profit shouldn't come into it"*. No participants were able to articulate alternative incentives to stimulate performance, instead drawing upon ideas of professionalism in place of incentives. Staff drew on their experience of the salaried service, where professionals were paid for their job, and expressed a view that difficulties such as long hours did not justify the need for profit:

> *"Well, I think it's a job and if you're salaried, that's your salary, isn't it? I'm sure there are other professions that work long hours and do overtime and are salaried."*
>
> ***Participant 20 (Community Nurse), line 157***

A number of staff expressed the view that if profit was made in a practice, that there should be a mechanism through which it could be retained to benefit the patients or the community, but not *"lost back to the black hole of the NHS"*. One primary care manager suggested that increased profit shouldn't result in increased salary for partners, but that the profit might be used to develop services within the practice, or in the wider community, through funding the third sector:

> *"I think if they made profit it would get ploughed back into delivering patient care it's not about that the more money we make the bigger the salary range. I think the salaried bit of what people get should be capped or banded the way that we've got under kind of current structures, but they could, e.g., invest in training and education, they could improve services. They could decide if they were very altruistic to say actually there's a voluntary organisation that we know, is providing a really good service for us and for our community, we'll actually put some of that money in."*
>
> ***Participant 13 (Primary Care Manager), line 249***

A minority of staff expressed positive views about profit. This group tended to portray profit as a legitimate reward for work done. One GP partner volunteered social enterprise as an alternative model. He felt strongly that profit was a good thing as it fitted with his belief that smaller, independent units were preferable to the bureaucracy of the NHS, and could be used to encourage excellent clinical performance, but suggested that it needed to be managed within a fairer, more transparent model. One of the key issues in his definition of social enterprise was the need for the objectives of the organisation to be acceptable to the local community. He also described the need for the community to share in the profit or loss of the enterprise/practice:

> *"I see general practices as prototypes for social enterprises. I'd like to retain the independent contractor model on the basis that it sustains small profit driven centres of excellence in primary care…it could be profit shared with local community, I think there are some models for this in England where community organisations are financial contributors to the practice .... Well, [as] in a normal business model they contribute, they invest and may or may not share a profit. They may share losses as well."*
>
> ***Participant 14 (GP Partner), line 5***

Opinion on the Quality and Outcomes Framework (QOF) of the new GMS contract was divided. A substantial group of participants did not support the QOF. This view was most common amongst GPs and nursing staff who saw the approach as focussing on processes at the expense of the therapeutic relationship. A number described that ticking boxes tended to *"dominate our consultations with patients"*. Some staff working within a PMS practice described that although many of the aims of QOF were desirable, that its implementation had had the effect of reducing the gains their practice had experienced by moving from GMS to PMS. The main effect had been the reduced flexibility in delivery and a sense that choices for tailoring services had been reduced by QOF, reducing quality:

> *"The difference from working in a GMS practice is that we've got a lot more autonomy with what we do although we are controlled more and more because of QOF…we still try to achieve better than the QOF standards, but it's not as easy to do that because you're controlled by making sure that you do what QOF wants rather than do necessarily what the clinical benefit to the patient might be."*
>
> ***Participant 7 (GP Partner), line 74***

In contrast, primary care managers and some GP Partners defended the QOF, seeing it as *"innately good"*. One GP Partner accepted that QOF was imperfect, but felt that it was sophisticated, taking into account prevalence of chronic conditions. This participant compared QOF to either item of service payments, or salaried service. He believed that *"the QOF avoids both those extremes"* in terms of potential disadvantages.

5.8.6 The future of CHPs

There was a clear dichotomy in views around the future of CHPs. All staff based within practices saw no future need for CHPs, which they thought *"just wouldn't be there"*. CHPs were seen as largely redundant, having very limited influence on practices at the moment, and little relevance within a future primary care structure. In contrast, most primary care managers saw the CHP as a solution to many problems faced by primary care. In their vision, a salaried service should be managed by the CHP:

> *"I can see no good reason why a CHP manager could not have a managing responsibility for a wholly managed practice where the GPs and everybody else are NHS employees…"*
>
> ***Participant 4 (Primary Care Manager), line 1116***

A number of practice-based staff described the decisions of CHPs as apparently *"opaque and arbitrary"* seeing a clear power struggle between the power of practices and that of the CHP managers. Others saw the CHP level of organisation as redundant, citing a better experience in the past when only the Board's primary care division and the practice levels were in operation. A number of staff referred to the Health Visitor Review[§§] as an example of this struggle. One GP Partner suggested that this could be resolved by transferring the management of community staff into practices, effectively resolving the power struggle by using the practice as the organising unit:

> *"One of the ways to solve this CHP problem would be if we did employ our district nurses and health visitors."*
>
> ***Participant 16 (GP Partner), line 182***

[§§]The Health Visitor Review was a process to redefine the relationship between general practices and newly integrated Community Health and Social Care Partnerships. This involved a decision to focus Health Visiting on preschool children and an end to the attachment of specific Health Visitors to each practice, replacing this with the alignment of teams of Health Visitors within a geographic area to groups of practices with premises within that area. This review led to a dramatic worsening in the relationship between GP practices and NHS Greater Glasgow and Clyde.

This view contrasted with that of one community nurse who felt that the CHP provided a necessary oversight role for practices, although she accepted that neither the practice nor the CHP had been able to deal effectively with professional underperformance issues.

One GP partner suggested that the organisation of the general medical services element of primary care was in effect a complex adaptive system. In making this suggestion, he was keen to stress the need for subtle change management, because of the impact of unintended consequences within such a system:

> *"It doesn't mean that you can't manage it, it's just that you have to be gentle with it and you have to steer it in the right direction. Adaptive systems do adapt, but they have to be steered in the right direction without damaging component parts."*
>
> ***Participant 13 (GP Partner), line 309***

5.9 Confusion

One of the central impressions gained through the interviews was the overwhelming feeling of disorder around primary care's organisation. Participants expressed a variety of possible explanations for this, including a lack of leadership, low levels of trust between the professions, management and Government and a struggle between professionals and managers about power and autonomy.

5.9.1 Absence of leadership

One primary care manager summed up the leadership vacuum around primary care in general. He described problems at the level of the Board, due to structural change and the move from a primary care division to ten CHPs, which had reduced the visibility of, and focus upon primary care within the local health service Board. In addition, he felt that there were problems with the location of leadership at the level of Government which were compounding local difficulties:

> *"Scotland is at the fag-end of a power base of England when it comes to negotiating the contract and even then Scottish government doesn't do enough to use its own discretion to influence a contract because it doesn't use boards to take soundings on what we might want to see on those bits of contracts like the LES that we could flex locally."*

Participant 18 (Primary Care Manager), paragraph 47

The same primary care manager went on to offer the view that internal reorganisation of primary care into CHPs had significantly reduced the focus on primary care within the Health Board, seeing it as something which would happen locally, very much at a distance from the Board itself. He felt that this had been a serious problem for primary care in a strategic sense. Another manager reinforced the lack of Board input into primary care. She suggested that in particular there seemed to be very little dialogue between the Board and Government about what was working and what was problematic:

> *"There is not enough input, certainly, in the world of primary care from Board level, which would be my immediate reaction… there is not enough input back into Scottish government health department."*

Participant 4 (Primary Care Manager), line 431

There was a sense that general practice strategy was fragmented because there was lack of alignment between the level at which decisions were being made and that at which contracts were being negotiated. A primary care manager reflected that local decisions and management couldn't be effective against a nationally negotiated contract:

> *"It is very difficult to truly devolve responsibility fully to a practice or CHP when it is undermined by a national negotiating process."*

Participant 2 (Primary Care manager), line 22

5.9.2 Professions versus management

Another important theme from practice staff was the lack of trust between professionals, the Board and Government. Staff were able to provide numerous

concrete examples which they believed corroborated this assertion, such as the patient experience survey, or the Health Visitor review:

> *"GPs do feel as if the government had in a way cheated them, you know... So I think, certainly, GPs have to distrust the government. There is probably a bit of distrust with the health board as well I would imagine."*

Participant 3 (GP Partner), lines 342-345

The lack of trust seemed to stem from unresolved issues around power between practice-based staff and Board/CHP managers. Many of the examples cited demonstrated a tension between GPs and primary care managers, with both competing to retain or gain control over decision-making across primary care:

> *"It just goes round and round in circles like a wee mouse on a wheel and I don't know how you will ever change that, and I think it's just because of how they... They have got two opposing viewpoints the board see it as one thing and the GP's see it as another side, and I don't think we will ever get the two of them to marry up [laughter]."*

Participant 20 (Community Nurse), lines 189-193

There was suspicion within primary care staff that this power struggle was based on deep-rooted animosity. An example of this depth of feeling was given by one GP who felt that CHP/Board managers disliked medical professionals and that there was a hidden agenda to 'tear apart' the existing general practice arrangement and replace them with something different. This GP also reflected what he felt was an attempt by management to make doctors feel important and powerful, whilst behaving in a manner which suggested that this was untrue:

> *"They [CHP and the Health Board] don't like doctors. Somewhere along the line it feels as if they're trying to take the primary healthcare team and tear it apart and that's a big worry… all the documents that come through go on and on about how they value us and how they know we're the most important, but what actually happens is different from what's written in these documents."*

Participant 16 (GP Partner), line 28

Some primary care staff, whilst agreeing that the relationship between GPs and management was very difficult, did not blame management for this, reflecting that GPs felt that they needed to be in charge, but found it difficult to share power:

> *"I would say that if the ones that are quite politically motivated don't feel that they are in charge then they are not happy there. They like to be the ones that can tell everybody else what to do, but as GPs I would say my experience is they don't like to be told [laughter] what they need to do."*
>
> ***Participant 20 (Community Nurse), line 80***

Another practice nurse reflected that GPs felt that they had to protect their practices from unskilled management who *"don't understand anything about general practice, and don't ask"*:

> *"I think the GPs protect their practices from it in a lot of ways by just saying no and putting their foot down."*
>
> ***Participant 17 (Practice Nurse), line 61***

5.9.3 Roles, models and outcomes

There was no agreement on roles being carried out within practices, and no agreement on the models through which different professional staff would work together. In some ways this fitted well with the observation that participants could not articulate a clear vision for what primary care was trying to achieve. Some staff spoke about skillmix in a positive way, but their understanding seemed to be relatively rudimentary, describing it as a way of displacing less skilled tasks to other groups of staff. Most of the skillmix which had happened within practices was the displacement of relatively straightforward chronic disease management tasks to practice nurses, without delegation of decision-making or judgement.

> *"I think skill mix has to be looked at. I definitely think there are a few things that could, a few more things that could be done by healthcare assistants."*
>
> ***Participant 17 (Practice Nurse), line 229***

A number of participants reflected that skillmix was a challenge because of protectionism within general practice, with GPs afraid that if they permitted staff without formal medical training to take on complex roles, that this would undermine their power and that ultimately it might result in GPs being replaced with nursing staff:

> *"I think GPs are very protective of their own skills and knowledge and because they've gone through, you know, 5 years of medical school and the nurse has only done whatever the nurse has done, they can't possibly have the same knowledge as the GP"*
>
> ***Participant 7 (Practice Manager), line 472***

A primary care manager's comments corroborated this view that GPs would become less common, being replaced by staff with less training who would be less expensive. Implicit within the view was the idea that the role of GP could be performed by other staff groups such as nurses:

> *"It is a very top heavy expensive medical model of care which is why I think they will not be replaced because you could embed that money in practice and spread it wider."*
>
> ***Participant 13 (Primary Care Manager), line 197***

In contrast, a practice nurse did not see nursing as a replacement for GPs, but as an addition, offering a different set of skills, and accepting that the role of GP was more skilled and thus better remunerated:

> *"I don't know 'instead of', I think 'as well as' is probably another perspective. I think there's fond hope that you can replace {GPs] at a cheaper level. So I don't think that's good. I think you want a good service and if you have to pay for it then you have to pay for it."*
>
> ***Participant 17 (Practice Nurse), line 216***

This practice nurse also voiced concerns that patients would not accept greater delegation of responsibility and more complex tasks to nurses and other staff groups within the practice:

> *"I don't think, in general, patients realise how educated nurses are nowadays. They don't realise that we can help in other ways."*
>
> ***Participant 17 (Practice Nurse), line 17***

The issue of tackling health inequalities provided insight into the lack of consensus on what primary care was seeking to achieve. There was evidence of inconsistency around the attitude to inequalities across participants, lack of agreement within practices, and even inconsistency in the approach taken by individual participants.

Some staff provided compelling evidence of their attempts to tackle inequalities by organising the way they provided care differently, and by providing more time, recognising that sometimes, the health issues could only be tackled once the more immediate social issues had been resolved. In contrast, others saw inequalities as outwith the remit of primary care.

One participant gave a clear example of disagreements around providing inequality-sensitive access, with patients and reception staff being caught between opposing ideologies and approaches on how to deal with late attenders. Within this example it was possible to see the tension within individuals when considering the issue of access within a professional paradigm (the higher self), and within the managerial or small-business paradigm (the lower self) as well as the issue of disagreements between partners of the priority to be given to inequality-sensitive access for late-comers:

> *So I've always run the practice that if people turn up late they're told they're late they've missed their appointment but if they don't mind waiting till the end of the surgery which may be an hour or more, you know, the doctor will see them and that's because it might be that the patient would just go away and not come back, but it's more likely they will come back a day or two later, when the situation may be worse, you'll have to do the work anyway. The benefits of seeing them at the end is that actually you can be very quick with them because*

they know they've missed their 10 minute appointment slot. Now I discovered a few weeks ago that the staff had been getting mixed messages from the partner, who we hadn't discussed this [with], who just thought it was like before when he worked previously which is if they missed their appointment tough, you know, they make another appointment."

Participant 14 (GP Partner), line 153

5.10 The patient

Perhaps one of the most surprising findings from the research is the absence of staff giving consideration to the patient's perspective in most of the responses, with the exception of the explicit focus upon health inequalities. Although a number of staff mentioned the public's views in passing, few commented directly on their perspective and involvement in the way care was organised. This was summed up by one community nurse who, when asked about how the organisation of practices could be improved to benefit the patient, was clear that patients already got a good deal and felt there wasn't much more that could be offered:

"Well I don't think patients could ask for anything more than they have got. They have got late night openings, they have got early morning surgeries, they have got ability to be seen on the day, they have got ability for phone consultations, and prescriptions can be ready same day if required. So I think that practice itself has probably got a model that should be what the public would expect from every practice, but I don't know if that practice could give any more."

Participant 20, line 25

Other reflections suggested that some groups of patients, particularly those who were housebound, were not receiving equitable care, because home visiting wasn't cost-effective in the new business paradigm within which practices were operating. One community nurse summed up that patients were in general loyal, and described why older housebound patients wouldn't necessarily move practice to get better services:

> *"I think that for the older people they put up with all the rubbish of not being able to get a house call. Patients seem to be very loyal. I have only had a couple of patients, or I have seen a couple, probably a handful that have said I am not putting up with this anymore."*
>
> ***Participant 20 (Community Nurse), line 97***

Staff didn't think that most patients had any idea that practices were independent contractors, or that they were making business decisions about which services to offer. One primary care manager described her experience of patients realising that these tensions were affecting the organisation of care:

> *"Most patients don't even realise their general practices are independent contractors. They are completely shocked that their GP is having to make business based decisions that will affect patient care….it's the thing that [dare] not speak its [name]."*
>
> ***Participant 4 (Primary Care Manager), line 734***

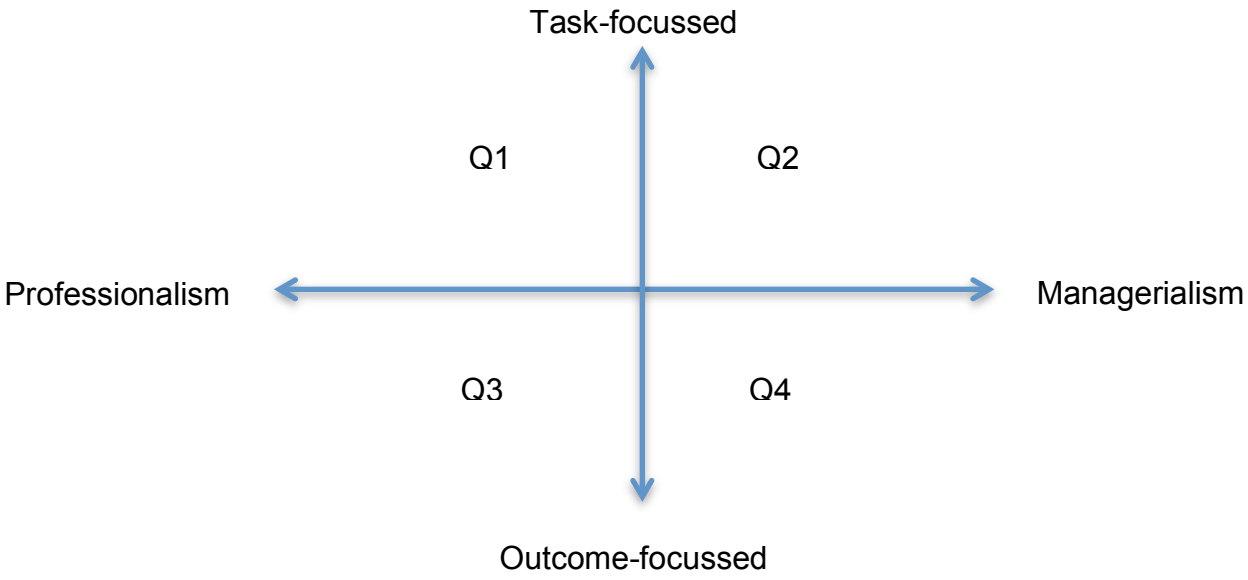
5.11 Understanding the tensions in primary care

The evidence provided by the participants clearly establishes the confusion around the roles and purpose of primary care, the lack of leadership around the primary care agenda, the tension between professionalism and managerialism, and between providing a process or an outcome-focussed service. The interplay between professionalism and managerialism and between process or outcome-focussed care can be considered using a framework provided by Iliffe (165) in which he describes trends in the development of British general practice as a process of industrialisation, moving from autonomous practice franchises to increasing incorporation into larger entities, with services being controlled by the market, albeit an industrial market within the UK, in comparison to a business market within the US (see literature review).

From the themes in the research, it is possible to revise the two axes as professionalism versus managerialism; and task-focussed versus outcome-focussed activity (shown in Figure 5.12). These influences shape the nature of

general practices. The industrialisation described by Iliffe, moving towards larger entities was fundamentally driven by market philosophy and the managerial imperative. It could be argued that both of these drivers are a manifestation of modernism and reductionism. As such, the change to Iliffe's original axis of autonomy versus incorporation can be viewed as the tension between the complex, and internally governed notion of professionalism and the modernist alternative of managerialism. In contrast, rather than the influence of different markets, the investigator proposes that the purpose of primary care, with a focus on either discrete tasks or outcomes is a major theme which needs to be considered.

Figure 5.1 Operational elements shaping practices. Practices are driven by governance which is a tension between professionalism and managerialism. Practice are influenced by the balance between being task or outcome-focussed.



The current models in place within primary care medical services are unclear, and although it might be tempting to suggest that post nGMS, the model operating occupies quadrant 2 (managerial and task-focussed), many other influences can be seen in the participants' views. The four quadrants each represent a particular combination of the dominant ideology governing a practice and the focus of activity within it. Quadrant 1 represents the technical general practice, analogous to specialist medical care, with professional governance and a focus on technical processes. Quadrant 2 is the managerial/technical practice, driven by business

rules, influenced by profit with an emphasis on delivering technical efficiency around an agreed set of tasks, as set out for example by the QOF of the nGMS contract.

Quadrant 3 is the professionally driven, outcome-focussed practice which focusses on maximising health for patients, driven by professional consensus and governance. Finally, Quadrant 4 is the managerial outcomes-focussed practice in which managerial business processes predominate over professional governance, with the practice focussing on maximising health outcomes for patients and profit/efficiency, rather than focussing on tasks.

Chapter six: identifying alternative models of primary care

This short chapter sets out the process through which the author integrated the findings from the historical perspective and literature review, public priorities event and interviews with primary care staff in order to select two alternative models for use in the next phase of the research.

6.1 What are the alternative models?

The investigator used the findings from the staff interviews to develop alternative models for primary care which might solve some of the issues identified. In doing this, he used the initial model descriptor used to inform the literature review chapter. Any alternative model should therefore meet the following criteria:

- the model should be generalisable to the whole population as is the current situation in Scotland;
- the scope of conditions covered should be universal, covering primary care for all those who are, or believe themselves to be ill, including acute and chronic conditions and health improvement;
- the model must specify the staff or skills necessary for operation and their inter-relationships;

- it should have a clear method of funding and provide clarity about how work is organised; and
- there should be clear governance to ensure safety and quality.

6.2 The public's priorities

Work with the public participants (chapter four) suggested a focus on better communication with patients and service users, access to services, resources, attaining value for money and ensuring that services remained free. There was also a prominence given to equity. In addition, some participants expressed concern about the dual role of the GP as both doctor and business owner. Holism was seen as central to the future of primary care.

Quality of care and good communication skills were seen as important. The participants also believed that GPs and other practice staff should empower patients to become involved in their own care and to encourage them to take responsibility for their health. The scenarios demonstrated a desire for meaningful engagement between patients and practices in order to ensure patients had a voice, not just in their own care, but in the organisation of practices. Preventing illness was also seen as a significant task.

6.3 Consensus findings from the staff interviews

The staff interviews provided some clear consensus views around staff preferences for any future models to provide general medical services in Scotland. Perhaps the clearest consensus was that participants overwhelmingly valued independence in preference to a salaried service because of the improved levels of autonomy, flexibility of decision-making, and more convivial culture and atmosphere. Participants generally saw the future as practice-based, with practices providing comprehensive, continuous, co-ordinated services to registered patients. A small number of staff expressed concerns about oversight and the protection of individuals within smaller organisations, so future models would need to balance their independence with safeguards on professional and managerial conduct.

A further finding was the strong desire for staff to be involved in decisions affecting their practice and the way in which services were delivered. This was true of GP partners and salaried staff alike, with all participants seeking a greater sense of being consulted and being responsible for the way in which the practice was organised and run. There was a sense that partnership lacked transparency and fairness with financial rewards (and losses) being reserved for a small proportion of those contributing to the service.

Practices needed to be able to set their own priorities, based upon a robust assessment of health inequalities as a core outcome for general practices and there was some evidence that staff wanted to have stronger links to their local communities in order to be able to tackle local health priorities.

There was clear evidence that staff saw skillmix as an important element of the future organisation of primary medical services, but that this required clarity on ensuring that staff worked within their own competence. There was a lack of clarity on how staff would work together in a more developed skillmixed team. There was a consensus for better and stronger links to a greater number of disciplines within the practice team, including health visitors, district nurses, mental health and addictions staff. Some staff held the view that it made more sense to embed more of these roles within the independent practice team rather than continuing with the confusion of practice staff and aligned staff, with competing management and governance structures.

There was a lack of patient perspective in the organisation of primary care. Staff commented on patients not being informed about the organisation of care, or that patients had little ability to make changes. Although not explicitly stated, it seemed clear that in any future models, patients should have greater influence.

Although staff felt that the QOF processes had brought benefits, there was a sense that the focus had moved away from outcomes for patients and towards the completion of processes and tasks for practices. Most staff felt that this needed to be adressed and that practices should deliver competent processes, which represented a basic level of quality and that in addition, there should be a greater emphasis on meeting the needs of the patient in terms of health outcomes including that of the overall patient experience.

There was a general concern about profit-making within independent practices. Most staff were uncomfortable with profit in general, although a few felt that it was an acceptable way of running an independent entity, pointing out that profits or losses could be made. A few staff reflected that greater transparency and profit-sharing with practice staff and the local community might be a way forward in a future model, ensuring that the beneficial incentives associated with profit could be maintained with a reduced risk of negative issues such as profit-taking and the potential for profit to be placed before quality and access to services.

Finally, there was a sense that the tension between professionalism and managerialism had been very damaging for all concerned. Staff reflected on this tension. It seemed sensible that any future model should combine and balance the professional and the managerial perspective in a more collaborative and respectful manner.

Through reflection on these findings, the investigator developed two alternative models for primary care medical services which could be considered against the status quo by both representatives of the public and by the staff participants.

6.4 Status quo: the General Medical Services contract (GMS)

In order to consider alternative models, it was important to define the status quo. Allowing for variation, the vast majority of practices in Scotland are based upon the new (2004) GMS contact. This contract includes:

- providing essential primary medical services to registered patients who are, or believe themselves to be ill;
- additional services such as child health, immunisation, cervical screening, minor surgery and antenatal care (unless opted out);
- out of hours care (unless opted out); and
- a small number of enhanced services, mostly to national standards, with a small number of local enhancements.

A substantial proportion of income in the GMS contract comes for QOF points earned against tasks performed around chronic disease management. The GMS

model was summarised in a manner which would be understandable to both primary care staff and public representatives. The content presented is summarised in Table 6.1.

Table 6.1 Synopsis of the attributes of Model 1 (the status quo).

What is the core GMS team?	The average GMS team in Scotland comprises 3 GPs; 2 nurses; reception and administration staff; and a manager.
What is the wider primary care team?	The wider primary care team includes health board and community pharmacists; local opticians; district nurses and health visitors who work closely with the practice; a podiatrist; physiotherapists; and a community psychiatric nurse. These staff are not employed by the practice; they are either employed by or contracted to the health board.
Wider services	Wider services available via the practice include access to hospital services; mental health services; addictions services. In addition, patients may be put in contact with social services and other community services as required.
What do GMS practices do?	Practices assess patients who are, or believe themselves to be ill; manage chronic disease; decide who would benefit from further investigation or specialist treatment by other health services; and certify illness for employers or the benefits agency.
How is quality ensured?	The technical processes of care are measured using the Quality Outcomes Framework and there are local checks on the claims made by practices. There are some process-based measures to attempt to ensure holistic care. Patient involvement can be rewarded under the QOF and practices are obliged to have robust complaints procedures for when things go wrong.

Cost and management issues in GMS	Practices are independent businesses contracting with the NHS. Two thirds of income is historically guaranteed, with around one third being related to tasks completed via the QOF. There are a small number of local enhanced services which are optional for the practice. Most practices employ a manager. The practice is usually owned by a small group of GPs who are partners, who share the profits of the business and make decisions about how the practice is run, including how profits are used.
Summary	The GMS contract is nationally negotiated by the GP profession and the UK Government. Practices are predominantly run by GPs with a small number of nurses and other staff. The wider primary care team and community services are managed by CHP and Board managers, or are independent contractors.

6.5 Personal Medical Services Plus (PMS Plus)

The PMS Plus model was an existing model for practices which was considered a viable alternative which might address some of the difficulties identified through the participant interviews. PMS is a locally negotiated, locally managed contract. It covers the elements addressed through GMS, but local negotiation allows greater flexibility to tailor the scope of practice to meet local needs. PMS Plus allows the practice to deliver services usually delivered through wider community services, secondary or social care.

The model was also described according to the six domains used for the GMS model: what is the core team; what is the wider primary care team; what is provided through wider services; what do the practices do; how is quality ensured; and how are the cost and management issues addressed. The content presented is summarised in Table 6.2.

Table 6.2 Synopsis of the attributes of Model 2 (PMS Plus).

What is the core PMS Plus team?	The PMS Plus has no average team composition, but might include a wider skillmix of GPs (salaried and partners); nurses, including extended nurse practitioner roles; reception and administration staff; a practice manager; and additional roles which might include district nurses and health visitors; and addictions staff.
What is the wider primary care team?	The wider primary care team would be adjusted to take account of the additional skillmix included within the core practice team.
Wider services	As with the wider primary care team, the wider services available would be adjusted to allow for additional roles which may have been embedded within the core team.
What do PMS Plus practices do?	As before, practices provide core care to those who are or believe themselves to be ill and manage chronic disease. They also decide upon the need for specialist investigation and treatment and certify illness. They may also take on additional community or secondary care services which are negotiated and included on the basis of the levels of need within the practice community.
How is quality ensured?	Quality is ensured via local checks on claims against a locally negotiated set of outcomes. Patient involvement may be set at the level of GMS, although the local flexibility might include additional roles and involvement of patients as part of the negotiated contract.

Cost and management issues in PMS Plus	Practices remain independent, private businesses, but are contracted locally in a manner which explicitly links objectives with local assessment of needs. Participation in QOF is optional, but some elements may be included dependent upon the prevalence of the need within the practice. Practices are owned by partners who are mainly GPs, but there may be an employed practice manager. Partners share the profits of the partnerships.
Summary	This is a locally negotiated and locally managed practice which seeks to match resources and outcomes with identified needs. There is the potential to transfer staff roles from the wider primary care, community and secondary care team into the core practice team.

This model retained independence and the practice entity and allowed greater flexibility for local needs to be reflected within the contract objectives. This model might improve the ability of a practice to address health inequalities. The introduction of novel roles within the practice team might also support a mature skillmix within the team. Quality processes were managed in a similar fashion to existing GMS arrangements, although the fact that objectives are locally designed increased their relevance. Finally, the local negotiation and agreement created may have the benefit of improving the balance between managerial and professional approaches and relationships between the practice and CHP/Board. The relationship between the PMS Plus model and the issues identified through the semistructured interviews is set out in Table 6.3.

Table 6.3 Extent to which the PMS Plus model addresses the challenges identified with the extant GMS practice model

Objective identified	Objective addressed
Independence	✓
Safeguards on professional and managerial behaviour	✖
Staff involvement in decision-making	✓
Focus on local needs and priorities	✓
Wider and clearer skillmix	✓

Improved patient involvement	✖
More patient outcome-focussed	✓
Address concerns around profit	✖
Ensure a respectful balance between professionalism and managerialism	✓

6.6 The Social Enterprise Practice (SEP)

The Social Enterprise Partnership was suggested by a GP participant. As stated in the literature review, social enterprise has been promoted by the UK Government as an alternative organisation for the delivery of healthcare. The main strength of social enterprise is the strong role for community governance. The model is a locally negotiated and managed model, based upon local assessment of practice community needs.

As for PMS Plus, the model is therefore described according to the six domains: what is the core team; what is the wider primary care team; what is provided through wider services; what do the practices do; how is quality ensured; and how are the cost and management issues addressed. The content presented is summarised in Table 6.4.

Table 6.4 Synopsis of the attributes of Model 3 (SEP).

What is the core SEP team	As with the PMS Plus model, there is no standard practice configuration, but most practices will contain GPs, nurses, extended nurse practitioners, reception/administration staff and a manager. Some will include health visitors and district nurses as well as community psychiatric nurses. Some SEPs may also include community workers, addictions staff or parenting support workers, depending on the needs of the practice population and community
What is the wider primary care team?	As with the PMS Plus model, the primary care team is adjusted to take account of staff roles transferred into the practice team in order to meet the needs of the practice community

Wider services	Wider services are unchanged, but take account of community and specialist roles transferred into the core SEP team.
What do SEP practices do?	In addition to acute and chronic care and the provision of specialist services within the practice, or referral to specialist services in secondary care, the practice has an explicit role to improve the health outcomes of individuals and the community, and to reduce the impact of local factors influencing health
How is quality ensured?	Quality is ensured via standard processes to ensure the locally agreed outcomes are achieved. The outcomes are locally negotiated to take account of local needs. Many of the outcomes are focussed less on processes and more on health outcomes and behaviours with a greater emphasis on holism and the patient experience. Patient representatives have a central role in the negotiation of the contract and play a part in the governance of the practice, ensuring scrutiny of decision-making and financial arrangements. SEPs have the usual arrangements for when there are complaints, however, patients' representatives have a place on the partnership board which runs the practice
Cost and management issues in SEP	The SEP model operates via community governance, in which patients and the local community have a significant role in the negotiation of the local contract, which is informed by an assessment of local needs. Patients and the community also have ongoing roles in the governance and oversight of the running of the practice. There is also an agreement to regulate profit within the practice, so that there is profit-sharing across all the staff within the practice who are all partners. There is an agreement which allows profit to act as an incentive to effective and efficient performance, but with a share of the profits being shared

	across the local community. The practice is run using SEP principles which aim to build the local community.
Summary	SEP is a locally negotiated and managed model informed by an assessment of local need in which there is robust patient and community representation in the ongoing governance of the practice. All staff are profit-sharing partners, but decision-making and profits are constrained by patient and community scrutiny combined with a profit-sharing agreement with the local community.

The extent to which the SEP model meets the issues identified in the interviews is set out in Table 6.5.

Table 6.5 Extent to which the SEP model addresses the challenges identified with the extant GMS practice model

Objective identified	Objective addressed
Independence	✓
Safeguards on professional and managerial behaviour	✓
Staff involvement in decision-making	✓
Focus on local needs and priorities	✓
Wider and clearer skillmix	✓
Improved patient involvement	✓
More patient outcome-focussed	✓
Address concerns around profit	✓
Ensure a respectful balance between professionalism and managerialism	✓

Chapter seven: the public's assessment of three models of primary care

This chapter built on previous work with members of the public. Priorities identified in the prior work in chapter four were discussed and agreed, creating a tool to facilitate deliberation on alternative models for the provision of primary care general medical services. Two alternative models of general practice (developed in chapter six) were presented and those attending were asked to discuss and score the relative merits of these models and the status quo against the agreed criteria. The results suggested that quality of care, communication and access were the top priorities for future models of care. The participants preferred a social enterprise model to the status quo and to a local contract model. The social enterprise model had significantly higher performance scores for patient influence, involvement, holism, improving health, joined-up services, continuity, and wider benefit to society. The participants were generally supportive of the process used to compare models which appeared to have face validity.

7.1 Methods

The principal aim was to explore how members of the public would view the alternative models of primary care in comparison with the status quo. In addition, the process used was designed to capture how well the models fitted with the values and priorities identified through previous work (see chapter four).

The event had a number of specific objectives:

1. to weight the relative importance of a number of previously determined priorities for any future primary care model;
2. to present, discuss and score alternative models of primary care against the priorities in order to create a numerical ranking of the models;
3. to explore the participants' views of each of the models; and
4. to seek the views of the participants on the face validity and acceptability of this approach in exploring alternative service models.

Detailed methods can be found in chapter three section 3.5.1.

7.2 Participants

Each of the Public Partnership Fora was invited to send 5 public representatives to one of 3 meetings organised. 29 participants attended. The detailed characteristics of participants were requested on feedback sheets. Of the 29 participants, 19 feedback sheets were received. From this feedback, all of the PPF areas were represented with the exception of Inverclyde and East Renfrewshire. There were representatives from each socioeconomic quintile (Scottish Index of Multiple Deprivation, 2009). The majority of the respondents were retired and were in the age band 60-79. Detailed tables describing the age, employment, geographic and area-based socioeconomic status of the respondents are found in Table 7.1. Two participants had disabilities for which they requested assistance. One had visual and hearing impairment and was supported through the use of a loop amplification system and supporter who helped with the completion of paperwork. Another participant had learning disability, visual and hearing impairment and was supported through additional discussion with the author and the use of the loop amplification system.

7.3.1 Weighting the priority domains

The twelve priorities identified through the public prioritisation event were discussed and scored by the participants. These are reproduced in Table 7.2. Despite the opportunity to record non-integer scores, the vast majority of scores were integers. Although there was significant variation between the domain scores, the overall scores were compressed between a median of 3.5 and 5.0, and a mean of 3.62 and 4.62. The majority of the scored domains demonstrated a degree of negative skewness (see Table A2.1 Appendix 2). The range varied from 2 to 4 with the minimum score being 1 and the maximum 5. The majority of the distributions were unimodal with acceptable levels of skewness towards higher scores. Taking the mean as the measure of centrality, the ranking order of the second round of scoring (post discussion) is shown in Table 7.3. The highest weightings overall were for quality of care, communication and access. A second group included involvement, equity, improving health, holistic care, continuity of care and patient influence within the practice. The lowest scoring domains included joining-up services, taking a wider perspective in the community and the cost of services.

Table 7.1 Respondents categorised by geography[***], socioeconomic status[†††], employment status, age-group and gender.

Geographic area	Number of Participants
Not known	6
North West Glasgow*	6
North East Glasgow*	1
South Glasgow*	4
Renfrewshire	3
East Dunbartonshire	3
West Dunbartonshire	2

SIMD quintile (2009)	Number of Participants
1 (most deprived)	5
2	1
3	3
4	3
5 (most affluent)	6

Employment response	Number of Participants
Employed	3
Retired	15
Did not answer	1

Age band	Number of Participants
30-44	1
45-59	2
60-79	11
80+	3
Did not answer	2

Gender	Number of Participants
Male	11
Female	8

*During the course of the study the five Glasgow Community Health and Care Partnerships were reorganised into three CHP areas: North West, North East and South Glasgow. The participants are described according to their revised geographic area.

††† Scottish Index of Multiple Deprivation (2009)

Although there were some minor changes in the scoring between round 1 and round 2, the 3 groups did not change and there were no significant differences between the first and second rounds of scoring (see Appendix 2 Table A2.2).

Table 7.2 Priority domains for models of general practice.

Domain	Description
Patient influence	How well are practices held to account by patients for the quality of services offered? Are patients able to bring about change when standards are not acceptable?
Cost	How high is the cost for the taxpayer to fund care?
Involvement of patients and carers	To what extent are patients and carers involved in clinical decision-making?
Equity	How well does the practice respond to people with different levels of need to try to ensure suitable access and services to try to bring about equal health for different groups?
Access to care	How easy is it to get access to services? Can patients easily make appointments? Is it easy to get to the practice and does it have good access for disabled people?
Holistic care	Does the practice work with and treat the whole person rather than simply responding to the patient's individual problems?
Quality of care	Does the practice ensure a high standard of care is provided? For example, does it provide good care for people with diabetes and heart disease, and does it store and share personal information properly?
Improving health	How well does the practice try to promote and improve health as opposed to only treating existing illness?
Communication	Is the practice good at communicating with patients, each other, and other services? For example, contacting hospital about patient referrals, sending newsletters, informing patients of test results?
Joined-up services	Does the practice try to join-up care offered by other services? For example by offering space for physiotherapy within the practice?
Continuity	How well does the practice ensure continuity of care?
Wider benefit to society	Does the practice try to bring wider benefit to the local community and to wider society? For example by contributing to community initiatives, linking to other local services such as social work or employment training?

Table 7.3 Weighting of priority domains for general practice (second round of scoring) with median and mean scores. N=26.

Priority	*Median*	*Mean*
Quality	5	4.62
Communication	5	4.62
Access	5	4.5
Involvement in care	4.5	4.38
Equity	5	4.31
Improving health	4	4.23
Holistic care	5	4.19
Continuity of care	5	4.19
Patient Influence	4	4
Joined-up care	4	3.75
Wider benefit	3.5	3.62
Cost	3	3.21

7.3.2 Understanding the priorities

The participants' comments validated the priorities from the previous PPF event, giving clear examples of what these priorities would mean for them. There were no comments which suggested that the priorities were incorrect. Participants mentioned a number of the specific domains, however a large number mentioned the importance of holism in general practice, having a clear understanding that this would mean *"treating the patient as a person*" and emphasising that *"[the] patient must be seen as an individual, not just a unit"*.

A few participants spoke of the importance of patient influence within the practice. One participant felt that this was an important, but often misunderstood issue. They believed that it was both right and necessary for patients to exert influence over their own care and the way services were organised, describing this as the flip-side of rights: *"with patient rights come patient responsibilities"*. This idea was linked to comments about the lack of willingness of patients to fully participate in taking such responsibility either in their own care, or for the organisation of services.

7.4 Assessing the performance of the current model

7.4.1 Scoring the performance of the current model

The most highly scored domains in the current model included quality and access. A second group of domains included joining services, continuity, communication, and improving health. The lowest scoring domains in the model included equity, holism, involvement, wider benefit to the community, cost and patient influence. The ranking of the performance scores based upon the mean score is shown in Table 7.4.

The characteristics of the distributions of the performance scoring are summarised in Table A2.3 of Appendix 2. The first model (the status quo) received the highest performance scores for quality, access and joining up services. A further group of intermediate scores included continuity of care, communication, improving health, and addressing equity in health. The lower-scoring domains included holism, involvement, wider perspective in the community, patients' influence within the practice and the cost of services (where lower scoring was interpreted as the service being costly). There was little change between the first and second rounds of scoring in terms of ranking and there were no significant differences statistically (Table A2.4, see Appendix 2).

Table 7.4 Performance scores for model 1 of general practice (second round of scoring) with median and mean scores.

Priority	*Median*	*Mean*
Quality	80	72.4
Access	75	67.36
Joinedup services	70	66.8
Continuity	70	63.8
Communication	60	63.2
Improve	60	62.8
Equity	60	59.6
Holistic	50	51.88
Involve	50	48.96
Wider	50	46.44
Influence	50	45.48
Cost	45	43.35

In order to take account of the relative importance of different domains, each participant's weighting scores for each domain was multiplied by their performance score, giving a weighted performance score. The weighted

performance scores for Model 1 are shown in Table 7.5. The detailed distributions of the weighted performance scores per domain are shown in the appendix. There was a relatively minor impact on the overall grouping of scores in terms of ranking following the weighting process. (Table A2.5 of Appendix 2).

By adding the weighted performance scores for each participant, a cumulative weighted performance score was calculated, giving an overall numerical estimate of how the participant rated the performance of the model overall. The final distribution of scores from the participants had a range of 2978; a minimum of 1732 and a maximum of 4710; a median of 2670; a mean of 2907.73; and a standard deviation of 919.09. The maximum possible cumulative, weighted performance score for the model was 6000. Therefore expressing the performance of the current model in terms of the maximum possible score, the median was 45% and the mean 48%. The histogram for the distribution is shown as Figure A2.1 in the appendix.

Table 7.5 Weighted performance scores for Model 1 (participant's domain weighting score multiplied by the participant's performance score for Model 1). The cumulative score is the arithmetic sum of all 12 weighted performance scores for each participant.

Priority	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Quality	350	339.2	101.774	-0.741	0.472
Access	320	305.4	108.065	-0.181	0.472
Comms	252.5	289	120.524	0.297	0.472
Improve	280	275.4	102.139	0.336	0.472
Continuity	240	273.1	129.579	0.529	0.472
Equity	240	252.5	108.967	0.847	0.472
Join	250	246.7	112.787	0.407	0.472
Involve	245	224.5	131.858	0.193	0.472
Holistic	180	220.2	139.451	0.778	0.472
Influence	160	182.6	126.838	0.652	0.472
Wider	155	179.4	116.472	0.43	0.472
Cost	100	146.6	142.762	1.409	0.524
Cumulative Total	2670	2908	919.095	0.434	0.524

7.4.2 Understanding the scoring of the performance of the current model

A large number of specific concerns about participants' own experiences of practice were written down. The majority of these related to two themes: a lack of

flexibility in practice processes (such as the provision of house calls) or a lack of holistic care, with patients being seen as a collection of individual tasks or problems, rather than as an individual. Some participants felt that the lack of holism was due to practices having a lack of time to link things together for patients. One participant felt that the problem had more to do with the practice's world view and priority – the practice or the patients:

> *"[We] need a more bottom-up approach. More patient perspective."*

Participants described the current model *as "good overall, but not perfect"* and *"generally just satisfactory, but improving"* citing the improvements which some had seen over the past 20 or 30 years. The incremental change was seen as a slow process, driven by a small number of leaders in practices.

A common theme raised was variation in approach and in quality across practices. Some participants were surprised by just how great the variability in provision was, with one participant writing:

> *"I have been with my practice for over 30 years, but after today I'm going to change [practice]".*

Participants had a clear understanding of the possible causes of the variations which were underpinned by skills, resources, aspirations and on *"what is communicated to the public by the wider NHS, politicians and others"*. This theme of varying expectation across patients and others was seen as just as important as the variation in quality and other domains.

7.5 Assessing the performance of a local contract model

7.5.1 Scoring the potential performance of a local contract model

As with Model 1, the participants viewed a structured presentation about Model 2, and were asked to score the potential performance of the Model within the domains. Participants then received some feedback of comments and there was time for plenary discussion before they were asked to re-score and provide written feedback if they wished. The performance scores ran from 1 (very low level of

performance) to 100 (very high level of performance). The unweighted performance scores are ranked in Table 7.6. Unlike Model 1, the majority of the domains exhibited significant negative skewness. The highest scoring domains for Model 2 included quality of care, access, communication, equity and holism. The intermediate scores were for the domains improving health, continuity of care, patient influence and involvement, joining-up care and taking a wider perspective within the community. The lowest scoring domain for this model was cost. The details of the distributions and the histograms are contained in the appendix (Table A2.6 in appendix IV). There were no significant differences between rounds 1 and 2 of scoring (see Table A2.7 of the appendix).

Table 7.6 Unweighted performance scores (second round of scoring) for Model 2 (local contract)

Priority	*Median*	*Mean*
Quality	80	73.2
Access	80	72.8
Comms	80	72.2
Equity	79	71.04
Holistic	75	70.4
Improve	80	68.6
Continuity	70	67.4
Influence	70	67.08
Involve	70	67
Join	70	66.28
Wider	75	65.84
Cost	46.83	46.91

The weighted performance scores for Model 2 were calculated by multiplying each participant's domain weighting score by their respective model domain performance score. The distributions of these weighted performance scores are shown in Table 7.7 (full distributions of data, see Table A2.8 of Appendix 2). The impact of weighting the performance scores had no effect on the grouping of performance scores.

Table 7.7 Weighted performance scores (second round) for Model 2 (local contract).

Priority	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Access	355	340.2	108.35	-1.102	0.472
Quality	355	336.66	104.75	-0.891	0.472
Comms	360	333.33	112.08	-1.069	0.472
Equity	300	315	106.04	-1.242	0.472
Holistic	295	300.41	117.85	-0.042	0.472
Improve	300	297.5	113.6	-0.147	0.472
Involve	290	292.7	90.12	0.192	0.472
Continuity	285	286.87	122.06	0.002	0.472
Influence	262.5	265.16	109.97	-0.102	0.472
Join	260	250.52	125.79	-0.278	0.472
Wider	232.5	239.45	107.34	0.07	0.472
Cost	100	173.16	154.39	0.809	0.501
Cumulative Total	3401	3399.52	889.54	-0.277	0.501

The cumulative weighted performance score for Model 2 had a range of 3180; a minimum of 1700 and a maximum of 4880; a median of 3401; a mean of 3399.52; and a standard deviation of 889.54. The maximum possible cumulative, weighted performance score for the model was 6000. Therefore expressing the performance of the current model in terms of the maximum possible score, the median and mean was 56.6 %. The histogram for the distribution is shown as Figure A2.2 in Appendix 2.

7.5.2 Understanding the scoring of the performance of a local contract model

The majority of the participants had a secure understanding of the proposed model, and were clear that the main benefits were around the ability to better match resources to local needs. Many felt that the model was an improvement on the status quo because it enhanced practices' ability to tailor care to specific groups and took a wider perspective on health, attempting to join-up services and deliver holistic care:

> *"This model is a big improvement [c.f. model 1] – more community and patient involvement – more listening to patients. It needs to be person-centred."*

In contrast, other participants saw this model as little changed from the status quo, except for the better ability to address local needs. There was some concern that the model might not achieve its potential because practice staff would continue to work in a traditional manner, making holism difficult:

> *"Staff might still work to traditional models, therefore [it might] not necessarily be better [at ensuring] a holistic approach."*

One participant raised the question of how local needs would be identified and agreed. In their view, there was a tension between the needs seen through a professional perspective, and those seen as important by patients:

> *"Who determines local needs: the professional/medical staff or with patients?"*

A participant commented positively on the model's ability to join-up services, but reflected that patients might need additional help to navigate the changes to services traditionally seen as external to the practice:

> *"Getting better, but patients might need help in navigating the system".*

Several participants thought that the model provided opportunity for practices to cherry-pick both patients and services on the basis of cost:

> *"GPs may offer easy, cheaper services…….practice could cherry-pick patients who are most cost-effective."*

As with model 1, participants found cost difficult to judge.

7.6 Assessing the performance of a social enterprise model

Participants viewed a structured presentation about Model 3, and were asked to score the potential performance of the model within the domains. Participants then received some feedback of comments and there was time for plenary discussion before they were asked to re-score and provide written feedback if they wished. The performance scores ran from 1 (very low level of performance) to 100

(very high level of performance). The unweighted performance scores are ranked in Table 7.8.

As with Model 2, a number of the domains exhibited significant negative skewness. The highest scoring domains for Model 3 included improving health, continuity of care, and communication. The intermediate scores were for the domains patient involvement, wider benefit, access, joining-up care, holism and patient influence. The lowest scoring domains for this model were quality, equity and cost. The details of the distributions are contained in the appendix (Table A2.9). There were no significant differences between rounds 1 and 2 of scoring (see Table A2.10 of the appendix).

The weighted performance domains for Model 3 are shown in Table 7.9. The full distributions are shown in Table A2.11 Appendix 2. The effect of weighting the domains moved quality into the high-scoring group, but moved wider perspective into the low-scoring group.

Table 7.8 Unweighted performance scores for Model 3 (social enterprise model)

Priority	*Median*	*Mean*
Improve	90	83.81
Continuity	86	81.85
Comms	86	81.24
Involve	90	80.95
Wider	85	80.33
Access	80	80.24
Join	90	79.14
Holistic	80	79.1
Influence	80	79.05
Quality	80	76.19
Equity	80	75.71
Cost	65	59.71

Table 7.9 Weighted performance domains for Model 3 (social enterprise)

Priority	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Comms	430	390	100.82	-1.336	0.524
Access	400	376.57	95.68	-0.660	0.524
Quality	400	368.94	110.84	-1.585	0.524
Improve	360	368.42	96.95	-0.430	0.524
Involve	375	356.57	101.92	-1.068	0.524
Continuity	400	352.94	129.24	-0.768	0.524
Holistic	360	346.26	96.95	-0.086	0.524
Equity	350	334.73	93.19	-0.458	0.524
Influence	360	315	121.2	-0.432	0.524
Join	320	295.13	135.81	-0.317	0.524
Wider	270	289.1	128.06	-0.123	0.524
Cost	210	208.21	135.13	0.211	0.524
Cumulative Total	4315	4001.92	916.21	-1.231	0.524

The cumulative weighted performance score for Model 3 had a range of 3279; a minimum of 1816 and a maximum of 5095; a median of 4315; a mean of 4001.92; and a standard deviation of 916.21. The maximum possible cumulative, weighted performance score for the model was 6000. Therefore expressing the performance of the current model in terms of the maximum possible score, the median was 71.9% and mean was 66.7 %. The histogram for the distribution is shown as Figure A2.3 in the appendix.

7.6.2 Understanding the scoring of the performance of a local contract model

There was general support for this model, but a number of participants felt that it was difficult to assess the overall impact, reflecting the scale of change within the model:

> *"This is a good model for primary care, but here are too many variables, e.g. the amount of people involved, and patients confidence in nurse practitioners for example……..Very difficult to guestimate, but I'm sure its not impossible. It needs a whole new way of thinking, planning and educating the public and professionals."*

One participant felt that the model was a good way of tailoring services to specific groups, such as those with progressive illnesses, carers, and those who needed social support such as home care. Another participant wondered how easy it might be to reconcile conflicting priorities in this model:

> *"Would the management board be able to easily reconcile between possibly different priorities of national, board-wide and local needs?"*

Participants felt that the model would create a focus on the wider community and on health improvement. One participant saw it as clearly better than the previous models:

> *"Model 3 is an improvement on models 1 and 2. [There is a] greater focus on patient involvement at a more formal level and poor- health prevention [health improvement] measures."*

The participants had a significant focus on the impact that this model would have on relationships and the balance of power within the practice unit. In general, participants felt that GPs would not like the model as it reduced their power, as well as having an impact on their remuneration through widening profit sharing:

> *"Social enterprise is excellent, but I'm not sure GPs would agree."*

A number of participants commented that the changes in the balance of power within the practice might result in "*in-house bickering*". One participant felt that the model might act to reduce the power of the GPs, but conceded that this might be a mixed-blessing:

> *"It could diminish the political defensiveness role of the GP which I like when I agree with them, [and which I find] obstructive when I don't!"*

One participant reflected that this model did not necessarily reduce variability in the quality of services. They felt that the issues around choice, patient participation and the skill-set of those employed were significant issues:

> *"So much of this is dependent on who the practice employs and the services they choose to offer. Also, this is reliant on a good knowledgeable cross-section of patients being involved."*

A number of participants mentioned that although this model widened opportunities for patient participation, it went further in that there was a presumption that patients would participate fully. There was an implicit theme that patients may not have the appetite for this level of involvement:

> *"Once again, it would depend on how willing the patients/carers were in shouldering some responsibility for care."*

7.7 Comparing the relative performance of all three models

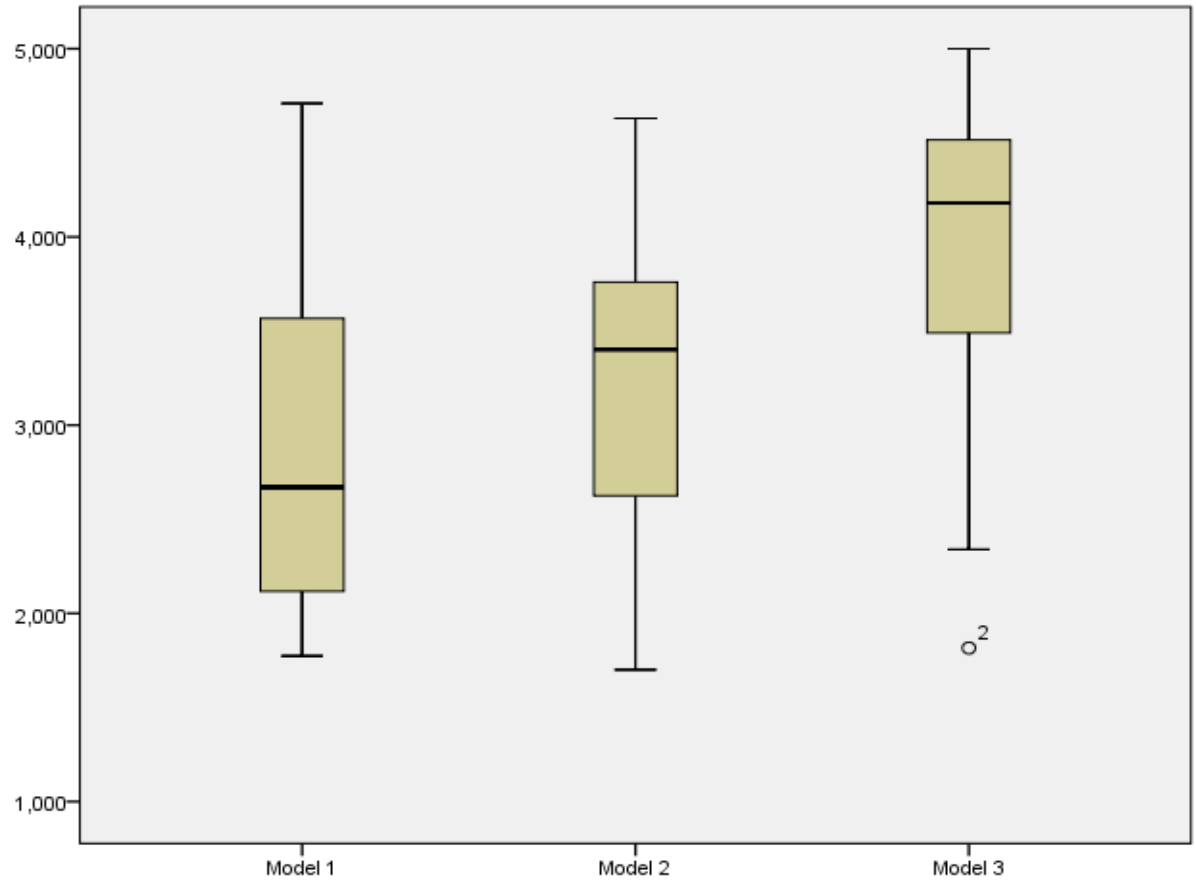
7.7.1 Overall cumulative performance

The purpose of the weighting, performance scoring and calculation of cumulative performance scores was to attempt to summarise the overall preferences for the 3 models using a quantitative approach. In short, the cumulative performance scores are shown in table 7.10. Given the level of skewness in the cumulative scores distribution for model 3, a nonparametric test of significance was chosen to test if there were any significant differences between the 3 distributions. Using Friedman's Related Samples Test for Two-Way analysis of variance by ranks, the null hypothesis was rejected (p=0.005), with there being significant differences between Model 1 and Model 3 (Wilcoxon Signed Ranks Test reached significance at p=0.001) and between Model 2 and Model 3 (p=0.006), though the null hypothesis was retained for the comparison between Model 1 and Model 2 (p=0.076). This is shown graphically in the boxplot in Figure 7.1.

Table 7.10 Distributions of the cumulative performance scores for the 3 models.

Model	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Model 1	2670	2907.73	919.09	0.434	0.524
Model 2	3401	3399.52	889.54	-0.277	0.501
Model 3	4315	4001.92	916.21	-1.231	0.524

Figure 7.1 Boxplot showing distributions of the cumulative weighted performance scores for Models 1, 2 and 3.



7.7.2 Comparing weighted scores between the three models

The differences between the weighted performance scores for the three models were tested for significance. There were significant differences between models for the domains: patient influence, involvement, holism, improving health, joined-up services, continuity, and wider benefit to society. These findings are summarised in Table 7.11.

Table 7.11 Summary of statistical tests of significance in weighted performance scores for individual domains between models.

Domain	Result of tests of significance
Patient influence	There was evidence that participants scored model 2 significantly higher in terms of patients influence than the status quo or Model 1 (p=0.003). The participants also scored Model 3 significantly higher than the status quo (p=0.000), however there was no significant difference between Models 2 and 3 (p=0.102, Repeated measures ANOVA with Bonferroni adjustment).
Cost	No significant differences (Related Samples Friedman's Two Way ANOVA by ranks, p=0.437)
Involvement of patients and carers	There was evidence of a significant difference in the scoring of patient involvement across the 3 models, with model 3 being the highest rates, followed by model 2 and finally the status quo. There was a significant difference between groups (Related Samples Friedman's Two Way ANOVA by ranks, p-0.000). Pairwise comparison using Wilcoxon Related Samples Signed Ranks Test confirmed significant differences between all 3 models: M1 v M2, p=0.006; M2 v M3, p=0.011; M1 v M3, p=0.000).
Equity	No significant differences (Related Samples Friedman's Two Way ANOVA by ranks, p=0.154)
Access to care	No significant differences (Related Samples Friedman's Two Way ANOVA by ranks, p=0.194)
Holistic care	There was a significantly higher score for holism in Model 3 in comparison with Model 1. There was a significant difference between Models 1 and 3 (Repeated measures ANOVA with Bonferroni adjustment, M1 v M2, p=0.196; M1 v M3, p=0.009; M2 v M3, p=0.318)
Quality of care	No significant differences (Related Samples Friedman's Two Way ANOVA by ranks, p=0.430)
Improving health	There was a significantly higher score for improving health in model 3 in comparison with model 1 and within model 3 in comparison with model 2, though not between models 1 and 2. There was a significant difference between Models 1 and 2, and between Models 2 and 3 (Repeated measures ANOVA with Bonferroni adjustment, M1 v M2, p=1.000; M1 v M3, p=0.003; M2 v M3, p=0.032)
Communication	No significant differences (Related Samples Friedman's Two Way ANOVA by ranks, p=0.060).
Joined-up services	There was a significantly higher score for model 3 in comparison with model 1. There was a significant difference between Models 1 and 3 (Repeated measures ANOVA with Bonferroni adjustment, M1 v M2, p=1.000; M1 v M3, p=0.050; M2 v M3, p=0.105).
Continuity	There was a significantly higher score in model 3 in comparison with model 1. There was a significant difference between Models 1 and 3 (Repeated measures ANOVA with Bonferroni adjustment, M1 v M2,

	p=1.000; M1 v M3, p=0.010; M2 v M3, p=0.054).
Wider benefit to society	There was a significantly higher score for wider benefit to society in model 3 in comparison with model 1 and in model 2 in comparison with model 1. There was a significant difference between Models 1 and 3, and between Models 1 and 2 (Repeated measures ANOVA with Bonferroni adjustment, M1 v M2, p=0.043; M1 v M3, p=0.001; M2 v M3, p=0.086).

7.8 Participants views about the process of weighting priorities and scoring models

During the plenary discussion, the participants felt that the scoring of the domains and the overall scores of the 3 models presented had produced results which fitted with their overall views.

19 of the 29 participants completed the questionnaire to explore participants' views of the research process in greater detail. Of those responding, 9 had been involved in the previous event which explored the future of general practice.

7.8.1 Participants' views of the scoring of the three models

Overall, participants agreed with the overall scoring hierarchy which saw model 3 scoring more highly than models 2 and 1.

The plenary discussion characterised model 3 as good overall, particularly because it had a greater patient involvement and influence and focus upon community health. There was a feeling that it would ensure that health needs were better met than the other models. However, the main challenges included the need to communicate effectively and the need to address the issue of profit. Whilst this model saw profit sharing and transparency as a way of addressing difficulties with profit seen in models 1 and 2, the participants had reservations about profit in general, and wondered if it might be possible to establish a further model without profit.

Other views saw that this model might be difficult to achieve, citing possible low GP buy-in as a problem for the model, which might be compounded if the incentive of profit were taken away entirely. This was summed up by the phrase *"it's like turkeys voting for Christmas"*.

Model 2 was seen as an improvement on model 1 in terms of equity – it was thought that it might better match resources and need. However, participants were concerned about the lack of patient influence in this model in comparison with model 3. Some participants were enthusiastic about this model as the information was thought to be available to allow a local contract to be developed, whilst others were concerned that a data-led approach might lead to uncommon conditions being marginalised. There were some general concerns about the lack of preventative healthcare in this model.

Model 1 was characterised by variable quality, and a general belief that the model did not promote holism. This was linked to time-poor consulting, a need for better communication and the desire for better training for all staff groups.

Overall, participants felt the process was a fair reflection of their views and sought to improve the role of patients in determining their own health and the shape of the services they needed. There was a consensus that services were inward looking, with little focus on the needs of patients. This was summed up by one participant who stated: "*today it's about services: tomorrow it's about patients."*

7.8.2 General comments

16 general comments were received. 13 comments described the event as very good, interesting or excellent:

> *"An interesting experience in which I was able to hear and make a contribution to the final result."*

In contrast, two respondents found the event difficult or confusing:

> *"Had difficulty in getting my head round answering some questions to different models."*

Some participants commented on the process of scoring. In general, the majority of comments suggested a clear understanding that the relative importance of the themes was being scored:

> *"Items graded 5 are considered essential. Other items with lower ratings reflect the importance in relation to the high scoring items."*

In contrast to this, one participant comments suggested that they had confused scoring importance with scoring performance (or achievement):

> *"In an ideal world we would achieve all 5s."*

Many of the participants struggled with the cost domain, summed up by the statement *"funding was difficult to grade"*.

7.8.3 Process

16 respondents provided a response to the question "did you find the process of considering different options helpful or unhelpful?" 13 of these responded positively. One participant said that they found the process quite confusing. This participant went on to describe disabilities which had been supported to facilitate participation.

7.8.4 Participant understanding

15 participants responded to the question "was it easy to understand the different parts of the process?" 14 responded positively, describing that they had good understanding or that it was well explained. One said that they did not have a good understanding. This respondent had a learning disability.

7.8.5 Face validity

16 participants responded to the question "did the results from the scoring fit with what people in the room were thinking?" 13 made comments which suggested good agreement. An example of such a comment was: *"Not too many surprises….general agreement amongst all".*

In contrast, 3 respondents said that they did not agree with the findings overall. Two simply stated *"no"* and *"not really"* and the third expressed surprise that model 2 scored more highly than model 1 (the status quo).

7.8.5 How to improve the process

13 participants responded to the question "how might we improve the process if we were to repeat it?" 5 participants suggested that the session should be longer to allow for more discussion. This was in contrast to one respondent who believed the session was too long. Other suggestions included increasing the number of participants, ensuring that participants represented a greater diversity of age and ethnicity, and one suggested that the session should include GPs and other primary care and social care professionals. One participant wanted written output from the session to help them remember the session.

7.9 Conclusions

Participants rated quality, communication and access as the highest priorities for primary care. These were followed by a second group which included patient involvement in their own care, health equity, health improvement, holism and continuity of care. The lowest priorities included patient influence, joined-up care, a wider community perspective and the cost of care.

The social enterprise model received a significantly higher overall score in comparison with the status quo, and a significantly higher score in comparison with the local contract model. The scoring did not find a significant difference between the local contact model and the status quo.

There was strong agreement between the outcomes of the scoring of the models and the qualitative comments made by participants, with the social enterprise model being the most highly-rated model overall, followed by the local contract model and then the status quo.

The domains scored significantly higher in the social enterprise model were: patient involvement, holism, health improvement, joining-up care, continuity of care, and a wider community perspective.

Participants had a sophisticated understanding of the organisational issues facing primary care, and demonstrated sensitivity to intended and unintended consequences of the suggested new models for both primary care staff and for patients.

The event allowed public representatives to weight the relative importance of the previously identified priorities for a future primary care model; presented, discussed and explored alternative models relative to the status quo in a manner which created a numerical ranking of the models; and identified participants views about the different models, deepening the understanding of what elements matter to the public about the organisation of primary care. The research also suggested that the process was broadly acceptable to the participants and had face validity in terms of their expressed views about primary care.

Chapter eight: staff assessment of three models of primary care

This chapter attempted to extend the work with the public on alternative models of general practice to primary care staff. Two alternative models of general practice were presented via an eDelphi process which allowed respondents to comment upon and score the relative merits of the models against specific criteria. The final part of the chapter compared the weighting and scoring of the three models of primary care general medical services between the public and the primary care staff groups. The results provide insight into the place of holism in the current model and provides a deeper understanding of GP views of patient influence in the organisation of services.

8.1 Methods

The main aim of this element of the research was to seek the views of staff who were already working in primary care about the two alternative models in comparison with the status quo. This involved describing the models to staff and seeking their views on the strengths and weaknesses of the models.

The research was carried out via an eDelphi, and there were a number of specific objectives:

1. to weight the relative importance of a number of previously determined priorities for any future primary care model;
2. to present, score and deliberate upon two alternative models of primary care using the priorities in order to create a numerical ranking of the models in comparison with the status quo; and
3. to explore the participants views of each of the models.

It was intended that the participants should have two weeks to complete the survey and that there should then be a break of two to three weeks followed by the second and final round, with the entire process lasting around eight weeks in total. In practice, due to reminder emails and technical problems, the process lasted around 14 weeks. The remainder of the methods are contained in section 3.5.2 of chapter three.

8.2 Participants

The original qualitative work with primary care staff involved 20 individuals. The eDelphi collected 20 responses, although only 18 of these were identifiable by code. Of these 18, all areas of the Board were represented with the exception of East Dunbartonshire. All of the staff groupings in the original qualitative work were represented. The characteristics of respondents are shown in Table 8.1.

Table 8.1 Respondents categorised by geography‡‡‡, staff grouping and gender. §§§

Geographic area	Number of Participants
Whole board area	4
North West Glasgow*	3
North East Glasgow*	3
South Glasgow*	6
Renfrewshire	1
East Dunbartonshire	0
West Dunbartonshire	1

Role	Numbers in each staff group
Practice manager	4
Primary care manager	3
GP partner	4
Salaried GP	3
Practice nurse	2
Community nurse	1
Practice receptionist	1

Gender	Number of Participants
Male	6
Female	12

*During the course of the study the five Glasgow Community Health and Care Partnerships were reorganised into three CHP areas: North West, North East and South Glasgow. The participants are described according to their revised geographic area.

§§§ 20 responses were received, two responses were not identifiable by code.

8.3 The priorities for the future of primary care

8.3.1 Weighting the priority domains

The same twelve priority domains identified through the public prioritisation event were presented, scored and commented upon by the staff respondents (see Table 7.2 in page 161 of chapter seven). The weighting scores varied for medians from 3 to 5, and in terms of means, from 3 to 4.82. The most highly weighted domains included quality, communication, access and holism. A second group included joining-up care, health improvement, equity and continuity of care. The lowest scoring group included cost, patient involvement, wider community perspective and patient influence within the practice. The distributions are shown in Table A3.1 of Appendix 3.

As with the weighting scores from the public, staff scoring showed an acceptable degree of skew, and the distributions were unimodal. A summary of the scoring showing both median and mean is shown in Table 8.2. There were no significant differences between the first and second round of scoring for any domain (see Appendix, Table A3.2).

Table 8.2 Weighting of priority domains for general practice (second round of scoring) with median and mean scores.

Priority	*Median*	*Mean*
Quality	5	4.82
Comms	5	4.65
Access	5	4.53
Holistic	4	4.41
Join	4	4.35
Improve	4	4.29
Equity	5	4.24
Continuity	4	4.12
Cost	4	3.76
Involve	4	3.71
Wider	4	3.65
Influence	3	3

8.3.2 Understanding the priorities

In general the staff participants agreed with the comments made in the first round of the eDelphi. This view was summed up by the following GP who reflected on

the shared goals underpinning healthcare and the fact that all staff may one day be patients too:

> *"This is not surprising- staff are patients too and what is important to us all is the quality of our care, access and communication."*

In contrast, one participant admitted that they were *"surprised...but encouraged"* by the high priority afforded to holism and health improvement.

The consensus on priorities did not reflect complete agreement on the role and remit of staff in primary care. One GP described how this issue of role and scope had affected their judgement in rating the priorities:

> *"The wider benefit to society I have placed as a lesser priority because I'm not sure if that is part of our job in primary care to tackle that issue."*

In common with comments made by public participants in chapter 7, staff found it difficult to reconcile the role and priority to be afforded to cost in primary care. Some reflected on the inconsistent approach to thinking about cost and budgets in the NHS. One nurse spoke of the tension between cost awareness and advocacy for excellent healthcare:

> *"…we must be aware of costs but surely our role is to be advocates for patients and provide excellent health care."*

8.4 Assessing the performance of the current model

8.4.1 Scoring the performance of the current model (status quo)

The domains of the current model which performed most highly (prior to weighting) included quality of care, communication and access. A second group included continuity of care, health improvement, equity, holism, joining-up care and cost. The lowest performing domains were wider community perspective, patient involvement in care and patient influence within the practice. The second round scores are shown in Table 8.3, whilst the full scoring (first and second rounds) is shown in Appendix 2 as Table A3.3.

Table 8.3 Performance scores for model 1 of general practice (second round of scoring) with median and mean scores.

Priority	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Quality	8	8	1.46	-0.15	0.58
Comms	7	7.33	1.63	0.05	0.58
Access	7	7.2	1.93	0.08	0.58
Continuity	7	6.93	1.9	0.03	0.58
Improve	7	6.8	1.42	0.74	0.58
Equity	7	6.67	2.12	0.04	0.58
Holistic	7	6.4	2.16	-0.25	0.58
Join	6	6.27	1.83	0.35	0.58
Cost	6	6.07	2.08	0.28	0.58
Wider	6.5	5.93	2.43	-0.16	0.59
Involve	5	5.67	2.02	0.22	0.58
Influence	5	5.33	1.83	-0.01	0.58

To take account of the relative weightings for the importance of each domain, participant's weighting scores were multiplied by their respective performance scores, creating a weighted performance score. The staff weighted performance scores for Model 1 are shown in Table 8.4. This did not change to the ordering of performance across the domains. Further detail on the distributions are included in Appendix 3 as Table A3.4.

By adding the weighted performance scores for each participant, a cumulative weighted performance score was calculated. The final distribution of scores from the participants had a range of 250; a minimum of 245 and a maximum of 495; a median of 314.5; a mean of 325.14; and a standard deviation of 77.44. The maximum possible cumulative, weighted performance score for the model was 600. Therefore expressing the performance of the current model in terms of the maximum possible score, the median was 52% and the mean 54%. The histogram for the distribution is shown as Figure A3.1 in Appendix 3.

Table 8.4 Weighted performance scores for Model 1 (participant's domain weighting score multiplied by the participant's performance score for Model 1). The cumulative score is the arithmetic sum of all 12 weighted performance scores for each participant.

Priority	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Quality	35	38.53	8.53	0	0.58
Access	35	32.6	9.58	-0.01	0.58
Comms	35	33.53	8.46	0.76	0.58
Improve	28	29.6	10.54	0.26	0.58
Continuity	30	28.06	10.27	0.09	0.58
Equity	27	27.26	9.56	0.4	0.58
Join	24	26.73	9.44	0.95	0.58
Involve	18	19.93	6.81	0.65	0.58
Holistic	28	28.06	10.23	0.3	0.58
Influence	15	16.53	8.95	0.68	0.58
Wider	21	21.85	12.37	0.69	0.59
Cost	20	22.13	9.17	0.61	0.58
Cumulative Total	314.5	325.1	77.44	0.79	0.59

8.4.2 Understanding the scoring of the performance of the current model

There was a strong consensus that although primary care was working hard, there were problems with the current model. These included a low priority being given to holism, widespread variation in practice, difficulties with addressing inequalities through the model, a feeling that general practice didn't have a good interface with secondary care, and concern about the role which cost played in shaping services.

One GP gave a succinct account of what was needed, and why the current model was failing to deliver the priorities. The participant believed that the changes of the last decade had reduced the factors required to deliver good outcomes, and questioned the overall role of the practice in health improvement and prevention:

> *"After 20 years in practice I am starting to get the hang of it! It is about providing a service by having (in this order), good communication skills, good clinical skills, continuity - which needs TIME, common sense, organisational skills, and more TIME for learning, administration, and to interact with peers. Nearly all the changes in the last few years, especially the new contract have*

TAKEN away from these core factors. IT has become a barrier to good care in many cases, QOF targets are a meaningless tick box exercise which make no difference to individual patients leading to polypharmacy of questionable benefit to the vast majority! Health promotion is largely a waste of time for us - most of the time the damage is done - the people who influence population health are politicians not doctors."

Holism

A number of participants reflected on the reason that holism was problematic in the current model. The nGMS contract was seen as a significant issue by a number of participants. Some participants took a new public sector management approach to this issue, implying that holism needed to be incentivised within the current contract:

"Holistic care is not remunerated in nGMS."

Another common issue affecting holism was the issue of distance from the needs of patients. Concerns stated included a belief that the new model of itself was responsible for this, insulating GPs from patients, whilst others saw this as an indirect issue, resulting from competing roles and demands within the current model. Some described this as *"los[ing] touch with our patients and their real health care needs in the community."* The competing demands for GPs were clearly set out by one participant, and they included issues of profit, the business model operating within the practice and the focus on administration, managerialism and the collection of information which could occur at the expense of direct patient care. They questioned whether these were appropriate roles for a GP:

"There are pros and cons to the independent contractor status- indeed profit and business models can mean that GPs are not as accessible due to earning money doing other things… Of course there are so many admin tasks - writing up cases for the contract and QOF, implementing all the Health and Safety things - that some days most time is spent on this and meetings and not on seeing patients. This is really not what we trained for."

Variation and not playing a part in the wider healthcare system

Most of the participants cited variation as a problem with the current model, seeing this as a difficulty, rather than a strength. The variation was viewed more as being the result of ways of working within the practice, although one comment suggested that *"the variance in general practice will in part be due to the balance between the ratio of deprived and non-deprived in each practice*". One participant suggested that skills and training was an important element of tackling this. They reflected that many staff working in practices were not trained, particularly those dealing with patients over the telephone or front desk. They described that when they began, they *"had no conception of how a practice operated and was thrown in at the deep end"*. The participant described the need for better training and felt that this was difficult because of the way general practice was run. She described eloquently the competing demands which underpinned variation and poor quality:

> *"I started about 17 years ago I had no conception of how a practice operated. A succinct training course during the first week I think would be of benefit just to make the employee feel au fait with things …I understand that since the inception of the New Contract it is entirely up to the individual employers and managers to train staff but surely a suggestion could be made. So many [staff members] are very unsympathetic and do not take time because they are multitasking. I have always been nice to every patient, and actually was told not to take so much time with them."*

Another theme linked to unacceptable variation was that of practice size and the role played by practices within the wider health and healthcare system. A primary care manager described a lack of transparency in the deployment of resources within practices, a lack of participation within the wider NHS endeavour and suggested that this required practices to group together to solve these issues:

> *"We are reaching a point where the independent model needs to be balanced with wider system needs. There is not enough leverage for GPs to work within and for that system. There is also no real transparency about what GPs do, how, when and how resources are deployed. The construct of small GP practices may need to change to be part of bigger groupings to enable this wider system impact."*

In contrast, from a practice perspective, the links with the wider NHS were also seen as problematic by the majority of participants. This was linked to the explicit contractual arrangements set out in the nGMS contract. One GP participant spoke of difficulties with relationships between practices and the NHS as a result of work shifting, where services are transferred from elsewhere in the NHS (secondary care or community) to general practice without a transfer of resources to fund these:

> *"Work shifting. There are many examples of workload shift without resource shift. This causes friction with GPs and makes contractual negotiations harder."*

Profit

There was clear evidence that profit was a competing demand which practice staff juggled in addition to managing patient care and quality. A number of participants reflected concern about this:

> *"The independent contractor model of care is costly, puts competing pressures on GP partners in terms of personal profit vs patient care, and is bureaucratic."*

Another GP participant linked the profit motive and business orientation of practices to the difficulties with holism, suggesting that there were just too many competing outcomes for the practice:

> *"We are very busy and somewhere along the way the patient is often forgotten while we chase targets and try to maintain profits. Like most GPs, l came into the job to provide a holistic approach to health care but l feel this is certainly being lost in the midst of all the red tape we are being asked to jump through."*

One participant suggested that profit should be removed from the equation, but still wanted GPs to remain independent:

> *"I agree that personal profit vs patient care is a problem in primary care…it is more than apparent when talking to other practice nurses that this is a real*

issue in many practices. I believe GPs should not be independent contractors but salaried, which would remove this issue."

A GP participant suggested that difficulties with profit were managed by a professional ethos and that the discussion about profit coming before care overlooked this fact:

"I think some of this devalues us as professionals. I believe most doctors want to do the best for their patients, and much of this comes from within."

Inequalities

A number of participants spoke about difficulties addressing inequalities through the current model. The views expressed reflected a lack of resources, particularly that of consulting time. Other participants suggested a need to consider if the current model was right for tackling inequalities. The GP participant suggested that people experiencing significant socioeconomic deprivation might be better served by a different model, in effect a targeted model of primary care, and that a lack of such a targeted model might account for some of the variability in primary care performance:

"Using the same model for patients with deprived and 'rubbish lives' as those in the rest of society is not working in primary care."

8.5 Assessing the performance of a local contract model

8.5.1 Scoring the potential performance of a local contract model

The domains of the local contract model which performed most highly (pre weighting) included quality of care, health improvement, communication, access and joined-up care. A second group included holism, continuity of care, cost and wider local perspective. The lowest performing domains were equity, patient involvement in care and patient influence within the practice. The second round

scores are shown in Table 8.5 whilst the full scoring (first and second rounds) is shown in the Appendix 3 as Table A3.5.

To take account of the relative weightings for the importance of each domain, each participant's weighting scores were multiplied by their respective performance scores, creating a weighted performance score. The staff weighted performance scores for Model 2 are shown in Table 8.6. This resulted in very minor changes to the overall ranking of the scores, such that wider perspective moved into the lowest scoring group and equity moved into the intermediate grouping. Further detail on the distributions are included in Appendix 3 as Table A3.6. There was no significant difference between the first and second rounds of scoring (see Appendix 3, Table A3.7).

By adding the weighted performance scores for each participant, a cumulative weighted performance score was calculated. The final distribution of scores from the participants had a range of 245; a minimum of 202 and a maximum of 447; a median of 341; a mean of 341.63; and a standard deviation of 67.5. The maximum possible cumulative, weighted performance score for the model was 600. Therefore expressing the performance of the current model in terms of the maximum possible score, the median and mean were both 57%. The histogram for the distribution is shown as Figure A3.2 in Appendix 3.

Table 8.5 Unweighted performance scores (second round of scoring) for Model 2 (local contract)

Priority	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Quality	8	7.75	1.21	-0.88	0.63
Improve	8	7.58	1.31	-0.79	0.63
Comms	8	7.5	1.56	-0.34	0.63
Join	7.5	7.5	1.56	0	0.63
Access	7	7.08	1.16	-0.18	0.63
Holistic	7.5	6.92	1.67	-0.4	0.63
Continuity	7	6.92	1.62	-0.45	0.63
Cost	6.5	6.58	1.88	0.43	0.63
Wider	6	6.45	1.63	0.09	0.66
Equity	6	6.08	1.24	0.15	0.63
Involve	6	5.83	1.69	-0.89	0.63
Influence	5.5	5.58	1.73	-0.61	0.63

Table 8.6 Weighted performance scores (second round) for Model 2 (local contract).

Priority	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Quality	35.5	36.91	7.01	-1.05	0.63
Comms	35	34.75	8.14	0.34	0.63
Improve	35.5	33.08	8.12	-2.29	0.63
Join	32	32	8.61	0.14	0.63
Access	32	31.58	5.71	0.03	0.63
Holistic	31	29.91	7.63	-0.36	0.63
Continuity	30	28.33	8.19	-0.37	0.63
Equity	25	25.58	8.28	0	0.63
Cost	20	24.33	8.29	0.68	0.63
Involve	24	22.83	9.36	-0.83	0.63
Wider	20	22.63	8.64	0.44	0.66
Influence	19	17.58	8.18	-0.13	0.63
Cumulative Total	341	341.63	67.5	-0.59	0.66

8.5.2 Understanding the scoring of the performance of a local contract model

Participant comments relating to the local contract model, with wider primary care staff embedded within practice teams were positive overall. In general participants liked the idea, particularly the issue of staff being embedded and the benefits of better co-ordination and integration of working, but were uncertain about difficulties with implementation.

Localism

Participants were positive about the ability to match services with local needs, although there were concerns about practicalities such as cost:

> *"I think matching local needs to local services makes a lot of sense. Is it practically possible – can we afford it?"*

The issue of uncovering needs and resourcing these needs was picked up by a number of participants who felt that whilst this was well intentioned, it might just raise issues which would not be resolved through a lack of funding or redistribution:

"My concern would be when we identify areas needing lots of support and resources do we have funds to cover that? There are already concerns that the Government is struggling to pay for healthcare changes, such as free 'scripts [prescriptions]."

One respondent felt that the local focus might result in better local ownership, resulting in greater matching of the needs of the community and the skills of the practice staff:

"[There is the] potential to have greater ownership at local level with people who are aware of patient and community needs but who also have specific knowledge of practice staff skills etc."

Working together

In addition, participants liked the idea of embedding extended primary care groups within the core practice team, feeling that this would bring benefits to patient care. One participant provided experience of working in such an environment:

"I have worked [in such an integrated team] and it is the best idea ever! I cannot begin to tell you how awful it would be if we did not have a CPN [Community Psychiatric Nurse] and an addictions worker accessible and on site."

Another respondent felt that this integrated working would improve communication, access and the joining-up of care:

"Having a local team working together with the same group of patients I think would improve team communication, joined-up care and access."

In the first round of the eDelphi, a participant had suggested that clustering of practices and the sharing of services such as midwifery, health visiting and district nursing, which would be embedded in the cluster, would be of value. There was disagreement on this issue, with one participant strongly objecting to this, feeling that it would undermine the relationship issues which were implicit to the proposed embedding of staff within the team:

"One respondent suggested that clustering of practice would allow cover for staff absence. That comment fills me with horror – staff should NOT be transferable to different practices. You have to know your patients and have an established relationship with them to have any meaningful care in place."

Implementation

A common theme raised was that of implementation difficulties. Building on the wicked issues already identified such as the need for resource redistribution, there was a lack of trust in those who might need to co-ordinate the assessment of local needs and matching of resources. One GP participant reflected on previous poor experiences of such endeavours:

"I like the sound of many of these changes, but it depends who runs them. I have very little faith in those that run our current CHP and so giving them more power with budgets etc doesn't fill me with any confidence and I think it may even make things worse."

8.6 Assessing the performance of a social enterprise model

The domains of the local contract model which performed most highly (pre weighting) included patient involvement, patient influence, quality and joined-up care. A second group included communications, continuity, holism, and health improvement. The lowest performing domains were access, wider community perspective, equity and cost. The second round scores are shown in Table 8.7 whilst the full scoring (first and second rounds) is shown in the appendix as Table A3.9.

To take account of the relative weightings for the importance of each domain, each participant's weighting scores were multiplied by their respective performance scores, creating a weighted performance score. The staff weighted performance scores for Model 3 are shown in Table 8.8. This resulted in substantial changes to the overall ranking of the scores, such that the most highly performing group of domains comprised quality and communication, with a larger intermediate group which included joined-up care, access, health improvement, patient involvement, and holism. The low scoring group included the domains continuity, equity, influence, cost and wider community perspective. Further detail on the distributions are included in Appendix 3 as Table A3.9. There was no significant difference between the first and second round of the scoring (see Table A3.10 of Appendix).

By adding the weighted performance scores for each participant, a cumulative weighted performance score was calculated. The final distribution of scores from the participants had a range of 376; a minimum of 132 and a maximum of 508; a median of 383; a mean of 361.33; and a standard deviation of 102.82. The maximum possible cumulative, weighted performance score for the model was 600. Therefore expressing the performance of the current model in terms of the maximum possible score, the median was 64% of the maximum possible score and mean was 60%. The histogram for the distribution is shown as Figure A3.3 in the Appendix.

Table 8.7 Unweighted performance scores for Model 3 (social enterprise model)

Priority	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Involve	8	8	1.78	-1.88	0.61
Influence	8	7.85	1.95	-1.17	0.61
Quality	8	7.46	1.94	-0.94	0.61
Join	8	7.46	2.06	-1.61	0.61
Comms	8	7.23	1.96	-0.45	0.61
Continuity	8	7.08	2.17	-0.91	0.61
Holistic	7	7	2.16	-0.82	0.61
Improve	7	7	2.12	-0.8	0.61
Access	7	6.92	1.97	-1.09	0.61
Wider	7	6.75	2.05	-0.96	0.63
Equity	8	6.62	2.32	-0.57	0.61
Cost	7	6.54	1.8	-0.47	0.61

Table 8.8 Weighted performance domains for Model 3 (social enterprise)

Priority	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Quality	35	35.84	10.35	-0.75	0.61
Comms	32	33.38	10.57	0.07	0.61
Join	32	31.61	10.88	-0.82	0.61
Access	35	31.46	9.97	-0.67	0.61
Improve	32	31.07	11.02	-0.97	0.61
Involve	32	31.07	11.24	-0.76	0.61
Holistic	32	30.46	10.73	-0.35	0.61
Continuity	32	28.38	11.65	-0.67	0.61
Equity	25	28.15	12.94	0.14	0.61
Influence	24	25.53	11.34	-0.43	0.61
Cost	20	24.61	10.81	0.59	0.61
Wider	24	24.25	9.71	-0.09	0.63
Cumulative Total	383	361.33	102.82	-0.78	0.63

8.6.2 Understanding the scoring of the performance of a social enterprise partnership model

Participants raised a number of issues around the social enterprise partnership model. The themes raised included those of power, involvement and control; profit; and challenges of implementation.

Of power, leadership and participation

A major theme emerging from the respondents in relation to the social enterprise model was that of power and control within practices. The issue of power (and profit) sharing was commented upon in a number of responses. A community nurse liked the idea of a wider sense of leadership, but was doubtful that GP partners would be keen to share their power with others. This was typical of a number of responses:

> *"It conjures up a good image. Limited profit sharing I imagine would exclude nurses again? Excuse the cynicism!"*

In contrast, a GP spoke of the need for leadership, but used a metaphor of strong, hierarchical leadership and control, such as the model found in a school:

> *"A good school usually has a good, strong headmaster. Who is the headmaster here?"*

The theme of leadership and the threats to power was a pervasive theme. Some participants saw the widening of patient influence in decision-making around the organisation of services as dangerous, creating the potential for inequity. No participant directly explored the loss of professional power, however the theme was implicit in a number of quotes. In the following quote a participant spoke of patient interest:

> *"Clear leadership is required and is difficult to imagine in such a model. There is a danger of vocal patients getting their interests through and others falling behind."*

In contrast to the comments around patient influence and the potential for changes to the balance of power, many participants welcomed opportunities for patient participation in terms of both the impact on services and the potential for changes in patient behaviour. This was summed up by one participant who gave a practical example of the kinds of changes which might be expected if such wider leadership were to be achieved:

> *"The more you involve patients [the greater the chance] they may change their habits when deciding if they need a GP or some other service. Also, if patients*

are more informed regarding medicines, they may take it and not just order it to sit in the cupboard."

Other participants commented on both points of view in the second round of the eDelphi, and there was a general sense that the potential benefits from greater participation and involvement of patients outweighed the potential for a widening of inequalities through the emergence of patient self-interest. The following quote commented on both perspectives: the opportunities borne out of greater involvement, and the risks of inequity. In essence, the future imagined was consistent with the co-creation of health through true partnership working with patients:

"I agree with both points. I am swayed more though that greater involvement from patients would perhaps mean a different attitude and life choices when it came to their health."

Profit and profit-sharing

Most of the respondents were negative about the concept of profit and uncertain about the impact that this would have on professional groups. A number of respondents were unhappy with the idea of profit taking across all of the models, and this was continued through the SEP model. In the following quote a respondent is making the case for indirect financial incentives, but suggesting that profit created should be channelled back into services:

"I don't agree with any profit to be made for GPs or nurses or anyone. I don't see health as a commodity and so I don't think profits should be made by anyone in the caring profession. I think we should be better paid with better working conditions i.e. sick pay, holidays etc, but no profits. Any profits made by a practice should be ploughed back in to make it a better practice."

A few respondents suggested that widening profit-sharing to include other professionals and the community might undermine the commitment of GP partners to a new SEP arrangement. The respondent suggested that little was known about the consequences of unpicking the current, complex arrangements, and warned of potential unintended consequences:

> *"I do not know what this will mean for the commitment of GPs to the NHS if profit is to be shared. Just now we do not know exactly how the current model motivates its principal professionals to behave."*

There was some agreement in the second round that this move might be unpopular with GPs. In contrast, the comment about unintended consequences and GP commitment provoked a strong reaction from a nurse respondent who believed that if profit was found to be an important motivator, then losing staff with this intrinsic motivation might be good for primary care. In the following quotation, the respondent is referring to the quotation about the unintended consequences of modifying profit sharing:

> *"This comment makes me think, if GPs lose commitment because profits are being shared, they are in the wrong job, they should have become lawyers not health care professionals. There is no place for that attitude in health care in my opinion. Perhaps this would be a good thing though, and prevent doctors entering primary care as their chosen profession if profits are so important to them."*

Implementation

As with the local contract model, whilst many welcomed the general direction of travel, were keen on involvement and participation and liked the potential to tailor staff roles to the needs of the practice community, there was a general consensus that implementing such a vision would require leadership and cultural change within primary care. The following respondent captured what seemed positive about the model for them:

> *"The GP practice is the hub and the first point of contact for nearly all patients. It seems logical therefore that they should be at the centre of the wheel and wider teams join onto that. Strong leadership would be important, but GPs and the practice team deciding on what's important seems a good thing to me."*

The participant also responded positively to comments from another in the first round who explored the structure versus function debate around services and

firmly endorsed function. The participant saw the SEP as a way of facilitating such a functional approach to service design:

> *"It is not about the design of the service, it is about how practices choose to function to involve patients and those responsible for the wider aspects of care, and to [in turn] influence their way of working."*

A number of participants, whilst supportive of the model, accepted that implementation would require *"a complete sea-change in practices and will also make them look at the wider population"*.

8.7 General comments

Few participants commented at the end of the eDelphi survey. One respondent stated that they believed that the local contract model was most likely to be delivered. Another respondent commented that the models did not address the fundamental issue of the independent contractor status which they believed would improve primary care:

> *"Neither new model addresses the fundamental issue – independent contractor status and thus the requirement for GPs to balance profit with service delivery, additional staff costs etc. The Board should directly manage practices (2C contract) and as independent contractors retire, introduce Board-employed, salaried GPs."*

8.8 Comparing the relative performance of all three models

8.8.1 Overall cumulative performance

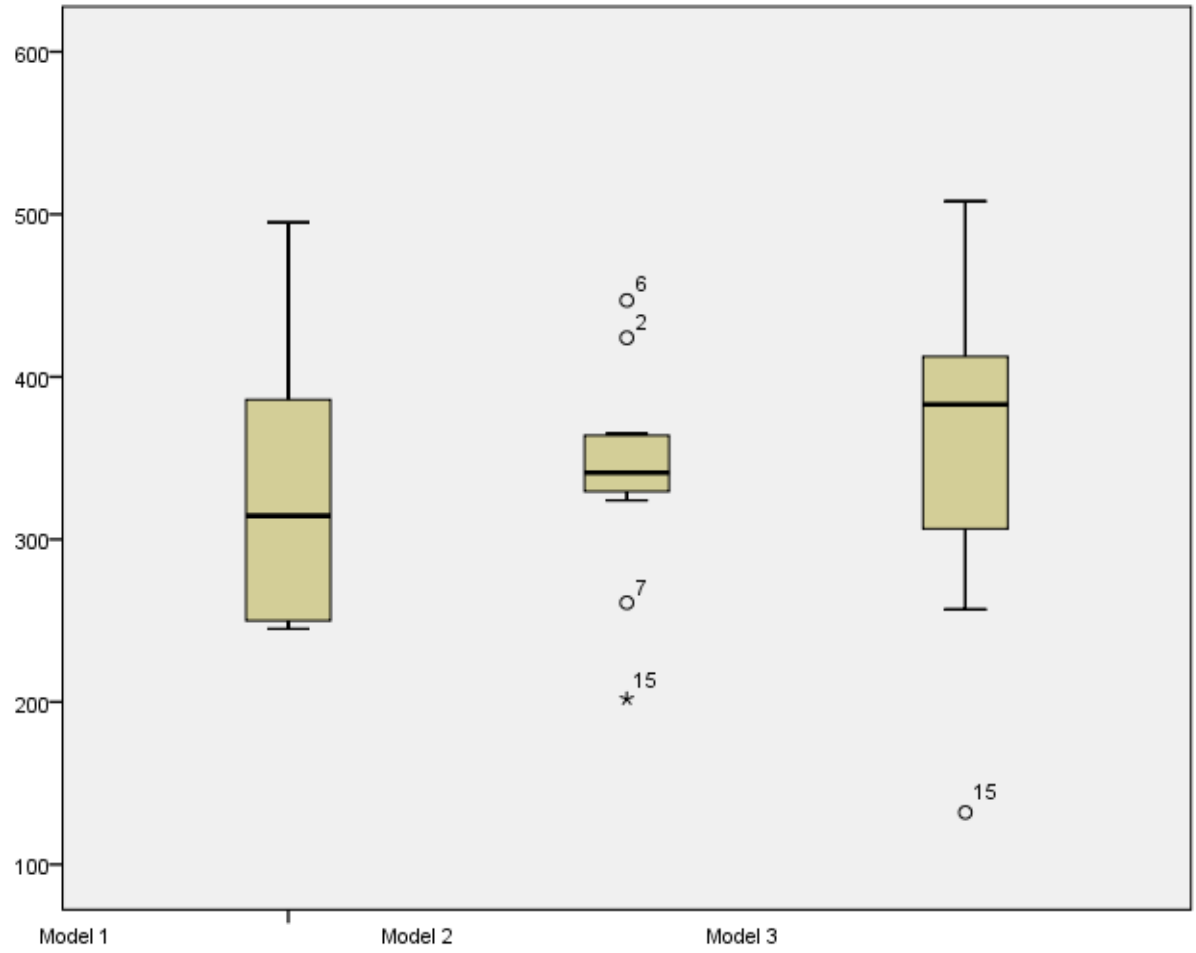
The purpose of the weighting, performance scoring and calculation of cumulative performance scores was to attempt to summarise the overall preferences for the 3 models using a number. In short, the cumulative performance scores are shown in Table 8.9. Using Friedman's Related Samples Test for Two-Way analysis of

variance by ranks, the null hypothesis was retained (p= 0.146). This is shown graphically in the boxplot in Figure 8.1.

Table 8.9 Distributions of the cumulative performance scores for the 3 models.

Model	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Model 1	314.5	325.1	77.44	0.79	0.59
Model 2	341	341.63	67.5	-0.59	0.66
Model 3	383	361.33	102.82	-0.78	0.63

Figure 8.1 Boxplot showing distributions of the cumulative weighted performance scores for Models 1, 2 and 3.



8.8.2 Comparing weighted scores between the three models

Comparison of the weighted domain scores across the three models confirmed significant differences in terms of both patient influence and patient involvement, with Model 3 having a higher score than Model 2 and Model 1. This agrees with many of the comments described previously in relation to each of the models. In general, staff believed that Model 3 provided greater patient participation, both in terms of their individual involvement in care and their influence in the

organisation of services. A summary of the statistical tests is provided in Table 8.10.

Table 8.10 Summary of statistical tests of significance in weighted performance scores for individual domains between models.

Domain	Result of tests of significance
Patient influence	There was a significant difference between Models 1 and 2 and between Model 1 and 3 (Repeated measures ANOVA). Pairwise analysis with Wilcoxon's related samples signed ranks test confirmed that Model 3 was significantly higher than Model 1, and that Model 3 was significantly higher than Model 2, but that there was no significant difference between Models 1 and 2).
Cost	There was a significant difference between groups (Friedman's Two Way ANOVA). Pairwise comparison using Wilcoxon's test did not confirm significant differences between the three models.
Involvement of patients and carers	There was a significant difference between groups (Friedman's Two Way ANOVA). Pairwise comparison confirmed that Model 3 was significantly higher than Model 1, and that Model 3 was significantly higher than Model 2, but that there was no significant difference between Models 1 and 2).
Equity	No significant difference found (Friedman's test (p=0.275)
Access to care	No significant difference found (Friedman's test (p=0.558)
Holistic care	No significant difference found (Friedman's test (p=0.146)
Quality of care	No significant difference found (Friedman's test (p=0.697)
Improving health	No significant difference found (Friedman's test (p=0.486)
Communication	No significant difference found (Friedman's test (p=0.575)
Joined-up services	No significant difference found (Friedman's test (p=0.070)
Continuity	No significant difference found (Friedman's test (p=0.214)
Wider benefit to society	No significant difference found (Friedman's test (p=0.164)

8.9 Participants views about the process of weighting priorities and scoring models

As with the public participants, the staff participants found some issues such as cost very difficult to score. This was partly because staff found it difficult to separate the idea of cost from their wider concerns about cost management within the NHS, and partly because prospectively assessing the cost of untested models was challenging.

One GP commented that the delay of a few months between rounds 1 and 2 caused them concern because they may have changed their minds and scores during the time which passed between the two surveys:

> *"I can't remember what I said the last time, so feel trepidation in completing [the survey] in case for various reasons I might feel/answer differently."*

8.10 Comparing public and primary care staff weighting and scoring of the models

The weights and scores collected in the work with the public (chapter seven) and with primary care staff were used as a basis for between group comparisons.

All of the weighting and scoring data for the primary care staff was ordinal. The data for the public events was continuous data, but in practice most participants scored as if it were on an ordinal scale. In addition, whilst the weighting data for both groups was measured on a similar scale, the scoring data for staff was scored from 1 to 10 in comparison with 1 to 100 for the public. In order to permit comparisons to be made, the staff scoring data was multiplied by a factor of ten. Data was analysed using SPSS 20.

8.10.1 Comparing weighting of domains between the public and staff

The second round of weightings for the 12 priority domains were compared between the two groups. Table 8.11. shows the distribution of the weightings for staff and the public. The independent samples Mann Whitney U Test was performed to establish if the weightings for each domain were the same across both groups. The test suggested that there was a significant difference between the groups in terms of their rankings of the importance of patient involvement and patient influence see Tables 8.12 and 8.13. Having adjusted for multiple comparisons, only the difference in terms of patient influence persisted, with the public group having weighted patient influence more highly than the staff group (P=0.004).

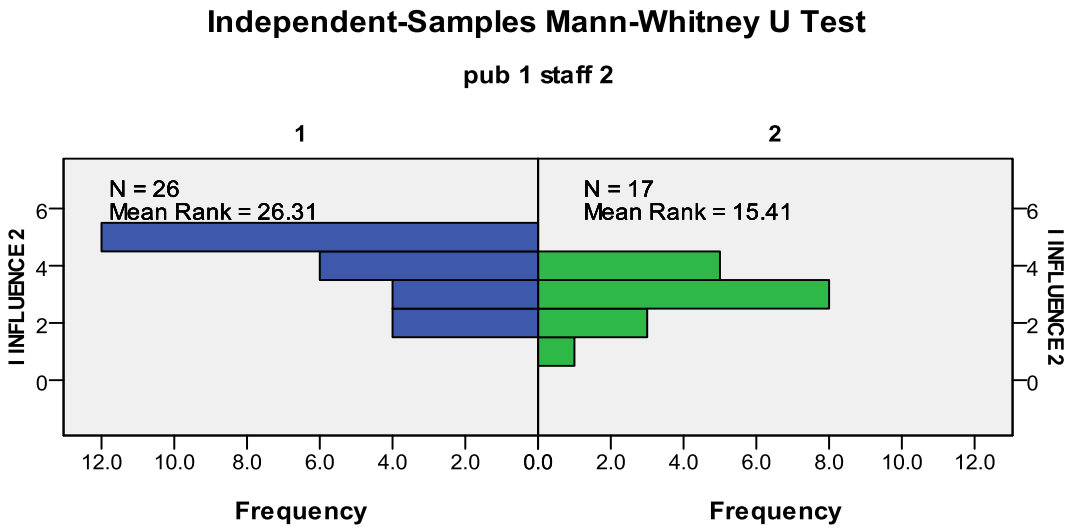
Table 8.11 Distributions for the weightings for the 12 domains of importance for both the public and staff groups

	Public				Staff				
Priority	*Median*	*Mean*	*Skewness*	*SE skew*	*Median*	*Mean*	*Skewness*	*SE skew*	*Priority*
Equity 2	5	4.31	-1.01	0.456	5	4.24	-0.523	0.55	Equity 2
Access 2	5	4.5	-1.103	0.456	5	4.53	-0.997	0.55	Access 2
Holistic 2	5	4.19	-0.414	0.456	5	4.82	-1.866	0.55	Quality 2
Quality 2	5	4.62	-2.159	0.456	5	4.65	-1.596	0.55	Comms 2
Comms 2	5	4.62	-2.159	0.456	4	3.76	-0.243	0.55	Cost 2
Continuity 2	5	4.19	-0.852	0.456	4	3.71	-0.84	0.55	Involve 2
Involve 2	4.5	4.38	-0.703	0.456	4	4.41	0.394	0.55	Holistic 2
Influence 2	4	4	-0.718	0.456	4	4.29	-1.344	0.55	Improve 2
Improve 2	4	4.23	-0.43	0.456	4	4.35	-0.634	0.55	Join 2
Join 2	4	3.75	-0.933	0.456	4	4.12	-0.919	0.55	Continuity 2
Wider 2	3.5	3.62	-0.287	0.456	4	3.65	0.147	0.55	Wider 2
Cost 2	3	3.21	-0.135	0.472	3	3	-0.65	0.55	Influence 2

Table 8.12 Comparison of group scoring of priority domains of the public versus primary care staff. Independent samples Mann-Whitney U Test for each of the twelve priority domains. Using a simple Bonferroni adjustment for multiple comparisons, the level of statistical significance is reduced from 0.05 to 0.004

Priority	*Significance (P)*
Equity	0.751
Access	0.989
Holistic	0.646
Quality	0.563
Comms	0.770
Continuity	0.538
Involve	0.009
Influence	0.004
Improve	0.676
Join	0.119
Wider	0.990
Cost	0.289

Table 8.13 Mann Whitney U Test comparing the weighting of the patient influence domain between the public (group 1) and staff (group 2).



Total N	43
Mann-Whitney U	109.000
Wilcoxon W	262.000
Test Statistic	109.000
Standard Error	38.947
Standardized Test Statistic	-2.876
Asymptotic Sig. (2-sided test)	.004

8.10.2 Comparing weighted scores between the three models

The cumulative weighted performance scores for the three models (see Table 8.14) were compared using the independent Mann Whitney U Test. In the case of the staff scorings, the scores were multiplied by a factor of ten to allow for the fact that the eDelphi technique permitted scoring on a scale of 1 to 10 fixed ordinal in comparison with the scale of 1 to 100 used for the public scoring. No significant differences were noted between the two groups for any of the models (see Table A3.12 of Appendix 3).

Table 8.14 Cumulative weighted performance scores for all 3 models by both public representatives and staff.

Public					Staff				
Model	*Median*	*Mean*	*Skewness*	*SE skew*	*Median*	*Mean*	*Skewness*	*SE skew*	*Model*
Model 1	2670	2908	0.434	0.524	314.5	325.14	0.79	0.59	Model 1
Model 2	3401	3399.52	-0.277	0.501	341	341.63	-0.59	0.66	Model 2
Model 3	4315	4001.92	-1.231	0.524	383	361.33	-0.78	0.63	Model 3

8.11 Conclusions

Respondents rated quality of care; communication, access and holism as the most important priorities for any primary care system. The lowest rated domains included cost, patient involvement, patient influence and the need to take a wider perspective on the practice community.

Overall, Model 1 (the status quo) had a overall score of 54%, with Model 2 (the local contract) scoring 57% and Model 3 (the social enterprise partnership) scoring 60%. These differences were not statistically significant. There were significant differences between the scoring of the social enterprise partnership (Model 3) in terms of both patient influence and patient involvement.

Comments made by participants through the eDelphi provided insight ito the reasoning behind the scoring of the models. Emergent themes included a general acceptance of the low status of holism in the current arrangements, unease with profit, and ambivalence around the value of patient influence within the design and organisation of primary care services. A central theme was that of the balance of power between GPs and patients. There was some support for the alternative models, but the general consensus was that these would be difficult to implement.

Chapter nine: discussion

This chapter sets out and discusses the findings from the research. The findings were set out in relation to the research questions. There was a discussion of the limitations and strengths of the research. Following this the value of this study is discussed. There was some personal reflection on the process and findings of the research as well as a section on the conclusions and recommendations.

9.1 Findings

The research aim was to explore the current organisation of general medical services in Scotland, and to identify an improved organisational model for the future delivery of primary care (general medical services) within the Scottish context. This ambitious task was subdivided into three research objectives:

1. To improve understanding of the views of the public in relation to the organisation of general practice (general medical services) within the wider context of primary care in Scotland;
2. To improve understanding of the views of staff working within the primary care team in relation to the organisation of primary care; and
3. To identify and refine models of primary care; and to test these models of primary care against the status quo with primary care staff and with representatives of the public.

The remainder of this section draws on the findings from the previous chapters in order to answer each objective in turn.

9.2 To improve understanding of the views of the public in relation to the organisation of general practice (general medical services) within the wider context of primary care within Scotland

9.2.1 Priorities

The public's priorities for primary care were explored in chapter four. This work involved group work with members of the public from NHS Greater Glasgow and Clyde's Public Partnership Fora. General themes raised included access, continuity of care, holism, and the integration of care as well as the role of the GP as doctor and business owner. Elements associated with scenario planning were utilised to identify and explore the priorities which the group would have for any future model of service. This identified a group of twelve priorities shown in Table 7.2 (page 161). These were verified in subsequent events with PPF members and chapter seven sets out how these were scored in terms of importance. The highest scores were assigned to the priorities of quality of care; communication; access to care; and holism.

The public's priorities can be compared with those of professional and managerial staff operating in primary care. Chapter eight includes details of a comparable process of scoring of the priorities developed by the public. There was general agreement on the priorities between the public and professional groups and this fits with the work of Jung (280, 281) who saw an emphasis on quality, communication and access. One participant thought that this was unsurprising since *"primary care staff are patients too"*. There was less agreement on the role of the patient and the wider public in deciding and overseeing the way in which practices were organised, with the public group scoring patient influence within the practice significantly higher than did primary care staff (median score of 4 versus 3, P=0.004).

Whilst a significant literature exists exploring the views of the public and patients to primary care, much of this focuses on views of particular services or more general issues such as ease of access or satisfaction with the care provided. (282) There is comparatively little known about the priorities of these groups, or their attitudes to the organisation of services. Where others have researched the views of the public or patients into primary care priorities, the focus has been on the role of politicians and professions. (283) Charles and De Maio's framework of public

involvement in healthcare decision making sets out a framework which classifies involvement by three domains: decision-making, role perspective, and the level of participation. (284) The research described in chapters four and seven can be therefore be classified as decision-making at the level of services and policy, with the role perspective of both policy and user, and the level of participation being described as being that of a partnership.

The priority given to issues such as access, communication and quality fitted well with the existing literature, (24, 244, 280, 285, 286) but the focus on equity was perhaps surprising. However, Crawford *et al's* systematic review of patient involvement in service planning indirectly suggests that improving equity was an outcome of patient involvement. (287) The high levels of health inequality in Scotland, particularly in the Greater Glasgow and Clyde area, and the participants invitation to represent their respective communities (Charles and Di Maio's policy role descriptor) may explain this focus, with participants and the researcher *"adhering to ethical principles"*, one of Wensing and Elwyn's objectives for patient involvement. (285)

9.2.2 Views about the current organisation of general practice

The public expressed a view that the current model was good overall, but not perfect. In particular it was characterised by variability, with inflexible processes which were run for the service, not for patients. This was summed up by the quote *"today is about services, tomorrow is about patients"*. Whilst the public representatives valued general practice, there was dissatisfaction with the lack of holism and the lack of patient influence around the way in which services were organised. There was evidence that patients were seen as a collection of tasks rather than as individuals. Holism is a relatively novel word in the literature, but is in widespread use by primary healthcare professionals. It is best understood as caring for the whole person. This concept has been prioritised by patients in the literature but often described in other ways, including *"humaneness"* and *"exploring patients' needs"*. (244) The lack of holism in current general practice fitted with the view of Gubb and Li who described the nGMS contract as reducing opportunities for patient-centred interpersonal care. (63)

Chapter seven also asked the public representatives to compare alternative models for providing primary care with the current model. There was a strong feeling that patients should have more influence within practices. There was also evidence of tensions around power issues between professionals and patients in terms of the organisation of care. This was exemplified through a discussion on *"who determines local needs: professionals or patients?"*

The value placed on having an influence within the practice fits with the discourse on user involvement within the literature. A number of writers have described the limited opportunities for citizens or patients to shape the health services they use in terms of the overall governance agenda. (288, 289) Pickard *et al (290)* have used Hirschman's framework for recuperation – how service users interact with businesses in order to register disapproval and seek change. (291) They concluded that in a state-controlled healthcare system, the opportunities for exit were limited, although it should be remembered that patients could move their GP. The existence of a *de facto* state monopoly on healthcare made it crucial that patients should have mechanisms through which they could give voice to their concerns about the way in which the system was run. Pickard *et al's* study concluded that there was limited opportunity for such voices to be heard within the NHS.

Overall the current model scored most highly in terms of quality, access and joining-up care. The status quo was rated as achieving a median score of 45% and a mean score of 48% of the total available.

9.3 To improve understanding of the views of professionals working within the primary care team in relation to the organisation of primary care

Chapter five reports the findings from qualitative interviews with a range of professionals and managers working in and with general practices in the west of Scotland. Chapter eight reports the findings of an eDelphi designed to seek the same staff members' views of the public's priorities for primary care, and of two alternative models for services.

9.3.1 General comments

Staff respondents provided a consensus view that primary care was working hard. There was a recognition that in the midst of contracts and tasks, sometimes the *"patient gets forgotten"*. There was an acceptance that there was a high level of variability in the system. Time was seen as an important resource which was needed to address quality, minimise variation and tackle inequalities. This fitted with the current literature. (292) There was, however, an isolated view that the nature of inequalities was so intractable that it required a different model of primary care from that provided to the mainstream population. The top scoring domains in Model 1were access, quality and communication. Overall the extant model was scored by staff as having a median of 52% and a mean of 54% of the total available.

9.3.2 Governance

Governance was a prominent theme in the primary care literature and it featured in a number of models and typologies of primary care organisation. Governance provided a useful framework within which to describe a number of the findings of the research. The overall impression from staff interviewed in the work in chapter five was one of confusion, in terms of the roles of general practice, the model which was in place and the outcomes being sought for the population. There was an agreement that current organisational arrangements promoted access, quality and communication, but not holism, patient involvement or patient/public influence over the organisation of services. The nGMS contract was considered to have had a negative influence on holism as this was not well remunerated under the current arrangements.

Primary care staff held negative views about the role of Community Health Partnerships and the Health Board in relation to primary care. Primary care managers expressed frustration at the lack of levers to effect change in general practice and a lack of leadership across the primary care agenda. There was clear evidence of the tension between professionalism and managerialism from both GP staff and managers and the suggestion of a fundamental lack of trust between the two groups.

In the discussions on the organisation of primary care, staff rarely mentioned the patient. In chapter eight, proposals to increase the involvement of patients and influence of the public were seen as threatening by some medical staff.

From the managerial perspective, the negative attitudes to CHPs espoused by the majority of practice staff fit well with Smith and Barnes' perspective on the governance arrangements for primary care. They reflected on the unpopularity of moving from voluntary to compulsory arrangements for governance of primary care, commenting that *"if it was difficult to work with volunteers, it is likely to be harder with conscripts"*. (293) North *et al* have pointed out how loose the governance in primary care actually was with autonomous units having little desire to work with PCTs (or CHPs) and managers having few levers within which to encourage joined-up working and governance. They described the situation thus *"a sizeable part of health policy depends upon a semi-detached part of the NHS"*. (294) Sheaff *et al* have speculated that governance was the manner through which the leaders in new primary care organisations, who had been given responsibility for the governance of practices, should win acceptance for specific policies, implement them and maintain their leadership status. (295) From the practice and professional perspective, the emergence of governance and the CHP marked yet another loss of autonomy. Some authors have described the emergence of managerialism and governance as the *"end of a golden age of doctoring"*. (296)

The resistance to the involvement of either the CHP or patients is evident in the responses of staff, both when interviewed, and when exploring the alternative models. Mahmood has described the challenges to autonomy which accompanied the emergence of primary care management and greater imperatives around the involvement of services users. He has suggested that restratification has taken place within GPs, moving this branch of the medical profession from a flat structure with minimal hierarchy and high levels of clinical autonomy, to a more hierarchical structure with the emergence of an elite, seen as involved in governance and entrepreneurial activity. (297) This restratification has seen the emergence of primary care medical elites who govern others using *soft governance.* Soft governance is seen as distinct from traditional harder forms of governance such as contracts and managerial discipline, and it is the main method through which governance is enacted in networks such as primary care CHPs. (295) Soft governance functions through professionalism, collegiality and by professionals appealing to fellow professionals through ongoing relationships and by drawing

on shared professional values. Primary care restratification can be seen as either an attempt to defend the profession (298) or to weaken it by reducing autonomy. (299) These themes of loss of autonomy and professional power fit well with the comments made about the relationship with managers and the CHP and with comments made in reaction to models which would see increasing patient influence, described as deprofessionalisation, in which increasing knowledge and skills within citizens reduces the role of the profession. (300)

9.3.3 Skillmix

Skillmix was a generally welcome development within practices, but some managers saw it as a way to reduce costs. There was an agreement that the nGMS contract had changed the relationship between GPs and nurses. There was a degree of frustration felt by nursing staff at the perceived reluctance of GPs to permit nursing staff to develop additional roles. (301)

The comments about using skillmix to reduce costs fits with a literature which sees the delegation of tasks which were once the medical preserve to others as a *proletarianisation* of medicine. This has been described as a process through which tasks are delegated to *"subordinate them to the broader requirements of production under advanced capitalism"* or in other words, to reduce costs. (302) GPs did not see such proletarianisation as a threat to their power. The cost issues were mentioned by a primary care manager. Nursing staff expressed views that they would wish to extend their skills to contribute to skillmix within the practice and this is in keeping with the literature on the emerging roles of nurses and nurse practitioners within primary care.

9.3.4 Independence

The independence of practices within the NHS system was seen as desirable by the vast majority of participants. Whilst there was an acceptance that this might lead to variability in quality, there was clear support for the autonomy over work which this brought. The majority of staff felt that practices treated their directly

employed staff more fairly than would be the case within a wider NHS-employed option.

The literature supports GPs' overwhelming desire to remain independent within the NHS. (151, 173) Staff described the importance of their autonomy and the comments already made about the threats to autonomy from the New Public Sector Management and restratification within primary care provide a possible explanation for these sentiments.

9.3.5 Ownership and profit

Partnership was seen as desirable by GPs who cited it as a measure of commitment to the practice. A number of respondents expressed concerns about variability in business approaches and a lack of financial transparency. Nursing staff felt excluded from the opportunities which partnership might provide in terms of influencing the organisation of services. Most respondents expressed concern on issues around profit sharing, though one suggested professionalism as an effective way of managing this issue.

Staff directly employed by practices (including salaried GPs) reported good experiences overall in their work, including a degree of clinical autonomy, however there was clear evidence that there was a distinction between their rights to influence the organisation of services and those of partners.

The preference of GPs for partnership rather than salary reflects views in the literature. In general, ownership and autonomy seem related in the practice enterprise. Even where salaried GPs described having autonomy, there was clear evidence that this was lower than their partner counterparts. A number of staff were uncomfortable with the lack of transparency in partnerships, but they felt that some form of oversight was preferable to removing partnership as a way of working. Given the resistance to other forms of governance, there was no clarity on how this might be achieved. A greater number of staff were uncomfortable with the issue of profit taking in relation to ownership. Whilst one participant believed that professionalism was an effective way of managing the potential tensions between profit and patient care, other staff felt strongly that ownership and profit should have no place in healthcare. On a worldwide basis, for-profit

primary care is the dominant model. However, a number of authors have questioned how ownership impacts on patient care, quality and service organisation. Crampton has studied the impact of ownership on practice characteristics in New Zealand. In this system, community ownership was associated with wider access, although there was some evidence that equipment availability in these practices was lower than in the privately owned enterprises. (303) Meads *et al* have described extended community and patient participation models as one of a small number of central themes in international health systems undergoing modernisation. (304)

9.3.6 Medical versus social model of health

There was a wide variation in the level of understanding of health inequalities in the participants. Many participants felt that service organisation could have an impact on health inequalities, but argued that these were very difficult to change. A small number of participants felt that this was not part of the role of general practice. Participants had mixed experiences of attempts to integrate health and social care in terms of the impact on practice organisation.

The impact of the current nGMS arrangements on health inequalities remains unclear. Doran *et al,* and Lester and Hobbs have suggested that the impact is mainly positive, (52, 305) although Peckham and Hann contend that the arrangements have had an as yet uncertain impact on the population health and health equity. (306) There were mixed views on a wider role within the community suggesting a tension between a traditional medical model for patients and a wider social model of health for the local community. The literature contains a number of reports of the reluctance of general practices to work with a wider, more participatory social model. (307) Indeed Meads' assessment of the current state of European primary care has suggested that community development models of practice were essentially absent. (308) The majority of participants had a negative opinion of attempts to integrate health and social care. This fitted with the existing evidence within the literature which suggests that there are important epistemological barriers to the approach to health taken by health or social care staff. (309)

9.4 To identify and refine models of primary care

Chapter six synthesizes the findings from the literature, the work from the public on priorities and the views of staff on alternative models to identify a discrete set of models which would be proposed as alternatives to the status quo. The models were developed using the following framework:

- the model should be generalizable to the whole population as is the current situation in Scotland;
- the scope of conditions covered should be universal, covering primary care for all those who are, or believe themselves to be ill, including acute and chronic conditions and health improvement;
- the model must specify the staff or skills necessary for operation and their inter-relationships;
- it should have a clear method of funding and provide clarity about how work is organised; and
- there should be clear governance to ensure safety and quality.

Within chapter five, staff were asked to suggest alternative models for primary care. Themes emerging included a clear focus on retaining the independent contractor status, the need to modify arrangements to focus on local needs and health inequalities, the need to create minimum and maximum practice sizes to ensure good quality care, and the need to find a solution to issues of ownership, transparency and incentives. The key issues to tackle in any future model were:

- retaining independence;
- safeguards on professional and managerial behaviour;
- staff involvement in decision-making;
- a focus on local needs and priorities;
- wider and clearer skillmix;
- improved patient involvement;
- olutcomes that were more patient-focussed;
- address concerns around profit; and
- ensuring a respectful balance between professionalism and managerialism.

Chapter four clarified the priorities for any future model. These are shown in Table 7.2 (page 161).

From the literature, two alternative models were identified which contrasted with the current status quo and were thought to address some of the aspirations of both groups. These were: the PMS Plus model and the Social Enterprise Partnership. These were refined to ensure that they could be presented in a comparable manner to lay and professional audiences for the work undertaken in chapters seven and eight.

The alternative models identified from the literature were designed to be seen as realistic alternatives by both the public and primary care staff. In addition, the models were selected to incorporate elements which would address some of the issues identified from the public's priorities, the literature and the views of primary care staff of the organisation of primary care.

9.5 To test these models of primary care against the status quo with primary care professionals and with representatives of the public

In order to test these alternative models against the status quo, two separate methods were developed to seek the views of the public and of primary care professionals. This was done to ensure that the public's views were not silenced by the presence of professionals.

The public group used consensus techniques to score the importance of the identified priorities for future primary care, and then to score the performance of the current organisational arrangements alongside the potential performance of the two alternative models: a local contract model (PMS Plus) and a Social Enterprise Partnership (SEP). The staff group was consulted via an eDelphi survey to attempt to reproduce a comparable set of findings with scoring and feedback of written comments rather than face to face discussion. This solution was designed to prevent a dominant professional view from stifling alternative views, and to accommodate time constraints on primary care staff.

9.5.1 Local Contract Model

Public

The public participants felt that the local contract model provided greater opportunities for meeting local needs. A number of participants saw it as an improvement on the status quo, but a significant minority saw it as little changed. There was a recognition that merely changing the model might not change practice and that the culture of staff work would need to change to improve things. The model revealed evidence of tension in the power held by practice staff and patients, with participants questioning if patients or professionals would decide local priorities in such a model. Overall, access, quality and communications were the most highly scored domains in the model, which achieved 56.6% of the total available. The public's overall score of the model was not significantly different from that of the status quo model, however, the domains of patient influence, the involvement of patients and carers, improving health and wider benefit to society all scored significantly higher for the Local Contract Model in comparison with the scores for the status quo.

Staff

Staff respondents supported the idea of embedding further community staff within the core practice team. It was felt that this might resolve some of the organisational and managerial tension, improving communication and effective working. A number of staff felt that the local focus might make such a model unaffordable, with needs being uncovered without a hope of resources being available to meet these. Finally, there was little trust that Board and CHP managers would implement this in a way which actually improved care. The three top scoring domains for staff were quality, communication and health improvement. The overall scoring was similar to that of the public at 57% of the total available. The staff scoring of the model was not significantly different from that of the status quo. There were no significant differences between staff scoring of the individual domains for the Local Contract Model in comparison with the scoring of domains for the status quo.

It is interesting that the Local Contract Model was considered better able to provide opportunities for patient influence and for the involvement of patients and carers by the public group. There was also some evidence suggesting that the group believed that there was greater opportunity for improving health and the potential for a wider benefit to society. Whilst these issues were in keeping with the current thinking on PMS practices, there has been limited formal evaluation of PMS or PMS Plus practices in the literature. There were no reports of patient or public satisfaction with the PMS model. The limited evaluation does suggest improvements in quality and performance, but the highly contextual nature of each PMS contract and the limited scale of the evaluation makes it difficult to judge the utility of these findings in the context of the public and staff findings. (310)

9.5.2 Social Enterprise Partnership Model

Public

The public group were generally supportive of this model, feeling that it improved patient involvement and widened the focus to include health improvement. One participant wondered if patients were ready for greater involvement and participation. Another participant found it difficult to score the new model as there were too many new elements involved. There was a significant focus on the issue of professional power with a number of participants feeling that GPs were unlikely to approve a model which gave more power to patients. The highest scoring domains in this model were communication, quality and access, and overall the model achieved a median of 71.9% of the total available score (mean was 66.7%). Overall, the public's total score for the SEP model was significantly higher than their scores for the status quo model and for the Local Contract Model. In addition, the domains for patient influence, the involvement of patients and carers, holism, joined-up services, continuity of care and wider benefit to the community were all significantly higher for the SEP model in comparison with the public's scores for the status quo. In addition the domain improving health and the involvement of patients and carers were significantly higher than the public scores for the Local Contract Model.

Staff

Similarly, the staff group had a significant focus on the risks associated with the increasing influence of patients and the public. The main concerns raised were around patients with specific interests distorting the priorities and functioning of a practice, potentially widening inequalities. Another GP felt that this undermined leadership, stating that such a complicated system needed a *"strong headmaster"*. On the second round of the eDelphi there was an emerging view that the benefits of wider patient involvement outweighed the potential risks, and that greater patient involvement might have the added value of directly influencing patient behaviour in terms of health and healthcare.

There were mixed views around profit and profit sharing. Whilst some welcomed the greater fairness, others did not agree with profit in any form, believing that staff should simply draw a salary and that profit incentive was unethical. A GP welcomed the idea but pointed out that this might have unintended consequences as there is little knowledge currently on what motivates current GP partners to perform. In common with the views of the public, staff pointed out that the model of practice mattered less than the culture underpinning the implementation.

The highest scoring domains for this model were quality and communication. The staff respondents' total score for the SEP had a median of 64% and a mean of 60% of the total score available. There were no significant differences between this score and the staff scores for the status quo or the Local Contract Model. However, staff scored the domains of patient influence and involvement of patients and carers significantly more highly in the SEP model than was the case for the status quo and the Local Contract Model.

Whilst the public group's scoring suggested that the SEP model performed better overall in terms of the agreed domains, this was not found with the staff group. This may reflect a genuine difference in perspective between the two groups or it may be a manifestation of the different arrangements used for scoring (via eDelphi). There did seem to be agreement between both groups that the SEP model performed best in terms of patient influence and the involvement of patients and carers, reflecting the more community-focussed governance which underpins the model. The model was an attempt to address some of the issues around governance within partnerships in terms of widening the distribution of power within practices to include other staff groups as well as patient and

community representatives. Much has been written about the importance of community empowerment in terms of public health (306) and community orientated primary care, but little is written about these models in the UK or Scottish contexts.

9.6 Understanding stakeholder perspectives on the organisation of primary care

As Hutchinson *et al* succinctly state: *"There is no single "right" model for the funding, organization, and delivery of primary health care. Different models have different strengths and weaknesses and may perform better or worse in different contexts and with different target populations. Most are capable of evolutionary development."* (311)

Whilst one of the objectives of this work was to identify and test alternative models for primary care in a local context, it is clear that the infinite variety of primary care makes a standard local model unrealistic. What this study does suggest is that there is significant agreement between primary care staff groups and patients on the priorities facing primary care. However, there remain uncertainties around the overall governance of primary care, the roles of the public and patients in such governance, and the changing nature of the relationship between GPs, CHP/Board primary care managers and patients.

One of the emergent themes from the work with professionals was the lack of agreed outcomes and roles across primary care and its constituent professions. McDonald *et al* have suggested that practitioners have uncertain roles in a complex system. They believe that an understanding and mutual acceptance of respective roles is central to safeguarding patient experiences and that the roles need to be agreed and seen as fair by all parties. (127) Given the importance of education in determining staff roles, perhaps a response to this would be the implementation of Frenk *et al's* recommendations for the third wave of health professional education, creating professionals who have flexible roles, good interprofessional skills and who can act locally whilst being part of a wider *global* system. (126) For those professionals already in practice, approaches which build on Lanham's principles for good interprofessional working need to be developed

within practices. (125) The development must occur within practices and must be flexible in order to be accepted. (312)

The managerial approach suggested by the New Public Sector Management philosophy is generic and utilitarian and is consistent with the will of government. Managers seek *synoptic legibility* from governance, or more simply, that the complexity is reduced to simple facts and figures which establish if objectives are being met. (313) This approach was underpinned by a different set of beliefs from practitioners in primary care who see themselves as autonomous and driven by a different set of values and accountabilities. For professionals, governance must have meaning for the adopter, and there must be the flexibility to adapt to fit local circumstances. (314)

As previously discussed, Iliffe's dual axes of autonomy versus incorporation, and business versus consumer markets appeared to be a useful way of conceptualising some of the tensions in primary care. (165) However, the framework was modified by the author so that the axes became professionalism versus managerialism, and tasks versus outcomes. The findings from later elements of the research would support these dual tensions within governance, played out as professionalism versus managerialism, and tasks versus more holistic, composite outcomes.

The study suggests that a fundamental issue is the lack of trust operating between primary care staff and Board/CHP managers. Walker *et al* have suggested that complex interprofessional and interagency tensions can be managed using a balance between trust and control processes. (315) Their context was that of a complex, pluralistic payer and provider network of primary care and the emergence of novel primary care networks. Trust was defined as *"The expectation that an actor can be relied on to fulfill obligations, will behave in a predictable manner, and will act and negotiate fairly when the possibility for opportunism is present." (316)* Their findings suggest that trust can complement other control methods such as organisational governance, structures and processes and this fitted with other guidance in the realm of joint working. (317) However, issues around public accountability and oversight are unlikely to disappear and the findings of this study suggested that there are perceived difficulties with the governance of privately owned primary care entities.

Baker has built on the central importance of trust and states that high quality clinical care demands that professionals exercise clinical judgement within a context of trust. He states that *"They require discretion to take decisions that are in the patient's best or expressed interests rather than decisions dictated by the organization or the state. If this is so, and I believe it to be so, then there is a limit to how a managerial approach to quality improvement can achieve all the progress we wish to see."(318)* In the comments made about the current state of primary care, there are clear references to the absence of effective leadership. Baker suggests that trust, combined with a strong and renewed professional leadership will be required to ensure that the outcomes from primary care balance the rights of the individual patient against the wishes of the state.

Trust is a recurring theme in healthcare literature. It is central to the doctor-patient relationship and has been described as a *prerequisite for healing in an uncertain world. (319)* Platnova *et al* have also suggested that trust is necessary for patient satisfaction and loyaly. (320) Abbott has suggested that despite the reliance on processes, rules and objects in high modernism, people still place expertise within the role of professionals. (321) The need to trust may well play a significant role.

Calnan and Rowe have suggested the concept of conditional trust for professionals. (322) This relates to Adler's work on the balance between checking and trusting, termed *reflective trust*. In effect, checking makes trust conditional. (323) Building upon this concept, Brown and Calnan propose trust as a civilizing process through which conditional trust might act to improve the governance within primary care. They contend that the current governential frameworks lack a sense of ownership and point to evidence that professionals subvert quality measures for this reason. (324) In a similar vein, Davies and Mannion suggest that governance must "s*trike a balance between checking and trusting*". (325) Howe *et al* have suggested that professional leadership is the solution to improving quality in general practice. (326)

The research raises some important issues around trust. The trust between primary care staff and patients may be undermined if patients become more aware of the profit motive which GPs need to consider alongside that of their clinical decision-making. In addition, the very nature of the QOF components of nGMS are underpinned by checking, creating Moran's *synoptic legibility* (313). This is consistent with the new public sector management philosophy, but may

mitigate against trusting relationships between practice staff and CHP/Board managers.

Therefore, whilst the model of primary care can evolve to make good some of the current deficits identified in this work and that of others, it may be that additional actions are needed to ensure that organisation is balanced with approaches which develop trust and a renewed sense of professional leadership which embraces participation by patients and managers whilst preserving the quality of clinical care and the care of individual patients and communities.

The issue of patient involvement in the governance of general practice is interesting. The reluctance of health professionals to embrace user involvement fits with much of the literature. (288, 289, 327, 328) Neuwelt's work sets out the differences between consumer feedback and user involvement, citing experience in the New Zealand primary care system, where community governance is a statutory requirement. She points out that genuine user involvement is complex and time consuming, and that it requires the development of trust-building between staff and patients. (329)

9.7 Limitations and strengths

9.7.1 General issues

The aim of this research was to explore the current organisation of general medical services in Scotland and to use a variety to methods to identify a more effective organisational model for future delivery. In order to achieve this ambitious aim, a number of key pieces of research were identified as necessary to inform the overall process. These included: an improved understanding of the public's views in relation to the organisation of general practice; greater understanding of the views of primary care staff and CHP/Board managers; a comprehensive understanding of the history and alternative models to provide general medical services; the development of alternatives to the current model which might address some of the limitations; and the public and primary care staff and CHP/Board managers' reflection on these models. Through the process of developing and testing alternative models, it was hoped that the work would provide a greater

understanding of the links between priorities, values and organisational arrangements.

In attempting to achieve such a diverse yet linked series of research objectives, the author elected to choose breadth and relevance over the alternative approach of greater focus and depth. This decision had implications for each of the strands of research as choices had to be made to ensure that rigorous research which answered the research questions was achievable within the time and resource available. The author believed that this choice was necessary as the complex and interrelated nature of general practice organisation required research which addressed the organisation of the system in a multifaceted manner, using mixed methods.

9.7.2 Literature review

The literature review was developed to provide a historical perspective, identify models of primary care and their relative strengths and weaknesses and to explore the views of primary care staff and patients or the public in relation to the organisation of the general medical services component of primary care. Some of the questions being answered by the review did not lend themselves to focussed literature search. To compensate for difficulties with the coding of organisational literature in relation to primary care, the approach taken combined broad general search strategies combined with focussed searches to enhance the coverage of specific issues, such as practice-based commissioning. This approach may have resulted in greater depth of review for specific topics in comparison with other areas.

9.7.3 The public's priorities for primary care

The work to deepen the author's understanding of the public's priorities for the future of primary care was started prior to registration for the research degree. The PPF group was a convenience sample which was utilised as the group was convened for the purpose of representing local communities in relation to health service issues. The role of the PPF members may have been a limitation of the

work. Engagement with members of the public can be through their roles as citizens or service users (patients). (330) In reality, Price has pointed out that in the final analysis, public representatives always have conflicting issues as citizens who take the wider interest, and potential or actual service users who may express self-interest. (274) In this work CHP participants had prior experience of representing their communities.

It was not possible to ensure the democratic, statistical or typical representativeness of the PPF participants. (331) The age of the participants was higher than that of the general population, and this probably increased the propensity for the participants to be regular service-users that would have been the case with a more statistically representative sample. In addition, the ethnicity of the participants was not recorded. It is therefore possible that the public sample for the priorities event was unrepresentative. Some authors have suggested that pragmatism is required in approaching representativeness with the public, suggesting that imperfect methods of involving the public are acceptable *"especially if there is some awareness of what kind of pieces are missing"*. (332) Given this approach, it was argued that interpretation of the public involvement findings was still possible, although it was accepted that a different set of priorities and a different emphasis on those priorities might have occurred had it been possible to recruit a wider, more statistically representative group.

9.7.4 The views of primary care staff and managers

Primary care staff and managers were recruited in a manner which attempted to ensure representativeness by staff group and geography. Given the acknowledged difficulties in recruiting primary care staff to research, by virtue of agreeing to participate, the staff were unlikely to be fully representative of their respective staff groups in general. This may mean that alternative subgroup views have not been captured within the research.

It is possible that the investigator's prior beliefs may have shaped the findings from the staff qualitative research. Firstly, it is possible that, despite taking care to structure the interview in a way which created open questions with balanced statements, his views might have influenced the direction of conversation. Secondly, his views could have had an impact upon the coding process during the

analysis phase. The investigator attempted to reduce this impact through providing an *a priori* statement of his beliefs and by double coding transcripts with a supervisor who was aware of his beliefs. In reality, the investigator's attitudes to the topic of the organisation of general medical services shifted substantially across the study, reflecting his openness to the consensus views which were emerging from the research. Despite this, it is possible that *a priori* beliefs could have influenced the findings.

9.7.5 The selection of alternative models for general practice

The choice of alternative models of general practice upon which to base the final elements of the research was based upon the researcher's understanding of the primary care organisational literature and his interpretation of the views of primary care staff and managers and the priorities of the public representatives. Given the vast literature on primary care organisation, the search for plausible alternative models might have been affected by the discounting of models from outwith the UK. Despite attempts to support the trustworthiness of the qualitative findings from the priorities session and the interviews with primary care staff and managers, it is possible that the author's views of the alternative models could have influenced the final choice. A contrasting view however would suggest that his decision not to include a salaried model, in keeping with his initial beliefs provided evidence that the choices were informed by other factors, such as the emerging evidence from the public, literature and the qualitative work with primary care staff, and the need to site this work in the current and near-future context of Scottish primary care.

9.7.6 Deliberative methods and the public

As with the public priorities event, the representativeness of the public participants was a limitation of this section of work (see section 9.7.3). The structured approach used for the deliberative methods with the public representatives was designed to reduce the propensity for participants to focus on their individual interests and to focus on agreed, collective priorities through which each model would be assessed. In addition, the approach was designed

based on the investigator's *a priori* intentions to develop a better model for general medical services. From this perspective, agreeing priorities in advance provided a rational and controlled framework through which deliberation occurred. An alternative approach would have included the development of a larger number of potential models, with the use of conjoint analysis techniques which might have identified specific organisational factors, situated above the level of general priorities, but below the level of models, which might have been preferred by the public. This approach might have had a better fit with Hutchinson *et al's* view that there are no perfect models, but that all models can be improved through evolution. (311)

The use of the prioritisation instrument as a method of deliberation can be considered as a potential limitation. Whilst the investigator sought to establish its face validity with the group, building it on the experience of others, there was no formal validation process. This can be explained by the change in the investigator's focus from that of seeking an idealised model to that of seeking to explore the beliefs, values and processes within the models as a method of improving the existing arrangements for primary care.

9.7.7 Deliberative methods and primary care staff and managers

The choice of eDelphi had several limitations. Firstly, the eDelphi process may have resulted in less rich data than would have been obtained in face to face deliberative methods such as those used with the public representatives. In comparison with the public's deliberative panels, the eDelphi created less consensus. This was the result of the research design, which intended to prevent a dominant professional opinion from emerging at an early juncture, potentially stifling alternative perspectives. Whilst the number of eDelphi cycles was limited to mirror the deliberative processes used with the public, a longer eDelphi process might have resulted in greater consensus.

Secondly, the priorities for primary care through which scoring and deliberation occurred, athough scored by the staff participants, were agreed by the public. There may have therefore been a dissonance for the participants who were asked to rate a series of priorities which may not have comprehensively represented their own priorities as a group.

The choice to re-approach the original staff participants was based upon the need for participants to have a critical mass of understanding around the organisation of primary care general medical services. Whilst this was a strength in terms of engagement and the richness of understanding, it may have reduced the transferability of the research to the wider constituency of primary care. Finally, the extended delay between the first and second eDelphi may have had an impact on the findings.

9.7.8 Scoring and quantitative comparisons

The quantitative elements of this thesis were designed to triangulate findings and to explore differences in preferences within and between each of the participating interest groups, and to build upon the prior findings in a way which extended understanding of the values and priorities of staff, managers and the public in relation to improving the organisation of primary care. As previously discussed, the groups used lacked the representativeness for generalisability. In addition, the prioritisation instrument used lacked formal validation. Nevertheless, it provided a mechanism through which complex organisational models could be deliberated upon, using agreed and transparent priorities and processes.

9.7.9 Alternative frameworks and approaches

Whilst the use of mixed methods to answer the research questions was the framework used by the author in developing and analysing the data for this research, alternative frameworks considered included policy analysis, and soft systems.

A soft systems approach was considered as a framework for the research as it offered a positive approach to investigating a complex and poorly defined set of problems with multiple stakeholder perspectives. Such an approach might have supported the author in gaining a deeper understanding of stakeholder perspectives and of the problems facing primary care and could have supported exploratory work with stakeholders on organisational design, including restructuring of primary care or refashioning of culture (333). Soft systems

methodology acknowledges the central role of group-based learning and consensus. Ultimately, despite many advantages the methodology was rejected because of concerns that group-based sessions with stakeholders, particularly in relation to the discussion of contractual and employment issues with a group of GPs might have stifled alternative views, limiting the value of the research in exploring and developing new understanding of stakeholder perspectives on the organisation of primary care.

A policy analysis framework was considered as a possible approach for analysis and synthesis of the findings from this research. Indeed, the approach used by the author which involved identifying the problems, setting evaluation criteria, identifying alternative approaches, evaluating these approaches owes much to the rational-policy analysis approach (334). A policy analysis approach would have provided a framework to describe and analyse the policy landscape for primary care, strategic approaches to implementation and the perspectives of different stakeholders in order to make recommendations for the necessary changes to bring about improvements in primary care. However, the decision to focus on stakeholders in a local system resulted in much of the focus of the work being strategic and operational rather than being developed at the policy level. For this reason, the author chose to focus on a methodology which had similarities to those seen within policy analysis, but not to include the use of policy matrices and other tools from formal policy analysis, preferring to develop a bespoke framework which built upon mixed methods for the analysis of stakeholder perspectives and data.

9.7.10 Strengths

The major strength of this study was its attempt to engage with the organisational problems facing general medical services in a comprehensive manner, seeking relevant, system-wide options for improvement. The use of mixed methods through which elements of research were designed to triangulate and build upon previous findings provided trustworthy findings within the limited group of staff and public representatives sampled.

Given the scope and ambition of the research, pragmatic mixed methods provided a robust methodology through which the author could explicitly take account of

prevailing contexts. In many ways, whilst these contextual factors imposed some limitations on the work, they also added to the credibility and utility of the findings. Despite the limitations, the work provides novel insights into the current organisational settlement, contributing to current knowledge in the area of primary care governance in terms of primary care staff, managers and services users.

Bryman's framework for the purposes of mixed methods was used to clarify the purposes for the choice of research methods. This is summarized in Table 9.1.

Table 9.1 Analysis of the purposes of the mixed methodologies used in the research based upon a nosology of mixed methods purposes developed by Bryman.(252)

Bryman's purposes	Explanation of purpose	How this research fits against the purposes
Triangulation	Comparing findings using more than one method to improve validity	Yes – findings from qualitative research with public and staff are tested using models
Offset	Offsetting the relative weaknesses of quantitative and qualitative methods by using a combination	Yes – qualitative and quantitative elements allow offsetting between and within different component of the research
Completeness	Providing a more comprehensive answer to the research question	Yes – given the complexity of the aim, mixed methods improves the completeness of the work
Process	Providing an understanding of both structural and process issues underpinning a research question	Yes – the narrative review, qualitative research with staff and the public and a combination of both methods provides an understanding of the structure and the underpinning processes within the organisation of primary care
Different research questions	To answer different research questions using alternative methods	Yes – qualitative or mixed methods were used to answer different research questions
Explanation	One methodology explains findings from another	Yes – qualitative findings were used to confirm and explain the quantitative findings in the testing of models with the public and staff groups
Unexpected results	To explain or explore unexpected findings	Yes – qualitative findings were used to explore the findings in the staff testing of alternative models
Instrument development	To develop a research instrument	No
Sampling	Where one method is used to facilitate the sampling of respondents or cases	Yes – in the most basic sense, the qualitative research was the basis for the second phase of work to test the alternative models.
Credibility	Employing both approaches enhances the integrity of the findings	Yes – using both methods provided a more robust and complete account of staff and public views around primary care organization

Context	Qualitative research provides contextual understanding of quantiative results coupled with either generalizable findings or broad relationships among variables	Yes – qualitative work in the testing of models explained quantitative findings and the relationship between priorities
Illustration	Where qualitative data is used to illustrate quantitative findings	No
Utility	Combining approaches increases the usefulness of the findings	Yes – multiple lines of evidence makes the work more accessible to different groups with interests in primary care
Confirm and discover	Qualitative findings generates hypotheses which are then tested quantitatively	Yes – the findings from the literature review and public priorities created hypotheses which were then tested quantitatively and qualitatively through the scoring of models
Diversity of views	Uncovering relationships between variables whilst exploring their meaning qualitatively.	Yes – the perspectives of a wider variety of stakeholders were explored qualitatively and quantitatively
Enhancement	Enhancing the findings from one piece of research by using a second methodology	Yes – findings form the public priorities, staff qualitative and literature work were refined through the testing of models with the public and staff groups

9.8 Reflections

At the start of this research, the writer's clear aim was to complete a programme of work which would result in a better model of primary care. Across the course of the research a number of factors resulted in a changed focus so that his aim was to consider ways in which the extant models could be improved to take account of the learning gained through research.

The first factor which resulted in this change of mindset was the difficulties involved in engaging with and characterising the model of general medical practice. Within the West of Scotland and indeed across the world, the provision of primary care is profoundly affected by local contexts in terms of its purpose, methods, payment, governance and so on. Given such variation, a huge change would have been required to create a standardised model.

Linked to the issue of variation were the findings from the interviews with primary care staff and managers. The writer was struck by the importance which staff attached to independence and their low regard for centralised and

bureaucratic processes. Whilst this work was exploratory, the strength of sentiment suggested that a new model was not only difficult to achieve, but that there was no appetite for this across the different disciplines which formed primary care general medical services and their associated colleagues.

Hutchinson *et al's* belief that there is no single right model accorded with the author's changing views. (311) Against this background, the alternative models suggested were used as a tool to explore the problems with the existing models and to suggest which evolutionary levers should be used to create improved outcomes in the local context.

On starting this research, the author had experience as a GP and as a public health doctor. This provided him with perspectives into the working of independent practices and the managed NHS. His initial thinking favoured a salaried option through which difficulties with governance might be solved and inequalities tackled through alternative ways of working. The research process convinced the author that independent primary care practices were preferable to a centrally managed approach because this would simply replace one set of problematic governance with another. He came to believe that the current model should evolve to ensure that there was a balance between professionals, managers and patients.

The research started with the aim of creating better alternatives to the current model of general practice. The complexity and inaccessibility of the literature around primary care organisation and the historical and local factors which continue to shape provision convinced him that the model was less important than the general principles which shape what primary care produces and holds individuals and organisations to account for the quality and impact of services on individuals and the population. His learning from the research is a greater appreciation of the reflexive nature of qualitative research which has created an opportunity for a radical shift in his perspective and the emergence of alternative themes for further research and exploration, such as that of patient and community governance and leadership as concepts which might help to evolve and improve the existing model of service delivery.

9.9 Possible implications of the findings

This study took a multifaceted approach to deepening understanding of the attitudes of the public, primary care staff and primary care managers to the way in which primary care is organised. Although patient satisfaction in their experiences of general practice is routinely high, the findings suggest that there are significant limitations in the current arrangements from the perspective of staff, managers and patients.

Staff saw primary care as confused and lacking in leadership, but were disillusioned by the structural management arrangements at the CHP and board level and lack trust in managers, undermining existing governance. In addition, staff were keen to remain independent within the NHS, but many recognise that the current ownership arrangements lack a degree of transparency and accountability. Managers seem to have few levers to enact governance and seem isolated from the reality of primary care delivery, being seen as irrelevant. Patients were keen for greater involvement and participation in the governance of primary care, but primary care staff were at best ambivalent about such a proposal.

The findings from this research suggested a number of hypotheses which could be tested for generalisability through further work. The research confirmed previous work which suggests that governance in primary care is problematic from the perspective of primary care staff and managers. In addition, the work suggested that whilst independence is seen as universally desirable by primary care staff and most managers, that there are problems which this creates in terms of equity of staff in terms of the organisation of primary care, and issues around transparency surrounding the issue of profit in relation to the organisation and delivery of services. This issue was complex as incentives have a place in payment systems, but are fraught with unintended consequences. Financial transparency and the balance between profit and service provision were some of these unintended consequences. This work also suggested that the current organisation of primary care is seen as problematic by services users, succinctly captured in the quote *"today is about services, tomorrow is about patients"*.

In the group of public representatives who participated in the research there was a strong desire for greater involvement in the organisation and running of primary care, whilst accepting that the involvement of patients and the wide community

was sometimes problematic. The work from the interviews with staff and managers provided a sense of confusion as to the core purpose of primary care general medical services and a distinctive absence of the patient from discussions about service organisation.

The tension between managers, primary care staff and patients is an appropriate tension, but this work suggested that at present primary care staff have disengaged from a governential process with managers. Perhaps an invigoration of primary care governance with service users would change this dynamic, creating a need for all three parties to work together to negotiate a shared vision for primary care at the level of the system and within local communities. Countries such as Australia and New Zealand, with pluralistic provision of services tend to have greater community governance and user involvement. It may be that the highly hierarchical Health Service in Scotland leaves little room for community governance and user involvement. Whilst changes in England focus on the creation of a business market, and ultimately a consumer market, one consequence may include a strengthening of user voice. The role of the public in community governance is poorly understood. Most resistance to public participation centres around issues of access to specialist content knowledge to aid decision-making or around representativeness of the citizen versus the viewpoint of the individual service user.

Nevertheless, lessons from the recently published Francis Inquiry into serious failings in secondary care which occurred at the Mid Staffordshire NHS Trust, suggest that an exclusively managerial governance, and indeed, an overreliance on structural approaches to governance in general, such as those involving targets, have unintended consequences. (335) Health professionals and managers rightly have overlapping, yet distinct perspectives and responsibilities within the system. Given the need to ensure that health professionals and system managers work together, perhaps the most important role for the public in governance is that of mediator: ensuring that health professionals and managers reach a shared position which encompasses the perspectives of the state, professions, patients and citizens.

The imposition of processes for governance and liaison are unlikely to be successful without the creation of trusting relationships through which governance is mediated. This may be the greatest issue which needs development.

A number of medical authors have commented on the end of a *golden era* for doctoring. An alternative perspective might be that professionalism and professional leadership requires to be renewed, creating new norms and frameworks for education which might underpin conditional trust through which governance might operate effectively. Work on professional restratification suggests that new hierarchies and approaches are emerging and are being accommodated within professions.

The suggestion that either a PMS Plus or a social enterprise model might be a valid alternative to the status quo has potential implications for policymakers in relation to devolution and the Scottish Government's stated intention to create a more Scottish-focussed GP contract. The policy context in Scotland has progressed from approaches which encouraged the patient perspective in services (336), through approaches which focussed on the co-creation of health and which promoted a Patient Focus, Public Involvement, culminating in a statutory basis for user involvement in the white paper Partnership for Care in 2003 (337) and mandatory quality standards around user involvement in clinical governance. (338) Against this backdrop, models which promote user involvement in the governance of primary care would fit. However, the given the historical reactions of the GP profession to contract change and the apparent unease which increased user involvement provoked in this work, such change would be challenging.

A future model for general medical services might build on the current arrangements, but with patients, practice staff and managers working collaboratively through conditional trust to ensure the operation of locally negotiated approaches to primary care which take account of local needs, resources and wider issues of health equity. A greater involvement of all three parties in meaningful governance would address many of the difficulties uncovered in this research.

9.10 Conclusions and recommendations

9.10.1 Conclusions

Qualitative work with public representatives confirmed the importance of quality, access and communication as priorities in primary care. In addition holism, patient and carer involvement in their care and patient/public participation in the organisation of primary care services were important issues.

Primary care staff recognised that there were problems with the current organisational arrangements in primary care. Ownership, and profit were contentious issues and there are variable approaches to health inequalities. Despite these limitations, almost all participants favoured continuing independence for practices within the NHS. Primary care managers recognised the lack of levers which existed to improve the current system. There was a lack of trust and a perceived lack of leadership within the primary care system.

A Local Contract Model and a Social Enterprise Partnership were considered as alternatives to the current organisational arrangements. The public representatives demonstrated a preference for the Social Enterprise Model. This may be related to this model's potential to increase patient involvement in the governance of primary care.

Primary care staff and managers demonstrated no significant preference for either alternative model in comparison with the status quo, however deliberation suggested ambivalence of professionals towards greater public involvement in the organisation of services and a lack of trust in CHP managers.

There is a role for the public in the governance of primary care. This role is contested through issues of representativeness and content knowledge. Given the different accountabilities of health professionals and managers, the main role of the public is to mediate priorities and approaches which are acceptable to the citizen, taking account of the views of professionals and managers.

9.10.2 Transferability

The nature of this programme of research was inherently qualitative, seeking to deepen understanding of the views around the organisation of primary care in Scotland. As such, the findings were not simply generalisable. However, the fact that many of the conclusions partly accord with existing knowledge supports the validity of the findings and suggests that the knowledge could be transferred in a way which could permit the findings to inform debate and the discourse of primary care as well as providing a basis for further research, both qualitative and quantitative.

9.10.3 Recommendations

Policy

1. Government, professions, managers and other stakeholders should consider the current governance arrangements for general practice. The complex network which exists has been problematic for staff, managers and patients. A reliance on soft governance and a lack of trust between parties underpins the current tensions. A new agreement is needed which combines improved relationships and trust as well as formal structural processes for accountability.

2. The variability in understanding and approach to tackling health inequalities within general practice needs urgent consideration by the profession and government. Given the policy imperative on reducing inequalities there needs to be further dialogue on the existing policy approach to inequalities in primary care.

Practice and future research

3. It is recommended that public involvement in the governance of primary care practices should be discussed by the public interest groups, professions, government and service managers. The divergent attitudes to greater user involvement would benefit from further debate and may provide a solution to ineffective governance mechanisms within primary care and more widely across healthcare.

4. Given some evidence of public enthusiasm for alternative models of primary care, stakeholders should explore ways in which the current model can evolve to better meet the needs of patients whilst safeguarding the independence of practices.

5. The importance which the public afforded to holism accords with contemporary professional views but is in conflict with the task-driven contractual arrangements which are in place across general practices. Stakeholders should be encouraged to explore ways in which the existing framework could be improved to provide a greater focus on person-centred care.

6. Conditional trust may be an important element of the new interdisciplinary professionalism needed to underpin relationships within primary care. This concept requires further development and research.

7. The mediating role of the public in community governance can be developed through the current frameworks. However, further research is needed to explore the mediating role and to ensure examples of good practice are replicated across primary care.

References

1. Mays N, Pope C, Popay J. Systematically reviewing qualitative and quantitative evidence to inform management and policy-making in the health field. Journal of Health Services Research & Policy. 2005 July 15, 2005; 10 (suppl 1): 6-20.

2. Organization WH. Primary Health Care: report of the International Conference on Primary Health Care, Alma-Ata, U.S.S.R., 6-12 September, 1978. Geneva: 1979.

3. Institute of Medicine. A manpower policy for primary health care. Washington D.C.: National Academy of Sciences, 1978.

4. Starfield B. Primary Care: Concept, Evaluation, and Policy. New York: Oxford University Press; 1992.

5. Interim report of the Council on Medical and Administrative Services. London: HMSO, 1920.

6. *The General Practitioner in Europe* Leeuwenhorst: Statement from the Second European Conference of the Teaching of General Practice. 1974.

7. Olesen F, Dickinson J, Hjortdahl P. General practice—time for a new definition. BMJ. 2000 2000;320 (7231): 354-7.

8. Howell JD. Reflections on the past and future of primary care. Health Affairs. 2010; 29(5): 760-5. PubMed PMID: 20439858.

9. WONCA Europe. The European Definitions of The Key Features of the Discipline of General Practice, The Role of the General Practitioner and A description of the Core Competencies of the General Practitioner / Family Physician, 2005 [Cited March 2013]. Available from: **http://www.woncaeurope.org/sites/default/files/documents/Definition%20EURACTshort%20version.pdf**

10. Majeed A. Primary care in Europe: entering the age of austerity. Journal of Ambulatory Care Management. 2012; 35(3): 162-6. PubMed PMID: 22668604.

11. Heywood P. The changing character of service provision. In: Tovey P, editor. Contemporary primary care: the challenges of change. Milton Keynes: Open University Press; 2000.

12. Webster C. The National Health Service: A political History. New York: Oxford; 2002.

13. Petchey R. Collings report on general practice in England in 1950: unrecognised, pioneering piece of British social research?[see comment]. BMJ. 1995; 311(6996): 40-2.

14. Hart J. The Political Economy of Health Care: A Clinical Perspective. 1 ed. Bristol: Policy Press; 2006.

15. Lawson JA. The Royal College of General Practitioners: its growth and influence over the past 40 years. British Journal of General Practice. 1992; 42(358): 210-1.

16. Gray DP. History of the Royal College of General Practitioners--the first 40 years. British Journal of General Practice. 1992; 42(354): 29-35.

17. General Medical Services Committee. A Charter for the Family Doctor Service. London: British Medical Association; 1965.

18. Lewis J. The Medical Profession and the State: GPs and the GP Contract in the 1960s and the 1990s. Social Policy & Administration. 1998; 32(2): 132--50.

19. Rhodes RAW. The New Governance: Governing without Government. Political Studies. 1996; 44(4): 652-67.

20. Department Of Health. Working for patients: the health service: caring for the 1990s: a summary of the white paper on the government's proposals following its review of the NHS. London: Department of Health; 1989.

21. Bosanquet N. Quality of care in general practice--lessons from the past. Journal of the Royal College of General Practitioners. 1989; 39(320): 88-90.

22. Bosanquet N, Leese B. Family doctors and economic incentives. Aldershot: Dartmouth; 1989.

23. Iliffe S. The modernisation of general practice in the UK: 1980 to 1995 and beyond: Part II. Postgrad Med J. 1996; 72(851): 539-46.

24. Smith CH, Armstrong D. Comparison of criteria derived by government and patients for evaluating general practitioner services. BMJ. 1989; 299(6697): 494-6.

25. Warwicker T. Managerialism and the British GP: the GP as manager and as managed. Journal of Management in Medicine. 1998;12(6):331-48, 20. PubMed PMID: 10351259.

26. Department of Health. On the state of Public health. Report of the CMO for 1991. London: HMSO, 1992.

27. Secretary of State for Health. Working for Patients. London: HMSO, 1989.

28. Dixon J. Can there be fair funding for fundholding practices? British Medical Journal. 1994: 772-5.

29. Dixon J, Glennerster H. What do we know about fundholding in general practice? BMJ. 1995 1995; 311(7007): 727-30.

30. Milne RG, Torsney B. Financial incentives, competition and a two tier service: lessons from the UK National Health Service internal market. Health Policy. 2003 Apr; 64(1): 1-12. PubMed PMID: 12644325.

31. Coulter A. Evaluating general practice fundholding in the United Kingdom. European Journal of Public Health, Oxford, vol 5, no 4, Dec. 1995; p. 233-239.

32. Department of Health. The National Health Service: a service with ambitions. London: HMSO, 1997.

33. Coulter A. Shifting the balance from secondary to primary care. BMJ. 1995; 311(7018): 1447-8. PubMed PMID: 8520313.

34. Department of Health. NHS (Primary Care) Act. London: HMSO, 1997.

35. Wright K. The National Health Service (Primary Care) Bill: Research Paper 97/16. London: House of Commons Library, 1997.

36. Lewis R, Gillam S, Gosden T, Sheaff R. Who contracts for primary care? Journal of Public Health Medicine. 1999; 21(4): 367-71.

37. Shapiro J. Personal medical services: a barometer for the NHS? BMJ. 2000; 321(7273): 1359-60. PubMed PMID: 11099265. Pubmed Central PMCID: PMC1119099.

38. Lewis R, Gillam S. Personal medical services. BMJ. 2002 16; 325(7373): 1126-7. PubMed PMID: 12433744. Pubmed Central PMCID: PMC1124623.

39. Riley AJ, Harding G, Meads G, Underwood MR, Carter YH. An evaluation of personal medical services: the times they are a changin'. Journal of Interprofessional Care. 2003; 17(2): 127-39. PubMed PMID: 12745295.

40. Department of Health. Choice and opportunity, primary care: the future. London: HMSO, 1996.

41. General Medical Services Committee. Core services: taking the initiative. London: British Medical Association, 1996.

42. Department of Health. The National Health Service (General Medical Services Contracts) Regulations. London: HMSO, 2004.

43. O'Donnell CA, Ring A, McLean G, Grant S, Guthrie B, Gabbay M, et al. The new GMS contract in primary care: The impact of governance and incentives on care. Final report. NIHR Service Delivery and Organisation programme, 2010.

44. Roland M. Linking physicians' pay to the quality of care - a major experiment in the United Kingdom. New England Journal of Medicine, vol 351, no 14. 2004 (Journal Article): 1448-54.

45. Davies P, Glasspool JA. Patients and the new contracts. BMJ. 2003; 326(7399): 1099.

46. NHS Scotland National Services Division (Information Services). General Practice: Quality and Outcomes Framework: Crown; 2005 [cited 2012 March 2013]. Available from: **http://www.isdscotlandarchive.scot.nhs.uk/isd/3373.html**.

47. Audit Scotland. Overview of Scotland's health and NHS performance in 2006/07. Edinburgh: Audit Scotland, 2007.

48. Audit Scotland. Review of the new General Medical Services contract. Edinburgh: Audit Scotland, 2008.

49. Shekelle P. New contract for general practitioners. BMJ. 2003; 326(7387): 457-8.

50. Steel N, Maisey S, Clark A, Fleetcroft R, Howe A. Quality of clinical care and targeted incentive payments: an observational study. The British Journal of General Practice 2007; 57(539): 6.

51. Doran T, Kontopantelis E, Valderas JM, Campbell S, Roland M, Salisbury C, et al. Effect of financial incentives on incentivised and non-incentivised clinical activities: longitudinal analysis of data from the UK Quality and Outcomes Framework. BMJ. 2011;342: 3590.

52. Doran T, Fullwood C, Kontopantelis E, Reeves D. Effect of financial incentives on inequalities in the delivery of primary clinical care in England: analysis of clinical activity indicators for the quality and outcomes framework. Lancet. 2008; 372(9640): 728-36.

53. Ashworth M, Medina J, Morgan M. Effect of social deprivation on blood pressure monitoring and control in England: a survey of data from the quality and outcomes framework. BMJ. 2008; 337: a2030.

54. Starfield B. Quality and outcomes framework: patient-centred? Lancet. 2008; 372(9640): 692-4.

55. Simpson C, Hannaford, P, McGovern M, Taylor M, Green P, Lefevre K, Williams D. Are different groups of patients with stroke more likely to be excluded from the new UK general medical services contract? A cross-sectional

retrospective analysis of a large primary care population. *Family Practice* 2007; 8(56): 6.

56. McLean G, Sutton M, Guthrie B. Deprivation and quality of primary care services: evidence for persistence of the inverse care law from the UK Quality and Outcomes Framework. Journal of Epidemiology & Community Health. 2006; 60: 917-22.

57. Wright J, Martin, D, Cockings, Polack, C. Overall Quality of Outcomes Framework Scores Lower in Practices in Deprived Areas. British Journal of General Practice 2006; 56: 277-279.

58. Doran T, Fullwood C, Gravelle H, Reeves D, Kontopantelis E. Pay-for-performance programs in family practices in the United Kingdom. New England Journal of Medicine, vol 355, no 4. 2006: 375-84.

59. Doran T, Fullwood C, Reeves D, Gravelle H, Roland M. Exclusion of patients from pay-for-performance targets by English physicians. New England Journal of Medicine. 2008; 359(3): 274-84.

60. Gravelle H, Sutton M, Ma A. Doctor behaviour under a pay for performance contract: further evidence from the Quality and Outcomes Framework. York: Centre for Health Economics, 2008.

61. Campbell S, Reeves D, Kontopantelis E, Middleton E, Sibbald B, Roland M. Improvements in clinical quality in English primary care before and after the introduction of a pay for performance scheme. *New England Journal of Medicine*. 2007; 357: 10.

62. Campbell S, Reeves D, Kontopantelis E, Sibbald B, Roland M. Impact of pay-for-performance on quality of English primary care: interrupted time series analysis. *New England Journal of Medicine*. 2009; 361: 368-378.

63. Gubb J, Li G. Checking-up on Doctors: a review of the Quality and Outcomes Framework for General Practitioners. London: Civitas: Institute for the Study of Civil Society, 2008.

64. Dixon A, Khachatryan A, Wallace A, Peckham S, Boyce T, Gillam S. Impact of Quality and Outcomes Framework on health inequalities. London: King's Fund, 2011.

65. Scott A, Sivey P, Ait Ouakrim D, Willenberg L, Naccarella L, Furler J, et al. The effect of financial incentives on the quality of health care provided by primary care physicians. Cochrane Database of Systematic Reviews [Internet]. 2011; (9). Available from: **http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008451.pub2/abstract**.

66. Roland M, Campbell S, Bailey N, Whalley D, Sibbald B. Financial Incentives to Improve the Quality of Primary Care in the UK: Predicting the Consequences of Change. Primary Care Research and Development. 2006; 7: 18-26.

67. Huby G, Guthrie B, Grant S, Watkins F, Checkland K, McDonald R, et al. Whither British general Practice after the 2004 GMS Contract? Stories and realities of change in four UK General Practices. . *Journal of Health Organization and Management*. 2008; 22(1): 63-78.

68. McDonald R, Checkland K, Harrison S, Coleman A. Rethinking collegiality: restratification in English general medical practice 2004-2008. Social Science & Medicine. 2009; 68(7): 1199-1205. PubMed PMID: 19232453.

69. Checkland K, Harrison S, McDonald R, Grant S, Campbell S, Guthrie B. Biomedicine, holism and general medical practice: responses to the 2004 General Practitioner contract. Sociol Health Illn. 2008; 30(5): 788-803.

70. Checkland K, Harrison S. The impact of the Quality and Outcomes Framework on practice organisation and service delivery: summary of evidence from two qualitative studies. Quality in primary care. 2010; 18(2): 139-46. PubMed PMID: 672203070.

71. Charles-Jones H, Latimer J, May C. Transforming general practice: the redistribution of medical work in primary care. Sociol Health Illn. 2003; 25(1): 71-92. PubMed PMID: 14498945. English.

72. Whalley D, Gravelle H, Sibbald B. Effect of the new contract on GPs'

working lives and perceptions of quality of care:a longitudinal survey. Br J Gen Pract. 2008; 58(546): 8-14.

73. McGregor W, Jabareen H, O'Donnell C, Mercer S, Watt G. Impact of the 2004 GMS contract on practice nurses: a qualitative study. British Journal of General Practice. 2008; 58(555): 711-719.

74. O'Donnell CA, Jabareen H, Watt GCM. Practice nurses' workload, career intentions and the impact of professional isolation: a cross-sectional survey. BMC Nursing. 2010; 9(2).

75. Exworthy M. Primary care in the UK: understanding the dynamics of devolution. Health and social care in the community. 2001; 9(5): 266-278.

76. Greer SL. Devolution and divergence in UK health policies. BMJ. 2008 2008; 337:a2616.

77. Simoens S, Scott A. How are Scottish integrated primary care organisations managed? Journal of Health Organization & Management. 2003;17(1): 25-36. PubMed PMID: 12800278.

78. Scottish Executive Health Department. Partnerships for care: Scotland's Health White Paper. Edinburgh: SEHD, 2003.

79. Scottish Government. Study of Community Health Partnerships. Edinburgh:Scottish Government, 2010.

80. Tobacco and Primary Medical Services (Scotland) Act 2010 Scottish parliament, 2010 Sess. (2010).

81. Government S. More Scottish Focussed GP Contract Edinburgh: Scottish Government; 2011 [cited March 2013]. Available from: **http://www.scotland.gov.uk/News/Releases/2011/12/19102020**.

82. Health Do. Alternative Provider Medical Services (APMS): Questions and Answers 2010 [cited March 2013]. Available from: **http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Primarycare/Primarycarecontracting/APMS/DH_4125919**.

83. Salisbury C, Chalder M, Manku-Scott T, Nicholas R, Deave T, Noble S, et al. The National Evaluation of NHS Walk-in Centres. Bristol: University of Bristol, 2002.

84. Department of Health. NHS Next Stage Review: Our vision for primary and community care. London: HMSO, 2008.

85. Imison C, Maybin J, Naylor C. Under one roof: will polyclinics deliver integrated care? 2008. London: King's Fund.

86. Royal College of General Practitioners. Primary care federations- putting patients first. London: RCGP, 2008.

87. Department of Health. The new NHS: modern, dependable. London: The Stationery Office; 1997.

88. Our Health, Our Care, Our Say: a new direction for community services. London: Department of Health; 2006.

89. Greener I, Mannion R. Does practice based commissioning avoid the problems of fundholding? BMJ. 2006; 333(7579): 1168-70.

90. Audit Commission review of the NHS financial management and accounting regime: a report to the Secretary of State for Health. 2006.

91. Curry N, Goodwin N, Naylor C, Robertson R. Practice Based Commissioning: reinvigorate, replace or abandon? London.: King's Fund, 2008.

92. Gillam S, Lewis RQ. Practice based commissioning in the UK. BMJ. 2009; 338: b832. PubMed PMID: 19282437.

93. Department of Health. Equity and Excellence: Liberating the NHS. London; HMSO, 2010.

94. Dixon A, Ham C. Liberating the NHS: the right prescription in a cold climate? London: The King's Fund, 2010.

95. Department of Health. Health and Social Care Bill. London: HMSO, 2011.

96. Royal College of General Practitioners. RCGP calls for Prime Minister to withdraw Health Bill 2012 [cited March 2013]. Available from: **http://www.rcgp.org.uk/news/press_releases_and_statements/rcgp_calls_for_bill_withdrawal.aspx**.

97. British Medical Association. BMA statement on Health and Social Care Bill London: BMA; 2012 [cited 2012 15 February 2012]. Available from: **http://www.bma.org.uk/healthcare_policy/nhs_white_paper/latestnhsreformstatement.jsp - .Tzuwg1HDPww**.

98. Greaves F, Harris M, Goodwin N, Dixon A, Greaves F, Harris M, et al. The commissioning reforms in the English National Health Service and their potential impact on primary care. Journal of Ambulatory Care Management. 2012; 35(3): 192-9. PubMed PMID: 22668608.

99. World Health Organization. World Health Report 2008. Primary Care: now more than ever. Geneva: 2008.

100. Wendt C. Mapping European healthcare systems: a comparative analysis of financing, service provision and access to healthcare. Journal of European Social Policy. 2009 December 1, 2009; 19(5): 432-45.

101. Dresang LT, Brebrick L, Murray D, Shallue A, Sullivan-Vedder L. Family medicine in Cuba: community-oriented primary care and complementary and alternative medicine. Journal of the American Board of Family Practice. 2005; 18(4): 297-303.

102. Kantarevic J, Kralj B, Weinkauf D. Enhanced fee-for-service model and access to physician services : evidence from Family Health Groups in Ontario. 2010. Journal of Health Economics, 2011; 30(1): 99-111.

103. Goroll AH, Schoenbaum SC. Payment reform for primary care within the accountable care organization: a critical issue for health system reform. JAMA. 2012;308(6): 577-8. PubMed PMID: 22871868. Epub 2012/08/09.

104. Rittenhouse DR, Shortell SM, Fisher ES, Rittenhouse DR, Shortell SM, Fisher ES. Primary care and accountable care--two essential elements of delivery-

system reform. New England Journal of Medicine. 2301; 361(24): 2301-3. PubMed PMID: 19864649.

105. Neuwelt P, Crampton P, Crengle S, Dew K, Dowell A, Kearns R, et al. Assessing and developing community participation in primary health care in Aotearoa New Zealand: a national study. New Zealand Medical Journal. 2005; 118(1218): U1562. PubMed PMID: 16027751.

106. Kringos DS, Boerma WG, Hutchinson A, van der Zee J, Groenewegen PP. The breadth of primary care: a systematic literature review of its core dimensions. BMC Health Services Research. 2010; 10: 65. PubMed PMID: 20226084. Pubmed Central PMCID: PMC2848652.

107. Meads G. Primary Care in the Twenty-First Century - An International Perspective. Oxford: Radcliffe Publishing Ltd; 2006.

108. Thomas P, Meads G, Moustafa A, Nazareth I, Stange KC, Donnelly Hess G. Combined horizontal and vertical integration of care: a goal of practice-based commissioning. Quality in Primary Care. 2008; 16(6): 425-32. PubMed PMID: 19094418.

109. Denton F, Gafni A, Spencer B, Stoddart G. Potential savings from the adoption of nurse practitioners in the Canadian health care system. Socio-Economic Planning Sciences. 1983; 17 (4): 199- 209.

110. The Future of general practice: articles published in the British Medical Journal. London: British Medical Journal; 1992.

111. Broadbent J. Practice nurses and the effects of the new general practitioner contract in the British NHS: The advent of a professional project? Social Science and Medicine. 1998; 47(4): 497-506.

112. Sibbald B, Shen J, McBride A. Changing the skill-mix of the health care workforce. Journal of health Services Research and Policy 2004; 9(supplement 1): 28-38.

113. Buchan J, Dal Poz MR. Skill mix in the health care workforce: reviewing the evidence. Bull World Health Organ. 2002; 80(7): 575-80. PubMed PMID: 12163922. Pubmed Central PMCID: PMC2567564. Epub 2002/08/07.

114. Nancarrow SA, Borthwick AM. Dynamic professional boundaries in the healthcare workforce. Sociol Health Illn. 2005; 27(7): 897-919. PubMed PMID: 16313522. Epub 2005/11/30.

115. Laurant M, Reeves D, Hermens R, Braspenning J, Grol R, Sibbald B. Substitution of doctors by nurses in primary care. Cochrane Database of Systematic Reviews. 2005 (2):001271.

116. Laurant MG, Hermens RP, Braspenning JC, Akkermans RP, Sibbald B, Grol RP. An overview of patients' preference for, and satisfaction with, care provided by general practitioners and nurse practitioners. Journal of clinical nursing. 2008; 17(20): 2690-8.

117. Flanagan L. Nursing practitioners: growing competition for family physicians? Family Practice Management. 1998; 5(9): 34-6.

118. Woodroffe E. Nurse-led general practice: the changing face of general practice? British Journal of General Practice. 2006; 56(529): 632-3.

119. Panlagua H. Do physicians' assistants have a role in the UK? British Journal of Nursing. 2004; 13(7): 349.

120. Philip M, Turnbull B. A study into the effectiveness of unqualified GP assistants. British Journal of Nursing. 2006; 15(14): 782-6.

121. Bosley S, Dale J. Healthcare assistants in general practice: practical and conceptual issues of skill-mix change. British Journal of General Practice. 2008; 58(547): 118-24.

122. Laurant M, Harmsen M, Wollersheim H, Grol R, Faber M, Sibbald B. The impact of nonphysician clinicians: do they improve the quality and cost-effectiveness of health care services? Medical care research and review : MCRR. 2009; 66(6 Suppl): 36S-89S. PubMed PMID: 19880672.

123. Senior T, Knight A. Rare diseases: a role for primary care. Lancet. 2008; 372(9642): 890.

124. Pullon S. Competence, respect and trust: key features of successful interprofessional nurse-doctor relationships. Journal of Interprofessional Care. 2008; 22(2): 133-47. PubMed PMID: 18320449.

125. Lanham HJ, McDaniel RR, Jr., Crabtree BF, Miller WL, Stange KC, Tallia AF, et al. How improving practice relationships among clinicians and nonclinicians can improve quality in primary care. Jt Comm J Qual Patient Saf. 2009 Sep; 35(9): 457-66. PubMed PMID: 19769206.

126. Frenk J, Chen L, Bhutta ZA, Cohen J, Crisp N, Evans T, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. Lancet. 2010 Dec; 376(9756): 1923-58. PubMed PMID: 21112623.

127. McDonald J, Jayasuriya R, Harris MF, McDonald J, Jayasuriya R, Harris MF. The influence of power dynamics and trust on multidisciplinary collaboration: a qualitative case study of type 2 diabetes mellitus. BMC Health Services Research. 2012; 12(63). PubMed PMID: 22413897.

128. McDonald R. Market reforms in English primary medical care: Medicine, habitus and the public sphere. Sociology of Health and Illness. 2009; 31(5): 659-72. PubMed PMID: 19392936

129. NHS Scotland Information Services Division. Top ten common conditions by staff discipline in PTI practices 2010/11 Edinburgh: NHS Scotland National Services; 2011 [cited March 2013]. Available from: **http://www.isdscotland.org/PTI/**.

130. Charles Jones H, Latimer J, May C. Transforming general practice: the redistribution of medical work in primary care. Sociology of Health and Illness. 2003; 25(1): 71-92.

131. Grant S, Huby G, Watkins F, Checkland K, McDonald R, Davies H, et al. The impact of pay-for-performance on professional boundaries in UK general

practice: an ethnographic study. Sociol Health Illn. 2009; 31(2): 229-45. PubMed PMID: 18983422.

132. Tomlinson D, MacKay D, Watt G, Whyte B, Hanlon P, Tannahill C. The shape of primary care in NHS Greater Glasgow and Clyde. Glasgow: Glasgow Centre for Population Health, 2008.

133. General practice in the UK: a basic overview. RCGP information sheet, no. 4. London: RCGP, 2005.

134. Hippisley-Cox J, Pringle M, Coupland C, Hammersley V, Wilson A. Do single-handed practices offer poorer care? Cross sectional survey of processes and outcomes. . British Medical Journal. 2001; 323(7308): 4.

135. Majeed A, Jeremy G, Gareth A, Carroll K, Bindman BA. Association between practice size and quality of care of patients with ischemic heart diseases: cross sectional study. British Medical Journal. 2003; 326: 371.

136. GreB S, Delnoij D, Groenewegen P. Managing primary care behaviour through payment systems and financial incentives (Chapter 10). In: Saltman R, Rico A, Boerma W, editors. Primary care in the driver's seat? Organizational reform in European primary care. England: Open University Press; 2006.

137. Engstrom S, Foldevi M, Borgquist L. Is general practice effective? A systematic literature review. Scandinavian Journal of Primary Health Care. 2001; 19(2): 131-44.

138. Gosden T, Forland F, Kristiansen IS, Sutton M, Leese B, Giuffrida A, et al. Impact of payment method on behaviour of primary care physicians: a systematic review. Journal of Health Services & Research Policy. 2001; 6(1): 44-55.

139. Krasnik A, Groenewegen PP, Pedersen PA, von Scholten P, Mooney G, Gottschau A, et al. Changing remuneration systems: effects on activity in general practice. BMJ. 1990; 300(6741): 1698-701.

140. Bodenheimer T, Grumbach K. Capitation or decapitation, keeping your head in changing times. JAMA. 1996; 276(13): 1025-7.

141. Gosden T, Torgerson D, Maynard A. What is to be done about fundholding? BMJ. 1997; 315: 170-2.

142. Lichtenstein RL. The job satisfaction and retention of physicians in organized settings: a literature review. Medical care review. 1984; 41(3): 139-79.

143. Gerada C. Changing partnerships. London: RCGP, 2008.

144. Ding A, Hann M, Sibbald B. Profile of English salaried GPs: labour mobility and practice performance. Br J Gen Pract. 2008; 58(546): 20-5.

145. Gosden T, Pedersen L, Torgerson D. How should we pay doctors? A systematic review of salary payments and their effect on doctor behaviour. Qjm. 1999; 92(1): 47-55.

146. Gosden T, Forland F, Kristiansen IS, Sutton M, Leese B, Giuffrida A, et al. Capitation, salary, fee-for-service and mixed systems of payment: effects on the behaviour of primary care physicians. Cochrane Database of Systematic Reviews. 2000 (3): 002215.

147. Hickling JA. Private companies and GPs: An inconvenient truth. BMJ. 2008; 336(7644): 574.

148. Moore G. Private companies and GPs: A crucial juncture. BMJ. 2008; 336(7644): 574.

149. Gosden T, Sibbald B, Williams J, Petchey R, Leese B. Paying doctors by salary: a controlled study of general practitioner behaviour in England. Health Policy. 2003; 64(3): 415-23.

150. Vohlonen I, Pekurinen M, Saltman RB. Re-organizing primary medical care in Finland: The personal doctor program. Health Policy. 1989; 13(1): 65-79.

151. Pereira Gray D. General practitioners and the independent contractor status. JCollGenPract. 1977; 27(185): 746-7.

152. Physician funding and healthcare systems - an international perspective 1997; London: Royal College of General Practitioners.

153. Lecky J. Salaried doctors: the problems. British Journal of General Practice. 2008; 58(546): 60.

154. Donaldson C, Gerard K. Paying general practitioners: shedding light on the review of health services. Journal of the Royal College of General Practitioners. 1989; 39(320): 114-7.

155. Williams J, Petchey R, Gosden T, Leese B, Sibbald B. A profile of PMS salaried GP contracts and their impact on recruitment. Family Practice. 2001; 18(3): 283-7.

156. Lian OS. Convergence or divergence? Reforming primary care in Norway and Britain. Milbank Quarterly. 2003; 81(2): 305-30.

157. Giuffrida A, Gosden T, Forland F, Kristiansen IS, Sergison M, Leese B, et al. Target payments in primary care: effects on professional practice and health care outcomes. Cochrane Database of Systematic Reviews. 2000 (3): 000531.

158. Geneau R, Lehoux P, Pineault R, Lamarche P. Understanding the work of general practitioners: a social science perspective on the context of medical decision making in primary care. BMC Family Practice. 2008; 9: 12.

159. Giddens A. Modernity and Self-Identity. Self and Society in the Late Modern Age. Cambridge: Polity; 1991.

160. Hughes D. General practitioners and the new contract: promoting better health through financial incentives. Health Policy. 1993 9; 25(1–2): 39-50.

161. McDonald R, Roland M. Pay for Performance in Primary Care in England and California: Comparison of Unintended Consequences. The Annals of Family Medicine. 2009; 7(2): 121-7. PubMed PMID: McDonald01032009.

162. Croxson B, Propper C, Perkins A. Do doctors respond to financial incentives? UK family doctors and the GP fundholder scheme. Journal of Public Economics. 2001; 79(2): 375-98.

163. Chaix-Couturier C, Durand-Zaleski I, Jolly D, Duriex P. Effects of financial incentives on medical practice: results from a systematic review of the literature

and methodological issues. Intenational Journal for Quality in Health Care. 2000; 12(2): 133-10.

164. Marc AR. Financial incentives for doctors. BMJ. 2004; 328(7452): 1328-9.

165. Iliffe S. From general practice to primary care: The industrialisation of family medicine in Britain. Journal of Public Health Policy. 2002; 23(1): 33-43.

166. Saltman R. John Fry Fellowship Lecture: primary care in the driver's seat? London: 2003.

167. Crampton P, Starfield B. A case for government ownership of primary care services in New Zealand: weighing the arguments. International Journal of Health Services. 2004; 34(4): 709-27.

168. Newton J, Eccles M, Soutter J. General practice partnerships: an exploratory review. Journal of Management in Medicine. 1996; 10(2): 62-71.

169. Marinker M. Partnership. Family Practice. 1987; 4(3): 157-9.

170. Smith G. An oral history of general practice 3: partnerships. British Journal of General Practice. 2002; 52(481): 692-3.

171. de Jong JD, Groenewegen PP, Westert GP. Mutual influences of general practitioners in partnerships. Social Science & Medicine. 2003; 57(8): 1515-24.

172. Jewell JA. The noose of the independent contractor status. BMJ. 1990; 300(6728): 885.

173. Baker M, Pringle M. Is there a future for independent contractor status in UK general practice? London: RCGP, 2000.

174. Gosden T, Williams J, Petchey R, Leese B, Sibbald B. Salaried contracts in UK general practice: a study of job satisfaction and stress. Journal of Health Services & Research Policy. 2002; 7(1): 26-33.

175. Lester H, Campbell SM, McDonald R. The present state and future direction of primary care: A qualitative study of GPs' views. British Journal of General Practice. 2009; 59(569): 908-15. PubMed PMID: 2009643015.

176. Department of Health. Social enterprise- making a difference: a guide to the right request. London: HMSO, 2008.

177. Department of Trade and Industry. Strategy for Social Enterprise. London: HMSO, 2002.

178. Health Secretary challenges 'narrow' definition of social enterprise. Social Enterprise Live. [cited March 2013]. Available from: **http://www.socialenterpriselive.com/section/news/policy/20100714/health-secretary-challenges-'narrow'-definition-social-enterprise**

179. Spear R. United Kingdom: A Wide Range of Social Enterprises. In: Borzanga C, Defourny J, editors. The Emergence of Social Enterprise. London: Routledge; 2001.

180. Hansard. House of Commons Debates. Introduction of the Health and Social Care Bill. London: Parliament, 2010.

181. Department of Health. What are the advantages of social enterprise? London: HMSO; 2012 [cited 16 Feb 2012]. Available from: **http://www.dh.gov.uk/en/Managingyourorganisation/Socialenterprise/Whataretheadvantages/index.htm**.

182. BMA Health Policy and Economics Research Unit. Social Enterprise Briefing Note. London: BMA, 2011.

183. Pollock A, Price D, Miller E, Viebrock E, Shaoul J, Mohan J. A literature review of the structure and performance of not-for-profit health care organisations. (SDO/106/2005) London: NHSSDO, 2007.

184. House of Commons Public Administration Select Committee. Public Sector and the third sector: rhetoric and reality. London: HMSO; 2008.

185. Crampton P, Davis P, Lay-Yee R, Raymont A, Forrest C, Starfield B. Comparison of private for-profit with private community-governed not-for-profit primary care services in New Zealand. Journal of health services research & policy. 2004; 9 Suppl 2: 17-22. PubMed PMID: 15511321.

186. Crampton P, Davis P, Lay-Yee R. Primary care teams: New Zealand's experience with community-governed non-profit primary care. Health Policy. 2005; 72(2): 233-43. PubMed PMID: 15802157.

187. Department of Health. Making Quality Your Business: The Right to Provide. London: HMSO, 2011.

188. Snow T. Nurses help lead the transformation in delivery of community care services. Nursing Standard. 2009; 23(43): 12-4.

189. Cheater FM. Improving primary and community health services through nurse-led social enterprise. Quality in Primary Care. 2010; 18(1): 5-7. PubMed PMID: 20359407.

190. Cookoo Lane Surgery: about the surgery. [cited March 2013]. Available from: **http://www.cuckoolanesurgery.co.uk/about-the-practice.html**.

191. Stephen WJ. An analysis of primary medical care: an international study. Cambridge: Cambridge University Press; 1979.

192. NHS Scotland Information Services Division. Information on Scottish GPs, Practices and their Populations Edinburgh: NHS Scotland National Services Division; 2008 [cited March 2013]. Available from: **http://www.isdscotland.org/Health-Topics/General-Practice/Practices-and-Their-Populations/**

193. Hansen J, Schafer W, Black N, Groenewegen P. European priorities for research on health care organizations and service delivery. Journal of Health Services & Research Policy. 2011; 16 Suppl 2: 16-26. PubMed PMID: 21737526.

194. Hood C. A public management for all seasons. Public Administration. 1991; 69: 1-17.

195. Harrison S. New Labour, Modernisation and the Medical Labour Process. Journal of Social Policy. 2002; 31(03): 465-85.

196. Newman J. Modernising governance: New labour, policy and society. London: Sage; 2001.

197. Rhodes RAW. The New Governance: Governing without Government. Political Studies. 1996; 44(4): 652-67.

198. Ouchi WG. A Conceptual Framework for the Design of Organizational Control Mechanisms. Management Science. 1979; 25(9): 833-48. PubMed PMID: Ouchi01091979.

199. Exworthy M, Powell M, Mohan J. Markets, Bureaucracy and Public Management:The NHS: Quasi-market, Quasi-hierarchy and Quasi-network? Public Money & Management. 1999; 19(4): 8.

200. DALY M. Governance and Social Policy. Journal of Social Policy. 2003; 32(01): 113-28.

201. Rhodes M. Clinical Governance in the Harrow West PCG. Journal of Clinical Governance. 2000; 8(2): 72-5. PubMed PMID: 2001000261.

202. Rhodes RAW. Understanding Governance: Policy Networks, Governance, Reflexivity and Accountability. Buckingham: Open University Press; 1997.

203. Bevir M, Rhodes RAW. British governance:from bureaucracy to networks. . In: Bang H, editor. Governance as social and political communication. Manchester: Manchester University Press; 2003

204. Pringle M. Clinical governance in primary care: participating in clinical governance. Bmj. 2000 Sep 23; 321(7263): 737-40. PubMed PMID: 10999908. Pubmed Central PMCID: Source: NLM. PMC1127862.

205. Sheaff R. Soft governance and attitudes to clinical quality in English general practice. Journal of Health Services Research and Policy. 2004; 9(3): 132-8.

206. Sheaff R. A subtle governance : 'soft' medical leadership in English primary care. Sociology of Health and Illness. 2003; 25(5): 408-28.

207. Courpasson D. Managerial strategies of domination: power in soft bureaucracies,. Organization Studies. 2000; 21(1): 16.

208. Sheaff R. Governmentality by network in English primary healthcare. Social Policy and Administration. 2004; 38(1): 89-103.

209. Dowling B, Pickard S, Sheaff R. Governance structures and accountability in primary care. Public Money and Management. 2008; 28(4): 215-22.

210. Campbell S, Roland M, Wilkin D. Primary care groups: Improving the quality of care through clinical governance. Bmj. 2001 Jun 30; 322(7302): 1580-2. PubMed PMID: 11431301. Pubmed Central PMCID: Source: NLM. PMC1120625.

211. Sheaff R, Benson L, Farbus L, Schofield J, Mannion R, Reeves D. Network resilience in the face of health system reform. Social Science and Medicine. 2010; 70(5): 779-86. PubMed PMID: 2010086110.

212. Marshall M. A qualitative study of cultural changes in primary care organisations needed to implement clinical governance. British Journal of General Practice. 2002; 52(481): 641-5.

213. Phillips CB, Pearce CM, Hall S, Travaglia J, de Lusignan S, Love T, et al. Can clinical governance deliver quality improvement in Australian general practice and primary care? A systematic review of the evidence. Med J Aust. 2010; 193(10): 602-7. PubMed PMID: 21077818.

214. Smith PC, Anell A, Busse R, Crivelli L, Healy J, Lindahl AK, et al. Leadership and governance in seven developed health systems. Health Policy. 2012; 106(1): 37-49. PubMed PMID: 22265340.

215. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Quarterly. 2005; 83(3): 457-502. PubMed PMID: 16202000.

216. World Health Organization. World Health Report. Primary health care; now more than ever. Geneva: WHO, 2008

217. Gauld R, Blank R, Burgers J, Cohen AB, Dobrow MK, Ikegami NKI, et al. The World Health report 2008 - Primary healthcare: How wide is the gap between its agenda and implementation in 12 high-income health systems? Healthcare Policy. 2012; 7(3): 38-58. PubMed PMID: 2012143898.

218. Institute for Healthcare Improvement. The Triple Aim. Optimizing health, care and cost. Healthc Exec. 2009 2009; 24(1): 64-6. PubMed PMID: 19601418.

219. Mladovsky P, Srivastava D, Cylus J. Health policy responses to the financial crisis in Europe. WHO European Office, 2012. [Accessed March 2013] Available at: **http://www.euro.who.int/__data/assets/pdf_file/0009/170865/e96643.pdf**

220. Kates N, Hutchison B, O'Brien P, Fraser B, Wheeler S, Chapman C. Framework for advancing improvement in primary care. Healthc Pap. 2012; 12(2): 8-21. PubMed PMID: 22842927.

221. Peckham S. Now we need a framework for action. Healthc Pap. 2012; 12(2): 60-4; discussion 6-70. PubMed PMID: 22842934.

222. Labonte R. Health Systems Governance for health equity: critical reflections. Rev Salud Publica (Bogota). 2010; 12 Suppl 1: 62-76. PubMed PMID: 20963302.

223. Sturmberg JP. Primary health care organizations - through a conceptual and a political lens. J Eval Clin Pract. 2011; 17(3): 525-9. PubMed PMID: 21496188.

224. Lewis J. Primary care--opportunities and threats. The changing meaning of the GP contract. BMJ. 1997; 314(7084): 895-8. PubMed PMID: 9093110.

225. Glendinning C. From general practice to primary care: developments in primary health services 1990-1998, in Brunsdon E, Dean H, Woods R (eds.), Social Policy Review 10. London: Guildhall University, 2008, p. 137-64.

226. Kark S. The practice of community-oriented primary health care. New Yord: Appleton-Century-Crofts; 1981.

227. Kark SL, Cassel J. The Pholela Health Centre: a progress report. SAMJ, 1952; 26(6): 101-4.

228. Gillam S, Epstein L, Harries J, McClenahan J, Pampling D. Community-oriented primary care. London: King's Fund, 1994.

229. Community Oriented Primary Care: New Directions for Health Services Delivery. Washington: Institute of Medicine, 1983.

230. Nutting PA, Wood M, Conner EM. Community-oriented primary care in the United States: a status report. JAMA. 1985; 253: 1763-6.

231. Longlett SK, Kruse JE, Wesley RM. Community-oriented primary care: historical perspective. Journal of the American Board of Family Practice. 2001; 14(1): 54-63.

232. Pollock AM, Vickers N. Deprivation and emergency admissions for cancers of colorectum, lung, and breast in south east England: ecological study. BMJ. 1998; 317(7153): 245-52.

233. Chaturvedi NB-SY. Deprivation and emergency admissions for cancers of colorectum, lung, and breast in south east England: ecological study. British Journal of General Practice. 1995; 45: 127-31.

234. McCormick A, Fleming D, Charlton J. Morbidity statistics from general practice: fourth national study, 1991-1992. London: Office of Population Censuses and Surveys, 1994.

235. Iliffe S, Lenihan P, Wallace P, Drennan V, Blanchard M, Harris A. Applying community-oriented primary care methods in British general practice: a case study. British Journal of General Practice. 2002; 52(481): 646-51.

236. Young R. Postcard 6...Community care. Social entrepreneurs are creating better communities. British Journal of General Practice. 2003; 53(497): 986-7.

237. Gillam S. Can community-oriented primary care help GP commissioning? London Journal of Primary Care, 2012; 2: 96-97.

238. Checkland K. National Service Frameworks and UK general practitioners: street-level bureaucrats at work? Sociol Health Illn. 2004; 26(7): 951-75.

239. Department of Health and Social Security. NHS Management (1983) Inquiry (The Griffiths Report). London: HMSO, 1983.

240. Manning N. The New Public Management and its legacy: World Bank; 2000 [cited 2013]. Available from: **http://www.mh-lectures.co.uk/npm_2.htm**.

241. Butt S. Trends in attitudes to health care 1983 to 2007: report based on results from the British Social Attitudes surveys. National Centre for Social Research, 2009.

242. Petek D, Kunzi B, Kersnik J, Szecseny J, Wensing M. Patients' evaluations of European general practice - revisited after 11 years. International Journal of Quality in Health Care, vol. 2011; 23(6): 621-8.

243. The state of medical education and practice in the UK report: 2012. London: General Medical Council, 2012.

244. Wensing M, Jung HP, Mainz J, Olesen F, Grol R. A systematic review of the literature on patient priorities for general practice care. Part 1: Description of the research domain. Social Science & Medicine. 1998 Nov; 47(10): 1573-88. PubMed PMID: 9823053.

245. Wensing M, Vedsted P, Kersnik J, Peersman W, Klingenberg A, Hearnshaw H, et al. Patient satisfaction with availability of general practice: an international comparison. International Journal for Quality in Health Care. 2002; 14(2): 111-8. PubMed PMID: 11954680.

246. Coulter A. What do patients and the public want from primary care? BMJ. 2005; 331(7526): 1199-201. PubMed PMID: 16293845. Pubmed Central PMCID: PMC1285107.

247. Guthrie B, Wyke S. Personal continuity and access in UK general practice: a qualitative study of general practitioners' and patients' perceptions of when and how they matter. BMC Family Practice. 2006; 7: 11.

248. McKissock K. Better Together: Scotland's Patient Experience Programme. Building on Experience. Public Priorities with Respect to General Practice Care. Edinburgh: HMSO, 2008.

249. Salisbury C, Munro J. Walk-in centres in primary care: a review of the international literature. British Journal of General Practice. 2003; 53(486): 53-9.

250. Greene JC. Mixed methods in social inquiry. San Francisco: Jossey-Bass; 2007.

251. Johnson RB, Onwuegbuzie AJ, Turner LA. Toward a definition of mixed methods research. Journal of Mixed Methods Research. 2007; 1(2): 112-133.

252. Bryman A. Integrating quantitative and qualitative research: how is it done? Qualitative Research. 2006; 6(1): 97-113. PubMed PMID: Bryman01022006.

253. Scottish GP Patient Experience Survey 2009/10. Edinburgh: Scottish Government.

254. van der Heijden K. Scenarios: The Art of Strategic Conversation. Chichester: Wiley; 2005.

255. Fielding J. Coding and managing data. In: Gilbert N, editor. Researching social life. London: Sage; 1993.

256. Beck CT. Qualitative research: the evaluation of its credibility, fittingness and auditability. Western Journal of Nursing Research. 1993; 15: 263-6.

257. Edmonson-Jones P. Getting the priorities right: a possible model for the future. phcom. 2005, no 2. London: Faculty of Public Health, 2005.

258. Schoemaker PJH. Multiple scenario development: its conceptual and behavioural foundation. Strategic Management Journal. 1993; 14(3): 193-213.

259. Ramalingam B, Jones H. Futures and Scenario Planning in the Public Sector. London: Ark Group, 2007.

260. Neiner JA, Howze EH, Greaney ML. Using scenario planning in public health: anticipating alternative futures. [Review]. Health Promotion Practice. 2004; 5(1): 69-79. PubMed PMID: 14965437.

261. Woude DV, Damgaard G, Hegge MJ, Soholt D, Bunkers SS. The unfolding: scenario planning in nursing. Nurs Sci Q. 2003; 16(1): 27-35. PubMed PMID: 12593311.

262. Scenario Analysis and Strategic Planning: Practical Applications for Radiology Practices. JACR Journal of the American College of Radiology. 2010; 7(5): 369-73. PubMed PMID: 2010323339.

263. Lederman L. High apprehensives talk about communication apprehension and its effects on their behaviour. Communication Quarterly. 1983; 31: 233-237.

264. Britten N. Qualitative research: qualitative interviews in medical research. British Medical Journal. 1995; 311: 251.

265. Richardson S, Dohrenwend B, Klein D. Interviewing: its forms and functions New York: Basic Books; 1965.

266. Secker J, Wimbush E, Watson J, Millburn K. Qualitative methods in health promotion research: some criteria for quality. Health Education Journal. 1995; 54: 74-87.

267. Jensen G. Qualitative methods in physical therapy research: a form of disciplined inquiry. Physical Therapy. 1989; 69(6): 492-500.

268. Geertz C. The interpretation of culture. New York: Basic Books; 1973.

269. Lincoln YS, Guba, E.G. Naturalistic enquiry. Newbury Park: Sage; 1985.

270. Mapstone J, Elbourne D, Roberts IG. Strategies to improve recruitment to research studies. . Cochrane Database of Systematic Reviews [Internet]. 2007; 2(Journal, Electronic). Available from: DOI: 10.1002/14651858.MR000013.pub3.

271. Mackay DF, Watt GCM. General practice size determines participation in optional activities: cross-sectional analysis of a national primary care system. Prim Health Care Res Dev. 2010; 11(03): 271-9.

272. Ryan M, Scott DA, Reeves C, Bate A, van Teijlingen ER, Russell EM, et al. Eliciting public preferences for healthcare: a systematic review of techniques. Health Technol Assess. 2001; 5(5): 1-186. PubMed PMID: 11262422.

273. Coote A, Lenaghan J. Citizens' Juries: Theory into Practice. London: Institute for Public Policy Research; 1997.

274. Price D. Choices without reasons: citizens' juries and policy evaluation. . Journal of Medical Ethics. 2000; 26: 5.

275. Coulter I, Adams A, Shekelle P. Impact of varying panel membership on ratings of appropriateness in consensus panels: a comparison of a multiand single disciplinary panel. . Health Services Research. 1995; 30(4): 577-591.

276. Stronks *K*, Strijbis *A*, Wendte *J*. Who should decide? Qualitative analysis of panel data from public, patients, healthcare professionals, and insurers on priorities in health care. British Medical Journal. 1997; 315(7100): 92–96

277. Bunge M. Realism and antirealism in social science. Theory and Decision. 1993; 35: 207-35.

278. Hammersley M. The generalisability of ethnography. In: Hammersley M, editor. What's wrong with ethnography? London: Routledge; 1992.

279. Ponterotto JG. Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. Journal of Counseling Psychology, 2005; 52(2): 126-136. PubMed PMID: 2005157472.

280. Wensing M, Mainz J, Ferreira P, Hearnshaw H, Hjortdahl P, Olesen F, et al. General practice care and patients' priorities in Europe: an international comparison. Health Policy, 1998; 45(3): 175-86. PubMed PMID: 10338949.

281. Jung HP, Wensing M, Grol R. What makes a good general practitioner: do patients and doctors have different views? British Journal of General Practice, 1997: 47(425): 805-9. PubMed PMID: 9463981.

282. What matters to patients: Developing the evidence base for measuring and improving patient experience. London: King's College London and The King's Fund, 2011.

283. Arvidsson E, Andre M, Borgquist L, Lindstrom K, Carlsson P. Primary care patients' attitudes to priority setting in Sweden. Scand J Prim Health Care. 2009; 27(2): 123-8. PubMed PMID: 19466679.

284. Charles C, DeMaio S. Lay participation in health care decision making: a conceptual framework. J Health Polit Policy Law. 1993; 18(4): 881-904. PubMed PMID: 8120350.

285. Wensing M, Elwyn G. Research on patients' views in the evaluation and improvement of quality of care. Quality & Safety in Health Care.11(2):153-7. PubMed PMID: 12448808.

286. Grol R, Wensing M, Mainz J, Ferreira P, Hearnshaw H, Hjortdahl P, et al. Patients' priorities with respect to general practice care: an international comparison. European Task Force on Patient Evaluations of General Practice (EUROPEP). Family Practice. 1999; 16(1): 4-11. PubMed PMID: 10321388.

287. Crawford MJ, Rutter D, Manley C, Weaver T, Bhui K, Fulop N, et al. Systematic review of involving patients in the planning and development of health care. BMJ. 2002; 325(7375): 1263. PubMed PMID: 12458240. Pubmed Central PMCID: PMC136920.

288. Milewa T. Local participatory democracy in Britain's health service: innovation or fragmentation of a universal citizenship? Social Policy and Administration. 2004; 38(3): 240-252.

289. Pickard S. User involvement in clinical governance. Health Expectations. 2002; 5(3): 187-98.

290. Pickard S, Sheaff R, Dowling B. Exit, voice, governance and user-responsiveness: the case of English primary care trusts. Soc Sci Med. 2006; 63(2): 373-83. PubMed PMID: 16472899.

291. Hirschman A. Exit voice and loyalty. Cambridge, Mass.: Harvard University Press; 1970.

292. Mercer SW, Hasegawa H, Reilly D, Bikker AP. Length of consultations. Time and stress are limiting holistic care in Scotland. BMJ. 2002; 325(7374): 1241.

293. Smith J, Barnes M. Developments: Developing Primary Care Groups in the New NHS: Towards Diversity or Uniformity? Public Money & Management. 2000; 20(1): 45-52.

294. North N, Khan P, Lupton C. Going with the grain? : general practitioners and the new NHS. Health and Social Care in the Community. 1999; 7(6): 408-16.

295. Sheaff R, Sibbald B, Campbell S, Roland M, Marshall M. Soft governance and attitudes to clinical quality in England general practice. Journal of Health Services Research and Policy, London, vol. 2004; 9(3): 132-8. English.

296. McKinlay J, Marceau L. The end of the golden age of doctoring. International Journal of Health Services Research. 2002; 32(2): 379-416.

297. Mahmood K. Clinical governance and professional restratification in general practice. J Manag Med. 2001; 15(3): 242-52.

298. Friedson E. The reorganization of the medical profession. Med Care Rev. 1985; 42(1): 11-35. PubMed PMID: 10271939. eng.

299. Coburn D, Rappolt S, Bourgeault I. Decline vs. retention of medical power through restratification: an examination of the Ontario case.

300. Haug MR. A re-examination of the hypothesis of physician deprofessionalization. Milbank Q. 1988; 66 Suppl 2: 48-56. PubMed PMID: 3251140.

301. McDonald R, Campbell S, Lester H. Practice nurses and the effects of the new general practitioner contract in the English National Health Service: the extension of a professional project? Soc Sci Med. 2009; 68(7): 1206-12. PubMed PMID: 19254819.

302. McKinlay JB, Stoeckle JD. Corporatization and the social transformation of doctoring. International journal of health services : planning, administration, evaluation. 1988; 18(2): 191-205. PubMed PMID: 3288563.

303. Crampton P. The ownership elephant: ownership and community-governance in primary care. N Z Med J. 2005; 118 (1222): U1663.

304. Meads G, Wild A, Griffiths F, Iwami M, Moore P. The management of new primary care organizations: an international perspective. Health Serv Manage Res. 2006; 19(3): 166-73. PubMed PMID: 16848957.

305. Lester H, Hobbs FD. Major policy changes for primary care: potential lessons for the US New Model of family medicine from the quality and outcomes framework in the United Kingdom. Family medicine; 39(2): 96-102. PubMed PMID: 17273951.

306. Peckham S, Hann A. General practice and public health: Assessing the impact of the new GMS contract. Critical Public Health. 2008; 18(3): 347-56. PubMed PMID: 2008467314.

307. Richardson A, Bray C. Promoting Health Through Participation: Experience of Groups for Patient Participation in General Practice. London: Policy Studies Institute; 1987.

308. Meads G. The organisation of primary care in Europe: part 1 trends--position paper of the European Forum for Primary Care. Quality in Primary Care. 2009; 17(2): 133-43. PubMed PMID: 19416606. English.

309. Kharicha K. Tearing down the Berlin wall : social workers' perspectives on joint working with general practice. Family Practice. 2005; 22(4): 399-405.

310. Riley AJ. An evaluation of personal medical services : the times are a changin'. Journal of Interprofessional Care. 2003; 17(2): 127-39.

311. Hutchinson B, Levesque JF, Strumpf E, Coyle N. Primary health care in Canada: systems in motion. Milbank Quarterly, vol. 2011; 89(2): 256-88.

312. Greenhalgh T, Macfarlane F. Senior managers' views on implementing clinical governance. British Journal of General Practice. 2002; 52(484): 940. PubMed PMID: 12434965. Pubmed Central PMCID: PMC1314448. English.

313. Moran M. The British Regulatory State: High Modernism and Hyper Innovation. Oxford: Oxford University Press.; 2003.

314. Greenhalgh T, Douglas H-R. Experiences of general practitioners and practice nurses of training courses in evidence-based health care : a qualitative study. British Journal of General Practice. 1999; 49(444): 536-40.

315. Walker R, Bisset P, Adam J. Managing risk: Risk perception, trust and control in a Primary Care Partnership. 2007; 64(4): 911-23.

316. Zaheer A, McEvily B, Perrone V. Does Trust Matter? Exploring the Effects of Interorganizational and Interpersonal Trust on Performance. Organization Science. 1998; 9(2): 141-59.

317. Hardy B, Hudson B, Waddington E. What makes a good partnership? A partnership assessment tool. Leeds: Nuffield Institute of Health, 2000.

318. Baker R. Renewing professionalism: The next challenge for clinical governance? Quality in Primary Care. 2004; 12(4): 279-82. PubMed PMID: 2005035115.

319. Sturmberg JP. Variability, continuity and trust - towards an understanding of uncertainty in health and health care. Journal of evaluation in clinical practice. 2010; 16(3): 401-2. PubMed PMID: 20604818.

320. Platonova EA, Kennedy KN, Shewchuk RM. Understanding patient satisfaction, trust, and loyalty to primary care physicians. Medical Care Research and Review, vol. 2008; 65(6): 696-712.

321. Abbott A. The System of Professions: An Essay on the Division of Expert Labor. Chicago: The University of Chicago Press; 1988.

322. Calnan M, Rowe R. Trust Matters in Health Care. Buckingham: Open University Press; 2008.

323. Adler P. Market, hierarchy, and trust: the knowledge rconomy and the future of capitalism. Organization Science. 2001; 12(2): 215-234.

324. Brown PR, Calnan M. The Civilizing Process of Trust: Developing Quality Mechanisms which are Local, Professional-led and thus Legitimate. Social Policy & Administration. 2011; 45(1): 19-34.

325. Davies H, Mannion R. Clinical Governance: Striking a balance between checking and trusting. In: Smith P, editor. Reforming Health Care Markets: An economic perspective. Buckingham: Open University Press; 2000.

326. Howe A, Mathers N, Steel N, Howe A, Mathers N, Steel N. Doing quality: an agenda for GP leadership to improve patient care. Quality in Primary Care. 2012; 20(5): 313-5. PubMed PMID: 23113998.

327. Muldoon L, Dahrouge S, Hogg W, Geneau R, Russell G, Shortt M, et al. Community orientation in primary care practices: Results from the Comparison of Models of Primary Health Care in Ontario Study. Canadian Family Physician. 2010; 56(7): 676-83. PubMed PMID: 20631283.

328. Hudson B, Hardy B. Localization and partnership in the 'New National Health Service' : England and Scotland compared. Public Administration. 2001; 79(2): 315-35.

329. Neuwelt PM. Community participation in primary care: what does it mean 'in practice'? Journal of Primary Health Care. 2012; 4(1): 30-8. PubMed PMID: 22377547.

330. Coulter A. The NHS revolution : health care in the market place : what do patients and the public want from primary care? BMJ. 2005; 331(7526): 1199-201.

331. Barnes M, Shardlow P. From passive recipient to active citizen: participation in mental health user groups. Journal of Mental Health. 1997; 6(3): 289-300.

332. Levenson R, Joule N. Listening to people. User involvement in the National Health Services - the challenge for the future. London: Greater London Association of Community Health Councils; 1992.

333. Checkland P, Scholes J. Soft Systems Methodology in Action. Chichester: John Wiley and Sons; 1990.

334. Patton C, Sawicki D. Basic Methods of Policy Analysis and Planning. Second ed. Englewood Cliffs, New Jersey: Prentice Hall; 1993.

335. Francis R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: HM Stationery Office, 2013.

336. Scottish Home and Health Department. Designed to Care. Edinburgh: HMSO, 1997.

337. Scottish Executive Health Department. Partnership for Care. Edinburgh: HMSO; 2003.

338. Clinical Governance and Risk Management Standards Edinburgh: NHS Quality Improvement Scotland; 2005.

Appendix 1

A1.1 Letter of invitation to PPF members to the scenario planning session

Level 6
39 St Vincent Place
Glasgow
G1 2ER
Tel. 0141 221 9439
Fax. 0141 221 5749

Date 21st October, 2008.
Your Ref
Our Ref JOD/20081021PPF
Enquiries to JJM O'Dowd
E-mail gcphmail@drs.glasgow.gov.uk

Dear [ ],

Opportunities for General Practice

Thank you for agreeing to attend the Opportunities for General Practice event which will be held in **The Vitra Suite at The Lighthouse**, in Glasgow's Mitchell Lane, on **Wednesday 29th October 2008** from **9.00 a.m. until 1 p.m.**

The Glasgow Centre for Population Health is a partnership between the NHS, Glasgow City Council, Glasgow University and the Scottish Government. It aims to bring new perspectives to health issues facing the people of Glasgow.

I look forward to meeting you on the day and hope to hear what you think matters most about general practice. I hope the group will help us to better understand what the public need from general practice services.

A map of the venue and directions are attached to this letter. If you need further information, please feel free to contact us.

[redacted]ours sincerely,

[redacted]

John O'Dowd,

For the Glasgow Centre for Population Health.

A1.2 Programme for the public priorities event

OPPORTUNITIES FOR GENERAL PRACTICE

Vitra Suit, The Lighthouse, Glasgow

OUTLINE PROGRAMME

9.00	Registration
9.10	Introduction and orientation
9.25	What matters most to me about general practice?
9.30	Understanding the shared task
10.00	Issues for general practice: what is most important?
10.20	Small group work
11.00	Break
11.15	Sharing small group work
12.00	Learning from our work and next steps
12.30	Lunch

A1.3 Semi-structured interview schedule

What are your views on the current way in which GP is organised?

- At a practice level
- At a CH(C)P level
- At Board, Scotland, UK level

Current contract:

- Views (spontaneously generated)
- What is good about it, and why?
- Are there any disadvantages about the contract, again why?

Changes from old to new contract:

- Changes to practice
- Changes to relationship with colleagues
- Changes to relationship with patients
- Changes to relationships with Board and Government

OOH

- Are they involved in OOH provision
- If so, views of this arrangement
- Impact of new OOH on:
    - Practice
    - Patients
    - Professionals
- Comparison with co-operatives
- Comparison with pre co-op days

Independence

- Do staff feel part of the NHS
- Do they feel independent?
- What are the pros and cons in your experience of practices being independent from the NHS:
    - For patients
    - For staff
    - For Boards
    - For Government

How does employment by the practice affect:

- You
- Patients
- NHS
- Government

Alternative organisations

- Self-generated models and thoughts
- Professionals' skillmix
- For practices
- For OOH

Professional/personal values:

- Effect of nGMS
- Effect of current model
- Effect of alternative arrangements

A1.4 Staff letter of invitation

August 2009

Dear colleague,

Understanding staff views about how primary care is organised

I am a GP and a public health doctor and I am interested in primary care staff's views of the way services are organised and delivered in Greater Glasgow and Clyde.

I am conducting a small number of interviews with a variety of practice and practice attached staff throughout the Board area. We hope to gain an understanding of staff's views of what works well and what could be improved in terms of the current way in which primary care is organised, and seek their views on alternatives.

You have been selected as part of a wider group to represent primary care staff within Greater Glasgow and Clyde. The interviews will take around an hour and can be conducted at your place of work, at a time and date of your choosing.

I would be grateful if you would consider participating in this piece of research which we hope will provide the NHS with a greater understanding of what works and what might improve primary care in the future. Most NHS staff hold views about how the NHS is organised: this is an opportunity to make your views known!

I enclose an information sheet. If you are happy to be involved in this work, please contact me by completing the tear off slip below and return it through the internal mail, contact me by email (johnodowd@nhs.net) or call me on 07984 178 038.

Please feel free to contact me should you need more information. If I receive no reply, I will send a single reminder after 14 days.

Yours sincerely,

Dr John O'Dowd

Name: Practice:

Contact email/number:

☐ I am happy to be involved in the research. Please contact me to arrange the interview.

Please return to:
John O'Dowd, c/o Level 4 West, Dalian House, 350 St Vincent Street, Glasgow, G3 8YZ.

A1.5 Staff participant information sheet

Understanding staff views about how primary care is organised: information sheet

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information. Please contact us if you need more information to reach a decision.

Purpose of the study

Most primary care staff have views about the service they work in, yet little research has been carried out looking at staff's views of how primary care is organised. This project is designed to improve our understanding of staff's views of how primary care is structured.

Why have I been chosen?

We have identified a number of practices across Glasgow, to reflect different areas, affluent and deprived. You have been chosen because you are a healthcare worker working in one of these practices. Around 15 staff from primary care in Glasgow and Clyde will be interviewed as part of the study.

Do I have to take part?

No. participation is entirely voluntary.

What will happen to me if I take part?

A researcher will arrange to meet with you either in a practice or in another healthcare setting. After explaining the interview, you will be asked to give consent to the interview. You will also be asked if the interview can be recorded to make your views easier to analyse. If you agree to the interview, this will be a series of questions, tailored to your views of primary care. It will be conducted in private and

should take around 35 minutes. No special knowledge or preparation is needed. Your experience and views are the focus of the interview. There will be no further commitment on your part.

What are the possible disadvantages and risks?

NHS staff are busy. This interview will take up to 35 minutes of your time.

Continued overleaf

What are the possible benefits of taking part?

Staff can have strong views about the service they work in. This study provides a way for your views to be taken into account. We will produce a report on the findings which will be fed back to those taking part, provided to the Board and, hopefully, published in the scientific literature.

Will my taking part in this study be kept confidential?

Yes. The answers you give will be anonymised and we will take great care to ensure your privacy and the recoding of your interview. We will seek your permission to publish the findings, even although your views will be anonymous.

What will happen to the results of the research study?

We will produce a report which we will share with you. We will provide a copy of the report to NHS Greater Glasgow and Clyde who are the research sponsors and funders. We hope to publish the findings in the literature.

Who is organising and funding the research?

NHS Greater Glasgow and Clyde are funding and sponsoring the research through The Glasgow Centre for Population health which is a collaboration of the Board, Glasgow University, Glasgow City Council and The Scottish Government.

Who has reviewed the study?

The study has been reviewed by NHS Greater Glasgow and Clyde's Research and Development staff and has been approved by the Primary Care Research Ethics Committee.

Contact for further information:

For further information, please contact the lead investigator:

John O'Dowd
Glasgow Centre for Population Health
39 St Vincent Street
GLASGOW
G1 2ER
Tel. 0141 221 9439
Cell: 07887 566 089
Email: **johnodowd@nhs.net**

A1.6 Staff consent form

Subject Identification Number for this trial:

CONSENT FORM

Title of Project: Understanding staff views about how primary care is organised

Name of Researcher: John O'Dowd

Please initial box

1. Iconfirm that I have read and understand the information sheet dated ..... (version.....) for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected. ☐

3. I agree to take part in the above study. ☐

4. I agree to the audio recording of this interview and understand that it will remain confidential. ☐

5. I agree to the publication of the findings from this work in an anonymised form. ☐

Name of subject	**Date**	**Signature**
Researcher	**Date**	**Signature**

1 copy for subject, 1 copy for researcher

A1.7 Letter of invitation to PPF participants to attend alternative models consensus panel

House 6
1st Floor
94 Elmbank Street
Glasgow
G2 4DL
Date October 2010
Your Ref
Our Ref
Enquiries to JJM O'Dowd
E-mail

Dear PPF Chairperson

Futures for Primary Care: exploring new models of primary care

Last October, the Glasgow Centre for Population Health held an event called *Opportunities for General Practice*. This event brought together people from each of Greater Glasgow and Clyde's Public Partnership Fora to discuss issues which may affect general practice in the future. The GCPH has been working on this topic since the event and the work has now reached the point where it would be valuable to seek views from those involved at the start of the process.

We would like to invite you to nominate up to five PPF members to attend one of two ***Futures for Primary Care*** events which will be held here at the Glasgow Centre for Population Health (map enclosed), on **TBC**.

The meetings will run for approximately two hours and lunch will be provided. Each event will follow a similar format. We are providing two meetings to accommodate PPF members in order to ensure as many people as possible can contribute.

The GCPH team feels that it is important to seek the views of PPF members who contributed very well to the first event. The work will create new understanding around models of primary care. For this reason, the work is supervised by Glasgow University's Medical Faculty Research Ethics Committee and we enclose an information sheet which provides more information for PPF members who are considering if they wish to attend.

Could you please contact the GCPH on 0141 287 6958 or email on gcphmail@drs.glasgow.gov.uk to confirm the details of your five nominated people. We will then contact these nominees directly to confirm their attendance.

Yours sincerely,
John O'Dowd,
For the Glasgow Centre for Population Health

A1.8 PPF consensus panel participant information sheet

Futures for Primary Care: exploring new models of primary care

Participant Information Sheet

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information. Please contact us if you need more information to reach a decision.

Purpose of the study

Most people have views about primary care, yet little research has been carried out looking at the general public's views of how primary care is organised. This project is designed to improve our understanding of the public's views of how primary care is structured. The GCPH has been working on how primary care might be improved in the future. We now wish to ask PPF members for their views on this work.

Why have I been chosen?

The Public Partnership Fora (PPF) are local groups of people who provide the NHS and others with the public's perspectives on health and health services. The Glasgow Centre for Population has worked very effectively with the PPFs over a number of years on the subject of primary care. You have been chosen because your PPF chairperson has identified that you may be willing to participate in a short event looking at possible alternatives for how primary care might otherwise be organised.

Do I have to take part?

No. Participation is entirely voluntary.

What will happen to me if I take part?

Your name and contact details will be forwarded by the PPF chairperson to the Glasgow Centre for Population Health. We will contact you to see which of

Continued overleaf

two events you wish to attend. You should only attend one event as they will be run in the same way, We are providing two so that more people can attend. At the event we will explain the background to the work and check that you are happy to participate. The event will last around 2 hours providing a combination of presentations on research already undertaken and discussion of your opinions of our initial findings. We will ask you to choose between some different alternative ways of organising primary care. These 'models' of services are purely for research purposes and are not at the moment being proposed by any parts of the NHS. Your views of these models are important as we are keen to know the public's views of our conclusions.

What are the possible disadvantages and risks?

Attending the event will take two hours plus travel time.

What are the possible benefits of taking part?

The public has views about the health services they receive. This study provides a way for your views to be taken into account. We will produce a report on the findings which will be fed back to those taking part, provided to the Health Board for their information and, hopefully, published in the scientific literature. The research will also form part of a Doctoral Research Thesis which will be examined at Glasgow University.

Will my taking part in this study be kept confidential?

Yes. The answers you give will be anonymous and we will take great care to ensure your privacy. We will seek your permission to publish the findings, but we will ensure you cannot be identified in work which we publish.

What will happen to the results of the research study?

We will produce a report which we will share with you. We will provide a copy of the report to NHS Greater Glasgow and Clyde. We hope to publish the findings in the literature and present them as part of a Doctoral Thesis.

Continued overleaf

Who is organising and funding the research?

The Glasgow Centre for Population health is a collaboration of the Health Board, Glasgow University, Glasgow City Council and The Scottish Government. Its aim is to work with people to provide new research and understanding which can improve the health of the people of Greater Glasgow and Clyde.

Who has reviewed the study?

The study has been reviewed by Glasgow University Medical Faculty's Research Ethics Committee.

Contact for further information:

For further information, please contact the lead investigator:

John O'Dowd
Glasgow Centre for Population Health
House 6, 1st Floor
94 Elmbank Street
Glasgow, G2 4DL
Tel. 0141 287 6958.
Email gcphmail@drs.glasgow.gov.uk

A1.9 PPF consensus panel consent form

Futures for Primary Care: exploring new models of primary care

Participant Consent Form

Name of Researcher: John O'Dowd

Please initial box

1. I confirm that I have read and understand the information sheet dated ..... (version.....) for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected. ☐

3. I agree to take part in the discussion event. ☐

4. I agree to anonymised quotations being used in written reports, peer-reviewed publications and presentations, but understand that I will not be personally identifiable. ☐

Name of subject	**Date**	**Signature**
Researcher	**Date**	**Signature**

1 copy for subject, 1 copy for researcher

A1.10 Scoring sheets (pre and post discussion) for priorities and each model.
These are carbonised to allow PPF members to score the model. The initial scores are then collected (sheet 1) and aggregated. Following feedback, the participant retains a note of their initial scores and has the opportunity to rescore.

Model 1: initial scores. Participant ID number

Area	***Description***	***Performance Score (1 to 100 where 100 is very good)***
Patient influence	How well are practices held to account by patients for the quality of service offered? Are patients able to bring about change when the standard of service isn't acceptable?	
Cost	How high is the cost for the taxpayer to fund care?	
Involvement of patients and carers	To what extent are patients and carers involved in decision making?	
Equity	How well does the practice respond to people with different levels of need? Does it try to ensure suitable access and services to bring about equal health for different groups?	
Access to care	How easy is it to access services? Can patients easily make appointments? Is it easy to get to the practice and does it have good access for disabled people?	
Holistic care	Does the practice work with and treat the whole person rather than simply responding to the patient's individual problems?	
Quality of care	Does the practice ensure a high standard of care is provided? For example, does it provide good care for patients with diabetes or heart disease, and does it store and share personal information properly?	
Improving health	How well does the practice try to promote and improve health as opposed to only treating existing illness?	
Communication	Is the practice good at communicating with patients, each other, and other services? For example, contacting hospital about patient referrals, sending newsletters, informing patients of test results?	
Joined-up services/care	Does the practice try to join-up care offered by other services? For example by offering space for physiotherapy within the practice.	
Continuity	How well does the practice ensure continuity of care?	
Wider benefit to society	Does the practice try to bring wider benefit to the local community and to wider society? For example by contributing to community initiatives, linking to other local services such as social work or employment training.	

Please give us your views of general practice today – good and bad points.

_____

_____

_____

_____

Area	*Description*	*Original Performance Score (1 to 100 where 100 is very good)*	*Revised Performance Score (1 to 100 where 100 is very good)*
Patient influence	How well are practices held to account by patients for the quality of service offered? Are patients able to bring about change when the standard of service isn't acceptable?		
Cost	How high is the cost for the taxpayer to fund care?		
Involvement of patients and carers	To what extent are patients and carers involved in decision making?		
Equity	How well does the practice respond to people with different levels of need? Does it try to ensure suitable access and services to bring about equal health for different groups?		
Access to care	How easy is it to access services? Can patients easily make appointments? Is it easy to get to the practice and does it have good access for disabled people?		
Holistic care	Does the practice work with and treat the whole person rather than simply responding to the patient's individual problems?		
Quality of care	Does the practice ensure a high standard of care is provided? For example, does it provide good care for patients with diabetes or heart disease, and does it store and share personal information properly?		
Improving health	How well does the practice try to promote and improve health as opposed to only treating existing illness?		
Communication	Is the practice good at communicating with patients, each other, and other services? For example, contacting hospital about patient referrals, sending newsletters, informing patients of test results?		
Joined-up services/care	Does the practice try to join-up care offered by other services? For example by offering space for physiotherapy within the practice.		
Continuity	How well does the practice ensure continuity of care?		
Wider benefit to society	Does the practice try to bring wider benefit to the local community and to wider society? For example by contributing to community initiatives, linking to other local services such as social work or employment training.		

Please give us your views of general practice today – good and bad points.

_____

_____

Following discussion, please put into words your views about the current model.

_____

_____

A1.11 PPF consensus panel itinerary

Futures for Primary Care: exploring new models of primary care

Itinerary

The event lasts 2 hours 15 minutes and is either followed or preceded by lunch

1. Registration: Lead investigator seeks informed consent to replace implicit consent, also covering agreement to publication of findings.

2. 15 minutes welcome and introduction setting out the purpose and format of the event.

3. 15 minute presentation on the priorities for primary care (developed at a previous PPF event).

4. 30 minutes presenting model 1 (the status quo) and ask participants to score how well it delivers their priorities and provide discussion and rescoring following the discussion.

5. 15 minutes tea/coffee break

6. 30 minutes presenting model 2 (local contractor model) and ask participants to score how well it might deliver their priorities and provide discussion and rescoring following the discussion.

7. 30 minutes presenting model 3 (social enterprise model) and ask participants to score how well it might deliver their priorities and provide discussion and rescoring following the discussion.

8. Feedback of scores and discussion of the links between priorities and how services are organised.

A1.12 PPF consensus panel participant questionnaire

FUTURES FOR PRIMARY CARE: CHOOSING A FUTURE

1. Please provide us with general comments about your experience of this event:

2. Have you attended any previous GCPH events? Yes/No

3. Would you like to be added to our network of contacts to be informed of future GCPH events? Yes/No

If so, please provide contact details:

4. Did you find the process of considering different options helpful or unhelpful?

5. Was it easy to understand the different part of the process?

6. Did the results from the scoring fit with your views or were the results surprising?

7. How might we improve this process if we were to repeat it?

8. Please complete this section to help us ensure our work includes as wide a group of people as possible.

Gender: male/female/prefer not to say

Age band: 18-29/ 30-44/ 45-59/ 60-79/ 80+/ prefer not to say

Employment: employed/ unemployed/ retired/ prefer not to answer

Representing voluntary agencies? If yes, please state which ones:

9. What is your home post code:

Thank you.

A1.13 Staff email of invitation for eDelphi

Dear colleague

RESEARCH FEEDBACK AND INVITATION

This email contains information about research you participated in and an invitation to participate in a survey about this findings. *If you do **NOT** wish to participate please press **DELETE**.*

The Glasgow Centre for Population Health has been working on the organisation of primary care and how this can improve the health of the people of Greater Glasgow & Clyde. The research has included a public event, a literature review, qualitative research with primary care staff across NHS Greater Glasgow and Clyde practices and we have developed a number of conclusions. This work is not related to work of NHSGGC, and began prior to the development of the Primary Care Framework.

You have been involved in this research. We have developed our thinking as a result of the interviews and have developed a small number of models of primary care which may be of benefit for the future. We are keen to feed back our findings and ask how valid you think these conclusions might be.

Please take time to read the participant information sheet which is attached to this email. If you have any questions, please contact us via email or telephone as detailed in the information sheet.

If you wish to participate and agree to the consent issues below, please ***REPLY TO THIS EMAIL.***

We will send you a link to the first survey and a unique ID code. The code will NOT be used to identify you, but will allow us to link you responses in the first and second surveys.

CONSENT ISSUES

1. I confirm that I have read and understand the information sheet for the study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.

3. I agree to take part in 2 brief online surveys.

4. I agree to anonymised quotations being used in written reports, peer-reviewed publications and presentations, but understand that I will not be personally identifiable.

A1.14 Staff participant information sheet for eDelphi

Futures for Primary Care: exploring new models of primary care

Primary Care Staff Participant Information Sheet

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information. Please contact us if you need more information to reach a decision.

Purpose of the study

Most people have views about primary care, yet little research has been carried out looking at the general public's views of how primary care is organised. This project is designed to improve our understanding of primary care professionals' views about how services might be configured. The GCPH has been working on how primary care might be improved in the future. We now wish to ask PPF members for their views on this work. This work is not related to work of NHSGGC, and began prior to the development of the Primary Care Framework.

Why have I been chosen?

You have been chosen as you participated in the previous research. We would like to ask you to comment on our findings in order to ensure we have drawn valid conclusions from the work.

Do I have to take part?

No. Participation is entirely voluntary. We will remind you of the invitation after 7 days and provide you with 2 further brief emails. If you would rather not receive further emails, please email gcphmail@drs.glasgow.gov.uk .

What will happen to me if I take part?

We will ask you to complete two short online surveys. These can be completed at the time and location of your choosing. All you need are the web links. The first survey will provide feedback on the findings of the research and ask you to provide some brief views on our conclusions. It takes 20 minutes to complete and is anonymous. We will then analyse your comments and provide one further email 2 weeks later with a link to the second and final survey. This survey will feedback the combined comments from all the primary care staff who participate, allow you to consider the comments of others, and provide the opportunity to change your views if you wish.

What are the possible disadvantages and risks?

The surveys take 20 minutes to complete on 2 occasions, a fortnight apart.

What are the possible benefits of taking part?

Primary care staff have strong views on how their work is organised and delivered. This study provides a way for your views to be taken into account. We will produce a report on the findings which will be fed back to those taking part, provided to the Health Board for their information and, hopefully, published in the scientific literature. The research will also form part of a Doctoral Research Thesis which will be examined at Glasgow University.

Will my taking part in this study be kept confidential?

Yes. The answers you give will be anonymous and we will take great care to ensure your privacy. We hope to publish the findings, but we will ensure you cannot be identified in work which we publish.

What will happen to the results of the research study?

We will produce a report which we will share with you by email. We will provide a copy of the report to NHS Greater Glasgow and Clyde. We hope to publish the findings in the literature and present them as part of a Doctoral Thesis.

Who is organising and funding the research?

The Glasgow Centre for Population Health is a collaboration of the Health Board, Glasgow University, Glasgow City Council and The Scottish Government. Its aim

is to work with people to provide new research and understanding which can improve the health of the people of Greater Glasgow and Clyde.

Who has reviewed the study?

The study has been reviewed by Glasgow University Medical Faculty's Research Ethics Committee.

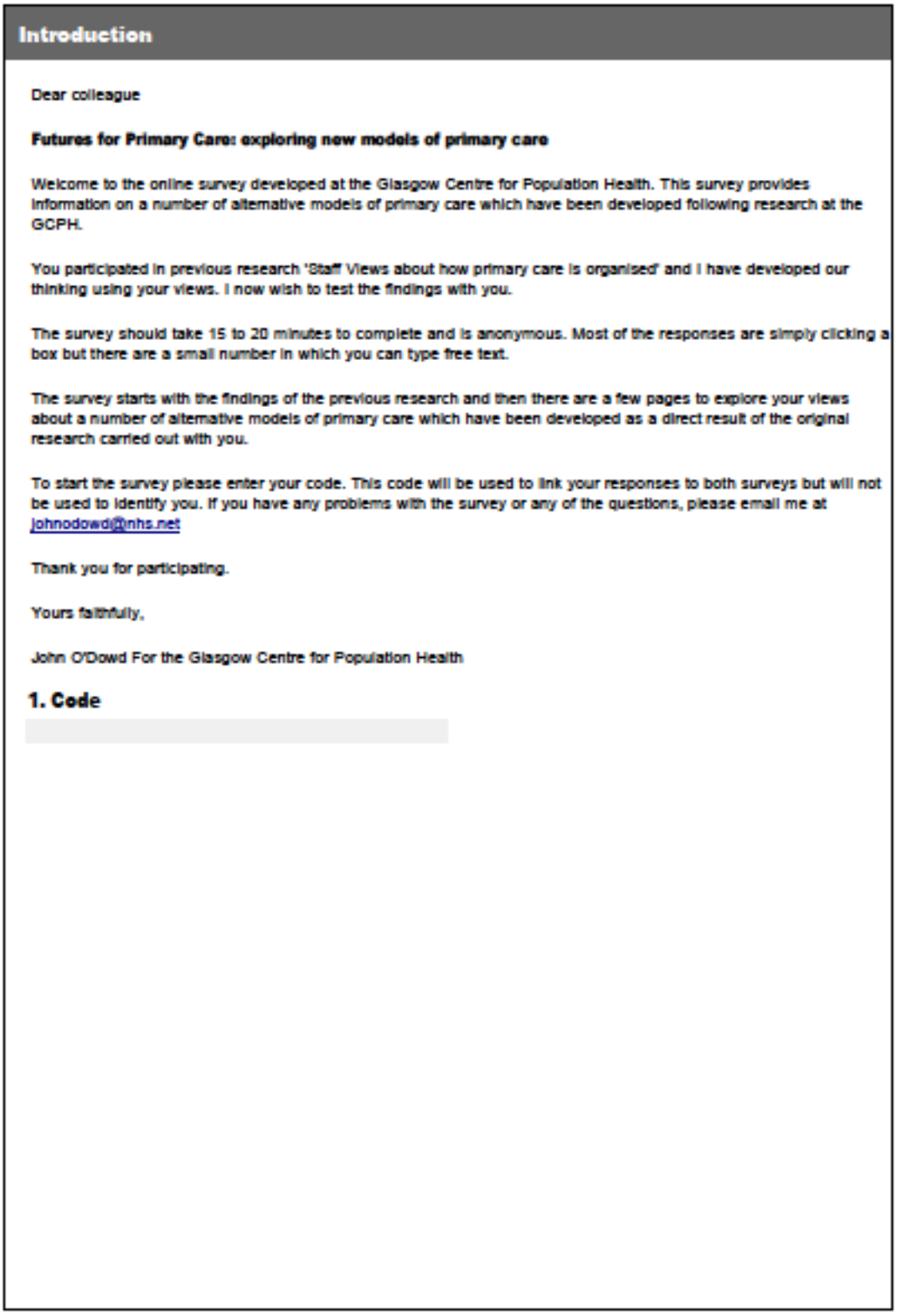
Contact for further information:

For further information, please contact the lead investigator:

John O'Dowd
Glasgow Centre for Population Health
House 6, 1st Floor
94 Elmbank Street
Glasgow, G2 4DL
Tel. 0141 287 6958, Email gcphmail@drs.glasgow.gov.uk

A1.15 First staff eDelphi.

The survey can be viewed at https://www.surveymonkey.com/s/ModelsofPC



Introduction

Dear colleague

Futures for Primary Care: exploring new models of primary care

Welcome to the online survey developed at the Glasgow Centre for Population Health. This survey provides information on a number of alternative models of primary care which have been developed following research at the GCPH.

You participated in previous research 'Staff Views about how primary care is organised' and I have developed our thinking using your views. I now wish to test the findings with you.

The survey should take 15 to 20 minutes to complete and is anonymous. Most of the responses are simply clicking a box but there are a small number in which you can type free text.

The survey starts with the findings of the previous research and then there are a few pages to explore your views about a number of alternative models of primary care which have been developed as a direct result of the original research carried out with you.

To start the survey please enter your code. This code will be used to link your responses to both surveys but will not be used to identify you. If you have any problems with the survey or any of the questions, please email me at johnodowd@nhs.net

Thank you for participating.

Yours faithfully,

John O'Dowd For the Glasgow Centre for Population Health

1. Code

Background Information

The qualitative research you participated in can be considered under a few headings. A synopsis is given below. A more detailed analysis will be included on the GCPH website in due course. You will be emailed when this is completed.

During the study 17 staff were interviewed. Staff groups included NHS management staff, practice managers, receptionists, GPs (partners and salaried staff) and practice nurses. Staff were drawn from a variety of different locations throughout the Board area.

The themes which emerged included:

Independence, partnership and identity

All practice staff viewed independence from the NHS as an advantage, including salaried GPs and nursing staff. Advantages centred around the scale of the practice versus that of the NHS, and a perception that there was fairer treatment within practices. This view was reinforced by many employed within NHS management.

Board and CH(C)P

Most staff from practices described poor engagement with and understanding of CH(C)Ps. Many practice staff shared views that CH(C)Ps were more difficult to engage with that their LHCC predecessors. A few GPs believed that the emphasis on integrating social care into primary care was one cause of the current difficulties. In contrast, all of the Personal Medical Services (PMS) practices interviewed, where locally negotiated contracts were in place between practices and the NHS had good working relationships with local CH(C)Ps.

Addressing health inequalities

There was a wide spectrum of understanding around inequality sensitive approaches to primary care with many staff confusing this concept with equality. A few practices described sophisticated approaches to tackling inequalities, including home visiting, outreach workers and combined clinics to address a number of health problems in a one-stop clinic. There was a common theme from practices serving disadvantaged populations that funding for disadvantage systematically underprovided for such populations and that this threatened the stability of practices.

Alternative models of organisation

A proportion of the GPs interviewed were salaried practitioners. The majority of those interviewed considered salaried work as being a negative experience, borne out of necessity rather than choice. Most interviewees saw a widening of skill mix as inevitable. However, there was a realisation that much of the increased work from the new contract had been absorbed by nursing staff in practices, but that they had little say within practices and had in the main been used to tackle the chronic disease management processes which underpin the QOF process.

There was a degree of frustration expressed by some practice staff at the ways in which their professional development had been significantly affected by the financial pressures of the practice. A number of interviewees stated the importance of registration and continuity in any alternative primary care system, and a few wondered if a social enterprise model might provide a fairer alternative, retaining the independence and financial incentives of the current model while addressing issues around transparency and profit, and the role of salaried staff and the wider community within the practice.

Priorities for Primary Care Model

We have worked with the public to establish their priorities for primary care. The priorities are summarised below.

Area of importance	Description
Patient influence	Practices are held to account by patients for the quality of service offered. Patients are able to bring about change when the standard of service isn't acceptable.
Cost	The cost for the taxpayer to fund care.
Involvement of patients and carers	Patients and carers are involved in decision making.
Equity	The practice responds to people with different levels of need. It tries to ensure suitable access and services to bring about equal health for different groups.
Access to care	It is easy to access services. Patients can easily make appointments and there are no problems getting to the practice which has good access for disabled people.
Holistic care	The practice works with and treats the whole person rather than simply responding to the patient's individual problems?
Quality of care	The practice ensures a high standard of care is provided. For example, it provides good care for patients with diabetes or heart disease, and it stores and shares personal information properly.
Improving health	The practice tries to promote and improve health as opposed to only treating existing illness.
Communication	The practice is good at communicating with patients, each other, and other services. For example, contacting hospital about patient referrals, sending newsletters, informing patients of test results.
Joined-up services/care	The practice tries to join-up care offered by other services. For example by offering space for physiotherapy within the practice.
Continuity	The practice ensures continuity of care.
Wider benefit to society	The practice tries to bring wider benefit to the local community and to wider society. For example by contributing to community initiatives, linking to other local services such as social work or employment training.

2. Please begin by rating each priority [1=Low priority : 5=High Priority]. You may use these values more than once.

	Low				High
Patient influence	○	○	○	○	○
Cost	○	○	○	○	○
Involvement of patients & carers	○	○	○	○	○
Equity	○	○	○	○	○
Access to care	○	○	○	○	○
Holistic care	○	○	○	○	○
Quality of care	○	○	○	○	○
Improving health	○	○	○	○	○
Communication	○	○	○	○	○
Joined-up services/care	○	○	○	○	○
Continuity	○	○	○	○	○
Wider benefit to society	○	○	○	○	○

Model 1: the status quo

To start things off we will first consider the current model of primary care.
The following describes some key features of the model in terms of its aims, organisation, quality and staff mix. This is summarised below.

Organisational issues	*Model 1: the status quo*
The core practice team	Average practice team: 3 GPs 2 Nurses Reception/admin staff Manager Some others
Wider primary care team	Pharmacists Opticians District nurses (2) Health Visitors (1) Podiatry Physiotherapy CPN
Wider services	Hospital-based services Other community services Mental health services Addictions partnership Social services
What do practices do?	Assess patients who are or believe themselves to be ill. Manage chronic diseases. Decide who needs specialist investigation or treatment by other health services. Certify illness for employers or benefits. Signpost other social services and community services.
Quality	Standard of technical care QOF Local checks on claims Holistic care Patient involvement Ongoing consultation When things go wrong
Cost and management	Private businesses National contract with a small amount of local variation Two thirds of income guaranteed from historical levels One third based on QOF - Quality and Outcomes Framework (optional) Local 'Enhanced' Services (optional) Managed by partners who may employ a practice manager Partnership mostly GPs, small number of managers Share the profit of the business
Summary	National contract negotiated between GP profession and Government. Predominantly GPs with some additional input from nursing staff and other professionals.

3. When thinking of your own experience of the model, please rate its performance or its ability to deliver the priorities we have already seen.

Please rate each item [1=Poor performance : 10=Excellent performance].

	Poor									Excellent
Patient influence	○	○	○	○	○	○	○	○	○	○
Cost	○	○	○	○	○	○	○	○	○	○
Involvement of patients & carers	○	○	○	○	○	○	○	○	○	○
Equity	○	○	○	○	○	○	○	○	○	○
Access to care	○	○	○	○	○	○	○	○	○	○
Holistic care	○	○	○	○	○	○	○	○	○	○
Quality of care	○	○	○	○	○	○	○	○	○	○
Improving health	○	○	○	○	○	○	○	○	○	○
Communication	○	○	○	○	○	○	○	○	○	○
Joined-up services/care	○	○	○	○	○	○	○	○	○	○
Continuity	○	○	○	○	○	○	○	○	○	○
Wider benefit to society	○	○	○	○	○	○	○	○	○	○

4. Any comment on the current model of primary care in general?

Model 2: Local Contract

Now we will consider the first new model. This model is based on the current one, but crucially, the contract is locally negotiated in order to better meet local needs. In addition, the mix of staff can include staff conventionally managed outside general practice, but within community services. We have summarised this model below.

Organisational issues	*Model 2: local contract*
The core practice team	No 'average' practice team: More GPs More Nurses Reception/admin staff Manager Others, such as: District nursing and Health Visiting, Addictions staff
Wider primary care team	Pharmacists Opticians Podiatry Physiotherapy Some staff moved into core practice team.
Wider services	Hospital-based services Other community services – may be affected by the new shape of primary care team Mental health services Addictions partnership Social services
What do practices do?	Assess patients who are or believe themselves to be ill. Manage chronic diseases. Decide who needs specialist investigation or treatment by other health services. Certify illness for employers or benefits. Signpost other social services and community services.
Quality	Standard of technical care QOF? Local checks on claims Local negotiation to meet local needs Holistic care Patient involvement Ongoing consultation When things go wrong
Cost and management	Private businesses Local contract informed by local need Income based on historic costs and also on independent local assessment of needs QOF- Quality and Outcomes Framework (optional) Local 'Enhanced' Services covered in local contract Managed by partners who may employ a practice manager Partnership mostly GPs, small number of managers Share the profit of the business
Summary	Contract locally negotiated between GP partnership and CHP/Board Potential for more staff roles to be transferred from CHP to practice team

5. Considering this new model, using your experience in primary care, please rate how you think this model might compare to the status quo. Please rate each item [1=Poor performance : 10=Excellent performance]. Please remember that these scores are relative to your scores for the existing model of primary care.

	Poor									Excellent
Patient influence	○	○	○	○	○	○	○	○	○	○
Cost	○	○	○	○	○	○	○	○	○	○
Involvement of patients & carers	○	○	○	○	○	○	○	○	○	○
Equity	○	○	○	○	○	○	○	○	○	○
Access to care	○	○	○	○	○	○	○	○	○	○
Holistic care	○	○	○	○	○	○	○	○	○	○
Quality of care	○	○	○	○	○	○	○	○	○	○
Improving health	○	○	○	○	○	○	○	○	○	○
Communication	○	○	○	○	○	○	○	○	○	○
Joined-up services/care	○	○	○	○	○	○	○	○	○	○
Continuity	○	○	○	○	○	○	○	○	○	○
Wider benefit to society	○	○	○	○	○	○	○	○	○	○

6. Any comment on Model 2: local contract?

Model 3: Social Enterprise Partnership

We now wish to present the final new model. In this model conventional GP partnerships are replaced by social enterprise partnerships. There is still a contract with the practice, but all the staff are partners and they share in the profits. Crucially, patients are also partners and have a say in the priorities of the partnership. The SEP (Social Enterprise Partnership) still has financial incentives to perform against a locally negotiated contract, but a proportion of the profit is shared with local community groups. This is summarised below.

Organisational issues	*Model 3: social enterprise partnership*
The core practice team	No "average" practice team GP Nurse Nurse practitioner Reception/admin Manager District nurses Health Visitors CPN Others: Community workers Addictions worker Parenting support worker
Wider primary care team	Pharmacists Opticians Podiatry Physiotherapy Some staff moved into core practice team.
Wider services	Hospital-based services Other community services – may be affected by the new shape of primary care team Mental health services Addictions partnership Social services
What do practices do?	Assess patients who are or believe themselves to be ill. Manage chronic diseases. Decide who needs specialist investigation or treatment by other health services. Certify illness for employers or benefits. Signpost other social services and community services. Improve the health of individuals and communities Act to reduce the impact of local factors influencing health
Quality	Standard of technical care QOF? Local outcomes agreement Local checks on claims Local negotiation to meet local needs Holistic care Patient involvement Ongoing consultation through representation on a partnership board When things go wrong
Cost and management	Social enterprises (profit sharing with the community) Local contract informed by local need Income based on historic costs and also on independent local assessment of needs QOF- Quality and Outcomes Framework (optional) Local 'Enhanced' Services covered in local contract Managed by partners –all core staff who may employ a

	practice manager and representatives of patients Partnership All stakeholders Limited profit sharing Social enterprise principles
Summary	GP partnership replaced by wider partnership board Practice run as a social enterprise business Contract negotiated between the partnership board and the CHP/Board Potential for wider variety of staff within the practice team

7. Please rate the social enterprise partnership with a local contract. Please rate each item [1=Poor performance : 10=Excellent performance]. Scores should take account of the scores you have given to the status quo and the first local contract model.

	Poor									Excellent
Patient influence	○	○	○	○	○	○	○	○	○	○
Cost	○	○	○	○	○	○	○	○	○	○
Involvement of patients & carers	○	○	○	○	○	○	○	○	○	○
Equity	○	○	○	○	○	○	○	○	○	○
Access to care	○	○	○	○	○	○	○	○	○	○
Holistic care	○	○	○	○	○	○	○	○	○	○
Quality of care	○	○	○	○	○	○	○	○	○	○
Improving health	○	○	○	○	○	○	○	○	○	○
Communication	○	○	○	○	○	○	○	○	○	○
Joined-up services/care	○	○	○	○	○	○	○	○	○	○
Continuity	○	○	○	○	○	○	○	○	○	○
Wider benefit to society	○	○	○	○	○	○	○	○	○	○

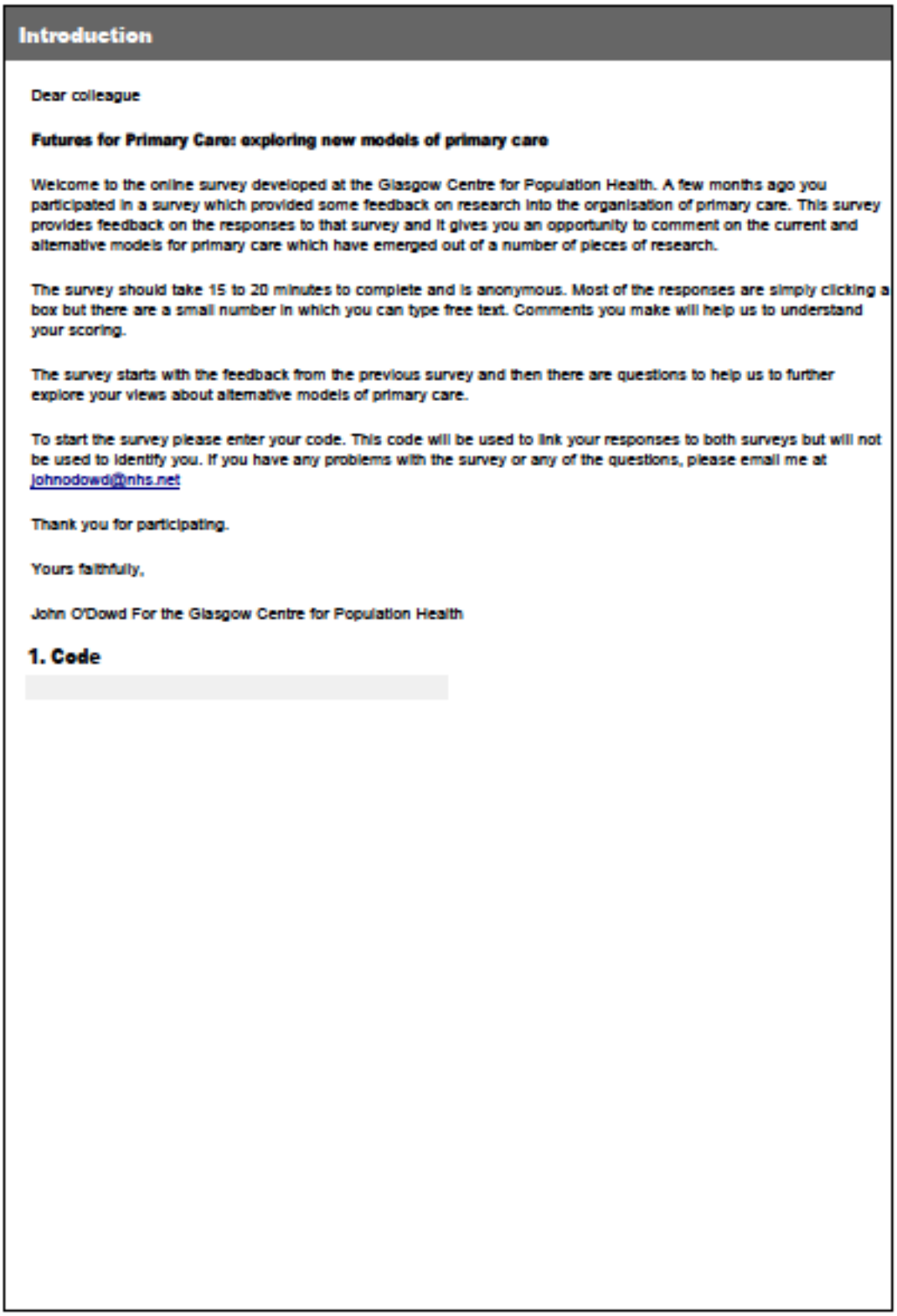
8. Any comment on Model 3: Social Enterprise Partnership?

9. The survey is almost over. If you have any general comments to make about the models or the domains which you haven't already made in the previous text boxes, please write these below.

When you click finished, the survey will end. We will email you in around 2 weeks with the second link which will contain feedback from other staff and you will have an opportunity to adjust your scores and change your comments.

Many thanks for taking the time to complete this study.

A1.16 Second round eDelphi.
This can be viewed at https://www.surveymonkey.com/s/FuturePCFollowup



Introduction

Dear colleague

Futures for Primary Care: exploring new models of primary care

Welcome to the online survey developed at the Glasgow Centre for Population Health. A few months ago you participated in a survey which provided some feedback on research into the organisation of primary care. This survey provides feedback on the responses to that survey and it gives you an opportunity to comment on the current and alternative models for primary care which have emerged out of a number of pieces of research.

The survey should take 15 to 20 minutes to complete and is anonymous. Most of the responses are simply clicking a box but there are a small number in which you can type free text. Comments you make will help us to understand your scoring.

The survey starts with the feedback from the previous survey and then there are questions to help us to further explore your views about alternative models of primary care.

To start the survey please enter your code. This code will be used to link your responses to both surveys but will not be used to identify you. If you have any problems with the survey or any of the questions, please email me at johnodowd@nhs.net

Thank you for participating.

Yours faithfully,

John O'Dowd For the Glasgow Centre for Population Health

1. Code

We worked with the public to establish their priorities for primary care. These are shown and described in the table below.

Area	Description
Patient influence	How well are practices held to account by patients for the quality of service offered? Are patients able to bring about change when the standard of service isn't acceptable?
Cost	How high is the cost for the taxpayer to fund care?
Involvement of patients and carers	To what extent are patients and carers involved in decision making?
Equity	How well does the practice respond to people with different levels of need? Does it try to ensure suitable access and services to bring about equal health for different groups?
Access to care	How easy is it to access services? Can patients easily make appointments? Is it easy to get to the practice and does it have good access for disabled people?
Holistic care	Does the practice work with and treat the whole person rather than simply responding to the patient's individual problems?
Quality of care	Does the practice ensure a high standard of care is provided? For example, does it provide good care for patients with diabetes or heart disease, and does it store and share personal information properly?
Improving health	How well does the practice try to promote and improve health as opposed to only treating existing illness?
Communication	Is the practice good at communicating with patients, each other, and other services? For example, contacting hospital about patient referrals, sending newsletters, informing patients of test results?
Joined-up services/care	Does the practice try to join-up care offered by other services? For example by offering space for physiotherapy within the practice.
Continuity	How well does the practice ensure continuity of care?
Wider benefit to society	Does the practice try to bring wider benefit to the local community and to wider society? For example by contributing to community initiatives, linking to other local services such as social work or employment training.

From the survey you recently completed
- Quality of Care;
- Communication;
- Access to Care;
- Improving Health; and
- Holism

were the areas rated as most important

2. Please provide any comment which you might have about the priorities given by staff participants through the last survey.

3. Please begin by rating each priority [1=Low priority : 5=High Priority]. You may use these values more than once.

	Low				High
Patient influence	○	○	○	○	○
Cost	○	○	○	○	○
Involvement of patients & carers	○	○	○	○	○
Equity	○	○	○	○	○
Access to care	○	○	○	○	○
Holistic care	○	○	○	○	○
Quality of care	○	○	○	○	○
Improving health	○	○	○	○	○
Communication	○	○	○	○	○
Joined-up services/care	○	○	○	○	○
Continuity	○	○	○	○	○
Wider benefit to society	○	○	○	○	○

4. Please add any comments which help us to understand your scoring of the priorities.

Model 1: the status quo

As in the first survey, we will first consider the current model of primary care.

The following describes some key features of the model in terms of its aims, organisation, quality and staff mix. This is summarised below.

Organisational issues	*Model 1: the status quo*
The core practice team	Average practice team: 3 GPs 2 Nurses Reception/admin staff Manager? Some others
Wider primary care team	Pharmacists Opticians District nurses (2) Health Visitors (1) Podiatry Physiotherapy CPN
Wider services	Hospital-based services Other community services Mental health services Addictions partnership Social services
What do practices do?	Assess patients who are or believe themselves to be ill. Manage chronic diseases. Decide who needs specialist investigation or treatment by other health services. Certify illness for employers or benefits. Signpost other social services and community services.
Quality	Standard of technical care QOF Local checks on claims Holistic care Patient involvement Ongoing consultation When things go wrong
Cost and management	Private businesses National contract with a small amount of local variation Two thirds of income guaranteed from historical levels One third based on QOF - Quality and Outcomes Framework (optional) Local 'Enhanced' Services (optional) Managed by partners who may employ a practice manager Partnership mostly GPs, small number of managers Share the profit of the business
Summary	National contract negotiated between GP profession and Government. Predominantly GPs with some additional input from nursing staff and other professionals.

Comments from staff on the current model

During the first round of this survey a number of comments were made in relation to the current model of general practice.

Workload and work-shifting

Many participants believed that the current model was "not bad" but felt that primary care was working "flat out" and that patients and the Health Board had unrealistic expectations of primary care. There was a feeling that an increasing volume of secondary care work was being transferred to primary care, but that this wasn't matched by a transfer in resources. There was a general feeling that GPs did not feel engaged with these processes.

Reduced time for patients

There was acceptance that GPs were sometimes distanced from patients in the current model and that interpersonal continuity was difficult to achieve. Some respondents felt that much of their time was taken up through trying to keep up with IT changes, with little time or energy devoted to clinical skills.

Holism and joined-up services

Some respondents commented that holistic care wasn't a priority

"Holistic care is not remunerated in nGMS…likewise joined up services."

Health inequalities

The issue of equity and tackling health inequalities generated some comments. One participant felt that the current model created inequalities, as the approach was

"variable from practice to practice".

In contrast, another suggested that there was

"a tendency to centralized services creates poor equity."

Inequalities were described as having their origins in

"high deprivation, rubbish lives, [and] poor education around health and lifestyle."

One participant felt that more time and money was needed to tackle these issues.

Independent contractor model

Some respondents felt that the current model made it difficult to address poor practices or clinical concerns and that practices were not really accountable to the patients they served. One respondent felt that the independent contractor model was costly and bureaucratic and that it

"Put competing pressures on GP partners – personal profit vs. patient care".

5. Please provide any reflections you might have on this feedback.

6. Having reflected and thinking of your own experience of the model, please rate its performance or its ability to deliver the agreed priorities.

Please rate each item [1=Poor performance : 10=Excellent performance].

	Poor									Excellent
Patient influence	○	○	○	○	○	○	○	○	○	○
Cost	○	○	○	○	○	○	○	○	○	○
Involvement of patients & carers	○	○	○	○	○	○	○	○	○	○
Equity	○	○	○	○	○	○	○	○	○	○
Access to care	○	○	○	○	○	○	○	○	○	○
Holistic care	○	○	○	○	○	○	○	○	○	○
Quality of care	○	○	○	○	○	○	○	○	○	○
Improving health	○	○	○	○	○	○	○	○	○	○
Communication	○	○	○	○	○	○	○	○	○	○
Joined-up services/care	○	○	○	○	○	○	○	○	○	○
Continuity	○	○	○	○	○	○	○	○	○	○
Wider benefit to society	○	○	○	○	○	○	○	○	○	○

7. Any further comments on the model which help us to understand your scoring?

Model 2: Local Contract

Now we will consider the first new model. This model is based on the current one, but crucially, the contract is locally negotiated in order to better meet local needs. In addition, the mix of staff can include staff conventionally managed outside general practice, but within community services. We have summarised this model below.

Organisational issues	*Model 2: local contract*
The core practice team	No 'average' practice team: More GPs More Nurses Reception/admin staff Manager Others, such as: District nursing and Health Visiting, Addictions staff
Wider primary care team	Pharmacists Opticians Podiatry Physiotherapy Some staff moved into core practice team.
Wider services	Hospital-based services Other community services – may be affected by the new shape of primary care team Mental health services Addictions partnership Social services
What do practices do?	Assess patients who are or believe themselves to be ill. Manage chronic diseases. Decide who needs specialist investigation or treatment by other health services. Certify illness for employers or benefits. Signpost other social services and community services.
Quality	Standard of technical care QOF? Local checks on claims Local negotiation to meet local needs Holistic care Patient involvement Ongoing consultation When things go wrong
Cost and management	Private businesses Local contract informed by local need Income based on historic costs and also on independent local assessment of needs QOF- Quality and Outcomes Framework (optional) Local 'Enhanced' Services covered in local contract Managed by partners who may employ a practice manager Partnership mostly GPs, small number of managers Share the profit of the business
Summary	Contract locally negotiated between GP partnership and CHP/Board Potential for more staff roles to be transferred from CHP to practice team

Comments from staff on the first new model

During the first round of this survey a number of comments were made in relation to this model for general practice.

Difficult to say....

There was agreement that it might be difficult to foresee the benefits and risks of this model as a number of changes were envisaged. Staff provided conflicting views of this model with some considering that it had "lots of pluses – I like the sound of many of these ideas" whilst others didn't feel it would make much difference in comparison with the current model.

Communication

Staff reiterated the pressure felt in primary care. Some welcomed the idea of community staff being embedded within a larger core practice team, feeling that this might improve communication and the retention of staff. One respondent suggested that an enhancement to the model might include ensuring that local practices were members of a larger cluster to allow cover for staff absence. There was less certainty that the model would improve access to care.

Private business

A number of staff commented on the description of the practice as being a private business. Whilst this was not intended as a change from the independent contractor status which exists under the current model, the comments made were important. Some staff felt that the involvement of big business would be unlikely because general practice would not be sufficiently profitable for them without major compromises being made to quality of care. Other respondents felt that the business focus might adversely affect clinical decisions and limit patient choices.

Local priorities

Some respondents felt that the model allowed local determination of priorities and better targeting of resources, although it was considered to be contentious as some would receive more and others less. In addition, respondents felt that this model would improve ownership at a local level, with staff having a clearer view of each other's skills and of local needs.

8. Please provide any reflections you might have on this feedback.

9. Reflecting on the feedback and using your own experience, please rate the model's potential performance or its ability to deliver the agreed priorities. Please rate each item [1=Poor performance : 10=Excellent performance].

	Poor									Excellent
Patient influence	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Cost	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Involvement of patients & carers	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Equity	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Access to care	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Holistic care	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Quality of care	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Improving health	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Communication	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Joined-up services/care	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Continuity	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Wider benefit to society	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

10. Any further comments on the model which help us to understand your scoring?

Model 3: Social Enterprise Partnership

We now wish to present the final new model. In this model conventional GP partnerships are replaced by social enterprise partnerships. There is still a contract with the practice, but all the staff are partners and they share in the profits. Crucially, patients are also partners and have a say in the priorities of the partnership. The SEP (Social Enterprise Partnership) still has financial incentives to perform against a locally negotiated contract, but a proportion of the profit is shared with local community groups. This is summarised below.

Organisational issues	*Model 3: social enterprise partnership*
The core practice team	No 'average' practice team GP Nurse Nurse practitioner Reception/admin Manager District nurses Health Visitors CPN Others: Community workers Addictions worker Parenting support worker
Wider primary care team	Pharmacists Opticians Podiatry Physiotherapy Some staff moved into core practice team.
Wider services	Hospital-based services Other community services – may be affected by the new shape of primary care team Mental health services Addictions partnership Social services
What do practices do?	Assess patients who are or believe themselves to be ill. Manage chronic diseases. Decide who needs specialist investigation or treatment by other health services. Certify illness for employers or benefits. Signpost other social services and community services. Improve the health of individuals and communities Act to reduce the impact of local factors influencing health
Quality	Standard of technical care QOF? Local outcomes agreement Local checks on claims Local negotiation to meet local needs Holistic care Patient involvement Ongoing consultation through representation on a partnership board When things go wrong
Cost and management	Social enterprises (profit sharing with the community) Local contract informed by local need Income based on historic costs and also on independent local assessment of needs QOF- Quality and Outcomes Framework (optional) Local 'Enhanced' Services covered in local contract Managed by partners –all core staff who may employ a

	practice manager and representatives of patients Partnership All stakeholders Limited profit sharing Social enterprise principles
Summary	GP partnership replaced by wider partnership board Practice run as a social enterprise business Contract negotiated between the partnership board and the CHP/Board Potential for wider variety of staff within the practice team

Comments from staff on the final new model

During the first round of this survey a number of comments were made in relation to this model for general practice.

Idealistic

Some respondents felt that the model was ideal, but questioned if it could be achieved. There was cynicism that staff groups other than GPs would be excluded:

"Limited profit sharing I imagine would exclude nurses again? Excuse the cynicism!"

Involvement

Some respondents felt that a focus on involving patients was positive, providing additional opportunities for behaviour change:

"The more you involve patients they may change their habits when deciding if they need a GP or some other service. Also if patients are more informed regarding what medication they are taking, they may take it and not just order it to sit in the cupboard."

In contrast others saw further patient involvement as a potential threat to equity:

"[There is a] danger of vocal patients getting their interests through and others falling behind."

Commitment of staff

Some respondants felt the model offered a wider, more social model of health, but others questioned what it might mean for the commitment of GPs:

"I do not know what this will mean for the commitment of GPs to the NHS if profit is to be shared. Just now we do not know exactly how the current models motivates professionals to behave."

Managerial capability and leadership

Others felt that widening involvement and scope would make the work of general practice unmanageable, and less efficient:

"The larger the beast the harder it is to manage. General Practice is very efficient as it is micro-managed. While it could work efficiently with a certain degree of expansion, there may be a point where it becomes too much like the NHS in general and less efficient."

There was a consensus that such an approach would require strong leadership if it were to succeed.

One respondent reflected that although the shape of the model was important, perhaps more important were the choices the practice made:

"It is not about the design of the service, it is about how the practices choose to function and involve the patients and those responsible for the wider aspects of care to influence their way of working."

11. Please provide any reflections you might have on this feedback.

12. Reflecting on the feedback and thinking of your own experience, please rate the model's potential performance or its ability to deliver the agreed priorities. Please rate each item [1=Poor performance : 10=Excellent performance].

	Poor									Excellent
Patient influence	○	○	○	○	○	○	○	○	○	○
Cost	○	○	○	○	○	○	○	○	○	○
Involvement of patients & carers	○	○	○	○	○	○	○	○	○	○
Equity	○	○	○	○	○	○	○	○	○	○
Access to care	○	○	○	○	○	○	○	○	○	○
Holistic care	○	○	○	○	○	○	○	○	○	○
Quality of care	○	○	○	○	○	○	○	○	○	○
Improving health	○	○	○	○	○	○	○	○	○	○
Communication	○	○	○	○	○	○	○	○	○	○
Joined-up services/care	○	○	○	○	○	○	○	○	○	○
Continuity	○	○	○	○	○	○	○	○	○	○
Wider benefit to society	○	○	○	○	○	○	○	○	○	○

13. Any further comments on the model which will help us to understand your scoring?

14. The survey is almost over. If you have any general comments to make about the models or the priorities which you haven't already made in the previous text boxes, please write these below.

Thank you for your participation. A copy of the finalised report will be sent to all those who have participated.

A1.17 NHS Research Ethics Approval for Research Objective Two

Primary Care Division

Research & Development Directorate
NHS Greater Glasgow and Clyde
The Tennent Institute
WG. 38 Church Street
Glasgow
G11 6NT

NHS
Greater Glasgow and Clyde

Dr JJM O'Dowd
Higher Research Fellow
University of Glasgow
Section of General Pracice and Primary Care
1 Horselethill Road
Glasgow
G12

Date 16 March 2009
Your Ref
Our Ref MT/GP/approve

Direct Line 0141 211 6389
Fax 0141 211 2811
Email maureen.travers@ggc.scot.nhs.uk

Dear Dr O'Dowd,

Reference Number: **PN09CH077**
Project Title: **A qualitative study of staff views of current and alternative configurations for primary care**
Chief Investigator: **Dr JJM O'Dowd**

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Management Approval** for the above study.

As a condition of this approval the following information is required during the lifespan of the project:

1. SAES/SUSARS – If the study is a **Clinical Trial** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004 (CTIMP only)
2. Recruitment Numbers on a quarterly basis (not required for commercial trials)
3. Any change of Staff working on the project named on the ethics form
4. Change of CI
5. Amendments – Protocol/CRF etc
6. Notification of when the Trial / study has ended
7. Final Report
8. Copies of Publications & Abstracts

Please add this approval to your study file as this letter may be subject to audit and monitoring.

Yours sincerely

[redacted]

Dr Maureen Travers
Academic Research Co-ordinator

A1.18 NHS Research Ethics Approval for Research Objective Three

University of Glasgow | Faculty of Medicine

Dr John O'Dowd
Consultant in Public Health Medicine
NHS Greater Glasgow and Clyde
Templeton on the Green
Room 421, Floor 4, Building 3
62 Templeton Street
Glasgow, G40 1DA

07 January 2011

Dear Dr John O'Dowd

Medical Faculty Ethics Committee

Project Title: Exploring novel models of primary care

Project No.: FM01810

The Faculty Ethics Committee has reviewed your application and has agreed that there is no objection on ethical grounds to the proposed study. They are happy therefore to approve the project, subject to the following conditions:

- The research should be carried out only on the sites, and/or with the groups defined in the application.
- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.
- If the study does not start within three years of the date of this letter, the project should be resubmitted.
- You should submit a short end of study report to the Ethics Committee within 3 months of completion.

Yours sincerely

[redacted]

pp Dr David Shaw
Faculty Ethics Officer

Dr D Shaw
Lecturer in Ethics & Ethics Officer

School of Medicine, University of Glasgow, 378 Sauchiehall Street, Glasgow, G2 3JZ

Tel: 0141 211 9755
E-mail: david.shaw@glasgow.ac.uk

Appendix 2

Table A2.1 Descriptive statistics for public weighting of domains (rounds 1 and 2).

Priority	*Range*	*Minimum*	*Maximum*	*Median*	*Mean*	*Skewness*	*SE skew*
Influence 1	3	2	5	4	4.12	-0.778	0.456
Influence 2	3	2	5	4	4	-0.718	0.456
Cost 1	4	1	5	3	3.36	-0.344	0.464
Cost 2	4	1	5	3	3.21	-0.135	0.472
Involve 1	2	3	5	4	4.32	-0.618	0.464
Involve 2	2	3	5	4.5	4.38	-0.703	0.456
Equity 1	3	2	5	5	4.23	-1.036	0.456
Equity 2	3	2	5	5	4.31	-1.01	0.456
Access 1	2	3	5	5	4.46	-0.807	0.456
Access 2	2	3	5	5	4.5	-1.103	0.456
Holistic 1	3	2	5	4	4	-0.439	0.456
Holistic 2	2	3	5	5	4.19	-0.414	0.456
Quality 1	3	2	5	5	4.62	-2.159	0.456
Quality 2	3	2	5	5	4.62	-2.159	0.456
Improve 1	2	3	5	4	4.19	-0.374	0.456
Improve 2	2	3	5	4	4.23	-0.430	0.456
Comms 1	3	2	5	5	4.62	-2.159	0.456
Comms 2	3	2	5	5	4.62	-2.159	0.456
Join 1	4	1	5	4	3.71	-0.905	0.456
Join 2	4	1	5	4	3.75	-0.933	0.456
Continuity 1	3	2	5	5	4.23	-0.976	0.456
Continuity 2	3	2	5	5	4.19	-0.852	0.456
Wider 1	4	1	5	4	3.62	-0.369	0.456
Wider 2	4	1	5	3.5	3.62	-0.287	0.456

Table A2.2 Summary of statistical tests of significance between round 1 and round 2 of weighting the domains. Ho is that there is no difference between the first and second round weighting of the domains

Domain	Result of tests of significance
Patient influence	No significant difference. Paired samples T test p=0.185
Cost	No significant difference. Paired samples T test p=0.083
Involvement of patients and carers	No significant difference. Paired samples T test p=0.327
Equity	No significant difference. Wilcoxon Signed Ranks Test p=0.157
Access to care	No significant difference. Wilcoxon Signed Ranks Test p=0.564
Holistic care	No significant difference. Paired samples T test p=0.057
Quality of care	No significant difference. Wilcoxon Signed Ranks Test p=1.000
Improving health	No significant difference. Paired samples T test p=0.327
Communication	No significant difference. Wilcoxon Signed Ranks Test p=1.000
Joined-up services	No significant difference. Paired samples T test p=0.574
Continuity	No significant difference. Wilcoxon Signed Ranks Test p=0.655
Wider benefit to society	No significant difference. Paired samples T test p=1.000

Table A2.3 MODEL 1 (THE STATUS QUO) Unweighted scores for Model 1 (the status quo)

Priority	*Range*	*Minimum*	*Maximum*	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Influence 1	79	1	80	50	43.88	25.2	-0.169	-0.464
Influence 2	99	1	100	50	45.48	27.208	0.003	0.464
Cost 1	99	1	100	50	46.11	26.602	0.342	0.524
Cost 2	99	1	100	45	43.35	28.37	0.359	0.512
Involve 1	89	1	90	40	46.36	24.008	0.022	0.464
Involve 2	99	1	100	50	48.96	25.709	0.102	0.464
Equity 1	80	20	100	60	59.8	24.13	-0.266	0.464
Equity 2	80	20	100	60	59.6	22.589	-0.026	0.464
Access 1	80	20	100	75	67.2	21.119	-0.569	0.464
Access 2	80	20	100	75	67.36	20.878	-0.484	0.464
Holistic 1	98	2	100	50	52.48	28.025	0.1	0.464
Holistic 2	98	2	100	50	51.88	27.832	0.159	0.464
Quality 1	70	30	100	80	72.2	18.319	-0.555	0.464
Quality 2	70	30	100	80	72.4	18.264	-0.626	0.464
Improve 1	80	20	100	60	62	23.229	-0.152	0.464
Improve 2	80	20	100	60	62.8	22.688	-0.215	0.464
Comms 1	70	30	100	60	63	21.651	0.183	0.464
Comms 2	70	30	100	60	63.2	22.168	0.114	0.464
Join 1	60	30	90	65	64.4	22.468	-0.274	0.464
Join 2	70	30	100	70	66.8	22.771	-0.464	0.464
Continuity 1	80	20	100	60	61.2	23.197	0.152	0.464
Continuity 2	80	20	100	70	63.8	24.549	-0.07	0.464
Wider 1	89	1	90	50	45.64	23.207	0.172	0.464
Wider 2	89	1	90	50	46.44	23.703	0.019	0.464

Table A2.4 Summary of statistical tests of significance between round 1 and round 2 of performance scores for Model 1. Ho is that there is no difference between the first and second round performance scoring of the first model (status quo).

Domain	Result of tests of significance
Patient influence	No significant difference. Paired samples T test p=0.530
Cost	No significant difference. Paired samples T test p=0.402
Involvement of patients and carers	No significant difference. Paired samples T test p=0.382
Equity	No significant difference. Paired samples T test p=0.901
Access to care	No significant difference. Paired samples T test p=0.787
Holistic care	No significant difference. Paired samples T test p=0.417
Quality of care	No significant difference. Paired samples T test p=0.574
Improving health	No significant difference. Paired samples T test p=0.327
Communication	No significant difference. Paired samples T test p=0.746
Joined-up services	No significant difference. Paired samples T test p=0.414
Continuity	No significant difference. Paired samples T test p=0.379
Wider benefit to society	No significant difference. Paired samples T test p=0.603

Table A2.5 Weighted performance scores for Model 1

Priority	*Range*	*Min*	*Max*	*Median*	*Mean*	*SD*	*Skewness*	*SE skew*
Quality 2	440	60	500	350	339.2	101.774	-0.741	0.472
Access 2	400	100	500	320	305.4	108.065	-0.181	0.472
Comms 2	400	100	500	252.5	289	120.524	0.297	0.472
Improve 2	365	135	500	280	275.4	102.139	0.336	0.472
Continuity 2	400	100	500	240	273.1	129.579	0.529	0.472
Equity 2	420	80	500	240	252.5	108.967	0.847	0.472
Join 2	425	75	500	250	246.7	112.787	0.407	0.472
Involve 2	495	5	500	245	224.5	131.858	0.193	0.472
Holistic 2	490	10	500	180	220.2	139.451	0.778	0.472
Influence 2	498	2	500	160	182.6	126.838	0.652	0.472
Wider 2	395	5	400	155	179.4	116.472	0.43	0.472
Cost 2	499	1	500	100	146.6	142.762	1.409	0.524
Cumulative Total	2978	1732	4710	2670	2908	919.095	0.434	0.524

Figure A2.1 Histogram showing the distribution of the cumulative weighted performance scores for Model 1.

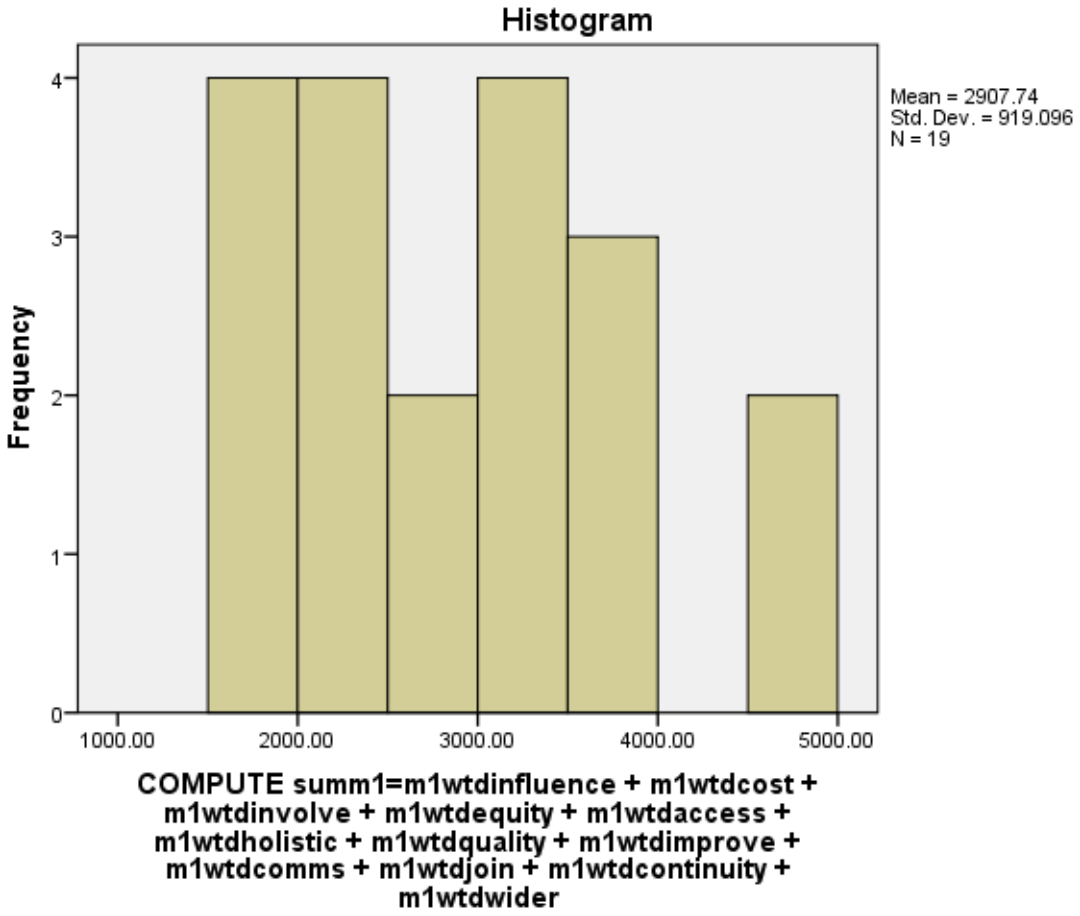


Table A2.6 Unweighted Performance Scores for Model 2 (Local contract)

Priority	*Range*	*Minimum*	*Maximum*	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Influence 1	98	2	100	75	68.08	22.132	-1.35	0.464
Influence 2	98	2	100	70	67.08	21.444	-1.180	0.464
Cost 1	89	1	90	48.42	47.66	27.43	-0.120	0.472
Cost 2	89	1	90	46.83	46.91	27.545	0.017	0.481
Involve 1	70	30	100	70	69.8	17.289	-0.588	0.464
Involve 2	70	30	100	70	67	18.085	-0.157	0.464
Equity 1	98	2	100	70	71.28	22.577	-1.560	0.464
Equity 2	98	2	100	79	71.04	22.549	-1.562	0.464
Access 1	80	10	90	80	73.6	20.337	-1.654	0.464
Access 2	80	10	90	80	72.8	20.467	-1.509	0.464
Holistic 1	90	10	100	75	70.36	23.029	-1.088	0.464
Holistic 2	90	10	100	75	70.4	23.581	-1.067	0.464
Quality 1	90	10	100	80	73	21.36	-1.278	0.464
Quality 2	90	10	100	80	73.2	21.207	-1.363	0.464
Improve 1	90	10	100	79	68.52	21.996	-0.825	0.464
Improve 2	90	10	100	80	68.6	23.784	-0.745	0.464
Comms 1	80	10	90	80	73.4	19.188	-1.835	0.464
Comms 2	80	10	90	80	72.2	20.211	-1.456	0.464
Join 1	93	2	95	70	66.68	23.606	-0.986	0.464
Join 2	88	2	90	70	66.28	23.455	-0.990	0.464
Continuity 1	90	0	100	70	67.4	22.598	-0.966	0.464
Continuity 2	90	10	100	70	67.4	22.32	-0.948	0.464
Wider 1	80	10	90	75	65.4	20.712	-0.80	0.464
Wider 2	80	10	90	75	65.84	20.52	-0.895	0.464

Table A2.7 Summary of statistical tests of significance between round 1 and round 2 of performance scores for the second model. Ho is that there is no difference between the first and second round performance scoring of the second model (PMS Plus).

Domain	Result of tests of significance
Patient influence	No significant difference. Wilcoxon Signed Ranks Test p=1.000
Cost	No significant difference. Paired samples T test p=0.402
Involvement of patients and carers	No significant difference. Paired samples T test p=0.382
Equity	No significant difference. Wilcoxon Signed Ranks Test p=1.000
Access to care	No significant difference. Wilcoxon Signed Ranks Test p=1.000
Holistic care	No significant difference. Wilcoxon Signed Ranks Test p=0.450
Quality of care	No significant difference. Wilcoxon Signed Ranks Test p=0.564
Improving health	No significant difference. Paired samples T test p=0.327
Communication	No significant difference. Wilcoxon Signed Ranks Test p=0.785
Joined-up services	No significant difference. Wilcoxon Signed Ranks Test p=0.785
Continuity	No significant difference. Wilcoxon Signed Ranks Test p=0.680
Wider benefit to society	No significant difference. Paired samples T test p=0.603

Figure A2.8 Weighted performance scores for Model 2 (local contract)

Priority	*Range*	*Minimum*	*Maximum*	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Influence 2	446	4	450	262.5	265.16	109.97	-0.102	0.472
Cost 2	449	1	450	100	173.16	154.39	0.809	0.501
Involve 2	330	120	450	290	292.7	90.12	0.192	0.472
Equity 2	440	10	450	300	315	106.04	-1.242	0.472
Access 2	410	40	450	355	340.2	108.35	-1.102	0.472
Holistic 2	450	50	500	295	300.41	117.85	-0.042	0.472
Quality 2	450	50	500	355	336.66	104.75	-0.891	0.472
Improve 2	450	50	500	300	297.5	113.6	-0.147	0.472
Comms 2	400	50	450	360	333.33	112.08	-1.069	0.472
Join 2	415	10	425	260	250.52	125.79	-0.278	0.472
Continuity 2	450	50	500	285	286.87	122.06	0.002	0.472
Wider 2	380	45	425	232.5	239.45	107.34	0.070	0.472
Cumulative Total	3180	1700	4880	3401	3399.52	889.54	-0.277	0.501

Figure A2.2 Histogram of the distribution of cumulative weighted performance scores for Model 2 (local contract).

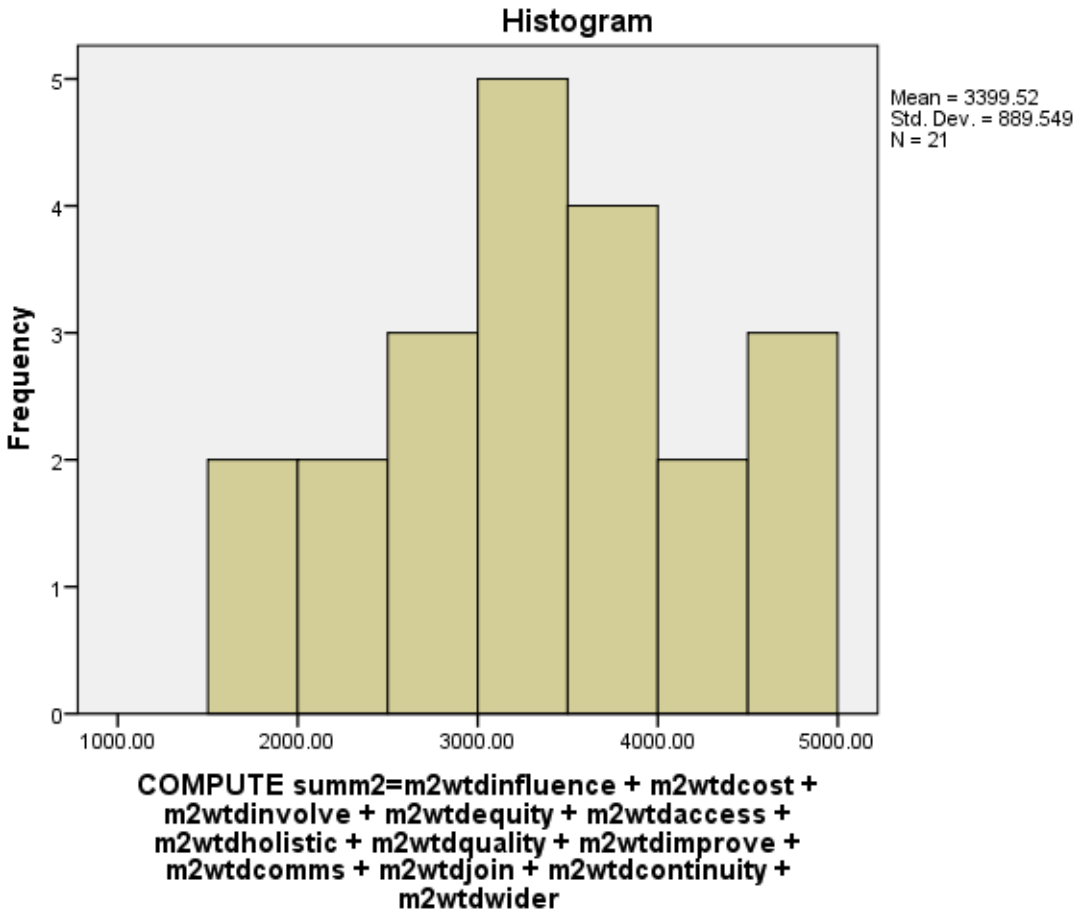


Table A2.9 Unweighted scores for Model 3 (social enterprise)

Priority	*Range*	*Minimum*	*Maximum*	*Median*	*Mean*	*andard Deviati*	*Skewness*	*SE skew*
Influence 1	45	50	95	80	80	12.55	-0.902	0.501
Influence 2	45	50	95	80	79.05	14.02	-0.943	0.501
Cost 1	80	10	90	60	60.19	22.809	-0.598	0.501
Cost 2	85	10	95	65	59.71	24.036	-0.488	0.501
Involve 1	60	40	100	90	81.67	14.691	-1.604	0.501
Involve 2	60	40	100	90	80.95	15.7	-1.768	0.501
Equity 1	50	50	100	80	78.33	11.21	-0.624	0.501
Equity 2	50	50	100	80	75.71	12.776	-0.414	0.501
Access 1	50	50	100	80	79.05	15.702	-0.63	0.501
Access 2	50	50	100	80	80.24	14.007	-0.733	0.501
Holistic 1	60	40	100	80	79.33	13.109	-1.076	0.501
Holistic 2	60	40	100	80	79.1	13.881	-0.959	0.501
Quality 1	60	40	100	80	75.95	15.86	-1.086	0.501
Quality 2	60	40	100	80	76.19	16.42	-1.056	0.501
Improve 1	40	60	100	90	84.05	12.2	-0.644	0.501
Improve 2	40	60	100	90	83.81	12.13	-0.597	0.501
Comms 1	60	40	100	86	81.95	14.96	-1.27	0.501
Comms 2	60	40	100	86	81.24	15.81	-1.235	0.501
Join 1	50	50	100	80	78.43	15.68	-0.647	0.501
Join 2	50	50	100	90	79.14	14.89	-0.845	0.501
Continuity 1	50	50	100	90	81.85	12.73	-1.094	0.512
Continuity 2	60	40	100	86	81.85	14.291	-1.584	0.512
Wider 1	70	30	100	85	78.9	16.34	-1.475	0.501
Wider 2	50	50	100	85	80.33	13.166	-0.79	0.501

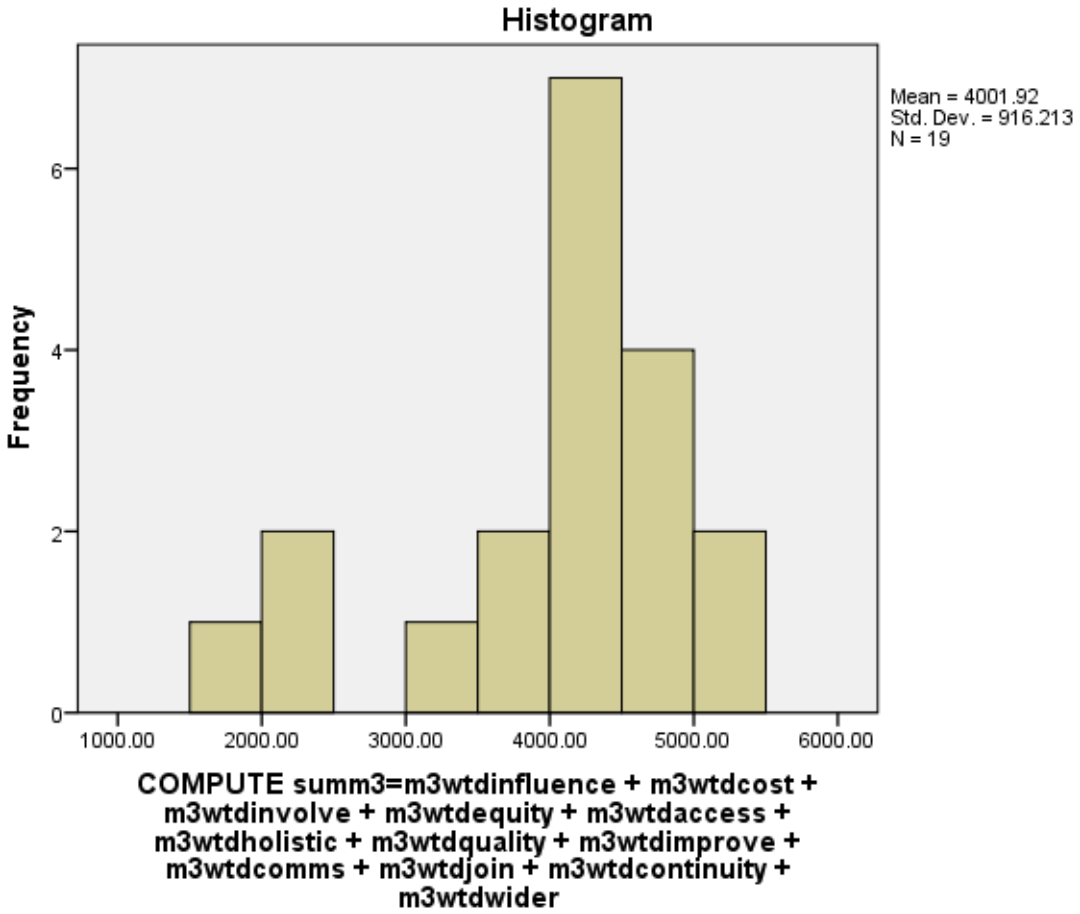
Table A2.10 Summary of statistical tests of significance between round 1 and round 2 of performance scores for the third model. Ho is that there is no difference between the first and second round performance scoring of the model (SEP).

Domain	Result of tests of significance
Patient influence	No significant difference. Paired samples T test p=0.329
Cost	No significant difference. Paired samples T test p=0.649
Involvement of patients and carers	No significant difference. Wilcoxon Signed Ranks test p=0.180
Equity	No significant difference. Paired samples T test p=0.199
Access to care	No significant difference. Paired samples T test p=0.424
Holistic care	No significant difference. Wilcoxon Signed Ranks test p=0.785
Quality of care	No significant difference. Wilcoxon Signed Ranks test p=0.655
Improving health	No significant difference. Paired samples T test p=0.667
Communication	No significant difference. Wilcoxon Signed Ranks test p=0.180
Joined-up services	No significant difference. Paired samples T test p=0.526
Continuity	No significant difference. Wilcoxon Signed Ranks test p=1.000
Wider benefit to society	No significant difference. Wilcoxon Signed Ranks test p=0.655

Table A2.11 Weighted performance scores for Model 3 (local contract)

Priority	*Range*	*Minimum*	*Maximum*	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Comms 2	340	160	500	430	390	100.82	-1.336	0.524
Access 2	350	150	500	400	376.57	95.68	-0.660	0.524
Quality 2	420	80	500	400	368.94	110.84	-1.585	0.524
Improve 2	320	180	500	360	368.42	96.95	-0.430	0.524
Involve 2	380	120	500	375	356.57	101.92	-1.068	0.524
Continuity 2	390	110	500	400	352.94	129.24	-0.768	0.524
Holistic 2	320	180	500	360	346.26	96.95	-0.086	0.524
Equity 2	290	160	450	350	334.73	93.19	-0.458	0.524
Influence 2	375	100	475	360	315	121.2	-0.432	0.524
Join 2	450	50	500	320	295.13	135.81	-0.317	0.524
Wider 2	440	60	500	270	289.1	128.06	-0.123	0.524
Cost 2	440	10	450	210	208.21	135.13	0.211	0.524
Cumulative Total	3279	1816	5095	4315	4001.92	916.21	-1.231	0.524

Figure A2.3 Histogram showing the distribution of the cumulative performance scores for model 3.



Appendix 3

Table A3.1 Descriptive statistics for public weighting of domains (rounds 1 and 2).

Priority	*Range*	*Minimum*	*Maximum*	*Median*	*Mean*	*Skewness*	*SE skew*
Influence 1	3	2	5	4	3.64	-0.74	0.59
Influence 2	3	1	4	3	3.00	-0.65	0.55
Cost 1	3	2	5	3	3.50	0.431	0.59
Cost 2	3	2	5	4	3.76	-0.243	0.55
Involve 1	2	3	5	4	4.07	-0.113	0.59
Involve 2	3	2	5	4	3.71	-0.840	0.55
Equity 1	2	3	5	4	4.14	-0.264	0.59
Equity 2	2	3	5	5	4.24	-0.523	0.55
Access 1	2	3	5	5	4.57	-1.303	0.59
Access 2	2	3	5	5	4.53	-0.997	0.55
Holistic 1	3	2	5	5	4.57	-2.437	0.59
Holistic 2	1	4	5	4	4.41	0.394	0.55
Quality 1	1	4	5	5	4.86	-2.295	0.59
Quality 2	1	4	5	5	4.82	-1.866	0.55
Improve 1	2	3	5	5	4.57	-1.303	0.59
Improve 2	3	2	5	4	4.29	-1.344	0.55
Comms 1	1	4	5	5	4.79	-1.566	0.59
Comms 2	2	3	5	5	4.65	-1.596	0.55
Join 1	3	2	5	4.5	4.36	-1.731	0.59
Join 2	2	3	5	4	4.35	-0.634	0.55
Continuity 1	2	3	5	4.5	4.43	-0.692	0.59
Continuity 2	3	2	5	4	4.12	-0.919	0.55
Wider 1	4	1	5	3	3.21	-0.468	0.59
Wider 2	3	2	5	4	3.65	0.147	0.55

Table A3.2 Summary of statistical tests of significance between round 1 and round 2 of weighting the domains. Ho is that there is no difference between the first and second round weighting of the domains

Domain	Result of tests of significance
Patient influence	No significant difference. Paired T test p=0.052
Cost	No significant difference. Paired T test p=0.066
Involvement of patients and carers	No significant difference. Paired T test p=0.758
Equity	No significant difference. Paired T test p=0.509
Access to care	No significant difference. Wilcoxon Signed Ranks test p=0.783
Holistic care	No significant difference. Wilcoxon Signed Ranks test p=0.739
Quality of care	No significant difference. Wilcoxon Signed Ranks test p=1.000
Improving health	No significant difference. Wilcoxon Signed Ranks test p=0.705
Communication	No significant difference. Wilcoxon Signed Ranks test p=0.317
Joined-up services	No significant difference. Wilcoxon Signed Ranks test p=0.317
Continuity	No significant difference. Paired T test p=0.678
Wider benefit to society	No significant difference. Paired T test p=0.066

Table A3.3 MODEL 1 (THE STATUS QUO) Unweighted scores for Model 1

Priority	*Range*	*Minimum*	*Maximum*	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Influence 1	7	2	9	5	5.25	2.00	0.40	0.63
Influence 2	7	2	9	5	5.33	1.83	-0.01	0.58
Cost 1	5	4	9	7	6.58	1.56	-0.18	0.63
Cost 2	7	3	10	6	6.07	2.08	0.28	0.58
Involve 1	6	3	9	5.5	5.67	1.92	0.29	0.63
Involve 2	6	3	9	5	5.67	2.02	0.22	0.58
Equity 1	5	4	9	5.5	6.08	1.78	0.66	0.63
Equity 2	7	3	10	7	6.67	2.12	0.04	0.58
Access 1	4	6	10	8	8.00	1.34	0.00	0.63
Access 2	6	4	10	7	7.20	1.93	0.08	0.58
Holistic 1	6	4	10	8	7.42	2.06	-0.52	0.63
Holistic 2	8	2	10	7	6.40	2.16	-0.25	0.58
Quality 1	4	6	10	9	8.58	1.08	-1.02	0.63
Quality 2	5	5	10	8	8.00	1.46	-0.15	0.58
Improve 1	6	4	10	7.5	7.50	1.97	-0.33	0.63
Improve 2	5	5	10	7	6.80	1.42	0.74	0.58
Comms 1	4	5	9	8	7.67	1.30	-1 .03	0.63
Comms 2	5	5	10	7	7.33	1.63	0.05	0.58
Join 1	5	4	9	7.5	6.83	1.89	-0.67	0.63
Join 2	5	4	9	6	6.27	1.83	0.35	0.58
Continuity 1	3	6	9	8	7.92	0.99	-0.47	0.63
Continuity 2	6	4	10	7	6.93	1.90	0.03	0.58
Wider 1	6	2	8	6	5.58	1.88	-0.54	0.63
Wider 2	8	2	10	6.5	5.93	2.43	-0.16	0.59

Table A3.4 Summary of statistical tests of significance between round 1 and round 2 of scoring Model 1 (status quo). Ho is that there is no difference between the first and second round scoring.

Domain	Result of tests of significance
Patient influence	No significant difference. Paired samples T test p=0.797
Cost	No significant difference. Paired samples T test p=0.108
Involvement of patients and carers	No significant difference. Paired samples T test p=0.516
Equity	No significant difference. Paired samples T test p=0.769
Access to care	No significant difference. Paired samples T test p=0.129
Holistic care	No significant difference. Paired samples T test p=0.048
Quality of care	No significant difference. Wilcoxon Signed Ranks Test p=0.234
Improving health	No significant difference. Paired samples T test p=0.336
Communication	No significant difference. Related samples Wilcoxon Signed Ranks test p=0.084
Joined-up services	No significant difference. Paired samples T test p=0.214
Continuity	No significant difference. Paired samples T test p=0.038
Wider benefit to society	No significant difference. Paired samples T test p=0.797

Bonferroni adjustment for multiple comparisons, significance reduced to p=0.004

Table A3.5 Weighted Performance Scores for Model 1

Priority	*Range*	*Min*	*Max*	*Median*	*Mean*	*SD*	*Skewness*	*SE skew*
Quality 2	25	25	50	35	38.53	8.53	0	0.58
Access 2	35	15	50	35	32.6	9.58	-0.01	0.58
Comms 2	26	24	50	35	33.53	8.46	0.76	0.58
Improve 2	38	12	50	28	29.6	10.54	0.26	0.58
Continuity 2	40	10	50	30	28.06	10.27	0.09	0.58
Equity 2	41	9	50	27	27.26	9.56	0.4	0.58
Join 2	29	16	45	24	26.73	9.44	0.95	0.58
Involve 2	23	9	32	18	19.93	6.81	0.65	0.58
Holistic 2	40	10	50	28	28.06	10.23	0.3	0.58
Influence 2	32	4	36	15	16.53	8.95	0.68	0.58
Wider 2	44	6	50	21	21.85	12.37	0.69	0.59
Cost 2	28	12	40	20	22.13	9.17	0.61	0.58
Cumulative Total	250	245	495	314.5	325.14	77.44	0.79	0.59

Figure A3.1 Cumulative weighted performance scores for Model 1

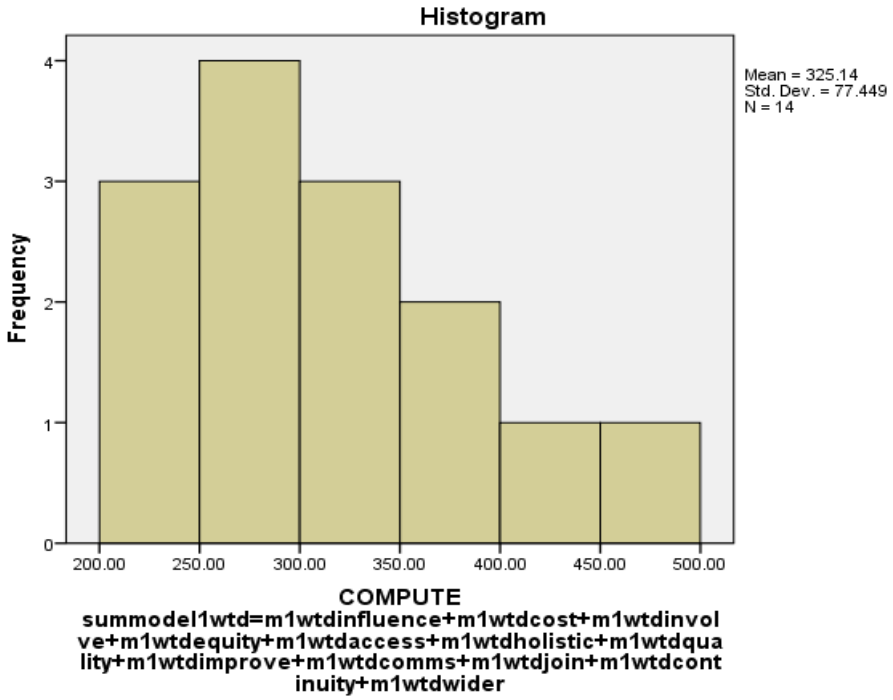


Table A3.6 Unweighted Performance Scores for Model 2 (Local contract)

Priority	*Range*	*Minimum*	*Maximum*	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Influence 1	5	3	8	7	6.31	1.70	-1.16	0.61
Influence 2	6	2	8	5.5	5.58	1.73	-0.61	0.63
Cost 1	6	3	9	7	6.23	2.16	-0.40	0.61
Cost 2	6	4	10	6.5	6.58	1.88	0.43	0.63
Involve 1	6	3	9	7	6.85	1.99	-1.16	0.61
Involve 2	6	2	8	6	5.83	1.69	-0.89	0.63
Equity 1	6	3	9	7	6.85	1.77	-1.21	0.61
Equity 2	4	4	8	6	6.08	1.24	0.15	0.63
Access 1	5	5	10	8	7.69	1.65	-0.59	0.61
Access 2	4	5	9	7	7.08	1.16	-0.18	0.63
Holistic 1	5	4	9	9	8.00	1.47	-1.85	0.61
Holistic 2	5	4	9	7.5	6.92	1.67	-0.40	0.63
Quality 1	2	8	10	9	8.77	0.72	0.39	0.61
Quality 2	4	5	9	8	7.75	1.21	-0.88	0.63
Improve 1	6	4	10	8	7.77	1.69	-1.16	0.61
Improve 2	4	5	9	8	7.58	1.31	-0.79	0.63
Comms 1	6	4	10	9	8.08	1.89	-1.26	0.61
Comms 2	5	5	10	8	7.50	1.56	-0.34	0.63
Join 1	5	5	10	9	8.38	1.38	-1.26	0.61
Join 2	5	5	10	7.5	7.50	1.56	0.00	0.63
Continuity 1	7	3	10	9	8.23	1.87	-2.08	0.61
Continuity 2	5	4	9	7	6.92	1.62	-0.45	0.63
Wider 1	6	4	10	7	6.92	1.93	-0.03	0.61
Wider 2	5	4	9	6	6.45	1.63	0.09	0.66

Table A3.7 Summary of statistical tests of significance between round 1 and round 2 of scoring Model 2 (PMS plus). Ho is that there is no difference between the first and second round scoring.

Domain	Result of tests of significance
Patient influence	No significant difference. Related samples Wilcoxon Signed Ranks test p=0.395
Cost	No significant difference. Paired samples T test p=0.476
Involvement of patients and carers	No significant difference. Related samples Wilcoxon Signed Ranks test p=0.451
Equity	No significant difference. Related samples Wilcoxon Signed Ranks test p=0.436
Access to care	No significant difference. Related samples Wilcoxon Signed Ranks test p=0.644
Holistic care	No significant difference. Related samples Wilcoxon Signed Ranks test p=0.088
Quality of care	No significant difference. Related samples Wilcoxon Signed Ranks test p=0.038
Improving health	No significant difference. Related samples Wilcoxon Signed Ranks test p=0.607
Communication	No significant difference. Related samples Wilcoxon Signed Ranks test p=0.216
Joined-up services	No significant difference. Related samples Wilcoxon Signed Ranks test p=0.058
Continuity	No significant difference. Related samples Wilcoxon Signed Ranks test p=0.332
Wider benefit to society	No significant difference. Related samples Wilcoxon Signed Ranks test p=0.439

Bonferroni adjustment for multiple comparisons, significance reduced to p=0.00

Table A3.8 Weighted performance scores for Model 2 (local contract)

Priority	*Range*	*Minimum*	*Maximum*	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Influence 2	30	2	32	19	17.58	8.18	-0.13	0.63
Cost 2	25	15	40	20	24.33	8.29	0.68	0.63
Involve 2	31	4	35	24	22.83	9.36	-0.83	0.63
Equity 2	28	12	40	25	25.58	8.28	0.00	0.63
Access 2	16	24	40	32	31.58	5.71	0.03	0.63
Holistic 2	24	16	40	31	29.91	7.63	-0.36	0.63
Quality 2	25	20	45	35.5	36.91	7.01	-1.05	0.63
Improve 2	30	10	40	35.5	33.08	8.12	-2.29	0.63
Comms 2	26	24	50	35	34.75	8.14	0.34	0.63
Join 2	27	18	45	32	32.00	8.61	0.14	0.63
Continuity 2	25	15	40	30	28.33	8.19	-0.37	0.63
Wider 2	24	12	36	20	22.63	8.64	0.44	0.66
Cumulative Total	245	202	447	341	341.63	67.50	-0.59	0.66

Figure A3.2 Histogram for cumulative weighted performance scores for Model 2

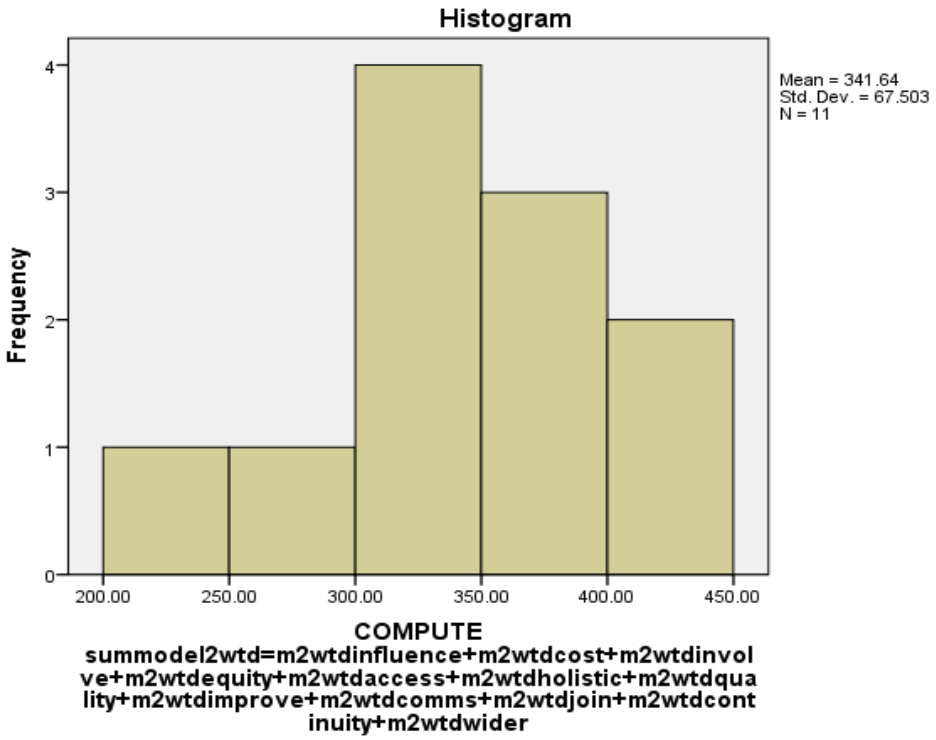


Table A3.9 Unweighted scores for Model 3 (social enterprise)

Priority	*Range*	*Minimum*	*Maximum*	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Influence 1	6	4	10	8	7.67	1.96	-0.64	0.63
Influence 2	7	3	10	8	7.85	1.95	-1.17	0.61
Cost 1	8	1	9	7	6.25	2.66	-0.66	0.63
Cost 2	6	3	9	7	6.54	1.80	-0.47	0.61
Involve 1	6	4	10	8	7.58	1.83	-0.63	0.63
Involve 2	7	3	10	8	8.00	1.78	-1.88	0.61
Equity 1	6	4	10	8	7.33	2.01	-0.54	0.63
Equity 2	8	2	10	8	6.62	2.32	-0.57	0.61
Access 1	4	6	10	8	7.92	1.37	-0.32	0.63
Access 2	8	2	10	7	6.92	1.97	-1.09	0.61
Holistic 1	5	5	10	8	7.67	1.49	-0.28	0.63
Holistic 2	8	2	10	7	7.00	2.16	-0.82	0.61
Quality 1	5	5	10	8	7.83	1.46	-0.48	0.63
Quality 2	7	3	10	8	7.46	1.94	-0.94	0.61
Improve 1	5	5	10	8.5	8.08	1.62	-0.77	0.63
Improve 2	8	2	10	7	7.00	2.12	-0.80	0.61
Comms 1	7	3	10	8.5	7.92	1.97	-1.47	0.63
Comms 2	6	4	10	8	7.23	1.96	-0.45	0.61
Join 1	7	3	10	8.5	7.92	2.06	-1.50	0.63
Join 2	8	2	10	8	7.46	2.06	-1.61	0.61
Continuity 1	5	5	10	9	8.2	1.54	-1.03	0.63
Continuity 2	8	2	10	8	7.08	2.17	-0.91	0.61
Wider 1	6	4	10	8.5	7.83	1.94	-0.87	0.63
Wider 2	8	2	10	7	6.75	2.05	-0.96	0.63

Table A3.10 Summary of statistical tests of significance between round 1 and round 2 of scoring Model 3 (SEP). Ho is that there is no difference between the first and second round scoring.

Domain	Result of tests of significance
Patient influence	No significant difference. Related samples Wilcoxon Signed Ranks test p=0.340
Cost	No significant difference. Paired samples T test p=0.103
Involvement of patients and carers	No significant difference. Related samples Wilcoxon Signed Ranks test p=0.595
Equity	No significant difference. Paired samples T test p=0.510
Access to care	No significant difference. Related samples Wilcoxon Signed Ranks test p=0.332
Holistic care	No significant difference. Paired samples T test p=0.736
Quality of care	No significant difference. Paired samples T test p=0.838
Improving health	No significant difference. Paired samples T test p=0.631
Communication	No significant difference. Related samples Wilcoxon Signed Ranks test p=0.785
Joined-up services	No significant difference. Related samples Wilcoxon Signed Ranks test p=0.785
Continuity	No significant difference. Related samples Wilcoxon Signed Ranks test p=0.480
Wider benefit to society	No significant difference. Related samples Wilcoxon Signed Ranks test p=0.

Bonferroni adjustment for multiple comparisons, significance reduced to p=0.004

Table A3.11 Weighted performance scores for Model 3 (local contract)

Priority	*Range*	*Minimum*	*Maximum*	*Median*	*Mean*	*Standard Deviation*	*Skewness*	*SE skew*
Comms 2	34	16	50	32	33.38	10.57	0.07	0.61
Access 2	42	8	50	35	31.46	9.97	-0.67	0.61
Quality 2	38	12	50	35	35.84	10.35	-0.75	0.61
Improve 2	46	4	50	32	31.07	11.02	-0.97	0.61
Involve 2	44	6	50	32	31.07	11.24	-0.76	0.61
Continuity 2	32	8	40	32	28.38	11.65	-0.67	0.61
Holistic 2	42	8	50	32	30.46	10.73	-0.35	0.61
Equity 2	44	6	50	25	28.15	12.94	0.14	0.61
Influence 2	37	3	40	24	25.53	11.34	-0.43	0.61
Join 2	44	6	50	32	31.61	10.88	-0.82	0.61
Wider 2	32	8	40	24	24.25	9.71	-0.09	0.63
Cost 2	33	12	45	20	24.61	10.81	0.59	0.61
Cumulative Total	376	132	508	383	361.33	102.82	-0.78	0.63

Figure A3.3 Histogram of the cumulative weighted performance scores for Model 3

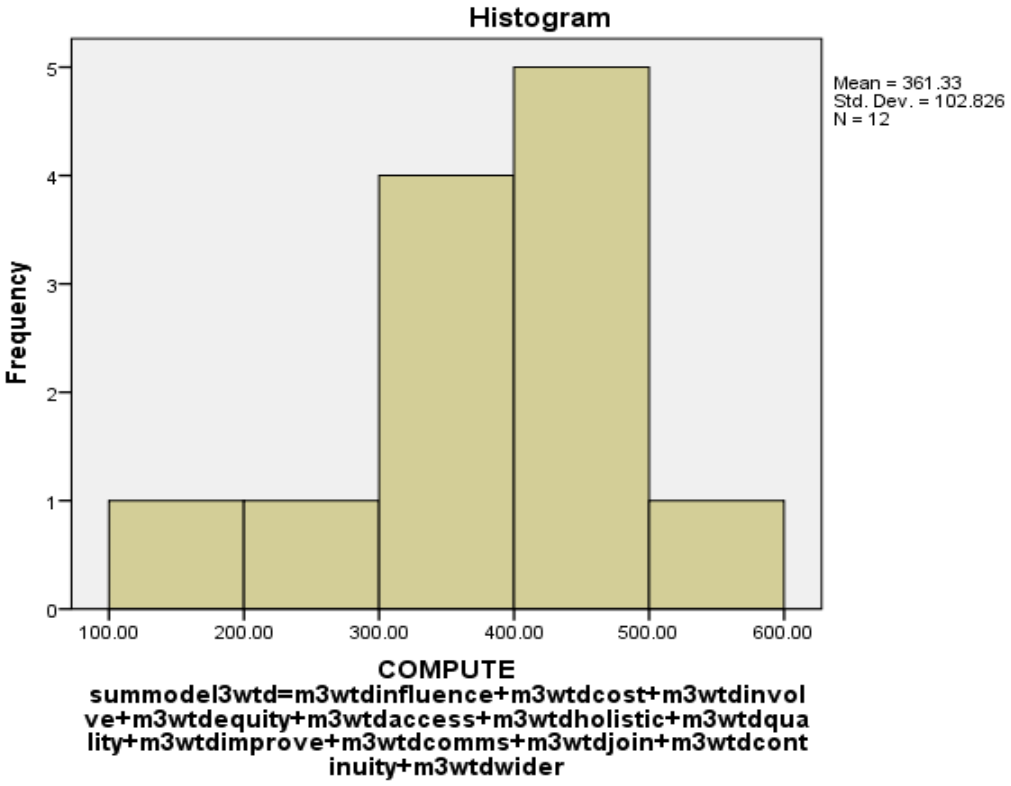


Table A3.12 Independent samples Mann-Whitney U Test comparing cumulative scores for Models 1,2 and 3 across two groups: public and staff.

Comparison	Result of tests of significance
Cumulative score for Model 1	No significant difference. Independent Samples Mann-Whitney U Test, p=0.199
Cumulative score for Model 2	No significant difference. Independent Samples Mann-Whitney U Test, p=0.969
Cumulative score for Model 3	No significant difference. Independent Samples Mann-Whitney U Test, p=0.177