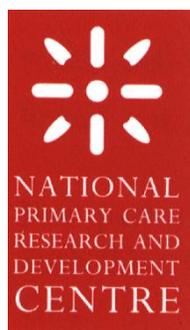


# **Alternative Providers of Primary Care in the English National Health Service: A study of commissioning, organisation and operation**

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## ***Executive Summary***

### **Background**

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

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

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

### **Aims and objectives**

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

### **Design and methods**

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

- Observation of 27 meetings (total approx 65 hours of observation) between PCT staff and APPC owners/employees.
- Interviews with 23 staff from both PCTs and APPCs.

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

## Results

### 1. Procurement

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

### 2. Models of APPC

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

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

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

### 3. Contract and performance management

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

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

Under each domain there were up to 21 specific indicators, and 25% of the contract value was dependent upon meeting these. There was a small amount of evidence that this tight specification could cause problems with, for example, one APPC arguing that a particularly tight definition of time taken to 'triage' walk in patients was preventing them from focusing upon the desirable goal of ensuring that all patients were seen as quickly as possible. We found a number of examples of both KPIs and contract terms which were regarded as being unclear, requiring further negotiation and discussion. In Site 1 this was compounded by the fact that a

different team was involved in monitoring the contract from that which undertook the procurement. In Site 2 there was overlap between these teams, ensuring that those monitoring the contract were aware of the intentions behind individual clauses. The monitoring process was regarded as time consuming for both PCT staff and practice staff. We also found that the experience of tightly monitoring APMS contracts in this way had caused PCT staff to start to think about standard GMS performance in a different way.

#### **4. Provider behaviour**

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

#### **5. Professional relationships, externalities and outcomes**

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

#### **6. Impact of the 2010 Health White Paper**

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

#### **7. Perceptions of 'success' and problems experienced**

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

- Meeting the KPIs within the contracts to date.
- Meeting QOF

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

Problems experienced included:

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

## **Conclusions**

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

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