The new GMS contract in primary care: the impact of governance and incentives on care

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Executive Summary

**Background**

Since its implementation in 2004, there has been much interest in the impact that the new GMS contract (nGMS), and in particular the Quality and Outcomes Framework (QOF), might have on practice performance, organisation and patient care. Much of the research until now has focussed on quantitative analyses of QOF performance or on qualitative insights into the impact that nGMS is having on practice teams. Much less is known about how the contract is being governed, and in particular the mechanisms that primary care organisations (PCTs in England; Health Boards and Community Health Partnerships in Scotland) are employing to monitor performance; whether these mechanisms vary depending on the service model (GMS/PMS practices; enhanced services; and out-of-hours services); the impact on staff; and, importantly, the impact on patients. This project also examined the impact of the devolving health care systems in England and Scotland, in relation to the GMS contract. These issues were informed by several theoretical approaches to governance, including Courpasson’s soft bureaucracy, principal-agent analysis and accountability chains.

**Aims**

This study aimed to explore the governance arrangements in different models of service provision emerging from the implementation of the new GMS contract; the impact of the incentives contained within the contract on the organisation and performance of primary care; and the impact of the new contract on professional skill-mix and patients’ experience.

Specific objectives were:

1. To examine the overall impact of the new GMS contract on clinical activity and patient process and outcome.

2. To describe how governance arrangements under the new contract are interpreted and implemented in the design and management of different provider organisations (practices, enhanced services and out-of-hours services).

3. To examine how governance arrangements impact on the relationships between PCOs and professionals working within different provider organisations and on the organisation of professional work.

4. To explore how new opportunities: (a) for patient and public involvement AND (b) to pursue population health or equity of care through commissioning or use of new resources, are understood and in what ways, if any, these are addressed.
5. To identify whether shared learning between provider organisations, either directly or via the PCO, occurs.

**Methods**

A multi-stage, multi-site study design was used utilising embedded case studies and a mixed methods approach to data collection. Four PCO case study sites were selected: two in England and two in Scotland. Within two of these sites, 6 embedded case studies were selected: 3 GMS practices; 1 PMS practice; the drug misuse enhanced service; and the out-of-hours service.

Specific methods included analyses of routinely available data on QOF performance and on workload distribution between GPs and practice nurses; interviews with 120 health care professionals working at national, regional (PCO) and practice/service level (67 in England; 53 in Scotland); case note review of patients with either diabetes or rheumatoid arthritis; and interviews with 19 patients (14 in England; 5 in Scotland).

**Results**

The principal contract holder in both England and Scotland for all three models of service delivery (GMS/PMS, enhanced service and out-of-hours) was the PCO. Both hard and soft mechanisms of governance were in evidence and these were inextricably linked. In England, greater weight was being given to hard mechanisms of governance, such as balanced scorecards. However, there was little evidence of punitive action being taken against poorer performers, although the enhanced and out-of-hours services acknowledged the potential for being de-commissioned.

Practices were subjected to both external monitoring, from the PCO, and internal monitoring from colleagues charged with monitoring practice performance towards QOF targets. A greater role was apparent for non-clinicians to monitor clinicians, for example in practices and in the out-of-hours services.

Practice nurses continued to take on an ever greater workload, not only in relation to QOF but also with the enhanced services. Some remained concerned about the degree to which their contribution to QOF achievement was recognised, either professionally or financially.

Evidence was equivocal in relation to unincentivised conditions. While there was no evidence of such conditions being actively neglected, the time spent on other incentivised areas left professionals and practices with little organisational slack to address these conditions fully.

Skill mix continued to develop, with evidence of a new pseudo-professional group emerging, the receptionist/health care assistant. GPs continued to deal with the most complex patients, either in
terms of age, multiple morbidity and/or social circumstances, thus continuing the “hierarchy of appropriateness”. However, while workload was clearly being re-distributed, there was little explicitly said about how that decision was taken. Workload was also being re-negotiated between practice nurses and community-employed staff, for example district nurses.

While gaps in QOF achievement had narrowed between the most affluent and most deprived practices, there was little evidence of QOF being used to target inequalities, despite the fact that almost all practices have opted into QOF. Despite the recent policy rhetoric in England, there was no evidence of proportionate universalism being enacted, whereby QOF could be applied globally, but with targeted approaches to increase uptake aimed at the most deprived.

Comparison of the impact of deprivation between the two countries was made more difficult due to this lack of patient-level postcode linked postcode deprivation data; the development of such a dataset in England would greatly enhance the ability to conduct local and comparative analyses of the impact of deprivation on health and health care use.

Patient care was improving year-on-year, both for patients with diabetes (selected as an example on a QOF incentivised condition), but also rheumatoid arthritis, selected as an unincentivised condition. Much of the routine monitoring was conducted by practice nurses, but GPs retained control over more complex treatment issues, such as prescribing.

Patients appeared unaware of the contract nor of changes in their care as a result of nGMS; indeed, most felt that their condition had always been monitored regularly, ever since diagnosis.

There was no evidence of patient/public involvement in monitoring and governance, with the exception of lay assessors in the QOF review visits to practices. However, increasing public involvement in governance of the contract may raise issues around contractual responsibility and probity.

**Conclusions**

Our research has highlighted a number of areas for policy, practitioners and for future research. We also reflect on the likely impact of changes proposed to the NHS in England by the Coalition Government in July 2010.

**Policy and practice**

Although nationally set, the continued devolution of health care systems in the UK may lead to renewed calls for localised approaches to the Quality and Outcomes Framework.
The central role of PCOs in monitoring and governing primary care contracts must be acknowledged, particularly in light of plans to abolish PCTs in England.

An increased reliance on bureaucratic and hierarchical systems of monitoring is likely, in time, to erode health care practitioners’ autonomy which may, in turn, reduce their willingness to meet targets and incentives.

The role of service de-commissioning needs to be re-considered, as such threats de-motivate local practitioners and may prevent service providers from tendering to provide services in the future.

The negative impact of more bureaucratic and hierarchical monitoring, coupled with a more explicit role for service de-commissioning, may be destabilising in the smaller organisations, such as the proposed GP Consortia in England.

The potentially universal coverage of QOF should be strengthened and linked with enhanced services and, in England GP Consortia, to develop appropriately targeted services at underserved and disadvantaged populations.

There is a need to consider the impact of QOF on other underserved groups, such as the elderly, minority ethnic groups and those who find it difficult to attend surgeries.

There is an expressed need to review the role and remuneration of practice nurses, who are clearly a key professional group in the delivery of QOF and services related to the new contract.

The development of new services and the monitoring associated with them are falling disproportionately on practice nurses. Future policy imperatives need to be cognisant of this and recognise the implications if the practice nurse workforce dwindles.

Innovative ways of involving patients and the public in the governance of contracts is required.

**Practitioners**

There is a clear need to support practice nurses who are charged with mentoring other members of staff e.g. health care assistants.

New roles are developing within primary care, particularly in relation to dual roles amongst administrative staff and health care assistants. Support and training for such staff will be required.

Similarly, the development of non-clinical managerial roles need continued support and development.

Learning opportunities within and across services need to be maximised.
Research

Our findings suggest that future research should be focused on the following areas.

Research into the impact of national devolution on service delivery and organisation is required, with shared policy learning a priority.

Research will be required into the impact of abolishing PCTs and establishing GP Consortia in England.

Research into the on-going impact on unincentivised care is still required.

Further research into the impact of non-clinical monitoring of clinical roles and the impact on autonomy and professional boundaries.

The development of comparable datasets is required to allow comparative analyses on practice and service performance, taking account of the populations served.

Further research into the impact of the contract on underserved and disadvantaged populations is required.
Addendum

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.