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Personal medical services in London: new solutions for an old problem?

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A number of inquiries over the last 20 years have found London's primary care to be deficient when compared with the rest of the country, notwithstanding several development programmes aimed at addressing this inequity. Personal medical services (PMS) pilots were introduced in 1998 to replace the national contract for general practitioners and were intended to offer planners and providers of primary care with more flexibility in meeting local health needs. PMS pilots have proved particularly popular in London. This paper describes the results of a review of 13 first-wave PMS pilots in London. The pilots have resulted in new and flexible primary care organizations, more resources for the primary care workforce and greater access to services for deprived or underserved populations. However, little evidence was found to suggest that PMS pilots impacted greatly on service quality. Personal medical services pilots involve the development of local contracts, although contract management processes remain underdeveloped. Nevertheless, personal medical services pilots may prove successful in addressing some of the relative deficiencies in London's primary care and offer a powerful new tool to the commissioners of primary care to meet the diverse needs of Londoners.

Key words: general practice; London; personal medical services pilots; primary care

London's primary care – an enduring 'problem'

This paper considers the implementation of personal medical services (PMS) pilots in London and their potential to tackle entrenched problems in the delivery of primary care. This is set in the context of a number of attempts by central government to address the performance of primary care in London.

Primary care in London has long been acknowledged as relatively deficient across a number of indicators when compared to the national average. As far back as 1981, the Acheson Report provided an expert review of general practice in the capital (London Health Planning Consortium, 1981). The report concluded that general practice faced specific challenges such as poor premises, poor access and a high level of single-handed practice. One result of this was an over-reliance on the hospital sector for services that elsewhere would be provided by general practitioners. The nationally specified contract for general practice services appeared to be a weak tool with which to address these issues. Acheson made more than 100 recommendations and his report was broadly welcomed by the government of the day.

However, more than a decade later, further inquiries by the King's Fund and a team led by Sir Bernard Tomlinson both concluded that a 'London problem' was still detectable in primary care (King's Fund Commission on the Future of London's Acute Health Services, 1992; Tomlinson, 1992). This was particularly evident in relation to access to services, the achievement of health screening targets, the availability of practice-based services and the quality of surgery premises. Like Acheson, the Tomlinson Report suggested that the complex rules and regulations that governed primary care were hindering the development of services that would be responsive to the needs of Londoners.

The government set in train a programme of

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change (Department of Health, 1993). While better known for its rationalization of London's hospitals, the 'Tomlinson programme' also served to invest in primary care. Between 1993 and 1999, a London initiative zone (LIZ) was established, more than £400 m was spent on improving primary care and limited flexibilities to the national general practice contract were negotiated within the LIZ (Lewis, 1998).

In 1997, the incoming Labour government commissioned yet another inquiry into London's health care (Department of Health, 1998a). Perhaps surprisingly, Sir Leslie Turnberg, the inquiry chairman, found continuing weaknesses in London's primary care when compared to the national picture. Consequently, a further programme of development was announced (Department of Health, 1998b).

Personal medical services pilots – the London experience

It is clear from this brief history that centrally inspired development programmes have had a limited impact on reducing the gap between London and the rest of the country in terms of primary care provision. However, as the LIZ began to wind down, the 1997 NHS (Primary Care) Act introduced PMS pilots (Department of Health, 1997). These pilots were intended to provide a new means of contacting for primary care services. The national general practice contract (known as General Medical Services (GMS)), which these pilots supplanted, was acknowledged to be an insensitive tool with which to deal with the variable needs of local populations. Throughout the 1990s, general practitioners were increasingly dissatisfied with their existing contractual options and PMS pilots provided new opportunities (GMSC, 1996). PMS pilots are founded on locally, rather than nationally, negotiated service agreements together with locally determined and cash-limited budgets. Greater freedoms within PMS pilots are provided for GPs to become salaried employees rather than independent contractors, the traditional hallmark of general practice. This initiative offered an opportunity to overcome the contractual and managerial obstacles to primary care development that had been identified by both the Acheson and Tomlinson Reports.

Figure 1 Uptake of personal medical services in London

Health authority	First wave	Second wave	Third wave	Total
Barking and Havering	1		15	16
Barnet, Enfield and Haringey	2	8	42	52
Bexley, Bromley and Greenwich	1	10	35	46
Brent and Harrow	1		7	8
Camden and Islington		1	7	8
Croydon	1		13	14
Ealing, Hammersmith and Hounslow	1		3	4
East London and City	2	3	31	36
Hillingdon	1	1		2
Kensington, Chelsea and Westminster	1		4	5
Kingston and Richmond		1	11	12
Lambeth, Southwark and Lewisham	4	22	47	73
Merton, Sutton and Wandsworth	1	3	25	29
Redbridge and Waltham Forest		2	11	13
Total	16*	51	251	318

*Three approved pilots did not go live.

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Figure 2 King's Fund research programme and methods employed

Research project	Brief description	Methods employed
In-depth case studies	A three-year study of four PMS pilots in London. Pilots comprised of: one nurse-led 'greenfield' practice managed by a NHS trust; one GP-led 'greenfield' practice managed by a NHS trust; two multipractice pilots owned and managed by GP principals	• In-depth semistructured interviews over three years with participants from: the pilot clinical and managerial team; commissioners, interested others (e.g., community health council, local medical committee) • Focus groups (in three of the four pilots) with individuals from organizations working closely with client groups identified as priorities by the pilots • Patient satisfaction survey (using the general practice assessment survey, GPAS).* Surveys were conducted twice for practice-based pilots (that pre-existed their pilot status) and once only for trust-managed 'greenfield' pilots • Practice profile questionnaire to gather basic descriptive data about the pilots* • Audit of angina care in three of the four pilots* • Questionnaire survey of registering patients in one 'greenfield' pilot
Review of nurse-led PMS pilots	A review of the establishment of the nine first-wave nurse-led PMS pilots and the views of the nurse leaders on their first two years of operation	Survey of basic descriptive data in relation to practice characteristics Two focus groups of nurse leaders held in 2000
Review of all first wave PMS pilots in London	A descriptive review of the 16 first-wave PMS pilots that were approved in London (of which 13 went 'live'). An assessment of pilot objectives and achievements	Analysis of documentary sources of information comprising (where available): • Pilot proposals • Service agreements • Routine monitoring reports • Annual reports by pilots or commissioners • Local evaluation reports • Reviews prepared for the secretary of state • Patient satisfaction survey results • Other relevant local material

*These research tools are the same as those used by the national evaluation to aid comparison.

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PMS pilots have proved relatively attractive in London. The first three waves of pilots has seen 17, 25 and 26%, respectively, located in London (see Figure 1) (Lewis *et al*., 2001a). This is significantly higher than would be expected based on share of population. One explanation for this relatively high uptake is that it may reflect dissatisfaction among commissioners and providers of primary care with the ability of the national contract to deal constructively with the multiple needs of Londoners.

At the same time that PMS pilots were emerging, the 1997 Labour government was introducing new policy measures that were transforming the nature of primary care. In particular, primary care groups (PCGs) and, later, primary care trusts (PCTs) were introduced to provide new collective structures for health planning and delivery. PCTs, by creating a powerful focus on primary care development and by involving primary care professionals formally in decision making, are intended to increase the 'voice' and capacity of primary care. The Department of Health has signalled that increasing power and resources are to be delegated to PCTs and that they can expect greater freedom from central control (Department of Health, 2001a). These changes, together with PMS pilots, provide a very different context for primary care development.

Evaluating PMS pilots in London – Methods and research questions

This paper draws mainly on the work of the King's Fund in evaluating PMS pilots in London (Lewis *et al*., 1999a; 1999b; 2001a; 2001b; 2001c) (see Figure 2 for details of research and methods used). This research programme includes:

- Longitudinal in-depth case studies of four PMS pilots in London
- A review of the 13 first-wave PMS pilots that became operational in London as part of the first wave in 1998 (see Figure 3 for details of the pilot sites)
- A review of first wave 'nurse-led' pilots in England.

Figure 3 First-wave PMS pilots in London

Pilot	Major characteristics
Pilot 1	• Multipractice pilot • Collaboration between four pre-existing practices
Pilot 2	• Single practice • Merger of two pre-existing practices
Pilot 3	• Managed by NHS Trust • Nurse-led new practice
Pilot 4	• Managed by single NHS Trust • New practice • Provision of sessional GP support to local practices
Pilot 5	• Single existing practice • Limited company
Pilot 6	• Managed by NHS Trust • Single new practice
Pilot 7	• Single pre-existing practice
Pilot 8	• Multipractice model • Collaboration between three pre-exiting practices
Pilot 9	• Managed by NHS Trust • Single practice building on temporary arrangement to cover vacancy
Pilot 10	• Single practice previously managed by university
Pilot 11	• Multipractice model • Collaboration between seven pre-existing practices
Pilot 12	• Single practice dedicated to the care of the homeless • Nurse-led services
Pilot 13	• Managed by NHS Trust • Nurse-led new single practice

A national evaluation team has been established to examine the progress of first-wave PMS pilots across England and has published its findings (The PMS National Evaluation Team, 2002). This paper draws on the results of the national evaluation where this is relevant to the analysis of London's primary care.

Four questions of central interest to policy makers are discussed below:

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- Have PMS pilots resulted in new models of primary care delivery?
- Have they improved the quality of care provided?
- Specifically, have they increased its accessibility?
- How has local contracting changed the nature of professional accountability?

Organizational innovation

The national general practice contract has led to organizational rigidity. General practitioners are independently and individually contracted to provide services to the NHS. They may choose to form partnerships, but these do not alter the individual accountability of each general practitioner. The first wave of PMS pilots in London, in contrast, stimulated a wide range of new organizational forms. Five organizational types for the contracting of services have been identified (see Figure 4).

Figure 4 Typology of PMS organizations in London (wave 1)

Single practice model: A partnership of independent contractor GPs contract to provide (and perform) primary care services
Multipractice model: A number of practices join together for the purposes of contracting to provide (and perform) PMS services through a formal collaborative agreement, while retaining degrees of individual practice autonomy
Practice subcontractor model: A practice contracts to provide PMS services subcontracting the performance of this duty to a semi-autonomous practice staffed by salaried GPs
NHS trust model: A community or acute NHS trust contracts to provide services employing salaried GPs as performers
Limited company model: A 'body corporate' contracts to provide PMS services using salaried GPs as performers. The performers may also own and direct the company

Importantly, the hegemony of the independent contractor model has been broken. Five of the 13 pilots were led by NHS trusts employing salaried GPs and other practice staff (in future this role is likely to be taken on by primary care trusts). This model has been used in areas where GMS practices have been unable or unwilling to establish sufficient services and appears to offer a powerful vehicle for tackling entrenched problems of underprovision (discussed further below).

It is also notable that three pilots adopted a 'multipractice' model, where previously independent partnerships and/or single-handed general practices formally linked together to provide PMS services jointly. This suggests that general practices may become larger if this model is adopted widely. Two of the multipractice pilots in London involved previously single-handed practitioners. Again, if this model is more widely adopted this would hasten the decline in the relatively high rates of single-handed and small practices in London.

PMS pilots are also able to contract to provide services beyond the normal scope of general practice (known as 'PMS plus'). In particular, this provides a vehicle for transferring services from the hospital sector to primary care. Three pilots in London used this flexibility in relation to intermediate care, mental health, pharmaceutical advice, community nursing and therapies services and complementary therapies.

Quality of care

The definition and measurement of quality in primary care are notoriously problematic. The national evaluation compares 23 first-wave PMS practices in 19 pilots (none of which are in London) with a similar sample of matched non-PMS practices. They examined a range of domains of service quality using quantitative and qualitative methods. The research team concluded that, overall, PMS pilots had made modest improvements in the quality of service provision when compared with GMS control practices (however, these findings did not apply to all domains of service quality) (Steiner, 2001).

Our in-depth case studies of four London pilots found little strong or consistent evidence of a 'PMS effect' on quality. Few pilot participants gave testimony to dramatic improvements, although interview evidence from multipractice pilots suggested

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that single-handed general practitioners perceived that their new collaborative arrangements reduced their feelings of professional isolation. Similarly, nurses within one large multipractice organization identified professional networking and collaboration as a distinct benefit of their pilot. It may be hypothesized that improved team working may lead to improved service quality, although this was not tested formally in our evaluation.

Patient surveys (using the same survey instrument as the national evaluation) found that, against most domains of quality, London pilots scored less well than both the PMS and control cohorts of the national evaluation. Conversely, the three London pilots assessed through an audit of angina care achieved higher scores than the average for both groups within the national evaluation.

The broader experience of the national evaluation confirms that nearly a third of salaried general practitioner doctors employed in PMS pilots will move on within one year (Sibbald, personal communication). For those patients whose expectation is of a long-term relationship, this is bound to be unsatisfactory.

Whether service quality has been achieved at an appropriate cost is difficult to determine. Certainly, the national evaluation found that PMS pilots had received a greater average annual increase in funding than had GMS practices in the control group (8.5 and 3.4%, respectively).

In our research, the trust-led pilots serving smaller, needier lists bore high costs per capita (this was particularly true of nurse-led pilots which tended to have a 'rich' skill mix and often low list sizes). These pilots were sometimes seen as inefficient in the eyes of other doctors and led to some suspicions that pilots had been unfairly favoured in the allocation of resources. PCTs face difficult decisions over future funding for such projects. However, the 'hidden' costs of inappropriate secondary care, Accident and Emergency Department usage and poor primary care may still outweigh extra investment in primary care. Certainly, the experience of other PMS pilots outside London suggests that much hospital work can be relocated to primary care (Kingsland, 2001; Richardson and Roscoe, 2001).

The quality of service management by NHS trusts was also questioned. This is significant given that five of the 13 London pilots have adopted this innovative organizational form. In particular, these large organizations have lacked the ability to react quickly and flexibly to the needs of general practice and have faced steep learning curves in implementing their pilots.

Access

Concerns over how better to deliver primary care to populations that have historically been poorly served featured in the majority of the London pilot proposals. NHS trust pilots, in particular, were established to serve particularly needy populations, such as homeless people, refugees and asylum seekers. While only a small minority had not previously been registered with a general practitioner, patients from black and minority ethnic groups, including refugees and asylum seekers, appear to have gained improved access to care from their PMS practices. One reason for this is that the NHS trusts brought additional resources to the table, for example, access to interpreting services and other relevant voluntary organizations. In many cases, these pilots experienced rapid registration of patients. Three pilots adopted a 'nurse-led' approach to primary care with nurses providing significant elements of first contact care. Nurse leads believe that this model of care is particularly suited to the needs of deprived or disadvantaged populations (Lewis, 2001c).

Focus group analysis at one London pilot suggested strongly that the overt mission to improve access for vulnerable populations had translated into a detectable improvement in responsiveness to patients' needs when compared with local GMS practices. Pilots welcomed, rather than deterred, patients from these populations. They were also prepared to be flexible over appointment times and to work closely with local voluntary and statutory agencies.

At the very least, first-wave pilots tended to be located in more deprived areas suggesting that PMS has been used to address issues of health inequality (Jenkins and Lewis, 1999). The national evaluation has also identified a wide range of schemes targeting vulnerable populations and evidence of a 'community development' approach to pilot implementation. The evaluators concluded that generally pilots targeting vulnerable populations experienced high levels of success in achieving their original objectives. Half of the sites in the study reported improved access to healthcare (Carter *et al*., 2000).

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New salaried GPs have been funded through PMS pilots. Ten of the London pilots cited the recruitment of additional GPs as a major objective and 12 whole-time equivalent posts were planned. PMS pilots have the potential to begin to address high average registered lists that have been a chronic problem in parts of London. However, these new salaried GPs have been seen as largely 'free goods' to the practices that receive them in that they have been fully funded by the Department of Health. This may not be perceived as fair by GMS and PMS practices alike. In addition, the ability to allocate these new resources in accordance with relative population needs is compromised by the voluntary nature of the PMS scheme and its current partial coverage.

Accountability

First-wave PMS pilots were allowed wide discretion in drawing up local contracts (for wave three and later pilots, the Department of Health has introduced a mandatory 'core' contract). In London, all but one pilot adopted a 'block' contract approach (i.e., financial rewards were made available for the total service provided and individual service elements and volumes were not differentiated financially). This is substantially higher than for the national sample, of which 77% used block contracts (Sheaff and Lloyd-Kendall, 2000). London pilots also made greater use of financial incentive/penalty structures than the national average (61% compared with 31%) although little evidence was found that these were enacted in practice.

Many London PMS pilot contracts specified quality standards in great detail. Health authorities took the opportunity to incorporate pre-existing quality programmes, thereby converting voluntary schemes into those enforceable by contract. As a result, many contracts contained large numbers of quality standards. However, very little evidence was found of systematic monitoring of these quality standards suggesting that, at most, they relied on self-regulation.

Few pilots extended their accountability through new relationships with their local communities. Indeed, greater accountability did not appear as a formal objective of any of the London pilots, notwithstanding the emphasis placed on this by Department of Health guidance. However, one pilot did agree a 'charter' with the local community health councils (CHCs). This set out expectations for collaboration between the organizations and arranged for regular quality monitoring visits by CHC staff to practice premises.

Conclusion

The use of special development initiatives over the last 20 years has so far failed to close the gap between London's primary care and that provided nationally. In part, this may be because health care commissioners and planners have lacked a sufficiently powerful tool to change the way in which services are delivered. The national GMS contract is geared to the average population – London's population is far from average.

By offering opportunities to closely match service delivery and funding to needs, PMS pilots may be a powerful new weapon in the armoury of primary care trusts. Our review of the first wave suggests that PMS pilots have already spawned many new models of primary care delivery and have moved far beyond traditional general practice.

Access to primary care has been a key concern since the days of the Acheson Report. PMS pilots have successfully established new practices in areas historically poorly served. These have often been under the aegis of NHS trusts (and have transfered to primary care trusts). This suggests that large NHS organizations may bring to London the strategic intent and the organizational power to tackle long-standing problems of service access (although trusts will need to ensure that they do not stultify services through their inherent bureaucracy).

While access has been improved, some interesting ethical issues have been raised. Anecdotal evidence suggested that 'mainstream' general practices began to direct certain patient groups (such as refugees) towards PMS practices. In some respects this was to be expected and welcomed. It does, however, raise the prospect of the 'ghettoization' of primary care. Should not refugees or homeless people also have a choice of practice?

Many local service agreements included wide ranging quality standards and incentives for efficiency, but there was little evidence of systematic performance management using these new tools. In part, this reflected the lack of capacity

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within commissioning organizations that were struggling amidst a sea of national and local priorities. It may also reflect the fact that fewer, more focused, performance measures may facilitate effective contract management.

A culture of overt local accountability may not easily evolve – not least because general practitioners transferring from GMS to PMS have the right to revert. Nor is it clear that greater quality of primary care has been encouraged through PMS pilots – the evidence so far is ambiguous, at least in London.

PMS pilots are unlikely to offer the definitive solution to the 'London problem'. For example, PMS pilots will not make it easier to secure high quality premises in already crowded and expensive parts of London. However, the first wave of pilots have made progress in a number of important respects namely in developing new and flexible primary care organizations, in attracting resources to increase the workforce, and in increasing access to services (particularly by establishing new practices in traditionally underserved areas). This should provide comfort to ministers who have recently announced that PMS is here to stay (Department of Health, 2001b).

References

Carter, Y., Curtis, S., Harding, G., Maguire, A., Meads, G., Riley, A., Ross, T. and **Underwood, M.** 2000: Addressing inequalities. In *National Evaluation of first wave NHS personal medical services pilots: integrated interim report from four research projects*. Manchester: NPCRDC.

Department of Health. 1993: *Making London better*. London: Department of Health.

Department of Health. 1997: *Personal medical services pilots under the NHS (Primary Care) Act 1997: a comprehensive guide*. London: NHSE.

Department of Health. 1998a: (Chairperson, L. Turnberg), *Health Services in London*. London: Department of Health.

Department of Health. 1998b: *The future of London's health services*. London: Department of Health.

Department of Health. 2001a: *Shifting the balance of power within the NHS – securing delivery*. London: Department of Health.

Department of Health. 2001b: Press release: reference 2001/0549. *Nearly a fifth of GPs in PMS – new flexible contract is here to stay, says Hutton*. (16/11/2001). London: Department of Health.

General Medical Services Committee. 1996: *Core services: taking the initiative*. London: GMSC.

Jenkins, C. and **Lewis, R.** 1999: Reducing inequality. In Lewis, R. and Gillam, S. editors. *Transforming primary care – personal medical services in the new NHS*. London; King's Fund Publishing.

King's Fund Commission on the Future of London's Acute Health Services. 1992: London health care 2010 – Changing the future of services in the capital. London: King's Fund London Initiative.

Kingsland, J. 2001: Improving waiting and access in the NHS – treating the cause. In Lewis, R., Gillam S. and Jenkins, C., editors. *Personal medical services pilots – modernising primary care*? London: King's Fund Publishing.

Lewis, R. 1998: *London initiative zone review – moving London's primary care in the right direction*. Report on behalf of the LIZ Health Authority Chief Executives. London: Barking and Havering Health Authority.

Lewis, R., Jenkins, C. and **Gillam, S.** 1999a: *Personal medical services pilots in London: rewriting the red book*. London: King's Fund Publishing.

Lewis, R., and **Gillam, S.** editors. 1999b: *Transforming primary care – personal medical services in the new NHS*. London: King's Fund Publishing.

Lewis, R., Jenkins, C. and **Gillam, S.** 2001a: *Review of first wave personal medical services pilots in London*. London: King's Fund.

Lewis, R., Gillam, S. and **Jenkins C.** 2001b: *Personal medical services pilots – modernising primary care*? London: King's Fund Publishing.

Lewis, R. 2001c: *Nurse-led primary care – learning from PMS pilots*. London: King's Fund Publishing.

London Health Planning Consortium. 1981: *Primary health care in inner London: report of a study group* (Chair, Donald Acheson). London: London Health Planning Consortium.

Richardson, R. and **Roscoe, A.** 2001: PMS plus – developing a new organisation and extending services. In Lewis, R., Gillam, S. and Jenkins, C, editors *Personal medical services pilots – modernising primary care*? London: King's Fund Publishing.

Sheaff, R. and **Lloyd-Kendall, A.** 2000: Principal-agent relationships in general practice: the first wave of English personal medical services pilot contracts. *Journal of Health Services Research and Policy* 5, 156–63.

Steiner, A., editor. 2001: *Does PMS improve quality of care? Final report from the Quality of Care Project, National Evaluation of PMS*. NPCRDC and University of Southampton: Southampton.

The PMS National Evaluation Team. 2002: National Primary Care Research and Development Centre. *National evaluation of first wave NHS personal medical services pilots summaries of findings from four research projects*. Manchester: National Primary Care Research and Development Centre.

Tomlinson, B. 1992: *Report of the inquiry into London's health service, medical education and research*. London: HMSO.

https://doi.org/10.1191/1463423603pc152oa Published online by Cambridge University Press