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Soft governance, restratification and the 2004 general medical services contract: the case of UK primary care organisations and general practice teams

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Abstract

Within the UK National Health Service (NHS), primary care organisation (PCO) managers have traditionally relied on the 'soft' leadership of general practitioners based on professional self-regulation rather than direct managerial control. The 2004 General Medical Services contract (nGMS) represented a significant break from this arrangement by introducing new performance management mechanisms for PCO managers to measure and improve general practice work. This paper examines the impact of nGMS on the governance of UK general practice by PCO managers through qualitative analysis of data from an empirical study within four UK PCOs and eight general practices drawing on Hood's (1998) four-part governance framework. Two hybrids emerged: (1) PCO managers emphasised a hybrid of 'oversight', 'competition' ('comptrol') and peer-based 'mutuality' through their granting of increased support, guidance and autonomy to compliant practices; (2) Practices emphasised a broad acceptance of increased PCO 'oversight' of clinical work that incorporated a 'restratified' elite of general practice clinical peers at both PCO and practice levels. Given the increased international focus on the quality, safety and efficiency within primary care, a key issue for PCOs and practices will be to achieve an effective, contextually-appropriate balance between the counterposing governance mechanisms of peer-led 'mutuality' and externally-led 'comptrol'.

Keywords:

General practice, primary care, performance management, soft governance, restratification, professional autonomy

Introduction

Primary care has a pivotal role in the delivery of accessible, appropriate, and cost effective healthcare (Starfield et al. 2005; WHO 2008). Care for common and chronic conditions is increasingly being provided by primary care rather than the hospital sector, with quality and safety improvement through performance management central components of international policy reform (e.g. Commonwealth of Australia 2011; Gauld 2012; Institute of Medicine 2001). Historically, general practitioners (GPs) within the UK National Health Service (NHS) have been largely insulated from the performance management culture that has become increasingly important in other areas of UK public services (Peckham and Exworthy 2003). Reinforced by their status as independent contractors to the NHS rather than employees, and underpinned by soft governance mechanisms based on professional self-governance (Sheaff et al. 2003), GPs have historically had a highly autonomous role within the NHS, working in partnership with other GPs in independent businesses ('general practices') that employ practice managers, practice nurses, healthcare assistants and administrative staff. The 2004 new General Medical Services contract (nGMS) (DoH 2003) represents a significant break from this independent status by introducing performance management, audit and inspection by local primary care organisations (PCOs) (Primary Care Trusts/Clinical Commissioning Groups in England; Health Boards in Scotland), which are administrative bodies responsible for commissioning primary, community and secondary care services from providers, including general practices,

Recent studies have described the increased performance management of GPs over the past decade as representing a shift from individual GP self-regulation based on professional expertise to increased external regulation by clinical and non-clinical PCO

managers (McDonald et al. 2007, 2009; Waring 2007). A key issue vis-à-vis nGMS is to understand the nature and extent of this shift, and the hybrid of governance mechanisms being employed by PCOs within the context of this and wider UK healthcare reforms. While previous studies examining the characteristics of PCO-practice relations have focussed on the views of either PCOs (Coleman et al. 2013; Sheaff et al. 2003) or practices (Exworthy et al. 2003; McDonald et al. 2009; McDonald 2012), this study examines both PCO and practice perspectives across two UK countries (England and Scotland), and the ways in which they differ or converge in the context of wider national reforms. After initial data analysis, we chose to draw on Hood's (1998) four-part analytic framework of governance and control in the public sector in order to offer insights into the interplay between performance management, soft governance and professional re-stratification in this context, because it resonated with emerging findings.

Governing medical professionals within the UK National Health Service

A central concept within the sociology of the professions is professional autonomy and the degree to which professionals are free to determine the training, content and rewards for their work (Dingwall 2008; Freidson 1985). Key characteristics of professional autonomy include: expert knowledge and practice (Harrison and Dowswell 2002); self-evaluation of performance and care (Exworthy et al. 2003); control over the nature and volume of medical tasks (Harrison and Ahmad 2000); and an etiquette of equality of competence across the profession. Since the early 1980s, there has been a significant shift in public sector organization from a bureaucratically centralised public administration associated with hierarchy and rational-legal authority, to a 'new managerialism' or 'neo-bureaucracy' (Harrison and Smith 2003) associated with privatisation, the creation of internal markets, and expanded local managerial discretion (McLaughlin et al. 2002).

Contained under the rubric of 'New Public Management' (NPM), this management philosophy includes a new emphasis on contractual relationships, the dismantling of professional bureaucracies, an emphasis on audit and quality improvement schemes, and new ways of defining and measuring performance (Bovaird and Loffler 2003).

In order to operationalise these new forms of control, Courpasson (2000) argues that managers need to influence professionals in a less directive manner to that of non-professional employees. Managers will thus attempt to foster amicable relationships with professional leaders wherever possible through 'soft' governance mechanisms in order to minimise opposition within the profession. In return for a lack of managerial interference, the profession is, in turn, responsible for the 'self-regulation' of the quality of its members' work through its own internal networks, thus assisting in the implementation of policies alongside general managers (Flynn 2004). 'Hard' managerial control of professionals is therefore possible (for example, through audit (Power 1997)), provided it is combined with the 'soft' acceptance of a limited professional autonomy. Courpasson (2000) writes that this is achieved firstly through 'flexible corporatism', in which professional elites possess a boundary role between managers and 'rank-and-file' members of their profession, and secondly through three 'structures of legitimacy' of managerial leadership to minimise professional revolt. Sheaff et al. (2003) summarise these as: (1) 'instrumental legitimisation' (promoting the organisation's aims in terms of performance indicators); (2) 'political legitimisation' (justifying the transfer of authority to managers through assurances that the relationship will be non-exploitive); and (3) 'liberal legitimisation' (representation by managers of various external threats to the organisation's survival, with managerial decisions ensuring that these threats are minimised).

nGMS represents a further departure from this professionally-led mode of governance through the introduction of new performance management mechanisms of audit and sanction into general practice by clinical and non-clinical managers. The following section describes the detail of these changes across two UK countries (England and Scotland) within the context of wider national healthcare policy changes since 2004.

Governing UK general practice

Prior to 1990, the majority of general practice income was derived from capitation, allowances, and a limited range of fees for providing particular services. The care provided in return for these payments was left largely to professional discretion, which limited the ability of local healthcare managers to influence the distribution, quality and range of services provided by GPs in their area (Huntington 1993). Historically, PCOs have lacked strong command or contractual authority over GPs. The 1990 General Medical Services contract introduced some performance management by providing GPs with financial incentives to achieve a small number of clinical targets and improve health promotion activities. During the late 1990s, PCOs were then given formal clinical governance responsibility for general practices in their area. In 2004, nGMS extended these trends by introducing performance indicators, financial incentives, and increased measurement and regulation of clinical work (Roland 2004). A key element of nGMS was the Quality and Outcomes Framework (QOF), in which practice-level quality of care is measured against a range of evidence-based indicators relating to clinical, organisational and patient experience aspects of care, with payments made according to practice achievement measured against ~150 quality indicators. As a UK-wide contract, nGMS was developed during a period of significant growth in healthcare resources, averaging nearly seven per cent per year until 2010/11 (Appleby et al. 2009), with

significant investment in general practice planned via nGMS (National Audit Office 2008). However, following the UK financial downturn in 2008, PCOs had been under increased pressure to reduce spending in primary care wherever possible due to reduced healthcare budgets. In NHS Scotland, while the overall health budget had increased since 2004, these increases were offset by demands on local PCOs post-2008 to make “efficiency savings”, whilst in NHS England there was a reduction in overall funding of approximately £15-20 billion over the three years from 2011-14 (Nicolson 2009).

nGMS has also undergone several changes since it was first introduced in 2004, including a major revision in April 2006 that included an increase in the number of clinical domains from 11 to 18, and a reallocation of points. Further minor changes had taken place during subsequent years, with further additions and reallocations of points across both the clinical and organisational domains. Over the past decade, nGMS has also been implemented in increasingly divergent ways across the four devolved UK countries which reflect wider political and ideological differences therein (Greer 2008). In NHS England, the delivery of primary care was designated to Primary Care Groups (later reformed as Trusts), with responsibility for commissioning primary and community-based services for defined populations. In 2004, practice-based commissioning (PBC) was introduced (DoH 2006), which devolved the commissioning of primary care services from PCTs to general practitioners and groups of practices (known as “consortia”) to provide more efficient, responsive services closer to patients’ homes (Checkland et al. 2009). Practice-level performance data was provided by PCTs, and practices within these groups were expected to make savings via financial incentives in areas such as prescribing and hospital referrals (Checkland et al. 2009). PBC forms a key component of

NHS England reform policy alongside payment by results, patient choice and enhanced competition between providers (DoH 2012).

In line with the wider political impetus in NHS England to introduce markets and competition, a further reform was introduced in 2006 that was designed to give PCTs new powers to negotiate contracts with commercial companies (Alternative Providers of Medical Services contracts or APMS) (DoH 2006) and employ GPs directly. These reforms were also intended to shift the role of PCTs from passive payers to active commissioners of care (McDonald 2012). Until 2013, PCTs were still legally responsible for the contracting process, and practices and local consortia were expected to work with their local PCTs to re-design services to improve the patient experience and keep them out of secondary care (Checkland et al. 2009). In April 2013, the commissioning budget was transferred from PCTs to 211 groups of general practices known as clinical commissioning groups (CCGs) who are responsible for approximately two thirds of the NHS England budget (Naylor et al. 2013) alongside supporting quality improvement work in practices and contract negotiation and performance monitoring. In NHS Scotland, the provision of primary and secondary healthcare has remained within integrated NHS Health Boards since the start of nGMS, with the provision and delivery of primary care services at locality level the responsibility of Community Health Partnerships (CHPs). These brought together general practice, community-based care and social care into single organisational entities with professional representation across the medical professions, and were charged with the delivery of primary and community-based services for smaller populations.

Sheaff et al. (2003) found in their pre-nGMS study that PCO managers relied on a modified version of Courpasson's (2000) concept of 'soft governance' by local professional leaders over rank-and-file GPs rather than general managers. Soft governance was legitimised through appeals to shared professional values and threats to professional autonomy and self-regulation by general management through 'a gradual introduction of managerial techniques and rather subtle individual [moral] incentives' (Sheaff et al. 2003: 425). Freidson (1985) describes the medical profession as increasingly "stratified", with an administrative elite guiding and evaluating the performance of professionals against standards developed by a knowledge elite (1985: 22). The nGMS requirement of practices to submit data on clinical and organisational aspects of their care, and the right and duty of PCOs to inspect their local practices for verification purposes has given PCOs greater direct managerial authority over practices than before, although it is unclear the range of mechanisms involved and how these may differ across these two UK national contexts at PCO and practice levels.

Hood (1998) writes that more than one governance mechanism can potentially exist at once at different organisational levels. Based on Douglas's (1978) Grid-Group cultural theory, Hood developed a four-part framework distinguishing 'oversight', 'mutuality', 'contrived randomness' and 'competition' as an analytical tool for comparing mechanisms of governance and institutional control at different organisational levels within the public sector (Figure 1). This framework is based on two axes indicating the degree of group boundedness in a particular situation (ranging from individualised to collectivised ('group')), relative to the degree of social stratification (ranging from externally-directed to self-governing ('grid')). A number of these modes of governance can exist simultaneously as hybrids that vary in emphasis depending on the nature of the

relationship being examined. This paper empirically examines the key characteristics of PCO governance of English and Scottish general practice via Hood's (1998) framework, focussing on the impact of increased performance management by PCO clinical and non-clinical managers via 'restratification' on the autonomy of general practice professionals.

Figure 1 here

Methods

This paper focuses on the mechanisms and meanings PCO managers and practice team members attach to the governance of general practice post-nGMS. The study took place in four PCOs located in Scotland and England in 2007-2009. A purposive sampling strategy was adopted to ensure heterogeneity in socioeconomic deprivation and urban/rural classification across the four PCOs: one PCO in each country was in an urban deprived location and the other was in a mixed urban/rural location (Table 1). Full details of the case study selection and project methodology can be found at <http://www.sdo.nihr.ac.uk/projdetails.php?ref=08-1618-126>. The first stage of the study comprised semi-structured interviews (n=50) with PCO clinical and non-clinical managers with responsibility for the strategic management and operational delivery of aspects of nGMS. Interviewees included clinical and non-clinical PCO managers with responsibility for the strategic management and operational delivery of the GMS contract and local representatives of professional bodies.

Table 1 here

After agreeing to participate, interviewees were sent a copy of the interview guide, a Participant Information Sheet and a consent form. The researcher conducting the interviewee (SG or AR) obtained informed consent before the interview commenced. The interview topics included: nature of contact with general practices; views on governance of general practice work pre-and post-nGMS; mechanisms of performance monitoring and sanctioning; mechanisms of support and guidance; and impact on patient care. The interviews lasted 60 minutes on average.

During the second stage, one PCO in each country (PCOs 1 and 3) was then selected for further detailed examination. Four embedded case study general practices were recruited within each, with a purposive sampling strategy employed to ensure heterogeneity on the basis of list size, QOF points achievement in 2005-6, enhanced services participation, and practice staff composition (Table 2). Semi-structured interviews (n=40) were conducted with a purposive sample of GPs, practice nurses, practice managers and administrative staff selected on the basis of their involvement in contract work (Table 3). The interview topics included: involvement in GMS-related work; nature of contact with PCO; views on PCO performance monitoring and sanctioning; views on PCO support and guidance; performance monitoring within the practice; and impact on patient care.

Table 2 here

Table 3 here

All interviews were recorded and transcribed verbatim. Analysis followed a grounded analytical approach (Strauss and Corbin 1998). Two researchers (SG and AR) read the

interview transcripts to become familiar with the data. Preliminary themes were identified through scrutiny of initial transcripts and a coding framework was subsequently developed that was grounded in the data collected (Mays and Pope 1995). Both researchers consistently applied the framework to the remaining transcripts using NVivo 8 software. The framework was refined according to emerging themes across the four PCOs. The modified framework was then reapplied to all transcripts to ensure that the findings were grounded in the data (Glaser and Strauss 1967). This constant comparative method continued until no further categories emerged. A selection of the transcripts were additionally coded by three other members of the research team (CO, BG and MG), and any differences in interpretation of the data were resolved through discussion and consensus across the whole team.

Ten key themes emerged from the data analysis which were central to the development of the interpretation of the findings from both PCO and practice interviews: national and local targets and specifications; PCO performance management; performance monitoring and accountability; PCO use of data; support and guidance; professional regulation and development; peer-clinician regulation; practice self-monitoring; skillmix; and professional boundaries. These themes show dimensions of the interrelationship between PCOs, practice team members and the governance of general practice post-nGMS. These dimensions are explained in the results and discussion sections through the medium of Hood's (1998) four-part framework across all PCO and practice case studies.

Results

In the following four sections, we review the extent to which PCO managers describe their employment of each of Hood's (1998) four types of governance post-nGMS: oversight (command and control techniques); contrived randomness (control through unpredictable processes); competition (control through rivalry and choice); and mutuality (control through collegiality); and practice team members' responses to these mechanisms.

Oversight

PCO perspectives

nGMS had led to a significant increase in the use of IT systems within practices for the recording of clinical and organisational data as part of the QOF. During the QOF year (April-March), the Quality Management and Analysis System (QMAS), a UK-wide IT system used to determine QOF payments to practices, constantly reported local and national disease prevalence to PCOs. At the end of the financial year, QMAS provided PCOs with access to the recorded prevalence of disease in practices and performance against all QOF indicators.

PCO managers also had new contractual rights of access to practices through three kinds of review visit. The first was QOF review visits, which were intended to be trust-based and supportive to facilitate practices' understandings of their own QOF achievement and how it could be improved. The second was contract review visits, which were intended to address practice performance in terms of activity levels, practice organisational and technical changes, enhanced services, and commissioning plans for the following year. The third was payment verification visits, where selected practices were subject to a

detailed audit to verify the financial claims they had entered into the QMAS system. Many interviewees associated these new visits with a need for assurance at PCO-level that they were receiving “value for money” and that practices were providing a level of care that met the minimum quality criteria:

I would say that with the contract, [practices] can't just say 'well, we'll sign up for the contract and provide anything' and think we are going to go away and leave them to it. They have to be monitored and the PCO has to be satisfied that we are getting value for money, simple as that.

(PCO 4, Interview 12, non-clinical)

All four PCOs had developed local standards and league tables as a way of monitoring local practice performance. While in Scotland the QOF measures were considered an adequate level of achievement, within the two English PCOs standards had been set by managers across a broader range of indicators and to a higher specification than the QOF “to drive up quality” and “promote best practice, not just the minimum standards” (PCO 2, Interview 12, non-clinical). A key aim of these tables was to identify “irregularities” and “outlying practices” whose QOF scores fell within the top and bottom 10% of local achievement levels, and who therefore required further inspection for potential underperformance or inflated reporting.

nGMS also provided PCO managers with a new range of regulatory interventions that were both ‘compliance-based’ (e.g. financial incentives), and ‘deterrence-based’ (e.g. sanctions) (Walshe 2003). Based on Walshe’s (2003) ‘hierarchy of regulatory

enforcement’, Figure 2 illustrates the range of regulatory mechanisms employed by PCOs on local practices:

Figure 2 here

In particular, PCOs had developed new regulatory systems that could be used against ‘outlying’ practices that did not deliver care to the specified standards, including the withholding of payments or the decommissioning of services:

If we are not satisfied then we will keep on talking to the practice, persuading them, harassing them until either they provide the service that they said they would - and we were expecting them to - or we will take the view that they are not fit to hold a contract and take some serious action against them.

(PCO 3, Interview 25, non-clinical)

In practice, however, there were very few cases of payments being completely withheld, or of a service being decommissioned in its entirety by any of the PCOs. Instead, managers usually identified the underlying issue as organisational or technical (e.g. that staff lacked experience with the new IT systems), and attempted to reach a solution with the practice. In Scotland, for example, CHP clinical managers would conduct “pastoral visits” to discuss relevant issues with practices. If such supportive approaches did not work and other uncontractual underlying issues were believed to be present, then decommissioning could then take place, although only around specific services or individuals through national disqualification involving referral to the General Medical

Council. While the contract provided PCOs with a new range of managerial tools for monitoring practices, non-clinical interviewees in particular described considerable limits regarding their ability to oversee the nature and quality of the services being provided by practices:

There comes a point where as a manager you need a stick and I don't have any, I don't think, that aren't incredibly cumbersome or that require the full might of my tribe to use, and I think that's just maybe too clumsy.

(PCO 3, Interview 24, non-clinical)

[It's] a high trust contract, [...] because a practice can earn a significant percentage of the points available, and at the same time there can be no great assurance a quality service has been provided. That's not to say there isn't one, its saying that it's not so easy to be assured.

(PCO 1, Interview 12, non-clinical)

Practice perspectives:

Across all eight of the practices in the study, the GPs, nurses and practice managers who were interviewed described a significant increase in PCO presence since the start of nGMS through review visits, practice quality profiles, balanced scorecard approaches and benchmarking activities, particularly by non-clinical managers at increasingly local levels. For example, in Scotland, local Community Healthcare Partnerships were responsible for administering the contract, with both clinical and non-clinical managerial involvement. Many practice team members described the increased PCO oversight as

necessary and an improvement to the organisation and monitoring of care, particularly for patients with chronic diseases:

You're [now] very used to outside people auditing, looking, measuring, all sorts of things within the practice; and it's commonplace to find somebody from the PCO or the medicine management team in here [...]. I think [it's] for the better really. It's much more open, and we're having to justify much more what we're doing.

(PCO 1, GP, Interview 66)

[...] you can understand what's behind reaching these targets. It's not all about the money in the back pockets of the GPs, it's about patient care and looking after your patients, particularly those that are on the disease registers.

(PCO 1, Practice Nurse, Interview 64)

However, PCO oversight was frequently described in terms of a gradual erosion of practice-level autonomy as PCOs adopted increasingly complex means of accessing and extracting clinical and organisational data from practices:

[...] it feels a bit like Big Brother. It feels like we don't own our patients any more. We don't own our software any more. I know we don't own the hardware because the PCT buys that, but we don't own our system any more because the PCT can come in, they can change patients' medication, they write to patients and you don't know what's going on.

(PCO 1, Practice Manager, Interview 42)

All eight practices had also re-organised the leadership and management of their clinical work since the start of the contract. For example, QOF achievement was monitored by the practice manager or lead GP through regular meetings to discuss progress throughout the year. While a lead GP was usually assigned overall responsibility for the clinical domains of the QOF, in Practice 1 the lead GP was also responsible for the organisational domains of the contract, while in Practices 3 and 5 this responsibility was shared with the practice manager and senior practice nurse respectively. Most practices had developed a team-based approach to the leadership of clinical domains of the contract, with individual GPs having responsibility for specific disease areas (e.g. asthma) alongside individual practice nurses, with the latter conducting most of the day-to-day contract work.

Contrived randomness

PCO perspectives

While both the QOF and wider contract review visits were conducted by the PCOs on a rolling basis, the more stringent payment verification visits were conducted by external NHS audit organisations on a random basis in order for PCO managers to distance themselves from this part of the process and so maintain practice trust. PCO managers explained that the random selection procedure ensured that all practices conducted their data collection and made their claims honestly, with the threat of this “policing visit” (PCO 3, Interview 6, non-clinical) a key driver for ensuring accurate practice data recording:

[It's] a high trust contract, so that's worth emphasising because a practice can earn a significant percentage of the points available and at the same time there can be no great assurance that a quality service has been provided. That's not to say there isn't one, its saying that it's not so easy to be assured. We don't have a kind of random 'I'm going to come and sit in your clinic today' kind of an idea. It wouldn't help you anyway because they would do it that day and they wouldn't do it the next.

(PCO 1, Interview 22, clinical)

However, as one PCO manager explained, the trust that many PCOs developed with local practices was neither easily nurtured nor uniform:

It's meant to be a high trust contract and I have high trust in ninety-five percent of practices, but I don't have the tools, I don't think, to deal appropriately with the five percent who I don't think are satisfactory, and they are after all the point of any effort.

(PCO 3, Interview 24, non-clinical)

Practice perspectives

Despite the random nature of practice selection, the majority of practice interviewees described the payment verification visits as a daunting experience, particularly for practice managers and GP leads, who were usually the main practice contacts with the PCO:

[The payment verification visit] was more scary because [...] they were double-checking. It was like an audit.

(PCO3, Practice Manager, Interview 48)

However, many GPs and practice managers explained that as long as they entered their data into the IT system honestly there was little for practices to be concerned about:

It's all computerised, and they suck it out of your system and they can see what you've done [...]. There's not really much capacity for doing naughty stuff unless you were extremely naughty, and most people haven't got the time to be that devious.

(PCO 3, GP, Interview 52)

However, some interviewees questioned the randomness of these visits and whether 'outlying' practices who sat in the 10% above or below the 'normal' range were being increasingly targeted by PCOs:

They are now focusing on the practices where they know that there's a problem, so practices are now complaining because they have maybe had three visits in a row and there's probably a good reason for that.

(PCO3, Practice Manager, Interview 63)

A further reason for increased visits to particular practices was the presence of clinical managers from *within* the practice team. In Practice 5, one of the GP partners was also clinical director of the local Community Healthcare Partnership and the GPs and practice

manager suspected that this was the reason why they received such a proportionately high number of payment verification visits. They were very clear to stress that it was not because the CHP did not trust the practice, but because the other local practices would have less trust in the system if there was not additional rigour vis-à-vis practices with a PCO managerial presence.

Competition

PCO perspectives

One of the intended consequences of nGMS was to increase the threat of external competition for general practice from alternative providers by building in provider choice through the new enhanced services. The introduction of increased locally-developed competition via nGMS enhanced services, alongside APMS and PMS contracts in 2006 was described by English PCT managers as a key motivating factor for practices to improve the quality of services that they provided, with stricter criteria being considered to help improve the quality of care in existing practices:

I think the prospect of private sector looming on the horizon has unsettled people in probably quite a positive way in terms of making them think about what they should be doing and taking [...] just the threat of it has probably had a big impact in terms of people improving care.

(PCO 2, Interview 4, non-clinical)

This is in line with the findings of Coleman et al. (2013), who explain that the PCT managers in their study believed that the presence of Alternative Providers of Primary

Care (APPCs) forced practices to “raise their game”. In Scotland, national policy during the period of data collection had moved in a less market-based direction, with less focus on alternative providers. Despite this difference, PCO managers explained that their main priority was to build up good relations with practices and for them to maintain their position as “preferred providers” for GMS services:

There aren't a whole range of providers out there who are saying 'well, in the event that you fall out with your existing provider here we are'. I think that Health Boards, with the exception of a poor contractor, will want to develop a good relationship with their good contractors.

(PCO 4, Interview 23, non-clinical)

Alongside QOF scores that were published annually across the whole of the UK, all four PCOs had also developed traffic lighting systems for the comparative benchmarking of local practices in order to promote professional rivalry and competition. For example, in PCOs 1 and 2, practices were benchmarked across a wide range of locally-developed quality indicators, and a traffic lighting system was used to highlight standards and determine practice performance across a range of quality measures including professional leadership within the practice and HR policies and procedures:

Every practice gets to see every other practice's score as well. Nothing is anonymous, which is very powerful, I think, because practices can then look over the fence and say 'well if they can do it that, I'll do it even better', and I think that generates the motivation to improve.

(PCO 1, Interview 16, non-clinical)

In Scotland, peer regulation was employed in a developmental way through a new instrument called the QOF Analyser Tool. This tool was developed in 2006 to be used by Board managers during QOF Review Visits and the results of the practice being reviewed were explicitly compared against all other practices in the CHP:

You go in there really armed with information, you can look at their achievement and if it's high then you can say so. Often annoyance with the QOF Review is about picking up the red bits – are there any deficiencies here that we can help to support? Even with high-performing practices you will always find in any domain probably three or four areas that possibly have potential for improvement.

(PCO 4, Interview 5, non-clinical)

Practice perspectives

While practices described the publication of QOF scores through league tables as an opportunity to compare their own performance with that of other local practices, it was not necessarily a key motivation for them to change their systems and practices beyond that:

I think it's very useful; we enjoy looking at that. We get all these charts; it's like league tables, which produces a lot of steam, a lot of hot air. I don't understand how some practices can score the points they do, do you know what I mean? I just don't know how they do it. So from my

perspective, we scored less than our neighbouring practice down the road and that really irritated me, really irritated me.

(PCO 1, GP, Interview 41)

In NHS Scotland, despite there being fewer wider national initiatives promoting competition across practices, individuals had a similar response to practices in England:

We all log on now to see how well everybody else has done and, you know, you take it as a personal slight if your practice hasn't done as well as Dr Blogs up the road.

(PCO 3, Practice Manager, Interview 32)

However, despite nGMS driving up 'like-for-like' comparisons of performance across practices, there was an equally strong claim that practices were still individual small businesses with their own unique patient populations that were never truly comparable:

Each practice is different irrespective of whether they're in the same sort of area or the same sort of client list size. Every practice will do something differently and that's what makes comparisons impossible.

(PCO3, Practice Manager, Interview 47)

Practices were generally not motivated to be the best, but to be "middle of the pack" where they would be less visible to PCOs as "it's the outliers who get all of the attention" (PCO 3, GP, Interview 7). nGMS has also highlighted for practices the need for PCOs to address performance irregularities across practices, and that there was no excuse for poor

performance. Practices also did not express a great deal of concern regarding the presence of alternative providers or of their services being decommissioned by PCOs, although it is possible that external competition has become an increasing issue for English practices.

Mutuality

PCO perspectives

PCO clinical and non-clinical managers often referred to the QOF as a voluntary “bonus scheme”, and that there should be no justification for penalising practices under these circumstances. Across both countries, clinical managers in particular described their approach as supportive and developmental in order to promote positive relationships with practices:

I think in the majority of cases the PCT has been there in a much more supportive role than anything else. Obviously it is important for the PCT to have a monitoring role and we are talking about public money...but there are practices that have had difficulties and actually the PCT thankfully, I think, have bent over backwards to help those practices.

(PCO 2, Interview 2, clinical)

It's theoretically a contractual arrangement, but it's also a colleague arrangement. It's not about checking or policing, it's more about what problems have you found? How are you getting on? What are the issues? What do you want to tell us? So you are kind of reviewing the situation

and trying to get a sense of just how the practice carries out its quality standards.

(PCO 3, Interview 6, clinical)

In the English PCOs, local managers were also developing systems to enable local practices to become more autonomous in their delivery of nGMS. One PCO clinical manager explained:

I think it's positive that GP practices themselves have become more autonomous and sort of self-sufficient in a way, rather than its dependency on the PCT. So you know you've got a contract, go and deliver it...I think that, in transactional terms, has sort of changed from a parent-child relationship to more of an adult to adult relationship.

(PCO 1, Interview 16, clinical)

Across both countries, general practice representatives were incorporated into the PCO management teams, usually as medical directors, and professional executive committee members (for example, the English PCTs has Professional Executive Committees (PECs), and the CHPs in Scotland had Professional Executive Groups (PEGs)) to provide clinical representation and leadership to rank-and-file GPs in their local areas. These individuals were considered to have a broadly sympathetic approach to practices, which would build up professional trust. GPs, nurses and practice managers were also involved in the QOF review visits, alongside PCO managers and members of the public to offer support and guidance to practices. For many clinical PCO managers, this was a key legitimating

aspect of the visit as it enabled professionals to give advice on best practice to fellow professionals:

Now the approach we have got at the moment is really just tackling bad performance. What we have really got to get to is excellent quality performance across the patch and we are thinking of using the Royal College's quality practice award as maybe a means to do that but it's very early stages [...] it will cover standards for better health and probably a bit more, but the beauty of it, in my eyes, is that it's peer review. It's your own kith and kin that have done this, it's not government or what have you, it's your own college, your own profession.

(PCO 1, Interview 19, clinical)

PCO 1 had also developed new practice visits by 'high performing' GPs and practice managers who were local professional development leads from a 'role model' group of local practices against whom all other practices were benchmarked:

If they come up with opposition we've kind of had to work through it, bring GPs with us, have champions who appreciate the way we're trying to do things and get them to peer influence.

(PCO 1, Interview 8, non-clinical)

It actually brings another dynamic to the process because obviously they've seen it from both ends and we've picked people who are [...] high

performers organisationally in their own practice and they're able to share that best practice with others.

(PCO 1, Interview 17, non-clinical)

At the same time, these peer reviewers were perceived by non-clinical PCO managers as being able to be stricter with practices because they had greater professional legitimacy:

They sort them out, they're much harder than we are...because they'll just say 'look, if you get inspected at 5% random you'll be in trouble so therefore this is how you do it', which I can't do [...]. And they're well-respected locally so that's how we've got around it.

(PCO 1, Interview 21, non-clinical)

Practice perspectives

Practice interviewees described limited face-to-face contact and increased email contact with PCO managers since the start of the contract, particularly regarding operation of the new IT systems. While many found the payment verification visits highly formal and imposing, the QOF review visits were described as both informal and supportive:

They're not designed to be formal, particularly, and they're not designed to pick fault. They're only there to see if you're falling down in anything, and if you were falling down in something they would do their utmost to help you and they would point you in the direction of, well, try this or try that. I found they were fine. It was quite informal. They were quite

happy with everything and the way we run the practice. They said it ran very smoothly and they were quite happy with everything.

(PCO 3, Practice Manager, Interview 48)

I suppose I expected more of a Spanish Inquisition, but it wasn't. It was just going through the different domains and saying "you've reached that one, but you haven't reached that, why is that?", that sort of thing.

(PCO1, GP, Interview 47)

Despite differences in the 'oversight' mechanisms employed, practices across both countries perceived there to be a great deal of freedom in terms of the way in which they delivered their care:

We've had people come and talk to us about chronic disease management and ischemic heart disease and things like that, mostly at our request, but there's not been anyone who's come out saying "we're going to tell you how to provide this service or that".

(PCO 1, GP, Interview 39)

However, some practice team members commented on the fact that PCO contact with practices wasn't consistently supportive across the board, with the more 'problematic' practices receiving far more help than those considered by the PCO to be "middle of the pack":

[...] there has in the past been carrots dangled in front of the non-performing practices whereas practices who have reached their targets are just left to get on with it and I don't think in certain circumstances it's been fair.

(PCO 1, Practice Manager, Interview 38)

Discussion

The application of Hood's (1998) typology of control and regulation to the relationship between PCOs and general practices in NHS England and Scotland post-nGMS has revealed the presence of complex governance hybrids in both PCO and practice accounts. As Waring and Currie explain, the boundary between professionals and managers is multifaceted, with the mechanisms of power "often uneven, contested and dynamic" (2009: 756). The following sections examine these two hybrids in more detail.

PCO 'comptrol' and managerial legitimacy

nGMS had provided PCOs with a new range of managerial tools for monitoring the performance of local practices that combine 'oversight', competition' and contrived randomness'. This increase in PCO-level 'oversight' can be conceptualised as a new form of managerial 'governmentality' (Foucault 1991) over medical professionals that parallels Hood's (1986) argument that since the 1980s, public organisations have been moving further towards a governance hybrid known as 'comptrol' ('competition' and 'oversight'). However, non-clinical interviewees in particular described considerable limits in their ability to oversee the nature and quality of the services being provided by practices, which was combined with a lack of punitive measures against outlying or

errant practices. While the increased use of ‘competition’ mechanisms was described by PCO managers in England in particular as driving up the quality of care across local practices, clinical PCO managers in particular relied heavily on ‘mutuality’ as a mechanism of peer support and guidance to retain a relationship of trust and goodwill with local practices (McDonald 2012; Prosser and Walley 2007).

In their pre-nGMS study, Sheaff et al. (2003) found that it was professional networks that employed soft governance mechanisms over rank-and-file clinicians. In this study, both clinical and non-clinical managers employed a form of ‘flexible corporatism’ in the performance management process through the inclusion GPs, nurses and practice managers as peer-reviewers in the QOF review visiting teams and as expert development leads in NHS England for outlying practices that required further remedial support and guidance. These clinical elites were described as being able exert firmer control over practices than non-clinicians due to a PCO perception of mutual respect and equality across professionals (Harrison and Ahmad 2000). PCO managers were also beginning to employ soft governance techniques through the application of three of Courpasson’s (2000) methods of legitimation. First, they relied on the ‘instrumental legitimation’ of the clinical and organisational domains of the contract based on the fact that they were national, evidence-based, and professionally-developed. Clinicians’ professional autonomy therefore remained largely unchallenged by PCO managers as they maintained clinical dominance of evidence-based medicine in the face of increased PCO ‘oversight’ through the promotion of a biomedical model of medical work (Armstrong 2002). Second, PCO managers employed a variant of ‘political legitimation’ as practices were assured that compliance with nGMS would result in limited external interference by the PCO, thus enabling practices to self-regulate both the recording and conduct of their work

through ‘personal ethics’ (Foucault 1991) rather than externally-led control. Clinical PCO managers in particular were keen to avoid entering into any form of direct performance management with their clinical peers. Third, PCO managers employed techniques of ‘liberal legitimation’ by stressing that practice failure to comply would result in harder ‘policing’ visits by external NHS audit organisations, and in England the commissioning of alternative providers was perceived as a threat.

Figure 3 illustrates the nature of the PCO governance hybrid using Hood’s (1998) typology and incorporating the ‘location’ and ‘expertise’ axes employed by Exworthy et al. (2003). The four-part diagram illustrates that for PCOs, nGMS has had a mainly ‘mutuality’-based framing aimed at technical rather than clinical issues, with professional autonomy and self-assessment remaining central. While the role of PCO managers has involved increased ‘oversight’ through both ‘competition’ and ‘contrived randomness’, peer-based ‘mutuality’ remained the key governance mechanism that they claimed to employ in practice.

Figure 3 here

Restratification and professional legitimation

Practices emphasised ‘oversight’ as the main governance mechanism employed by PCO managers post-nGMS by an emergent layer of restratified general practice leadership in the form of clinical directors, peer-reviewers and practice-level “chasers” (Armstrong 2002; Exworthy et al. 2003; Freidson 1985; McDonald 2012). The work of these individuals was broadly accepted by most practices as they focussed most of their

attention on outlying practices ('political legitimisation'). Practices were also broadly accepting of the purpose of the contract itself (instrumental legitimisation') provided that they were able to retain a degree of autonomy and independence from PCO 'oversight' ('liberal legitimisation'). Less effective were PCOs' use of 'competition' and 'contrived randomness' mechanisms. While practices found inter-practice comparisons informative, the lack of punitive action against 'poor' performers and the perceived lack of 'real' external competition from alternative providers during the period of data collection created limited motivation for practices to improve in these areas. Random payment verification visits by external auditors removed PCO managers from the process, however practices had started to lack trust in the selection process and question the heavy PCO focus on 'poorer' performing practices. While PCO managers emphasised their role in nGMS as "light touch", few practices described it in these 'mutuality'-based terms despite PCO intentions to be supportive and facilitative through the inclusion of practices' own "own kith and kin" (i.e. GPs nurses and practices managers) within the PCO leadership and as peer-reviewers. However, the majority of practice interviewees explained that they were not familiar with their local PCO clinical leads, and instead described PCO managers as unilaterally working towards similar performance and financially-driven ends through increased proletarianism of practice professionals (Britten 2001; Harrison and Dowswell 2002). Figure 4 illustrates the nature practice perceptions of the PCO governance hybrid.

Figure 4 here

Practices were also making themselves more internally auditable (Power 1997) through internal restratification and the development of practice-level nGMS teams of GPs,

nurses and practice managers who acted as “chasers” to monitor and manage the performance of the rest of the practice team (Grant et al. 2009). Since the start of nGMS, practices had become less ‘impervious to penetration by the nascent clinical governance activities’ (Sheaff et al. 2003: 420-1), with ‘rank-and-file’ (Armstrong 2002) members of both sub-cultures managerially ‘restratifying’ (Freidson 1985) themselves to make their work more externally auditable. Going against more traditional professional values to resist judging others (Harrison and Ahmad 2000), GPs and nurses were prepared to comment on and criticise poorly performing practices on the basis that elements of their care fell below a nationally-accepted threshold.

The practices in this study were purposively sampled to include a range of sizes of teams, geographical locations (i.e. urban and rural) and patient populations. However, it was difficult to make any direct connections between rurality and deprivation and practice relationships with PCOs. We found that the most important factors impacting on practice perceptions of and relationships with PCO managers were deeply entrenched professional values (Broadbent et al. 1992) and the internal practice culture, including whether the practice was internally- or externally-focussed. As Scott et al. (2003) note, these internal cultural and sub-cultural elements are not directly linked to practice organisational structure, location or patient profile and we found that such generalisations could not be made on that basis in either country.

Conclusion

Since the start of nGMS in 2004, general practices have been increasingly encouraged to improve the quality, safety and efficiency of the care that they provide, and to be more

responsive to the needs of patients while facing increasingly constrained financial budgets. This pattern is likely to continue through the further iterations of nGMS that are taking place alongside wider national policy developments that aim to increase the role of an administrative elite GP stratum further through, for example, CCGs in England and partnership-based CHPs in Scotland. These governance arrangements will be dependent on the increased application of ‘mutuality’ governance mechanisms by PCO/CCG clinical and non-clinical managers, alongside ‘oversight’ and ‘competition’ through, for example, nGMS QOF, enhanced services, and the expansion of APMS contracts (Coleman et al. 2013).

nGMS is part of a much broader landscape of performance management in the NHS and similar patterns of clinician- and managerially-led performance management are emerging internationally. For example, recent studies of high-performing healthcare systems have highlighted the importance of strong and effective clinical leadership and rank-and-file engagement across traditionally disparate and independent professionals such as general practice in the UK, Australia and New Zealand, and family and internal medicine in the US (Baker et al. 2008). However, the issue of rank-and-file GP ownership of elite professional groups is complex, and PCOs will adopt different hybrid mechanisms with differing emphases depending on the wider policy setting, healthcare system and historical professional-managerial relationships. A key concern that emerged from this study has been the achievement of an effective, contextually-appropriate balance between the counterposing governance mechanisms of ‘mutuality’ and ‘control’ by both PCO managers and practices (Exworthy et al. 2003; McDonald et al. 2009; Waring and Currie 2009).

Despite increasingly divergent healthcare policies and approaches to nGMS across NHS England and Scotland (Greer 2008), we found PCO and practice-level perspectives on nGMS governance relationships to be broadly similar across both countries. Further examples of the complexity of these ‘mutuality’-‘comptrol’ based arrangements can be found internationally in the USA, Australia and New Zealand (McDonald 2012; Gauld 2012; Smith and Mays 2007). For example, MacDonald (2012) reports that in the USA rank-and-file doctors were less accepting of performance targets and peer ‘oversight’ than in England, and that elite members of medical groups committees had less zeal for implementing new reforms due to their proximity to front-line working. The effective soft governance and restratification of general practitioners can therefore only be achieved through careful, contextually-appropriate reconciliation of the need to maintain rank-and-file practice trust, engagement and professional legitimation (via ‘mutuality’ mechanisms), and the development of appropriate methods of measuring, challenging and supporting the performance of all practices (via ‘comptrol’ mechanisms).

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Tables:

Table 1: Characteristics of PCOs 1-4

PCO 1	PCO 2
Primary Care Trust in England Population served: >450,000. Deprivation score (income)*: 31.0 Mean of 3.1 WTE GPs per practice Number of PCO interviews: 14	Primary Care Trust in England Population served: <250,000. Deprivation score (income)*: 10.6 Mean of 4.7 WTE GPs per practice Number of PCO interviews: 8
PCO 3	PCO 4
NHS Health Board in Scotland Population served: >500,000. Deprivation score (income)*: 24.2 Mean of 3.6 WTE GPs per practice Number of PCO interviews: 17	NHS Health Board in Scotland Population served: >500,000. Deprivation score (income)*: 12.5 Mean of 5.1 WTE GPs per practice Number of PCO interviews: 11

*Deprivation score represents the percentage of the PCO who are eligible for benefits on the basis of low income. The higher the score, the greater the deprivation.

Table 2: Characteristics of practices 1-8

Practice 1	Case Study: PCO 1 List size: large QOF points in 2005-06: Quintile 5* Participated in substance misuse enhanced service. Staff included: 3-5 GPs; 1-2 practice nurses; practice manager.
Practice 2	Case Study: PCO 1 List Size: large QOF points in 2005-06: Quintile 1 Participated in substance misuse enhanced service. Staff included: >5 GPs, >2 practice nurses, practice manager.
Practice 3	Case Study: PCO 1 List size: large QOF points in 2005-06: Quintile 1 Did not participate in substance misuse enhanced service Staff included 3-5 GPs, 1-2 practice nurses, practice manager
Practice 4	Case Study: PCO 1 List size: medium QOF points in 2005-06: Quintile 4 Did not participate in substance misuse enhanced service. Staff included 3-5 GPs, 1-2 practice nurse.

Practice 5	Case Study: PCO 3 List size: medium QOF points in 2005-05: Quintile 1 Participated in substance misuse enhanced service Staff included 3-5 GPs; >2 nurses; practice manager
Practice 6	Case Study: PCO 3 List size: medium QOF points in 2005-05: Quintile 1 Did not participate in substance misuse enhanced service. Staff included >5 GPs; 1-2 practice nurses; practice manager
Practice 7	Case Study: PCO 3 List size: small QOF points in 2005-06: Quintile 1 Participated in drug misuse enhanced service Staff included 3-5 GPs; 1-2 practice nurses; practice manager
Practice 8	Case Study: PCO 3 List size of small QOF points in 2005-05: Quintile 2 Participated in substance misuse enhanced service. Staff included 3-5 GPs; 1-2 practice nurses; practice manager

*1=highest, 5=lowest

Table 3: Practice interviewees by profession

	GP	Practice Nurse	Practice Manager	Administrative Staff	Total
Practice 1	3	1	1	-	5
Practice 2	2	2	1	-	5
Practice 3	2	1	1	1	5
Practice 4	1	1	-	2	4
Practice 5	2	2	1	-	5
Practice 6	2	2	1	-	5
Practice 7	2	2	1	-	5
Practice 8	2	2	1	1	6
Total	16	13	7	4	40

Figures

Figure 1: Hood's (1998) four basic types of governance over public services

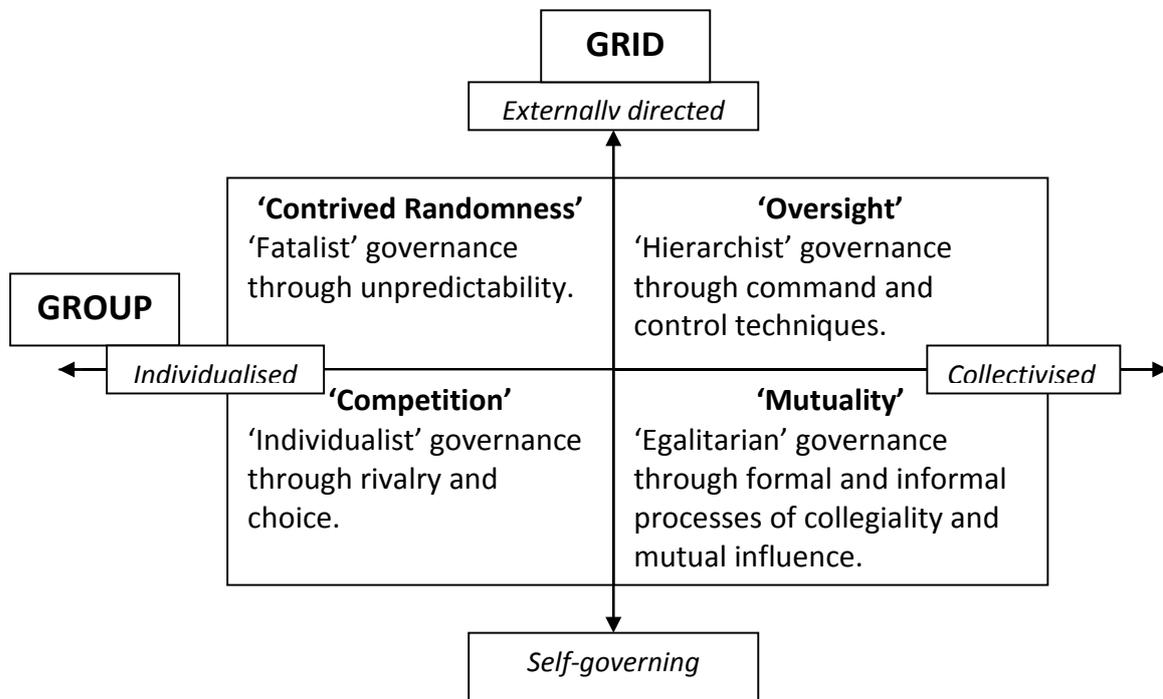


Figure 2: PCO hierarchy of regulatory enforcement post-nGMS based on (Walshe 2003)

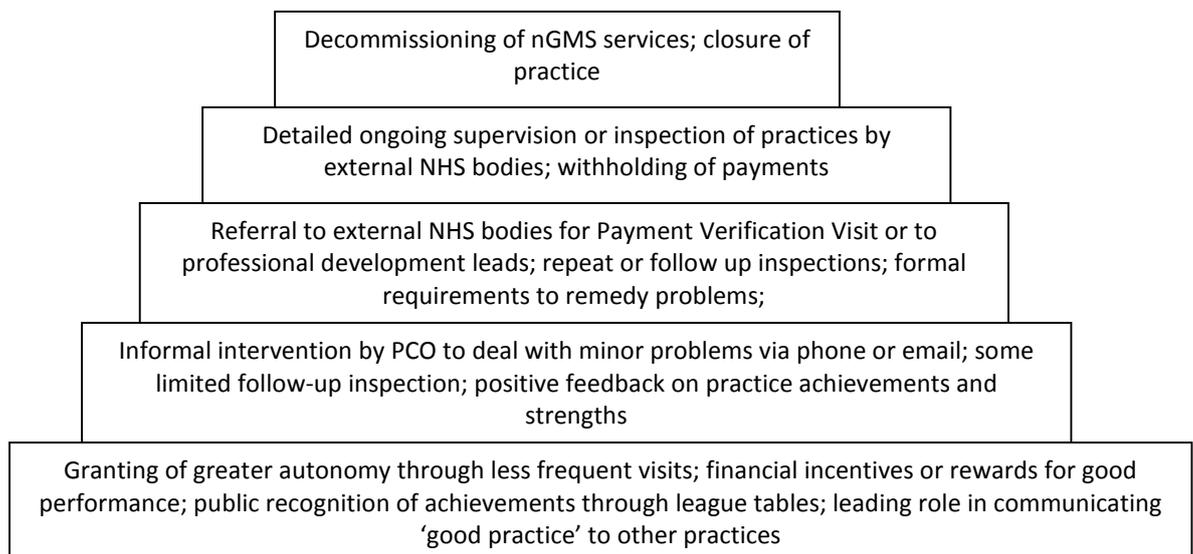


Figure 3: PCO perspective on governance hybrid post-nGMS (based on frameworks by Hood (1998) and Exworthy et al. (2003))

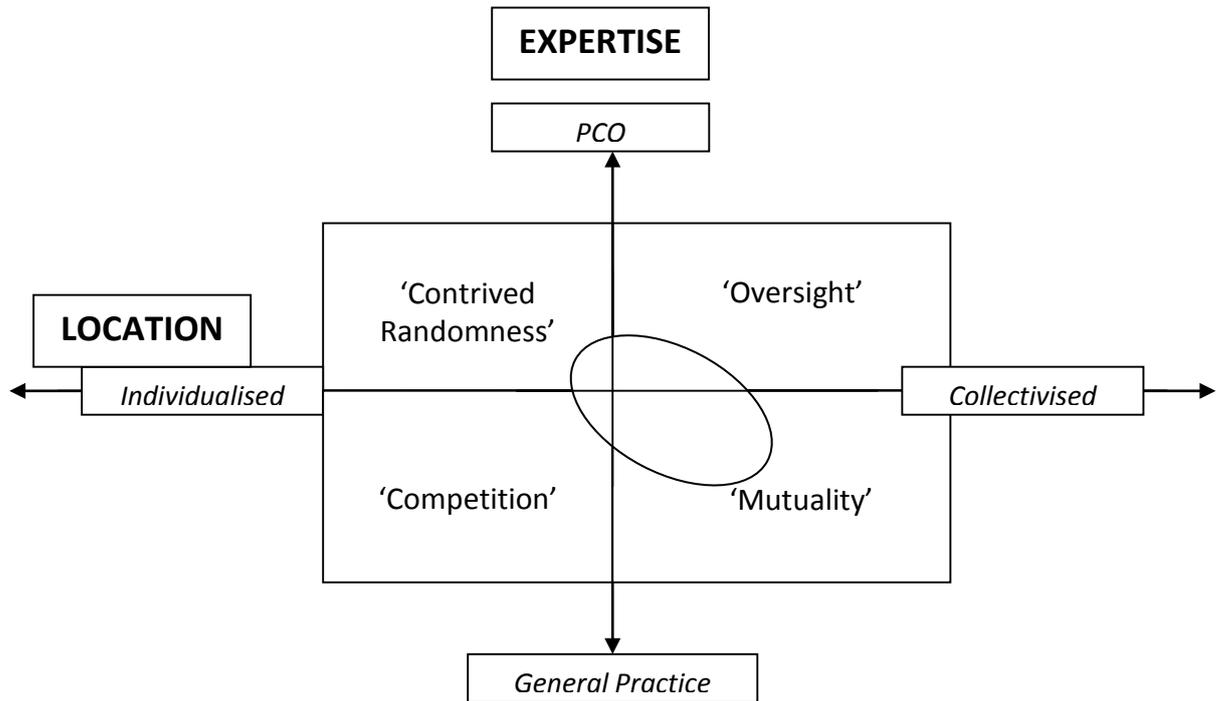


Figure 4: Practice perspective on governance hybrid post-nGMS (based on frameworks by Hood (1998) and Exworthy et al. (2003))

