THE SCOTTISH OFFICE

Department of Health

NHS
MEL(1997)49

NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG

8 August 1997

Dear Colleague

PERSONAL MEDICAL SERVICES PILOTS AND THE NHS (PRIMARY CARE) ACT 1997

This MEL accompanies "A guide to the approval and evaluation of personal medical services pilots under the NHS (Primary Care) Act 1997" and follows on from The Guide to Personal Medical Services Pilots under cover of MEL(1997)19 issued in April 1997.

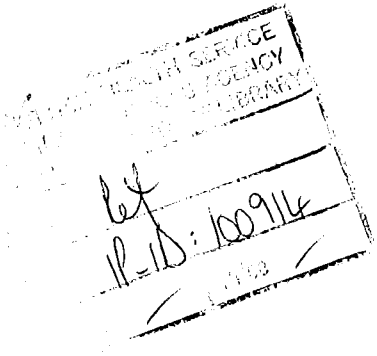
The guide sets out the information Health Boards, General Practitioners and NHS Trusts need in order to submit a full application to undertake a pilot under the 1997 Act.

Applicants should submit finalised applications to their local Health Board by 17 October 1997. However, these should be discussed with the Board and other relevant parties well before this date to ensure there is time for adequate consultation. Applications, along with a recommendation and summary of the conclusions of the consultation, have to be with the ME by 31 October 1997.

A copy of the guidance is being sent separately to each of the 19 applicants whom we have recommended should proceed to the next stage. Health Boards should make a copy of the guide available to any practice or NHS Trust who requests it or who expresses an interest in participating in a personal medical services pilot.

Yours sincerely

AGNES ROBSON
Director of Primary Care



Addressees

For action:
General Managers, Health Boards

For information:

Chief Executives, NHS Trusts

General Manager,
Common Services Agency

Executive Director, SCPMDE

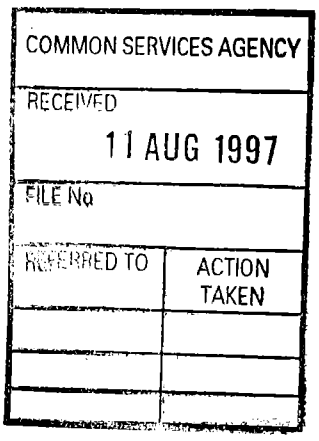
General Manager,
State Hospitals Board for Scotland

General Manager, Health Education Board for Scotland

Enquiries to:

Mrs Susan Malcolm
NHS - Management Executive
Directorate of Primary Care
Room 75
St Andrew's House
EDINBURGH
EH1 3DG

Tel: 0131-244 2680
Fax: 0131-244 2326



PWI13507

NHS IN SCOTLAND
MANAGEMENT EXECUTIVE

A GUIDE TO THE APPROVAL AND EVALUATION OF PERSONAL MEDICAL SERVICES PILOTS UNDER THE NHS (PRIMARY CARE) ACT 1997

NACP0101

July 1997

This document sets out information on:-

- ❑ the background to Primary Care Act Pilots (PCAPs)
- ❑ the application and approval process
- ❑ evaluation

It is intended for use by:

(a) potential applicants - GPs, NHS Trusts etc

(b) Health Boards

Further guidance will be issued on other matters such as financial arrangements, contracts etc.

CONTENTS

1. THE BACKGROUND

1.1 THE NHS (PRIMARY CARE) ACT 1997 AND PERSONAL MEDICAL SERVICES PILOTS

The NHS (Primary Care) Act 1997 allows those who wish to do so to pilot different methods for delivering general medical services - testing the practical implications of the methods and the benefits they could bring.

The NHS (Primary Care) Act includes a number of important principles:

- new approaches will be piloted and participation will be voluntary;
- pilots will be evaluated and must be reviewed before more permanent arrangements (based on those pilots) can be established and which will then exist alongside the current arrangements under Part II of the NHS (Scotland) Act 1978;
- Health Boards may only put forward proposals for pilot schemes from and enter into contracts with members of the "NHS Family";
- pilots must be approved by the Secretary of State.

NHS MEL(1997)19 issued on 9 April 1997 offers additional information on the basic safeguards and rights for patients and doctors who are affected by the establishment of pilots under the NHS (Primary Care) Act 1997.

What is a Personal Medical Services Pilot Scheme?

Primary Care Act Pilots (PCAPs) are an opportunity to test different ideas for delivering General Medical Services (GMS), focusing on local service problems and bringing about improvements. A pilot is implemented through new contractual arrangements with the Health Board, for delivery of these services to the registered patients of practices involved in the scheme.

"Personal Medical Services" (PMS) are those types of services currently provided by general medical practitioners under Part II of the NHS (Scotland) Act 1978. Pilots must therefore incorporate all of the kinds of services that patients are entitled to receive from GPs under GMS. They will also need to provide continuity of care for **all** their patients - as GPs do now - including out-of-hours cover. Pilots cannot pick and choose elements of service or remuneration to be retained outwith the new contractual arrangements; they must move all elements to the new contract.

In addition, pilots can embrace a wider range of services, for example by combining PMS with other services and responsibilities into a single contract with the Health Board.

A pilot cannot solely target one or two specific GMS services. It must demonstrate that those involved will replace the full range of existing GMS services with PMS services that are

equivalent to them, as well as showing which specific or additional services will be dealt with differently by the scheme and explaining how this will be done.

All pilot schemes will need:

- to have clear objectives;
- to have clear benefits to patients and professionals alike;
- to be approved by the Secretary of State.

Who can Apply to Take Part in the scheme?

Health Boards can only put forward proposals from members of the "NHS Family" to provide services under a pilot scheme and contract with them. This means that to propose a pilot, you must be one of the following:

- a suitably experienced medical practitioner (this means a doctor who does, or could, provide general medical services under the NHS (Scotland) Act 1978);
- an NHS Trust;
- an NHS employee (eg nurses, practice managers);
- a qualifying body (which is a company limited by shares, all of which are legally and beneficially owned by suitably experienced medical practitioners or NHS employees);

Partnerships or groups solely comprised of those listed above may also put forward schemes.

Other Points to Note

Applicants should take the following points into account:-

- proposals should demonstrate that the co-operation and agreement of participants has been sought. It is important that anyone whose contract would change as a result of the pilot is fully aware of the consequences;
- patients of a pilot will continue to have the right to register with the doctor(s) in the pilot for the full range of personal medical services. Pilot schemes will therefore have a registered patient population. Patients may, where the pilot is so organised, have the choice of registering with a practice as a whole (ie on a pooled practice list) rather than with an individual GP;
- if a proposal is likely to have an effect on the distribution or number of GPs, the Secretary of State will consult the Scottish Medical Practices Committee.

1.2 DIFFERENT TYPES OF PROPOSAL

The new local contractual arrangements for PCAPs can take various forms and there are some specific implications that applicants should consider in making a proposal for a pilot scheme.

(a) Salaried GPs

If a pilot scheme is to take the form of employing a GP or GPs on a salaried basis the full range of PMS services must be provided all the patients registered with the practice.

If GPs want to use a PCAP to employ a salaried GP, it will mean changing the contractual arrangements for all PMS services provided by all the GPs and practices affected.

The exception to this rule would be if one practice were to employ a salaried GP to cover the registered list of **another practice** (eg in the case of a single-handed practice vacancy). In this case they could enter into a new practice-based contract, **without** affecting their own practice, patients or the services provided.

Where a Trust wishes to employ a salaried GP, it must either employ a complete, existing practice or employ a GP to provide services to an existing vacant list.

A Trust cannot use a PCAP to employ a salaried GP:

- to provide services to a local population which is already registered with a practice or practices, unless the practice or practices have agreed to enter the pilot or are willing to have alternative arrangements put in place for some patients;

- to provide a limited service (eg out-of-hours provision only);

- for a wholly unregistered population (for example in the case of a homeless population they must be registered with the GP who provides their services). It cannot simply provide GMS at a "drop-in" centre, as GMS must **always** be for a defined and registered population.

(b) Practice-based Contracts

Practice-based contracts can take two basic forms - PMS only or PMS plus Primary Care.

PMS only pilots are concerned solely with the delivery of the full range of PMS services to the patients of the practice.

PMS plus Primary Care proposals are concerned with the delivery of PMS plus some or all practice based primary care services eg community health services.

The following points should be noted for practice-based contracts:-

- practices wishing to have integrated (ie including community) nursing services as part of a pilot can do so through a PMS-plus contract by seeking to employ the nursing staff directly or by sub-contracting with a Trust. If a pilot includes more than one practice, all the practices have to take on the same type of responsibility;

- a practice (or practices) can enter into a PMS-only pilot and continue as a fundholding practice (standard or PCPI), but the two arrangements and funding streams will be kept totally separate;

- a practice (or practices) which enters into a PMS-plus pilot which includes any element of what is currently in the fundholding scheme (eg community nursing) must withdraw from the fundholding scheme because there will be a unified budget for the pilot as a whole. The exception to this is prescribing, the budget for which can be included in PMS while maintaining fundholding status;

- pilots cannot include a mixing of funding for PMS and dental services, nor can they include the core services provided by pharmacists or optometrists. It is also not possible for there to be any formal mixing of the funding streams between health services and social work services.

1.3 THE TIMETABLE FOR SELECTION AND APPROVAL

Preparation of detailed applications, including local consultations		June 1997 - October 1997
Submission of proposals by applicants to Health Boards		17 October 1997
Closing date for applications to be sent by Health Boards to the Secretary of State		31 October 1997
Notification of approval by Secretary of State		30 November 1997
Completion of local preparations		December 1997 - March 1998
Pilots go live		1 April 1998

2. THE APPLICATION AND APPROVAL PROCESS

2.1 MAKING A FORMAL APPLICATION

It is still possible for new applicants to join the process, even though the initial stage of making an "expression of interest" is now past. However, formal applications must be made to Health Boards by 17 October, so that submissions can be made to the Secretary of State by 31 October.

(a) The Role of the Applicant

In order that the Secretary of State can judge whether or not the criteria for approval have been met (see Section 2.2), the application should have sufficient detail to demonstrate that, if approved, the proposed new arrangements will provide improvements to the delivery of personal medical services to patients. The proposal should cover:-

Introduction:

- clear identification of issues/problems the pilot is intending to address and the rationale for the proposed development;
- a statement of the aims and objectives of the new arrangements;
- a statement of who the proposed providers are and what arrangements the signatories to the contract with the HB intend to underpin their collective contract (eg partnership, limited company etc).

How the proposals will benefit patients in terms of:

- meeting their needs, providing/improving equitable access to services, maintaining continuity of care and contributing to improvements in quality of care;
- the health outcomes/gains that will be produced;
- the impact on wider health and social care provision locally;
- how stability and continuity of patient care will be protected without limiting innovative arrangements.

How the proposal will benefit the Primary Health Care Team in terms of:

- recruitment and retention of primary care professionals;
- developing co-operation and care partnerships between GPs, Nurses, and other providers, as well as working with Health Boards and Trusts to improve the planning and delivery of services across primary and secondary care and working with other care agencies to develop integrated local service provision;

- meet good employment practices (eg equal opportunities, education, training and staff development requirements).

Other Information:

- identification of the likely preparatory cost (and timetable) to establish new arrangements;
- identification of any new management costs and an indication of funding source;
- identification of any new service costs and an indication of funding source;
- the accountability arrangements (financial, clinical and to the public) including:
  - how possible conflicts of interest have been satisfactorily addressed
  - transparency of complaints system to users
  - transparency in management and decision making arrangements
  - effective quality assurance mechanisms in place ie regular audit and clinical reviews
- credible, but proportionate, proposals for necessary local evaluation;
- an agreement to participate in any central evaluation programme and to provide national data/information.

(b) The Role of the Health Board

Under the Act, there is an explicit procedure to follow before any pilot scheme can be set up: if a member of the "NHS Family" applies to provide piloted services, the Health Board must prepare proposals for the scheme and put them forward to the Secretary of State. Where a scheme covers more than one Health Board, each Health Board must put forward the proposal, although this clearly can be a joint exercise.

Naturally, the schemes' proposers and Health Boards will need to work together to prepare the proposals. For example:

- looking together at the objectives for the proposed pilot;
- sharing information, in order to complete a detailed proposal looking together at the impact of a proposal on other local services.

Health Boards are expected to provide relevant support and help to applicants in the preparation of proposals.

Information which Health Boards should include in making recommendations to the Secretary of State

Health Boards should consider:

- why the proposal should proceed under the NHS Primary Care Act rather than through developing existing service arrangements;
- the likely impact on existing services and service arrangements;
- funding arrangements for service and management costs;
- the level of support for the proposal including details of the outcome and response to the local consultative process (see Section 2.3);
- the applicants' commitment and availability of the necessary management skills to deliver and manage the project arrangements;
- how they would manage the cessation of any pilot, in terms of immediate local service provision and the impact on the wider location;
- how the proposal underpins the development of good primary care and local services;
- how it addresses issues identified within the Health Board's emerging Health Improvement Programme;
- how patients and local people will continue to be involved in influencing service provision after the initial consultation process;
- value for money not only in financial terms but also in improved quality of care.

(c) The Role of the Secretary of State

When Health Boards submit proposals, the Secretary of State must:

- use the information provided to approve a proposal (with or without modifications) or reject it;
- decide which pilots will go ahead;
- notify the Health Board of his decision in writing. The Health Board will then tell the scheme's proposer(s).

The Secretary of State must also consider what effect the proposals (including any modifications stipulated) are likely to have on the distribution of general practitioners and consult the SMPC where the number of GPs is likely to change.

In making judgements the Secretary of State will have a range of information to take into account when considering applications. This will include:

- details of the proposal being put forward by applicants and information resulting from the consultation which will have been carried out in line with directions which will be issued to Health Boards;

- the Health Board's recommendations on the planned arrangements, on how they fit within other local service developments, arrangements for appropriate evaluation and the resources identified to implement proposals;

- national considerations as identified in the 1998/99 Priorities and Planning Guidance.

2.2 CRITERIA FOR APPROVAL

In considering whether to approve a proposal, the Secretary of State will judge how effectively the proposed scheme meets various key criteria. It is therefore essential that Health Boards and scheme proposers understand what those criteria are and ensure that their application shows how the proposed scheme will fulfil them. The Secretary of State will have in mind the principles of "good" primary care - appropriate and accessible services delivered effectively and efficiently to meet local needs.

General Criteria

In selecting which Primary Care Act Pilots to approve, the Secretary of State will:

- wish any proposal to demonstrate that the pilot scheme is capable of improving services and providing personal medical services in a satisfactory manner (ie the full range of services to all patients affected) or securing other services to be included in the new contractual arrangements.

- consider the effect that the proposals (in the form in which he intends to approve them) are likely to have on the distribution of general practitioners;

- need to ensure that satisfactory provision has been made for any participant to withdraw from the scheme, if they choose to do so;

Specific Criteria

The Secretary of State will want to be satisfied that the proposal will be better for:

- **Patients - improving service provision**

  through

  - the development of services to meet patients' identified needs
  - new models or arrangements for delivering care focused on the provision of appropriate and necessary care
  - improvements to services targeted to provide improvements in the quality and access of treatment for **all** patients
  - plans to reduce variations in the quality of services by raising standards in areas where patient groups are experiencing a lower quality of service
  - provision to increase responsiveness of services to local needs and circumstances

- **Professionals working in the health service**

  through

  - provision of opportunities for greater co-operation between GPs, nurses and other clinical providers
  - enhancement of team working and provision of closer professional integration in service delivery
  - extension of opportunities for the provision of improved services by extending roles and development of clinicians within primary care
  - greater opportunity for more flexible working between primary care professionals and wider caring organisation

- **The National Health Service**

  through

  - provision of value for money not only in financial terms but in improved quality of care

- creation of more flexibility in organisational and employment arrangements within general practice which leads to more satisfying careers and improve recruitment and retention

- greater co-operation in planning and developing local health service provision

Other Factors

The Secretary of State will also consider:

- whether the proposed scheme qualifies as a pilot ie that proposals cannot be delivered within existing provisions;

- whether overall a range of new options should be piloted;

- the probability of being able to generalise the proposed contractual arrangements;

- the general desirability of establishing new contractual arrangements for the delivery of services to patients, including the possible impact on planned policy developments.

2.3 LOCAL CONSULTATION

The NHS should provide and develop health services and care which are responsive to the needs of its users. Since the Primary Care Act pilots are new developments in the delivery of services and care, it is essential that the views of those who will be affected are sought and incorporated in the development of proposals.

Health Boards are required to examine each new arrangement proposed and carry out appropriate local consultation. This means achieving the right balance, so that the scale of consultation is **proportionate** in extent, manner and details to the scale and scope of that proposal. To enable local flexibility, there is no fixed list of organisations with whom the Health Board must consult although there will be directions and regulations, on which further guidance will follow, specifying the requirements for consultation with Local Health Councils and Area Medical Committees. In addition, they would normally be expected to consult with LHCs, Area Medical Committees, GP Sub Committees, other GPs and NHS Trusts who may be affected by the proposed pilot scheme and any other relevant professional or consumer organisations.

A key principle of consultation is to attempt, wherever possible, to consult with as broad a constituency of individuals and/or groups as possible, to ensure that the perceptions, expectations and needs of all those potentially affected by an initiative are addressed. This can often be a challenging task, as there may be some areas of the community where special targeting or additional support is required, to ensure that all concerned are able to participate on an equal footing.

However, consultation can be expensive (both financially and in people's time) so it is also important that the scope of the consultation is kept in proportion to the scale of the proposed scheme and that those involved in the consultation are appropriate to the aims, objectives and focus of the consultation exercise. A good practice guide on local consultation with patients and local people has been prepared by the Scottish Association of Health Councils and is attached at Annex A.

Consultation and any resulting adjustments to the proposed pilot schemes needs to take place prior to the formal application being submitted to the Secretary of State.

Those proposing pilot schemes may already have links with local organisations or groups and have discussed the proposal with these. If so, the formal application should include the names of those organisations or groups, giving an indication of their level of support for the proposed new arrangements.

When Health Boards prepare their recommendations to the Secretary of State, they **must** include an analysis - derived from the consultation - of the level of support for the proposed new arrangements.

3. OPERATIONAL FRAMEWORK FOR EVALUATION OF PRIMARY CARE ACT PILOTS (PCAPs)

3.1 INTRODUCTION

In choosing to allow the establishment of pilot schemes under the NHS (Primary Care) Act 1997, the Secretary of State is required to carry out a review of those service arrangements within 3 years of them being set up. This review will establish what benefits, if any, have been obtained for the National Health Service and whether such provision of services should continue. This section outlines an operational framework for the evaluation of Primary Care Act Pilots. It is set out in broad terms to allow for some flexibility of application in the context of particular local circumstances.

All those involved with the development of PCAPs should be aware of the considerable importance which is attached to evaluation in taking forward these new models of primary care provision. The prominent role of evaluation in the PCAPs initiative can be seen within the context of the wider policy of strengthening the R&D base for primary care. Evaluation of pilots represents a major opportunity to promote the culture of R&D within primary care and contribute to evidence based change in the organisation of the health service.

Operational arrangements for evaluation will be put in place both at the local level and through central mechanisms. Broadly:

- **local level** is concerned with evaluating individual pilots;
- **central level** deals with strategic policy issues covering multiple pilot sites.

3.2 ARRANGEMENTS FOR LOCAL EVALUATION

The key principles are that local evaluation should be on a scale proportionate to that of the pilot itself and produce soundly based information with the minimum of bureaucracy. Local evaluations will generally fall into one of two categories:

- **systematic project monitoring** is the basic form of evaluation which will be a *necessary* feature of all approved pilots and perhaps in most cases a sufficient scale of evaluation. Generally, this will be an intrinsic evaluation giving descriptive information on the extent to which:
  - delivery of the service has been consistent with its objectives. For example: in delivering benefits to patients, reducing bureaucracy within general practice or in establishing a more flexible workforce
  - the project has reached the intended population
  - appropriate use has been made of resources and identifying the costs of the new arrangements.

Where existing data allow, a comparison could be made with previous trends in the service. The design of basic evaluation needs to be planned carefully, to minimise the burden of bureaucracy and to maximise the value for project development and the credibility of information.

- **Intermediate evaluation** (eg incorporating a comparative element - ie control practices/patient groups) may be particularly appropriate for some larger scale pilots, which are regarded as having the potential to achieve more major changes in local health services organisation. This approach would enable the impact, that can be specifically attributed to the pilot project, to be defined more clearly and the effects on the wider population/other service providers.

Planning for evaluation should be a flexible process, allowing a suitable balance between the complexity of evaluation design and the scale/scope of the pilot project. The plans should also recognise that **specific additional central funding will not be made available for this purpose**. For the most part, local evaluation will need to be resourced from within the budget for each pilot proposal. And, although Health Boards may be able to provide some support (see below), evaluation plans should not assume that substantial research grants will flow from this source.

An **evaluation guidance manual** has been commissioned from the Institute of Health Policy Studies (University of Southampton), to support the formulation and implementation of local evaluation. This will be sent out separately. Annex B contains a summary of some of the main principles which should apply to local evaluation.

3.3 ROLE OF PILOTS

Pilots will be responsible for ensuring that an appropriate and robust evaluation plan is included with their proposal. In particular it should:

- state clear objectives:
  - identifying the measures which define achievement of those objectives
  - describing the arrangements for collecting the relevant data
- take account of the resources required to implement the evaluation plan, in the budget proposed for the pilot.

The IHPS guidance manual (see above) includes suggestions on ways of involving users in the evaluation process and pilots could also refer to the Scottish Association of Health Councils Good Practice Guidance on Involving Patients (copy attached at Annex A). In addition, the manual describes ways of using evaluation information. Pilots should be prepared to share learning with others involved in or planning pilot projects, in addition to their specific responsibility to provide national data and to take part in any central evaluation.

3.4 ROLE OF THE HEALTH BOARDS

Health Boards will be responsible for ensuring that agreed evaluation arrangements are in place at the local level and for facilitating this process. This will involve agreeing plans with pilots for appropriate project evaluation, which is in proportion with the scale of the pilot - including an assessment of the resource requirements for implementing each evaluation plan - and overseeing delivery of these plans. Delivery of evaluation plans can be incorporated as a requirement within Health Boards' contracts with pilots.

Health Boards also have a role in co-ordinating pilot activity, sharing information and encouraging learning in their own Board area and across other Board areas.

3.5 ARRANGEMENTS FOR CENTRAL EVALUATION

The central evaluation is not intended to support individual pilot evaluations. The totality of approved pilots will constitute a sampling frame from which researchers will be able to draw sample sites according to the research questions they have been commissioned to address. The researchers will be required to undertake a proper process of negotiation and consultation involving pilots and Health Boards in order to gain agreement for access and data collection from sites. At the same time, it will be part of the terms of approval of pilots that they should respond positively to reasonable approaches.

Ongoing work to formulate a specification

The specification for the central evaluation has not yet been finalised. Some illustration of the kind of approaches and issues that may be covered can be given:

- assessing the impact of HB contracting on the quality of primary care services;
- assessing the success of different piloted schemes in addressing a particular identified problem - eg access to services;
- comparing the impact of new organisational forms of personal medical services on equity of provision;
- assessing whether new local contractual arrangements lead to more responsive patient care;
- assessing how far new organisational forms and roles in primary care represent an efficient use of resources.

The primary aim of the central evaluation is to provide an evidence base for central policy development but it will also aim to benefit the pilots and local health service by incorporating approaches to evaluation which support pilot development. Thus, researchers will be expected to identify areas of strength and weakness, barriers to innovation and factors promoting success which can be disseminated in the course of the research programme and not simply at the end of it.

- leaflet distributed to interested parties eg, Local Health Council, Community Council, voluntary organisations, self help groups etc; or

- leaflet distributed through public places eg, libraries, pharmacies, clinics etc.

Feedback Mechanisms

It is **essential** that people are given an opportunity to respond to, and to be involved in, this process. There are a number of ways to listen to people's views. When using an information leaflet think about the following ways:

- tear off response slip;

- freepost envelope;

- phone contact;

- notify of local meeting etc.

and/or

Use an information leaflet as the basis for a more structural consultation with a scientific approach:

- defined audience (sample) to achieve representation from a cross section of patients;

- defined questions (questionnaire or focus groups);

- formal analysis of findings.

and/or

Use an information leaflet as the basis for discussions and meetings:

This type of approach can be very effective but relies on independent collection and collation of the views expressed. It is preferable that at least one person attends all meetings. The meetings could be structured as follows:

- **where** - small local meetings, accessible venues;

- **who** - wide range of key stakeholders and patient population;

- **how** - traditional style public meeting (not too effective) or audience in smaller groups with facilitator to guide discussion and give information;

- **when** - evenings and weekends are preferred by many;

ANNEX A

GOOD PRACTICE GUIDANCE ON LOCAL CONSULTATION

Patients' Involvement

Finding out people's views on pilot proposals is important. Within a full application to pilot Personal Medical Services it will be necessary to provide the views of those consulted. It should be remembered that it is important to consult those whom the proposal will affect; the bigger the scope of the proposal, the more extensive the consultation will have to be. Some thought will therefore need to be given to how views of those involved/affected will be sought. Specifically how the patient population will be involved will need to be planned. There is no standard process to be followed but the following are some suggestions:

- identify someone to plan and co-ordinate the consultation process and compile the responses;
- use existing mechanisms where possible;
- identify a budget and other resources which will be required;
- learn from the experiences of others eg Local Health Council, Health Board, NHS Trusts, Consulting Consumers (1995 SCC and NHSME).

Giving Information

It is suggested that one of the most important tasks is to set out clearly and succinctly the message including:

- what the proposal is about, objectives, timescales etc;
- what the benefits to patients will be, what changes they can expect; and
- how the patient population views will be heard.

Use diagrams or pictures wherever possible, keep the message simple and avoid using jargon. Ensure you have given thought the visually impaired and non-English speakers.

Distribution Mechanisms

Each pilot will need to define the audience and consider how they can be informed this may be by, for example,

- leaflets available in the practice for all patients;
- leaflet mailing - targeting all on the practice list, a cross section or a random selection;

- **how many** - will vary considerably depending on local circumstances.

Local Health Councils

Many Health Councils wish to be more actively involved in Primary Care and there are many ways in which Health Councils can pursue that objective, for example:

- advising on local consultation with local communities;
- meeting GPs about public contact and involvement;
- advising on patient satisfaction surveys;
- promoting and supporting patient participation groups;
- participating in locality planning;
- potentially advising on evaluation methods for pilots from the patient's perspective.

Existing patient feedback mechanisms may help to identify ways to involve patients and the public. Local Health Councils may usefully be involved at an early stage. If no existing patient involvement mechanisms exist there may be resource implications.

SUMMARY

Investment in patient participation techniques will help support more structured public consultation and patient involvement in decision making. There is help at hand locally and it can be a positive process. It may be appropriate to appoint an independent person/agency (eg the Health Council) to co-ordinate the consultation and write up the views of those consulted.

PRIMARY CARE ACT PILOTS

FRAMEWORK FOR LOCAL EVALUATION

DEFINITION AND PURPOSE

Within Primary Care Act Pilots evaluation will be considered as "a set of procedures to judge a pilot's merit by providing a systematic assessment of its aims, objectives, outcomes and costs". The purpose of any evaluation process is to be supportive rather than punitive. Local evaluation will not require complex research designs but will require dedicated information systems, an understanding of standard methods of appraisal of performance, a clear evaluation plan and agreement about who will conduct the evaluation at a local level.

ITEMS TO BE COVERED

For each pilot, the evaluation will need to produce a body of evidence to support a well informed review process. This will cover:-

(I) Analysis of needs for initial conditions forming the baseline for the development of the pilot.

(ii) Statement of objectives defined in a way which indicates what could count as evidence of their achievement.

(iii) Structure - the setting, financial and human resource inputs.

(iv) Process - how and what services are provided and how patients interact with them.

(v) Evidence demonstrating progress made towards the achievement of the specified objectives - including outcomes as applicable, in terms of health and other benefits for patients, efficiency gains and service delivery, improved inter-agency/professional working, and the wider impact on the locality of the activities.

METHODS OF EVALUATION

The choice of design and methods for evaluation will be primarily determined by the questions which individual projects are attempting to answer. These questions will have to be negotiated, agreed and clearly stated at an early stage of the project as they will be the benchmark against which projects will be judged. In addition, an evaluation plan will be an integral part of any pilot project (see Box 1). However, it is recognised that as projects proceed and develop, additional questions will arise which will have to be included in any process of review.

At all times, flexibility will be essential to match individual pilot characteristics and local circumstances. When planning and conducting evaluation, there are some pitfalls to be avoided and they are outlined in Box 2. At the beginning of the project, it will be essential to have agreement about not only the questions/methods for evaluation but agreement about the

people who conduct any assessment. Where evaluation is attempting to look at specific health outcomes or cost effectiveness, then it will be extremely important that expert advice is sought and there are appropriate methods of testing outcomes in these subject areas.

Within any system of evaluation, it is worth considering both quantitative and qualitative issues:

Quantitative

Relates largely to numerate data which are considered relevant to the project. It will be necessary to remember to focus on important data as opposed to interesting data; ie avoid collecting too much information.

Key questions can include:-

What data are important to collect routinely and why?

If sampling has to occur how will this be conducted?

How will it be collected and by whom?

Who will analyse and interpret the data and how often?

How will feedback be provided to key players in the project?

Qualitative

Relates largely to participants' views of progress. Key questions to be posed at defined intervals can include:-

What is going well?

What are the problem areas?

What are the unresolved issues?

What are the next steps and who is taking responsibility for them?

Pilot projects can be enhanced by following such a sequence at regular intervals.

The above frameworks are not intended to be prescribed blueprints for local evaluation, as flexibility will be essential to match individual pilot characteristics. It will be crucial to the success of pilot projects that too much emphasis is not placed on over-complicated assessment procedures.

For those who wish further information on methods of evaluation, a guide will be available from Health Boards who may also have contacts with people with expertise in this field.

BOX 1: THE EVALUATION PLAN

- ❑ **Rationale**
- ❑ **Aims and Objectives**
- ❑ **Design (including methods of data collection and analysis)**
- ❑ **Ethics**
- ❑ **Evaluation Team**
- ❑ **Costs of the Evaluation**
- ❑ **Timescale**
- ❑ **Dissemination**
- ❑ **References**

Checklist for Choosing the Evaluation Team

- ❑ **Who will conduct the evaluation?**
- ❑ **Will an independent evaluation be used? If yes, have their costs been identified? If not, what are the implications for the objectivity of the evaluation?**
- ❑ **Who will be included in the evaluation team? Practitioners? Health Board Staff? Service Users? Voluntary Sector Staff?**
- ❑ **Does the evaluation team possess all the required skills?**
  - **Questionnaire Design?**
  - **Statistical Expertise?**
  - **Health Economics?**
  - **Qualitative Methods?**
- ❑ **Is it clear who is leading or co-ordinating the team and what the respective responsibilities of the team members are?**
- ❑ **Have the costs of the evaluation team been included in the pilot costings?**

BOX 2: AVOIDING COMMON PITFALLS IN PLANNING PILOT EVALUATION

❑	**Ownership**	- **make sure you know who is responsible for co-ordinating and carrying out the evaluation, including producing any reports.**
❑	**Time**	- **give yourself enough time. Evaluation always takes more time than you think.**
❑	**Timescale**	- **don't wait until the pilot is up and running to begin thinking about evaluation. Start planning the evaluation as you plan the pilot.**
❑	**Evidence**	- **take time to identify and read relevant research reports, and incorporate the evidence into your plan.**
❑	**Objectives**	- **avoid a long list of unspecific and unmeasurable objectives.**
❑	**Evaluation Plan**	- **be sure you write one early in-pilot planning and consult widely on it.**
❑	**Advice**	- **don't wait until you have collected your data to seek statistical, design or other expert advice.**
❑	**Design**	- **make sure your design is determined by your evaluation questions, and is proportional to the scope of your pilot.**
❑	**Resources**	- **be sure you consult widely on the financial and human resources necessary to conduct the evaluation.**
❑	**Data Collection**	- **be economical in data collection by restricting it to information relevant to the evaluation questions.**

ANNEX C

HEALTH BOARD RESPONSIBILITIES

PCAP applicants can expect a range of action and support from their Health Board (HB) in the proposal, approval, implementation and evaluation phases of the schemes.

Accepting and Preparing Proposals for Approval

- ❑ HBs may only put forward proposals for pilot schemes from members of the "NHS Family"

- ❑ Each HB affected by a proposal must put it forward, although this clearly can be a joint exercise.

- ❑ HBs will examine whether the proposed idea needs a pilot scheme or could be done under existing arrangements.

- ❑ HBs will work with PCAP proposers to prepare proposal documents, for example:

  - looking together at the objectives for the proposed pilot
  - sharing information, in order to complete a detailed proposal
  - looking together at the impact of a proposal on other local services

- ❑ HBs must examine each new arrangement proposed and carry out appropriate local consultation.

- ❑ HBs recommendations to the Secretary of State **must** include:

  - reasons why the new contractual arrangements are appropriate;

  - a clear assessment of the impact on existing services and service arrangements;

  - explanation of how the proposal underpins the development of good primary care and delivers benefits both to patients and in developing local services;

  - demonstration that the proposal has addressed issues identified within the HB's Health Improvement Programme;

  - confirmation that the proposal demonstrates value for money either in financial terms or quality improvement;

  - agreement to ensure that patients and local people will continue to be involved in influencing service provision after the initial consultation process;

  - a consideration of the capacity of the applying organisation's skills to manage within the pilot arrangements;

- an analysis - derived from the consultation - of the level of support for the proposed new arrangement.

❑ HBs will inform applicants of the Secretary of State's approval (including any modifications stipulated) or refusal of the pilot.

Implementing Approved Schemes

- HBs are required to implement approved pilot schemes in the form agreed by the Secretary of State.

- An approved pilot requires new contractual arrangements with the HB. HBs will ensure this safeguards delivery of **all** GMS to **all** the registered patients of practices involved in the scheme.

- HBs will ensure that the pilot contract covers **all** parties involved.

- HBs will seek ways to support closer working amongst members of the primary care health team.

- Where a scheme covers more than one HB, each one must take action to implement it, although the operation of the scheme may subsequently be delegated to a lead authority.

Local Evaluation

- HBs will be responsible for ensuring that agreed evaluation arrangements are in place at the local level and for facilitating this process:

  - agreeing plans with pilots for appropriate project evaluation.
  - overseeing delivery on these plans.

- HBs will ensure that good R & D support is available.

- HBs also have a role in co-ordinating pilots' evaluation activity, sharing information and encouraging learning in their own area and across other areas.