North Hillingdon Personal Medical Services (PMS) pilot

King's Fund Evaluation Report
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Contents

Executive Summary

Background

The North Hillingdon PMS pilot became one of the first PMS pilots in the country when it 'went live' in April 1998, and the only first-wave PMS pilot in the Hillingdon health authority area. Made up of one group and two single-handed practices located in Ruislip, the practices planned to work more closely together, using their PMS pilot status and a new organizational model to provide more coherence to the services they had previously provided independently.

The key aims of the pilot were to:

- Increase capacity by attracting appropriate general practitioner (GP) and nursing resources
- Share clinical and management resources
- Make better use of skill mix and develop a team approach to service delivery
- Improve the management of specific patient groups such as the elderly
- Reduce individual practice administrative workload

The King's Fund has been working with the North Hillingdon PMS pilot over the last three years as part of an evaluation of four PMS pilots in London. Using a variety of research methods, including in-depth interviews, a patient satisfaction questionnaire (GPAS), an audit of chronic disease management and a practice profile questionnaire, a range of data were collected with which to review the services provided by the practices. With the exception of the interview schedules, the research tools used in the North Hillingdon evaluation replicated the data collection methods used in the National PMS pilot Evaluation, coordinated by the National Primary Care Research and Development Centre (NPCRDC) in Manchester. This allows comparison to be made between the achievements of the North Hillingdon PMS pilot and a sample of PMS pilots and control group of non-PMS practices nationally.

Purpose of the report

This report provides an overview of the development of the North Hillingdon PMS pilot over its first three years as a pilot, and an analysis of the major themes that have emerged from the evaluation. The various data sources and collection methods have enabled a number of different evaluation perspectives to be presented:

- The qualitative views of pilot participants, commissioners and other stakeholders have been collected through 29 interviews
- The views of patients have been analysed through the use of a patient satisfaction questionnaire
- The organization of the pilot and key practice characteristics have been assessed through a practice profile survey
- A 'snapshot' of clinical quality is provided through an audit of angina management

Key findings

- The PMS pilot was seen as having been initiated very much by the lead GP of the group practice, and there appeared to be relatively little engagement of other staff members in the pilot process. There was some concern expressed by the health authority that the single-handed practices were not as signed up to the project as they could have been.

- Interviewees at the health authority were unclear about the purpose of the bid, feeling that a pilot, based in the affluent area of Ruislip, might not address an area of greatest population need. However, health authority enthusiasm increased as pilot developed, and they felt that the pilot would provide useful learning for the Primary Care Trust.

- Both practice and health authority staff painted a very negative picture of their experience of drawing up a local contract. The contract between the pilot and the health authority was signed late, and difficulties in agreeing funding had been a feature of the pilot since its initiation. Arguments between the pilot and the health authority were described.

- The practices all felt that they provided a high quality service, but were hopeful that being part of a PMS pilot would lead to quality improvements, for example improving management structures, setting up common clinical protocols between the practices, better care of older people and providing additional services such as chiropody. Results from the angina audit showed that all three practices scored more highly than National Evaluation PMS pilot practices. In addition, the North Hillingdon practices scored more highly than the national PMS pilot sample and their matched controls on the organization, prescribing and chronic disease management scales of the practice profile questionnaire, and only very slightly lower on the access scale.

- Patient satisfaction, recorded using the GPAS questionnaire, varied between the three practices, with patients rating quality of care to be higher in the two single-handed practices than in the group practice for all scale scores. The view of the health authority was that the advantages to patients, by year two at least, were more behind the scenes than visible. This perception is borne out by the GPAS scores which showed very little difference in patient satisfaction ratings between the two rounds of GPAS carried out in September 1999 and September 2000.

- In the group practice, practice notes have been fully computerised and patients may choose to be seen at either of the surgeries. This would appear to offer significantly greater service access to patients. However, patients' rating of accessibility measured using GPAS actually fell between the first and second rounds.

- Some of the most positive comments made by interviewees in the practices in the early years of the pilot concerned the benefits that increased communication between groups of staff in the three practices had brought about, or had the potential to bring about. However, by year three, there was a sense of

disappointment that more had not been made of the opportunities presented by closer inter-practice working.

- While the level of joint working between the three PMS practices was felt to have fallen short of expectations, there was a similar sense that the pilot had not maximised opportunities to collaborate with other external organizations, most notably the PCT. The PMS pilot crosses a locality boundary within the PCT, which may have increased the relative level of isolation of the pilot.

- Levels of job satisfaction and morale amongst practice staff were variable. One of the key aims of the pilot was to reduce levels of administration in the practices, but this had only been partially achieved. Workloads had decreased for some but increased for others, and 'item of service' claims were still being recorded.

- In common with the other three PMS pilots taking part in the King's Fund London evaluation, there was a recognition that implementing change 'takes longer than you think', but a sense of disappointment was expressed that achievements had been more limited than they had hoped. There was, however, some feeling that things were getting moving again in year three – particularly with the elderly care project. It appears, for this pilot at least, that the time horizon for service development is more than three years.

Conclusion

The practices making up the North Hillingdon PMS pilot have assessed themselves to be providing high quality primary care, and scored highly on practice profile and chronic disease management measures. The two single-handed practices also scored highly on the GPAS patient satisfaction questionnaire. It is worth considering the extent to which this level of quality is due to any 'PMS effect'. On the basis of these results, and on the findings from other London PMS pilots involved in this evaluation, the answer would appear to be 'not yet'. There has been some disappointment about the slow progress of the pilot, and a feeling that more could have been made of the closer working relationships between the three practices. However, there was also a sense, among both provider and commissioner, that the pilot, after a slow start marred by difficulties in its relationship with the health authority, was beginning to make some progress. The pilot is situated within one of the first Primary Care Trusts in the country, and the experiences gained over the last three years should prove valuable learning for primary care development in the area.

Introduction to the North Hillingdon PMS pilot

The North Hillingdon PMS pilot is made up of three practices – one group practice (led by Dr Mashru) and two single-handed practices (led by Drs Karim and Patel) – located in Hillingdon in north west London. The application document for PMS pilot status[1] describes the catchment area served by the practices as "an area of mixed demography, mainly of average social need but with a few pockets of deprivation... *(the)* patient population has a very high proportion of elderly patients, an above average number of under 16s as well as a higher than normal level of cancer incidence". The practices, who have a combined list size of just under 10,000, previously provided General Medical Services (GMS) independently of one another. Key issues highlighted in their bid document, and which they hoped to address using PMS and an innovative, more collaborative, organizational model, included:

- The limited flexibility of operating as small and single-handed practices in maintaining adequate access for patients, and also in focussing on the needs of particular groups of patients such as the elderly
- The impact of demography and associated presenting health needs, on the practices' capacity to provide an adequate level of service
- Difficulties in recruitment and retention of general practitioners (GPs) (identified as a problem in one of the practices)
- The level of administration in each of the practices

By bringing the practices closer together under a PMS pilot umbrella, the key aims of the pilot were to:

- Increase capacity by attracting appropriate GP and nursing resources
- Share clinical and management resources
- Make better use of skill mix and develop a team approach to service delivery
- Improve the management of specific patient groups such as the elderly
- Reduce individual practice administrative workload

North Hillingdon PMS pilot's bid was successful, and the pilot was given approval by the Secretary of State for Health to 'go live' in April 1998, becoming the only first wave PMS pilot within the Hillingdon health authority area. The contract between the pilot and the health authority was signed late because of difficulties in agreeing contract terms. The three practices, who took on 'NHS body' status, were contracted to provide the full range of GMS services and to extend the scope of the services they provided to older people.

An initial evaluation report, outlining the perceptions of the participating GPs in the pilot's first 'acclimatisation' year, was carried out independently at the invitation of the pilot practices and the health authority.[2]

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[1] North Hillingdon PMS pilot: Application for a Personal Medical Services Pilot under the NHS (Primary Care) Act 1997. PHD, 1997.
[2] North Hillingdon PCAP: initial year evaluation. John Tate. Undated.

PMS pilots in England – a brief history

Set up in response to the dissatisfaction voiced by primary care professionals and managers at the rigidity of a single national contract, PMS pilots were viewed as a way of providing more flexibility in the provision of primary care services, particularly in areas such as the inner city. Offering the same broad range of services as traditional General Medical Services (GMS) practices, PMS pilot practices, unlike their GMS counterparts, draw up a local contract with their own health authority, and aim to be more responsive to the needs of local populations.[3] A first wave of 83 PMS pilots 'went live' in April 1998.[4] A second wave, which went live between October 1999 and April 2000, increased the number of pilots to nearly 300[5] and the recently-announced third wave, giving the go-ahead to a further 1,231 pilots, means that, from April 2001, 20% of English GPs will be working under PMS contracts.[6] While it has not always been clear how PMS pilots fit in with the Primary Care Group model, the government has been keen to promote their development. The Department of Health has predicted that, by 2004, half of all GPs in England will be working under PMS pilot contracts.[7]

Practice characteristics

All three practices are currently registered for child health surveillance, minor surgery and maternity care and all operate GP appointment systems with an average of 10 minute consultations. Both Dr Karim's and Dr Mashru's practices were fundholding practices and Dr Mashru's practice is a training practice. The practices share four surgery premises between them – Dr Mashru's practice operates a main and a branch surgery and, as practice notes are fully computerised, patients may choose to be seen at either of the surgeries. Dr Mashru's and Dr Karim's practices are within the North Hillingdon locality area of the Hillingdon Primary Care Trust (PCT) and Dr Patel's practice is within the Uxbridge and Hillingdon locality. Table 1 below shows the numbers of clinical staff working at each of the practices, together with practice list sizes.

Staff turnover was high in the first year of the PMS pilot - three partners left, two from Dr Mashru's practice and one from Dr Karim's practice (albeit all for family reasons), only two of whom had been replaced.[2] A nurse practitioner was appointed to work in the group practice in November 1998.

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[3] Department of Health. Personal medical services pilots under the NHS (Primary Care) Act 1997: a comprehensive guide - second edition. London: NHSE, 1998.

[4] Jenkins C. Personal medical services pilots - new opportunities. In Lewis R, Gillam S, eds. *Transforming primary care: personal medical services in the new NHS*, pp 18-28. London: King's Fund, 1999.

[5] Department of Health press release 99/0520. 32 new pilots takes total to nearly 300: additional personal medical services pilots announced. 1999.

[6] Department of Health press release 2000/0724. Local doctors and nurses voting with their feet for reform. 2000.

[7] Great Britain. Parliament. The NHS Plan: a plan for investment, a plan for reform. London: Stationery Office, 2000.

Table 1: Practice staffing (clinical posts)

	Dr Mashru	Dr Karim	Dr Patel
Number of patients registered at the practice (January 2001)	5,814	1,551	2,373
Number of GP principals (wte)	3	1	1
Number of additional GPs eg registrars, assistants, retainees (wte)	1.75	0	0
Number of nurse practitioners (wte)	0.62	0	0
Number of practice nurses (wte)	1.1	0	1

Wte = whole time equivalent

Evaluation

Evaluation is a key component of the PMS process – all pilots are expected to carry out a local evaluation of the services they provide, at a scale relative to the size and complexity of the project. In addition, the Department of Health has commissioned a national evaluation,[8] coordinated by the National Primary Care Research and Development Centre (NPCRDC) in Manchester. Unlike the local evaluations, which generate learning based on the experiences of individual PMS pilots, the aim of the national evaluation is to address strategic policy issues by evaluating the characteristics and experiences of all the first wave PMS pilot sites.

Evaluation of the North Hillingdon PMS pilot

The King's Fund evaluation of the North Hillingdon PMS pilot has followed the development and operation of the pilot since its setting up in April 1998. We used the following data collection methods in Hillingdon:

• In-depth interviews	to ascertain the views of key stakeholders in the pilot and other organisations working closely with the pilot
• Angina audit	an audit tool to look at the quality of chronic disease management in the pilots, together with the extent of data recording
• GPAS	the General Practice Assessment Survey is a validated patient satisfaction questionnaire, used in each practice at least once to investigate patients' perceptions of quality
• Practice Profile questionnaire	based on validated practice-level indicators, this tool measures performance on the four scales: access, organisation, prescribing and chronic disease management.

[8] National Evaluation of First Wave NHS Personal Medical Services Pilots. Integrated interim report from four research projects. Manchester: National Primary Care Research and Development Centre. December 2000.

King's Fund Evaluation of four London PMS pilots - methodology

The King's Fund has been working with four PMS pilots in the London area over the last three years on their local evaluations. The four pilots were chosen to reflect the diversity of pilots nationally and include practice-based, trust-based and nurse-led pilots. A multi-method case study approach has been adopted to enable the pilots to 'tell their own stories'. Over 150 in-depth interviews have been carried out with key staff in the practices, health authorities, community trusts, Primary Care Groups and Trusts (PCG/Ts), Local Medical Committees (LMCs), Community Health Councils (CHCs) and with Social Services representatives on PCG/T Boards. We have also used a variety of other methods of data collection including focus groups, patient satisfaction questionnaires, audit of chronic disease management and a descriptive questionnaire of practice characteristics (see table below). Where appropriate, we have used the same research tools as those used in the National Evaluation (marked * below), to allow us to compare the results of the four London PMS pilots taking part in our evaluation with a larger sample of PMS pilots nationally.[9]

	Hillingdon	SW London	Isleworth	Lambeth
Interviews	Annually, summer/ autumn	Annually, summer/ autumn	Annually, summer/ autumn	Annually, summer/ autumn
Angina audit*	Mar 00	Mar 00	Dec 00	Dec 00
GPAS*	1: Sep 99 2: Sep 00	1: Nov 98 2: Sep 00	Sep 00	Sep 00
Practice profile questionnaire*	1: Apr 99 2: Dec 00	1: Nov 98 2: Dec 00	1: Feb 99 2: Dec 00	1: Apr 99 2: Dec 00
Focus group	X	Sep 00	Mar 00	April 00
Registration questionnaire	X	X	Spring 99	X

The Interviews

A major component of the evaluation was the in-depth interviewing we carried out annually, in the summer and autumn, over the three years of the project:

Table 2: Interviews carried out at the North Hillingdon PMS pilot

	Year 1	Year 2	Year 3	Total
Practice interviews	5	7	6	18
Health authority interviews	3	2	2	7
'other' interviews	0	2*	2*	4*
Total	8	11	10	29

(* telephone interviews)

Interviewees were selected randomly from the practices, making sure that lead GPs, non-lead GPs, practice nurses, nurse practitioners, district nurses, health visitors and

[9] Andrea Steiner (Ed). Does PMS improve quality of care? Interim report to the Department of Health from the Quality of Care Project (TQP) for the National Evaluation of Primary Care Act Personal Medical Services Pilots. NPCRDC and University of Southampton, 2000.

practice managers were all represented. The majority of the interviews followed a face-to-face interviewer-administered questionnaire with the respondent, although a small number of the interviews were conducted over the telephone. Face-to-face interviews were tape-recorded, with the respondents permission, and detailed notes taken. Quotes used in this report are anonymous, identified only by the organization by which the interviewee was employed (for example, health authority, practice, Local Medical Committee) and by the year in which the interviews were undertaken. Examples of an interview schedule we used is given in Appendix 1.

The Angina Audit

The National Evaluation of PMS pilots used a chronic disease management questionnaire to evaluate the clinical care and note-taking for patients with angina, asthma and diabetes in five PMS pilot practices and five matched control practices. The clinical reviews took place in June and July 1999 and a team of researchers completed the chronic disease management questionnaires. We used the same angina audit questionnaire in our evaluation of London PMS pilot practices (see Appendix 2), however, in our study, the practices were asked to complete their own questionnaires. Both the National Evaluation and the King's Fund evaluation studies included patients aged 18 and over who had been registered at the practice for two years or more (in Lambeth and Isleworth, two of the King's Fund sites, this figure was reduced to 14 months), and had been prescribed a 'Top 20' angina drug in the last 6 months (Appendix 3). Sampling, therefore, was by repeat prescribing, not by inclusion on a particular disease register, or by diagnosis. Patients were selected randomly. Data items were scored on a yes/no basis, dependent upon the data being both available and recorded. Where data were missing for individual questions, we recoded the missing value as a 'no' response. Patient scores were re-scaled to range from 0 to 100, and mean scores were calculated for each practice.

The angina audit questionnaires were sent out to the practice-based PMS pilot practices (South West London and North Hillingdon) in March 2000, and in December 2000 to the community trust-based pilots (Lambeth and Isleworth). The reason for this was that the community trust-based pilots were both 'greenfield' sites and the audit was carried out as late as possible in the study to allow the maximum number of patients sampled to have been registered for 14 months or more in these practices. Not all practices were able to identify 20 patients with a diagnosis of angina – Lambeth was unable to identify any patients who fulfilled the inclusion criteria.

The General Practice Assessment Survey (GPAS)

The General Practice Assessment Survey (GPAS) was modified from a validated American questionnaire – the Primary Care Assessment Survey (PCAS) by the National Primary Care Research and Development Centre in Manchester. GPAS has been designed to assess those aspects of care which are most highly valued by patients. There are nine sub-scales of GPAS:

- Access
- Inter-personal care
- Receptionists
- Trust
- Continuity of care
- Doctors' knowledge about the patient
- Technical care
- Practice nursing care
- Communication

In addition, there are several non-scaled questions – these relate to referral, coordination, likelihood of recommendation of GP to family and friends, overall satisfaction and a number of socio-demographic questions. Scale scores are calculated from the results recorded in each scale – a minimum number of items must have been recorded (normally half) for an item to be calculated. If there are insufficient scores recorded for any scale, then the scale as a whole is listed as missing. In all scales, the possible range of scores is 0-100 – interpreted as the percentage of the maximum possible score. GPAS is only available in English at present, and therefore is unsuitable for use by those patients who do not understand written English. A study testing the psychometric properties of GPAS has assessed it as being a useful and reliable instrument for assessing a number of dimensions of primary care.[10]

The General Practice Assessment Survey (GPAS) has been used twice during our three year evaluation of the North Hillingdon PMS pilot (see Appendix 4). The initial mailing was sent in September 1999 to 200 randomly-selected patients aged 16 and over, who had been registered for more than 12 months, at each of the three pilot practices in Hillingdon. A reminder letter to non-responders was sent later that November. The overall response rate in the three practices was 52%. Unfortunately, the patient address labels, used in the mailing out of the questionnaires and requested by the pilot from the health authority, contained details of children aged under 16 years. A total of 42 responses (7% of the total sample) had to excluded from subsequent analysis as a result.

A second round of questionnaires was sent out to a new sample of 600 patients in September 2000, with a reminder to non-responders mailed in October/November of that year. Response rates were higher this time, averaging 64% for the three practices. Further details of the results from the GPAS data collection and analysis are given in Appendix 5. Comparative data from the National Evaluation GPAS study of 23 PMS pilot practices (making up 19 PMS pilots) and 23 comparator practices is referred to in this report. The National Evaluation GPAS study differed slightly from the King's Fund use of GPAS. In our study, questionnaires were sent to patients aged 16 and over, whereas in the National Evaluation, GPAS was sent to patients aged 18 and over. We sent one reminder to non-responders, while the National Evaluation study sent two reminders to all but one of the participating practices.

[10] Jean Ramsay, John L Campbell, Sara Schroter et al. The General Practice Assessment Survey (GPAS): tests of data quality and measurement properties. Family Practice, vol 17, no 5, pp372-379. 2000.

Practice Profile Questionnaire

The Practice Profile Questionnaire was designed at the NPCRDC, based on Health Authority Practice Performance Indicators (HAPPI) against which quality of care can be assessed.[11] The indicators, all of which have been validated, assess the following areas of care:

- Access and availability
- Range of services provided
- Care for chronic conditions
- Prescribing

The Practice Profile Questionnaire was sent out to the four London PMS pilot sites taking part in the King's Fund evaluation, between November 1998 and April 1999 and again in December 2000. This was designed to provided a 'before' and 'after' picture of the practices' development during their first three years of PMS status. Comparative practice profile data from the National Evaluation study of 23 PMS pilot practices and 23 matched controls are referred to in this report. The individual questions making up the four practice profile scales are given in Appendix 6.

Focus Group

We have conducted focus groups at each of the other three sites participating in the King's Fund evaluation of London PMS pilots, and found the data we collected to be very useful in understanding the collaborative work being undertaken by the pilots. We had hoped to carry out a focus group at the North Hillingdon PMS pilot looking at the work being carried out by professionals and voluntary and community groups in the area of elderly care. Unfortunately, despite numerous requests, practice staff were unable to identify suitable attendees for our meeting and we were unable to go ahead with the focus group. As a consequence, we have not been able to assess the impact of the pilot as fully as we had planned.

The Registration questionnaire

This site-specific questionnaire was designed to provide a descriptive profile of patients registering at the Isleworth Centre PMS pilot in West London, a new practice set up from scratch to provide services for patients who had previously found it difficult to register with a general practice. We did not replicate the use this questionnaire at our other three PMS pilot sites.

[11] Campbell SM, Roland MO and Buetow S. Defining quality of care. Social Science and Medicine, 51:1611-1625. 2000.

The Findings

Summary of year one interview data

The main findings from the first year interviews (see Appendix 7) and from the first round of GPAS (included in Appendix 5) have already been reported. Overall early themes were derived, in the most part, from the interview data, and included the following:

- The pilot was seen as having been initiated very much by the lead GP, with other members of staff being less clear about the aims of the pilot.
- Opinions varied as to how unanimous individual practices were about joining the pilot.
- Interviewees at the health authority were unclear about the purpose of the bid, feeling that a pilot, based in the affluent area of Ruislip, might not address an area of greatest population need.
- Both practice and health authority staff painted a very negative picture of their experience of drawing up a local contract.
- The practices all felt that they provided a high quality service, but were hopeful that being part of a PMS pilot would lead to quality improvements, for example improving management structures, setting up common clinical protocols between the practices, improving care for older people, and providing additional services such as chiropody.
- Practice morale in year one was judged by members of staff to be variable.
- The first twelve months of the project was seen very much as being a time for building relationships.

By the time we undertook data collection in subsequent years, there had been some structural changes in the practices. Additional staff had been taken on – two retainees in one of the practices and a vacancy had been filled at one of the other practices. Extra doctor appointments had been provided as a result. Patient numbers had increased at the group practice by nearly 500 patients over the two years between 1998 and 2000, and in one of the single-handed practices by 200. The reasons for this included infill housing being built in the area, the increased prominence of one of the surgeries following redevelopment work, a number of closed GP lists in the area and new asylum seekers moving into the area. The themes arising from the various methods of data collection over the three years of the pilot include:

- Local contracting
- Quality of care
- Accessibility
- Inter-practice working
- Relationships with other organizations
- Roles
- Workload

The rest of this report considers the developments that have taken place over the lifetime of the PMS pilot, using the identified themes.

Local contracting

PMS pilots draw up their own local contract with the health authority whereas GMS practices operate within a national contract for primary care. The local contract aims to make PMS pilots more responsive to the needs of their local populations. In Hillingdon, the experience of drawing up the first local contact with the health authority was described as 'painful', a description confirmed by the health authority. The contract had not been altered in year two, and although there were no concrete plans to change it in year three, the project lead stated that it would be altered 'if need be'. Both the practices and the health authority viewed the contract as being broadly similar to GMS:

> **(*there are*) not a huge number of differences. Most contract issues have stayed the same, but we don't have an automatic over-75s check for the worried well (practice, year two)**
>
> **It replicates GMS without the hurdles or hoops (health authority, year two)**

Local contracting offers an opportunity to introduce new contract measures that are locally sensitive and focussed on clinical quality and outcome measures. This opportunity has not yet been grasped in this pilot as the contract used is little different to that under GMS. However, this finding is common to a number of other PMS contracts surveyed. [12]

Difficulties in agreeing funding had been a feature of the pilot since its initiation – and tensions remained by the time we carried out our final round of interviews, with one member of practice staff referring to 'argy bargy and arguments' between the pilot and the health authority.

> **The health authority are encouraging us to do 'flu injections – last year it was meningitis. GMS practices get Item of Service payments – we don't – we have to bid for money. We got a lump sum payment for the meningitis jabs, irrespective of how many we gave. For 'flu we've ordered for 90% of the target group – the health authority are expecting us to get 60%. If they say we can only get a lump sum, we may not be adequately rewarded – we may not get the fee (practice, year three)**
>
> **...the NHSE gave us growth money – the health authority wouldn't give us the money until we got a proper plan. *(The lead GP)* then wrote his plan – it was one and a half years until the health authority agreed we could do it.....the money is sitting around in the health authority, unused (practice, year three)**

Such disagreements were seen as running counter to the aims of PMS – as one member of practice staff pointed out :

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[12] Richard Lewis, Stephen Gillam, Toby Gosden and Rod Sheaff. Who contracts for primary care? Journal of Public Health Medicine, vol 21, no 4, pp367-371, 2000.

.....paperwork is not reduced and admin time is wasted (practice, year 3)

Perhaps because of all the debates over funding, relationships between the health authority and the pilot were reported to be, at times, strained. When we interviewed in year two, relationships with the health authority appeared to have improved:

...there was initially some friction, but I think that's been resolved and the degree of trust has improved (practice, year two)

It's certainly been a relationship that's had its ups and downs. At the moment (*it's*) quite good, and better than it was before the pilot, but there have been times when it was a lot worse (health authority, year two)

However, by year three, the more positive comments we had heard about the relationship between the pilot and the health authority during year two, seemed more muted:

***(there has been)* hardly any support at all (practice, year three)**

The health authority has not helped in pushing through the service developments that were part of the pilot – they could have been more proactive (practice, year three)

From their side, the health authority felt that perhaps the practices 'should be taking on more responsibility':

I think the practice has a slightly over-opportunistic view of the support we can give (health authority, year three)

However, when asked directly, two respondents in the practices did not feel that the PMS pilot had had any impact on the practices' relationship with the health authority, while another said:

Originally it deteriorated because the experience was so frustrating, but it has improved a little recently (practice, year three)

The health authority acknowledged the mutual frustration in getting the PMS pilot going and described the relationship between the pilot and the health authority as a 'haphazard relationship', suffering from the 'regular changing relationship at health authority and PCT level' but felt that relations had improved since the setting up of the PCT. Clearly, the creation of the PCT and the reconfiguration has (not surprisingly) impacted on the implementation of the PMS pilot.

Quality of Care

When we interviewed in year one, all the practices felt that they were already providing high quality primary care. In addition to the self-reported views on service quality, we used three additional data collection methods to assess more objectively

the quality of care provided in the practices – the Angina Audit, the Practice Profile Questionnaire and GPAS, a patient satisfaction questionnaire.

The Angina Audit

The results of the Angina Audit are given in Table 3 below, and show that although the practice scores vary quite widely, all the North Hillingdon PMS pilot practices score more highly than the five National Evaluation PMS pilot practices and their matched controls. It is worth noting that, in our angina audit study, the practices filled in their own questionnaires whereas the National Evaluation used a team of researchers to carry out the practice audits. It may be the case that our methodology is more likely to lead to variability in the recording of data, and thus in the overall results.

Table 3: Angina Audit results for North Hillingdon PMS pilot

Practice	Mean score	Sample size	Std. deviation	Min score	Max score
Dr Karim	69.39	11	14.25	40	91
Dr Mashru	84.18	17	15.41	50	100
Dr Patel	56.66	10	17.17	27	91
North Hillingdon PMS pilot total	76.32	41	17.64	27	100
King's Fund PMS pilot practices*	67.59	144	20.82	18	100
National evaluation PMS pilots	55.6	78	18.26	24.46	84.7
National evaluation controls	62.5	100	25.14	25.42	95.42

** does not include Lambeth, who did not identify any patients with angina*

Practice Profile Questionnaire

The results of the Practice Profile questionnaire are given in Table 4 below. They show, that in all three of the North Hillingdon PMS pilot practices, as in the National Evaluation PMS pilot practices and in the four King's Fund London PMS pilots, improvements have been made across all four of the profile scales between the first and second data collection rounds. Compared with the National Evaluation data for year two, the North Hillingdon practices score more highly than the national PMS pilot sample and their matched controls on the organization, prescribing and chronic disease management scales, and only very slightly lower on the access scale.

Table 4: Practice Profile Questionnaire results for North Hillingdon PMS pilot

Practice	Organization score		Access score		Prescribing score		Chronic disease management score	
	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2
Dr Karim	100.0	100.0	75.0	75.0	60.0	80.0	100.0	100.0
Dr Mashru	100.0	100.0	100.0	100.0	100.0	80.0	90.9	100.0
Dr Patel	66.7	100.0	50.0	75.0	60.0	100.0	63.6	100.0
North Hillingdon PMS pilot total	**88.9**	**100**	**75.0**	**83.3**	**73.3**	**86.7**	**84.9**	**100.0**
King's Fund PMS pilot practices (n=12)	87.8	*90.0*	86.4	87.5	80.0	86.0	*82.6*	*90.9*
National evaluation PMS pilots (n=23)	94.2	95.7	80.4	84.2	68.2	75.2	72.4	85.5
National evaluation controls (n=23)	-	97.1	-	84.2	-	71.3	-	80.2

GPAS Questionnaire

Both the angina audit and the practice profile questionnaire analysed self-reported data from the practices. The GPAS patient satisfaction questionnaire allowed a random sample of patients to give their own assessment of the quality of care provided by the PMS pilot practices. In our evaluation of four London PMS pilot practices, we used the questionnaire twice during the study, and hoped that by using GPAS as early as possible, and then as late as possible in the initial three years of the PMS pilot's life, we would be able to look on the results as providing a 'before' and 'after' snapshot of patient satisfaction with the PMS pilot. Detailed results from individual questions for both rounds of GPAS can be found in Appendix 5. In summarizing the data, Table 5 below shows the overall scale scores for each of the domains of quality, together with results from the National Evaluation.

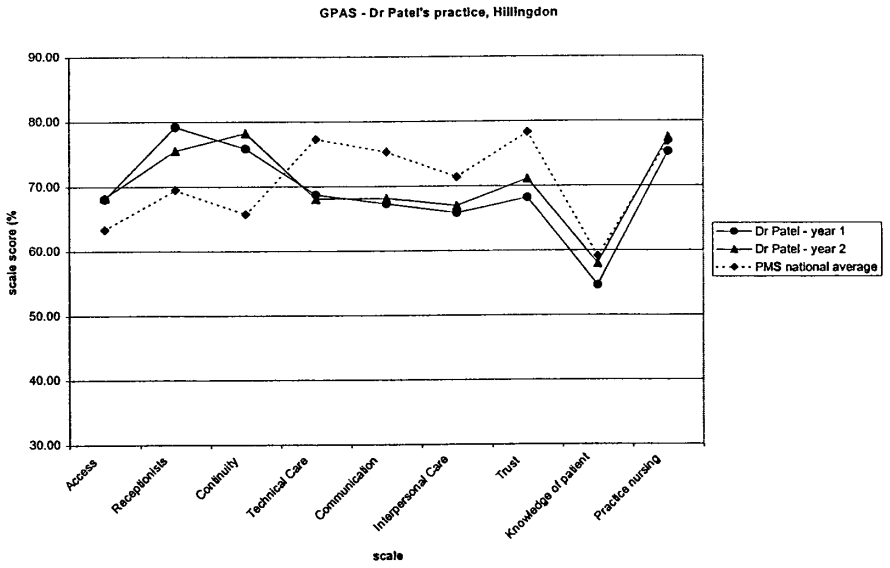
Table 5: GPAS scores for North Hillingdon PMS pilot

	Response rate		Access		Recept-ionists		Continuity		Technical care	
	%	N	Mean	N	Mean	N	Mean	N	Mean	N
Round 1 – Hillingdon PMS	52.0	310	65.48	306	80.51	313	65.65	294	71.22	272
Round 2 – Hillingdon PMS	63.5	381	64.44	367	76.89	380	67.32	347	70.10	328
Nat Eval PMS pilots	64.8	2940	63.3	2877	69.5	2899	65.7	2731	77.3	2530
Nat Eval Control practices	39.5	1751	63.5	1716	71.0	1730	69.1	1704	77.4	1599

	Comm-unication		Interpers-onal care		Trust		Knowledge of patient		Practice nursing	
	Mean	N	Mean	N	Mean	N	Mean	N	Mean	N
Round 1 – Hillingdon PMS	69.01	277	65.95	280	70.77	276	52.90	268	77.78	192
Round 2 – Hillingdon PMS	68.63	346	66.41	349	71.20	349	54.35	340	78.38	204
Nat Eval PMS pilots	75.3	2633	71.4	2625	78.3	2631	59.1	2565	76.8	1590
Nat Eval Control practices	73.9	1661	71.5	1659	77.7	1656	61.4	1614	76.4	1075

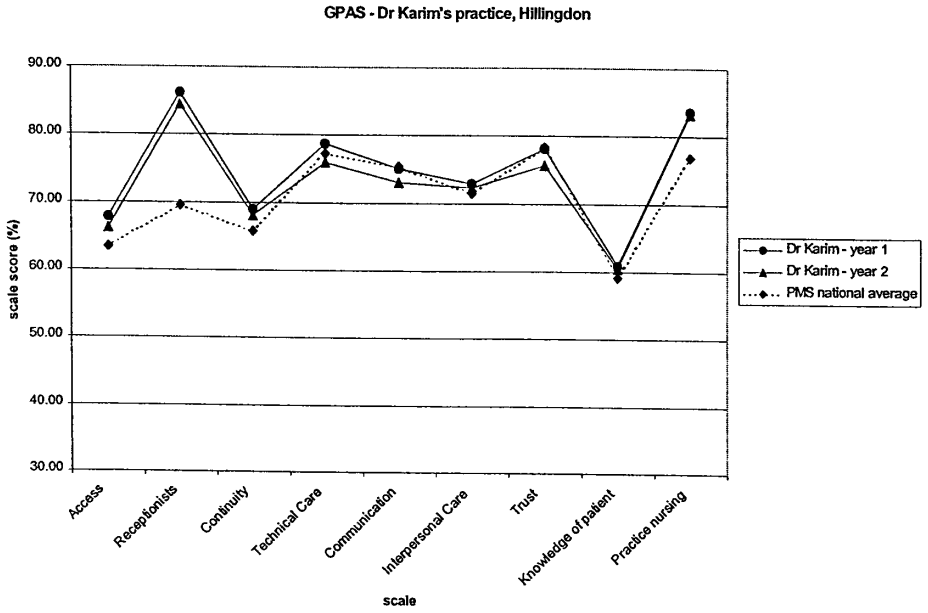
Scores for individual questions and for the nine domain of care scores varied between the three practices, with patients rating quality of care to be higher in the two single-handed practices than in the group practice for all scale scores. Changes in scale scores between years one and two for each of the individual practices are shown in the charts below, and show that there is some variation – however, the differences are small and may be due simply to chance. It may also be the case that two years is too short a timescale over which patients can judge changes in quality (although this finding accords with the health authority's perception that the pilot developments have impacted more 'behind the scenes').

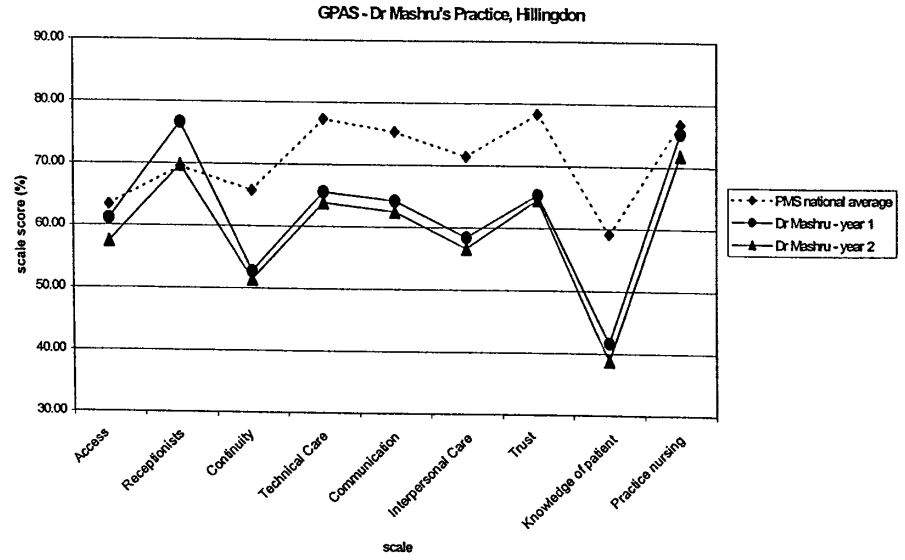
When looking at the results generated from the GPAS questionnaire, it is worth pointing out that direct inter-practice comparisons should be treated with a degree of caution as there may be differences in the socio-demographic characteristics of the practice populations (although the three practices are geographically closely located). Whether the practice is doing relatively 'well' or 'badly' may well be related to a range of population and/or environmental factors which we have not analysed. In addition, there are a number of methodological issues to be borne in mind when interpreting the results of patient satisfaction questionnaires. Satisfaction surveys, typically, yield little variability in results, with certain groups of patients, particularly older patients, tending to express greater levels of satisfaction with the services they receive.[13]



[13] What do Londoners think of their general practice? Gill Malbon, Clare Jenkins, Steve Gillam. King's Fund, London. 1999.

When comparing King's Fund evaluation results with National Evaluation results, it is worth noting that none of the National Evaluation PMS pilot sample sites were in London or the South East, although some of the non-PMS control group were. In the National Survey of NHS patients[14] response rates in London were lower than in any other region of England, and it may be the case that there is a 'London effect' in results obtained using patient satisfaction questionnaires. However, it is notable that each of the North Hillingdon PMS pilot practices, and the single-handed practices in particular, have achieved higher scores for at least some of the GPAS scales than national evaluation PMS pilot practices. This was most marked for the receptionist scale.





[14] National surveys of NHS patients: General Practice 1998. NHS Executive, 1999.

Accessibility

Self-reported access scores on the Practice Profile Questionnaire stayed the same or improved between the first and second rounds of data collection, although were slightly lower overall than those for National Evaluation PMS pilot practices and matched controls. Certainly, when we interviewed in years two and three, practice interviewees suggested that access had improved for patients, particularly in Dr Mashru's practice.

> **We're working far more successfully as a single practice – we used to be two totally different surgeries. All our doctors work at both sites...We've got the new phone system put in. We're paperless in so far as all the hospital letters are scanned in, so patients can be seen at either surgery. We couldn't do that before. So in that respect it's far better. Whether that would have happened, pilot or not, I'm not sure (practice, year three)**

Staff in the practices felt that information sent out to patients about the services provided by the pilot had been very beneficial, and this view was reiterated by the health authority.

> **....I think patients have definitely seen a benefit, in the sense that they are getting a greater level of communication, a lot greater clarity about the services that are available, and what the expectations are from us (practice, year 2)**

> **...there is no doubt that the information to patients about what is going on in the practice has improved (health authority, year 2)**

Although staff in the practices felt that access had improved, and that the information available to patients had increased, the health authority felt that these changes had not been particularly visible so far:

> **To date, from the perception of the patients, I would say that the advantages to them are not that visible – they would largely be behind the scenes (health authority, year two)**

This more pessimistic view was borne out by the results of patient satisfaction data derived from GPAS which showed a slight fall in satisfaction on the access scale for the three Hillingdon practices, but most noticeably in Dr Mashru's practice, between the first and second mailings of GPAS. This suggests that increasing accessibility in the practice has not yet been experienced by the patients.

Inter-practice working

Some of the most positive comments made by interviewees in the practices in year two concerned the benefits that increased communication between groups of staff in the three practices had brought about:

Being single-handed, I was on my own. Now I've got the benefit of a group, while maintaining my independence – I get the benefits of both (practice, year two)

We've been able to have a lot of team work, educational team work....we spend roughly one to two hours every week on clinical team meetings, which include all the clinical providers of care, such as doctors and nurses, to challenge each other, to try to look towards more protocol-driven care, so we've developing a lot more protocols (practice, year two)

However, although it was acknowledged that communication had improved, it had not gone as far as everyone would have wished:

There's been a certain amount of liaison with the other practices, but not as much as there could have been, or was hoped (practice, year two)

By year three, comments were less positive - regret was expressed that more effort hadn't been made to forge closer working relationships between the three practices:

It hasn't worked as well as it could have with the three practices. We have Friday meetings to discuss clinical problems – *(the other GPs)* don't come. Perhaps we haven't made as much effort as we could have (practice, year three)

Relationship with other organizations

While the level of joint working between the three PMS practices was felt to have fallen short of expectations, there was a similar sense that the pilot had not maximised opportunities to collaborate with other external organizations, most notably the PCT. Although it was felt that the relationship between the PMS pilot and the local PCG/T should be no different from any other practice, several members of staff alluded to difficulties in the relationship:

I haven't noticed any support – I don't think they like us! (practice, year three)

....the PCG's prescribing initiative scheme... didn't include us. They simply hadn't read the contract and didn't understand. It took six months to get them to agree, but by then all the monies had been paid out (practice, year three)

The fact that the pilot practices had straddled a PCG boundary caused the health authority some concern:

.....this led to the PMS pilot accountability lying with the health authority and not the PCG, except for the development plans (health authority, year two)

In addition, several external commentators felt that the pilot might have become more isolated as a result of its PMS pilot status, although this was not a problem ever mentioned in the interviews we carried out in the practices themselves:

It's isolated the practice from the rest of GPs (LMC, year two)

It's not much discussed in the PCG – they've gone on in their own sweet way. They may have been mildly successful, but we don't get to hear about it (CHC, year two)

Interestingly, from the perspective of external stakeholders, PMS pilot status appears to be perceived as outwith other, more collaborative developmental initiatives within primary care. Again, this view has been confirmed in other sites. PMS pilots are not yet seen as a wholly integrated part of the New NHS.

Roles

In describing the North Hillingdon PMS pilot as an 'autocracy', there was some concern amongst health authority staff that the smaller practices may have been disadvantaged by being subsumed within a larger organization. They were concerned that 'the two single handers didn't understand what they were getting themselves involved with', and a warning was issued that 'enthusiasm mustn't snowball without everyone knowing what they are engaged in'. This view was not unfounded - when we interviewed at the practices in year one, it was clear that some members of staff were less well informed than others, as this GP's uncertainty about employment status reveals:

I asked if we have a contract and what happens, you know, am I salaried? Or am I employed? Or what's the status like, and what's in the contract? And nobody could give me any answers to any of that..... (practice, year one)

Practice staff perceived that the pilot had been initiated and led very much by the lead GP, leaving some staff feeling that they didn't know enough about the pilot and wanting more information. This very strong lead role taken on by the lead GP was still evident in year the year two interviews:

A lot of it is led by myself.... (lead GP, year two)

We didn't know what we were getting in to, and even today, we don't know what it's about (practice, year two)

If, as seems likely, an informed team is conducive to effective team behaviour, the pilot would benefit from greater engagement of all team members.

In terms of skill-mix within the practices, it was felt that PMS gave them an opportunity to be more creative:

Previously we had two practice nurses, we have been able to move to employing a nurse practitioner, which was one of our intentions and that

was a deliberate move brought about by being in the PMS. We looked at our practice team a lot more carefully, analysed the jobs everybody's been doing, and said 'Right, what jobs are there? What are the gaps? How do we fill that gap?' and instead of replacing a nurse with another nurse, we kind of took an active step to replace those with a nurse practitioner, so there have been changes like that (practice, year two)

None of the GPs we interviewed in year one expected their roles to change as a result of the PMS pilot. In year two, their predictions proved to be accurate, and none felt that their roles had in fact changed, apart from the lead GP who stated that:

...my personal role has changed. I've taken on a lot more of the executive kind of responsibilities within the practice....my workload has increased as a result of it though! (practice, year two)

Additionally, in year one, most of the GPs we spoke to felt that PMS would *not* impact on their clinical behaviour, although some mentioned that there might be an impact on referrals and on the areas of care provided, such as services to older people. In year two, however, the majority of GPs felt that PMS *had* had a positive impact on their clinical behaviour, and this was linked to working more closely as a group:

Working with other practices gives you more insight, so you may change (practice, year two)

There's a lot less in the way of ad-hoc prescribing or ad-hoc referral practice which doesn't actually go through some kind of evidence-based discussion by the whole practice team....we're critically looking at each other's clinical work on a regular basis and actually questioning and challenging people on that (practice, year two)

Levels of job satisfaction and morale in year two were again variable – those who expressed high levels of satisfaction in year one remained satisfied in year two and vice versa. However, those who mentioned poor levels of morale made it clear that they did not hold PMS pilot status directly responsible for their low levels of job satisfaction. Several people mentioned finding change difficult – both within the PMS pilot itself, as well as in the NHS as a whole:

It's the continuous change, organization and reorganization of the NHS - before we settle down with one thing, another change is coming – and not knowing where you're going makes life very difficult (practice, year two)

A disbenefit has been associated with managing change, it always leads to stress and friction and all that, which one has to handle (practice, year two)

By the time we interviewed in year three, extra staff had been taken on, and this had a positive benefit, which was particularly appreciated in the practice where the new elderly care nurse had been appointed:

We have learned quite a lot – we have insight into the working of the pilot now that we have the nurse. In year one, I don't think we knew what we were doing. Now, with *(the)* extra help, we can concentrate on patient needs (practice, year three)

***(we have a link to)* social services and other agencies, for example, occupational health, via the nurse, which saves our time and energy as well, and the patients get a good service (practice, year three)**

As in previous years, job satisfaction expressed in our final round of interviews was variable. Two respondents felt that their job satisfaction had increased, and for two others, their job satisfaction levels were described as 'very high' or 'very good'. The remaining two respondents described their job satisfaction levels as 'very bad' and 'four out of ten'. Three of the respondents (all of whom had expressed high levels of job satisfaction) felt that the PMS pilot had increased their job satisfaction levels, two felt that it had stayed the same, and one felt that job satisfaction had diminished due to increased workload brought about by PMS.

Workload

In year two, there was some debate as to whether administrative changes brought about by PMS had led to improvements, or not. For some people there had been a reduction in administration, for others there had been an increase in workload:

Admin-wise there's been less work for the other two practices in financial areas – I'm doing their quarterly returns. So they've saved time – I haven't! We've continued to record Items of Service, but one of the points was that we shouldn't do it (practice, year two)

One of the practices mentioned that the different method of payment was an improvement on what happened before:

There is a financial advantage – I get some monies in advance, which I didn't used to (practice, year two)

In year two, the main disadvantage in terms of workload was seen to be the extra time that had been taken up in the planning and setting up of the pilot, and in agreeing the contract:

There's been a lot of unpredicted workload, especially around contract negotiation and all that kind of stuff. It's been a very time-consuming process. It's all new work, with no compensation for it (practice, year two)

(*It has*) been an awful lot of work for everybody.... (*there have been*) tensions and strains as with all new things that have had solicitors involved (health authority, year two)

With hindsight, we clearly underestimated what would be involved. It didn't feature highly in our priorities. Had we prioritized it, it would have made more progress (health authority, year two)

Opinions varied in year three, too, as to whether workload had increased. Those who felt it had increased listed a variety of reasons, including carrying out health checks for older people and an increase in the responsibilities taken on by nurses. One person mentioned that the increase in the number of GPs employed in the practice made work more pleasurable:

I was only going to give 10 minutes to a patient this morning, but I gave 15. I feel much more relaxed working now (practice, year three)

Overall impact of the pilot

The Hillingdon PMS pilot was set up to bring together three practices with the aim of providing more coherence to the services they provided. Throughout the three years of the King's Fund evaluation, we were repeatedly told that 'the pilot hasn't worked as well as it could have'. However, data from the angina audit questionnaire showed that the overall score for the three practices was considerably higher than the National Evaluation PMS pilot and control practices. By the time the second round of the Practice Profile questionnaire was undertaken in Hillingdon, the scores for all scales, except for access, were higher than the National Evaluation PMS and control practices. Using these tools, and comparing Hillingdon results with National Evaluation results, the three practices scored more highly than national comparator practices. Results from GPAS, the patient satisfaction questionnaire, revealed that patients are more satisfied overall with the two single-handed practices than with the group practice. Perhaps not surprisingly, the 'continuity' and 'knowledge of patient' scores for the single-handed practices were markedly higher than for the group practice.

During our interviews in year one, interviewees recognized that any developments arising as a result of PMS would take time to achieve:

It's really building the relations in the first 12 months. I think in the second and third years the patients will start benefiting (practice, year one)

The development process is still going on. Year one means no change, but a chance to work out what changes for later (health authority, year one)

By year two, there was a sense of disappointment that predicted changes were, as yet, not really in evidence:

We haven't done much! I haven't felt any difference if I'm honest. Work-wise, there's no difference, it's the same as before (practice, year two)

....there's not really been a great deal of change, so far. The doctors still seem to be working the same amount, the clinical work is the same..... I don't see great change (practice, year two)

So far it's been PMS, not PMS plus (practice, year two)

However, by the time we interviewed in year three, respondents were more positive about the developments that had been made, such as the elderly care project finally getting off the ground, structural changes in one of the practices leading to improvements in patient access, resolving recruitment difficulties and financial benefits:

More recently it has been successful. The project on the elderly is coming off, and we are starting to see improvements in clinical practice (practice, year three)

Although the health authority was not particularly enthusiastic about the initiation of the North Hillingdon PMS pilot, they viewed it as a 'strategic marker', a role seen as being particularly important, as Hillingdon became one of the first Primary Care Trusts (PCTs) in the country. This view of the pilot as a test-bed for experimenting with different ways of providing primary care services was echoed in the pilot itself:

As a whole, (*PMS pilots*) are part of the evolution away from independent contractor service, which is a good thing....(*we*) will lose half of the GPs in Hayes and Harlington over the next ten years, and they won't be replaced by independent contractors because people won't work like that. PMS offers a route (health authority, year two)

Initially it started off as quite a negative thing really. As time's gone on, it seems as though I'm glad that we went in to it, because it seems that for future development, this will serve as a very good model for others to learn from, so from a research point of view, and for a service development point of view, I'm personally quite glad that we did go along with it (practice, year two)

However, there was some concern about the 'clarity of purpose' of the pilot and a feeling that the same outcomes could have been achieved in other ways:

***(I'm)* not sure what they've achieved that couldn't have been delivered by other means (health authority, year three)**

There's no real purpose to them around here – they're not adding to real local need (LMC, year two)

During the third year interviews, we asked respondents in the practices whether, with the benefit of hindsight, they would choose the PMS option again. Despite a certain level of ambivalence about the achievements of the pilot, four out of seven staff expressed an opinion, and all agreed that they would choose PMS again – but for a variety of reasons:

...the concept is right, and in PCTs we should move to a position where every GP is salaried (practice, year three)

I think yes because you get the funds in advance and can allocate the money (practice, year three)

In summary, there was a sense, from both the practices and the health authority, that, by year three, the pilot was:

'becoming more successful as time goes on' (health authority, year three)

However, in terms of describing the *overall* success of the pilot, the view expressed by the health authority that 'the jury is still out', does not seem at odds with the opinions expressed in the pilot itself. or the findings of this evaluation. Ultimately three years has proved too short a time frame to judge the ability of the pilot to achieve its own objectives. This may seem slow progress, however, the time period in question has coincided with huge organisational change that has impacted greatly on all local stakeholders.

Hillingdon PMS pilot: meeting local and national objectives?

Local objectives[15]	
To increase capacity by attracting appropriate GP and nursing resources	There had been considerable staff turnover at the beginning of the pilot. Concerns were expressed about the ambiguity of contract status of some GPs. A number of new doctors and a nurse practitioner had been appointed.
To share clinical and management resources	In the early years of the pilot, staff spoke enthusiastically about the potential for closer working relationships between the three practices, and the benefits this might bring. Protocols had been developed, but in later years, regret was expressed that not all GPs attended meetings and that more had not been made of this potential. Some administrative duties had been taken on by the practice manager of the group practice, which meant reduced workload for the single-handed practices.
To make better use of skill mix and to develop a team approach	A nurse practitioner replaced a practice nurse in one of the practices.
To improve management of specific groups eg the elderly	The elderly care project, one of the key elements of the PMS pilot, only got underway in year three. The outcomes of this project are as yet unclear. We were unable to set up a focus group to explore issues around provision of services for older patients.
To reduce individual practice administrative workload	Items of Service are still being recorded. Reductions in bureaucracy for the two single-handed practices have led to a perceived increase in workload for the practice manager of the group practice.

[15] North Hillingdon PMS pilot, Application for a Personal Medical Services Pilot under the NHS (Primary Care) Act 1997, PHD, 1997

Key national questions[16]	
Have pilots improved *fairness* of provision by developing needs-related services, enhancing quality and improving access for disadvantaged groups?	Access to the group practice has been increased by the practice going paperless – patients can now be seen in either the main or the branch surgery. However, results from the second round of GPAS in this practice show that patients rate accessibility as less good than in the initial year.
Have pilots improved *efficiency* and value for money by making best use of staff and non-staff resources through extended roles and development of primary care staff and by ensuring a given quantity and quality of service provision at minimum cost?	Our evaluation did not include an economic analysis, however, we note that additional resources were made available by the health authority. Local contract did not include any efficiency incentives.
Have pilots improved *effectiveness* by providing appropriate and necessary care which is acceptable to patients, based on sound evidence and able to produce intended outcomes?	Quality of care has been assessed using the Angina Audit and the Practice Profile Questionnaire, both of which show the North Hillingdon PMS pilot to be achieving higher scores than National Evaluation comparator practices.
Have pilots increased *responsiveness* by meeting identified patient needs in the context of local priorities and circumstances and by taking better account of patient preferences?	Patient views have been sought using GPAS. There is no evidence of patient views being used as a basis on which to alter service provision.
Have pilots improved *integration* of local provision both within the NHS and with other local services by enhancing team working, increasing cooperation among clinical and inter-sector professionals and contributing to strategic planning of local health services?	We have no evidence of closer working with other professionals. Interviewees have spoken of the 'isolation' of the pilot. A focus group planned to investigate further the proposed collaborative working around elderly care did not go ahead as the pilot was unable to provide a list of potential invitees.

[16] Personal Medical Services under the NHS (Primary Care) Act 1997. A comprehensive guide – second edition December 1998, NHSE.

Have pilots introduced new *flexibility* in working relationships, organizational forms and employment arrangements which might improve professional morale, recruitment and retention in primary care?	The PMS pilot has introduced a new organizational structure, linking small practices and sharing infrastructure. Morale in the pilot throughout the three years has been variable. Those reporting low morale early on in the project tended to report low job satisfaction later on.
Have pilots improved *accountability* to local communities and to health authorities?	There was a considerable delay in agreeing the local contract with the health authority, and also ambiguity, at least initially, in agreeing accountability arrangements of salaried GPs in the pilot. The pilot's relationship with the health authority has been volatile. There has been some evidence of relationships improving in year three.

Appendix 1

Example of interview schedule

PMS pilot interviews – year 3

General practitioner

Achievements

- How would you describe the overall success or otherwise of **this** PMS pilot?
- Related to this PMS pilot - is there anything that you have been **particularly pleased** about?
- Is there anything that you have been **particularly disappointed** by?
- With the benefit of hindsight, **would you choose the PMS option again**?
    - If yes, is there anything that you would choose to do differently, second time round?
    - If no, is there anything that you would do differently, which would make you change your mind?

2. Impact on other organizations

- How would you describe the HA's level of support for PMS pilots in general, and this one in particular?
- What impact has the pilot had on the practice's relationship with the health authority? *(only for practice-based pilots)*
- How would you describe your PCG's/T's level of support for PMS pilots in general, and this one in particular?
- How would you describe your pilot's relationship with your local PCG/T?
- What impact has the pilot had on other local providers of care?
- What do you feel is, or will be, the impact of PMS pilots on the NHS as a whole?
- What are your views on the proposals to expand the use of PMS contracts under the recent National Plan?

3. Contracts, quality and efficiency

- *(Only for project leads)*
- Have you altered the contract specification in Year 3?

- Do you anticipate altering it in the future?

- Would you consider shifting your contract from the HA to PCT?
  If yes, why?
  If no, why not?

- Do you feel that the quality of clinical and non-clinical services your practice provides has improved over the lifetime of the pilot?
  - If so, in what ways? What enabled these quality improvements to be made?
  - If not, what has prevented quality improvements from being made?

- Do you feel that the efficiency and cost-effectiveness of the services your practice provides has improved over the lifetime of the pilot?
  - If so, in what ways? What enabled these efficiency/cost improvements to be made?
  - If not, what has prevented these efficiency/cost improvements from being made?

- In what ways, if any, have patient views been sought? *(for practice manager, project lead and HA only)*

4. Roles, Workload and Job Satisfaction

- On a day to day basis, how different, or not, is it working under PMS, compared with GMS (*ie for you, what does the **PMS** aspect deliver?)*

- How would you describe your current level of job satisfaction?

- Do you think the PMS Pilot has had an impact on your job satisfaction?
  Improved it/stayed the same/diminished it?
  What are the reasons for this?

- Do you think your workload has changed as a result of the PMS Pilot?
  Increased it/stayed the same/decreased it?
  What are the reasons for this?

5. Summary

- Given your comments throughout this interview, are there any factors that you would identify as being particularly important in contributing to the success (or failure) of the pilot?

- Is there any advice that you would pass on to future pilots, say, for example, the third wave going live next spring?

- Do you have any additional comments that we haven't covered?

Appendix 2

sc:3/9/1998 angina.fin

Angina review criteria

For Office use only

i). Health Authority

ii. Practice ID

iii). Chronic ID **Angina**

iv). Patient ID (1 to 20) .....

v). Age .....

vi). Sex Male ❑ 1 Female ❑ 2

vii). Registered *here* **in last 14 months**? Yes ❑ 1 No ❑ 2 **If YES exclude**

viia). Date registered with this practice .....

viii). Number of consultations **in the last 14 months**
0-2 ❑ 1 3-5 ❑ 2 6-9 ❑ 3 10+ ❑ 4

ix). Top 20 angina drug (prescribed within last 6 months) Yes ❑ 1 No ❑ 2

If yes, list .....

x). Does the patient have:

a). Diabetes Yes ❑ 1 No ❑ 2

b). Contraindications to beta-blocker:
(*Asthma, COPD,COAD, chronic bronchitis, AV block, peripheral (vascular disease, heart failure - CEF/CCF -, sick sinus syndrome, (marked bradycardia)*) Yes ❑ 1 No ❑ 2
If yes, what?

xi). Has the patient had revascularization ? Yes ❑ 1 No ❑ 2
(*Coronary bypass surgery/CABG, Angioplasty/PCTA)*

x1a). Has the patient had a prior MI? Yes ❑ 1 No ❑ 2

xii). Is the patient hypertensive? Yes ❑ 1 No ❑ 2

xiii). Has the patient been seen by a hospital specialist *relating to angina* **in the last 14 months?** (e.g. cardiologist, general physician, geriatrician)
Yes ❑ 1 No ❑

Any Comments (For example, incomplete notes)
.....

CHECKLIST: notes ❑ computer ❑ Angina clinic notes ❑ hospital letters ❑

DRUG TREATMENT **CURRENT**

Does current medication include:

a). **Aspirin** ***(Caprin, Dispirin , Nu- Seals Aspirin, Aspro).*** ***(contraindicated = Gastro-intestinal ulceration, peptic ulcer disease, DU / GU; haemophilia)***

YES❑$_1$ NO ❑$_2$ NA ❑$_3$ *(NA = Contraindicated)*

b). Sublingual glyceryl trinitrate or buccal nitrate *(Glyceryl trinitrate, Coro-Nitro, Glytrin, GTN, TNT,Nitrolingual,Nitromin, Suscard, trinitrine)*

YES ❑$_1$ NO ❑$_2$

c). Beta-blocker

Acebutolol (Sectral) **Atenolol** (Tenormin), **Bisoprolol** (Emcor, Monocor), **Metoprolol** (Betaloc, Lopresor), **Nadolol** (Corgard), **Oxprenolol** (Trasicor), **Pindolol** (Visken), **Propranol** (Inderal, Half Inderal LA, Inderal LA), **Timolol** (Betim, Blocarden, Prestim) **Sotalol** (Beta Cardone, Sotacor)

YES ❑$_1$ *(If yes go to d)* NO ❑$_2$

ci). For patients on maintenance treatment who are not on betablockers, is there any evidence that the patient is intolerant to beta-blockers in the last 5 years?

YES ❑$_1$ NO ❑$_2$ NA ❑$_3$ (NA= not on maintenance treatment - c,d, e or f)

d). Calcium antagonist

Amlodipine (Istin) **Diltiazem** (Adizem, Tildiem, Anglitil, Calcicard, Dilzem, Slozem, Viazem, Zemtard), **Felodipine** (Plendil), **Nicardipine** (Cardene) **Short-acting Nifedipine** (Adalat) **Long-acting Nifedipine** (Adalat Retard, Adipine MR, Angiopine MR (Modified Release), Cardilate MR, Coracten MR, Hupolar, Nifedotard, Nifedipine SR (Slow Reslease), Nifedipine MR, Nifelease, Nifensar, Tensipine MR, Unipine) **Nisoldipine** (Syscor) **Verapamil** (Cordilox, Securon, Half-Securon, Univer, Verapress)

YES ❑$_1$ NO ❑$_2$ *(If 'no' go to e). nitrate)*

If yes,

i). Short-acting nifedipine *(Nifedipine or Adalat only)* YES ❑$_1$ NO ❑$_2$

ii). Verapamil *(Verapamil or Cordilox)* YES ❑$_1$ NO ❑$_2$

iii). Beta-Adalat or Tenif *(Atenalol Beta-blocker/Nifedipine combinations)* YES ❑$_1$ NO ❑$_2$

iv). More than one calcium antagonist YES ❑$_1$ NO ❑$_2$

e). Nitrate

Isosorbide Mononitrate (Elantan, Ismo, Isotrate, Monit. Mono-Cedocard, Elantan, Imdur, Isih 60XL, Ismo Retard, MCR-50, Modisal XL, Monit SR, Monomax SR) **Penuerythritol Tetranitrate** (Mycardol). **Isosorbide Dinitrate** (Cedocard, Isoket, Isordil, Sorbichew, Sorbid, Sorbitrate). **Transiderm nitro.**

YES ❑$_1$ NO ❑$_2$

f). Potassium Channel Blocker : **Nicorandil** (Ikorel) YES ❑$_1$ NO ❑$_2$

g). Cholesterol lowering treatment

Statins: **Atorvastatin** (Lipitor), **Cerivastatin** (Lipobay), **Fluvastatin** (Lescol), **Pravastatin** (Lepostat), **Simvastatin** (Zocor) Anion exchange resins: **Cholestyramine** (Questran), **Colestipol** (Colestid). Clofibrate group: **Bezafibrate** (Bezalip), **Ciprofibrate** (Modalim), **Clofibrate** (Atromid-S), **Fenofibrate** (Lipantil), **Gemfibrozil** (Lopid). Ispaghula **Ispaghula** (Fybozest Orange). Nicotinic acid group: **Acipimox** (Olberam) **Nicotinic acid** (Nicotinic acid tablets). Fish oils: **Omega-3 Marine Triglycerides** (Maxepa)

YES ❑$_1$ NO ❑$_2$

h). Number of current angina maintenance drugs 0❑ 1❑ 2❑ 3❑ >3❑
(categories c,d, e and f **ONLY** - *exclude a, b and g)*

FREQUENCY OF ANGINA EPISODES — LAST 14 MONTHS

1. Is there a record in the last 14 months of (Annotate both answers)

a). frequency of angina episodes YES ❑1 NO ❑2 NA ❑3
(e.g. daily, 3x a week) *(not attended in last 14 mths)*

b). pattern of angina YES ❑1 NO ❑2 NA ❑3
(e.g. in cold winds, when exercises) *(not attended in last 14 mths)*

1c. Is the patient more than minimally symptomatic?

YES ❑1 (more than minimal symptoms) NO ❑2 (no symptoms or minimal symptoms) DK or unclear ❑3

Annotate answer:

CHOLESTEROL

2. Is there a record of a total cholesterol reading in the last 5 years? YES❑ NO ❑2

If yes, Last cholesterol reading ..... mmol/litre
Date: ..... .

3. Has the patient been offered dietary therapy in the past 5 years ? YES ❑1 NO ❑2

3a. Has the patient has been offered a statin drug in the past 5 years ? YES ❑ NO ❑2

4. Is there a record that treatment (including diet therapy) for cholesterol was offered, initiated or increased - on basis of the last cholesterol recorded above:

YES ❑1 NO ❑2 NA ❑3 (*NA= no reading in last 5 years*)

BLOOD PRESSURE — LAST 14 MONTHS

5. Is there a record of a blood pressure reading? YES ❑1 NO ❑2

(i) Last BP / date .....
(ii) 2nd BP / date .....
(iii) 3rd BP / date ..... .

Take an average BP of 5i. to 5iii. (if only 1 - repeat).

(iv) AVERAGE BP /

6. Has the patient had treatment for Blood Pressure offered, initiated or increased in the last 14 months? (see glossary)

YES ❑1 NO ❑2

Annotate answer:

20000 048572 0200

SMOKING AND WEIGHT — LAST 5 YEARS

7. Is there a record of smoking status? YES ❑1 NO ❑2

8. Is there a record that the patient was offered advice to:

a). Stop smoking (*annotate answer*) YES ❑1 NO ❑2 NA ❑3 (*doesn't smoke*) DK ❑4

b). Lose weight (see glossary) YES ❑1 NO ❑2 NA ❑3 (*not obese*) DK ❑4
(BMI >27 : height divided by weight **or** record)

EXERCISE — LAST 14 MONTHS

9. If the patient has attended over the last 14 months is there a record of either the exercise capacity or the amount of exercise undertaken?
YES ❑1 NO ❑2

EXERCISE — LAST 5 YEARS

10. Is there a record that the patient was offered advice needed to exercise?
(annotate answer)
YES ❑1 NO ❑2

REFERRAL TO A SPECIALIST / EXERCISE TESTING — EVER

11. Is there a record that the patient has ever been offered referral :

a). to a specialist for their angina YES ❑1 NO ❑2
b). for an exercise ECG YES ❑1 NO ❑2 (*If NO, finished*)

REFERAL TO A CARDIOLOGIST/ EXERCISE TESTING — EVER

If **unclear**, *annotate ....*

12. Is there a record that if the exercise ECG test was <u>POSITIVE</u> the patient was offered referral to a cardiologist?

YES ❑1 NO ❑2 NA ❑3 (*was negative*)
DK ❑4 (*not done yet*) DK ❑5 (*no result recorded*)

13. Is there a record that if the exercise ECG test was <u>NEGATIVE</u> the patient was offered referral to a cardiologist if they were on two drug therapy?

YES ❑1 NO ❑2 NA ❑3 (*was positive*)
NR ❑4 (*not on 2 drug therapy*) DK ❑5 (not done yet) DK ❑6 (*no result recorded*)

NATIONAL PRIMARY CARE RESEARCH AND DEVELOPMENT CENTRE

Date: .....

Name: .....

Practice name:.....

Appendix 3

Angina Review Criteria Questionnaire - Guidance Notes

General points

This audit requires that the notes of **20 randomly-selected patients with angina** be assessed. To select patients randomly, print out a list of patients from the practice computer with:

- the diagnosis of angina
- **AND** who have been registered at the practice for two or more years.

Select every n^{th} patient. For example, if you generate a list of 100 patients, select the notes of every 5^{th} patient, until 20 sets of notes have been assessed.

You will need to look at hospital letters/results as well.

Points relating to specific questions

vii). Exclude patients who have been registered at the practice for less than two years.

viia). If registered in last 5 years - questions ONLY relevant in the time period registered at this practice e.g. 3 years

viii). Number of consultations in last 2 years
This **includes** - consults with a GP, nurse, diabetic clinic/asthma clinic etc., practice based PAM, OOH contact with practice GP, telephone contact with practice GP.
It **excludes** - requests for repeat prescription, OOH contact with non-practice GP, A&E or hospital appointments.

ix). Top 20 drug (see attached list) - excludes aspirin but includes all GTNs.

xa). Diabetes - confirmed diabetic , albeit dietary advice, IDDM or NIDDM

xb). Contraindications to betablocker. For example:

- COPD = chronic obstructive pulmonary disease
- COAD = chronic obstructive airways disease
- Peripheral vascular disease OR claudication

Heart failure is a contraindication **but** heart disease **is not** (as angina is heart disease)

xi). Revascularization = prior perctutaneous transluminal coronary angioplasty or coronary artery bypass surgery. This **excludes** non cardiac grafts (e.g. in the leg)

xii). *Hypertensive* - confirmed diagnosis (i.e. on summary card)

xiii). Hospital specialist relating to angina or general CHD.

Current medication

Prescribed as repeat prescription in last 6 months. GTN tablets must be last 6 months
Except - GTN spray which can be 12 months (annotate when last prescribed).
Always underline or highlight the relevant one e.g. beta-blocker : <u>atenolol</u>

a). Aspirin
If not had a repeat for aspirin in last 6 months BUT records says patient buys it OTC - tick yes.

ci). Intolerant to beta blocker stated in notes e.g. cold peripheries (hands, feet)

di). Short-acting nifedipine = annotate if unsure i.e. nifedipine 2 prn

dii). " " " " annotate

Frequency of angina attacks
Annotate in full. If in doubt leave blank for time being

1c. **Is the patient more than minimally symptomatic? Annotate. However, general rules of thumb:**
- any mention of angina at rest or unstable angina = more than min symp
- angina if exercise for 15 or less minutes = more than min symp

If no mention of angina in records in last 14 months = DK or unclear

Cholesterol

2. Record most recent cholesterol recording

3. Dietary therapy = seen dietician or any reference to diet advice

4. Statin - any time in last 5 years NOT just currently

Blood Pressure

5. Blood pressures. This includes BP taken in GP or hospital or by a OOH doctor. BP lying down or standing. Include ONLY the lying down one if both recorded.

6. Treatment offered, initiated or increased. This includes hospital changes to medication. Annotate answer. e.g. atenolol increased to 50 mg od.

Smoking / weight

8b). If BMI recorded >27 fine. Otherwise, statement by GP/nurse that patient is overweight will do. See BMI chart.

Exercise

9. If the patient has had an exercise test in last 14 months this is yes if exercise ECG explains it e.g. chest pain after 3 minutes.

10. Annotate in full. e.g. told swimming is okay after CABG.

Referral

11,12 These two questions are EVER. Irrespective, of whether the patient joined the practice, say 3 years ago, even if in 1973 for example. Offered referral for an exercise ECG: this is yes if the patient refuses or hasn't had it yet.

13. Drug therapy = 2 maintenance drugs (e.g. adalat and atenolol) NOT GTN and NOT aspirin.

Exercise ECG

If the letter says positive or negative, fine; hwr, this is rare.

Exercise testing is contraindicated if there is unstable angina, severe hypertension, infarction less than 7 days previously, poorly controlled ventricular arrhythmia's.

Suggestions of a positive test

- significant ST depression > 1mm usually with pain
- ST depression > 3mm without pain
- slow ST recovery to normal (5 minutes or greater)
- angina with or without ST changes at low workload < 6 minutes
- exercise for less than 6 mins

Suggestive of a negative test

- exercise to level 3 (9 minutes) or level 4 (12 minutes) of the Bruce Protocol without pain or no ST changes.

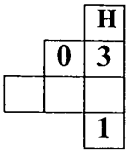
If in doubt annotate and check with clinician.

'Top 20' sampling frame of drugs – Angina

- Adalat LA
- Adalat Retard
- Amlodipin
- Atenolol
- Beta-Cardone
- Coracten
- Diltiazem MR
- Imdur
- Inderal LA
- Isosorbide Mononitrate
- Isosorbide dinitrate
- Istin
- Monit
- Nifedipine
- Nicardipine
- Propranolol
- Tildiem Retard
- Transiderm Nitro
- Verapamil
- Metoprolol
- GTN - tablets or spray
- Nitrolingual spray
- Coro-nitro

NATIONAL PRIMARY CARE RESEARCH AND DEVELOPMENT CENTRE

Appendix 4



You and Your Doctor

The General Practice Assessment Survey (GPAS)

Thank you for taking the time to complete this questionnaire. Please try to answer every question and not leave any out. Please mark the box that applies to you clearly. If you have any comments, please write them on the final page. When you have completed the questionnaire, please return in the FREEPOST (pre-paid) envelope provided.

1. How long have you been registered with your practice?

☐1 Less than 1 year ☐2 1 to 2 years ☐3 3 to 4 years ☐4 More than 4 years

2. In the past 12 months, how many times have you seen a doctor or a nurse from your practice?

☐1 None ☐2 Once or twice ☐3 Three or four times ☐4 Five times or more

3. How would you rate the convenience of your practice's location?

☐1 Very Poor ☐2 Poor ☐3 Fair ☐4 Good ☐5 Very Good ☐6 Excellent

4. How would you rate the way you are treated by the receptionists in your practice?

☐1 Very Poor ☐2 Poor ☐3 Fair ☐4 Good ☐5 Very Good ☐6 Excellent

5. a) How would you rate the hours that your practice is open for appointments?

☐1 Very Poor ☐2 Poor ☐3 Fair ☐4 Good ☐5 Very Good ☐6 Excellent

b) What additional hours would you like your practice to be open? (Please tick all that apply)

☐1 Early morning ☐2 Evenings ☐3 Week-ends ☐4 None, I am satisfied

6. Thinking of times when you want to see a particular doctor:

a) How quickly do you get an appointment?

☐1 Same day ☐2 Next day ☐3 2 - 3 days ☐4 4 - 5 days ☐5 More than 5 days ☐6 Does not apply

b) How do you rate this?

☐1 Very Poor ☐2 Poor ☐3 Fair ☐4 Good ☐5 Very Good ☐6 Excell-ent ☐7 Does not apply

7. Thinking of times when you are willing to see any doctor:

a) How quickly do you get an appointment?

☐1	☐2	☐3	☐4	☐5	☐6
Same day	Next day	2 - 3 days	4 - 5 days	More than 5 days	Does not apply

b) How do you rate this?

☐1	☐2	☐3	☐4	☐5	☐6	☐7
Very Poor	Poor	Fair	Good	Very Good	Excell-ent	Does not apply

8. If you need an urgent appointment to see your GP can you normally get one on the same day?

Yes ☐1 No ☐2 Don't know/never needed one ☐3

9. a) How long do you have to wait at the practice for your appointments to begin?

☐1 Not at all, they begin on time

☐2 Less than 5 minutes

☐3 6 to 10 minutes

☐4 11 to 20 minutes

☐5 21 to 30 minutes

☐6 31 to 45 minutes

☐7 More than 45 minutes

b) How do you rate this?

☐1	☐2	☐3	☐4	☐5	☐6
Very Poor	Poor	Fair	Good	Very Good	Excellent

10. Thinking about the times you have phoned the practice, how would you rate the following?

	Very Poor	Poor	Fair	Good	Very Good	Excell-ent	Don't know
a) Ability to get through to the practice on the phone.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
b) Ability to speak to a doctor on the phone when you have a question or need medical advice.	☐1	☐2	☐3	☐4	☐5	☐6	☐7

11. a) In general, how often do you see your usual doctor (not an assistant or partner)?

☐1	☐2	☐3	☐4	☐5	☐6
Always	Almost always	A lot of the time	Some of the time	Almost never	Never

b) How do you rate this?

☐1	☐2	☐3	☐4	☐5	☐6
Very Poor	Poor	Fair	Good	Very Good	Excellent

12. The next questions ask you about your usual doctor. If you don't identify one doctor as your usual doctor answer the questions about the doctor in the practice who you feel you know best. If you don't know any of the doctors, go straight to question 25.

13. Thinking about the technical aspects of your care, how would you rate the following:

	Very Poor	Poor	Fair	Good	Very Good	Excell-ent	Don't know
a) Your doctor's medical knowledge.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
b) Thoroughness of doctor's physical examination of you to check a health problem.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
c) Arranging the tests you need when you are unwell (e.g. blood tests, x-rays etc).	☐1	☐2	☐3	☐4	☐5	☐6	☐7
d) Prescribing the right treatment for you.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
e) Making the right diagnosis	☐1	☐2	☐3	☐4	☐5	☐6	☐7

14. Thinking about talking with your usual doctor, how would you rate the following:

	Very Poor	Poor	Fair	Good	Very Good	Excellent
a) Thoroughness of your doctor's questions about your symptoms and how you are feeling.	☐1	☐2	☐3	☐4	☐5	☐6
b) Attention the doctor gives to what you say.	☐1	☐2	☐3	☐4	☐5	☐6
c) Doctor's explanations of your health problems or treatments that you need.	☐1	☐2	☐3	☐4	☐5	☐6

15. How often do you leave your doctor's surgery with unanswered questions?

☐1	☐2	☐3	☐4	☐5	☐6
Always	Almost always	A lot of the time	Some of the time	Almost never	Never

16. Thinking about the <u>personal aspects</u> of the care that you receive from your usual doctor, how would you rate the following:

	Very Poor	Poor	Fair	Good	Very Good	Excellent
a) Amount of time your doctor spends with you.	☐1	☐2	☐3	☐4	☐5	☐6
b) Doctor's patience with your questions or worries.	☐1	☐2	☐3	☐4	☐5	☐6
c) Doctor's caring and concern for you.	☐1	☐2	☐3	☐4	☐5	☐6

17. Thinking about how much you **TRUST** your doctor, how strongly do you <u>agree</u> or <u>disagree</u> with the following statements:

	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
a) I completely trust my doctor's judgements about my medical care.	☐1	☐2	☐3	☐4	☐5
b) My doctor would always tell me the truth about my health, even if there was bad news.	☐1	☐2	☐3	☐4	☐5
c) My doctor cares more about keeping down costs than about doing what is needed for my health.	☐1	☐2	☐3	☐4	☐5

18 All things considered, how much do you trust your doctor? (Please tick one number)

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10

Not at all Completely

19. Thinking about how well your doctor <u>knows you</u>, how would you rate the following:

	Very Poor	Poor	Fair	Good	Very Good	Excellent
a) Doctor's knowledge of your medical history.	☐1	☐2	☐3	☐4	☐5	☐6
b) Doctor's knowledge of what worries you most about your health.	☐1	☐2	☐3	☐4	☐5	☐6
c) Doctor's knowledge of your responsibilities at home work or school	☐1	☐2	☐3	☐4	☐5	☐6

20. Have you seen a nurse in your practice in the last year? Yes ☐1 No ☐2

If YES please go to question 21. If NO please go to question 22.

21. Thinking about the nurses you have seen, how would you rate the following:

	Very Poor	Poor	Fair	Good	Very Good	Excellent
a) The attention they give to what you say.	☐1	☐2	☐3	☐4	☐5	☐6
b) The quality of care they provide.	☐1	☐2	☐3	☐4	☐5	☐6
c) Their explanations of your health problems or treatments that you need.	☐1	☐2	☐3	☐4	☐5	☐6

22. Thinking about the last 12 months, was there any time when your doctor didn't send you to a specialist when you thought you needed it? Yes ☐1 No ☐2

23. Does your doctor co-ordinate care that you receive from outside the practice?

☐1	☐2	☐3	☐4
Yes a lot	Yes a little	Not at all	Does not apply

24. Would you recommend your usual doctor to your family and friends?

☐1	☐2	☐3	☐4	☐5
Definitely not	Probably not	Not sure	Probably yes	Definitely yes

25. All things considered, how satisfied are you with your practice?

- ☐1 Completely satisfied, couldn't be better
- ☐2 Very satisfied
- ☐3 Somewhat satisfied
- ☐4 Neither satisfied nor dissatisfied
- ☐5 Somewhat dissatisfied
- ☐6 Very dissatisfied
- ☐7 Completely dissatisfied. couldn't be worse

26. Are you: ☐1 Male ☐2 Female

27. What is your date of birth?

Day Month Year

____ ____ ____

28. Are you 1☐ Single 2☐ Married/cohabiting 3☐ Widow/er, divorced or separated

29. To which of these groups do you consider you belong? (Please tick one box only)

White	☐1	
Black - Caribbean	☐2	
Black - African	☐3	
Black - Other	☐4	Please describe .....
Indian	☐5	
Pakistani	☐6	
Bangladeshi	☐7	
Chinese	☐8	
Any other ethnic group	☐9	Please describe .....

30. Do you have any **long-standing illness, disability or infirmity?** By long-standing I mean anything that has troubled you over a period of time or that is likely to affect you over a period of time.

Yes ☐1 No ☐2

31. How is your health in general? Would you say it was:

☐1 Very good ☐2 Good ☐3 Fair ☐4 Bad ☐5 Very bad

32. Is your accommodation.....

☐1 Owner-occupied?
☐2 Rented from local authority/housing association?
☐3 Rented from a private landlord?
☐4 or is it under other arrangements?
if so, please describe:

33. Is there a car or van normally available for use by you? Yes ☐1 No ☐2

If yes, how many are normally available? One ☐1 Two or more ☐2

Acknowledgement. The following items in the GPAS have been adapted, with permission, from the Primary Care Assessment Survey (PCAS), Copyright 1996 Safran/The Health Institute: Items 1-3, 5-7, 9-11, 13b, 14-19, 24-25.

Please return your completed questionnaire in the FREEPOST envelope provided, to:

Clare Jenkins
The King's Fund
11-13 Cavendish Square
London W1M 0AN

King's Fund

Appendix 5

Patient views – the General Practice Assessment Survey (GPAS)

Table 1: Response rates

	Dr Mashru		Dr Patel		Dr Karim	
	Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1
% overall response rate	*57*	*56*	*68*	*50*	*67*	*51*
base	113	200	135	200	133	200

Table 2: Socio-demographic characteristics of respondents

		Dr Mashru		Dr Patel		Dr Karim	
		Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1
Sex	% male	*38*	*38*	*39*	*38*	*40*	*43*
	% female	*63*	*62*	*61*	*62*	*60*	*57*
	base	112	110	135	99	132	101
Age group	% 16 to 24	*6*	*3*	*11*	*6*	*6*	*8*
	% 25 to 34	*8*	*11*	*6*	*10*	*12*	*22*
	% 35 to 44	*13*	*17*	*22*	*23*	*28*	*33*
	% 45 to 54	*18*	*17*	*16*	*24*	*27*	*20*
	% 55 to 64	*20*	*17*	*14*	*9*	*12*	*10*
	% 65 to 74	*14*	*17*	*17*	*16*	*12*	*3*
	% 75 and above	*21*	*18*	*13*	*12*	*5*	*4*
	base	109	100	126	94	127	97
Marital status	% single	*18*	*14*	*15*	*8*	*16*	*20*
	% married/cohabiting	*61*	*72*	*69*	*73*	*72*	*69*
	% widow/er/divorced/separated	*21*	*14*	*16*	*19*	*12*	*11*
	base	112	109	134	100	132	100
Ethnic group	% white	*95*	*89*	*93*	*87*	*97*	*88*
	% other	*5*	*11*	*7*	*13*	*3*	*12*
	base	111	110	134	100	131	101
Accommodation	% owner occupied	*88*	*88*	*86*	*89*	*86*	*79*
	% rented from local authority/housing association	*8*	*7*	*5*	*6*	*9*	*16*
	% rented from a private landlord	*3*	*3*	*2*	*3*	*3*	*4*
	% under other arrangements	*2*	*2*	*7*	*2*	*2*	*1*
	base	106	108	133	98	132	98
Car available?	% yes	*75*	*90*	*86*	*83*	*85*	*74*
	% no	*25*	*10*	*14*	*17*	*15*	*26*
	base	105	105	133	96	131	100

Table 3: Attendance at the practice and self-reported health status of respondents

		Dr Mashru		Dr Patel		Dr Karim	
		Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1
How long have you been registered with your practice?	%1-2 years	*4*	*15*	*4*	*9*	*7*	*14*
	% 3-4 years	*10*	*5*	*4*	*5*	*5*	*9*
	% more than 4 years	*87*	*79*	*92*	*86*	*88*	*77*
	Base	113	112	135	100	133	101
In the last 12 months, how often have you seen a doctor or nurse from your practice?	% none	*6*	*11*	*12*	*4*	*9*	*15*
	% once or twice	*38*	*33*	*37*	*39*	*39*	*34*
	% three or four times	*31*	*28*	*35*	*28*	*38*	*29*
	% five times or more	*25*	*28*	*16*	*29*	*14*	*22*
	Base	113	111	135	100	133	100
Do you have any long-standing illness, disability or infirmity?	% yes	*47*	*38*	*36*	*41*	*35*	*30*
	% no	*53*	*62*	*64*	*59*	*65*	*70*
	Base	109	104	134	100	132	99
How is your health in general?	% very good	*25*	*21*	*28*	*24*	*22*	*28*
	% good	*45*	*53*	*53*	*51*	*50*	*53*
	% fair	*25*	*26*	*16*	*20*	*28*	*18*
	% bad	*4*		*3*	*3*	*1*	*1*
	% very bad	*1*			*2*		
	Base	110	109	135	100	133	100

Table 4: Access

		Dr Mashru		Dr Patel		Dr Karim	
		Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1
Overall access score	%	57.4	*61.1*	68.3	*68.1*	66.1	*67.7*
	Base	103	109	132	98	132	99
How would you rate the convenience of your practice's location?	% fair	*10*	*6*	*7*	*6*	*5*	*6*
	% good	*87*	*93*	*93*	*94*	*94*	*93*
	Base	113	112	135	100	132	312
How would you rate the hours that your practice is open for appointments?	% poor	*8*	*3*	*7*	*4*	*5*	*5*
	% fair	*20*	*21*	*27*	*22*	*12*	*19*
	% good	*71*	*77*	*66*	*74*	*83*	*76*
	base	108	112	135	100	132	311
What additional hours would you like your practice to be open?	Early morning	*8*	*10*	*18*	*15*	*17*	*12*
	evenings	*24*	*28*	*19*	*20*	*14*	*23*
	weekends	*38*	*38*	*35*	*38*	*33*	*36*
	base	113	112	135	100	133	313

Table 4: Access (contd)

		Dr Mashru		Dr Patel		Dr Karim	
		Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1
How quickly do you get an appointment when you want to see a particular doctor?	% same day	*7*	*4*	*35*	*34*	*20*	*19*
	% next day	*24*	*26*	*40*	*36*	*31*	*31*
	% 2-3 days	*34*	*39*	*9*	*10*	*33*	*26*
	% 4-5 days	*12*	*6*		*1*	*4*	*5*
	% more than 5 days	*4*	*2*			*4*	*1*
	% does not apply	*19*	*24*	*16*	*19*	*8*	*18*
	base	111	109	134	100	132	309
How do you rate this?	% poor	*14*	*14*	*8*	*4*	*15*	*10*
	% fair	*34*	*32*	*12*	*11*	*24*	*23*
	% good	*35*	*32*	*65*	*66*	*53*	*50*
	% does not apply	*17*	*23*	*15*	*19*	*8*	*17*
	base	110	111	133	99	131	309
How quickly do you get an appointment when you want to see any doctor?	% same day	*19*	*25*	*25*	*26*	*18*	*33*
	% next day	*45*	*39*	*30*	*28*	*33*	*26*
	% 2-3 days	*18*	*25*	*9*	*5*	*24*	*27*
	% 4-5 days	*6*	*2*			*4*	*3*
	% more than 5 days	*1*				*1*	
	% does not apply	*12*	*9*	*37*	*41*	*20*	*11*
	base	108	110	134	100	131	97
How do you rate this?	% poor	*18*	*9*	*4*	*4*	*11*	*14*
	% fair	*23*	*36*	*15*	*11*	*20*	*18*
	% good	*45*	*47*	*45*	*44*	*50*	*57*
	% does not apply	*14*	*8*	*36*	*41*	*19*	*11*
	base	108	109	131	93	127	96
If you need an urgent appointment to see your GP, can you normally get one on the same day?	% yes	*45*	*43*	*69*	*67*	*77*	*70*
	% no	*16*	*13*	*6*	*7*	*6*	*8*
	% don't know/never needed one	*39*	*45*	*25*	*26*	*17*	*22*
	base	108	110	133	100	133	99
How long do you have to wait at the practice for appointments to begin?	% 5 mins or less	*16*	*17*	*10*	*9*	*8*	*14*
	% 6 to 10 minutes	*58*	*56*	*41*	*40*	*35*	*39*
	% 11to 20 minutes	*25*	*23*	*35*	*39*	*42*	*37*
	% 21 to 30 minutes	*2*	*3*	*11*	*13*	*11*	*7*
	% 31 to 45 minutes		*2*	*3*		*5*	*2*
	% more than 45 minutes			*1*		*1*	
	base	106	109	130	96	130	97
How do you rate this?	% poor	*11*	*11*	*16*	*12*	*12*	*14*
	% fair	*41*	*34*	*33*	*45*	*44*	*31*
	% good	*48*	*54*	*51*	*43*	*44*	*55*
	base	102	105	129	95	127	97

Table 4: Access (contd)

		Dr Mashru		Dr Patel		Dr Karim	
		Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1
How would you rate your ability to get through to the practice on the phone?	% poor	*15*	*5*	*2*	*4*	*6*	*7*
	% fair	*19*	*18*	*5*	*5*	*21*	*16*
	% good	*62*	*72*	*92*	*85*	*71*	*73*
	% don't know	*4*	*5*	*1*	*6*	*2*	*4*
	base	108	109	133	99	133	100
How would you rate your ability to speak to a doctor when you have a question/need medical advice?	% poor	*10*	*15*	*7*	*7*	*4*	*5*
	% fair	*8*	*6*	*6*	*9*	*9*	*9*
	% good	*10*	*10*	*33*	*30*	*41*	*46*
	% don't know	*72*	*69*	*55*	*54*	*46*	*39*
	base	106	107	132	97	130	99

Table 5: Receptionists

		Dr Mashru		Dr Patel		Dr Karim	
		Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1
Overall receptionist score	%	69.7	*76.6*	75.6	*79.2*	84.4	*86.1*
	base	113	112	135	100	132	101
How would you rate the way you are treated by receptionists in the practice?	% poor	*3*	*4*		*1*	*1*	*2*
	% fair	*16*	*4*	*14*	*6*	*6*	*5*
	% good	*81*	*92*	*86*	*93*	*93*	*93*
	base	113	112	135	100	132	101

Table 6: Continuity

		Dr Mashru		Dr Patel		Dr Karim	
		Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1
Overall continuity score	%	51.4	*52.7*	78.3	*75.9*	68.0	*69.0*
	base	93	101	127	97	127	96
In general, how often do you see your usual doctor (not an assistant or partners)?	% always, almost always, a lot of the time	*42*	*47*	*97*	*96*	*84*	*79*
	% some of the time	*37*	*30*	*2*	*3*	*12*	*19*
	% never, almost never	*20*	*23*	*2*	*1*	*4*	*2*
	base	99	107	131	100	132	99
How do you rate this?	% poor	*15*	*11*		*3*	*5*	*6*
	% fair	*38*	*37*	*6*	*5*	*13*	*11*
	% good	*47*	*52*	*94*	*92*	*83*	*82*
	base	93	101	127	97	127	96

Table 7: Technical Care

		Dr Mashru		Dr Patel		Dr Karim	
		Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1
Overall technical care score	%	63.8	*65.5*	68.1	*68.7*	75.9	*78.7*
	base	75	82	128	96	125	94
Thinking about the technical aspects of your doctor's care, how do you rate the following:		Dr Mashru		Dr Patel		Dr Karim	
		Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1
Your doctor's technical knowledge?	% poor	*1*	*2*	*2*	*3*	*1*	*2*
	% fair	*13*	*9*	*10*	*18*	*6*	*4*
	% good	*66*	*74*	*83*	*72*	*87*	*89*
	% don't know	*20*	*14*	*6*	*7*	*6*	*5*
	base	85	85	133	96	132	97
The thoroughness of your doctor's physical examination?	% poor	*13*	*8*	*8*	*4*	*2*	*6*
	% fair	*16*	*13*	*17*	*16*	*16*	*7*
	% good	*54*	*74*	*70*	*78*	*82*	*85*
	% don't know	*17*	*5*	*5*	*2*	*1*	*2*
	base	83	86	133	98	132	97
The arranging of tests you need when you are unwell eg blood tests, x-rays etc	% poor	*4*	*3*	*4*	*3*	*1*	*3*
	% fair	*14*	*5*	*10*	*7*	*5*	*10*
	% good	*64*	*79*	*78*	*85*	*86*	*77*
	% don't know	*19*	*13*	*9*	*5*	*8*	*9*
	base	85	86	134	98	132	97
Prescribing the right treatment for you?	% poor	*7*	*7*	*5*	*5*	*2*	*4*
	% fair	*14*	*11*	*17*	*17*	*11*	*10*
	% good	*70*	*75*	*73*	*75*	*81*	*81*
	% don't know	*8*	*7*	*5*	*3*	*6*	*4*
	base	83	85	133	96	132	97
Making the right diagnosis?	% poor	*8*	*6*	*4*	*4*	*3*	*4*
	% fair	*14*	*17*	*19*	*18*	*10*	*9*
	% good	*65*	*70*	*71*	*72*	*79*	*82*
	% don't know	*12*	*7*	*7*	*6*	*8*	*4*
	base	83	84	133	97	131	96

Table 8: Communication

		Dr Mashru		Dr Patel		Dr Karim	
		Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1
Overall communication score	%	62.4	*64.2*	68.1	*67.3*	73.1	*75.0*
	base	83	85	132	96	131	96
Thinking about talking with your doctor, how would you rate the following:		Dr Mashru		Dr Patel		Dr Karim	
		Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1
The thoroughness of the doctor's questions?	% poor	*15*	*9*	*9*	*5*	*4*	*2*
	% fair	*15*	*19*	*18*	*22*	*15*	*13*
	% good	*71*	*72*	*73*	*73*	*81*	*85*
	base	82	85	132	96	131	96
The attention the doctor gives to what you say?	% poor	*14*	*11*	*7*	*4*	*3*	*5*
	% fair	*17*	*22*	*15*	*16*	*17*	*7*
	% good	*69*	*67*	*78*	*80*	*80*	*88*
	base	83	85	132	96	131	96
Doctor's explanations of your health problems or treatments you need?	% poor	*12*	*12*	*10*	*7*	*5*	*6*
	% fair	*21*	*20*	*16*	*20*	*18*	*12*
	% good	*67*	*68*	*74*	*73*	*78*	*82*
	base	82	85	132	96	131	95
How often do you leave the surgery with unanswered questions?	% always, almost always, a lot of the time	*15*	*13*	*7*	*7*	*4*	*4*
	% some of the time	*31*	*22*	*26*	*33*	*24*	*22*
	% never, almost never	*54*	*65*	*67*	*59*	*72*	*74*
	base	85	86	132	96	131	96

Table 9: Interpersonal care

		Dr Mashru		Dr Patel		Dr Karim	
		Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1
Overall interpersonal care score	%	56.6	*58.4*	67.0	*65.8*	72.3	*72.9*
	base	86	87	132	96	131	97
Thinking about the personal aspects of care you receive from your usual doctor, how do you rate the following?		Dr Mashru		Dr Patel		Dr Karim	
		Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1
The amount of time the doctor spends with you?	% poor	*9*	*7*	*7*	*6*	*2*	*3*
	% fair	*33*	*32*	*26*	*19*	*15*	*10*
	% good	*58*	*61*	*68*	*75*	*84*	*87*
	base	86	88	133	96	131	97
Doctor's patience with your questions or worries?	% poor	*12*	*8*	*4*	*1*	*2*	*8*
	% fair	*23*	*29*	*17*	*21*	*14*	*4*
	% good	*65*	*63*	*79*	*78*	*84*	*88*
	base	86	87	131	96	131	97
Doctor's caring and concern for you?	% poor	*12*	*8*	*6*	*3*	*3*	*7*
	% fair	*27*	*25*	*16*	*20*	*18*	*5*
	% good	*62*	*67*	*78*	*77*	*79*	*88*
	base	86	87	132	96	131	97

Table 10: Trust

		Dr Mashru		Dr Patel		Dr Karim	
		Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1
Overall trust score	%	64.5	*65.3*	71.1	*68.2*	75.7	*78.2*
	base	85	85	133	95	131	96
I completely trust my doctor's judgement about my medical care	% disagree	*9*	*8*	*8*	*9*	*6*	*3*
	% not sure	*31*	*28*	*27*	*25*	*21*	*13*
	% agree	*60*	*64*	*65*	*65*	*73*	*84*
	base	85	86	133	95	131	95
My doctor would always tell me the truth about my health	% disagree	*2*	*1*	*1*			
	% not sure	*49*	*49*	*37*	*37*	*19*	*22*
	% agree	*48*	*50*	*62*	*63*	*81*	*78*
	base	81	84	130	95	129	95
My doctor cares more about keeping costs down than about my health	% disagree	*54*	*57*	*60*	*54*	*75*	*71*
	% not sure	*38*	*30*	*32*	*29*	*16*	*20*
	% agree	*9*	*13*	*8*	*17*	*8*	*9*
	base	82	83	130	95	130	96
How much do you trust your GP	(mean score: 1=not, 10=totally)	7.0	7.19	7.8	7.67	8.1	8.45
		84	85	132	95	130	97

Table 11: Knowledge of patient

		Dr Mashru		Dr Patel		Dr Karim	
		Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1
Overall knowledge of patient score	%	38.8	*41.6*	58.0	*54.6*	60.5	*60.9*
	base	81	81	130	93	129	94
Thinking about how well your doctor knows you, how would you rate the following?		Dr Mashru		Dr Patel		Dr Karim	
		Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1
Doctor's knowledge of your medical history?	% poor	*24*	*11*	*8*	*5*	*4*	*3*
	% fair	*40*	*46*	*22*	*24*	*21*	*19*
	% good	*35*	*43*	*70*	*71*	*75*	*78*
	base	82	82	132	95	130	95
Doctor's knowledge of what worries you about your health?	% poor	*35*	*26*	*12*	*18*	*13*	*11*
	% fair	*35*	*42*	*25*	*30*	*24*	*30*
	% good	*30*	*32*	*62*	*52*	*62*	*60*
	base	80	81	130	93	127	94
Doctor's knowledge of your work and home responsibilities?	% poor	*48*	*48*	*21*	*18*	*18*	*15*
	% fair	*30*	*29*	*26*	*31*	*26*	*27*
	% good	*22*	*23*	*54*	*52*	*57*	*58*
	base	79	77	125	91	129	93

Table 12: Practice nursing

		Dr Mashru		Dr Patel		Dr Karim	
		Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1
Overall practice nursing score	%	71.8	75.3	77.5	75.3	83.2	83.6
	base	48	61	77	73	79	58
Have you seen a nurse in last year?	% yes	56	69	59	74	60	60
	% no	44	31	41	26	40	40
	base	90	89	131	98	131	97
How would you rate the attention the nurse gives to what you say?	% poor	2	2	2	1	1	0
	% fair	13	8	6	5	2	3
	% good	85	91	92	93	97	97
	base	54	66	83	75	86	58
How would you rate the quality of care the nurse provides?	% poor	4	2	2			
	% fair	11	8	5	4	3	3
	% good	85	91	93	96	97	97
	base	54	65	83	75	86	58
How would you rate their explanations of your health problems or treatments you need?	% poor	2	1	4	1		2
	% fair	13	6	6	8	6	2
	% good	85	93	90	91	94	97
	base	54	67	82	75	86	58

Table 13: Non-scaled items – coordination and referral, overall satisfaction and recommendation

		Dr Mashru		Dr Patel		Dr Karim	
		Yr 2	Yr 1	Yr 2	Yr 1	Yr 2	Yr 1
Was there any time the doctor didn't refer you when you needed it?	% yes	7	7	7	10	6	6
	% no	93	93	93	90	94	94
	base	81	83	127	92	125	95
Does your doctor coordinate care you receive outside the practice?	% yes	26	27	20	28	35	37
	% no	10	8	5	7	4	4
	% does not apply	64	65	76	65	61	59
	base	84	86	128	97	129	92
Would you recommend your usual doctor to your family and friends?	% definitely/probably not	18	14	14	14	6	7
	% not sure	13	16	11	12	11	5
	% definitely, probably yes	69	69	75	74	82	88
	Base	88	91	134	99	131	99
All things considered, how satisfied are you with your practice?	% completely satisfied	8	9	20	13	24	30
	% very/somewhat satisfied	67	71	57	65	66	58
	% neither satis nor dissatisfied	12	9	14	13	5	7
	% very/somewhat dissatisfied	12	10	9	9	5	5
	% completely dissatisfied	1					
	Base	110	106	135	100	131	101

Appendix 6

Practice Profile Questionnaire – scoring schedule

	Max possible score
Organization scale	
• Is the practice registered for the following: child health surveillance, minor surgery, maternity care?	3
Access scale	
• Can patients get an urgent appointment on the same day? • Can patient get information over the telephone if they believe that a consultation is unnecessary or impractical? • Is a member of the practice team available to answer the telephone between 9:00am and 5:00pm on weekdays? • Does the practice have access to translators for patients whose first language is not English?	4
Prescribing scale	
• Does the practice have a computerised repeat prescribing system? • Does the practice have any written policies on prescribing? • Does the practice have a written policy for informing patients about prescribing and repeat prescribing? • **Has the practice carried out an audit of repeat prescribing in the last 3 years?*	5
Chronic disease management scale	
• Does the practice have a written management protocol for diabetes; angina; asthma? • Does the practice have a register for patients with diabetes; angina; asthma; hypertension? • Does the practice have a recall system for diabetes; angina; asthma? • Does the practice undertake annual calibration of sphygmomanometers?	11

*this question replaces the National Evaluation question 'practice holds regular repeat prescribing meetings'.

Appendix 7

North Hillingdon Personal Medical Services (PMS) Pilot
King's Fund Evaluation Feedback Meeting
Monday 21 June 1999

Background

The North Hillingdon Personal Medical Services pilot bid (1997), outlined the setting up of a new project involving three practices within the Hillingdon Health Authority area. Serving a population of 10,000 patients in an area described as being 'of average social need, but with a few pockets of deprivation', the practices hoped to address issues of accessibility, patient demography, recruitment and practice management and administration. If successful with their bid, the new PMS pilot would draw up a practice-based contract with Hillingdon Health Authority, to provide a full range of GMS services and to extend the scope of their services for the elderly. They also planned to improve the way in which chronic illness was managed in the practices, and to make more flexible use of skill mix in their primary care teams. Adopting NHS body status as a merged partnership, the three practices would, in addition, offer new GPs the option to choose salaried status.

Although the pilot received the go-ahead from the Secretary of State to 'go live' in April 1998, the contract with the Health Authority has not been signed until recently. An evaluation, invited by Dr Mashru and David Kemsley, was carried out by J.B. Tate, to review the objectives and achievements of the pilot over the first 'acclimatisation' year.

The Interviews

The information presented below is based on a series of interviews carried out by the King's Fund last year. Interviews took place with key informants at Hillingdon health authority (n=3) and at the practices (n=5). The format of the interviews followed an interviewer-administered questionnaire, with unstructured responses and time given at the end for additional discussion. Detailed notes were taken during the interviews, which were also recorded, unless the interviewee asked otherwise. The interviews covered the following areas: initiation and setting up of the PMS pilot, views on the General Medical Services (GMS) contract, other contracting issues and objectives for the pilot. Practice interviews included questions on primary care service provision, communication, job satisfaction and professional activities. Health authority (HA) interviews took place in July 1998, and practice interviews took place in June and August 1998.

The following report of information collated from the interviews looks at the development of the pilot in chronological order – from initiation, through development work with local stakeholders to bidding, drawing up the local contract and launching the new service. Our interviews were carried out prior to the invited evaluation, and the uncertainties that some members of staff expressed in our interviews appear to have been resolved by the time the later interviews were carried out.

Initiation of the PMS pilot

Dr Mashru was seen as being the key player in initiating the PMS pilot. He identified three key areas where he saw developments being made:

> **The salaried service option. Working closely with neighbouring practices - single handed practices. (Fitting) in with agenda and long-term business plan. (Practice)**

Other members of staff were less clear why the pilot was being set up:

> **Not my decision. (Practice)**
>
> **Dr Mashru can answer that question better. (Practice)**
>
> **Dr Mashru (is) very forward thinking – (he) leads from the front and we're following. He's involved with the HA. To him, (it's) a natural progression. (Practice)**

They thought that more information about the background to the pilot would have been helpful:

> **Preparation for the pilot should have been better. As a partner, I don't know enough - fundamental questions aren't solved .... (Practice)**
>
> **A bit more information would be good. Dr Mashru forgets that the information doesn't come down unless he sends it down. (Practice)**

Opinion varied as to how unanimous practices were about joining the PMS pilot.

> **(I) think we're all quite please to be doing it - it's new, (it) gets you thinking, gets you working together. (Practice)**
>
> **We are supporting at the moment, there are no major issues we are not. (Practice)**
>
> **Partners were asked whether they objected and they didn't. (Dr Mashru) wanted to go in so we did. (Practice)**
>
> **(I) haven't noticed much in the way of support. (Practice)**

It was felt that perhaps there were different levels of understanding about the project:

> **All three practices are pretty signed up to up it - I think the outline support is there, but the level of understanding may not be the same as someone like me who initiated it. So it's difference in understanding. (Practice)**
>
> **.... enthusiasm mustn't snowball without everyone knowing what they are engaged in. (health authority)**

Specific areas where staff wanted more clarification included finance generally, covering, locums, clarity of roles and holiday.

Health authority respondents, similarly, were not entirely clear about the purpose of the bid:

> **I couldn't see what the advantage was over what was being delivered already. (Health Authority)**

> **(We were) quite curious, the bid was very late in the day with very little Health Authority involvement. (Health Authority Manger)**

The Health Authority felt that the bid had been put together quite well:

> **(It was) developed by our using some set-up money to allow the GP to work with PHD who developed an application, very much along standard PHD lines - then modified by the lead GP. I think quite well and to a greater extent than possible some applications put in by PHD might have been changed. (Health Authority)**

But they also thought that the timescales were very tight:

> **(They) realised it was a very short timescale with a lot to do..... that they had to have a watertight contract; sort out legal issues, an SLA and a sense of added value. This should have taken a year rather than a few weeks. (Health Authority)**

The Health Authority supported the bid, but listed a number of caveats to their support:

- **That the care benefits to patients should be clearly articulated.**
- **That the project had the clear support and commitment of all the Gps who put forward the application.**
- **That the implementation of the pilot would distort the Health Authority's plans for the equitable distribution of healthcare resources across the district. (Health Authority)**

It was felt perhaps that the PMS pilot, based in the affluent area of Ruislip, didn't address areas of greatest population need:

> **(The) concept and thinking behind PMS pilots is positive and exciting, but in future more care needs to be given to targeting those pilots in areas where very clear improvements in healthcare are needed. (Health Authority)**

It was felt that although there were some positives around the PMS pilot, the overall feeling was that the benefits that might arise from the PMS pilot could be achieved equally well using other means:

> **This bid has some benefits in embracing single-handers and sharing the team and has an explicit focus around the elderly. (Health Authority)**

(We) came to the conclusion that PMS had extra risks that would not be outweighed by the benefits ..... (and) didn't think the benefits would be more than could be achieved by normal means. (Health Authority)

(I) can't really see added benefit. (I) would be surprised if there was a measurable patient benefit. (Health Authority)

Contracting Issues

Positive aspects of the traditional GMS contract listed by respondents were fairly few in number, mostly linked to it being well-established and a known-entity which is equal for everybody across the country. Disadvantages of the GMS contract listed included that it is inflexible and cannot be adapted to local population needs. There was disagreement as to whether GMS lacked incentives – one GP felt that:

Because it's an annual budget, certain changes of improving care - like if we suddenly improve our vaccinations or something - we won't be rewarded for it, so I think that is a disadvantage. So there's no incentive to actually start increasing the level of service - because you have those services agreed prior to your contract being signed. (Practice)

While another felt that it was the salaried option under PMS which lacked incentives:

Not salaried – (you're) always anxious to work more, produce more. Items of service - do more, get paid more. Salaried – (there is) no enthusiasm to do more – (you) just do the bare minimum. (Practice)

Respondents expected the new PMS contract to differ from the traditional GMS contract in a variety of different ways:

All the regulations around employment and all that - I think there's going to be the ability for greater flexibility in it. (Practice)

Eventually I can the see the advantage of not having to worry about filling in forms every time and all that, so it'll make it a lot less bureaucratic. (Practice)

It's going to be less cumbersome. (Practice)

(We) can adjust it to local/practice needs - to what we think is important. (Practice)

(One) can focus in on outcomes rather than process of healthcare delivery and by tailoring rewards and payments to outcome - coupled with internal flexibility in pilot - it opens a lot of new avenues for doing things in better ways. (It) increases professional fulfilment, (and) increases accountability to patients. Substantial streamlining of transaction business and reducing bureaucracy - though locally they were quite advanced in reducing bureaucracy anyway. (Health Authority Manger)

Some practice staff were uncertain what the changes would actually mean as, although they had seen drafts of the contract, it had not been finalized.

We asked our interviewees to identify particular advantages and disadvantages for different groups associated with the new PMS pilot arrangements, and they listed the following areas:

For:	**Advantages**	**Disadvantages**
HA	• Understanding models of primary care • Less paperwork – could reduce staff • Streamlining transaction costs • Clear deliverable objectives for a given population • We're a health authority with a pilot!	• Staff losing jobs Time consuming • Where does this fit with PCGs? Crosses PCG boundaries Possible financial risk
Trusts	• Experience of primary care • Accelerate development of fully integrated PHCT	•
Patients	• Accessibility over 3 sites • Coordination of nursing care • Better, clearer information • Treatment closer to home	• Salaried service may affect continuity of care • Increasing size – affect on patient knowledge of practice staff • Less choice of registering with s/h
Practice	• Fits into our long-term plan • Being at the forefront of developments. • Working towards one goal • Coordination of nursing care • Provides a better service more economically • Multi-disciplinary PHCT	• Time consuming • Problems of communicating with a larger group • Pilot = an experiment. Will it work or not? • Creating barriers – boundaries drawn around PMS pilots
Pilot staff	• Less paperwork • Personal/professional fulfilment • Reduce isolation	• Salaried status?
Local GPs	• Learning lessons from the PMS pilot	• Creates divisions and fragmentation
Others	• Learning for PCGs • Liaison with other local practices	•

Respondents at the practices gave a very negative response of their experience of drawing up a local contact (the contract still hadn't been signed at this stage):

Very painful! (Practice)

Very unhappy. (Practice)

Tortuous and tedious! (Practice)

Opinions varied as to whether staff at the practices felt that the Health Authority had provided sufficient support to draw up the local contract:

They've tried hard. They've tried very hard. (Practice)

No - a lot of fundamental issues (are) not answered - I still haven't seen a contract. (The) budget with the health authority (is) a key issue. (Practice)

The pilot had sought a variety of external advice to enable them to draw up their contact:

We've had legal advice and financial and accountancy advice. (Practice)

Respondents at the Health Authority also felt negative about their experience of drawing up the PMS pilot contract, and questioned whether the scale of the project necessitated such a level of input:

Tediously difficult. (Health Authority)

Painful and unproductive.... time consuming. (Health Authority)

There is something about scale – I feel more comfortable if I am putting time into negotiations with PCG size populations/PC groups – (it) feels worthwhile rather than lots of time for 5 principals and 10K populations. (I) don't feel (the) service needs to be that different at this low level of focus. (Health Authority)

Unnecessary..... (We) will be able to achieve enough with the freedom within the new structure of NHS. (We) shouldn't have to sit down with expensive lawyers and knock out a 90 page contract. (Health Authority)

Quality of Primary Care Services in the practices

The practices all felt that they provided high quality services:

... we get ourselves peer reviewed on a very regular basis through trainer assessment as well as through doing accreditation and all that kind of stuff on a voluntary basis, so we set ourselves very high standards basically. (Practice)
Good. (Practice)

Excellent. (Practice)

However, areas where they felt improvements could be made included:

- **... we haven't got a formulary. (Practice)**
- **Inconsistent standard of locums (Practice)**

- **Variable referral rates (Practice)**
- **Might benefit from a nurse practitioner to take some pressure off. (Practice)**
- **Premises (Practice)**
- **Appointments are a bit difficult with staff moving - biggest gripe with patients - they get to know GP and then they move on. Patients perceive they want continuity and appointments when they need them. (Practice)**
- **More reception staff (Practice)**

Staff were hopeful that being part of a PMS pilot would mean improvements to their practices:

> **(It) should improve it – (that's the) whole point of changing. (Practice)**

> **We are all hoping it will improve it - it WILL improve it! (It) should make us all feel worthy - that we're all working towards the same goal. (Practice)**

And they listed the following areas where they though improvements could be made:

- **I think our management structures will improve. (Practice)**
- **Common clinical protocols between the three practices. (Practice)**
- **Perhaps we might even move into single sites - one of the surgeries may wish to merge with us, so we'll be providing care for a larger number of patients, so probably the amount of services we can provide will improve. (Practice)**
- **Care of the elderly (Practice)**
- **Possible provision of primary care services not currently available eg chiropody. (Practice)**
- **Might be able to do different hours of appointments for example afternoon appointments which we haven't currently got, for example for mothers. (Practice)**
- **Possibly better provision for care when surgeries are shut - could extend cover so wouldn't have to employ deputising services. (Practice)**
- **Patients want to book appointments, be seen, and don't want to go off to different places. They just want things to move quicker - it's up to us to support them in what they want to do. This should help. (Practice)**

Health Authority Priorities/Impact on the PCG

Respondents at the Health Authority felt that they had clear priorities for primary care development:

> **We've got very clear programmes of development for premises, practice staff and use of GMS cash-limited budget. (Health Authority)**

Specific areas mentioned included:

- intermediate care services for elderly
- greater support for single-handed Gps

- integration of community services
- premises
- staff development
- broader work on PCGs
- development of new community hospitals
- to understand what is meant by clinical governance in primary care
- to see that the HIP is consulted on by PCG and reflects local needs
- to ensure that primary care is resourced to take on these challenges
- the development of community pharmacies
- extending the role of pharmacists

The timing of the setting up of the PMS pilot amidst all the arrangements for setting up PCGs was mentioned:

> **(We've been) taken over by events, (and are) now acting on government priorities. (Health Authority)**

However, none of our respondents at the practices were able to give details of the Health Authority's strategy for primary care development in their area.

> **I don't think the HA have actually set out any priorities. They haven't got a primary care strategy. (Practice)**

> **I'm not sure I understand what you mean by Health Authority priorities. (Practice)**

Because staff were so uncertain about Health Authority priorities, they were unable to say whether their practices had influenced the Health Authority in the past. However, some felt that learning from the PMS pilot might be helpful in the future:

> **If we can shift parameters and do different things - if this works out, the Health Authority might adapt things from us - that's why we're piloting. (Practice)**

> **We've been led by Health Authority for a while now - you can see the corner being turned now - different priorities are coming in from the community - rather than being imposed. (Practice)**

It was suggested that the move towards PCGs may have overtaken the importance of learning from PMS pilots:

> **No – I don't think it will (*influence Health Authority priorities in the future*). It's small and only for 3 years. They'll be moving into larger groupings - that's more what they'll be concerned with. (Practice)**

However, others thought that the learning from PMS pilots might be important for PCGs:

> **I think the primary care groups will have a lot to learn from the lessons of PMS pilots. (Practice)**

I think the PMS pilot is like a PCG in a different sense, but it's something similar, I think it's a different way of trying that out, I would have thought. It's all about contracts, wider groups, deciding how to spend money, where to put emphasis. My understanding of why we're doing the pilot - to modify the PCGs and because, as far as I can understand, it's not quite clear how the PCGs will work in practical terms - nobody knows how the budget is going to be allocated, who says what, what the dynamic structure is, what the hierarchical, if any, structure will be, and I think that's quite important if you're going to have such a large group. (Practice)

Impact on other local providers of care

Staff in the practices felt that their PMS pilot status could potentially impact on other local providers of care in a number of different ways, both positive and negative:

- A streamlining of services, with Community Trust staff seconded to the pilot.
- Possibility of local practices learning from the lessons of the PMS pilot.
- With common protocols, referral rates could go down. Hospitals reliant on income could therefore get less income from the pilot.

Roles, workload and job satisfaction

Morale was judged by respondents to be variable:

Personally, I think it's pretty reasonable. I quite enjoy general practice. (Practice)

Medium, not because of the work I'm doing but more because of the setting. I actually feel more confident in the clinical work and the patients, I feel good about that, but its more the managerial side around it and decisions which I think have to change in the future. (Practice)

Good - it's a lovely job, a lovely practice. Very content. (Practice)

Do you really want me to tell you? .... (It's) morale in general, nothing to do with the pilot. (Practice)

Not very great. (Practice)

None of the GPs we interviewed felt that their roles would change as a result of taking part in the PMS pilot. Other members of staff weren't so sure:

Possibly – (it) depends on how much the doctors intend to amalgamate admin - this isn't clear at the moment. (Practice)

Yes, I'm prepared for it to change, but (I'm) not sure what direction. (Practice)

I think we've all just got to be more flexible and just take on roles that may not traditionally have been ours, but make it more cohesive. (Practice)

It was generally felt that the roles of some other members of staff could change:

I think the community attached staff may change, yes. Not actually the employed staff within the practice. The attached staff, like health visitors and district nurses may have a slightly different role. (Practice)

Central telephone answering - .... would affect receptionists. Central computer – (would) affect appointment booking (Practice)

The potential for job satisfaction to increase by being part of a PMS pilot was considered a possibility by some of the respondents, but not by others.

I think it will increase it, yes. I think I'll feel more in control, and I'll be able to develop primary care services without having to worry too much about secondary care. (Practice)

Nursing is evolving so fast, it's hard to keep up. This is so new - we've got no guidelines to follow..... Eventually it'll be wonderful! (Practice)

No. (Practice)

No. Not positive, anyway. (Practice)

None of the GPs we spoke to felt that workload would increase as a result of taking on PMS pilot status, though it was pointed out that a lot of time had been spent on preparatory work, getting ready for the PMS pilot:

Until now, (there's been) a lot of time-consuming financial work. (Practice)

The practice nurse we interviewed felt that workload could change, but she wasn't sure in what way:

I expect it to alter, but I don't know where, in what direction. Nursing is flexible, we can change with what's needed. You think on your feet anyway - it's the nature of the job. (Practice)

Efficiency Savings

Opinions in the practices varied as to whether the pilot would be able to make efficiency savings:

Yes. (Practice)

Yes - I hope so. (Practice)

I think, probably. (Practice)

I don't think so. (Practice)

No - not in the first year. (Practice)

Areas where savings could potentially be made included:

Rationalizing the management and administrative structure (Practice)

Not recording individual items (Practice)

There was general agreement that the Health Authority would be seeking savings from the pilot:

Yes - that's their driving force. (Practice)

Yes, they've got to want that, haven't they? (Practice)

The health authority would like us to do the savings..... (Practice)

I don't think they'll have any right to. (Practice)

Areas where respondents thought the Health Authority might look for savings included:

- Staff salaries.
- Prescribing.
- In-patient treatments.
- Referral rates.
- Elderly care.

Respondents at the Health Authority did feel that savings might be possible, although not necessarily in the short term, and listed the following areas where they thought that savings could potentially be made in PMS pilots:

- Within the admin and management support systems of the practices.
- Premises
- Rationalising workforce
- Offering new services
- Prescribing

Influence on clinical behaviour

We asked whether involvement in the PMS pilot would influence clinic behaviour. Interviewees varied in their responses:

No. (Practice)

No. (Practice)

I hope not - but it might do, (such as) referrals. (Practice)

If we have more involvement - I think at the moment it's all happening a little bit removed from us, but yes, I think so. (Practice)

The practice nurse we interviewed felt that there were extra roles that nurses could take on:

Nurses (are) more and more doing minor ailments.... nurses can triage and allow GPs more time for other things. With more training I could take on more roles - since I've done diplomas I'm more able to take things on, (for example the) asthma clinic is virtually nurse-led, obviously with doctors around if needed. Most things I'm happy to do at the moment. The more competent I am, the more I can take on. Asthma, diabetes, family planning, travel health is all mine, on a good day! (Practice)

Evaluation

We asked respondents what success criteria they would choose for evaluation, both in the long-term and in the short-term. The following areas were suggested:

- In the first year I think you should concentrate around relationships between practices, within practices and with the primary health care team and with the Health Authority. In the second year, in subsequent time, it should be any changes in clinical care provision, service developments and the impact of the salaried service doctors.
- Personal satisfaction of members
- Personal satisfaction of patients
- Clinical outcomes
- Budget
- Smear rates - a high %?
- Time to get an appointment - going up or down?
- Waiting time in surgery - going up or down?

Some respondents were unclear about criteria for evaluation, which they said was due to lack of clarity around the objectives for the pilot as a whole, and their lack of understanding of it:

So difficult to answer. Nobody knows what the aim is, none of the doctors, none of the FHSA. (It's) difficult to know what to evaluate. (Practice)

When I've seen the contract, and know what we're doing, I'll know what to evaluate! (Practice)

Respondents at the Health Authority similarly saw the first year evaluation to be based upon the building of relationships between the practices:

(The) extent to which the 3 practices have now cemented relationships. (Health Authority)

Internal dynamics. (Health Authority Manager)

Other areas suggested by respondents at the Health Authority where the evaluation could look at included:

- The extent to which good practice has been developed in all 3 practices.
- The level of support for the 2 smaller practices.
- That clear health improvement objectives are achieved for year 2.
- Better access and information for patients.
- How use of nurses impacts on success.
- Numbers, range and mix of practitioners.
- Scale, efficiency and range of disciplines involved.
- Measurable health outcomes.
- Some clarity of what pilot objectives are.
- Changes in patient perceptions - are they aware of health promotion?
- For the elderly, are there reductions in admissions?
- Has the number of prescriptions/PU gone done?

Pace of change

As in other practice-based PMS pilots, it was suggested that changes to the way in which services were provided would not happen immediately, but would start to be seen in years two and three:

> **For patients - I think the real benefit for patients hasn't actually come through yet because we're generally functioning as before and that's what we've been doing. In the first 12 months, we actually deliberately took that decision - there weren't going to be any major changes. It's really building the relations in the first 12 months. I think in the second and third years the patients will start benefiting. (Practice)**

> **The development process is still going on. Year one means no change, but a chance to work out what changes for later. (Health Authority)**

Clare Jenkins
June 1999

Appendix 8

King's Fund PMS publications

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