Isleworth Centre Practice
Personal Medical Services (PMS) pilot

King's Fund Evaluation Report
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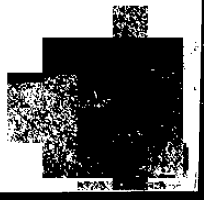

Table 3 (p. 14) amended 10/4/03

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Executive Summary

Background

The Isleworth Centre Practice PMS pilot was set up as a 'greenfield' practice by the Hounslow and Spelthorne Community and Mental Health Trust (HSCMHT) in response to the perceived lack of primary care in this part of Isleworth. Earlier needs assessment work in the area suggested that population levels in the locality were rising and that, as local branch surgeries closed, primary care provision was not keeping pace with population growth. Based in a local authority day care centre, closed due to lack of funding, it was planned that the PMS pilot would employ a comprehensive primary care team and provide a full range of services under a 'PMS plus' contract. Given permission to 'go live' by the Secretary of State for Health in April 1998, the practice (the only PMS pilot project within the Ealing, Hammersmith and Hounslow health authority area) opened its doors in September. Employing two job-share general practitioners in one whole-time-equivalent post and a range of other staff, the practice grew rapidly, registering up to 80 new patients a week at one stage, and had 1300 patients registered at the end of the first twelve months. The aims of the practice were:

- To provide a full range of Personal Medical Services to the population of Isleworth
- To reduce health inequalities amongst this community
- To offer this community the full range of extended primary care services
- To deliver, through various contractual arrangements, co-ordinated services which cut across traditional NHS and local authority managerial boundaries
- To provide this service through a multi-skilled and multi-professional primary care team, including the employment of a salaried GP and a specialist nurse
- To promote local primary care in general by working closely with local providers, including local GPs, to provide advice about the services available in the area and how they can be accessed

The King's Fund has been working with the Isleworth Centre Practice 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 and a focus group with key stakeholders, a patient satisfaction questionnaire (GPAS), a registration questionnaire, 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 practice. With the exception of the interview schedules, registration questionnaire and focus group, the research tools used in the Isleworth Centre Practice 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 Isleworth Centre Practice 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 Isleworth Centre Practice over its first three years as a PMS 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 interested partners have been collected through 31 interviews
- The implementation of the pilot's proposals to work more collaboratively with a range of other organizations has been assessed through a focus group including pilot and key staff from a range of partnership organizations
- The views of patients have been analysed through the use of a patient satisfaction questionnaire
- The demographic characteristics of patients newly registering at the practice have been assessed using a registration questionnaire of new patients
- 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 pilot, in common with around a third of first-wave PMS pilots across England, set up a new model of providing primary care with a community trust as key provider organization.

- Close collaboration between the trust and the health authority was reflected in the strong management of the pilot from the most senior levels of the two organizations. Pilot steering group meetings were held regularly and included representatives from a wide range of local organizations. Local groups were consulted widely at the outset – giving so-called 'people power' to the project.

- Despite the keen interest in the pilot from both trust and health authority, pilot staff felt that lines of communication were made difficult because key decision makers in senior positions were not based on-site. They felt that having to clear decisions with 'a million people' first, there was a tension between their full clinical responsibility for patients, and their lack of administrative autonomy. This was extremely problematic. This finding was reiterated at the other trust-led pilot in the King's Fund evaluation.

- The list size grew rapidly and practice staff were concerned about their ability to balance accessibility with providing high quality services. The practice list was closed temporarily to allow the pilot to 'draw breath'. This caused some consternation locally, with the accusation by other GPs that the pilot GPs were *"wimps"* for not being able to manage a list less than half the size of neighbouring practices.

- However, there was anecdotal evidence that patients with high levels of need were being referred to the practice from other local practices and also by the Community Health Council. Practice staff described their list as being made up of a high proportion of patients with complex needs who generated a high workload. This raises the question whether 'specially targeted' practices need a higher staff-to-patient ratio than more 'mainstream' practices.

- Patient satisfaction scores on 'receptionist' and 'practice nursing' scales of GPAS were high. It was notable that 76% of patients said that they saw a practice nurse over the past 12 months – higher than any of the other eleven practices taking part in the King's Fund PMS pilot evaluation (apart from one nurse-led pilot). This suggests that patients are making use of the comprehensive primary care team based in the practice.

- However, patient satisfaction for a range of other scores, such as accessibility, continuity of care and knowledge of patient was low in comparison with National Evaluation PMS pilot practices. There may be a number of reasons that help to explain this. The practice population is young, and younger people are known to be more critical in patient satisfaction questionnaires of the services they receive. The local population is mobile and may not be able build up strong relationships with practice staff over many years and obviously, as a brand new practice, patients would have been registered at the practice for a maximum of 24 months at the time they completed the questionnaire. However, this low satisfaction rating may also be cause for further investigation.

- Particular points of concern highlighted by patients were the lengths of time they waited to make an appointment with a doctor (whether any doctor, or a doctor of the patient's choice), and also the length of time they waited for the appointment to actually begin. Evaluation work carried out at the health authority suggests that consultation times at the practice are long, and often very long. As a consequence, Isleworth patients surveyed in GPAS were more happy with the amount of time the doctor spent with them than in the other three PMS pilots taking part in the King's Fund evaluation. There is clearly a difficult balance between offering long consultations on the basis of need and the ability of patients to make early appointments. However, over half of Isleworth GPAS respondents said that they would like the practice to be open for additional hours in the evenings and at the weekends.

- Both job-share GPs left the practice after the first year, and there are obvious implications in the employment of salaried GPs on continuity of care, highlighted by patients in the results of the patient satisfaction questionnaire.

- The practice scored highly in the angina audit survey in comparison with National Evaluation PMS pilot practices, although the sample size for the Isleworth practice was extremely small. Scores on the practice profile questionnaire, similarly, were higher than National Evaluation PMS pilots on three out of four domains (with the exception of the chronic disease management score).

- Practice staff were enthusiastic about the opportunities co-location brought them to work more collaboratively with a range of other organisations such as Barnardo's and the NSPCC. However, there was a sense of disappointment that a greater degree of partnership had not been built up with the local authority and the police, for example, and that, in some cases, services had been withdrawn from the building. Respondents at the focus group found working more closely with colleagues in primary care beneficial to their work with patients.

- Senior trust staff were very enthusiastic about the pilot project and its achievements. A dissonance of views was observed, with practice staff being more downbeat about the innovations they had made, and about how different their practice really was from a more traditional GMS practice. This was a common finding in all four PMS pilot practices taking part in the King's Fund evaluation.

- Practice staff reported that the pace of change and steep learning curves involved in setting up a new practice had been underestimated from the outset. High workloads, reportedly caused by the demands of patients with high levels of need, meant that staff felt they did not have the time to do anything other than 'see patients'.

Conclusion

Staff at the Isleworth Centre Practice have assessed themselves as providing high quality primary care, and scored highly on practice profile and angina audit questionnaires. However, concern was expressed by practice staff about their ability to maintain high levels of quality primary care as the list size increased. Patient satisfaction levels were variable across the nine domains of care measure by GPAS, but generally low compared to the national evaluations. It is worth considering the extent to which levels of quality are due to a 'PMS effect'. On the basis of this evaluation, and on the findings from other London PMS pilots involved in the King's Fund evaluation, the answer would appear to be 'not yet'. While the practice has clearly achieved a great deal since it opened its doors in September 1998, the high expectations of staff in year one had given way to a more downbeat feeling of lost opportunities that a wider range of more innovative services had not been established more quickly.

Introduction to the Isleworth PMS pilot

The Isleworth Centre Practice PMS pilot was set up in response to the perceived 'gap' in the provision of primary care services in Isleworth, in the London borough of Hounslow. The PMS pilot bid document[1] described a situation where population levels had grown in Isleworth over the last 10 years (due to housing association developments); council estates had become more run-down and primary care provision had fallen as branch surgeries in the area closed. At the time the bid was written, there were no GP practices in the two wards of Isleworth North and Isleworth South, with a combined population of 20,000; the nearest health centre was three miles away, and, in addition, the lists of some local practices were closed. The demographic profile of Hounslow was described as young, with almost a quarter of the population being from ethnic minority groups. Deprivation levels were similar to those in deprived areas of inner London.

The aims and objectives of the pilot were as follows:

- To provide a full range of Personal Medical Services to the population of Isleworth
- To reduce health inequalities amongst this community
- To offer this community the full range of extended primary care services
- To deliver, through various contractual arrangements, co-ordinated services which cut across traditional NHS and Local Authority managerial boundaries
- To provide this service through a multi-skilled and multi-professional primary care team, including the employment of a salaried GP and a specialist nurse
- To promote local primary care in general by working closely with local providers, including local GPs, to provide advice about the services available in the area and how they can be accessed

The PMS pilot, led by Hounslow and Spelthorne Community and Mental Health Trust (HSCMHT) and offering personal medical services through the employment of a salaried GP working within a comprehensive primary health care team, was given approval to go live in April 1998 by the Secretary of State for Health. Total list size was predicted to reach 3000 at the end of the pilot's first three years, and it was envisaged that staffing would increase as the list size increased.

[1] 'Mind the Gap: filling holes in primary care provision in Isleworth' prepared by Hounslow and Spelthorne Community and Mental Health Trust and Ealing, Hammersmith and Hounslow Health Authority

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.[2] A first wave of 83 PMS pilots 'went live' in April 1998.[3] A second wave, which went live between October 1999 and April 2000, increased the number of pilots to nearly 300[4] 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.[5] 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.[6]

Practice characteristics

The Isleworth Centre Practice was set up in the Isleworth Day Centre, originally used by the local authority as a day centre for older people, but closed for financial reasons. The PMS pilot practice opened its doors for new patient registration at the beginning of September 1998 and twelve months after opening, a total of 1300 patients had joined the practice list. Table 1 below shows the numbers of clinical staff working at the practice and the number of patients registered.

Table 1: Practice staffing (clinical posts)

	Isleworth
Number of patients registered (Jan 2001)	1994
Number of GP principals (wte)	1.3
Number of nurse practitioners (wte)	0.56
Number of practice nurses (wte)	0.48

Wte = whole time equivalent

[2] Department of Health. Personal medical services pilots under the NHS (Primary Care) Act 1997: a comprehensive guide - second edition. London: NHSE, 1998.
[3] 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.
[4] Department of Health press release 99/0520. 32 new pilots takes total to nearly 300: additional personal medical services pilots announced. 1999.
[5] Department of Health press release 2000/0724. Local doctors and nurses voting with their feet for reform. 2000.
[6] Great Britain. Parliament. The NHS Plan: a plan for investment, a plan for reform. London: Stationery Office, 2000.

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 proportional to the size and complexity of the project. In addition, the Department of Health has commissioned a national evaluation,[7] 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.

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 3 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 and controls nationally.[8]

	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

[7] 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.

[8] 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.

Evaluation of the Isleworth PMS pilot

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

The Interviews

A major component of the evaluation involved 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 Isleworth PMS pilot

	Year 1	Year 2	Year 3	Total
Practice interviews	3	5	6	14
Health authority interviews	3	2	1	6
Community trust interviews	2	2	1	5
'Other' interviews		4*	2*	6*
Total	8	13	10	31

(* 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 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 respondent's permission, and detailed notes taken. Quotes used in this report have been anonymised, identified only by the organisation by which the interviewee was employed (for example, health authority, practice, Local Medical Committee) and by the year in which the interviews were undertaken. An example of one of the interview schedules 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 practices 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 was designed to assess those aspects of care 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. 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.[9]

[9] 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.

The General Practice Assessment Survey has been used twice during our three year evaluation of London PMS pilots (see Appendix 4), but only once in Isleworth and Lambeth, where patients would not have been registered for more than 12 months at the time we carried out the first survey. In Isleworth, the questionnaire was sent out in September 2000 to 200 randomly selected patients aged 16 and over, who had been registered for more than 12 months at the Isleworth Centre Practice. A reminder letter to non-responders was sent in October. The overall response rate at the practice was 48%, which compared favourably with other inner London practices in our study.

Results from the GPAS data collection and analysis in Isleworth 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 are 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.

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.[10] 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 is referred to in this report. The individual questions making up the four practice profile scales are given in Appendix 6.

Focus Group

We conducted focus groups at three of the fours 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. One of the key aims of the Isleworth Centre Practice PMS pilot was to work more closely

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

with co-located voluntary organisations, and we used this as a theme for our focus group discussion. In addition to the two King's Fund and three Isleworth Centre Practice staff who attended the meeting, four representatives from the London Borough of Hounslow, the Community Health Council, Ethnic Alcohol Counselling in Hounslow (EACH) and Age Concern attended the meeting. See Appendix 7 for key themes explored during the focus group.

The Registration questionnaire

This site-specific questionnaire was designed to provide a descriptive profile of patients registering at the Isleworth Centre Practice PMS pilot, to see how far the practice appeared to be registering the groups of patients it had set out to attract (Appendix 8). This was not replicated at the other three PMS pilot sites. The questionnaire was handed out to new patients registering at the practice during spring 1999, and a total of 99 were returned (a one in five sample of the adult practice population registered at the time the survey was carried out). The report outlining the findings of this study is given in Appendix 9.

In addition to the registration questionnaire, an attempt was made to investigate further the patterns of patient registration in the Isleworth area, both at the Isleworth Centre Practice and in neighbouring practices. However, despite repeated requests, the health authority was unable to provide the information that had previously been discussed with them.

The Findings

Summary of year one interview data

The main findings from the interviews we carried out in Isleworth in the first year have already been reported (Appendix 10). The main themes, which emerged, can be summarised as follows:

- The pilot was seen as having been 'very much a joint effort', resulting from close working between Ealing, Hammersmith and Hounslow health authority and the community trust. However, there was a feeling that support at the health authority did not come, at least initially, from the highest levels. Financial issues and the crowded agenda in the setting up of PCGs were felt to have played a part.
- The PMS pilot bid was developed with input from a large range of local groups, described as adding 'people power' to the bid. The bid was built on existing public health work that had been carried out in the area, and was able to identify a suitable building in which to base the practice. Despite support from groups such as the local authority and the Community Health Council, there was some local opposition to the pilot. The concerns of local GPs about the impact of the pilot on their list sizes appeared to lessen as the pilot became operational.
- Staff in the pilot practice, who were interviewed as they came into post, described the steep learning curves they had encountered in setting up a brand new practice. Perceived external pressures to 'go live' as soon as possible were described, which led to a feeling that the opening of the practice had been 'rushed' when a full complement of staff, equipment, computers and protocols were not fully in place.
- New patient registration happened more quickly than had been anticipated. However, morale in the practice was described as being high – 'it's new and exciting'.

By the time data collection was carried out in subsequent years, there had been some turnover of staff and patient numbers had increased to just under 2000 in January 2001. The themes arising from the various methods of data collection in years two and three included the following topics:

- Local contracting
- Quality of care
- Accessibility
- Partnership working
- Relationships with other organisations
- Roles
- Workload
- Trust-led primary care

The rest of this report considers the developments that have taken place in the PMS pilot in years two and three, 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. The Isleworth contract, drawn up between the community trust and the health authority, was described as being a 'very simple one about the delivery of services' (community trust, year 2), being more akin to a service level agreement than a re-working of the Red Book. The contract was not changed in the second year, although there were some outstanding funding issues, which needed to be addressed by the NHSE. In year three, the community trust did not intend to change the contract 'unless the health authority raises issues that they wish to be changed'. The contract did not include a broad range of clinical outcomes and process measures, and could be described as 'minimal' in terms of its level of detail. However, this is consistent with the findings of a survey of nine first wave PMS pilot contracts. [11]

Quality of Care

Staff at the Isleworth Centre Practice believed that they were providing a high quality service to patients:

> **...our doctors, nurses and receptionists provide a really, really excellent service for our patients. I'm really proud of the service we offer (practice, year 3)**

and at the focus group, one of the respondents spoke of her view of the high regard in which local residents held the practice:

> ***(The pilot is)* getting well known, they're trusted. In two years I haven't heard a bad word against them. We used to get loads of complaints, now there are none. They're prepared to listen. It's open, it's accessible, it's friendly, it's supportive and the public feel comfortable, which is strange for this area" (CHC, year2)**

However, there was concern from within the practice that increasing patient numbers made it more difficult to provide a high quality service:

> **If you only had 10 patients, you could provide a *perfect* medical service. If you had low numbers for the number of GPs you had, given that they're a needy population, you could provide a good service. We have average, moving towards above-average lists for the number of GPs hours we've got. You don't feel confident that you're providing quality – mainly because you don't have a chance to go back and check on it (practice, year 3)**

[11] 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.

The tension between list growth and the quality of care the team were able to provide was heightened by the emphasis staff felt the trust were placing on increasing the size of the list. This raises the issue over what level of quality can be offered, and the equity of service quality within the local area. It seems likely in the early days of the pilot at least, that service quality was relatively high due to the low list size registered at the practice. This changed as the pilot progressed. We used three data collection methods to assess more formally the quality of care provided in the practices – the angina audit, the practice profile questionnaire and GPAS, a patient satisfaction questionnaire.

The results of the angina audit are given in Table 3 below. Only three patients were identified as having angina who had also been registered at the practice for 14 months or more. That the practice was only able to identify a small number of patients with angina is not an unreasonable finding when the age/sex structure of the list[12] is compared with national morbidity statistics[13] – the practice population is very young (74% aged under 35 years), and more than half of the patients (57%) are female. The mean score calculated for the practice showed that it scored more highly than the five PMS pilot practices taking part in the National Evaluation, and also than the five matched control practices. 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 overall results.

Table 3: Angina Audit results for Isleworth Centre Practice PMS pilot

Practice	Mean score	Sample size	Std deviation	Min score	Max score
Isleworth Centre Practice	67.22	3	7.528	60	75
King's Fund PMS pilot practices*	69.93	14	20.75	20	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*

The results of the Practice Profile questionnaire are given in Table 4 below. They show that, in the Isleworth Centre Practice, as in both the National Evaluation PMS pilot practices and 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 National Evaluation data for year two, the Isleworth Centre Practice scored more highly on the organisation, access and prescribing scores and slightly lower than the sample of PMS pilot practices on the chronic disease management scale.

[12] List size in September 1999, to allow patients to have been registered for 14 months when the angina audit was carried out

[13] McCormick A, Fleming D, Charlton J. Morbidity statistics from general practice : fourth national study 1991-1992 : a study carried out by the Royal College of General Practitioners, the Office of Population Censuses and Surveys, and the Department of Health. London : H.M.S.O., 1995

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

Practice	Organization scale		Access scale		Prescribing scale		Chronic disease management scale	
	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2
Isleworth Centre Practice	66.7	100.0	75.0	100.0	40.0	80.0	*63.6	81.8
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

** missing data for this scale*

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. In the Lambeth and Isleworth PMS pilot practices however, we were only able to use GPAS once as sufficient numbers of patients would not have been registered at the practices for more than 12 months at the time of the first mailing. Detailed results from our use of GPAS in Isleworth can be found in Appendix 5. In summarising 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 Isleworth Centre Practice PMS pilot

	Response rate		Access		Recept-ionists		Continuity		Technical care	
	%	N	Mean	N	Mean	N	Mean	N	Mean	N
Isleworth Centre Practice	48	95	51.58	88	72.98	94	47.8	82	68.61	73
Nat Eval PMS pilots	64.8	2940	63.3	2877	69.5	2899	65.	2731	77.3	2530
Nat Eval Control practices	39.5	1751	63.5	1716	71.0	1730	69.	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
Isleworth Centre Practice	69.76	75	65.8	73	66.72	74	46.71	71	77.3	57
Nat Eval PMS pilots	75.3	2633	71.	2625	78.3	2631	59.1	2565	76.	1590
Nat Eval Control practices	73.9	1661	71.	1659	77.7	1656	61.4	1614	76.	1075

Scores were lower than National Evaluation PMS pilot practices and control practices for all domains except receptionists and practice nursing (see chart below). In some cases, scores were substantially lower, for example access, continuity and knowledge of patient. It is worth noting that three quarters (76%) of Isleworth respondents had consulted a nurse at the practice in the preceding 12 months, a

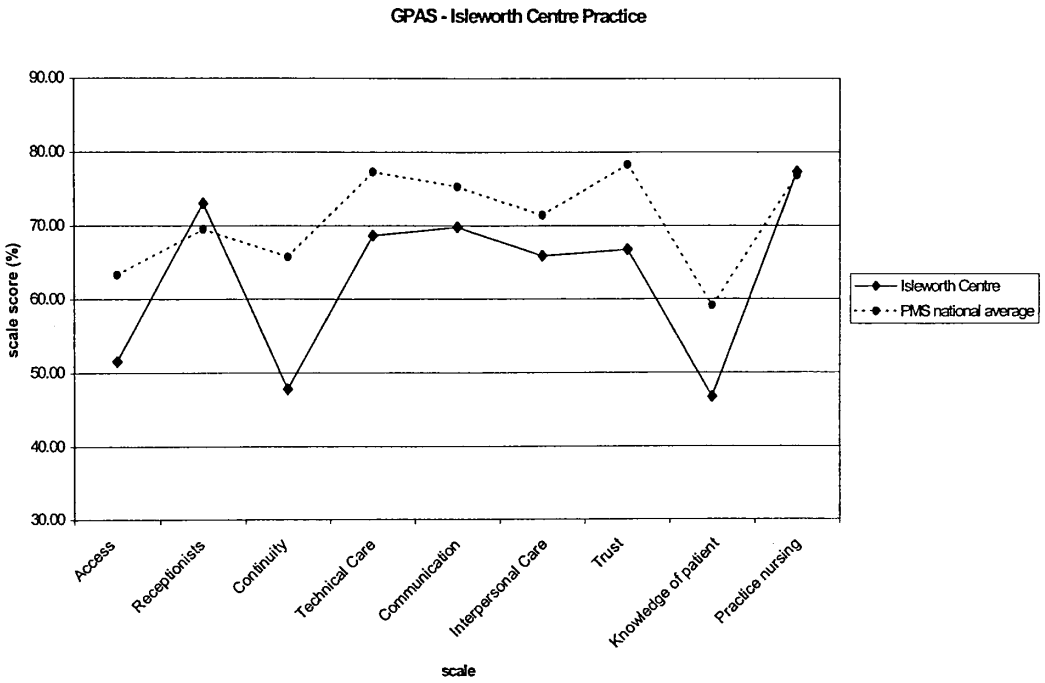
higher proportion than any of the other PMS pilot practices taking part in the King's Fund evaluation (apart from one nurse-led pilot). The overall scale score for continuity was low, and this may have been influenced by staff turnover in the second year of the pilot. It may be hypothesised that access and continuity are related. That is, a high degree of access may mitigate against continuity and vice versa. However, the pilot scored poorly in both of the domains. As the pilot is a new practice it is perhaps not surprising that the overall score for the knowledge of patient is low, and is likely to be related to the continuity scale score.

Overall access scale scores for the practice were also low in comparison to national comparator practices – Isleworth respondents to GPAS highlighted the length of time they spent waiting for appointments to start – two thirds of patients (66%) waited for more than 20 minutes, nearly a third (32%) waited for more than 30 minutes, and almost a quarter (22%) waited for more than 45 minutes, although it is worth pointing out that not all surgery sessions at the practice have booked appointment slots. Almost half (49%) of Isleworth respondents rated the length of time they waited for their consultation to begin as 'poor' or 'very poor' (this is 10% points higher than any of the other practices taking part in the King's Fund evaluation of London PMS pilots). They also recorded the number of days they waited for an available appointment (55% of respondents waited for four or more days to see a doctor of their choice, while 23% of patients waited for four or more days to see any doctor in the practice. This is significantly worse than the national access targets for primary care announced by the government and incorporated into the national contractual framework for PMS pilots. A total of 51% of Isleworth respondents rated the wait for an appointment with a particular doctor as 'poor' or 'very poor', and 39% 'poor' or 'very poor' for the wait to make an appointment with any doctor. In both cases, these scores were more than 10% points worse than any of the other PMS pilots taking part in the King's Fund evaluation.

There was clearly a level of patient dissatisfaction with elements of care provided in the practice – while 60% of respondents said that they were completely, very or somewhat satisfied with the practice, (the lowest satisfaction rating of the four King's Fund London PMS pilots), 18% said that they were very or somewhat dissatisfied with the practice. However, when asked how they would rate the amount of time the doctor generally spent with them, the Isleworth Centre Practice scored more highly than the other three London PMS pilots taking part in the King's Fund evaluation (80% rating it as 'good', 'very good' or 'excellent'). There is clearly a difficult balance to be made between offering longer consultations and the ease with which patients can make appointments.

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 are likely to be differences in the socio-demographic characteristics of the practice populations. 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.[14] It is also worth pointing out that the Isleworth Centre practice is a new practice and patients' perceptions of the quality of care they received were based on a maximum of 24 months experience of the practice. For several of the scales, patients who have had a chance to build up a relationship with a GP over many years may be more likely to score more highly than patients in a new practice. Additionally, it could be argued that many trust-led pilots have taken on more complex projects than traditional practice-based pilots, seeking to register often highly deprived populations and delivering services in a new way, which may impact on patient satisfaction levels.



When comparing King's Fund evaluation results with National Evaluation results, it is worth noting that none of the National Evaluation PMS pilot sites were in London or the South East. In the National Survey of NHS patients[15] 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.

Accessibility

One of the key aims of the Isleworth Centre Practice was to increase access in an area that was considered to lack primary care provision. While registration had occurred rapidly at the practice, suggesting that there indeed had been an unmet

[14] Gill Malbon, Clare Jenkins, Steve Gillam. What do Londoners think of their general practice? King's Fund, London. 1999.
[15] National surveys of NHS patients: General Practice 1998. NHS Executive, 1999.

need in the area, we wanted to look in more detail at the patterns of registration at the Isleworth Centre Practice and to answer a number of questions:

- Were new patients moving into the area from outside and registering for the first time in Isleworth?
- Or were patients choosing to transfer to the pilot from neighbouring GP practices?
- Was the practice meeting its aim of registering those who hadn't registered before?
- Had the numbers of patients deducted from local practices at a doctor's request (DDR) changed since the new practice opened?

After discussion with the health authority, we chose to look at a sample of the six Ealing, Hammersmith and Hounslow practices who registered sizeable numbers of Isleworth patients. The six practices we chose had between 23% and 78% of their patients living in the Isleworth area. An initial review of the registration patterns in these practices revealed that the numbers of registrations in four of the neighbouring practices had fallen by between 2% and 11% between December 1997 and December 1999, while in two practices patient numbers had increased by up to 5%. In the 16 months that the PMS pilot practice had been open, up to December 1999, registrations had risen to 1554 patients. However, despite agreement to do so, and despite numerous requests, the health authority was unable to provide us with this information.

Information from the registration questionnaire, carried out in the practice early in 1999, was designed to explore the socio-demographic characteristics of patients registering at the Isleworth Centre Practice. A total of 97 patients responded to the survey (representing around one in five of the adult practice population registered at the time). The table below compares registration questionnaire data, total practice population (in November 1999) and 1991 Census data for Hounslow and Spelthorne.

	Registration questionnaire (n=97)	Total practice population (Nov 1999)	1991 Census data
Age <45 years	77%*	87%	65%
Age >45 years	23%*	13%	35%
Male	34%	43%	49%
Female	66%	57%	51%
Housing tenure - owner occupied	30%	-	67%
Lone parent family	20%	-	3%
Ethnicity – Bangladeshi, Indian, Pakistani	8%	-	13%
Ethnicity – Black	3%	-	2%
Ethnicity – White	86%	-	82%
Ethnicity - other	3%	-	4%

* of total responders to questionnaire (aged 17+)

The practice population was more likely to be younger and female and slightly more likely to be White than the population of Hounslow and Spelthorne overall.[16] The

[16] Health area monitor: 1991 Census, North West Thames Region. London: OPCS. 1993.

proportion of single-parent families and those living in rented accommodation was substantially higher than those recorded in the census. While these figures allow us to compare the practice population with the population of Hounslow and Spelthorne overall, they do not tell us how different, or not, the practice population is from the registered populations of neighbouring practices. While those for whom English was not a first language might have been unable to take part in the survey, refugees and asylum seekers made up 4% of practice questionnaire responders.

The convenience of the practice location was mentioned by 79% of responders to the practice registration questionnaire. Almost a half of responders to the question asking how they had heard of the practice said that they had seen the practice whilst going past. Data obtained from the stakeholder interviews produced some mixed views as to the location of the practice. While some were positive, others felt that the surgery should have been sited nearer the Ivybridge Estate:

....they couldn't have picked a better place, slap bang in the middle of where there was nothing previously. There are so many new housing developments – it's a really useful place.... (practice, year 3)

It's at the edge of Ivybridge, and I'm not sure it's reached the people we'd hoped. Social Services are in the building and the building is a good asset to the community. It's super – but I'm not sure that was what the pilot was about (PCG, year 2)

It hasn't helped the population it originally was set up to – the Ivybridge Estate population – because it's sited too far away (LMC, year 2)

Apart from location, the other aspect of accessibility mentioned by interview respondents was the availability of appointments and waiting times. This was clearly a concern to patients, and articulated in the responses to the GPAS questionnaire, the results of which have been outlined above.

We get lots of different views about appointments here – one group of patients who *love* the open surgeries and who *love* being able to just drop in, and then it's mostly the people we're not targeting – the ones who work in well-paid professional jobs where they can't take time off easily who whinge about it... (practice, year 3)

Complaints are around the time they have to wait when they get here - it's an open system in the morning. It's not unusual for people to wait for three to four hours – that's a long time to wait, especially with small children. People are waiting from 8 o'clock and the GPs don't start till 9.30am. The GPs do try to give them a bit of quality time, but to do this, you need appointments. By 9.30 the waiting room is choc-a-block. But this is what the patients wanted (practice, year 3)

***(the patients)* feel the GPs have got the time to sit and listen. That's what the patients say to me..... In other surgeries, they've got their five minute slot, its 'oh, take these pain killers, we'll send you up to the specialist' without getting at what the basic problem is (practice, year 2)**

While patients appreciate the length of time the GP is able to spend with them, they are less happy with other aspects of accessibility.

Partnership working

One of the areas respondents were most positive about in the setting up of the Isleworth Centre Practice was the opportunity to work more closely with organisations such as Barnardo's and the NSPCC whose offices were co-located in the building:

...with co-location it's greater than the sum of the parts – you get a dynamism and a cross-flow of ideas that you wouldn't otherwise get, even if you just provided the two services separately. And I think the other huge benefit is for the clients, the users themselves. If they come to a centre where they see that there's a nurse and a health visitor and a doctor AND a housing person, welfare rights person, and the police, it creates a better idea of what health is all about – that it's not just about going to the doctor and getting a prescription. People are being treated as a whole person, not just a collection of different problems (community trust, year 2)

By bringing in salaried GPs, there's been a much greater sense of partnership working from day one with voluntary organisations, police and local authority staff now in the building. It's an excellent model of primary care (PCG, year 2)

If the pilot hadn't happened we wouldn't have had the NSPCC...this has been the biggest impact on my work. I've been referring on to them. In the past my only recourse was to send on to a local child and family centre which was very, very expensive. Now that the NSPCC are here, we now put together a package where children can go to a playgroup for a couple of sessions a week and the local Social Services fund it - a very inexpensive, but amazingly effective package, but if we didn't have the pilot here, we wouldn't have that either. PMS and this have gone together, they're my lifeline (practice, year 2)

....it is really fantastic because you're actually working alongside in the same premises, with better communication... (focus group, year 2)

However, despite these very positive comments, there was a feeling that perhaps even more could have been made of closer working relationships, and there was a sense of disappointment that this had not happened:

Organisations such as Social Services, benefits advice, were very keen to put new services in, but don't have the money, so it's not happening. There are no CPN sessions, counselling, physiotherapy sessions, here. The expectation was that there'd be lots of new things here that haven't happened. The police have a room here, but the only time they've been here is for the official opening! (practice, year 2)

Our relationship with the local authority is a big disappointment...We're not working in partnership, we just rent the building off them (practice, year 3)

Some services, which had initially been provided by the practice, had been cut because of difficulties in providing reception cover to make appointment bookings:

We've had Benefits Rights here, which is very important, and the housing people *(but)* the receptionists are no longer taking appointments so the public aren't here any more, and the services have been withdrawn (practice, year 3)

Relationship with other organisations

One of the key messages from the first year interviews was the positive outcome of the close working relationship between the health authority and the community trust, although at the outset, support had not come from the highest levels within the health authority. In years two and three, the good working relationship had been maintained:

Since (*year one)* there's been tremendous support – we don't get any hindrance. The managers have been absolutely excellent (community trust, year 2)

Relationships with other organisations were thought to be more variable. On one hand, staff reported that neighbouring practices believed that the Isleworth Centre Practice was 'nicking patients', with local list sizes decreasing by a reported 300 patients a month. Conversely, there was a view that local practices were advising some of their more demanding, or geographically outlying patients, to register at the new PMS practice:

Initially, the perception was that GPs rapidly told their outliers to join us, and in some cases contracted their practice boundaries – Brentford practices saw it as an opportunity to lose their Isleworth patients. Anecdotally, patients have told us that if they didn't like their practice, they could join us (practice, year 3)

The relationship with the PCG was described by some members of staff as being quite positive, but less so by others:

***(they are)* supportive...They're certainly keeping us involved, just as they would any GMS practice (practice, year 2)**

....you hear one thing officially, sometimes I think many are very suspicious of PMS in general. Officially, they're supportive. Personally they're suspicious, but we're not penalised (practice, year 2)

A perception of preferential funding for the PMS pilot was reported by several respondents, as well as a view that resources had been given to the pilot at the expense of other local services:

> **We're still a bit of an anomaly. Other practices in the PCG are still wary of us. I get the impression that they think we shouldn't really be here – due to the misunderstanding that the health authority are throwing money at us. They think we're on a cushy number "oh, but you don't have to meet targets..." (practice, year 2)**

> **It's withdrawn a lot of resources from practices in the area (LMC, year 2)**

> **From talking to other practices, what they've found is that community staff – district nurses and health visitors – have been taken away. They've lost out on district nurse and health visitor input time-wise.... (LMC, year 2)**

One respondent felt that the practice was not as involved as it could be in the running of the PCG:

> **...it doesn't seem to have integrated into the PCG as well as other practices have. I'd say of the twenty PCG practices, there are four or five practices who are less involved, and the PMS is one of these (LMC, year 3)**

On a more positive note, respondents at the focus group were very enthusiastic about the degree of input the local community (through the Isleworth Network) had at the planning stage of the project. The Community Health Council were enthusiastic about the pilot, saying that they were able now to refer patients, who had been turned away from other practices, to the PMS pilot practice.

Roles

The setting up of the new practice led to the employment of two job-share salaried GPs, a nurse practitioner, a practice nurse and administrative staff. Health visitors were based in the practice for the first time. GPs and other practice staff we interviewed felt that their roles *were* different under PMS, but felt that this was perhaps due to the process of setting up a new practice:

> **In my previous jobs I've just had a clinical role – in this role there is far more communication, far more setting up systems, far more managing (practice, year 2)**

> **From speaking to other practice managers, I'd say yes *(my role is different).* I attend a lot of meetings they wouldn't. There are people looking around because we're a PMS pilot, and presentations (practice, year 2)**

However, none of the clinical staff we interviewed felt that their clinical roles had changed because of PMS. Self-reported morale amongst staff was variable for a variety of reasons – the most common being a sense of being overwhelmed by high workloads:

I enjoy working here, but it can be very stressful, and I can feel very overwhelmed (practice, year 3)

Several respondents pointed out the balance between freedom and responsibility for salaried GPs:

I'm not the boss. I'm being told what to do. On an irritable day, I'm quite annoyed that I don't have full responsibility – though I do clinically, so I would like the whole responsibility at times (practice, year 2)

It's a different role to be the doctor, but not the employer, and not to be able to make the ultimate decisions. But on balance, it's only happened on a couple of occasions that it's really riled me, for example, closing the list. If we were self-employed we'd just have done it and not told anybody.... (practice, year 2)

....there are various stages in your life when PMS is a good place to be, and there are stages in life when it isn't – and some people will like it, and some people won't... (practice, year 3)

Both the original GPs left the Isleworth Centre Practice in the second year, and two new GPs were appointed. Other staff had also left the practice, impacting, staff felt, on the day-to-day work of the pilot:

...there's been high staff turnover – of doctors and administrative staff, which has caused feelings of upheaval and insecurity (practice, year 3)

Efficiency, though, is affected by high turnover of staff – we try to cover, put things on hold....In my previous GMS practice there wasn't the turnover of reception staff there is here...Our reception and admin staff are VITAL to the running of the PMS – if we're even one down it's difficult – we have been two down sometimes (practice, year 3)

Workload

In the interviews we carried out in the first year, staff spoke of the variability in workload due to not being a 'steady state practice' – patient numbers were low, but there were high levels of administrative tasks as a result of setting up new systems:

There are times that we've all felt terribly overwhelmed in putting systems in place. I don't think other people know what it's been like here. I worry that we may be seen to be failing, when we're all working 100% (practice, year 2)

Of the staff who were able to make a comparison when we interviewed in year three, two felt that their PMS workload was comparable with that in previous GMS posts, and two felt that their workloads had increased.

Several respondents felt that the type of patient registering at the Isleworth Centre Practice was different from that in a standard practice:

> ***...(these are)*** **genuinely more demanding people who are dissatisfied enough to change their GP (health authority, year 2)**

> **I often feel that we have a lot more of the kinds of patients that other practices would shut their lists to. That's good, because that's what we were set up for, but it's very hard work. I often feel that our patients aren't very "well trained" if you know what I mean – they don't understand the processes, or how the NHS works, they ask all sorts of non-general practice questions, which I'm sure most GMS practices wouldn't get (practice, year 3)**

> **It is a very demanding practice – our patients need *time* (practice, year 3)**

Interview respondents at the practice, at the community trust and at the health authority all spoke of the steep learning curves and rapid pace of change that had occurred in the setting up of the new practice, and which had taken many of them by surprise:

> **None of us appreciated how long it'd take to get everything up and running. It's taking longer than we thought it'd take (practice, year 2)**

> **...we were taken by surprise by the amount of work involved and the depth of work.... (health authority, year 2)**

Practice staff found combining clinical work with setting up the new practice a difficult balance:

> **It's been very busy and I think we've all felt that we're trying to do standard practice work AND implement systems and set things up. We're all part-time and still have to see patients. We've got lots of meetings and it feels like there isn't enough time. There are great hopes and aspirations – but where do you get the time really? You feel quite frustrated (practice, year 2)**

> **...with one whole time equivalent we spend all our time doing daily surgeries.... (practice, year 2)**

Patient registration happened very rapidly, with practice staff reporting that up to 80 new patients registered during one week at the outset:

> **At the beginning, they were opening a can of worms, people hadn't seen a GP for months, years. It was like Custer's Last Stand initially (practice, year 3)**

At one stage, it was decided to close the practice list temporarily to new registrations, which caused disappointment to practice staff and drew comments from other respondents:

...because this is a pilot, everyone's looking, you know, and we have to write to the PCG and to the health authority and have a discussion and then it's in the paper: 'Isleworth Centre practice has been so successful and is overrun by patients and they've had to close their list at 1200' and yet doctors say '1200! You wimps, we've got 3000!'. It was page three of the local paper, it wasn't, like, front page, but it was open the first page, and it was top line right the way across the whole page. And you know, it was a temporary closure, a temporary halt, it wasn't even a 'this is the end of it', we were just drawing breath for a period (practice, year 2)

We were supposed to be meeting unmet need – now patients can't access us (practice, year 2)

They shut their list at 1200, which caused a lot of fuss. The average list size round here is 1800-2000. They said they couldn't cope. That was really very questionable. If you say you are a one-man practice then you should be able to do one man's work (PCG, year 3)

Some practice respondents felt that the practice's registration policy should have been clearer from the outset, and the practice now operates a strict set of criteria for the groups of patients they are able to register.

Trust-led primary care

One of the key frustrations highlighted by practice staff was running a general practice under the umbrella of a larger organisation, particularly related to getting decisions made when decision-makers were based outside the practice:

....you can't make your own decisions without clearing it with a million people first – and that's the frustration (practice, year 3)

In GMS practices, you'd ask the senior partner – the difference is that it's somebody within the practice – someone outside can't always appreciate the significance (practice, year 2)

The big organisation doesn't understand the small organisation's needs (practice, year 2)

Going through the Trust to get anything done takes such a long time – getting the cogs in the machinery to get moving – for example, it takes three months to appoint staff (practice, year 2)

The Trust hinders the *running* of the practice (practice, year 3)

This theme of a new PMS practice finding it difficult to work within the structures of a community trust was reiterated by the other trust-led pilot in the King's Fund evaluation. It also contrasts with the high degree of support from senior trust management. Clearly, enthusiasm and commitment does not automatically translate into practical support.

Summary

The Isleworth Centre Practice, which opened its doors in September 1998, registered patients rapidly and now has a list standing at just under 2000 patients. The pilot had been strongly managed from the outset, with commitment from the highest levels of the community trust and from within the health authority, although it was felt that the Chief Executive of the health authority was not 'on board' at the outset. Regular steering group meetings have been well attended by representatives from a range of local organizations such as the LMC, the PCG, and the local authority. The community trust, who initiated the project, were very positive about the achievements of the pilot:

It's been very, very successful, it really has (community trust, year 2)

I'm ecstatic about it (community trust, year 3)

However, these views are at one end of a spectrum, and don't necessarily reflect the range of differing views about the pilot. Significant concerns were expressed by the LMC, but this was a common finding from the other PMS pilot practices taking part in the King's Fund evaluation. There was a degree of disillusionment expressed by staff that, although workloads felt very high, the practice had not developed in the way that they might have hoped and this led them to feel that their new practice was perhaps not so different from a more traditional GMS practice:

The different ways of working haven't really happened. We're based in a centre and people just come to us - it doesn't feel any different to GMS (practice, year 2)

Having come here and all of us feeling very excited, it came to feel not so new. It feels a bit like any other GMS practice. The initial idea was to provide care in different ways, for example, doing "eating on a low budget" sessions. We were all very enthusiastic, but as the practice got bigger. We just didn't have the time to do it - or more interagency work (practice, year 3)

It's a small practice, so perhaps *(patients)* get LESS of a service...we haven't been able to add extras like some ex-fundholding practices. So, in some ways I think the patients get a raw deal. We're just like a non-fundholding practice (practice, year 2)

Practice staff expressed a tension between working independently within a practice being operated by a larger organization, in this case, a community trust. There was a widely held feeling that 'you can't make your own decisions', partly because higher management was not based on-site, and this resulted in a slow pace of change and frustration.

Certainly, in terms of providing additional services in an underdoctored area, the pilot does appear to have been successful in setting up a brand new service from scratch and at registering patients – although whether these patients are those who have

been unable to access primary care before, or those re-registering with a more local practice, is not clear. Anecdotal evidence from the stakeholder interviews, and confirmed by the CHC in the focus group, suggests that 'difficult' patients are being referred to the practice – it is worth considering whether such practices, which provide 'special' services, act as a magnet for patients that other practices do not want. This raises interesting and complex questions about 'specially targeted' practices being set up for certain types of patients. We would have liked to have looked in more detail at the movement of patients between practices in the Isleworth area over the lifetime of the pilot, but we were unable to access the information.

The pilot set out to work in different ways – forging links with other organisations – and it has been partly successful in doing this, and respondents at out focus group meeting were generally very enthusiastic about the benefits of closer working relationships with primary care. However, high morale amongst practice staff in the first year – "....it's new and exciting...." (practice, year 1) appeared to have given way to a more downbeat feeling that "...we haven't broken as much ground as was hoped" (practice, year 3). Practice staff talked about the high workloads brought about by their registered population, and the extra demands placed on them by this group of needy patients. The findings of the patient satisfaction questionnaire suggested that problems were being encountered in the length of time patients waited to make an appointment at the practice, the length of wait for the appointment to actually begin and a lack of continuity.

Isleworth Centre Practice PMS pilot has achieved a great deal over the last three years. The practice was set up in an under-doctored area, and the practice list grew rapidly. To describe the setting up of the pilot as 'more of a whimper than a bang' (LMC, year 3) seems somewhat unfair. However, practice staff felt that they could have achieved more especially in setting up new services and around establishing closer working relationships with a wider range of other organizations; and patient satisfaction with a number of issues, such as waiting times and continuity need to be addressed.

Isleworth PMS pilot: meeting local and national objectives?

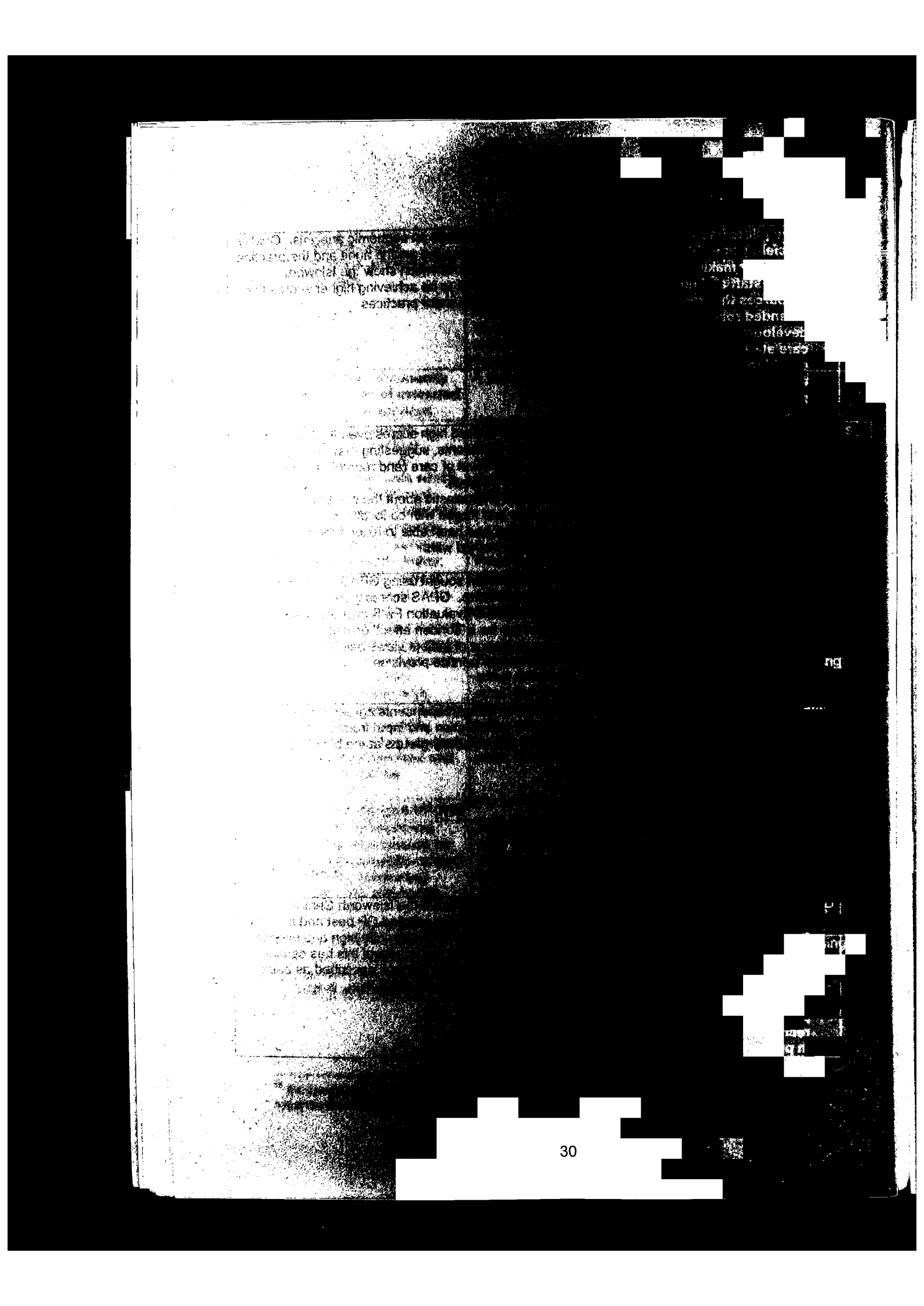
Local objectives[17]	
• **To provide a full range of Personal Medical Services to the population of Isleworth**	The practice had been successful in setting up a brand new service from scratch – providing a full range of primary care services in an under-doctored area. However, the list was closed for a short time. The pilot was founded on the basis of needs-based work previously carried out in the Isleworth area.

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

• **To reduce health inequalities amongst this community**	The practice had set out to register patients who had encountered difficulties in registering with a local general practice, and also those who had not registered previously. It is not clear whether this has happened, or whether patients have re-registered from neighbouring practices. The registration questionnaire suggests that the practice population broadly reflects the demographic characteristics of the local population.
• **To offer this community the full range of extended primary care services**	A comprehensive primary care team was established.
• **To deliver, through various contractual arrangements, co-ordinated services which cut across traditional NHS and Local Authority managerial boundaries**	Closer working relationships had been forged with agencies such as Barnardo's and the NSPCC, seen as being very positive. However, staff expressed regret that more partnership working had not evolved – and, in some cases, services had been removed.
• **To provide this service through a multi-skilled and multi-professional primary care team, including the employment of a salaried GP and a specialist nurse**	A comprehensive primary care team was established. Results from GPAS show that over three quarters of respondents saw a practice nurse in the previous twelve months, suggesting that patients are making use of the primary care team at the practice.
• **To promote local primary care in general by working closely with local providers, including local GPs, to provide advice about the services available in the area and how they can be accessed**	Representatives of the PCG regularly attend pilot steering group meetings, however some doubts were expressed about the level of integration of the PMS pilot into the PCG. Anecdotal evidence suggests that more needy patients are being referred from local practices to the PMS pilot practice, but the lack of data from the health authority meant that we could not investigate this further.
Key national questions[18]	
❑ **Have pilots improved *fairness* of provision by developing needs-related services, enhancing quality and improving access for disadvantaged groups?**	The original PMS pilot bid was based on earlier public health work which had been carried out in the locality. Respondents to the registration questionnaire stated that convenience of location was a major factor in their choice of the practice, but there was some feeling amongst stakeholder interviewees that the practice should have been located closer to the Ivybridge Estate.
❑ **Have pilots improved *accountability* to local communities and to health authorities?**	Interview respondents have been unanimous in describing a close and positive working relationship with the health authority.

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

❑ **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. Quality of care was assessed using the angina audit and the practice profile questionnaire, both of which show the Isleworth Centre Practice PMS pilot to be achieving higher scores than National Evaluation comparator practices.
❑ **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?**	The angina audit produced high scores overall, albeit with a very small sample of patients, suggesting that the practice was providing a high level of care (and recording data efficiently) to these patients. Practice staff were enthusiastic about the closer working relationships they had forged with co-located organizations, but wished that they had been able to extend the range of organizations they worked with.
❑ **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 and the patient registration questionnaire. GPAS scores were generally lower than the National Evaluation PMS pilot practices – although there may be a 'London effect' on scores. We did not collect any evidence of patient views being used as a basis on which to alter service provision.
❑ **Have pilots improved *integration* of local provision 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?**	Interview and focus group respondents agreed that there had been widespread consultation and input from a variety of local community and voluntary groups at the bid stage.
❑ **Have pilots introduced new *flexibility* in working relationships, organisational forms and employment arrangements which might improve professional morale, recruitment and retention in primary care?**	New posts have been created at the Isleworth Centre Practice, including a job-share salaried GP post and a nurse practitioner. Staff turnover has been quite high and interview respondents have described the upheaval this has caused. Morale at the beginning of the pilot was described as being quite high, but has been more variable since.



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 copyright: NPCRDC

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: Yes ❑ 1 No ❑ 2
(*Asthma, COPD,COAD, chronic bronchitis, AV block, peripheral (vascular disease, heart failure - CEF/CCF -, sick sinus syndrome, (marked bradycardia)*
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:

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 – NPCRDC 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 : atenolol

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

Appendix 4

NATIONAL PRIMARY CARE RESEARCH AND DEVELOPMENT CENTRE

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0 3
1

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 Always	☐2 Almost always	☐3 A lot of the time	☐4 Some of the time	☐5 Almost never	☐6 Never
b) How do you rate this?	☐1 Very Poor	☐2 Poor	☐3 Fair	☐4 Good	☐5 Very Good	☐6 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 personal aspects 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 agree or disagree 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 knows you, 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

Isleworth Centre Practice GPAS results

Table 1: response rates

	Isleworth Centre Practice
% overall response rate	48
base	95

Table 2: Socio-demographic characteristics of respondents

		Isleworth
Sex	% male	*29*
	% female	*71*
	base	93
Age group	% 16 to 24	*8*
	% 25 to 34	*38*
	% 35 to 44	*25*
	% 45 to 54	*11*
	% 55 to 64	*9*
	% 65 to 74	*4*
	% 75 and above	*4*
	base	91
Marital status	% single	*31*
	% married/cohabiting	*51*
	% widow/er, divorced or separated	*18*
	base	93
Ethnic group	% white	*78*
	% other	*22*
	base	91
Accommodation	% owner occupied	*37*
	% rented from local authority/housing association	*51*
	% rented from a private landlord	*11*
	% under other arrangements	*1*
	base	89
Car available?	% yes	*62*
	% no	*38*
	base	91

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

		Isleworth
How long have you been registered with your practice?	%1-2 years	*88*
	% 3-4 years	*9*
	% more than 4 years	*2*
	base	95
In the last 12 months, how often have you seen a doctor or nurse from your practice?	% none	*7*
	% once or twice	*23*
	% three or four times	*36*
	% five times or more	*34*
	base	95
Do you have any long-standing illness, disability or infirmity?	% yes	*36*
	% no	*64*
	base	91
How is your health in general?	% very good	*24*
	% good	*48*
	% fair	*23*
	% bad	*3*
	% very bad	*2*
	base	92

Table 4: Access scores

		Isleworth
Overall access score	%	51.6
	base	88
How would you rate the convenience of your practice's location?	% poor	*2*
	% fair	*9*
	% good	*88*
	base	95
How would you rate the hours that your practice is open for appointments?	% poor	*32*
	% fair	*29*
	% good	*39*
	base	95
What additional hours would you like your practice to be open?	early morning	*27*
	evenings	*51*
	weekends	*52*
How quickly do you get an appointment when you want to see a particular doctor?	% same day	*6*
	% next day	*6*
	% 2-3 days	*27*
	% 4-5 days	*20*
	% more than 5 days	*29*
	% does not apply	*12*
	base	94

Table 4: Access scores (contd)

How do you rate this?	% poor	*45*
	% fair	*20*
	% good	*23*
	% does not apply	*12*
	base	93
How quickly do you get an appointment when you want to see any doctor?	% same day	*22*
	% next day	*12*
	% 2-3 days	*37*
	% 4-5 days	*11*
	% more than 5 days	*10*
	% does not apply	*8*
	base	90
How do you rate this?	poor	*36*
	fair	*27*
	good	*30*
	does not apply	*8*
	base	90
If you need an urgent appointment to see your GP, can you normally get one on the same day?	yes	*52*
	no	*19*
	don't know/never needed one	*29*
	base	89
How long do you have to wait at the practice for appointments to begin?	% 5 mins or less	*6*
	% 6 to 10 minutes	*11*
	% 11to 20 minutes	*16*
	% 21 to 30 minutes	*34*
	% 31 to 45 minutes	*10*
	% more than 45 minutes	*22*
	base	89
How do you rate this?	% poor	*49*
	% fair	*34*
	% good	*17*
	base	83
How would you rate your ability to get through to the practice on the phone?	poor	*3*
	% fair	*14*
	% good	*78*
	% don't know	*4*
	base	91
How would you rate your ability to speak to a doctor when you have a question/need medical advice?	% poor	*14*
	% fair	*11*
	% good	*26*
	% don't know	*49*
	base	90

Table 5: Receptionists

		Isleworth
Overall receptionist score	%	73.0
	base	94
How would you rate the way you are treated by receptionists in the practice?	% poor	*2*
	% fair	*11*
	% good	*87*
	base	94

Table 6: Continuity

		Isleworth
Overall continuity score	%	47.8
	base	82
In general, how often do you see your usual doctor (not an assistant or partners)?	% always, almost always, a lot of the time	*43*
	% some of the time	*43*
	% never, almost never	*14*
	base	86
How do you rate this?	% poor	*20*
	% fair	*34*
	% good	*46*
	base	82

Table 7: Technical care

		Isleworth
Overall technical care score	%	68.6
	base	73
Thinking about the technical aspects of your doctor's care, how do you rate the following:		
Your doctor's technical knowledge?	% poor	4
	% fair	14
	% good	76
	% don't know	5
	base	76
The thoroughness of your doctor's physical examination?	% poor	4
	% fair	15
	% good	76
	% don't know	5
	base	74
The arranging of tests you need when you are unwell eg blood tests, x-rays etc	% poor	4
	% fair	8
	% good	72
	% don't know	16
	base	75
Prescribing the right treatment for you?	% poor	11
	% fair	12
	% good	75
	% don't know	3
	base	75
Making the right diagnosis?	% poor	9
	% fair	15
	% good	70
	% don't know	5
	base	74

Table 8: Communication

		Isleworth
Overall communication score	%	69.8
	base	75
Thinking about talking with your doctor, how would you rate the following:		
The thoroughness of the doctor's questions?	% poor	5
	% fair	13
	% good	81
	base	75
The attention the doctor gives to what you say?	% poor	7
	% fair	12
	% good	81
	base	75
Doctor's explanations of your health problems or treatments you need?	% poor	8
	% fair	13
	% good	79
	base	75
How often do you leave the surgery with unanswered questions?	% always, almost always, some of the time	12
	% some of the time	23
	% never, almost never	65
	base	74

Table 9: Interpersonal care

		Isleworth
Overall interpersonal care score	%	65.8
	base	73
Thinking about the personal aspects of care you receive from your usual doctor, how do you rate the following?		
The amount of time the doctor spends with you?	% poor	5
	% fair	15
	% good	80
	base	74
Doctor's patience with your questions or worries?	% poor	4
	% fair	16
	% good	79
	base	73
Doctor's caring and concern for you?	% poor	8
	% fair	19
	% good	72
	base	72

Table 10: Trust

		Isleworth
Overall trust score	%	66.7
	base	74
I completely trust my doctor's judgement about my medical care	% disagree	15
	% not sure	26
	% agree	59
	base	74
My doctor would always tell me the truth about my health	% disagree	4
	% not sure	34
	% agree	62
	base	74
My doctor cares more about keeping costs down than about my health	% disagree	55
	% not sure	29
	% agree	16
	base	73
How much do you trust your GP	(mean score: 1=not, 10=totally)	7.4
		74

Table 11: Knowledge of patient

		Isleworth
Overall knowledge of patient score	%	46.7
	base	71
Thinking about how well your doctor knows you, how would you rate the following:		
Doctor's knowledge of your medical history?	% poor	22
	% fair	25
	% good	53
	base	72
Doctor's knowledge of what worries you about your health?	% poor	26
	% fair	21
	% good	53
	base	70
Doctor's knowledge of your work and home responsibilities?	% poor	35
	% fair	29
	% good	36
	base	69

Table 12: Practice nursing

		Isleworth
Overall practice nursing score	%	*77.3*
	base	57
Have you seen a nurse in last year?	% yes	*76*
	% no	*24*
	base	75
How would you rate the attention the nurse gives to what you say?	% poor	*2*
	% fair	*7*
	% good	*91*
	base	57
How would you rate the quality of care the nurse provides?	% poor	*2*
	% fair	*5*
	% good	*93*
	base	57
How would you rate their explanations of your health problems or treatments you need?	% poor	*4*
	% fair	*7*
	% good	*89*
	base	56

Table 13: Non-scaled items

		Isleworth
Was there any time the doctor didn't refer you when you needed it?	% yes	*15*
	% no	*85*
	base	*72*
Does your doctor coordinate care you receive outside the practice?	% yes	*39*
	% no	*14*
	% does not apply	*46*
	base	69
Would you recommend your usual doctor to your family and friends?	% definitely/probably not	*19*
	% not sure	*17*
	% definitely, probably yes	*64*
	base	*75*
All things considered, how satisfied are you with your practice?	% completely satisfied	*13*
	% very/somewhat satisfied	*47*
	% neither satis nor dissatis	*22*
	% very/somewhat dissatisfied	*18*
	% completely dissatisfied	
	base	90

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

ISLEWORTH CENTRE PRACTICE
PERSONAL MEDICAL SERVICES (PMS) PILOT

FOCUS GROUP
At the Isleworth Centre Practice
Thursday 30 March
12:30-2:30pm

'IMPROVING WORKING BETWEEN PRIMARY CARE AND OTHER AGENCIES'

Thank you for agreeing to attend our focus group. This is part of an evaluation of the Isleworth Centre PMS practice that is being carried out by the King's Fund (we are an independent health charity).

The Isleworth Centre PMS practice is one of a small number of pilots established in the NHS to look at new ways of providing primary care. The Isleworth Centre PMS pilot has focused on:

- meeting the needs of patients who have previously been poorly served by primary care; and
- improving the relationships between primary care and other caring agencies (in both the statutory and the non-statutory sectors)

The purpose of this focus group is to consider progress in meeting the second objective. The focus group has been designed to obtain the views and perspectives of groups and individuals that work in the same area as the practice, in particular to understand the relationships that they currently have with the practice, or might have in the future.

At the focus group we want you to feel free to raise the issues that are important to you. Therefore, we shall not impose a structure on the discussion. However, you may find it helpful to consider the following questions:

- What has been your experience of working with primary care in the past or in other areas?
- What has been your experience of working with the Isleworth Centre practice?
- How would you describe your relationships with the Isleworth Centre practice?
- How successful have you been in working together with the Isleworth Centre practice to improve patient services?
- How might your relationships and joint working with the Isleworth Centre practice be improved?

We shall be writing up a report of the focus group and will, of course, send you a copy. Thank you again for your support in this exercise.

If you would like further details about this meeting please contact:
Clare Jenkins, The King's Fund, 11-13 Cavendish Square, London, W1M 0AN.
Tel: 020-7307-2689 Fax: 020-7307-2810 Email: cjenkins@kingsfund.org.uk

Appendix 8

Evaluating the Isleworth Centre Practice

146 Twickenham Road, Isleworth, Middlesex, TW7 7DJ
Tel: 0181-321-3604

The Isleworth Centre Practice was opened in September 1998. One of the aims of the project is that our services are available to ALL groups of people living in the Isleworth area. For this reason, we want to find out who is currently registering with us, and are asking you to give us details about yourself, and the reasons why you chose to come to this practice.

The information we are asking you for will be kept confidential and will only be used for research purposes, to help us improve the work we do and to tailor our new services to the people of Isleworth.

We would be very grateful if you could complete the following questions. If you have any queries about any of the questions on this questionnaire, please ask one of the receptionists to help you. When you have filled in the answers, please return this form to reception.

If you have any queries or comments about the service we provide, please speak to one of our receptionists, or ask to see our practice manager, Nisha Pandit.

Thank you very much for helping us with our research.

Dr Liz Walker
General Practitioner

Dr Michelle Nunes
General Practitioner

Nisha Pandit
Practice Manager

About yourself

1. **Are you:** *(please tick one of the boxes)*

   male
   female

2. **How old are you?** *(please write in the space below)*

   ..... years

3. **Do you have any children aged under 16 living with you?**
   (please tick one of the boxes)

   Yes No

   (if yes, please write the numbers of children living with you in each age group in the spaces below)

   aged 0 to 4 years ..... Child/ren
   aged 5 to 9 years ..... Child/ren
   aged 10 to 15 years ..... Child/ren

   Are you a single/lone parent with sole responsibility for any of the above children? *(please tick one of the boxes)*

   Yes No

4. **Which ethnic group do you belong to?**
   (If you are from more than one ethnic or racial group, please tick the box you consider you belong to, or tick the 'other' ethnic group box and describe your ancestry in the space provided)

   White
   Black - Caribbean
   Black - African
   Black - other
   Please describe:
   .....
   Indian
   Pakistani
   Bangladeshi
   Chinese
   Other ethnic group
   Please describe:
   .....

5. **What language do you find easiest to use?** *(please write in the space below)*

   .....

6. **Do you consider yourself to belong to one of the following groups?**
(please tick whichever statements apply to you. Please note that you are FULLY entitled to use this service).

A refugee/asylum seeker to this country
A gypsy, nomad or traveller
None of the above

7. **Which type of accommodation do you currently live in?**

(please tick one of the boxes)

Owner-occupied
Rented from Local Authority
Rented from Housing Association
Rented from a private landlord
Living with your family/parents
Living in temporary accommodation
Homeless

If homeless, please describe your accommodation
(eg living in hostel, private-rented accommodation)

.....

Other *(please describe)*

.....

8. **What is your postcode address?**
(This information will only be used to see where patients using our practice live. It will NOT be used to identify individual patients).

.....

9. **How long have you lived at this address?**
(please write in the space below)

.....

10. **How many addresses have you had in the last two years?**
(please write in the space below)

.....

11. **Do you have any long-term illness, health problem or handicap which limits your daily activities (eg breathing, moving, thinking or feeling) or the work you can do?** *(please tick one of the boxes)*

Yes No

12. **Are you currently registered with a GP somewhere else?** *(please tick one of the boxes)*

Yes No

About why you chose to join this practice

13. **Why have you chosen to register with this practice?** *(please tick whichever statements apply to you. You may tick more than one box)*

It was recommended to me
It is convenient to my home
There is a female doctor here
I've just moved in to the area
I've found it difficult to register elsewhere
I was dissatisfied with my previous practice
Other reason
(Please give brief details):

.....

14. **How did you hear about the practice?** *(please tick whichever statements apply to you. You may tick more than one box.)*

I read about it in the local press
I heard about it via a community group
I saw it while I was going past
It was recommended by friend/family
It was recommended by someone else
(Please give brief details:)

.....

Other reason *(please state:)*

.....

Thank you very much for your help in completing this questionnaire. We hope to use the information you have given us to provide a better service for our patients.

Appendix 9

Findings from the Isleworth Centre Practice PMS pilot registration questionnaire 1999

Clare Jenkins
King's Fund
February 2000

Introduction

Isleworth Centre Practice opened its doors to new patients in September 1998. One of the aims of the new practice was to increase accessibility in an area where registration with a GP had traditionally been difficult. The Personal Medical Services (PMS) pilot proposal document[19] described the major population growth in the Isleworth area and reduction in General Medical Services (GMS) services over the last 10 years coupled with the marginalization of a population with increasing health needs. But how far was the practice registering the particular groups of patients it had set out to attract?

A registration questionnaire was designed by a group from the practice, the community trust and the King's Fund in December 1998 using questions from a variety of sources (Appendix 1). The questionnaire was revised after feedback from practice staff and others. Some of the questions were already being used by staff in the practice which had been adapted from the RCGP registration questionnaire (Appendix 2). The ethnic status question was taken from the 1991 census[20] and the long-term illness question was adapted from the General Household Survey (GHS).[21] Other questions were added: the accommodation and number of addresses and refugee/nomad status questions, together with the single parent and children's' ages questions were included as these were felt to give an indication of the registration of particularly marginalized groups in the area.

The questionnaires were handed out by practice reception staff in early 1999 to new patients registering at the practice. Overall, the questionnaires appeared to be filled in clearly – with very little missing data, but reception staff felt that the numbers of questionnaires returned were quite small when compared with the numbers handed out. A total of 99 questionnaires were returned during spring 1999. The total practice population in January, when the questionnaires were first used, was 747, of whom 495 were aged 17 or over. The completed questionnaires therefore represented a 1 in 5 sample of the adult practice population registered at the beginning of 1999, and a 1 in 11 sample of the current practice population (based on November 1999 figures). Two questionnaires filled in by children were excluded

[19] Mind the Gap: Filling holes in primary care provision in Isleworth. Proposal to set up a Personal Medical Services Pilot. Prepared for Hounslow and Spelthorne Community and Mental Health Trust and Ealing, Hammersmith and Hounslow Health Authority. November 1997.
[20] 1991 Census data provided by Ealing, Hammersmith and Hounslow Health Authority

from analysis. Obviously, because of the questionnaire's format (with the text closely spaced, in English) a proportion of the practice population would have been unable to complete a questionnaire, so the results inevitably represent only a partial picture of the patients at the Isleworth Centre Practice.

Using the 97 questionnaires as a basis for analysis, and the National Survey of NHS patients in general practice 1998,[22] the General Household Survey 1996 and the 1991 Census as comparisons where appropriate, the results were as follows.*

Results

Response rate

A total of 32 (34%) males completed the questionnaires and 62 females (66%) with 3 non-responders. This compares with the November 1999 practice population (n=1049, aged 17 years and over) of 40% male and 60% female. Questionnaires were therefore somewhat more likely to be returned by female patients than males when compared with the adult practice population. 1991 Census figures for the wards of Isleworth North and Isleworth South show that, in both wards, the populations aged 16 years and above were made up of 47% males and 53% females, confirming that the Practice has proportionately more female patients registered than in the local population overall.

Age/Sex mix of responders

Overall, questionnaires returned matched the age profile of the practice population (see Table 1). However, when looked at separately by the sex of the respondents, there were slight differences – the questionnaires returned slightly over-represented young men (aged 17-24) and under-represented men aged 45-54. Young women (aged 17-24) were under-

[21] Living in Britain: results from the 1996 General Household Survey. HMSO, London, 1998.
[22] National Surveys of NHS patients: general practice 1998. Department of Health, 1999.
* The base for the various data sources varies slightly – 1999 Census and General Household Survey 1996 data have been used from ages 16 years and above, the National Survey of NHS patients 1998 from 18 years of age and above, and practice data from 17 years of age and above. In each case, the age ranges referred to have been stated in the text.

represented, while women aged 25-34 were slightly over-represented. The numbers in each age category are relatively small.

Table 1: Age and sex breakdown of practice population and responders to questionnaire

	Practice population - All		Questionnaire responders - all		Practice population - Male		Questionnaire responders - male		Practice population - Female		Questionnaire responders - female	
Age	N	*%*	N	*%*	N	*%*	N	*%*	N	*%*	N	*%*
17-24	191	*18*	14	*15*	68	*16*	7	*22*	123	*20*	7	*11*
25-34	437	*42*	43	*45*	174	*41*	12	*38*	263	*42*	31	*50*
35-44	220	*21*	17	*18*	98	*23*	7	*22*	122	*19*	10	*16*
45-54	94	*9*	9	*9*	39	*9*	1	*3*	55	*9*	8	*13*
55-64	57	*5*	6	*6*	25	*6*	3	*9*	32	*5*	3	*5*
65-74	24	*2*	2	*2*	9	*2*	0	*0*	15	*2*	1	*2*
75-84	19	*2*	4	*4*	6	*1*	1	*3*	13	*2*	2	*3*
85-89	5	*1*	0	*0*	1	-	0	*0*	4	*1*	0	-
90+	2	-	1	*1*	1	-	1	*3*	1	-	0	-
Total	1049	*100*	96	*100*	421	*98*	32	*100*	628	*100*	62	*100*

(96 patients recorded their age, 94 specified whether male or female)

Lone-parent families

The registered population of the Isleworth Centre Practice has a younger demographic profile than the national average, with twice the national average of children under five, and also twice the national average of those aged 25 to 34, the majority of whom are female.[23] Nearly half of the Practice questionnaire respondents (47/97, 49%) had children aged under 16 living with them (14 male, 32 female, one non-responder). The number of children in a family ranged from one to five, and the mean number of children per family was 2.0 (n=95/47).

[23] Primary Care Act pilot: Mind the Gap. First year annual report of the Isleworth Centre Practice. Hounslow and Spelthorne Community and Mental Health NHS Trust. 1999.

Nineteen people (20% of respondents, n=19/97, and 40% of parents, n=19/47), classified themselves as being single or lone parents with sole responsibility for a total of 39 children aged under 16 (four of the single parents were male, and 15 female). The average number of children in a lone-parent family was 2.1, and ranged from one to four children. In families with two parents, the average number of children was 2.0 (n=56/28) and ranged from 1 to 5 children in the family. In the national survey of NHS patients, the proportion of single parents was 7% of all responders in England (the figures were not broken down by region), and the General Household Survey 1996 found that 21% of all families with dependent children were headed by a lone or single parent.

Ethnicity

The ethnicity question from the 1991 census was used to collect data on which ethnic group patients felt best described their ancestry (see Table 2). The question was answered by all but four respondents (n=93). The overwhelming majority of people classed themselves as 'white' (n= 80/94, 85%), with small numbers in the other groups specified. A total of eight people recorded their ethnic group as 'other' – either in addition to one of the other categories listed above (eg white, Polish), or as a separate group (eg Kurdish).

Table 2: Ethnic status of responders

	Questionnaire			1991 Census figures			
				Isleworth North		Isleworth South	
Category	**N**	**%**	**Grouped**	*%*	*Grouped*	*%*	*Grouped*
White	80	*86*	*86*	*86*	*86*	*87*	*87*
Black – African	1	*1*	*3*	*2*	*3*	*1*	*2*
Black – Caribbean	0	*0*		*1*		*1*	
Black – Other	2	*2*		*0*		*0*	
Bangladeshi	3	*3*	*8*	*0*	*7*	*6*	*7*
Indian	3	*3*		*6*		*1*	
Pakistani	1	*1*		*1*		*0*	
Chinese	0	*0*	*0*	*1*	*1*	*1*	*1*
Other ethnic group	3	*3*	*3*	*2*	*2*	*2*	*2*
Total	93	*99*	*100*	*99*	*99*	*99*	*99*

The ethnic composition of the group of patients who completed the Isleworth Practice registration questionnaire appeared to reflect fairly closely that of the 1991 Census data for the two Isleworth wards (aged 16 years and over). While there were some small differences in the composition of the practice population compared with the census data, it is worth remembering that the numbers of questionnaires analysed was small (n=97) and any differences could be due to chance. In the National Survey of NHS patients 1998, 81% of the responders in the London area classed themselves as being 'white', 7% 'black', 8% 'Asian', 1% 'Chinese' and 4% 'other'.

Language spoken

The Practice questionnaire asked which language people found it easiest to use, and 89% (n= 78/88, 9 non-responders) said English. Small numbers of respondents listed other single languages such as Bangladeshi, Gujerati, German, Polish, Portuguese and Somali, and some languages were mentioned in combination with English – Gujerati, Bangladeshi, Welsh and sign language. This figure compares closely to the 90% of London responders to the Survey

of NHS patients questionnaire who said that English was the language they spoke most often at home.

Refugees and asylum seekers

Four patients (4%) said they were refugees or asylum seekers (n=4/91, 6 non-responders), but none of our respondents classed themselves as a gypsy/nomad or traveller (n=0/91, 6 non-responders).

Housing

The PMS pilot proposal document described the local housing situation as being of particular concern in Isleworth. The council estates in the area were described as having become "more run down over the last 10 years, manifesting many of the problems associated with inner city areas of high deprivation". In addition, new housing association developments were reported by the Rowntree Foundation, to be characterized in general by extremely high levels of deprivation, with 95% of tenants qualifying for some form of benefits. We asked our respondents to record the type of accommodation they currently lived in and compared these with figures from the 1991 Census. Far fewer of the Practice questionnaire respondents lived in houses they owned, instead being much more likely to be renting from Housing Associations and private landlords (see Table 3). While it does seem that, in terms of housing tenure at least, the Isleworth Centre Practice is registering a different population from those in the Isleworth North and Isleworth South wards overall, it is worth noting that there has been rapid housing development in the Isleworth area in recent years. It is likely that the larger numbers of questionnaire respondents renting from Housing Associations and private landlords may, at least in part, be explained by the more general changes in housing tenure that have taken place locally in the eight years since the Census was carried out.

Table 3: Housing Tenure*

Type of accommodation	Questionnaire		1991 Census	
			Isleworth North	Isleworth South
	N	%	%	%
Owner-occupied	29	*30*	*65*	*46*
Rented from Local Authority	27	*28*	*25*	*44*
Rented from Housing Association	20	*21*	*2*	*3*
Rented from private landlord	16	*17*	*8*	*7*
Living with family/friends	5	*5*	-	-
Living in temporary accommodation	0	*0*	-	-
Homeless	0	*0*	-	-
Total	97	*101*	*100*	*100*

New to the area?

The Practice questionnaire asked people how long they had lived at their current address (n=96, one non-respondent). The results are shown in Table 4. More than half of our respondents had lived at their address for 24 months or less (n= 58/96, 60%), with 42% having lived at their current address for 12 months or less. The 1991 Census included a question which asked whether the person's current usual address was the same as it had been 12 months ago. In Isleworth North, 13% of persons aged 16 and over reported a different address 12 months ago, with 12% saying the same in Isleworth South. The responders to our questionnaire were therefore more than three times as likely to have moved within the last 12 months than the ward populations overall recorded in the 1991 Census. The Practice

* Persons classified in the 1991 Census as renting a property with a job or business have been omitted from these figures as a corresponding category did not appear on the Practice questionnaire. In addition, In Isleworth South, the 1991 Census recorded 0.43% of persons as living in non-permanent accommodation. The 1991

questionnaire was specifically given to new patients registering at the surgery, and it seems probable that a sizeable proportion of these may have been recent incomers to the area, although we know that at least some of Practice questionnaire respondents were moving from other practices in the area.

Table 4: How long have you lived at your current address?

	How long at current address?	
	N	%
0-6 months	26	*27*
7-12 months	14	*15*
13-24 months	18	*19*
25-36 months	15	*16*
> 36 months	23	*24*
Total	96	*101*

When asked how many addresses people had lived at in the last two years, the responses ranged from one to five. 46% (n=43/93, 4 non-responders) of people had lived at two or more addresses. This figure matches that of the previous question.

Long-term illness

The GHS question on long-term illness was adapted for inclusion on the Practice questionnaire. Overall, 18% of people (n=17/96, one non-respondent) said that they had a long-term illness, health problem or handicap which limited their daily activities. Results from the General Household Survey 1996 showed that 26% of respondents aged 16 years and above reported a long-standing illness, disability or infirmity which limited their activities in some way. Rates of incidence of recorded long-term illness tend to be higher in populations with greater proportions of older people – the Isleworth Centre Practice has a young

Census figures quoted are for the total ward populations – the Practice questionnaire includes only 16+ year olds.

population, so this may account for lower levels of self-reported long-term illness than in the general population.

Currently registered with a GP?

We asked whether respondents were currently registered with a GP somewhere else. More than four fifths of patients (85%, 82/96, one non-responder) said that they were not currently registered with a GP. We had intended that this question would find out how many patients were not registered with a GP at all. However, it seems likely that this question is ambiguous since 14 of the 82 patients (17%) who said they weren't currently registered elsewhere gave dissatisfaction with their previous practice as a reason for choosing to register at the Isleworth Centre Practice. Alternatively, it may be that some of the patients who completed the questionnaires filled them in some time after they had registered at the Isleworth Centre Practice. Results from the national survey of NHS patients shows that 1% of responders in London were not currently registered with a GP.

Why have you chosen to register with this practice?

We asked people why they had chosen to register at the Isleworth Centre Practice, and gave them a range of options to choose from (they could choose more than one). All respondents, except for one, recorded at least one reason why they had chosen to register at the Isleworth Centre Practice. The reasons given were as follows:

Reason given	**N (96)**	**%**
It is convenient to my home	76	*79*
There is a female doctor here	29	*30*
I've just moved to the area	25	*26*
It was recommended to me	18	*19*
I was dissatisfied with my previous practice	17	*18*
I've found it difficult to register elsewhere	7	*7*
Other reason	3	*3*

By far the most common reason given was that the practice was convenient to the patient's home (79% of respondents mentioned this), but other common reasons were that there was a female doctor at the practice (30%) and that the patient had just moved into the area (26%).

Three people added their own comments, these were:

- I liked the write up in the local press
- All other practices weren't taking on patients
- I had to wait too long for appointment to see doctor

How did you hear about the practice?

All but one respondents stated at least one way in which they had heard of the Isleworth Centre Practice.

Reason given	**N (96)**	**%**
I saw it while I was going past	45	*47*
I read about it in the local press	29	*30*
It was recommend by friend/family	27	*28*
It was recommended by someone else	13	*14*
I heard about it via a community group	1	*1*

Almost half of all respondents (47%) had seen the practice when they were going past, but other common reasons for learning about the practice were reading about it in the local press (30%), and recommendation from friends or family (28%). Of those who said the practice had been recommended to them by someone else, the majority did not record who had given them the information, although another GP or practice, the chemist and the Thompson Local Directory were mentioned in one case each.

For those patients newly moved into the area, the most common reason for hearing about the practice was by seeing it while going past - 72% (n=18/25) of newly-moved patients mentioned this. The most common reason for these patients to choose the practice was

convenience of location – again, 72% (n=18/25) newly-moved patients mentioned this. Patients who gave 'I've just moved into the area' as a reason for registering at the practice, had lived at their current address for an average of 6.8 months (range from one week to two and a half years). For those 71 respondents who didn't cite a recent move into the area, the most common reasons for having heard about the practice were: having seen the practice while going past and having read about the practice (27/71, 38% each) and the practice having been recommended by friends or family (24/71, 34%). This group of patients had lived at their current address for an average of 5 years (range 2 weeks to 36 years).

Again, there were three additional comments. These were:

- Another GP recommended
- The statement in the Informer was about the practice being part of the community. That's what is needed, plus the premises is modern not Dickensian, plus the doctors and staff are not off-putting.
- It was easier for me to get to from home

Summary of results

The Isleworth registration questionnaire was designed to investigate a range of socio-demographic characteristics of patients seeking to join the Isleworth Centre Practice list, and their reasons for choosing this particular practice. Questionnaire respondents appeared to broadly reflect the overall practice population in terms of age and sex and they reflected the local population in terms of ethnic background.

Lone-parent responders to the questionnaire made up over a third of all parents who took part in the survey, a high figure compared with those nationally. Housing status differed from the figures given in the 1991 Census quite markedly - there were fewer owner-occupiers, with more responders renting from local housing associations and private landlords. Refugees and asylum seekers made up 4% of Practice questionnaire responders, although language difficulties are likely to have prevented those for whom English is not a first language from taking part in the survey.

The reasons given for registration at the practice may reflect the difficulties that patients have had in the past in registering at a practice close to their home – convenience of the practice location was mentioned by 79% of responders. Almost a half of responders to the question asking how they had heard of the practice said that they had seen the practice whilst going past. This 'accidental' way of finding out about the practice appears to have been more effective than the publicity in the local press, although almost a third of responders said that they had read about the new practice in the paper. Recommendation was another important way of finding out about the practice – 28% had been recommended the practice by family or friends, and 14% had received a recommendation from somebody else. Newcomers to the area were most likely to have discovered the practice whilst going past it, rather than by any other means of publicity and to have chosen the practice for its convenient location rather than any other reason.

Appendix 10

Isleworth Personal Medical Services (PMS) Pilot
King's Fund Evaluation Feedback Meeting
Thursday 11 March 1999

Background

The Personal Medical Services (PMS) pilot bid 'Mind the Gap' (November 1997) outlined the setting up of a new primary care centre operated by Hounslow and Spelthorne Community and Mental Health Trust in partnership with Ealing, Hammersmith and Hounslow Health Authority. The community trust planned to employ a whole-time equivalent salaried GP, a clinical nurse specialist and a full range of other health care professionals to work in the pilot.

The level of primary care provision in the Isleworth area had fallen in recent years, health needs had grown and levels of deprivation ranked alongside those of deprived areas of inner London.

The pilot was set up in a building owned by the Local Authority (LA) – a day care centre for the elderly which was closed due to lack of funds. The practice recruited staff in the summer 1998, and opened its doors in September of that year. Registration has occurred more rapidly than expected – there are now more than 900 patients on the list.

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 Ealing Hammersmith and Hounslow Health Authority (n=3) and at Hounslow and Spelthorne Community and Mental Health Trust (n=2). In addition, interviews were carried out with staff at the practice, as they came into post (n=3). 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. Trust and Health Authority (HA) interviews took place between April and June 1998, several months before the pilot actually 'went live'. Practice interviews took place in September and October 1998. The responses to the interview schedules at least in part reflect the timing of the interviews – community trust and HA respondents spoke in more detail about the background to the pilot, the bidding and local contracting processes and their objectives for the pilot project. Practice staff, who were appointed after the pilot contract had been signed were less likely to talk about the background to the project, as they hadn't been involved at this stage, and to talk more about the practicalities of setting up a new service from scratch. If the same interviews were repeated now that the practice has been live for 6

months, the responses to the interview schedules would be likely to have a different emphasis again.
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 and then contracting; recruitment of practice staff, setting up the new service, going live and registering the first patients. Because of this ordering, the views of the community trust and HA respondents are more numerous at the start of the report and the comments from practice staff tend to appear later on – this simply reflects their major involvement at different stages of the project.

Initiation and setting up of the PMS Pilot

Respondents at both the community trust and the Health Authority saw the initiation of the PMS pilot as being something that had resulted from **joint working** between the two organizations.

> *"...developing the bid was 'very much a joint effort' between the parties involved".* (HA manager)

The project was seen as being firmly based on needs assessment that has already being carried out in the Isleworth area. Key players were seen as being Abi Gilbert and Julia Wightman, who had both worked in the local area. So, the pilot was viewed as **building** on work that had already been done or was ongoing.
The pilot raised a lot of enthusiasm, particularly from the community trust:

> "(PMS pilots were) ... *a heaven-sent opportunity, and tied in with the strategic direction of the Trust, so we went for it".* (Trust manager)

> *"...probably the best opportunity for this health authority that there has been for many years".* (Trust manger)

> *"In parts of the borough, primary care is underdeveloped. I'd be disappointed and quite angry if we miss this opportunity".* (Trust manager)

There was a perception that the community trust was innovative and go-ahead:

> *"... very entrepreneurial in approach - interested in developing new initiatives".* (HA manager)

However, interviewees at both the Health Authority and the Community Trust identified a problem from the start that the more senior staff at the Health Authority had not become involved until later on:

> *"...at the HA was 'middle-level' people which was where the interest lay in the subject...not being driven from the top".* (HA manager)

The reasons given for this were that financial issues at the HA were a priority, and the timing of the PMS pilots coincided with the move towards PCGs – a very crowded agenda.

Developing the bid

A lot of work was carried out in discussing the project with a wide range of other groups:

> *"We visited all* (GPs) *on the borders of the area asking - do you have a problems with this? How would you like to interface with this* (the pilot)?" (Trust manager)

> *"Local Authority - development work around the location of the PCAPS in the Isleworth Day Centre - the rent, use of the building. They've been a very supportive arm of the whole development - a good example of development approach".* (Trust manager)

> *"I visited all the directors in the Local Authority when I started here - housing, leisure, social services, also leader and deputy leader of the council, local politicians, Social services committee and Age Concern. Sounded them out. Tremendous support, which gave me the confidence to take it forward".* (Trust manager)

> *"The political dimension - LMC and HA, handled without problems, although the LMC are still watching it carefully".* (Trust manager)

> *"CHC - discussed it with them what the needs of the area were. At one point the CHC were to have a base in the day centre - not now".* (Trust manager)

> *"Sue Brown - head teacher of Smallbury Green Primary School - I discussed long and hard with her the needs of the new intake - 4 and 5 year olds".* (Trust manager)

> *...other PCAPS sites who've contacted us.* (Trust manager)

Support for the project from other groups was viewed by both the HA and the Trust as being strong. The Regional Office, the Community Health Council, local councillors and the Local Authority were all seen as being supportive. However, Trust and HA respondents described the level of LMC support variously as 'low', 'not supportive' and 'hostile'. Neighbouring GPs were initially suspicious, but it was evident that there was some misunderstanding about the role of the pilot.

> *"One GP said 'is it drop in centre like at Victoria Station'? They didn't realize we'd be registering patients and being a general practice."* (GP)

This position has changed somewhat as the pilot has become operational – there appears to be less suspicion now that pilot GPs have become more involved in local medical politics and the setting up of the primary care group (PCG).

One respondent felt that the project had generated a great deal of support locally, the motivation and support being from those on the ground, rather than being imposed top-down:

> *"... interesting thing for this project - support from external partners: LA, Ivybridge public health work, CHC, local community activists, people power to this project. There hasn't been equivalent support from statutory health partners. Also, temperature check demonstrated that individual practices - whether LMC or not, were very supportive of the pilot".* (Trust manager)

Contracting issues

Positive aspects of the traditional GMS contract listed by respondents were fairly few in number, limited to it being well established and a known entity:

> *"...well established, well tried,* (you) *know what pattern you get out of it..."* (HA manager)

Perhaps not surprisingly, since PMS seeks to replace the old-style contract with something better, general criticisms of the GMS (Red Book) contract were more numerous:

> *"...the GMS contract is a straitjacket that has little to do with patient care".* (HA manager)

> *"The inherent financial incentives lead to perverse incentives".* (HA manager)

Many of the criticisms of GMS related to areas where it was felt that PMS would/could improve the situation (and relate to areas in Choice and Opportunity such as flexibility, accessibility etc):

> *"It is hard to monitor whats going on and hard to change things - there are very few levers to effect change and to relate service to population needs".* (HA manager)

> *"...the old contract doesn't suit every practitioner who wants to be in general practice eg women and older people - rather than saying that all who go into general practice must do it this way".* (Trust manager)

> *"It needs to be more flexible - apparent inflexibility - though groups of Gps have pushed at the boundaries and employed lots of other staff".* (Trust manager)

> *"The pilot is in an underdoctored area and couldn't get doctors into this deprived population".* (HA manager)

> *"GP practices not offering services that meet the special needs of the population in question".* (HA manager)

All these criticisms relate to a lack of flexibility in the old contract and PMS was seen as being a way to improve a whole range of areas, from the general:

> *"... a 'fresh start. We have just chucked out 50 years of the Red Book distorting what people do.* (The) *Red Book has a lot to answer for".* (HA manager)

> *"PMS changes peoples' thinking and attitudes..."* (HA manager)

To the more specific:

- Allows skill mix to be studied
- Allows access for a population who don't have good access at the moment
- Allows more flexibility
- Reduces bureaucracy

- Encourages collaboration
- Brings in social services and voluntary organizations
- Allows experimentation with the traditional 'GP as lead' role
- Allows experimentation with outreach

In fact, one respondent thought that PMS could allow a completely different way of working and thinking:

> *"If I'd joined an existing practice as a part-time GP I'd do my sessions and I don't think I'd have stopped to think about how I was consulting or tried to change anything. The way the project has been set up, I'm thinking about it all the time. In a traditional practice, I'd be maximizing Items of Service. In this practice, it's been the actual layout of the service, surgery hours, clinical care. I've had to think about them far more. In another practice I wouldn't have had so much leeway".* (GP)

Respondents were asked to list advantages and disadvantages of PMS for particular groups and these are as follows:

For:	**Advantages**	**Disadvantages**
HA	To monitor a GP service To show local GPs that being salaried is an option Attract better GPs than otherwise Learning to inform future primary care strategy To raise the HAs profile To be seen as forward-thinking GP services where there weren't any before	PMS an expensive way of providing GMS? Might need a lot of HA input Possible antagonism of local GPs Lost opportunity - if learning isn't used to inform change What if the project fails? Where does PMS fit in? Uncertainty – what happens after 3 years?
Trust	Getting involved in same business as HA – breaks down barriers To prove that a new provider CAN provide primary care services To raise the Trust's profile To be seen as forward-thinking Medication – cheaper for Trust to bulk buy Provides learning about primary care	Might threaten capacity – time consuming What if the project fails? Where does PMS fit in? Uncertainty - what happens after 3 years?
Patients	Access to services improved Can 'tap into' wide range of Trust services Empowering Knock-on effects eg to schools Don't have money 'attached to them'	GPs working to protocols – patients may not get what they want Expectations raised may not be delivered Uncertainty – what happens after 3 years?

For:	Advantages	Disadvantages
Pilot staff	Salaried option frees time and thinking Less bureaucracy Employment benefits Maximizing use of skills Better collaborative arrangements Career progression within Trust for PM Access to Trust services eg IT, finance Trust training available Trying to work as part of a larger team	What if traditional barriers aren't broken? Expectations raised may not be delivered Bureaucracy of the Trust (esp supplies) Learning curve – starting practice from scratch Only a three year contract
Local GPs	Could reduce their workload Learning from the PMS pilot	Concerns of local GPs re finance List sizes might go down
Others	Bringing the CHC closer More links with LA via co-location More links with voluntary sector	

Efficiency savings?

All those interviewed - both at the Trust and at the HA - acknowledged that the possibility of the PMS pilot being able to deliver efficiency savings is a difficult question to answer. There was general agreement between respondents at both the HA and the Trust that the HA have not indicated that they will be looking for savings. Such savings have never been attached to other primary care providers, and there are also the issues of unmet need in the area. Respondents felt that efficiency savings were not particularly likely, especially initially.

All staff in the practice thought that the HA would be seeking efficiency savings. They felt that savings could be made, but wouldn't happen immediately as start-up costs were high.

The experience of local contracting

The experience of local contracting was viewed very much as being an experiment involving working in unknown territory. However, it was acknowledged that this was likely to be the case for other PMS pilots as well:

> *"...challenging and unknown territory - but this seems to be a common experience".* (HA manager)

The Trust led on the drawing up of the contract, and felt that the HA were supportive on a philosophical and intellectual level. Management consultancy support was sought for putting the bid together.

However, the GPs felt that the contract wasn't that different from a GMS contract:

> *"I thought they WOULD be quite different - but the service contact drawn up by the Trust and the HA appears to be the same ..... for example, the requirement to state how many hours you're doing in the surgery, so I don't know how different it is".* (GP)

> *"... the only difference is the wording - GMS:PMS".* (GP)

Setting up a new practice

Recruitment

Staff at the practice were asked why they had been attracted to the possibility of working at the new practice. For the GPs the major attraction was the opportunity to work on a part-time basis so that their work fitted in with family commitments. Other important aspects included reduced commitment to financial and management side, protected academic time and the valuable experience of setting up a practice. For the other staff member interviewed, the increased accessibility that the PMS pilot would offer was important:

> *The fact that it was primary care - different from traditional general practice, not motivated by finance. I saw people in my previous job in secondary care who hadn't been able to access primary care.* (Practice manager)

Making the practice operational

Practice staff described the steep learning curves involved in setting up a completely new service on a new site. Areas mentioned included:

- Equipment which took time to order
- Practice staff were recruited and came in to post gradually
- Protocols and task lists were not immediately in place
- Computers were installed just before the opening – staff were still being trained
- Patients were "tramping the stairs with builders about"
- It was perceived that there external pressures to be seen to 'go live' as soon as possible
- Registration has taken place at a much faster rate than anticipated

Other new PMS pilots have described similar experiences.

Particular priorities for development

Respondents at the practice were asked where they felt particular priorities for development were. These relate to the development of new services ranging from getting the basics in place to a list of areas where new services could be set up:

"What I want to establish is all the ORDINARY services because we're new and this isn't set up". (GP)

Specific areas mentioned included behavioural problems in young children, diabetes, asthma and health promotion for example.

Priorities listed did not just refer to setting up new services, but to **working** in a different way. Areas mentioned included:

- Educating people.
- Enabling ethnic minorities able to access services and to overcome language barriers using Trust interpreters
- Providing high quality services for marginalized or vulnerable groups. As one respondent said "I'd like to see a lot of refugees, homeless - when they go to general practice, they don't have nice services. I'd like to see them getting nice services just like anyone else". (GP)
- Dealing with patients in a different way. One respondent talked about the difficulty some patients have in accessing primary care and suggested that staff attitudes in general can be important. "The way we are to patients for example, receptionists - not being confrontational, judgmental. Educating non-clinical staff not to judge people". (Practice manager)
- Providing a range of appointment lengths and setting appointment times and lengths depending on need.

Roles and workload

Staff acknowledged that their current roles and workloads were affected by the fact that the practice was new (and some staff were carrying out tasks they wouldn't normally expect to do). They were spending time networking and linking people in. A lot of time was being spent setting up and learning new roles. By year two they felt they would be more confident and the practice population might be more stable.

While it was thought that bureaucracy would decrease, patient numbers will increase, leading to an increased workload. All PMS pilots are involved in evaluation and this will mean extra work:

"When you're evaluating something, you're constantly thinking about it. Training practices are much better than others because they're always thinking about how they're providing their service - the same with us". (GP)

Neither GP felt that involvement in a PMS practice would directly affect their clinical decision making with individual patients – but felt that they would be able to offer access to a different range of services.

Morale was judged to be good:

Morale is high at the moment, as it's new and exciting. (GP)

The team is very good, we work very well together... (GP)

Evaluation

Respondents were asked to list success criteria for the PMS pilot project – for the long term and for the short term. The following areas were listed:

Short term:
- list size
- Patient satisfaction
- Clinics set up eg asthma, diabetes
- Registration of patients not previously registered with general practice

Long term:
- related to GMS – levels of screening being undertaken
- Map where patients come from and then consider outreach
- Are the HA happy with the service being provided?
- Change service provision in response to user views
- Annual reviews for patients with diabetes
- Some measure of mental health improvement
- Impact of quality of care on other measures eg perinatal mortality locally
- How the project impacts on wider determinants eg back to work, housing
- The impact on 'educating patients' in how they use the practice

The majority of these areas are being covered in the evaluation so far (some are very descriptive, others covered in the 'hard to reach populations' questionnaire). The impact on the PMS pilot on some of the areas mentioned (especially the last four) are unlikely to be seen in the 3 years of the project's lifetime.

Summary

The following section summarises themes that have emerged from the interviews, and introduces some areas for discussion:

Positive aspects

- Joint working between the Trust and the HA – very much a joint effort (both Trust and HA acknowledge this)
- Enthusiasm for the project (especially from the Trust)
- Perseverance in setting up and developing the proposal
- Development work – Trust staff went out to meet local stakeholders and explain the project to them
- Support from other groups eg LA, CHC, council, local groups
- Local political support
- 'People power' to the project – support from the ground
- The project built on work already undertaken and ongoing – Abi Gilbert

- Based on identified need – 'the gap' of the bid title
- Enthusiasm for respondents about the possibilities for new ways of thinking
- Rapid registration

Negative aspects

- Support variable from different levels of staff at HA – CE 'not on board' at start
- LMC not supportive
- Some local GPs suspicious
- Steep learning curves of setting up a new practice
- Rapid registration (affects capacity of practice?)

Other themes (which did not necessarily emerge from the interviews):

- Membership of steering group tries to be inclusive – includes LA (social services and housing) and LMC. Our other pilots don't have such broad representation.
- Trust approach (entrepreneurial, go-ahead)
- Publicity – press releases in all local papers, Pulse and GP. Official opening – Frank Dobson.
- Building available in good location
- Isleworth Network – capital challenge funding
- Future of project in doubt in early stages (May 1998) – HA/Trust meeting "if it needs stopping, we should stop it now..."
- LMC opposition around MPC (LMC asked for a copy of the approval), cover for out-of-hours, whether GPs would be qualified eg on minor surgery register, diversion of GMS monies to PMS, whether prescribing budget would be cash-limited or non cash-limited etc.

Questions from the Evaluation

What learning have the HA taken on from the first year of the PMS pilot?
What learning have the Trust taken on from the first year of the PMS pilot?
How will this learning assist second wave pilots?
How will this learning assist in the development of primary care trusts?
Is the PMS pilot addressing priorities it set out in the bid?
What are the expectations of the evaluation?

Clare Jenkins
March 1999

Appendix 11

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